Sex tourism in an era of globalisation, technology, harm reduction and disease migration

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Abstract

Background

There is a well-developed body of literature on sex tourism, a phenomenon that is experienced in almost every corner of the world. While extant literature depicts the complexity of sex tourism, it does not acknowledge the extent to which globalisation has irrevocably changed the industry. To date, there is a distinct lack of examination and understanding of the theoretical aspects of sex tourism that effectively conceptualise the intricate phenomenon within a contemporary worldview. For clarity, this thesis defines sex tourism as a phenomenon involving tourists, planned or spontaneously purchasing sexual services or experiences.

Aim

Sex tourism is a multifaceted and complex phenomenon. Using existing visual and theoretical frameworks and extensive analyses of literature, a model was created to depict the contemporary realities of those involved in the sex tourism industry. Using the country specific context of Thailand, this research took a public health and social science approach to map out sex tourism by drawing on the situation of sex workers, tourists, healthcare professionals, and community workers, as well as wider global forces such as technology, human rights, law enforcement, sexual health, and healthcare provision.

Methodology

The research consisted of four stages. Stage 1 was a critical analysis of extant literature, resulting in the development of an initial, conceptual sex tourism model. Stage 2 was an empirical, pragmatic, qualitative study, using unstructured and then semi-structured interviews with community workers, healthcare professionals, tourists, and sex workers. The interviews explored the unmet needs of stakeholders involved in sex tourism. Following this, the interviews sought to understand increased risky sexual behaviour in the context of globalisation; analyse the impact of technology on relationships between tourists and sex workers in Thailand; and discuss required changes to UK public health and social policy, clinical practice, and sexual health programmes. Stage 3 analysed and compared findings generated from

Stages 1 and 2. Stage 4 scrutinised and refined the contemporary sex tourism model based on the combined findings from the previous stages, as well as presenting a sexual health patient pathway for tourists before travel and upon return to the UK.

Results and future research

To date, the holistic conceptual model is unique as it was built upon existing bodies of work whilst incorporating distinctive aspects of the industry that have not yet been considered in the field. The model consists of interacting, multi-level associations. Whilst the separate micro, contextual, meso, and macro levels are versatile, decision-makers and practitioners will be equipped to understand sex tourism in its entirety. The model should be used to inform international public health policy, practice and investments in country specific contexts. Following acceptance of the conceptual model, further empirical research should be undertaken to prove the validity and reliability of the model, adapt it where necessary, and expand the scope of the current research.

Key words

Sex tourism; sexual health; HIV; disease migration; model; globalisation; service provision

Declaration

No portion of the work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning;

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Abbreviations

AMR	Antimicrobial resistance
APCOM	Asia Pacific Coalition on Male Sexual Health
Apps	Applications
ART	Antiretroviral treatment
BASHH	British Association for Sexual Health and HIV
BBV	Blood borne virus
BHIVA	British HIV Association
C&C	Capability and capacity
COVID-19	Severe acute respiratory syndrome coronavirus 2
CSAM	Child sexual abuse material
CW	Community worker
DfID	Department of International Development
ECCG	European Collaborative Clinical Groups
FCO	Foreign and Commonwealth Office
GAS	Gender affirmation surgery
GBV	Gender-based violence
GP	General practitioner
HIC	High income country
HIV	Human immunodeficiency virus
HPV	Human papillomavirus
HRA	Health Research Authority
HSV	Herpes simplex virus
IPV	Intimate partner violence
IRAS	Integrated Research Application System
ISSWSH	International Society for the Study of Women's Sexual Health
IUSTI	International Union against Sexually Transmitted Infections
LGBTQ+	Lesbian, gay, bisexual, transgender, queer, plus
MNC	Multinational corporation
MSM	Men who have sex with men
NHS	National Health Service
NGO	Non-governmental organisation
NSWP	Network of Sex Work Projects
PEP	Post-exposure prophylaxis
PLWHIV	Person/people living with HIV
POC	Point of Care
PPE	Personal protective equipment
PrEP	Pre-exposure prophylaxis
RD&I	Research, Development and Innovation
REC	Research Ethics Committee
SRS	Sex reassignment surgery
STI	Sexually transmitted infection
SWING	Service Workers in Group
SWOP	Sex Workers Outreach Project
TGSW	Transgender sex worker
UHC	Universal Health Coverage
UK	United Kingdom
UN	United Nations

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Conference Presentations

Alyson Hillis. *Why is sex tourism changing the way we look at sexual health?* [oral presentation and poster]. LJMU PHI PhD Symposium. July 2019

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Alyson Hillis. *The motivations, sexual behaviours and public health implications of people who travel for sex (PWTFS) to Thailand* [oral presentation] Public Health Institute internal seminar. February 2021

Chapter 1: Introduction

1.1 Introduction

1.1.1 Sex tourism

'*Travelling represents a symbolic liminal process whereby the tourist leaves a familiar place, arrives at a new destination and then returns to the familiar place…By entering the liminal state associated with travel, a person can express things that he or she would otherwise suppress*' (Garrick, 2005, p. 498). Escapism (Black, 2000), '*fantasy enactment*', '*wish fulfilment*' (Ryan and Kinder, 1996, p. 507), anonymity, and the removal of inhibitions (Benotsch et al., 2006; Brisson, 2017) are key motivations for individuals to travel, whilst also potentially engaging in the sex industry. In 2019 international tourist arrivals had grown to 460 million annually (UNWTO, 2021); yet this must be taken in the context of a 95% decline in the first five months of 2020 due to the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2 or COVID-19). With approximately 20 to 34% of international travellers engaging in casual sex while abroad (Keystone, Workowski and Meites, 2019)[1], the tourism industry undeniably markets sex as an alluring and pleasurable mainstream entertainment product (Yeoman and Mars, 2012). Sex tourism is, therefore, not a deviant form of tourism but a norm in relation to the activities that take place when an individual travels (Ryan and Kinder, 1996).

Since the 1980s, sex tourism research has investigated tourists' travel motivations in a bid to define the phenomenon (Graburn, 1983; Hall, 1992; O'Connell Davidson, 1996; Ryan and Kinder, 1996; Oppermann, 1999). Oppermann (1999) departed from traditional definitions of sex tourism as travelling for commercial sex, by exploring the relationship between the tourist and sex worker. Ryan and Kinder (1996, p. 507) described the overlapping '*liminality*' of sex work and tourism as separate behaviours

[1]Here Keystone, Workowski and Meites (2019) define sex tourism as '*travel for the specific purpose of having sex, typically with commercial sex worker[s]*'. However, they define casual sex as '*informal sexual encounters with fellow travellers or locals. Although some travellers may expect to have casual sexual encounters, others who have sex do not*'.

that '*operat[e] at social thresholds*', while Bauer and McKercher (2003) and others discussed how sex and tourism are symbiotic (Bender and Furman, 2004; Eaglen and Maccarrone-Eaglen, 2005; Garrick, 2005). Interpretations of sex tourism widened to incorporate pragmatic global relationships, with literature making connections between the '*global and local*', and drawing '*attention to both the production and consumption of sexual services*' as well as the greater external forces that shape its determinants (McMichael and Beaglehole, 2000; Wonders and Michalowski, 2001; Guise, 2015). Once sex tourism was recognised as an intricate and complex phenomenon, research began to tackle it from specific angles, focusing on travel for intentional and planned sexual experiences and emphasising the exploitative nature and economic inequalities (Bauer, 2014; Tolson, 2016; Brooks and Heaslip, 2018; Xu, 2018; Kock, 2020). Whilst some literature discusses consensual, affirming, and non-transactional encounters (Xu, 2018), this thesis concentrates on commercial sex tourism, taking a public health and social science approach. It defines sex tourism similar to that of the Centers for Disease Control and Prevention (CDC, 2019), as a phenomenon involving tourists, planned or spontaneously purchasing sexual services or experiences.

At the same time, this thesis also recognises that the expanding reach and intensity of globalisation has become the driver of contemporary sex tourism (Singh and Hart, 2007). The process of globalisation is taking place at an unprecedented rate due to the interdependency of countries across the world (McMichael and Beaglehole, 2000), propelling the spread of knowledge, migration, diseases, and communication (Buse et al., 2002; Koplan et al., 2009). Our globalised system exacerbates the socio-economic disparities of populations by stripping identities, diluting cultures, and commodifying human beings (McMichael and Beaglehole, 2000; Wonders and Michalowski, 2001; Guise, 2015). Devika (2015, p. 72) describes it as the '*industrialisation of the sex trade*', involving '*mass production of sexual goods and services framed around a regional and international group of labour*'. Furthermore, globalisation has dramatically altered social norms relating to sexual exploration. It has enabled the liberation of gender identities across the world (Herdt,

2018), leading to the pluralisation of sexualities, conducive to the declining currency of the traditional sexual dichotomies of heterosexual and homosexual identification. This in turn has contributed to the phenomenon of heterosexually identifying men engaging in same-sex relationships as well as men seeking their own sexual and gender identity when travelling (Minichiello, Scott and Callander, 2015; Monterrubio, 2018). Finally, the Internet and geo-spatial applications (apps) have diminished geographical borders, changing the way people meet, shifting values, and reaching hidden populations. There is a vast amount of literature exploring how the Internet facilitates the seeking of offline and cyber-sexual activities, as it provides anonymity and reduces stigma (Liau, Millett and Marks, 2006). Furthermore, those who sex-seek online report having riskier sexual interactions when the relationship moves offline; thus, expediting the transmission of sexually transmitted infections (STIs) and human immunodeficiency virus (HIV) (Liau, Millett and Marks, 2006; Mimiaga et al., 2008; Reisner et al., 2008; Minichiello, Scott and Callander, 2013; 2015).

1.1.2 Thailand

Due to the sheer expanse of sex tourism, Thailand's sex industry will be the focal point of this research. Thailand has been chosen for numerous reasons. The name '*Thailand*' literally translates as "*The rulers of the land of the free*" (Singh and Hart, 2007, p. 156). It is a country conflicted by the notion that one of their largest sources of revenue, tourism, is also their greatest source of humiliation (Singh and Hart, 2007). War bore the Thai sex industry, with former female slaves choosing sex to survive – initially with the abolition of slavery in 1905, followed by the influx of sex workers during Japanese occupancy and American presence through the Second World War and the Vietnam War, respectively (Reyes, 2015). Literature commonly reports Thailand and Southeast Asia as the main places for men to travel abroad for sex (Groom and Nandwani, 2006; Jones et al., 2014), due to the offerings of cheap holidays and a hot climate (Prior and Peled, 2019). Now, the Thai sex industry is worth $25 billion – around 12% of the gross domestic product (Brooks and Heaslip, 2018). The industry is promoted as part of the Thai national marketing strategy

(Brooks and Heaslip, 2018), with messaging portraying an air of disinhibition and tourists expecting casual sex and experimentation (Travelling Jezebel, 2020).

Literature has shown that over the last century, Thailand has entered a new era of sexual modernity (Jackson, 2009). Whilst many specifically identify Bangkok as the capital of gay and queer culture in Southeast Asia, the multidimensional changes continue to rapidly expand geographically, commercially, and politically (Jackson, 2009). According to Thailand's Civil and Commercial Code Section 1448, Thailand still criminalises same sex marriage (although allows same sex relationships) (Stonewall, 2019). Therefore, community organisations primarily work with the lesbian, gay, bisexual, transgender, queer, plus (LGBTQ+) community, particularly gay men, men who have sex with men (MSM), and transgender women. For example, Asia Pacific Coalition on Male Sexual Health (APCOM), a network of non-profit organisations, takes a public health approach targeting key populations (MSM, sex workers and their clients, transgender people, and people who inject drugs), whom account for 60% of HIV infections in Thailand, and continue to fight for equity, dignity, and social justice (APCOM, 2021b; AVERT, 2021).

1.2 Rationale

1.2.1 Disease migration

This sub-section sets the scene for contemporary public health narratives around global disease migration, specific to sexual health and infectious diseases. Whilst the majority of prevalence statistics used here are obtained from the WHO, who utilise complex longitudinal data sets for epidemiological modelling, there are undoubtedly limitations that must be stated to contextualise the data. Statistics, as used here, are restricted to global prevalence figures and do not reflect different cultural, socio-economic or political norms that impact on individual and community levels of disease. Furthermore, especially in the case of sexual health, sex work, and sex tourism, there will undoubtedly be underreporting, particularly for those most vulnerable or hidden. This is further discussed in the overall research limitations in chapter 5. For the purpose of this PhD, the usefulness in presenting quantitative data

of this nature is to highlight the importance of how '*surveillance data can be explored to characterize drivers of transmission heterogeneity at the community level and provide evidence for the rational deployment of control interventions*' (Corder et al., 2019, p. 1).

Each day more than one million STIs are acquired worldwide and each year an estimated 376 million new infections are contracted of chlamydia, gonorrhoea, syphilis or trichomoniasis (WHO, 2019a). These are the four main infections that are curable. Hepatitis B, herpes simplex virus (HSV or herpes), HIV, and human papillomavirus (HPV) remain incurable (WHO, 2019a). The latter infections are of particular concern as HSV type 2 and syphilis can increase the risk of acquiring HIV; and HPV infection causes 570,000 cases of cervical cancer and over 300,000 cervical cancer deaths each year (Korenromp et al., 2019). Although the incidence of HIV infections each year has lowered by 37% since 2000, it remains at 1.5 million worldwide, with 37.7 million people currently living with HIV (WHO, 2021c). The WHO (2016) highlighted the need to understand where the HIV epidemic was affecting certain populations, with MSM, sex workers, and transgender people disproportionately impacted by the burden of disease. These key populations account for 62% of HIV acquisitions globally (Ward and Aral, 2006; Mimiaga et al., 2008; Minichiello, Scott and Callander, 2015; WHO, 2016; UNAIDS, 2020b). Concerning Thailand, many associate Bangkok with transgender sex workers (TGSWs). TGSWs experience high levels of alcohol use, marijuana (32%), ecstasy use (36%), unprotected oral and anal sex (87% and 27%, respectively), and are at high-risk of HIV (Nemoto et al., 2012) as well as abuse, harassment, and violence (UNAIDS, 2021b). Due to this, HIV has a prevalence of 2.8% in sex workers and 11% in transgender people in Thailand (UNAIDS, 2021b). Whilst condom use for sex workers is currently at 83.1%, antiretroviral treatment (ART) coverage remains low at 9.3% (UNAIDS, 2021b). For transgender people, condom use averages 78.8% of the population but only 44.2% engage with HIV prevention services (UNAIDS, 2021b). Across the literature, global HIV prevalence among TGSWs is between 10% and 13%, with only 40% knowing their HIV status (Nemoto et al., 2012; AVERT, 2017; Aidsmap,

2021). From the tourist's perspective, research has highlighted that in 2010, 68% of United Kingdom (UK) nationals visiting Thailand were male, of which 45% were 45 years old and above (Rice et al., 2012). The same study reported that in England, between 2002 and 2010, 15% of men diagnosed with HIV, acquired the virus outside of the UK (Rice et al., 2012), with 31% of these men contracting it in Thailand (Garrick, 2005; Rice et al., 2012).

Sex tourists, therefore, are a source of many international sexual health issues, due to high-risk behaviours such as condomless sex with multiple partners or sexualised drug use whilst abroad. Literature demonstrates that condom use varies and is dependent on the location and those involved, with up to 50% of short-term travellers taking part in sexual activities while abroad, and only around half of those used condoms (Korzeniewski and Juszczak, 2015). More generally, condom usage ranges from very low, to sex workers using condoms more than 85% of the time (Avery and Zenilman, 2015; Bozicevic et al., 2020). However, research also shows that condom use declines when the sex seeker is outside of their own country (Lau, Tang and Tsui, 2003; Avery and Zenilman, 2015; Lu et al., 2020). With a higher prevalence of STIs and HIV in sex workers (Korzeniewski and Juszczak, 2015), those who engage in high-risk transactional sex when travelling are prone to both STIs and HIV, such as herpes, a 'newer' dermatological STI (*tinea genialis*) associated with Southeast Asia (Luchsinger et al., 2015), and notoriously gonorrhoea (Beauté et al., 2017). Most treatment options remain viable to tourists in high-income countries (HICs); however, antimicrobial resistance (AMR) continues to spread. There is evidence of AMR of the *haemophilus ducreyi* bacteria, which cause genital ulcers, in low and middle-income countries (LMICs) (Ward and Plourde, 2006). Furthermore, there is ART resistance in MSM with HIV (Grant-McAuley et al., 2020; Raymond et al., 2020), along with 50% of gonorrhoea cases reporting penicillin resistance (Memish and Osoba, 2006; Sethi et al., 2006; Baker et al., 2015; CDC, 2018a), and shigellosis originating in African and Asia through sexual intercourse presenting with resistance to azithromycin, the first line of therapy (Baker et al., 2015). These types of global

sexual health challenges combined with risky sexual behaviours pose significant threats to the international, domestic, and community transmission of disease.

1.2.2 Harm reduction interventions and policies

As globalisation relentlessly expands, the sex tourism industry will only continue to grow at the same rate. Therefore, considering PrEP and the subsequent increasing STI and HIV transmission, researchers need to look for ways to start making the industry safer for all involved (Bender and Furman, 2004). One of the main research gaps that has emerged from the literature is the need for safer sex strategies, advocates, and increased support from international organisations (Disogra, Mariño and Minichiello, 2005). Led by the work of Minichiello (Browne and Minichiello, 1997; Mariño, 2000; Disogra, Mariño and Minichiello, 2005; Minichiello, Scott and Callander, 2013; 2015), there is a call for a greater public health impact and services on an international scale.

> '*Major new and focused investments will be required to strengthen community-based services to: provide appropriate interventions for adolescents; tackle effectively gender-based violence, also related to harmful alcohol use; reduce the vulnerability of girls and young women; bring men and boys into treatment; reach key populations (notably men who have sex with men, people who inject drugs, sex workers, transgender people and prisoners); expand harm reduction programmes for people who use drugs; and deliver services to mobile and displaced populations. More has to be done to overturn laws and change policies that marginalize and stigmatize populations, promote risk behaviours, create access barriers to effective services and perpetuate these inequities and inequalities*' (WHO, 2016, p. 15).

Research has documented some forms of health prevention techniques for tourists. Travellers who receive pre-travel health advice, such as having vaccinations and fewer sexual partners, are at lower risk of contracting STIs and HIV when abroad (Crawford et al., 2016). Furthermore, sex tourists have reported using pre-exposure prophylaxis (PrEP), a biomedical HIV prevention tool, on an event-based regimen, as it reduces the perceived threat of HIV acquisition. As travel-related HIV diagnoses have increased more recently (Lu et al., 2020), PrEP would play a substantial preventative role for high-risk tourists.

The development of sex tourism and the role of globalisation is undoubtedly challenging disease surveillance and the implementation of health initiatives, creating stigma and discrimination for both tourists and sex workers, whilst perpetuating pre-existing vulnerabilities. There is a need to identify and understand contemporary sex tourism in the wider context of globalisation, technology, and harm reduction to enable public health practices, policy and decision-makers, local and national governments, and international agencies to tailor their approaches and interventions in overcoming the developing issues associated with sex tourism.

Reflection Box 1: My road to writing a PhD on sex tourism

I previously worked as a Health Care Assistant in a sexual health clinic in West London. I saw several groups of men, usually stag parties, who had been abroad to countries with high rates of HIV, and were returning to the UK after having had unprotected sex with either other tourists, or sex workers – sometimes sexually experimenting with men or transgender women. During the asymptomatic consultations, when I stated that there was a window period for an infection or virus, the patient would leave the clinic and usually not return. I assumed that they would then be passing any contracted infections on to their regular partners or soon-to-be wives in the UK. During my MSc in International Public Health at LJMU, I enquired into a PhD and shared the story of the stag parties travelling to Thailand, which I soon found out was under-researched. When I started the PhD, I typed 'sex tourism' into Google, and quickly realised I needed to break my ideas down into areas of interest. I mapped out that it was sexual health, people's behaviour when travelling, and the larger contributors of globalisation and technology, which piqued my interest. People are always going to travel. It is culture, engrained in human behaviour, and it is getting easier to do. I wanted to find the safest way to do it, inform policies, and try to protect and support those involved.

1.3 Research aims and objectives

The principal aim of this doctoral research was to map out contemporary sex tourism through the development of a new, theoretical model. This was achieved through the following objectives:

1. Critically analyse multi-level factors that impact sex tourism in an era of globalisation, technology, harm reduction, and disease migration;
2. Gain insight into how sex tourism operates in one selected country, Thailand;
3. Explore multi-stakeholder perceptions around the short and long-term public health impact of sex tourism on the UK and Thailand;

4. Identify the unmet needs of UK tourists in the domains of public health, social policy, clinical practice, and sexual health programmes.

To address the overall aim, chapter 2 presents a new model that I developed from the findings and themes of an in-depth exploration and review of extant literature. Using multi-level associations, the model is a depiction of contemporary sex tourism in its entirety. Whilst the chapter could be considered as a study in itself due to the development of the conceptual model, it is fundamentally a literature review that would be presented in its current position in a more traditionally formatted thesis, and its purpose is to set the stage for the rest of the PhD. It is, therefore, separate from the empirical study that constitutes the remainder of the thesis. As with other public health research, the empirical study requires its own specific, detailed methodology and justifications, which are presented in chapter 3. Whilst at first, the structure of this PhD differs from more traditional theses, this explanation hopefully provides an insight into the decision-making process, and aids the reader with a greater understanding and appreciation of its novel approach. Following this rationale, Chapter 3 paves the way for a subsequent empirical study. It details the methodology, research design, theoretical underpinning, and ethical process for the qualitative piece of research. Chapter 4 presents the findings of the study through individual case studies that draw on topics outlined in the model as well as detailing new theories and relationships that were generated from the conversations with participants. Chapter 5 draws together the previous chapters by using the empirical study findings to refine and adapt the model, which organically leads to discussions around the implications of the model on sexual health service provision in the UK, recommendations for multi-stakeholder and international or cross-border initiatives, and future research in the field.

Chapter 2: New conceptual sex tourism model

2.1 Introduction

This chapter presents a new conceptual model that I developed following an in-depth, critical analysis and review of extant literature. The model provides an extensive revision to existing models that have historically only considered the relationship between the tourist and sex worker. To date, five publications have visually depicted sex tourism in the form of a model (Oppermann, 1999; Ryan, 2001; Ryan and Hall, 2001; Bauer and McKercher, 2003; Eaglen and Maccarrone-Eaglen, 2005). Oppermann (1999) initiated the conversation and used the following six parameters to illustrate the tourist and sex worker relationship: the purpose for having sex, monetary exchange, length of time, relationship dynamic, sexual encounter, and identification of who travels. Building on these foundations, Ryan (2001), Ryan and Hall (2001), and Bauer and McKercher (2003) constructed their own dimensions, with each framework discussing the voluntary or exploitative nature of the relationship. Ryan (2001) and Ryan and Hall (2001) described the commercial or non-commercial transaction, whilst illustrating the impact on self-image and integrity of involved parties. Bauer and McKercher (2003) utilised the work of Oppermann (1999) in demonstrating the motivation for travel, and prioritised tourism as a facilitator of sexual activity as it provides a setting for sexual encounters to take place. Ryan and Hall (2001) progressed the narrative by analysing the dimensions through micro and macro perspectives, asserting that they are interdependent and interactive (Ryan and Hall, 2001). Eaglen and Maccarrone-Eaglen (2005) employed a similar approach, placing sex tourism into a wider operational system, prescribing to spatial, temporal, and cognitive functionalities, through a dynamic 'butterfly' configuration. They also differentiated by '*Io*' (the self, personality, and perceptions),

micro level, and macro level; yet the overall description of sex tourism was limited to listing elements of the phenomenon. Undoubtedly, there is a well-developed body of sex tourism literature. However, there are no updated models that conceptualise the multifaceted phenomenon within a contemporary worldview. Whilst existing papers broach elements including choice of destination, gender, sexuality, human rights, and exploitation, they do not include them in the respective models.

2.2 Methods

To create a new model that encompasses all aspects of contemporary sex tourism, I had to undertake an extensive literature review, which verged on research or evidence synthesis, using scoping review techniques acquired from practicing Arksey and O'Malley's five stage process in previous research project (Arksey and O'Malley, 2005). Aligning to Daudt, van Mossel and Scott's definition, a scoping review maps out the literature and '*provide[s] an opportunity to identify key concepts; gaps in the research; and types and sources of evidence to inform practice, policymaking, and research*' (Daudt, van Mossel and Scott, 2013, p. 8). This review was loosely based on the earlier stages of the scoping review framework (Arksey and O'Malley, 2005). Relevant sources were identified through exploratory searches on Google Scholar, Web of Science and Scopus databases using key search terms such as '*sex tourism*', '*sex industry*', '*sex worker OR prostitute*', '*travel for sex*', and '*sexual health and travel*'. From these, I manually searched through reference lists and for grey literature. The final sources were downloaded to EndNote, which was the software used to support reference and citation management. As I read the full text of each source, I made hand written notes, extracted and charted the data on Microsoft Word and Excel, and documented emergent key themes, sub-themes, quotes, and points of interest. The initial draft was categorised and written up thematically. However, the entire process was iterative and conducted over an 18-month period.

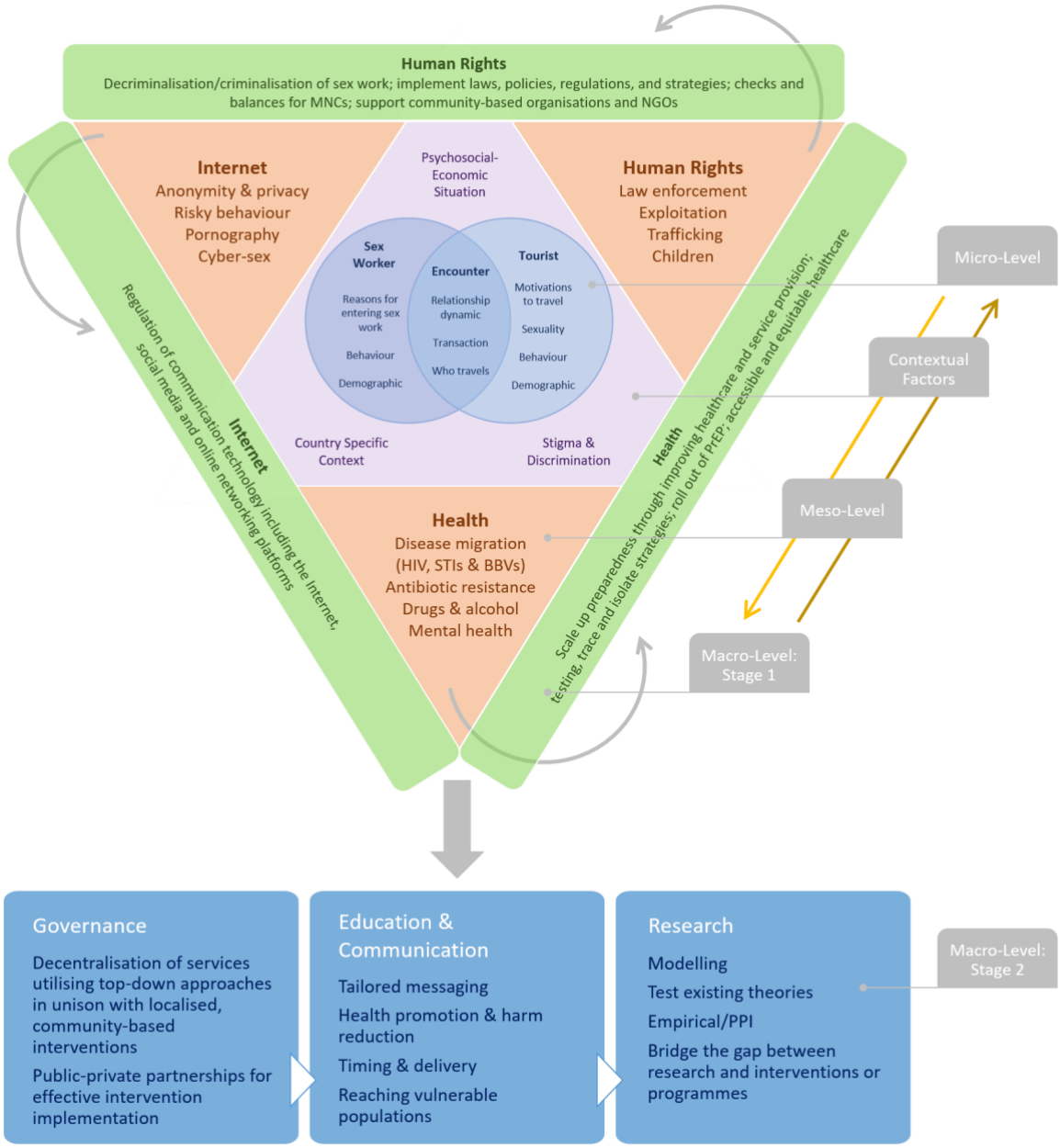
Once the scoping exercise were consolidated into a manuscript, I began to visually map out the themes and sub-themes into a model. The structure of the new model is underpinned by the recommendations from Richter and Dragano (2018) and the World Health Organization (WHO, 2002), who reiterate the importance of micro, meso, and macro levels for social science and health-related concept models. The conceptual sex tourism model is presented in Figure 1. It is worth noting that the model is placed at the beginning of the chapter so that it can be used as a reference for the accompanying reasoning, justification, and wider literature, which are presented later in the chapter to support the decisions made during the model's development, particularly in regard to overlapping levels and conceptual links made throughout.

The newly developed model draws upon multi-level factors and associations that impact sex tourism, with each level building upon the last. The micro level is the centre of the model, directly influenced by contextual factors (a separate level). The meso level draws on smaller scale social arrangements, and the macro level is comprised of structural, institutional forces, the wider community, and governance systems (Richter and Dragano, 2018). Two bi-directional arrows can be seen to the right of the main model (Figure 1) to signify the constant interactions, dependency, and associations between the levels. The model places sex tourism into the wider context of globalisation, technology, harm reduction, and disease migration, as well as weaving in ongoing global issues such as exploitation, stigma, and inequalities.

The rest of this chapter will outline, describe, and analyse the domains and elements that constitute each level (micro, contextual, meso, and macro). The labels observed in the model have been italicised throughout the text for clarity. This chapter is adapted from the published conceptual paper by Hillis et al. (2021b), Appendix 3: 'Hillis, A., Leavey, C., Kewley, S. and Van Hout, M. C. (2021) Sex tourism in an era of

globalisation, harm reduction and disease migration: a new conceptual model. *Tourism Review.* DOI: 10.1108/TR-04-2021-0184'.

Figure 1: A new conceptual sex tourism model



Key: MNCs – multinational corporations; HIV – human immunodeficiency virus; STIs – sexually transmitted infections; BBVs – blood borne viruses; PrEP – pre-exposure prophylaxis; PPI – patient and public involvement

2.3 Micro level

Previous frameworks consisted of the relationship between the tourist, the sex worker, and the sexual encounter. In this new model, at an individual level, the tourist and sex worker have remained central to all activities. To distinguish overlapping characteristics between the sex worker, tourist, and their sexual encounter, they are represented in a Venn diagram.

2.3.1 Sex workers and tourists

The sex workers' circle of the Venn diagram includes the *reasons for entering into sex work*, *behaviour* (level of risk), and *demographic* information (age, nationality, and ethnicity). The tourist's circle includes the *motivations to travel*, previously stated in Oppermann's (1999) work as '*intentions*' and '*travel purpose*' (Oppermann, 1999), and refers to subjective attributes, for example escapism or relaxation (Ryan and Kinder, 1996). Again, their *behaviour* (for example preferences regarding condomless sex, drug and alcohol use, and number of partners), and *demographic* information such as gender identification, age, country of origin, and ethnicity, are included in the circle.

Additionally, the circle takes into consideration the tourist's *sexuality* to ensure the provision of appropriate services and interventions (Cantor, 2018). Tourism is a means for which individuals can explore their sexual identity (Hughes, 1997). Monterrubio (2018, p. 2) believed that social interaction between people, socially constructs an individual's entire identity. Therefore, global societies and communities should allow individuals to explore inner pathways to find one's self, which may or may not be outside varying comfort zones. If we place these ideas into the context of current globalisation discourse around the deconstruction of sexual

dichotomies (Minichiello, Scott and Callander, 2015), then sexual and gender fluidity should be the ideal scenario to strive towards. In fact, if we achieved this ideal globally, the need for an individual to identify with a specific identity then becomes obsolete. However, as society still lacks this type of progression, people continue to travel to find justification for their feelings and actions (Monterrubio, 2018), which must then be supported by the implementation of safe and preventative sexual health strategies.

2.3.2 Encounter

The sexual encounter, labelled as 'Encounter' in the model, between the tourist and sex worker constitutes the intersection of the Venn diagram. It details any *transaction* that has taken place between the two individuals; *who travels for the encounter*; and the *relationship dynamic*. The relationship dynamic includes descriptions such as the length of time (years or minutes) or the nature (long-term or single occurrence) of the relationship, and is a core, overlapping feature within the micro level due to the power differentials between the tourist and sex worker, which is further examined below.

Much of the literature around sex tourism, as well as wider sex work, discusses power differentials between the tourist and sex worker, predominantly in respect to a male tourist and a female sex worker. With gender-based violence (GBV) '*a global public health and human rights priority*', Krüsi et al. (2012, p. 1154) argue that by addressing structural issues, '*enabling environments*' can be created to reduce it, decrease STI transmission in the sex industry, and protect the rights of sex workers. A dearth of literature draws on early, first wave, radical feminist discourse regarding sex workers, their agency, and the subsequent power dynamics with clients (Gerassi, 2015). Abolitionist theories view sex work as exploitative, derived from the understanding

that society sits on patriarchal foundations (Comte, 2014), leading to violence, drug use, poor health, and deprivation (de Graaf et al., 1994; Kinnell, 2008; Sanders, O'Neill and Pitcher, 2009; Shokoohi et al., 2019; Zehnder et al., 2019). The second wave of radical feminism questioned the abolitionist perspective, which refused to acknowledge women's agency and decision-making power (Bell, 1994). Sex positivist feminists believe that sex workers recognise the constraints they face, proactively make conscious decisions, and choose how they use their bodies (Lankenaua et al., 2005; Weitzer, 2005; Sanders, O'Neill and Pitcher, 2009). Over time, discourse has dichotomised the theoretical underpinnings of sex work into 'exploitation' and 'choice' (Nguyen, 2017). In some societies, sex workers remain, culturally or socially unaccepted, particularly in lower socio-economic contexts. Consequently, risks such as GBV, rape, and murder persist (Kinnell, 2008), stigma prevails (Sanders, O'Neill and Pitcher, 2009), and sex workers' circumstantial choices are restricted (Chapkis, 1997). Furthermore, male sex workers and TGSWs experience similar risks to female sex workers, such as psychosocial and physical abuse as well as substance use (Nguyen, 2017). Men are '*no longer the exclusive consumers of sex*' (Minichiello, Scott and Callander, 2015, p. 1), and TGSWs '*occupy the lowest stratum of the status hierarchy…fac[ing] greater difficulties than female or male prostitutes*' (Weitzer, 2005, p. 221). Regardless of gender, sex workers obtain agency through knowledge and understanding of their situation, allowing them to assert power into relationships (Grenfell, Platt and Stevenson, 2018). Taking a more nuanced approach and considering contextual factors (gender, race, class, or sexuality), sex work should be interpreted on a spectrum of choice (Scoular, 2004; Sokoloff and Dupont, 2005; Benoit et al., 2018).

2.4 Contextual level

The contextual level of the model consists of three domains, which are explored in detail below: 'Country Specific Context', 'Psychosocial-Economic Situation', and 'Stigma & Discrimination'.

2.4.1 Country specific context

Richter and Dragano (2018) and Sauzet and Leyland (2017) identify how the country specific context in which individuals live, directly contributes to health inequalities and power dynamics, as individuals are reflective of their originating country's historical political, health, and socio-economic situation (Dorfman, 2011). Gender and tourism literature has begun to contextualise findings based on their geographical location, due to differing social boundaries between originating and destination countries (Bishop and Limmer, 2018; Brooks and Heaslip, 2018). There is a propensity to '*conceptualise women from the West as guest[s] and women from the rest as host[s]*', reinforcing female marginalisation and postcolonial sentiments (Jeffrey, 2017, p. 1042). When considering gender tourism, literature typically sets the female tourist, who travels to destinations of lower socio-economic status, against the stereotypical male tourist laden with hegemonic masculinity, white supremacy, and fear of sexual inferiority (Weichselbaumer, 2012; Spencer and Bean, 2017). Copious research implies that Euro-American males dominate 'sex tourism' (Spencer and Bean, 2017), while female tourists embody 'romance tourism', providing ongoing financial support as opposed to direct monetary exchange (Weichselbaumer, 2012), with Pruitt and LaFont (1995) the first to publish in respect to racial myths of Western women's attraction to black male bodies. This set the stage for studies investigating female sex tourism and '*beach boys*' in the Caribbean (Kempadoo, 2001; Phillips, 2008; Spencer and Bean, 2017), The Gambia (Nyanzi et

al., 2005), Costa Rica, and the Dominican Republic's '*sanky pankies*' (Bauer, 2014, p. 24). From the East, Bandyopadhyay (2013, p. 2) added, '*it is important and possibly more interesting to explore Asian tourists*' *sexual adventures in the West*'. Other studies have also investigated female Asian solo travellers, who were found to be at greater risk of GBV and sexualised attention from their white, male counterparts, due to their ethnicity and the '*erotic representation of Asian women in destinations where sex tourism prevails*' (Yang, Yang and Khoo-Lattimore, 2019, p. 1050). Therefore, researchers should stress the intertwining intersectional factors such as race, gendered power relations, and class, to challenge assumptions of sex tourism in the Global South, as the concept of '*otherness*' is '*borne from a history of racism multifaceted exploitation*' (Spencer and Bean, 2017, p. 15).

2.4.2 Psychosocial-economic situation

Regarding sex work literature, the 'Psychosocial-Economic Situation' label in the contextual level refers to the discourse characterised as '*survival sex*' or '*gay for pay*' (Gerassi, 2015; Minichiello, Scott and Callander, 2015). This is due to social and economic disparities, with many entering sex work due to poverty (Lankenaua et al., 2005), unstable living conditions and depression (Weber et al., 2001), a poor familial situation such as a history of maltreatment and physical abuse (Newman, Rhodes and Weiss, 2004), as well as a lack of education and drug and alcohol use (Weber et al., 2001; Newman, Rhodes and Weiss, 2004; Minichiello, Scott and Callander, 2015).

For tourists, Jones et al. (2014) are among the few to address the recent rise in risky sexual behaviour. Deemed '*situational sexual behaviour*' they implore that, '*sexual behaviour which is different to an individual's normal sexual behaviour, like paying for sex, is sometimes determined by the set of circumstances in which individuals find themselves*' Jones et al. (2014, p. 120). For wider context, the set of circumstances

that leads tourists to partake in high-risk behaviours may include changing social boundaries (Bishop and Limmer, 2018; Brooks and Heaslip, 2018), low self-esteem and depression (Geibel et al., 2008), lack of self-identification, and therefore, excessive alcohol consumption (Jones et al., 2014), and drug use (Minichiello, Scott and Callander, 2013).

2.4.3 Stigma and discrimination

Individuals and communities experience stigma and discrimination for innumerable reasons and in a variety of ways. Globalisation, technology, and tourism has enabled the liberation of gender identities and sexual experimentation (Herdt, 2018), with heterosexually identifying people engaging in same-sex relationships when abroad (Minichiello, Scott and Callander, 2015). However, homophobia and transphobia persist, and exacerbated by stigma associated with sex work and disease transmission.

Travel for sexual experimentation can incite social stigmatisation (Monterrubio, 2018). Concurrently, LGBTQ+ tourism advocates sexual diversity. Markets underpinned by sexuality, '*exemplif[y] contemporary queer theorizations of how the neo-liberal state sustains particular acceptable, non-threatening ideas of gayness – the* homo*normative*' (Waitt, Markwell and Gorman-Murray, 2008, p. 782). The West continue to fashion heteronormative acceptances, masking the lived realities of those within the industry, heightening discrimination and persecution experienced by non-binary and transgender individuals in non-Western nations (Waitt, Markwell and Gorman-Murray, 2008). In a study conducted in Bangkok, Thailand, more than half of the transgender participants reported experiencing transphobia, with 70% expressing they did not feel accepted in Thai society (Nemoto et al., 2012). From a health perspective, there is ample research on the stigmatisation of LGBTQ+ people

living with HIV (PLWHIV) (Wong, Holroyd and Bingham, 2011; Smit et al., 2012; Calabrese and Underhill, 2015; Monterrubio and Valencia, 2019; Zehnder et al., 2019). Notably, as sex workers experience secondary, '*layered or intersectional*' stigma, which is internalised, self-deprecating stigma combined with enacted stigma from others that question social constructs, such as male sex workers LWHIV (Fitzgerald-Husek et al., 2017, p. 2).

Homophobia and transphobia manifest in the criminalisation of same-sex relationships (Fitzgerald-Husek et al., 2017). Advocacy work continues to progress LGBTQ+ equality and legal protection. In international human rights law, the Yogyakarta Principles (2006; 2017) 2b, 6b and 33, declare that each individual has the right to be free from criminalisation regarding their sexual orientation, gender identity or expression, and sexual characteristics. However, the International Lesbian, Gay, Bisexual, Trans and Intersex Association (ILGA) World organisation, published a report stating '*the polarizing trends that are taking place at a global scale mean that while more…of us have seen our rights legally recognized, more LGBTI people are also in greater danger of being discriminated, attacked, persecuted and even murdered*' (ILGA, 2019, p. 5). It remains illegal to have consensual same-sex sexual acts in 68 (35%) United Nations (UN) member states (ILGA, 2019).

2.5 Meso level

The meso level of the model identifies the structural elements that support contemporary sex tourism. Since the publication of previous models, the literature review has identified three main developments as influential to sex tourism: the 'Internet', 'Health', and 'Human Rights'.

2.5.1 Internet

The Internet is a tool for *anonymity*, *privacy*, expression, relationships, and sex-seeking (Ward and Aral, 2006; Minichiello, Scott and Callander, 2013; Lewnard and Berrang-Ford, 2014; Wang et al., 2019). Some communication technologies permit sex workers and their businesses to advertise and utilise the Internet for clients. This is a key example of how technology deconstructs pre-existing borders, allowing sex workers to be in contact with a vast number of potential clients (Ward and Aral, 2006). In Thailand, one of the earliest audio-visual software programs, Camfrog, served as a community and virtual venue for young Thai women to provide live sexual acts to men online, find potential partners offline, for masturbation and sexual intercourse as well as to explore fluid sexual and gender identities (Samakkeekarom and Boonmongkon, 2011; Boonmongkon et al., 2013). The behaviour and performances of *cyber-sex* – conducted by Thai women at a rate of more than 1,000 users per night – sheds light on the balance between a woman's sexual agency and the potential sexual exploitation taking place (Samakkeekarom and Boonmongkon, 2011; Boonmongkon et al., 2013). Furthermore, dating apps, such as Tinder and Grindr, are now used extensively for sex-seeking, so much so that the Tourism Authority of Thailand recently partnered with Tinder for package trips designed for single people (TAT, 2020)[2].

There is a vast amount of literature exploring how the Internet is now facilitating unsafe sex (Liau, Millett and Marks, 2006; Mimiaga et al., 2008; Reisner et al., 2008; Minichiello, Scott and Callander, 2013; 2015). For example, Mimiaga et al. (2008) ascertained that sex workers who find clients on the Internet have inconsistent

[2] https://www.tatnews.org/2021/02/tat-organises-second-single-journey-trip-to-ko-khai-in-phang-nga/

condom use, high rates of unprotected sex, low rates of HIV status disclosure, and may not have screened for STIs. Liau, Millett and Marks (2006) explained the association through two hypotheses. Firstly, the self-selection hypothesis details that men who are prone to risky behaviour are more likely to use the Internet for sex-seeking than those who are more risk adverse. From this, the accentuation hypothesis outlines the dynamic process, where once the individual is online, the Internet accentuates risky behaviour, which in turn increases the likelihood of STI transmission if the relationship moves offline (Liau, Millett and Marks, 2006; Mimiaga et al., 2008; Reisner et al., 2008; Minichiello, Scott and Callander, 2013; 2015; Wang et al., 2018). This timeline of sexual behaviour and activity is key to understanding the cognitive decision-making behind *risky behaviour*.

More recently, COVID-19 has escalated risky sexual behaviours by intensifying sexual exploitation, online grooming, and human trafficking (Hillis et al., 2020b). Sex workers have described how moving online to work during COVID-19 has led to being '*constantly abused' with 'dozens of violent messages every week. The abuse…has increased tenfold*' (Hurst, Martinez and Monella, 2020, paragraph. 5). In a statement by the Sex Workers' Rights Advocacy Network (SWAN), sex workers are increasingly moving online for business. In European countries such as Ukraine, they are facing criminal prosecution, as those in power deem their work-related activities as pornographic; in Russia, sex workers are dealing with blackmail and the amplification of scapegoating online (SWAN, 2020). Yet, in some circumstances, the COVID-19 pandemic is proving to be '*countercyclical*' as sex-related companies, sites, and platforms have documented record traffic and sales (Barrica, 2020, paragraph. 1). Sex workers in the porn industry (*pornography* in the model) have gained autonomy and agency, as they have been able to make personal connections with their clients,

'*something for which ethical and feminist directors have been striving for [for] decades*' (Barrica, 2020, paragraph. 19).

2.5.2 Health

The 'Health' domain in the model broadly covers disease migration (HIV, STIs, and blood borne viruses [BBVs]), AMR, drugs and alcohol, and mental health. This section will address each element separately. Firstly, travelling for sex and the movement of high-risk individuals is associated with unprotected anal intercourse (Darrow et al., 2005), with MSM currently representing the largest number of new STIs (Mimiaga et al., 2008), thus contributing to global *disease migration*. For example, one Brighton-based survey found that around half of the MSM sample interviewed, who had travelled abroad, had sex with a new partner while on holiday (Hamlyn, Peer and Easterbrook, 2007). Furthermore, Mimiaga et al. (2008, p. 55) reported that MSM and sex workers have increasingly been '*transmit[ting] HIV and other STIs to non-sex work partners*'. In similar studies, 25% of MSM have never taken an STI test, 28% were diagnosed with a STI at some point in time, with increased rates of syphilis, hepatitis C, and HPV, and a third reported living with HIV (Mimiaga et al., 2008; Laar and Richel, 2017). These statistics are concerning as tourists are reluctant to access sexual health services before or after travelling (Croughs et al., 2016).

Secondly, with high-risk of STI and HIV transmission, AMR has become a global concern (*antibiotic resistance*) (CDC, 2018a). The UK recently observed the spread of lymphogranuloma venereum in MSM (Avery and Zenilman, 2015), and is currently experiencing the highest levels of syphilis in nearly 70 years, especially among the MSM community (Groom and Nandwani, 2006; BBC, 2018). More recent literature identifies the emergence of drug resistant HIV in an MSM in 2019 (Raymond et al., 2020), and drug resistant strains in sex workers from Tanzania and the Dominican

Republic, who reported partial or full adherence to ARTs (Grant-McAuley et al., 2020). Furthermore, there has been significant increase in the prevalence of gonorrhoea (Sethi et al., 2006; CDC, 2018a). The transmission of 'quinolone-resistant *Neisseria gonorrhoea*' (QRNG), an antibiotic resistant strain of gonorrhoea, accounts for 40% of gonorrhoea diagnoses in Asia, and is widely circulating around parts of Northern America (Memish and Osoba, 2006). Those infected do not necessarily present with initial symptoms, and so subsequently bring the infections back to the home country and pass them on to unassuming partners (Memish and Osoba, 2006).

Finally, other health concerns relating to tourists and sex workers must also be considered, including *mental health* (Rössler et al., 2010; Krumrei-Mancuso, 2017; Zehnder et al., 2019); low self-esteem and depression (Geibel et al., 2008); workplace violence; transgender-related healthcare; and social support access (Grenfell, Platt and Stevenson, 2018). Literature commonly reports *drug and alcohol* use, as it lowers inhibitions and negotiation barriers in transactional encounters (Jones et al., 2014; Shokoohi et al., 2019). For example, Darrow et al. (2005) in a Florida-based study found that tourists were more likely to use cocaine and ketamine than local residents, and then go on to engage in unprotected anal intercourse. In a different study, Kenyan male street-based sex workers had increased rates of alcohol consumption at the same time as diminished HIV testing, which correlated with high frequencies of condomless anal sex with clients (Geibel et al., 2008).

2.5.3 Human Rights

Two topics fall under the umbrella and domain of 'Human Rights' in the model: the trafficking and exploitation of women and children, and law enforcement. There has been a shift in sex research to focus on human *trafficking* and the commercial and

sexual *exploitation* of women and *children* (George and Panko, 2011; Kosuri and Jeglic, 2017; Dewey, Crowhurst and Izugbara, 2018; Majic and Showden, 2018).

> '*Much of the Thai sex tourism industry is concerned with selling juvenility, encouraging men to think that their sexual partners are young, innocent and childlike…for a complete analysis of [child-sex tourism and adult-sex tourism], both must be looked at in conjunction and the interplay between them acknowledged*' (Montgomery, 2008, p. 914).

According to United States law, sex trafficking is when, '*A commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such act has not attained 18 years of age*' (Human Rights First, 2017, p. 2). Human trafficking, or forced labour, is a transactional process that has claimed nearly 25 million victims across the world, of which 4.8 million have been sexually exploited (Human Rights First, 2017). Although men are forced into labour for commercial sex, women and girls constitute 71% of victims, and of these, 25% are children (UNODC, 2016a; 2016b; Human Rights First, 2017; 2018). Last year, The Guardian (2020) reported that Thailand rescued 1,807 human trafficking victims, increasing from 622 in 2018; of which, 60% were women forced into either the seafood industry or sex labour. Current domestic abuse and violence activist agendas have led to legislative change (Majic and Showden, 2018). The UN Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, supplementing the UN Convention against Transnational Organized Crime (United Nations Treaty Collection, 2019), enforced in December 2003, was one of the most rapidly endorsed legal instruments in history (UNODC, 2016a). Regarding children, since the COVID-19 pandemic, the number of child sexual abuse material (CSAM) referrals to Europol has increased from below 200,000 per month in February 2020 to over one million in March 2020, with the Internet Watch Foundation reporting nearly nine million attempts in accessing CSAM in April 2020 in the UK (Europol, 2020). The increase in

online presence, sharing of CSAM and other abusive materials, is an emerging public health crisis. With desensitisation to content, the exploitation of vulnerable groups is of growing concern alongside mental health and sexual issues with those engaging in voyeuristic activities (Walker, 2008; Merdian et al., 2013).

Taking a different angle, popular culture depicts the significant overlap between exploitation and sex tourism. Television programmes and films such as the UK BBC's *McMafia* (Watkin, 2018) and *The Night Manager* (Bier, 2016), and Morel's *Taken* are key examples of how sex trafficking entered into mainstream media (Morel, 2008). At first, scholars perceived this portrayal in a positive light as it raised awareness of the cruelty of sexual exploitation (Bickford, 2018). However, these interpretations glorify pimping culture and deviant sexual exploration of women (Garcia, 2016). There is no expectation that fiction should adhere to accurate representation; yet in contemporary society, the film industry must be vigilant and take responsibility for '*reinforcing misperceptions and myths*' regarding sexual exploitation so that popular culture neither perpetuates it nor prohibits its eradication (Bickford, 2018, p. 98). In contrast, Todres (2015, pp. 22-23) stated that although a misconception is evident, popular culture '*serve[s] as a basis for action*'…'*If film and other media create a particular understanding…then the push for legislative action will demand measures that are responsive to that construct*'. However, Todres (2015) continued, pointing out that if the depictions are fundamentally wrong or privilege other stories over the social problem, then there could be negative repercussions. In relation to sex tourism, the representation of sex work in films is relatively under-researched. Coy, Wakeling and Garner (2011, p. 442) discussed how the narrative of sex work in film reconstructs understandings of the sex industry and defines it as '*symbolic violence*', particularly observed in dominating male roles and through power inequalities between characters. This normalisation of transactional sex is currently framed as a

form of entertainment: '*Casual normalisation of the exchange of women's bodies for money tells a strong story about how prostitution, not just sexualisation, has become a lexicon and potential paradigm for heterosexual relationships*' (Coy, Wakeling and Garner, 2011, p. 444). It is the intersecting perspectives between sex tourism and trafficking that make modern slavery a contemporary global crisis, requiring urgent attention (Brooks and Heaslip, 2018).

The second element within the 'Human Rights' domain to be discussed is the role of law enforcement in the sex tourism industry. Recently, promotive and preventative public health research has acknowledged the integral role played by public security and *law enforcement* (van Dijk et al., 2019). Dewey, Crowhurst and Izugbara (2018) discuss the current regulatory and legislative issues of the global sex industry. Through the discourse of culpability, they highlight that European law blames clients for perpetuating sex work. Contrastingly, African countries deem their clients as the vulnerable population requiring targeted public health interventions, whilst the Americas only consider sex workers in policies (Dewey, Crowhurst and Izugbara, 2018). Thai law heavily implicated sex workers in the Prevention and Suppression of Prostitution Act of 1996. Although it states that customers are also culpable, sex worker organisations emphasise that Article 6, which declares that '*anyone who associates in a place of prostitution*' is a '*blanket presumption of guilt*', is particularly oppressive towards women in the Thai sex industry (Empower Foundation, 2017, p. 4). Undoubtedly, these claims are generalisations and scholars must apply them to specific aspects of the sex industry. For example, from the perspective of child exploitation, Bang et al. (2014, p. 35) take a firm stance that the offender is the one that travels: sex tourism offers '*an opportunity to engage in illicit sexual activities with marginalised populations beyond the threat of prosecution because different legislative bodies rule foreign countries*'. They dub sex worker clients as '*sexual*

offenders' and blame them for using the sex industry '*to expedite travel and facilitate crime*' (Bang et al., 2014, p. 35). However, their viewpoint does not deliberate the tourists' perspective or place it into a wider, holistic context.

Specifically for sex workers, there has been minimal progression on the part of law enforcement to promote public health measures in supporting sex workers, with exception of the recent establishment of the Law Enforcement and HIV Network (LEAHN), a ground-breaking initiative to centralise the role of police forces in public health and HIV responses. Harm reduction strategies should be adopted by law enforcement to create an enabling environment, taking a multi-sectoral approach (van Dijk et al., 2019; LEAHN, 2020).

2.6 Macro level: Stage 1

Stage 1 of the macro level consists of institutional international, national, and community responses, designed to address the inner levels of the model. This stage envelopes and responds to the three domains ('Internet', 'Health', and 'Human Rights') of the meso level. Based on the analysis provided in the 'Internet' domain of the meso level, it is clear that there is an urgent need for countries to *regulate communication technology sources including the Internet, social media, and online networking platforms.* Additional responses to the 'Health' and 'Human Rights' domains are investigated below.

2.6.1 Health

Thailand was the first country to record a COVID-19 case outside of China on the 13th January, 2020 (WHO, 2020b). To date[3], there have been 247,472,724 confirmed

[3] As of Wednesday 3rd November, 2021 at 17:21 CET

cases and 5,012,337 deaths reported to the WHO worldwide (WHO, 2021e). Since the start of the outbreak, we have witnessed the devastating human and economic consequences of a globalised virus.

The world remains focused on the COVID-19 pandemic. Each country has responded to COVID-19 in extremely different ways, arguably reflective of an individual country's political systems and power structures. Although lockdowns have restricted the movement and interaction of people, international sexual health issues prevail and have been exacerbated in many circumstances. Global populations are changing their social and health behaviours to adapt to the continually altering situation. Early in 2020, the BBC reported that COVID-19 could be a '*fatal blow*' to HIV in the UK (BBC, 2020b, paragraph. 1). Yet inevitably, the countries most impacted are those with overstretched government resources and chronically fragile health systems. For example, Zimbabwe was unable to provide consistent ART to the 14% of their population living with HIV (Muronzi, 2020a). By early April 2020, Zimbabwe had tested 392 people for COVID-19 compared to 1,500 in Rwanda and 68,000 in South Africa (Muronzi, 2020b). At the same time, South Africa saw a public scandal in the health service with underlying corruption and the misappropriation of allocated COVID-19 funds such as personal protective equipment (PPE; BBC, 2020a). For vulnerable people, especially sex workers, the pandemic has shone a brighter light on their situation as the lockdowns and restricted movement of people has heightened social disparities, especially relating to racism, sexism, and poverty. Human rights violations underpinned by GBV, sexual exploitation, and online grooming, however, are mounting, with escalating police harassment, discrimination, and punishment towards sex workers (UNAIDS, 2020a).

At the beginning of 2020, lead scientists working on combatting COVID-19, spoke of how countries could utilise recognised sexual health and infectious disease

strategies, as they are similar in nature and '*centre [on] human rights, acknowledge intersecting injustices, recognise power structures, and unite across identities*' (Hall et al., 2020, p. 1176). Professor Chris Whitty, England's Chief Medical Officer, when writing about Ebola in 2015, detailed the need to '*stall [its] transmission in the community*' with '*passive case-finding*' and '*community isolation*' (Whitty et al., 2015, p. 193). The British government should have immediately implemented the same principles in their COVID-19 response. From a sexual health perspective, '*isolation'* and '*case-finding*' tactics would equate to sexual abstinence and contact tracing, which scientific evidence has proven with the likes of STI or tuberculosis contact tracing following incubation periods. Using lived experiences from Ebola, Middle East Respiratory Syndrome, Severe Acute Respiratory Syndrome, and malaria, the WHO recommended to test, trace, and isolate in response to COVID-19 (WHO, 2020b). In the UK, the COVID-19 NHS tracing phone app continues to function, in some capacity. The two other main strategies that the UK have adopted are vaccination and border control policies. With similar administration as HPV and hepatitis vaccines, 7,027,377,238 doses have been dispensed (WHO, 2021e);[4] and the UK is operating a traffic light border control system for entering England (GOV.UK, 2021). Undoubtedly there will be inquiries and reports into the response of the government; however due to the overlap between the asymptomatic and symptomatic transmission and migration patterns of COVID-19, STIs, BBVs, and infectious diseases, international sexual health programmes can use key learnings from the pandemic to address current gaps in policies and interventions.

At this stage of the pandemic, we cannot say exactly what the repercussions will be regarding health risk behaviours. With its waning, it would be reasonable to expect

[4] As of Wednesday 3rd November, 2021 at 17:21 CET

a surge in offline sex-seeking behaviours and high-risk sexual activity (which the UK is already observing since the easing of restrictions), potentially reigniting the cycle of international to domestic and community transmission of BBVs and STIs. New learnt behaviours will perpetuate risky activities; with some such as sexual gratification through technology potentially becoming permanent features in the industry, intensifying sexual exploitation, online grooming, and human trafficking (Hillis et al., 2020b). Based on these observations, core strategies have been outlined in the model, including the need to *scale up preparedness for future crises through ensuring effective healthcare and service provision*; reinstate and develop existing *test, trace, and isolate* functionalities; and ensure that all *healthcare is accessible and equitable*, in alignment with the WHO (2019b; 2021a) Global Action Plan for Healthy Lives and Well-being for All.

Finally, the 'Health' domain investigated the use of PrEP. Literature has tended to focus on the positive impact of PrEP, with daily intake reducing the contraction of HIV by more than 90%, and 70% for those that inject drugs (CDC, 2018b), leading tourists to use it as a preventative measure (Brooks et al., 2018). Conversely, negative messaging draws on the impact that PrEP can have on the individual and wider society. Such narratives include an increase in unprotected anal intercourse (Elsesser et al., 2016), a heightened laissez faire attitude towards relationships shown through increases in infidelity (Thomann et al., 2018), and a renewed stigma with associations drawn between those taking PrEP and stereotypical homophobic promiscuity (Calabrese and Underhill, 2015). Furthermore, studies have reported a rising number of STI diagnoses in PrEP users versus non-PrEP users (Kojima, Davey and Klausner, 2016). In turn, these effects can aid the geographic dispersion of STIs and HIV, from areas of high to low prevalence of the disease (Groom and Nandwani, 2006; Tanton et al., 2016). Whilst PrEP polarises opinions, the scientific community is observing an

increase in cross-border STI transmission. They predict that there will be a resurgence of STIs such as HCV and syphilis predominantly among high-risk HIV-negative MSMs taking PrEP.

Furthermore, recent literature discusses the relationship between PrEP and sexual behaviour in the context of risk compensation theory (Underhill and Mayer, 2013; Newcomb et al., 2018). Risk compensation allows individuals to adjust their risk-taking behaviour in response to a given intervention. For HIV, the intervention was initially condoms. Now that the intervention is PrEP, risk compensation occurs whereby those taking PrEP reduce the perceived threat of HIV acquisition (Blumenthal and Haubrich, 2014); therefore, putting themselves and their partners at risk of HIV and STIs (CDC, 2018b). Although risk compensation theory suggests that PrEP use may potentially increase risky sexual behaviours and STI transmission, evidence shows that primary HIV infection is the leading STI contracted by tourists (Nouchi et al., 2019). The literature is unanimous in that travellers who engage in risky sexual behaviour are a high-risk group for STI and HIV acquisition (Marrazzo, 2005; Schlagenhauf, Santos-O'Connor and Parola, 2010; Svensson et al., 2018). However, there needs to be more research conducted into the health services and interventions supporting travellers (Darrow et al., 2005; Simkhada et al., 2016), especially in the context of the ongoing, global *roll out of PrEP*.

2.6.2 Human Rights

The WHO (2017, p. 9) framework outlines the operational approach to address aspects of sexual health, which advocates for the '*recognition and enforcement of [sexual and human] rights*', through the *implementation of laws, policies, regulations, and strategies* and *checks and balances for multinational corporations (MNCs)* as multilevel influences and structural forces on international sexual health.

Concurrently, the WHO (2019b; 2021a) Global Action Plan primarily calls for stronger collaboration through *supporting community-based organisations and non-governmental organisations (NGOs)*, as well as *holding corporations accountable* with regard to human rights advocation, sustainable financing, research and development, and innovative and accessible programming.

At the same time, there is a need for judicial reformation to support the sex work community. Current state legislations are based on the selling, purchasing, and organising of sex work (NSWP, 2020). In Thailand, the 1996 Prevention and Suppression of Prostitution Act (NATLEX, 1996), criminalises sex work in Thailand, leading to sex workers hiding their profession from the authorities and the police (Keene, 2019). As Thai sex workers operate in dangerous areas, with their work falling outside of the law, the profession acts as a gateway for corruption and in turn, exploitation.

While the majority of countries criminalise selling sex, the purchase of sex is legal in most of Central and South America, Eastern Europe, Asia, and many African Countries. In some Australian states, there are controlled zones with obligatory condom use, HIV testing, and STI testing. Full criminalisation is enacted in parts of the Middle East, South Africa, and Argentina; with complete legalisation observed in Bolivia, Peru, Ecuador, and Uruguay; and full decriminalisation practiced in New Zealand (Platt et al., 2018; NSWP, 2020). All countries criminalise coerced behaviour and child prostitution, and most prohibit non-resident migrants to work legally or in a regulated environment (Platt et al., 2018). However, regulation implementation remains controversial. In 17 countries that legalised some aspect of sex work, sex workers had a lower HIV prevalence than in countries that fully criminalise it (Reeves et al., 2017). Conversely, although New Zealand has shown that sex workers feel more protected, many enter into sex work due to financial hardship and are likely to

experience abuse and violence working outdoors (Schmidt, 2017). The Nordic Model, also known as the Sex Buyer Law or End Demand, advocates for the *decriminalisation of sex work*, whilst providing holistic support services such as housing, legal advice, and healthcare (Nordic Model Now, 2020). However, the Nordic Model declares that sex work is '*inherently violent*', and criminalises the purchase and advertising of sex online (Nordic Model Now, 2020, line. 6). Decrim Now (2021), a UK coalition of charities, NGOs, grassroot activists, and stakeholders such as Amnesty International UK, have written an open letter to the UK government asking to terminate the legislation's introduction to Parliament as it '*will only exacerbate violence against women, including those who are being exploited*'. They claim, as the COVID-19 pandemic has shown, that when sex workers are unable to sustain income, they are pushed into poverty (Decrim Now, 2021, paragraph. 4).

2.7 Macro level: Stage 2

The second stage of the macro level is set aside from the main model as it incorporates the flow of responses found in the first stage, covering elements related to 'Governance', 'Education & Communication', and 'Research'. Although the macro level has two stages within the same level, they are interconnected and should be considered together in the development of interventions, programmes and policies.

2.7.1 Governance

Governments and international organisations must align with CWs and frontline practice to ensure the appropriate use of sex tourism models in implementing interventions. By supporting the development of legal governance and regulations to protect the population, global sexual health services can be improved and efficiently delivered to all levels of society (Ozano et al., 2019). Developing countries

that experience epidemics have effectively *decentralised services and utilised top-down approaches in unison with localised, community-based interventions* (Boland et al., 2020). Notably, governments should regionalise service providers, as they understand the epidemiology of infectious and sexual diseases within their locality. Decision-makers should also consult service providers on surveillance delivery, testing, and monitoring schemes, particularly for HIV and STI management. Finally, to achieve comprehensive primary and universal health coverage (UHC), '*urgent policy level exploration is required for recognising and strengthening* public-private [partnerships]' (Ozano et al., 2019, p. 11).

2.7.2 Education and communication

Industry and national governments appear ambivalent to engage in sexual health education for tourists and sex workers, resulting in lack of support and insufficient, inaccessible prevention services. Structural drivers must be leveraged to remove barriers to health education and care (Platt et al., 2018). Community-based interventions encourage community empowerment (Cowan et al., 2018; Silberzahn et al., 2021), such as peer outreach for sexual *health promotion*, *harm reduction*, and HIV prevention (Cornish and Campbell, 2009), and locally *tailored messaging* and programmes and, for instance, the Zimbabwean Adherence Sisters HIV programme (Cowan et al., 2018).

Whilst communication should inform decisions as opposed to eliminate sex (Ward and Plourde, 2006), current messaging only reaches a small percentage of tourists (Berdychevsky, 2017). With *hard to reach populations arguably the most vulnerable* and in the greatest need of support, innovative communication strategies relating to sexual health risks are required to allow access to appropriate services, before and after travelling (Hillis et al., 2020b). The *timing and delivery* of such messages is

crucial to support and inform the decision-making process of tourists, pre and post-travel.

2.7.3 Research

Researchers must incorporate recent political, social, and economic developments so that decision-makers have sufficient research at their disposal to execute programmes. To achieve this, strategists need to *bridge the gap between research and interventions or programmes*. Suggested research includes monitoring sexual behaviour trends and tourist activities; communicating international sexual health messages in pre- and post-travel settings (Tanton et al., 2016); and conducting studies in collaboration with sex workers and tourists to provide greater representation in findings (Farley and Barkan, 2008). Of note, Wahab and Sloan (2014, p. 3) eloquently explain:

> '*Research into sex work is often limited to the more visible and accessible sectors such as street prostitution, and that a mix of class and gender discrimination and a theoretical bias based on radical feminist convictions leads to an overemphasis on the victimised, powerless and marginalised sex worker. This ignores the diversity and heterogeneity that exist among workers in this occupational group. As a result, mainstream studies arrive at recommendations that advocate inappropriate interventions or policies.*'

Finally and arguably most pertinently, is the need to test existing models through further empirical research. While this chapter has developed a conceptual model, researchers must apply it in larger, real-world settings to demonstrate validity and reliability. The second stage of the macro level exemplifies this point, with the labels of *modelling*, *test existing theories*, and *empirical* or *patient and public involvement (PPI)*.

2.8 Conclusion

This chapter has interrogated, critically analysed, and modernised outdated theories on sex tourism. The holistic public health model, using multi-level associations, is the first piece of research to date that theoretically conceptualises the phenomenon in its entirety. One of the distinguishing factors that sets apart the theoretical model from previous ones is how the well-being of sex workers and tourists are focal points across the different levels. Health should act as a linchpin for many of the domains and respective elements discussed: from behaviour in the micro level, to socio-economic status correlating with health outcomes in the contextual level. The model combines these forces and places them into the wider context of globalisation, technology, harm reduction, and disease migration in the meso and macro levels; thus, achieving one of the core objectives of the thesis. Whilst the levels are versatile and not intended to be rigidly interpreted, researchers, decision-makers, and practitioners will be equipped to understand sex tourism as a whole. By considering structural drivers for sex tourism, legislation, policies, and interventions can be reformed to remove barriers to healthcare (Platt et al., 2018), and ensure that the greatest threats facing international sexual health are effectively being managed.

In order to develop the concepts outlined in this chapter, chapter 3 outlines the methodology used to scrutinise and refine the model through an empirical qualitative study.

Chapter 3: Methodology

This chapter details the overall research design of the thesis, with focus on the theoretical underpinnings, sampling, data collection and analysis, rigour and quality, and ethical approval of the empirical qualitative study conducted to consolidate the conceptual model and meet the overarching aims and objectives.

Recap of aims and objectives

Aim: To map out contemporary sex tourism through the development of a new, theoretical model.

Objectives:

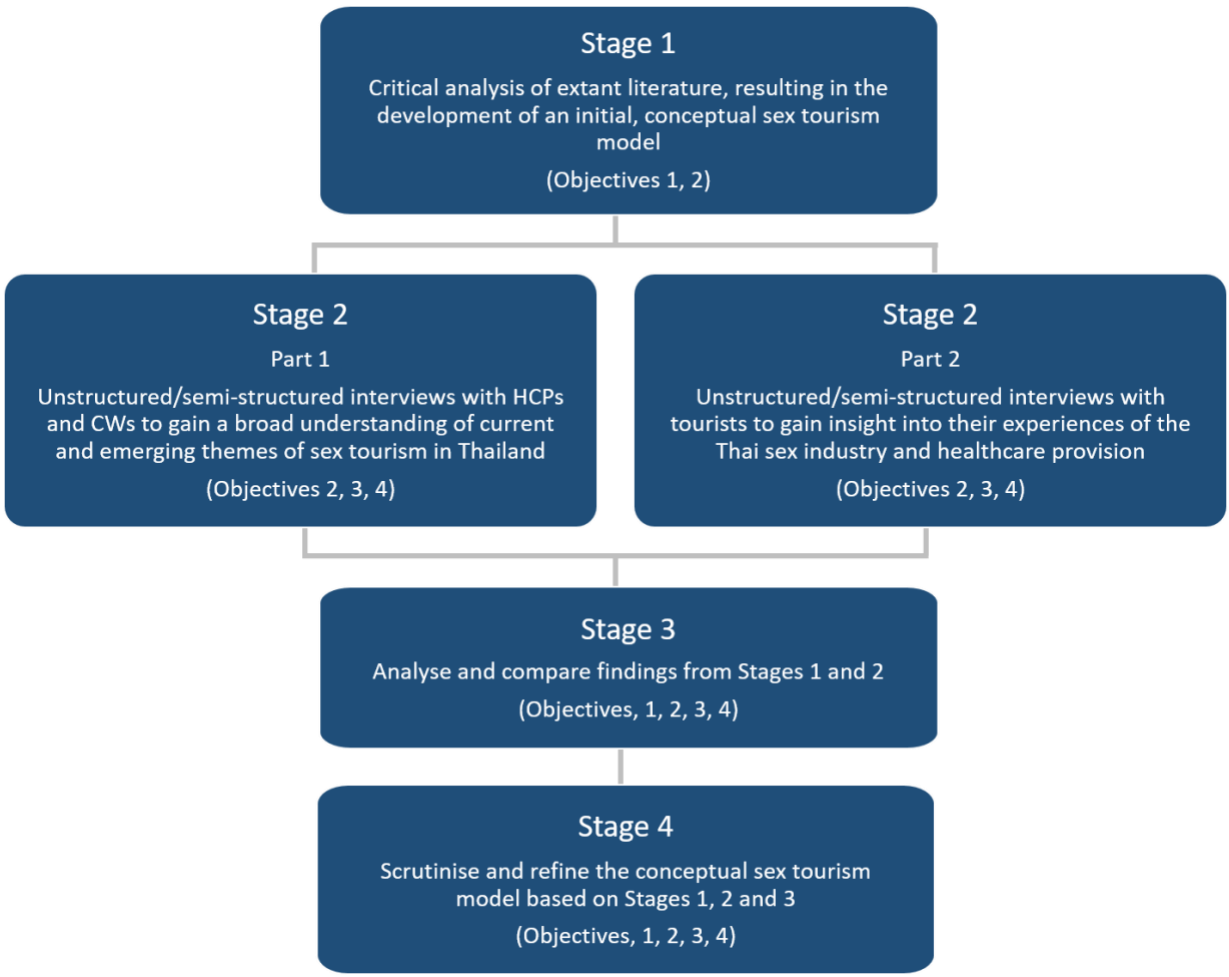
1. Critically analyse multi-level factors that impact sex tourism in an era of globalisation, technology, and disease migration;
2. Gain insight into how sex tourism operates in one selected country, Thailand;
3. Explore multi-stakeholder perceptions around the short- and long-term public health impact of sex tourism on the UK and Thailand;
4. Identify the unmet needs of UK tourists in the domains of public health, social policy, clinical practice, and sexual health programmes.

3.1 Research design

The research consisted of four stages (Figure 2). Stage 1 was a critical analysis of extant literature, resulting in the development of an initial, conceptual sex tourism model (chapter 2). This met objectives 1 and 2. Stage 2 was an empirical, pragmatic, qualitative study interviewing UK and Thai community workers (CWs) and healthcare professionals (HCPs; part 1) and tourists (part 2). The study met objectives 2, 3, and 4 of the thesis. Interviews with participants gained a broad understanding of motivations and behaviours of UK tourists travelling to Thailand; established patient pathways of tourists in UK health services; and explored the unmet needs of tourists. Following this, the interviews sought to understand increased risky sexual behaviour

in the context of globalisation; analysed the impact of technology on relationships between tourists and sex workers in Thailand; and discussed required changes to UK public health and social policy, clinical practice, and sexual health programmes. Stage 3 analysed and compared findings generated from Stages 1 and 2, leading to Stage 4. This final stage scrutinised and refined the contemporary sex tourism model based on the combined findings from the previous stages, as well as presenting a sexual health patient pathway for tourists upon return to the UK.

Figure 2: Stages of the thesis



3.1.1 Qualitative descriptive approach

Stage 2 of the thesis used a qualitative descriptive methodology, as opposed to systematic, qualitative frameworks such as ethnographic, phenomenological, and grounded theory methodologies, which are restrictive and detract from the overall context, research question, and objectives (Thorne, Kirkham and MacDonald-Emes, 1997; Sandelowski, 2000; Creswell et al., 2003). To obtain greater flexibility and reactivity in qualitative research, this study adopted a generic qualitative approach that was more pragmatic in positioning and '*not guided by an explicit or established set of philosophical assumptions*' (Caelli, Ray and Mill, 2003; Creswell et al., 2003, p. 2).

To achieve the flexibility and reflexivity required for qualitative descriptive studies (Bates, 2019), the research combined multiple characteristics from a variety of accepted qualitative methodologies (Caelli, Ray and Mill, 2003), and was fundamentally led by the research question (Tashakkori and Teddlie, 1998). In this instance, what do we know about the experiences and public health implications of tourists and sex tourism? It used generic qualitative techniques such as deploying iterations of data collection and analysis; constant comparison of data; analytic induction; generalisations; and theory formation (Miles and Huberman, 1994; Mays and Pope, 1995; Sandelowski, 2000), to meet the aims of the research in generating a contemporary sex tourism model.

3.1.2 Methods

3.1.2.1 Sampling and recruitment

Based on qualitative research principles, purposive, response-driven, and snowball sampling were used for recruiting all participants (Cooper and Endacott, 2007), '*to*

obtain cases deemed information-rich for the purposes of the study' (Sandelowski, 2000, pp. 337-338). Although the sampling criteria had no geographical restrictions, UK-based participants were mainly from the Northwest and Southeast of England. Thai HCPs and CWs were based in Bangkok or Chiang Mai.

Criteria

HCPs and CWs must have been in contact with patients that have travelled abroad for sex or were thinking of travelling to Thailand for sex. They must have been in a role such as a healthcare assistant, nurse or nurse practitioner, consultant, health advisor, outreach worker, CW or volunteer. Furthermore, they must have been working in a healthcare or community setting that specialises and works in infectious disease, sexual health and HIV, genitourinary medicine, travel, or with key populations such as the LGBTQ+ community.

Tourists must have been over 18 years old and English speaking, as well as having travelled to Thailand for sex, have had sex in Thailand with a new partner or have intentions to travel to Thailand for sex in the future. All genders and sexualities were considered for the study, regardless how an individual self-identified. The study was open to men, women, non-binary, cisgender, and transgender populations, with no restrictions made in relation to the gender or sexuality of the participants' sexual partner.

Recruitment strategies

Due to the many external changes that took place over the course of the research project (see Reflection Box 3), accompanied by the anticipation that recruitment, particularly of tourists, would be difficult, a comprehensive, multi-channel, iterative approach to recruitment was undertaken. Whilst a variety of recruitment strategies

were carried out, the NHS, referrals, word of mouth and pursing leads, led to the recruitment of the final participants. These are described below.

Firstly, HCPs and CWs held the roles of gatekeepers to tourists and as interviewees. Through NHS Health Research Authority (HRA) ethical approval, once Trusts confirmed and issued their capability and capacity (C&C), they contractually agreed to provide a specified number of tourists for the research. For three of the Trusts, I was able to speak directly with consultants as well as speak and present at their respective clinical or multi-disciplinary team meetings to help staff members understand and onboard them onto the project. Staff members were then equipped to inform and signpost service users of the study and its objectives, and ask them if they would be willing to participate in an interview. Unfortunately, due to COVID-19, this recruitment channel for accessing tourists did not materialise. On the other hand, it was through this process that I was able to interview three UK based HCPs, which lead to four interviews.

Secondly, tourists were targeted through a wide distribution of study materials. A website (www.pwtfs.com) was created to provide a point of contact and a safe space for participant involvement at the same time as advertising the study for anonymous participant recruitment (Appendix 4). It contained a full description and expected outcomes of the research, contact information for the researcher, information sheets (Appendix 5), consent forms (Appendix 6), publications, and signposting to local organisations and services. The website did not require any personal information to gain access or download documents, and was publicly available. Posters were created to advertise the study for recruitment purposes (Appendix 7). NHS services, travel clinics, HIV, PrEP and LGBTQ+ organisations and communities were contacted (Appendix 8). Community organisations were also contacted and they shared information on social media and associated websites for signposting

people to the study. It was planned for posters to be displayed in bars, pubs, and nightlife venues with the managers' consent. The poster and website link were extensively shared across social media (Twitter, Facebook, and Instagram; Appendix 9). PowerPoint slides were created and added to information reels in NHS and community organisation waiting areas (Appendix 10), and I gained ethical approval to attend drop-in clinics at service locations to distribute the materials and interview potential participants onsite. Business cards were created and distributed to community organisations, NHS sites, and peers (Appendix 11). Regardless of these far-reaching sampling and recruitment tactics, due to COVID-19 restrictions on travel, the appropriate de-prioritisation of non-COVID-19 research, and the impact that the pandemic had on daily lives, no tourists were recruited through these means. Whilst recruitment materials were altered and ethically approved to include a COVID-19 statement: 'Are you someone who normally travels for sex but can't because of COVID-19? Have you had to adapt and change?', I had to further extend the recruitment strategy and use a more informal approach. Word of mouth in social and professional networks, and subsequently referrals or suggestions from participants, quickly became the only viable recruitment tactic for the study, utilising a proactive response-driven sampling method.

Finally, after discussions with the Liverpool John Moores University (LJMU) ethical sponsor, I had the opportunity to pilot a research website through the Doctoral Academy at LJMU, *Call for Participants*.[5] I posted an advert with similar content to materials described above, and a tourist (participant 3, case study 3) volunteered for an interview. Using the same approach, I reached out to my own personal network, and I was put in touch with a Thai-based community worker (participant 2, case study

[5] https://www.callforparticipants.com/study/page-summary/EXFE9/summary

2). During this interview, participant 2 mentioned a sex worker organisation in Thailand, which lead to case study 6. Similarly, participant 4 (case study 3) mentioned a testing campaign that was led by participant 10's community organisation.

The study aimed to recruit five to ten HCPs and CWs (Braun and Clarke, 2006). In total, it recruited three UK-based HCPs, one Thai HCP, and four Thai-based CWs. As a consequence of COVID-19, the aim was to recruit two to three tourists and the study successfully recruited two people (the tourist and their partner; participants 3 and 4, case study 3). Table 1 below demonstrates the effective sampling method and referral system used in the recruitment process, highlighting the use of response-driven sampling.

Table 1: Recruitment tactics

Case study (Participant)	Role	Thai/UK	Recruited from
1 (no. 1)	HCP	UK	NHS HRA
2 (no. 2)	CW	Thai	Peers/social network
3 (nos. 3 and 4)	Tourists	Thai &	Call for Participants
4 (no. 5)	HCP	UK	NHS HRA
5 (no. 6)	HCP	UK	Colleague of participant no. 5
6 (nos. 7, 8 & 9)	CW	Thai	Community organisation mentioned by participant no. 2
7 (no. 10)	CW	Thai	Community organisation mentioned by participant no. 4
8 (no. 11)	HCP	Thai	Peers/social network

3.1.2.2 Data collection

Interviews were conducted with all participants, except in one case where data were collected over email (participant 4, case study 3). In the early stages of the data collection period, the interviews were unstructured in nature, with an interview schedule focused on core topics related to sex tourism, which were informed by the initial literature review. The interview schedule can be found in Appendix 12. The

topics discussed during the course of data collection were continually evaluated and refined, moving towards a more semi-structured interview style to allow for maximum variation, theory development, and emergence of new concepts so that the richest possible data was collected throughout the project (Cooper and Endacott, 2007). Memos and reflections were documented throughout data collection and analysis to support the search for relationships and patterns. This form of data collection was carried out until data saturation: when the researcher '*continue[s] to recruit participants until no new data emerge*' (Cooper and Endacott, 2007, p. 818). See Table 1 for further details.

All interviews were conducted over videoconference software (Zoom or Microsoft Teams). Participants were advised to conduct interviews in a quiet and safe environment that was comfortable for them and where they would not be exposed to interruption. This was part of the ethical approval application, in the participant information sheet, mentioned in email correspondence prior to the interview, and discussed at the beginning of the interviews. The interviews were held at a mutually convenient time and typically lasted an hour, ranging from 35 minutes to an hour and 18 minutes for HCPs and CWs. One HCP had a follow up interview a year after the first. The tourist interview lasted an hour and 46 minutes, with follow up over email with them and their partner. The interviews were recorded using a dictaphone and immediately transcribed. The transcriptions were anonymised and uploaded recording onto Microsoft Word. Further details can be found in section 3.2 Ethical approval.

Reflection Box 2: Positionality

I believe that reality is mediated through language, meaning-making, and social context. For tourists and sex workers, their realities are shaped by social, political, cultural, ethnic, and gender values, that are under constant internal and external influence. My research has some form of emancipatory goal, such as exposing hegemony or a social injustice. These goals are achieved through broadening cultural contexts and focusing my work on disempowered and vulnerable populations. I, therefore, currently lean more to a critical realist perspective, feeding into the idea of challenging existing social structures and enacting systemic changes (Crotty, 1998).

I am a white, middle-class, educated, heterosexual woman. Some of the participants (mainly tourists and community workers) were either from sexual minorities, low socio-economic backgrounds, or a different race to myself. Although being a woman today means I have experienced systemic inequalities and discrimination, I acknowledge the obstacles that I face will always be from a position of privilege. Through my own professional experiences working in frontline sexual health clinics, I have learned not to hold or demonstrate any judgement, and be open-minded and empathetic, which I carried through all of the interviews. If participants discussed something morally questionable, I knew how to effectively remove my own emotions from the conversation and not project my own outlooks onto the participants. At the same time, working in sexual health, in the NHS and research, and being in very open but private conversations with younger and older MSM meant that I learnt not just what to say but how to say things, as well as to anticipate certain sensitivities. Although this may come across as a generalisation, each individual and therefore interview was tailored, and I was hyper-aware of social cues (even more so as the interviews were conducted over video conferencing software). Particularly over the last two years, I continually try to truly listen to other's when they are sharing life experiences that are very different from my own. By this, I mean that I want to

understand their perspective in its entirety so I can comprehend the phenomena being explored at the same time as people's lived experiences and what matters to them. Taking this approach, meant that the questions in the interview schedule could only take an unstructured to semi-structure nature, as I wanted to be guided by the participant, respond to what they wanted to share with me, and ultimately learn. At the beginning of every interview, I explained that this was my intention and approach to the interview and overall study, which I found immediately built rapport with all participants. As each interview progressed, and due to the informal environment, I was able to gain trust and hopefully respect, whether I was speaking to a UK based HCP, a Thai tourist or a CW. This is further discussed in Reflection Box 5.

3.1.2.3 Data analysis

Data collection and analysis occurred simultaneously as they mutually shaped each other (Sandelowski, 2000). Two types of analyses were conducted concurrently to meet the objectives of exploring multi-stakeholder perceptions, unmet needs, and the operationalisation of sex tourism. Firstly, thematic analysis followed suit of the chosen qualitative descriptive methodology, as it enabled an '*accessible and theoretically flexible approach to analysing qualitative data*', and allowed for a combination of data-driven (inductive) and theoretical (deductive) interpretations to be made throughout the data collection and analytical process (Braun and Clarke, 2006, p. 77). Secondly, the data were analysed and written up as case studies as this type of analysis provided an intensive, individualist, and holistic description of sex tourism (Merriam, 1992). The eight individual case studies are presented in chapter 4.

In alignment to Braun and Clarke's (2006) six-step guide, the data were analysed through the familiarisation with data; generation of initial codes; search, review and

define themes; and summarisation of findings. Following the six-step guidance (Braun and Clarke, 2006), all interviews were audio-recorded, transcribed, and anonymised. The transcription of each interview was imported into NVivo QSRTM and coded into themes. As analysis was undertaken after each interview was held, the codes underwent continual revisions, iterations, and constant comparison to ensure that the study retained openness and the data spoke for itself (Glaser and Strauss, 1967; Braun and Clarke, 2006). The data were then written up into case studies using a narrative, informal way, embodying short-story techniques, excerpts of dialogues, and descriptive detail (Radley and Chamberlain, 2001; Riessman, 2003; Ellet, 2007).

Although case study analysis deviates from Braun and Clarke's (2006) guidance, by using the two types of analyses, the themes that were developed in Stage 1 (model generation), were deductively tested at the same time as allowing for new themes to inductively emerge from the qualitative data (Sandelowski, 2000). This ensured that any gaps were accommodated for by the other set of analyses (Mays and Pope, 2000), which was particularly important as the combined themes were then used to scrutinise the model, conceptualisations, and assumptions in the Discussion (Thorne, Kirkham and MacDonald-Emes, 1997; Mays and Pope, 2000).

3.1.2.4 Rigour and quality

Methodological research continues to questions the value of qualitative studies. Some academics argue that qualitative and quantitative studies cannot be measured or assessed by the same criteria as they are from distinct paradigms and built on the notion of multiple social realities (Lincoln and Guba, 1985). Conversely, subtle realists agree on a single, underlying reality and that research attempts to represent it (Mays and Pope, 2000). However, pragmatically, participants experience their own reality,

which is separate from the need to uphold a level of quality within health-related research.

To address quality in qualitative research from a health perspective, Thorne, Kirkham and MacDonald-Emes (1997), Mays and Pope (2000), and Cooper and Endacott (2007) identified core ways that assess the rigor and, therefore, quality, of a generic qualitative study. Table 2 details their combined assessment criteria and the corresponding strategies that were taken during this research to ensure quality was achieved and maintained throughout the duration of the project.

Reflection Box 3: The impact of COVID-19

One year and four months into the project, the WHO announced COVID-19 as a global pandemic. England was in lockdown, HCPs were redeployed to the frontline, and the movement of people became severely restricted, significantly affecting the global tourism industry. When discussing the pandemic with my supervisory team, I drew parallels between how globalisation facilitates the transmission of COVID-19, HIV and STI migratory patterns. From this, I was able to publish an editorial in the *Journal of Travel Medicine* (Appendix 1).[6] It spoke to the international strategic responses to COVID-19, which can be applied to sexual health and, by proxy, the sex tourism industry, particularly when borders fully reopen. The editorial received correspondence from Doctor Nikola Naumov at the University of Northampton, who commented that while this type of research is warranted, '*we first need to focus more on the nature, context and realities of sex tourism in order to understand and anticipate the inevitable changes in the post-pandemic era*' (Naumov, 2021, p. 1; Appendix 2). The thesis sought to achieve exactly this and so I began to develop the conceptual model, whilst recruitment was halted. I published the model in *Tourism Review* (Appendix 3).

COVID-19 pushed me to question my own decisions and refocused my priorities. The changes that were made were therefore positive to the research, as the findings were much more encompassing of the phenomenon, and the model became more holistic in nature and a truer depiction of the reality. It is for this reason that the study should remain at the forefront of the research field. The longer the pandemic persists, the more permanent behavioural change will be, which must then be documented in future iterations of the conceptual model.

[6] Hillis, A., Leavey, C., Kewley, S., Church, S. and Van Hout, M. C. (2020) Sex tourism, disease migration and COVID-19: lessons learnt and best practices moving forward. *J Travel Med*. DOI: 10.1093/jtm/taaa144

Table 2: Strategies to uphold rigor and quality

Assessment criteria	Strategy used to meet assessment criteria
Triangulation	
Triangulation compares the findings from a minimum of two different sources, looking for convergence or divergence in the results.	The study did not use a specific triangulation framework such as Farmer et al. (2006), as the different stages required sequential analysis. However, the study achieved elements of triangulations through carrying out an extensive literature review and developing the model; collecting data from multiple sources; and using two sets of analyses, which together maximised the strength of the individual elements.
Respondent validation/feedback/memberchecking	
Transcriptions or analyses are returned to the participant for amendment or approval.	All participants were asked if they were willing to provide feedback and validation of the findings. Two case studies were member checked, feedback was provided, and suggestions incorporated ahead of inclusion in the thesis.
Research process	
A clear account must be given for all stages of the research design and process, including analytical categorisations and frameworks.	The research design was presented earlier in this chapter. At each stage of the thesis, decisions are clearly highlighted and reiterated to ensure transparency. Furthermore, a traceable audit trail and record process were documented, allowing the research to be replicated in other settings.
Reflexivity	
Reflexivity should be practiced to understand the researchers' position, recognise bias and prior assumptions, and identify 'distance' between the researcher and those being researched.	Reflexivity was exercised throughout the study, with memos and reflections documented throughout data collection and analysis. Important deliberations were written up in Reflection Boxes that are placed in their relevant positions throughout the thesis. Most notably, Reflection Box 2 details my current positionality as a qualitative researcher.
Fair dealing	
The research design must incorporate a wide range of perspectives to avoid over-representation and lack of generalisability for the depiction of a phenomenon.	Participants included tourists, their partners, HCPs, and CWs, each with distinct roles within the sex tourism industry. Participant demographics as well as personal and professional backgrounds were wider ranging, offering UK and Thai perspectives.
Saturation	
Data saturation is when the researcher '*continue[s] to recruit participants until no new data emerge*' (Cooper and Endacott, 2007, p. 818).	Recruitment of participants and interviews finished once *data* saturation was reached – once the themes from Stage 1 (model development) were accounted for, no new data themes emerged, and the interviews reached their natural conclusion. It is worth noting that saturation of *recruitment* was not feasible for this study due to COVID-19. Future research should target wider recruitment of key populations.

3.2 Ethical approval

Ethical approval was obtained from the NHS HRA Research Ethics Committee (REC; reference: 19/NW/0253) and the LJMU REC and LJMU Sponsor (reference: 19LJMUSPONSOR004NHS). The complete ethics application can be found on the Integrated Research Application System (IRAS) portal (ID: 256202) and confirmation is provided in Appendix 13. Two amendments were approved during the research project. The first minor amendment was adding new research sites, and the second was a substantial amendment relating to recruitment methods following the impact of COVID-19. See Reflection Box 3 for background on the changes implemented, and Appendix 14 for ethical amendment approvals.

Ethical considerations were taken into account at every stage of the research process. The study materials contained no coercive language or imagery and were written with sensitivity to culture, gender, and sexual differences. The recruitment pathway meant that tourists had to have been referred or have seen the study materials before they voluntarily made initial contact. I did not initiate contact with potential tourist participants. To open communication with HCPs and CWs, this was either done through gatekeepers at RD&I departments or I sent a generic, pre-approved email to the organisation's research email address or online enquiry boxes rather than directly to an individual. In all cases, I ensured that no assumptions were made and the emails were factual and limited to the scope of the research. No incentives were offered at any stage of the project.

Once a participant agreed to participate in an interview, I sent them a participant information sheet (Appendix 5) and consent form (Appendix 6). I also directed them to the study website (Appendix 4) in case they wanted to consume the information in their own time. Participants returned their signed consent forms ahead of the

interview. At the beginning of each interview, I re-explained the study, went through the participant information sheet, asked if the participant had any questions, and gained verbal consent to ensure the participant was content to proceed at that point in time. I also advised participants that they were not obligated to answer any questions they do not wish to answer, were be able to skip questions, end the interview at any stage, and that if the interview needed to be stopped, it would have no impact on the services they may want to receive regarding support and helplines.

Minimal personal data were collected such as contact details and demographic information depending on the role of the participant (race, age, gender, sexual orientation and location for tourists, and job title, profession and place of work for HCPs and CWs). Participant codes were assigned. These data were saved on a password-protected Microsoft Excel file. Personal details were stored separately to raw data and personal. Identifiable data will be stored for 10 years in alignment of LJMU policy.

As mentioned, the interviews were recorded using an encrypted dictaphone and immediately uploaded onto my personal, password-protected LJMU OneDrive account. Once uploaded, the recordings were deleted from the dictaphone and shortly after, I transcribed and anonymised them from the uploaded recording onto Microsoft Word, where they were again, stored in a password-protected LJMU OneDrive account.

Whilst the interviews were written up as case studies, all personal data were removed to ensure that the participants were unidentifiable. During the interview, all participants were offered to review the first draft of their own case study for validity, reliability, and to ensure ethical transparency. Pseudonyms were used for all case studies except in case study 6 (participants 7, 8 and 9), who asked for their real

names to be used as they believed the use of pseudonyms was reflective of the silencing of sex worker voices in research. This was discussed with all supervisors, who agreed that no ethical complications arose from this, as the topics that were covered in the interviews discussed their role as a CW and representative of sex workers and the situation and rights of sex workers in Thailand. They did not comment on any sex workers and no identifiable information was shared or compromised in the interview and therefore the case study. Participant 2 (case study 2) was concerned about identifiable information as they now no longer work in the role they were discussing during the interview. The participant made the adjustments to the case study itself, so that when they returned it to me, they were comfortable with the information within the final version. For the UK based HCPs, I personally removed or generalised identifiable information in their case studies. This did not represent or raise any ethical issues or compromise the reporting of the findings, and was more for ethical due diligence.

During the HRA REC, one of the main ethical concerns was the impact on participants if sensitive topics arose during interviews, as they could potentially cause psychological distress. Particularly with CWs and tourists, the interview schedule centred on sexual behaviour and sexual experiences that may have been traumatic for the participant such as abuse, risky behaviour, sexual orientation, and gender identity. To minimise the risks, it was emphasised that the focus of the research was on the processes within sex tourism and that the outcomes were to provide public health interventions if and where necessary. Furthermore, I have considerable experience working with vulnerable populations in healthcare settings and through research. Participants were provided with multiple channels to access support services through anonymous platforms. To my knowledge, these were not utilised or requested.

The entire ethical approval process took nine months to complete. The exercise of NHS HRA and REC ethical approval was arduous with the application and approval of individual site research passports, confirmations of C&C, letters of access, statements of activity and distribution of UK Local Information Pack. However, there was effective collaboration with NHS site Research, Development and Innovation (RD&I) departments, consultants, HCPs, and CWs, which built relations ahead of recruitment. The process presented significant challenges. The initial response from the REC raised ethical concerns around the disclosure of illicit activities and my lack of training relating to activities such as terrorism, money laundering, and human trafficking. To minimise these risks, the primary aim of the research was emphasised and the LJMU Sponsor supported and approved changes made to the statements used in the participant information sheets regarding conferring with colleagues to maintain (or not maintain) confidentiality in order escalate the situation to appropriate professionals. No participant made any such disclosures. Other challenges included lack of communication of changes to the IRAS application process, differing internal processes between each NHS RD&I site, and finally, once approval was granted, sites still did not accept the project due to C&C or the lack of priority given to research within a Trust, meaning further amendments needed to be made before the project was able to commence. To accommodate these challenges, the LJMU Sponsor and my supervisors were particularly helpful, responsive to queries, and supportive of the application.

Following the recruitment and data collection, data analysis was undertaken and the interviews were written up in case studies, which are presented in the following chapter.

Chapter 4: Case studies

Reflection Box 4: Writing up the case studies

'*In the social sciences…a case study is a twice-told tale, involving actions of a subject and actions of an investigator, who transforms a person into a 'case.' When done well, the investigator* "recreate[s] the presentational features of the encounter in a way that replicates the experience of the investigation" (*Radley and Chamberlain, 2001, p. 328). The reader or listener can then re-create the individual in imagination, locating him/herself through identification in the social world of the patient*' (Riessman, 2003, pp. 5-6).

There are exhaustive amounts of literature on sex tourism, sex workers, tourists, the police, and community organisations, to name a handful. Some of the reading can be particularly heavy, describing dark scenarios such as abuse and exploitation. Yet in all the reading, I do not feel that I can put a face to many of the individuals and populations described. By using case studies, I hope I have shone a new light on some of the people involved in sex tourism and given the reader an unseen glimpse into the industry that they may not have seen before. I wanted them to feel as though they were on the journey with me as I spoke to the participants. I sought for the readers to immerse themselves into the conversations, to have insight into my own thought processes, and to put themselves in the shoes of the participants by closely reading my perception of their emotions, reactions, and memories.

An interpretive case study approach was taken instead of a more generic thematic structure to present the data and findings of the interviews in order '*to develop conceptual categories…or challenge theoretical assumptions held prior to the data gathering*' (Merriam, 1992, p. 38). Thus, supporting the overarching intention of the research. More specifically, as the case studies provided varying perspectives of the sex industry, when combined, they worked as a powerful tool to challenge public assumptions of sex tourism, whilst also allowing for the exploration into the complexities of the phenomenon and gaining greater insight into the lived realities, experiences, and attitudes of those involved (Gillham, 2000).

This chapter presents the eight interviews that were conducted with 11 participants between April 2020 and June 2021. The case studies are presented in the chronological order that the interviews were conducted in (except for the follow up interview in case study 1). Dessie (case study 1) interviewed twice. Dao (case study 2) and Liz, Ping Pong and Mai (case study 6) requested their case studies to be returned to them for their review ahead of inclusion in the thesis, which took place over email. Korn (case study 3) provided statements over email, whilst George (case study 3) and Naw (case study 8) confirmed facts and translations over email,

following their interview. All the case studies use pseudonyms for anonymity and confidentiality, except for Liz, Ping Pong and Mai, who requested their actual names used throughout the research. Of the 11 people interviewed, six were women (inclusive of Liz as a translator in case study 6), four were men, and one was a transgender woman. Within this, all the conversations discussed a sexual encounter between a male tourist and a female or transgender woman sex worker.

Although sex tourism is a global phenomenon, the case studies achieve the objective of gaining insight into its operation within Thailand, particularly in the conversations with tourists and CWs based in Thailand. At the same time, the cases offer multiple perspectives from the various stakeholders in the UK and Thailand, providing unprecedented and original perceptions into short and long-term public health impacts of sex tourism and the needs of tourists and sex workers relating to public health policy and programmes, clinic practice, and sexual health service provision.

It is also worth noting that before COVID-19 and during initial recruitment, I had planned for the interviews to focus on sex tourism, the interaction of individuals within the sex industry, and the impact of this on sexual health services in the UK. When the interviews occurred, COVID-19 was encompassing the world and everyone I would subsequently speak to would describe very different scenarios, responses, and outlooks depending on regional and country specific situations.

4.1 Dessie – 'What happens in Thailand stays in Thailand'

Interview 1 of 2

For my first interview, I was able to speak to Dessie, a Consultant in Sexual Health at a city hospital in the Northwest of England. Our first conversation took place in April 2020, our second almost a year later.

Dessie had met many 'sex tourists' in her clinic who travel to Thailand. Reflecting on her conversations with her patients, she had the impression that in Thailand, '*you can pretty much go into any tourist bar and you will be able to access commercial sex*'. With many travelling for escapism and excitement, she declared, '*what happens in Thailand stays in Thailand*'. The majority of her patients were heterosexual males who were having sex with Thai female partners – but she had also dealt with MSM who travel for sex to Thailand, usually in groups, having sex with each other and travellers. When pressed to consider the possibility of holidaying in Thailand to sexually experiment, Dessie responded, '*So nobody has ever told me that'.* This concept sparked the idea '*that there's maybe more acceptability in Thailand to have MSM partners or transgender partners'.*

Dessie articulated that three distinct age groups existed in her patients that travelled to Thailand for sex. The first cohort were '*lads'* in their twenties and thirties who were holidaying in groups, having sex with multiple partners, and not necessarily wearing condoms. After their holiday, they attend Dessie's clinic, '*extremely anxious about exposure'*. The second cohort were over forty years old who '*travel regularly through work'.* The final cohort were over sixty, white, tended to be living with HIV, and had '*long term Thai partners, who live in Thailand'.*

Dessie explained how the '*lads*' were not as forthcoming about their sexual encounters in Thailand as the older men, and they presented a spectrum of behaviours ranging from substance use, excessively drinking in bars, or having unplanned sex. She described how sex was often unintentional and how '*some people have had so many episodes of sex with different people, you kind of feel like it's not just some random occurrence, you know, they must have been seeking sex because you know if you're on a two-week holiday and you managed to have ten partners…*'. To Dessie, this epitomised '*sex-seeking'*.

In the ten years that Dessie had been working in sexual health, she had observed the impact of package holidays, with many from lower socio-economic backgrounds now able to afford to travel to Southeast Asia. Consequently, sexual health clinics are seeing '*people having more sex and traveling to say Thailand, than we would see in people who have gone on holidays to Eastern Europe*.' When Prague or Amsterdam used to be the only accessible foreign red-light district, tourists were having sex with one or two partners during the holiday, whereas those that are now travelling to Thailand are '*averaging at least one partner a day if not more. I don't know how they have the time!*'

Dessie's patients were more anxious about casual encounters abroad than those at home were. In the UK, unprotected MSM sexual encounters are high-risk. Yet, they believe that their overseas partners pose a greater threat to their sexual health, and present with distorted self-assessments for risk, particularly in relation to condom use.

> '*Maybe they just had oral sex with the partner or they've had vaginal sex with a condom and they'll be really anxious about that. And yet, they'll have had another partner where they didn't use a condom and there was some blood involved or something like that. And you'll think, "Goodness, that's the*

episode [that] I'm really worried about" and yet they won't be worried at all about that'.

Dessie thought that this was to do with the individual's choice of, and instincts towards, their sexual partner. She named this concept, the '*partner specific decision*'. If the patient did not feel content about the encounter, they would display anxieties relating to HIV and STI exposure, regardless of the actual risk.

The second cohort identified were businessmen. It was clear that businessmen attending Dessie's sexual health clinic after travelling require minimal treatment. They understand their risks, and consistently adhere to guidelines. While Dessie reported that they tend to have multiple partners in various countries, they are usually taking PrEP and attend '*regular 3 monthly check[s]'.* Finally, for older males, Dessie recalled specific cases from her time working in the South of England. Anecdotally, there were around ten to twenty cases of where a white, older, British male had married a Thai woman and brought her back to the UK; and it was the Thai woman that transmitted HIV to the British man. While Dessie described the Thai women as '*beautiful, intelligent [and] delightful*', by comparison, the men were '*older, less good looking, less pleasant as a human being to deal with in clinic*'; leading her to think, '*why has this woman married this man?*', and that the transaction is the relationship.

Aside from Thailand, Dessie interestingly recalled that her female patients tended to visit African countries, '*who are maybe second generation or first-generation expats or...immigrants to the UK and they're traveling maybe back to their home country and then when they get there…having sex*'. Adding that she believed this was *'with a regular partner and also with casual partners'*. It is also worth noting that during her medical training, Dessie observed a cohort of people who travel to various countries for child sexual exploitation purposes. In these early years, Dessie suspected child

grooming was taking place. '*I guess it's easier to have underage sex abroad'*. One patient was prosecuted, and another had their case handled by the police.

Service provision

Dessie confirmed that her patients who travel to Thailand, access PrEP and antibiotics abroad if symptomatic. However, this is problematic for sexual health clinicians in the UK, as they do not know the antibiotics that Thai-based HCPs prescribe to patients, their symptoms may have not cleared, and '*the PEP that has been started is not what we would choose to start in the UK*'. Whilst Dessie made me aware of the prevention and treatment options that were in place, such as the self-referral service, walk-in clinics, encouraging patients to seek medical advice within 48 hours, and proactively contacting high-risk patients who travel to consider initiating PrEP, she confirmed that there are no specific, recognised pathways for those that are planning to travel for sex. Some patients have little understanding of HIV testing and window periods. If patients miss window periods, they are then illegible for post-exposure prophylaxis (PEP). This concerned her, as '*often patients come back and they've taken an enormous risk*', they are in '*absolute shock*' as '*they had no idea they're placing themselves at the degree of risk we would consider them to be at*'. For example, they may not have considered the incidence of HIV in Thai sex workers in comparison to the UK. It was at this point that I had the realisation that as researchers, we collaboratively need to deliberate ways to protect tourists', and their partners' sexual health. Dessie highlighted that it verges on a political issue due to the liberal nature of what we are proposing, as was seen with the advocation of PrEP. However, this rhetoric stayed with me during the rest of my interviews.

Dessie also shared that patients may not disclose previous sexual histories or activities to practitioners. It was apparent that this was a regular obstacle in Dessie's

consultations. She tries to make the clinic have an '*open environment'*, by offering tests that are associated with high-risk behaviours, such as rectal swabs, in '*a really neutral way'. 'Having said that the odd patient will say, "oh yeah, I'll have it swabbed". So you kind of think that they probably have had sex with a man or something'.* Dessie confirmed that she had observed generational differences in attitudes to sexuality, remarking that,

> '*Judgment regarding sexual activity has definitely relaxed over time...I can easily ask a patient in their twenties, a male patient in their twenties, "Have you ever had sex with a man?", and they'll just say no and there's no offense taken at all. Whereas you have to be often quite careful how you introduce that kind of question in the older generation*'.

Impact of COVID-19

During the interview, Dessie discussed four ways COVID-19 affected sex tourism. Firstly, the tourism industry had come to an abrupt halt as countries closed their borders, the government furloughed people working in tourism, and many lost their jobs. Secondly, Dessie described an '*anti-Asian sentiment seen with COVID*', '*that's going to affect Thailand and Thailand's tourist industry*', or '*people will be more anxious to travel to kind of more tropical locations because of the risk of infection*'. Thirdly, '*COVID has demonstrated very clearly just how interconnected we are*'. For example, the spread of lymphogranuloma venereum and Hepatitis A in MSM, and transmission of antibiotic resistant gonorrhoea (or super gonorrhoea) from Thailand to Australia, the Netherlands, and the UK. Finally, we talked about the way people were using the Internet differently to satisfy their sexual needs. Whilst some people met their partners online as they lived in other countries, Dessie reminded me that, '*Tinder and Grindr are what keep us in business*'. With dating app use high, Dessie shared how it was her '*PrEP patients [that] access their partners through Grindr*' and that people attend clinic following a sexual assault, usually from meeting their

partners online, with some getting together after attending virtual sex shows. Recent literature highlights that the COVID-19 pandemic has forced Thai sex workers to move online for work. I raised this issue with Dessie who stated, '*Absolutely...It's very worrying, isn't it? Because you think once COVID is over, you know, not only is living in poverty terrible for your health, but it also easier for you to take risks that you might not otherwise take'.*

Recommendations

To protect those who are travelling for sex, Dessie described existing working groups. The British Association for Sexual Health and HIV (BASHH); the European equivalent, International Union against Sexually Transmitted Infections (IUSTI); as well as specific European Collaborative Clinical Groups (ECCG) develop high-quality guidelines, of which Dessie is a member of and publishes regularly on topical issues such as the management, testing, and treatment practices of gonorrhoea and herpes. Dessie emphasised the differing management standards between countries, which could '*massively increase risk of resistance and treatment failure'.* With people constantly travelling between countries, this is an issue; '*There's no doubt about it: it's not just enough to put our own hats in order when it comes to care of STIs...[if] we don't make international decisions we're going to reap the problems in our own patient cohort*'. I suggested the idea of communication between Thai and UK-based sexual health services to encourage the exchange of communication. Dessie responded, '*Yeah, absolutely'*. She described a case in which a man was diagnosed with antibiotic resistant gonorrhoea and the story hit the media; yet, there was no comment on '*who else ha[d] been exposed within the network'*. There was a consistent narrative that interventions warrant greater international communication to achieve health for all and bridge the inequality gaps within and between countries.

'*Stigma is a massive, massive barrier*' for patients accessing sexual health and social services in the UK. Regardless of the patient's background or context, Dessie hears the recurring statement in consultations: '*I'm not the kind of person that needs to come to a sexual health clinic'.* Dessie believes that patients continue to feel shame and guilt regarding sex and their bodies, and that seeking medical advice deems them a failure. They do not want to discuss risk or harm reductions while in clinic, as '*there is a degree of kind of resistance to receiving education*' in a clinical environment. Therefore, she suggested the need for improvement in '*basic sexual health messaging*', education, and communication. Using a similar example of PrEP, Dessie's patients were hearing about PrEP through word of mouth, the LGBTQ+ community, and their social networks. Fascinatingly, Dessie identified that the same cohorts considered high-risk for HIV, required PrEP education and did not step forward for the IMPACT trial (heterosexual men and women, and transgender people): *'[They] are putting themselves most at risk from a sex tourism point of view...[and] they're quite a difficult group to reach for any health message actually*'. Insightfully, as a member of the NICE guidelines committee pre-COVID-19, Dessie and her colleagues were compiling a 'Reducing STIs Guidelines', which to her own admission, was based on '*pretty weak evidence*' and so '*whether it actually makes a difference – I think some of it's doubtful'.* She suggested that information should target tourists before they travel, for example as they are getting on a plane or in travel clinics when getting vaccinated, as this would be an ideal opportunity to share updated information on sexual health advice before travelling abroad. Dessie based these recommendations on her experience that she only sees patients after they have travelled, and she believes this is the missed opportunity.

From a medical prevention perspective, Dessie stated that she '*would really like to be able to offer short term PrEP prescriptions for people who aren't necessarily people*

that travel regularly but might be going on that holiday of a lifetime, and would benefit from a short-term PrEP prescription'. When the interview took place, the NHS was not funding PrEP, which limited access to a restricted criterion. Yet, Dessie wanted to see a future scenario where a clinician could prescribe a month's worth of PrEP and advertise to patients: '"*Are you about to go on holiday to Thailand and if you're likely to have sex, come in and see us...start your PrEP before you travel, take PrEP while you're away*"'. She recalled how she already sees this in her herpes patients, who request short term suppression while they are on holiday, so Dessie believes HIV management via PrEP can replicate this in a '*safe and controlled manner'.* Not only would this protect individuals from HIV but it would also increase footfall in sexual health clinics. Dessie began to run with the idea, highlighting that,

> '*We saw it with Ebola, where you have lower resourced country trying to tackle such diseases, that effectively puts the whole world at risk, including those very advanced healthcare systems...how we spend our development money and targeting health services is going to be important*'.

Finally, Dessie emphasised the need to focus on social and health disparities. This conversation opened up what was to then inform some of the main underpinnings of the research: the idea that '*poverty is not just bad for your health because you do not have enough money to look after yourself, but you also [do] not receive health messages*'.

Interview 2 of 2

The second interview with Dessie was nearly a year later. As we were over 12 months into the pandemic, the interview had a very different feel to the first.

Testing

I began by asking, '*what has happened over the last year in regards to sexual health services in the UK?'* Dessie's response was eye opening and painted a vivid picture of the realities of COVID-19. Due to social distancing measures combined with staff being sick, shielding or redeployed, the sexual health service had undergone '*astronomical'* change. Before the pandemic, two hundred people would previously attend the walk-in clinic each day, with forty people in the waiting room at any time, and all seen within an hour. At the time of speaking, the department was only seeing emergency or urgent health cases, not even symptomatic patients, with around twenty patients a day able to have face-to-face access to a practitioner. Phone triaging, phone consultations, and the mail posting of medications and home-testing kits transformed the service. Dessie's silver lining was the creation of asymptomatic online testing.

> It is '*something we've been wanting for years, and I think the Commissioners had always been hesitant to introduce it...for financial reasons...we've certainly had some people testing online who have never been into clinic before, so it certainly helped us access some new populations*'. Insightfully adding, '*there obviously is something about the kind of anonymity of getting something through a website, filling it in, you know, completing it in the privacy of your own home*'.

The uptake of testing during COVID-19 had been acceptable, with patients learning about the changes through self-referral or phone consultations. '*Some patients expressed anxiety around accuracy [of the tests]',* with one patient attending the face-to-face clinic after it had partially re-opened due to fear that they had received a false negative result. Dessie seemed surprised that patients were questioning the validity of the tests, assuring them that they had met sensitivity and specificity standards. I pressed her on where she thought patients' anxieties derived from. Dessie explained how a few years ago, following research that proved the effectiveness of patients self-swabbing, they took their own samples. As the clinician

did not take the swabs, there was initial reluctance and questioning of the validity of the tests but over time, patients adjusted. I posited whether there was any subliminal messaging obtained from the media publishing stories on the specificity and sensitivity of COVID-19 lateral flow and polymerase chain reaction (PCR) tests at the time. Dessie remarked that she had not considered this angle and added that the same could be said for vaccinations as well, '*Yeah, I wonder if it's increased people's scepticism of what we're offering'.*

Contraception and sexual health pathways

While Dessie acknowledged that people might have been having less sex during the pandemic, she wanted to be clear that '*there's been a massive lack of provision'* with '*contraception [being] particularly hard hit'*. The service stopped all long-acting contraception, and posted contraceptive pills to patients. On top of this, there are currently discussions taking place around stopping home-based termination of pregnancies; '*choice has completely gone*'. Given the geographical location of the clinic in the Northwest of England, a region particularly affected by COVID-19 with three intense lockdowns, contraceptive services have not been active for a year, with no knowledge of when normal services will resume.

Due to the reduced services available during the pandemic, the PrEP pathway was one of the main areas that has been severely impacted. Dessie explained how clinicians conducted follow-up phone consultations every three months, sent a home testing kit, and when patients received the results, staff sent three months of PrEP in the post. Either the annual renal tests were postponed or the clinic called the patient in, so patients achieved a certain level of maintenance and adherence during lockdown. Dessie reported that '*a lot of our PrEP patients actually stopped during lockdown because they weren't having sex. And then we had the odd one who*

stopped and didn't restart even though they were then having sex again and needed to be on PrEP'.

Dessie also commented on recent STI diagnostic trends, '*I feel like we've seen a lot of gonorrhoea this year, and I can't decide if there is a lot of gonorrhoea or if it's just [that] we've been seeing less of everything else'.* According to Dessie, the incidence of STIs has not reduced, as they initially anticipated it would, and those who had been experiencing symptoms for over year have started to present in clinic with the likes of warts and herpes. Furthermore, following '*few diagnoses during lockdown*...*we've already had a little surge of HIV diagnoses'* in March and April of 2021, nearly all of whom were young MSM. Whilst '*some of those [were] recently acquired',* many have been unable to test and have been seroconverting for a year or two. For Dessie, this reflected the lack of access to testing services combined with ceasing PrEP during lockdown. She mentioned the work carried out by a different sexual health clinic. At this particular clinic, at the beginning of the pandemic, they viewed lockdown as an opportunity to break HIV transmission through heavy testing. From the tone of her voice I got the impression she may be critical of the intentions and success of the project; especially as she confirmed that people '*are still having plenty of sex'*. Later Dessie described it as '*total naivety'.*

Interestingly, Dessie explained how patients have been anxious to disclose information about sexual encounters during lockdown, as they are worried about judgement associated with breaking national lockdown rules. Apparently, patients would concoct '*crazy stor[ies]'* about their support bubbles: '*They weren't worried about kind of sexual judging, but they were worried about COVID judging*'. Furthermore, some of her long-term HIV patients who were diagnosed in the 1980s and 1990s had been saying that '*COVID is a taste of what life has been like for them*' as '*nobody wants to touch anyone else, there's all this kind of keep away from me*

and this stigma with COVID is actually what their life has been like for a long period of time'. She articulated how this must be the case for many individuals in society – to be afraid or stigmatised.

With the reopening of hospitality venues, Dessie is expecting everyone '*to go out and have a party*', to have casual sex or to reunite with partners. Therefore, Dessie and her colleagues are '*certainly planning to be very, very busy over the next few months*'. Yet, with the lack of testing, access to services, preventative pathways disrupted, and patients untreated, there is serious concern for when the sex tourism industry is reignited and international borders reopen. During lockdown, Dessie's patients who attended clinic following frequent travel have not been receiving the '*regular sexual health dialogue'.* Further to this, she pondered over '*whether people's risk perception will have changed...will [people] be more reluctant to travel abroad, whether they'll be worried about getting stuck somewhere or, you know, how many people have been vaccinated and whether that will change activity*'.

Access

Although the phone triage helped absorb the backlog of patients unable to attend walk-in clinics, and the service provided phone translators, the most vulnerable populations such as children and victims of domestic abuse would have had little to no access options to vital services. At first, there was higher reporting of GBV and intimate partner violence (IPV) but that reduced over the course of the year. Dessie deliberated whether this reflected the actual situation or whether individuals were experiencing greater repression through phone monitoring and inability to leave the home. Therefore, she concluded that although at times the service '*allowed some kind of emergency walk-ins where we thought people were additionally vulnerable*',

those '*less IT literate and...more socially vulnerable without access to the Internet or phones have definitely been disadvantaged this year*'.

Dessie conveyed the severity of the lack of access, stressing that it was '*a major concern going forward*'; worryingly stating, '*I can't think that I have seen a single sex worker in clinic in the last year*'. Referring to drug using sex workers who have '*chaotic lives*', Dessie explained how the new set up of the clinic excludes their needs, especially for those without a permanent address who would not be able to receive medication or testing kits through the post. As anticipated, COVID-19 reflected systemic '*socioeconomic divisions in society*'. Dessie worries that the Trust will not reinstate walk-in clinics, and that '*many places will look to cut sexual health services because they've effectively been cut in the past year anyway*' but '*we know that people in lower socioeconomic groups already have a far higher burden of STIs and need our services more*'. She concluded, '*It's sort of depressing, isn't it?*'

Preparation and the future

As expected, Dessie wants to keep the online testing as it has proven to be '*absolutely fantastic'.* She also suggested ways to improve the facility, such as signposting to online testing outside of the sexual health clinic, for example in toilets, asylum centres, job centres and pharmacies, thus extending the access points to potential service users and further, normalising testing. Dessie also shared similar ideas for the phone triage and consultation system, which allows patients to receive medications in the post; so far, the clinic has '*had a lot of feedback about how it's been a very efficient and easy service*'. However, as previously mentioned, Dessie is committed to the '*re-introduction of walk-in clinics*' for access purposes. Yet, staff members '*really like appointments'*, as previously there was '*the pressure of numbers pouring in, and peaks and troughs throughout the day, and you don't know what's going to*

be there when you come in', whereas '*appointments are very controlled*'...'*it's much easier*'. Dessie suggested that following increases in staff capacity, the clinic must examine who was, is, and should be accessing the clinic; potentially introducing phone lines specifically for children, and walk-in services tailored to certain groups '*in a way that doesn't "other" people'.*

The online move has facilitated sharing information and education between staff. Dessie highlighted that staff members had improved attendance to virtual information group sessions, as they found them '*less pressuris[ed]'*, and less intimidating. '*There's a lot to be explored here in the way we communicate with people*'. Yet Dessie's priorities lay with the widening socioeconomic '*gap*', explaining that some of her current HIV patients '*don't have a device that can get on the Internet and if they do, they don't have data'.* Again, Dessie potently concluded, '*I think it's a good thing, but it can't be the only thing*'.

To address this global issue of access, Dessie believes that it '*should be considered...at a national political level'.* If an individual does not have access to technology or the Internet, '*[their] ability to engage with society [is] significantly curtailed'* and in turn, this has a costly impact on one's health. The national discussion must focus on the inextricable association between poverty and health vulnerability, as '*ultimately what improves health outcomes is just giving people money*'. There is undoubtedly a need to evaluate the benefits system within the UK welfare state. Apologetically, Dessie remarked, '*I don't actually believe any of this is going to happen, Alice*'.

4.2 Dao – 'The industry is multifaceted: there are consenting adults making informed choices but there is still a part of the industry that intentionally takes advantage of vulnerable people, including young people, and children. Children cannot consent to their exploitation.'

Dao allowed their case study to be included for the PhD examination but asked that it be removed for any form of external use.

4.3 George and Korn – 'We need to become more globalised…be more understanding of other people' and 'accept other cultures' ways to illness and health and sex'

As part of the recruitment strategy, I uploaded the study profile onto a website called, *Call for Participants*. Towards the end of the recruitment period, George sent me a message through the website, saying he thought he might be able to provide some insight into sex tourism in Thailand. The interview took place, and it lasted nearly two hours. Although he did not fully immerse himself in the sex tourism industry, he provided valuable insight with his anecdotes and observations, and through his comparisons of rural villages and large cities. Clearly, George has a devoted attachment and deep-rooted respect for Thai culture and people.

George is 21 and a white, British, cisgender, gay man. When we spoke, he was currently writing his dissertation for his Social Anthropology undergraduate degree, which had a focus on Thailand, and fed into the interview. When George was 18, in his final year of A Levels, he applied for a volunteer charity project. He was accepted and allocated to Thailand with 15 other volunteers. The project paired up the

volunteers and sent them to different locations across the country. For six weeks, he attended a language course in Chiang Mai, and was then deployed to a Northeastern rural town, an hour from the Laos border. For nine months, he taught English to three to 11-year-olds, in a local school. In this time, he was also able to travel around the country. *'It was the best year of my life…as soon as I graduate, I'm going straight back*'.

A few days before he returned home to the UK, George downloaded Tinder but set his location to his UK university city. A Thai person appeared on his screen. George swiped right. Then, back in the UK, at the Fresher's Fair, they '*walked past each other, and decided to go on a date and [they've] been together for two years now*'. Korn is from Bangkok and they spent the summer of 2019 travelling and visiting Korn's family in Thailand for six weeks. Throughout the interview, George tells me anecdotes of where he has previously asked Korn questions relating to Thailand. I have woven these anecdotes, as well as information that Korn shared with me directly over emails, throughout the case study.

From the start, George wanted me to understand that Thailand's sex tourism industry is not a representation of the country. '*Ladyboys and sex work and things like that…[are] the last thing that come to mind. It's such a conservative country…[sex tourism] is a minor element of their society*'. In fact, George held the impression that the country is strongly conservative, reflected in their lack of sexual health education in schools as well as from his own experiences of using protection (condoms), which he labelled as a '*Western culture*'. Korn supported these statements, '*The only time that I think Thailand is seen in a sexual way is from the perspective of Westerners*'. Due to these sentiments, George continually 'checked' himself (and me) throughout the conversation, with comments like, '*I'm not Thai so I can't comment*', and '*I don't want to speak for Thai people*', reflecting his respect for Thailand.

COVID-19 pandemic

When George and I spoke, we were in the middle of the second wave of the pandemic. From his perspective, I wanted to understand whether there had been significant differences with how the UK and Thai governments and health systems had handled the situation.

In relation to sex workers, he claimed that as sex work is illegal in Thailand, those in the industry have limited rights and are unable to report crimes to the police, as they will be the ones that will be penalised. At the same time, Korn told me that '*lots of things fly under the [police] radar which foreigners looking for sex might like*'. Through watching documentaries, George was aware that sex workers were suffering due to the impact of COVID-19. He described how while Phuket was '*notorious [for] a lot of prostitutes*', the pandemic had significantly affected their incomes, reducing their negotiation parameters and agency, '*they'll kind of go with anyone because they want money but then that person might be dangerous*'. Korn added, '*There are also deals going on under the table where people might take off their mask for extra pay and such*'.

George pointed out that the UK had become accustomed to having thousands of new cases a day, whereas in Thailand, '*to have any cases at all, to have 10-20…it's definitely shocking*'. He repeatedly put this down to the fear mongering of UK media, the rapid response of the Thai government to close the borders, and the civic duty that Thai people embody: '*It's more of a collective, "I don't want to hurt anyone so I will wear a mask"'*, in contrast to the UK where the mentality is, '*'"I don't want to wear a mask because it stops me from breathing"'.* Regrettably, George believes that Thai patriotism is becoming distilled by globalisation and capitalism.

Sexual encounters

At the beginning of George's trip, he met a Thai man and had a short relationship for two weeks, which ended, as George had to return to the rural village where his volunteer project was based. Apart from this sexual encounter, there were only, '*one or two people, not a massive amount*'. On one occasion, George was in a bar in Chiang Mai with his volunteering group, when he saw a Thai man dancing. His friends '*dared [him], "oh go and dance with him"*'. George went to dance. '*We ended up kissing, and then I think we exchanged numbers or something*'. Four days after they met, his friends again persuaded him to meet the same man for a date. '*We went back to his apartment and I think we slept together three times*'. George really wanted me to know that '*it was safe, we used protection*'. Interestingly, and I am not quite sure why, he added, '*he was quite…Westernised*'. During his time in Thailand, George was able to travel to Bangkok. He stayed near designated gay streets, and recalled massage parlours and people shouting to foreigners, '"*Would you like a massage…we do happy endings*"'. He likened the Bangkok scenes to Pattaya beaches, concluding that, '*white men in that area…[are] seen as a financial opportunity*' as opposed to '*find[ing] romance*'.

George also shared stories about his roommate, whom he has remained close friends with. They are five days apart in age with *'a lot more [sexual] experience than [George]*'. George never shared his name with me but for ease, I will refer to him as Cal. Throughout the interview, George mentioned Cal on numerous occasions. What I found particularly interesting, is that although George was adamant that sex tourism is '*insignificant*' in Thai culture, Cal's stories suggest that one does not have to venture far to come across the sex industry, in an open and inviting way. Cal, along with two of the other volunteers became '*very involved in the gay scene*'. Early in their trip, they went to Chiang Mai, and '*from that point they were really involved in the drag scene and they would go to all the drag shows and they became friends with*

a lot of the [Thai] drag queens'. It was during the shows that Cal would meet other guys.

Cal experienced '*a couple of scares in terms of sexual health*', which led him to '*[get] a HIV test*' from a free clinic when he visited Bangkok. I got the impression that during these trips, he had multiple partners and his behaviour was risky with condomless sex and excessive alcohol consumption. According to George, Cal had lost a significant amount of weight. Due to his size, and because he was white, George stated that Cal was attractive to Thai people. George clarified: '*there's certain, not fetishisation, but there's a romantifcation of foreigners in Thailand*'. Later in the conversation, George also added that in Thailand, *'pale skin is preferred'* and that '*a lot of people bleach their skin to look paler. And a lot of the make-up that they wear is like white powder and it's meant to look a bit ghostly*'.

George described how they would enjoy the nightlife in a city near to the village. Beforehand, Cal would meet men on dating apps and '*hook up*' with them in a hotel. On a different occasion, Cal had met a Thai man on Grindr, who flew to their town '*for one day to sleep with him and then flew back to Bangkok the same day*'. Later in the conversation, George added that Cal would visit various men in the same city, who, again, he had met on dating apps. George explained how Tinder is universal, and there are '*a lot of people on Grindr as well*', which '*isn't really romantic…it's just hook ups*'. As the larger cities in Thailand, such as Bangkok, accommodate many foreigners, those on Grindr in Thailand are normally tourists. George recalled seeing profiles of companies and hotels on Grindr when on an island off Phuket. He received messages such as, '"*come to mine, we've got an orgy", and it was like sexual parties. I even got invited to be a bar man, to work, but you'd have to like wear underwear and go behind the bar*'.

Sexual health education and cultural relativism

Korn described how Thailand offers minimal sex education as it is '*a Buddhist country and many teachers do not feel comfortable talking about such topics*'. The American Peace Corp positioned a female volunteer, who had travelled alone, in the same village as George. I will refer to her as Cathy. George was not entirely sure of Cathy's role but believed it to be in social welfare as she created an entire sexual health project that she delivered to the children in the village. In Thailand, George described how '*there is an element of shame when it comes to sex*', and so Cathy '*wanted to set up a box where they could collect free condoms and things like that*'. However, Cathy found it problematic to carry out the project, as '*she struggled to get a sense of authority within the community*' for two main reasons; '*she was a woman and sexual health in general, is quite taboo*'. To combat this, Cathy recruited George and his peers for a day to encourage the children to engage with the sexual health materials. He pointed out that if they did want to access the information, it is available through social media.

Korn reported that gay and transgender people are disproportionately at risk of HIV, with '*a third [of] gay men in Bangkok…HIV positive*'. Furthermore, young, underage women, experience high levels of unwanted pregnancies. He believes that the only barrier for foreigners to access healthcare in Thailand is language related, and noted an increase in free sexual health services for the LGBTQ+ community, where they provide condoms. George stated that there was, therefore, a need for '*awareness and normalisation'* of sexual health issues, as well as '*social change to come with the health change*'. To achieve this, we must transform the perception of Thailand as a sexual hub so that people can be '*humanise[d]*', as presently, '*people get disconnected from [sex workers as people]…and [similar to] COVID-19…with illnesses*'. While my research and work to date has arguably explored the destructive

nature of globalisation, George asserted that, '*we need to, in a sense, become more globalised, and be more understanding of other people*'…'*We need to accept other cultures' ways to illness and health and sex*'.

Katoey and the LGBTQ+ community

George described how the Thai transgender population represent themselves in society and how society receives and perceives them. George confirmed that they, like sex workers, have limited legal rights. For example, the ability to change their gender on passports – something that I would hear in the interviews on numerous occasions – they are unable to change their name; and they have limited job opportunities, '*a lot of them do porn'*, '*sex work and things*'. Furthermore, he added that from a social perspective, '*it's not desirable for parents, for their children to be transgender*'; however, '*it doesn't carry as much social impact as it might [in the UK]*'. He continued, depicting Thailand as socially accepting of transgender individuals, '*I had students who were trans*'. '*In some sense [Thai society] are more accepting of trans people than gay people*'.

This is a surprisingly different narrative to current research that posits how transgender populations experience violence, banishment, and substance use. Immediately, George pointed out that it depends on the location, with significant divides between rural and urban regions in Thailand. In Bangkok, there is '*a lot of sex*'. Therefore, '*people might end up in that career because of abuse and things that have happened with their family… I would definitely say there's a duality. I wouldn't say it's a given for every trans person*'.

According to George, Thailand's widely broadcast comedy shows feature transgender people as leading characters. One sitcom follows three transgender women that travel the world, and another is the Thai version of *RuPaul's Drag Race*,

but with transgender women and men dressing in drag. '*It is a bit niche but it is still mainstream*'. '*From what I've seen, trans people and gay people are more like jokers*'. This led to an incredibly informative discussion on the use of language within the LGBTQ+ community in Thailand. Firstly, George stated that Thai society use the word, katoey or kathoey, for both transgender men and transgender women as well as people who identify as gay or homosexual. Korn clarified that it is specifically for transgender women, transvestites, and '*very feminine acting gay men*'. Katoey is a derogatory term that means *'faggot; like a kind of slur*'. George asserted that the LGBTQ+ community have '*adopted [the katoey] in the same way as gay people here have adopted 'bi', and they call each other [it] as like a term of endearment*'. Korn furthers this, stating that it is now '*used by gay/trans people who reclaim the word or actual homophobic or transphobic people*'. Due to these connotations, Korn had previously warned George to be careful; '*if you don't know someone personally and you're trying to have this serious conversation, you might offend someone*'. According to George, the other, more general term to use is, '"*phuying praphet song"*, *which is like "second woman" or "second man"'.* This is because in Thailand, '*they see it more as four genders. There's like man, woman, and then transgender woman and transgender man*'. With comparisons to the UK where current activism is advocating for '*transgender women are women*', in Thailand '*it's more like transgender women are transgender women*', in that '*they want to live in the realm of women but they don't necessarily want to be seen as a cisgender woman*'. At the same time, '*women who look masculine [are called] "Tom" like Tomboy, like "she's a Tom'*…'*I'm not sure if that means she's a masculine lesbian or if she's a transgender man*'. More broadly, LGBTQ+ people identify with 'เพศที่สาม *(ped tii sam)*', which is translated as '*the third gender*', and is used in a professional context.

In Thailand, the transgender community have their own dialect, called '*flower language*'. '*In a lot of cultures there's [a] gay lexus…like drag race and terms that people adopt*'. Therefore, to understand the jokes and references in the sitcoms, the viewer must be able to speak the dialect or '*katoey steer*'. Throughout history, marginalised communities have cultivated their own languages to affirm their identity, for safety and to separate themselves from their oppressors. This felt very similar. George mentioned that '*there is stigma in that they are very funny or very sexual*'. From what he was saying, it seemed that the Thai transgender community were living up to assumed norms from the non-transgender community, like that of homonormativity with the gay community. Later in the conversation, we touched upon the use of language and labelling again. George beautifully articulated that '*gender fluidity in Thailand goes back like hundreds [of years]. It's not a new thing that's just popped up… they're not influenced by the way we perceive gender and sexuality but they've also got such a history of their own, that they think of it in a different way*'.

Role of women and older white men

Korn (case study 3) explained how Thai women historically entered sex work, describing how the military built bases near Pattaya in World War Two, which inevitably lead to '*poor farm girls [being] drawn into sex work with foreign soldiers. It was seen as disgraceful at the time but was still a stable source of income for those girls*'. A recent Thai fictional drama, ผู้หญิงคนนั้นชื่อบุณรอด, translated as Lakorn, depicted the historical account. Korn, continued, explaining how societal discrimination exacerbates cisgender women's health problems, poverty, and abuse. This, combined with multiple other factors, has led to an exponential increase in Thai women, transgender women, and gay men, soliciting sex abroad, particularly in South Korea, where they are able to earn significantly more money.

George shared his dissertation findings on the role of women in Thai society. '*Women are treated differently than men. There's social standards for women and the idea of the housewife and that's definitely been in Thai culture for a long time*'. He noted that as Thailand has become globalised and by proxy, urbanised, the woman's role is evolving too but the traditions are hard to relinquish. Therefore, women are expected '*to work and try to maintain the idea of the housewife*'.

> Fascinatingly, '*they call them "Plastic Bag Housewives" because they go to the market and they buy their curries in a bag, and they'll take it how you present it like a home cooked meal*'. He added, '*I feel like a lot of women perhaps are content with it, they're not necessarily against the notion of being a housewife…things that might be called like oppression [in the UK] really, they might not see it as oppression*'.

It was also common for George to observe older white men with a Thai wife during his time in Thailand. Korn added: '*The people that use the sex tend to be more like older men rather than young backpackers…[as they] are more desperate for affection and may have more money*'. To support this statement, when out in their local city in Thailand, George acknowledged that, '*there is definitely stigma in Thailand*'. He asked Korn what the perception was of Thai women who marry older, foreign men. He replied with civility:

> '*[If] they are both getting something out of it and they're both consensual, then what's wrong with it? If the man wants to give her clothes and money, and obviously he might have sex with her and marry her, but she's getting the money getting sent to her family and it's consensual and she's not being assaulted or anything. There's nothing necessarily wrong with that dynamic, it just might not be like, what people view the most like moral situation*'… '*Sometimes it's just, you know, [a] financial solution*'.

George continued, explaining that these connotations are different across Thailand, with more acceptance in Bangkok and Chiang Mai as opposed to smaller cities; although he held the stereotype that with older foreign men, '*you kind of knew what they were there for*'. George poignantly reflected that at the beginning of his Social

Anthropology degree, he wanted to change the world, but has since learnt that in developing countries, we can '*become a white saviour*'. What we must do, therefore, is '*understand and help, rather than pursue*'. This has been one of my own greatest learnings from the PhD.

4.4 Adam – 'Gays...[are] given a license to have sex wherever we want'

Adam has extensive experience in sexual health, having been a medical doctor for 18 years, in sexual health and HIV for 13 years, and a consultant for eight. Adam currently works at a busy sexual health clinic in the South of England, with sixty percent of patients born outside of the UK, who frequently travel and have sex in other countries. His priorities as a Consultant Physician in Sexual Health and HIV lie in risk reduction and preventative medicine, such as PrEP.

Sex and sexuality in Thailand

Although Adam does not ask patients about previous or future travel, he identified some of his HIV patients are '*British born but actually live in Thailand*' and '*one or two Thai patients…have moved for economic reasons to the UK*'. Some of his patients travel to Thailand to have sex with their '*regular partner*', for casual sex, '*to have gay sex'*, '*because it's cheaper, or [because] sex is easier to come by*'. Adam made the distinction that tourists who travel to Europe have sex with people from the same country, but when travelling to Thailand '*you're not having sex with your own countrymen*'. Regarding female tourists, Adam could only identify one Thai woman who is in a long-term relationship with an Australian born man. They are both HIV positive, which to Adam is unusual for a heterosexual couple. He also recalled a specific patient who volunteers in Thailand, has sex there, but utilises the UK clinic

for their HIV care. It is worth noting here that Adam believes HIV in Thailand to be of '*intermediate'* risk and that '*being MSM is high enough [risk] so that trumps any country that you'd be in'*, if one was travelling.

Given that the clinic sees a high proportion of MSM, Adam holds the opinion that '*the gays don't tend to do lads holidays to Thailand*' as '*it doesn't seem like a young gay destination'*. This is contradictory of the demographic of tourists reported by Dessie in case study 1. Although he did describe seeing older, wealthy, gay men, who visit Thailand to find a younger partner, potentially bringing them back to the UK, in some cases he has '*[met] their partners when they come to the UK, who may or may not be HIV positive and having care here*'. In fact, Adam later stated that '*gays, as a community...we're given a license to have sex wherever we want to*'. According to Adam, gay men '*indulge in the same sort of sex but with a different menu of men in other countries'.* For example, a person '*might be UK born and traveling just to have a German. But the sort of sex they're having might be very similar to what they're having [at home]*'. Adam, therefore, concluded that to '*people in the gay scene, it feels like [they] travel, to be just a bit more exotic rather than to have different types of sex*'. He confirmed that most of his patients, who have travelled to Thailand, self-identify as gay, but did not know if they were also having sex with transgender women or transgender men whilst there. '*I'm trying to think. You've challenged me that when I next see them, maybe I'll talk to them about that*'.

As most patients at Adam's clinic '*self-identify as gay men*' or '*men who have sex with men*', we discussed the use of gender and identity sensitive language during consultations. Adam stated, '*I think [it's] a really interesting conversation to have*', as it demonstrates awareness, helps to gain rapport, and builds trust with patients. Adam used a Thai example, with the English term, '*lady boys'*. Clarifying, '*I'm not sure if I were to use that term, what I mean by it, and I'm certainly not sure what they*

understand if I bring it up'. Ironically, like '*katoey*', '*lady boys*' is generally considered derogatory.

As again mentioned by Dessie (case study 1), complexities arise when the HCP or the patient do not define or clarify the sexual encounter or relationship, leading to patients withholding or misunderstanding information during consultations. '*You have to come to an understanding about what they mean by what they're doing*'…'*The stories that you're given may well in some ways be edited to some degree*'. Even though Adam's patients may not provide him with the complete picture, this did not appear to trouble him, as he believed that '*in a correct clinical context, you only seek the information that is going to change your management, and so maybe you don't need to know how people self-identify because that's research*'.

Service provision during COVID-19

During COVID-19, Adam's colleagues took the opportunity to test and screen patients for STIs and HIV while there was a reduction in imported infections. The campaign, which was subsequently adopted by national organisations, heavily promoted online testing. Adam confirmed that this specific strategy was able to reach individuals that had not previously accessed sexual health or HIV care. Yet he believed that it held '*quite a dangerous political message'* due to comparisons between other countries and the differing responses to the COVID-19 pandemic. Interestingly, he did express that the UK government should have used Sexual Health Advisors and replicated the established and effective "Test and Trace" services. Many UK asymptomatic STI testing programs closed during COVID-19. *'We directed a lot of asymptomatic STIs online. Now, it's not clear to me if people did test online. I think some people did'*. At

the same time, the clinic maintained their express services for more vulnerable populations such as sex workers, to obtain rapid results throughout the pandemic.

Even though '*higher risk gay men in particular...didn't really change their sexual behaviour'*, Adam reported that PEP use had decreased over the last year, which he attributed to a reduction in high-risk sexual encounters. Those that previously accessed PEP typically engaged in activities such as '*chems[sex]'* as '*it's almost like an addiction'.* He had not heard of people moving online to find sex or sexual partners. Yet, he agreed that researchers should investigate the theory, as the ones who have riskier sex could also be those accessing sex online, and will be the first to reinitiate sex abroad post-COVID-19.

Furthermore, a cohort of Adam's patients have been unable to return to the UK from Thailand. While some have '*managed to get their viral load down and their kidney function and liver function done fairly efficiently…mak[ing] me think that they must have a fairly good provision of care out there*', others have been remotely contacting the clinic for HIV, PEP, and PrEP advice, as they have not been accessing local Thai services. Adam posited whether this was due to a lack of trust in foreign healthcare information. If tested, tourists can email their results to the clinic and have a phone consultation.

Inevitably, we discussed post-COVID-19 preparations, and coincidentally, Adam and other senior clinicians had met earlier in the day to discuss what the landscape will look like in the future. '*I suspect people will have a lot more sex*'. '*There's a perception that we need to be prepared to treat lots more infections and be prepared to give people PrEP that need it'*, as well as providing '*combination prevention both for HIV but also risk reduction for all STIs*'. As the clinic is outside of a hospital setting, they focus solely on sexual health and HIV care. Therefore, Adam aptly commented that

other sexual health services have had staff redeployed to COVID-19 wards, units, and clinics, so their preparation will be '*managing the backlog of stuff that was left behind',* and regrettably '*swimming against the tide'.*

Recommendations

Adam recommended that UK sexual health services maintain awareness of the risks of sex at the same time as enabling free, quick, and accessible care that is devoid of judgement. He also drew attention to the need for clinicians to appreciate that patients may not '*perceive themselves to be at risk'*, for example those *'that don't identify as gay or at high-risk of STIs*'. To address this issue, he suggested greater education, information sharing, advertising risk reduction services, and increase testing, as around half of people diagnosed with HIV in the service have not previously tested in the clinic. Thai clinics tend not to diagnose tourists with HIV, as testing usually takes place upon return to the UK and patients must be outside of the window periods for STIs (two weeks) as well as HIV and syphilis (six weeks). This thought process sparked the idea that services could '*offer people online testing kits as they disembark from certain high-risk destinations*'. '*You could hover at Heathrow airport*'. Alternatively, the testing campaign from the start of COVID-19, which was mentioned earlier, led Adam to appreciate the effectiveness of advertising services and social media, such as Instagram and TikTok, for targeting younger demographics.

Adam also acknowledged that '*Britain is special'* as *'STI care is free'* and '*the [patient] notes are anonymous'...'It's things that you perceive as given are not given in other countries and that can be a barrier very often'.* However, it should be noted that the Thai Red Cross work closely with sex workers, testing them and placing them on PrEP. Adam attributed Thailand's '*innovative'* preventative care to an effective healthcare system and favorable attitudes towards sex and HIV.

Finally, throughout the interview we discussed the transmission of infectious disease, namely HIV and COVID-19. I wanted to add to this narrative by incorporating cross border transmission of STIs and subsequent antibiotic resistance of gonorrhoea. Adam declared that '*[he didn't] want to overstate [AMR]*'...'*I'm slightly laid back about that*'. He added, '*there aren't that many cases, and we're pretty good at surveillance',* insinuating that the scientific community can, at times, '*be prudish'*, as he believes people do not use condoms, and clinicians now perceive them as '*clunky*' since the introduction of PrEP. Although Adam could see how PrEP may '*drive...antibiotic resistance',* if an individual has multiple partners, '*it's probably better that you're on doxycycline to protect you against syphilis and gonorrhoea*'. I was not entirely satisfied with his response. Returning to international communication requirements for sexual health, Adam concluded that, it '*would be colonialism sort of, culture of colonialism in a way. I'm not sure what I think even about universities partnering up'*. Adam was clear that as '*sexual health is pretty straightforward'*, and that sexual health services are effectively functioning in their current state in the UK, international collaboration is currently unnecessary.

Reflection Box 5: Musings, reality checks, and learnings from the interviews

I have always enjoyed talking to people from all walks of life but one of my strengths as a qualitative researcher, is that I am acutely aware of those around me, body language, and *how* people are saying things. If I had written this thesis 10 years ago, I would have been just as reflective (or critical) in the way I conducted the interviews. However, in the last five years, the UK has become politically polarised and everyday conversations have turned into divisive debates, notoriously with Brexit. We have witnessed the gender and racial disparities across the world, igniting the Me Too and Black Lives Matter movements, respectively. In the last few months, health narratives have turned to discussions about free will, civic duty, and human rights in response to mask wearing and vaccinations.

The interviews took place over a 14-month period. My first interview was with a UK HCP that I had previously worked with on HIV-related research, and we mainly discussed service provision and expectations for the future – the conversation flowed easily from the start. The second interview was with Dao and we got on well. After I wrote the case study, I returned it to her for her review and

feedback, and I was disappointed with myself when I had not accurately conveyed her point of view. I had tried to remain neutral and factual in my descriptions, and to remove myself from bias as a qualitative researcher. Yet, in doing so, I had undermined her perspective as a Thai woman. As a Western woman, I will continually be educating myself on white supremacy and privilege, but unfortunately my naivety about Thailand and the exploitation side of sex tourism, shone through the first draft. From this early learning in the interviews, I became even more conscious of my use of language when describing or trying to articulate potentially sensitive subjects. One way that I tried to do that was to discuss the participants' background as well as my own, and the terminology they are comfortable with, from the offset. This meant that when we moved onto talking about their views on more emotive topics such as Western and Eastern cultural differences, the role of religion, or agency and power imbalances within sexual encounters, I had hopefully built some rapport and trust. The tone of the conversation became more relaxed and informal, as they knew I wanted to learn about their reality, that I was not there to judge, and that the intentions of the research were to share their viewpoints and support the work they were already doing.

Striking the balance with language was particularly difficult. Referring to the terms 'sex tourist' and 'sex worker', Ping Pong and Mai, stated that '*every time there is a special word, everything gets worse'*. Adam, a British MSM and Consultant, inferred a similar sentiment from a clinical perspective by saying that labels regarding a patient's sexual identity are not necessarily needed as, '*you only seek the information that is going to change your management*'. Yet, for Naw, who is a Thai transgender woman and Consultant, sexual orientation and gender identity are vitally important to her in healthcare as it ensures that the individual is provided with optimal, tailored services that are holistically aware of their needs. When trying to find out the correct terminology for transgender people as well as gay and bi men and women in Thailand, the translations and connotations were vastly different. Although my most pertinent learning from the whole interview and PhD experience is to be even more aware of historical and present differences, I have found a new fascination with the Thai language and popular culture, and will always remember the passion and love that the Thai participants (and George) have for Thailand.

4.5 Una – 'International funding…gets targeted on things that are sexy rather…than prevalent'

The last HCP interview I conducted was with Una. Una described herself as *'Eurasian'...'I suppose I see it from the other side as well'.* Fascinatingly she explained how she '*was part of one of the first generations of Eurasian kind of offspring*' due to '*international trade opening up in the seventies, eighties'*. She is a Consultant in HIV and sexual health in the same clinic as Adam, which she described as '*a hub of STIs'*. She has been working in sexual health for just under a decade, has undertaken a

Masters in Epidemiology and Public Health, and has practiced medicine in the Philippines.

Demographic of tourists, the sex industry and transactional sex

Una immediately identified that there may be more patients that travel to Thailand for sex than she actually comes across in the clinic due to the hidden nature and stigma associated with sex tourism. These patients are mostly men, although '*we don't ask women as often'*, and tend to be between forty and seventy, with a limited number of over sixties attending the clinic in general. Throughout the interview, Una discerned five groups of tourists that she observes in clinic.

Firstly, for some, Una ponders if their attendance is related to sex tourism as they visit to test en route to the airport. Secondly, there are a group of patients that have taken antibiotics in Thailand and require further advice or treatment. Thirdly, there is a cohort of older, male patients '*that do have long term partners in Thailand*'. The fourth are those in relationships in the UK, who have recently returned from Thailand to have sex with sex workers; therefore, '*they often worry about HIV risk and STI risk*'. Finally, '*there are a couple of patients that do come in after a trip*' and are similarly '*concerned. So you can often tell when a patient's extremely nervous about something*'*...'it's very palpable'...'they're sweating and they're anxious, and they're sat at the edge of the seat*'. Una described how she explores these experiences by asking '*So what? Why are you so concerned? Why do you seem jittery right now?*', explaining that the anxieties are often a consequence of having had sex with a sex worker. In one case, Una described a patient that had sex with a transgender woman for the first time and it was the potential HIV exposure that was preoccupying them. Typically, these are men that have travelled to Thailand to have sex with other men,

or have condomless sex, for the first time. Una's clinical experiences mirror those of Dessie (case study 1).

When asked about the differing risk assessments between the patient and the healthcare professional, Una responded, '*I think that's the case quite often with any patient to be honest*'...'*particularly in the age of the Internet where people Google something that they're worried about*'. HIV is apparently a key driver for individuals to attend the clinic even though in most cases they are '*actually [having] fully protected sex, [which] isn't going to be a HIV risk and actually it is all the other things that you have to be mindful about*'. In fact, when Una has delved into patient histories, it is the anxious patients that will normally have had unprotected sex in their home country, which in some areas have a high prevalence of STIs, but as they have had sex abroad with a sex worker or a transgender person, for example, there is a greater perceived concern. The taking of histories is difficult as clinicians often provide a sexual history timeframe such as three or six months, however the '*risk through their own personal lives' changes*'. Una puts the worries down to stigma; '*I think that drives then that stigma conversation unfortunately*'. Interestingly, she believes that the stigma '*does tend to be associated with Southeast Asia more than the rest of the world'.* Furthermore, labelling patients that travel to Southeast Asia as 'sex tourists' is problematic, as they would not consider themselves to be engaging with the sex industry, especially if they consider it '*a drunken mistake'.*

Whilst working in Manila in the Philippines in 2016, Una described the sex tourism scene to be '*very obvious and prominent'.* In comparison, '*the assumption was that Thailand had cracked down a little bit on their sex tourism'.* Typically, the demographic of tourists in Manila was, '*elderly, white male, kind of in the[ir]...sixties, seventies, eighties, with a much younger female, you know, often in the[ir] twenties, thirties*'. Like the reputation of the Khaosan Road in Bangkok, street-based sex

workers are plentiful but the major difference that Una reported was that the sex industry appeared to be across many districts as opposed to Bangkok's designated red-light areas. I enquired about other forms of transaction, and Una expectedly confirmed, '*we don't tend to ask that in the sexual health clinic*'. To Una and her colleagues, the importance lies in asking the routine questions, '*do you feel safe in the relationship?*' and '*do you feel like there's been any exploitation?*'

Use of antibiotics, PEP, and antibiotic resistant gonorrhoea

Una reported that the prescribing of antibiotics is more of an issue for those who travel to Thailand for sex. Tourists can access healthcare abroad, such as in '*pharmac[ies] to pick up pills, 'cause they're convinced that they have an STI. And they've just bought doxycycline quite often, say in a group that's really experienced with STIs. They know exactly what they need*'. Tourists also commonly purchase PEP abroad. They '*get half of PEP, for example, and then come back to get the other half'.* However, '*the PEP is different, but that's often based on what's available in the country and what their resistance patterns are in country. And then we have to switch it when they come back*'.

This situation feeds into the wider global health concern, as it is causing '*resistance issues with things like gonorrhoea'* which *'is coming from Southeast Asia'.* Although the prevalence levels have not changed significantly over the past decade, Una is aware of recent varying reports; '*something's definitely changed*', although she cannot pinpoint the root cause. She explained that there have been increases of antibiotic resistant gonorrhoea over the last year but then stated that Public Health England data from 2019, documents how '*gonorrhoea stayed stable...I think it's slightly improved*', which Una speculated could be a result of changing the antibiotics. Public Health England revaluate gonorrhoea therapy lines when cases exceed the

surveillance thresholds. '*For gonorrhoea, we changed it to ceftriaxone only, but a higher dose. So whether getting rid of azithromycin actually has helped improve that resistance pattern*' is something to be investigated. There has also been a change in the route of administration of the medication. Previously patients took gonorrhoea treatment orally and now it is injectable, and so HCPs must administer it in clinic, making the ease of accessing the antibiotics slightly more difficult. Una also added that it is current practice for '*every gonorrhoea positive patient [to be] cultured and sent to the labs and every resistant gonorrhoea is reported to Public Health England*'.

COVID-19 pandemic

Una eloquently articulated how '*the similarities of STIs and pandemic discussions have been prevalent throughout time*'. Even to the extent of the language used, with STIs described as romantic, while with COVID-19 and lower socio-economic diseases, it is more clinical, for example '*you get this romanticism of syphilis...that you don't get perhaps at the other end with TB*'. At the same time, COVID-19 positive patients do not experience the same levels of stigma as those who have an STI or who are HIV positive. Due to this, Una explained how there is less of a blame culture associated with COVID-19 transmission. Similarities between sexual health and COVID-19 lie in their management with contact tracing, '*epidemiology of control*', individual responsibility, and disease migration, so for '*all these similar principles...we're now becoming much more used to as a population*'.

Una reported that during the first lockdown in the UK (March to June 2020), her colleagues surveyed people to investigate if they were having sex during lockdown. According to Una, around '*57% of people are still having sex*'; yet this did not clarify if it was with regular partners, fewer partners than usual, within "bubbles", or at sex parties. Therefore, Una concluded that '*it would be interesting to see how those sex*

patterns have developed'. If people were having sex with one partner, then '*those risks will be contained'.* At the same time, Una told me how she ran a HIV testing campaign during the first lockdown. The premise was that if '*a quarter of people are staying at home and not having sex, and everyone gets tested for HIV at the same time, wouldn't that be fantastic?*', with the aim of '*get[ting] all the undiagnosed…fully diagnosed*'. Dessie (case study 1) and Adam (case study 4) also refer to the same campaign.

Since the COVID-19 pandemic, there is a heightened need to address the reduction in access to walk-in and face-to-face clinics. Although online testing and postal kits are effective for those that know of them, there is an urgent requirement to target vulnerable groups to provide access to vital, preventative services. The service promoted online testing, as '*something like 47% of sexual health clinics closed during the first lockdown'.* Una's clinic tended to the redirected patients, who were '*desperate',* with some newly diagnosed with HIV and syphilis due to lack of testing. She continued to set the scene by raising concerns for the sex workers and their income. Una confirmed that they were '*still providing outreach to sex workers*'...'*making sure that they're getting condoms and they don't have to pay for it'*, and '*making sure that they are still getting screened*'.

While Una did not know of any connections between sex tourism and PrEP, she was aware that '*people are buying PrEP from around the world...quite cheaply',* as well as obtaining it from friends. Una noted that healthcare professionals might not yet notice any changes in patient's sexual behaviours when abroad because of PrEP, as the NHS only made the preventative medicine available in July 2020. Una mentioned that the clinic was currently running two PrEP campaigns. The first is a consequence of '*people [having] stop[ped] stocking PrEP during lockdowns*', and so they are '*making sure people know how to restart PrEP properly*'. The second, is educating

people on '*how to quickly start PrEP'* as with lockdown, the clinicians speculate that individuals are out of the habit of taking PrEP. Post-COVID-19, **'***I think we're going to be fairly busy'... 'we are anticipating a boom of STIs [and HIV]...when things start to return back to normality'*, be it undiagnosed STIs or HIV, from lack of testing or due to exposure after restrictions ease.

Recommendations

For Una, one of the main recommendations for cross border harm reduction strategies related to sex tourism is sexual health education. Primarily, she stated that younger generations prefer to consume information online; yet, contrastingly, older patients who did not receive sex education in school require a greater input of information. Regardless of age, Una highlighted that schools still do not educate on PrEP or PEP, which is something that HCPs are heavily encouraging.

Whilst over the last year, as a population, we have adapted to an online environment, Una emphasised the need to ensure accessibility to information. Specifically, for STI and HIV risk reduction and prevention purposes when travelling abroad, Una proposed that airport facilities share the information, as we need '*to figure a way of how to target that population group 'cause it's so transient*'. Discounting distribution channels of educational materials, Una was fervent that there should be no judgement of an individual's activities, as otherwise, '*they'll never come back for support*'. Combined, Una suggested that leaflets at the airport not only contain sexual health advice but also support the narrative of, '"*we're here...come see us"...in a non-judgement way*'. Vocalising these ideas led Una to conclude that only a limited number of potential tourists would be engaged; therefore, she proposed a more general approach: to provide '*awareness of what services are available, but also*

what prevention people can take', giving the example that some populations remain unaware that PrEP even exists.

I asked whether Una thought these could be adopted at an international level, and she insightfully replied, '*international funding unfortunately gets often targeted on things that are sexy rather than things that are prevalent and that can be difficult to address*', such as PrEP as opposed to chlamydia. However, she added that '*there would definitely be some great scope internationally for just more awareness of all the prevention services being accessible for all the countries, particularly for HIV*'. She perceptively added the need to understand the risks involved, especially with the introduction of PrEP, the changing attitudes since the 1980s and 1990s, and recent data reporting that a low HIV viral load means one is undetectable and therefore cannot transmit HIV. Una identified shocking discrepancies in levels of knowledge in patient age groups as well as between healthcare workers. Her clinic runs an under 25-year-old campaign for STIs and HIV. At the same time, they accommodate for older members of society, who have just begun exploring their sexuality later in life. '*Over the last 10 years there are definitely more men who have sex with men who are coming and having unprotected sex*'. Although this is a UK focused anecdote, Una questioned whether online activity reflects this behavioural shift for those travelling abroad, especially as the '*fear of STIs seems to be much lesser now than what it was for [the] young generation...thirty years ago. And whether that has an impact abroad in sex tourism in the future will be interesting to see as well*'. Therefore, institutions should improve the dissemination of knowledge to service users and service providers, provide information on the services available in holiday destinations, and target services at specific age groups or populations.

4.6 Liz, Ping Pong and Mai (EMPOWER) – 'We're going to bring down capitalism'

In case study 2, Dao mentioned the sex worker organisation, EMPOWER. I reached out to them. Liz, who is based in Chiang Mai, responded, '*Aside from usual work, EMPOWER is quite busy in people's movement against our military government working for democracy'*. She agreed to organise a Zoom call with herself acting as a translator for two sex workers. I replied, conveying my worries that I did not have ethical approval to interview sex workers. Liz's response changed the course of the PhD and led to the publication of a journal article (Appendix 14):

> '*EMPOWER is a sex worker organisation this means it is led, run and managed by sex workers. Other people wanting us to help them with their studies have also had the same problem of not having "approval to interview sex workers". By barring sex worker's participation, it effectively silences sex workers in research that is about them and may impact on them. EMPOWER finds this is unethical practice and casts doubt on the credibility of all research done about sex workers without sex workers*'.

As EMPOWER's staff members are sex workers and employees, my approved ethics permitted me to conduct the interview. I was conscious that there were multiple participants taking part in the interview but Liz quipped, '*You buy one you get one free, Alice!'* I transcribed the interview immediately, so I was able to match the voices on the recording to the respective person. For reader accessibility, the case study will combine the voices in the interview, as I posed the same questions to both participants, with Liz also adding her insights throughout. Liz, Ping Pong, and Mai joined the call. These are not pseudonyms. Ping Pong explained how anonymising their stories, '*makes us feel like we really are criminals...or we're so stupid that we don't know how to protect ourselves'.* Furthermore, they did not want to fit the

Western '*racist idea [of] little Thai women',* which to them, epitomised global power imbalances.

EMPOWER refers to their four different work streams as "clubs". These include the legal club, job and study club, their own bar, and a sex worker history museum. It '*works more like a family than any other kind of bureaucracy so everybody does everything*'. Mai teaches Thai literacy, is a representative of sex workers, and is responsible for outreach and advocacy work for the sex work community. Ping Pong has been at EMPOWER for many years. She started as a student studying English and currently she coordinates EMPOWER's relationships with other organisations as well as the government. They jest that Ping Pong '*sells sex work to the government'.* They tell me how EMPOWER tries to enact societal change through art and performance, which Ping Pong manages. Regarding the types of issues and challenges that sex workers are currently dealing with in Thailand, Mai remarked on, '*the removal of the prostitution act; to take away the criminal law against prostitution*'. It is the prostitution act that '*keeps them outside the laws, like the labour law*'. However, Ping Pong paused, and stated that presently, their greatest concern '*is finding food*' as Thailand's '*economic situation...is so bad*'. Her concern extends to all sex workers as the government, due to COVID-19, '*closed entertainment places before they closed everything else. And they were the last to reopen'.* Ping Pong explained that 80% of sex workers are mothers, so women are struggling to provide for the entire family: '*when their wage goes down, everybody goes down'.* She poignantly remarked, '*we're not even seen'.* To which, Liz says, '*I see you'.*

For context, Mai is stateless. She described how '*indigenous women and migrant sex workers [In Thailand]...haven't been able to get any assistance from the government at all*', so much so that the Thai Prime Minister has announced relief payment to all except migrant workers, which is a violation and breach of basic human rights. She

was obviously upset, with Liz adding that '*Mai feels really hurt and angry'...'the treatment of migrants and indigenous people is a factor in sex work'.* I asked whether there was governmental support before COVID-19. Liz laughed and Ping Pong said, in English, '*not really...'*. Liz added, '*we're only being seen now because of the thirty-year fight that we have undertaken to make them see us*'.

Sex and tourists

Regarding Thailand's sex tourism industry being part of the national marketing strategy, Liz translated that '*it's not direct advertising but it's inherent'.* Since the 1960s, government funded tourism campaigns featured Thai women, usually at waterfall vistas. The type of tourists that visit Chiang Mai are men, travelling alone, aged from 18 to 70. According to Mai, men under forty have '*no money and no manners'*, and try to negotiate; she remarked, '*you don't bargain for sex, you just pay for it*'! Those over fifty appeared to be needy, which they prefer as these men '*have more life experience...they're calmer, they're more respectful'.* Liz wanted me to understand that *'if you ask twenty different sex workers, you'll get twenty different answers'*.

Male tourists are predominantly from China, Japan, America, and the UK. '*Every country in the world comes to Thailand',* especially from countries where sex work is illegal. '*The year before COVID, 42 million tourists came to Thailand'* and '*nobody is coming to see the beach every year'*! Having said that, Thailand is a favourable destination as '*the weather is so good, it's not an expensive place to be, [and] the service is very good*'. Whether planned or not, tourists in Thailand take part in excursions during the day, and then visit the sex work districts at night. Therefore, '*[they] don't know what is a sex tourist...they're just tourists'.*

Transactional sex

In relation to the types of transaction that take place between sex workers and tourists, '*if it's not monetary then it's not sex work'...'That's called love!'...'That's called a relationship!'* Other relationships, outside of single occurrences are, '*regular, long-term customers'. 'They may go off for a month together, but he has to pay for a lump sum for that whole, for their time'*. Interestingly, if sex workers were to receive gifts, '*it would have to be gold*' and '*not dinner and a show, you know?*' When Ping Pong and Mai asserted that '*sometimes the guy wants to think that they're not having a financial transaction'*. It was abundantly clear that they were socially aware of the intentions, and arguably vulnerability, of their clients. With autonomy, they compared the transactions with their clients to those in other occupations. '*You get your haircut, and your hairdresser thinks you're great, but you still have to pay*'.

Relationship dynamics

I moved onto power dynamics within the relationship. Jokingly, Liz translated, '*power imbalance only exists until he's naked*' and then more seriously Mai shared that, '*as a sex worker, that's part of the job, you must be the one that controls how things go'.* Ping Pong also learnt this from her friends and by observing how other women control the situation. Fascinatingly, and something that I still reflect on, is that Liz had to explain Western feminist assumptions of Asian women holding less power than their male counterparts, to Ping Pong and Mai. '*I don't think they're so aware, that people in the West, or especially women in the West, imagine that these guys have less power than the White man, because he's White and he has money. I don't think they've heard that theory*'. I reiterated that I was talking about '*a patriarchal society, a male dominated society*'. Ping Pong accepted the '*theory...[in] the big picture'*; however, '*it doesn't play out like that really. You have to be the one that knows what they're doing. And his power goes down*'. Mai complemented this, sharing that '*most*

men and customers are quite respectful and they're not the demons that sometimes they're made out to be'.

Decriminalisation of sex work, law enforcement, and being 'forced, exploited, and tricked'

Liz set the scene of EMPOWER's activism movement: '*we're at a very historical time'...'we've only just got to get democracy back and then we're ready to go'*! Their patience is inspiring. The continually changing autocratic government disregard proposed laws, and so Liz articulated that they are waiting until the optimum time. Mai is an advocate for the decriminalisation of sex work as she believes it will reduce the stigma experienced by sex workers, as society perceives them as '*bad', 'lazy'* and '*immoral women'*. Ultimately, their aim is for Thai society to view sex workers as equal to other women.

'*The first thing that they think you should understand about the judicial law is that, [it is an] open door for corruption*'. During COVID-19, Ping Pong and Mai both acknowledged that bribery has reduced. However, before COVID-19, they believe that the police must have to reach a quota of arrests in a certain timeframe, and so sex workers become their prime target. Even to the point whereby '*people volunteer to be arrested'.* Furthermore, if sex workers need to report a crime, it is unlikely that the police will document it; alternatively, they will arrest the person filing the report for being a sex worker. *'The law is a farce basically*'. EMPOWER do not see the need to build or maintain a working relationship with the police, as the root of the problem is within the system. *'The corruption is at the top'*, so EMPOWER work to reform the system, and by this they mean, '*getting them to agree that the prostitution law can get abolished*'.

EMPOWER does incredible advocacy work against human and sexual trafficking. Liz pointed out that the Thai language does not use the word trafficking, and generally, women use the words forced, exploited, or tricked to describe their situation. With COVID-19, the economic downturn and lack of demand, there is a hope that exploitative organisations '*can just go away forever'* but it is too early to discern. In allusion to COVID-19, Liz quoted, '"*the demand for prostitution doesn't come from men's need for sex, it comes from women's need for money*"'. As a consequence of the pandemic, many are impoverished, falling into debt, and because they are unable to receive financial support due to their occupation as sex workers, they are susceptible to exploitation. , the conversation returned to legislation, as Ping Pong added that '*removing the criminalisation will...give women more independence and power'*.

Healthcare

Liz ascertained that Thailand has UHC, describing it as '*a bonus'.* Yet, Mai added that there is still a charge for STI and HIV screening for Thai nationals, whilst tourists tend to use the private hospitals. Both Ping Pong and Mai confirmed that nearly all clients use condoms out of fear of contracting STIs or HIV, and that Thai sex workers currently have lower STI and HIV rates than non-sex workers do. Anecdotally, sex workers will agree to condomless sex when they first meet a potential client, '*but when you're in the bedroom everything changes*', or if this is not possible, Ping Pong said that '*there are so many ways to get a condom on a man without them knowing it was ever there...this is the profession*'. This returns to the idea that they are in control of the situation. According to Mai and Ping Pong, in some cases, men will negotiate an increased price for condomless sex. However, for Mai to agree to condomless sex, '*it's gonna have to be millions not thousands'*. When I asked about COVID-19 negotiations and removal of PPE, Mai raised the price to ten million.

The future

Ping Pong relayed that after sex work laws are abolished, '*we really want to see a proper welfare state in Thailand*' such as '*money for mothers and carers*' so that they can '*choose the [customers] we want, choose different jobs*'. '*Then after that, we're going to bring down capitalism*'! They, again, inferred that sex tourists are only tourists. By using terms such as sex tourism and sex tourist, '*it indirectly increases the stigma against us as well*'. '*Every time there is a special word, everything gets worse*'. Whilst legitimising sex work constitutes part of their goals, their pursuit for '*respect for women*' in the sex industry, in a bid to obtain equal protection and rights, is unquestionably their driving ambition.

The interview with Liz, Ping Pong, and Mai at EMPOWER was undoubtedly my favourite. What was particularly interesting to reflect on was that Liz had to translate our cultural concepts and ideologies, not just our language. By the end of the interview, I was in awe of these women. They defied most of the literature and stereotypes of Thai sex workers, and they were some of the fiercest, strongest women I have met. I took away a sense of revolution. They are grassroot activists, with clear liberating and emancipatory goals, who know how to negotiate all levels of society patiently and strategically, from their clients, to the patriarchy, and even Thailand's dictatorship.

4.7 Mechai – 'Enjoy yourself but protect yourself!'

In the email exchange with George and Korn (case study 3), they mentioned a HIV testing campaign, which was operated by a community organisation based in Thailand. I got in touch with the organisation and was able to speak to a member of staff. Mechai was suave, articulate, and progressive. The organisation was

established in 2008 and Mechai has been working there for the last decade in their Bangkok office. He described how they collaborate with community stakeholders, government, and multilateral organisations such as the UN and donor development agencies. They have been able to navigate collaboration between the various stakeholders due to their long-term commitments and relationship, developing and expanding together over the last 14 years. Most of their funding is through the Global Fund and pharmaceutical companies, yet Mechai asserted that this was not enough to support their work, especially with the transitioning of countries such as Thailand, Vietnam, Indonesia, and the Philippines, from Official Development Assistance. Mechai explained the difficulties in securing international funding, with Australia withdrawing resources from the region, the backlash from protests in Thailand and Myanmar, COVID-19, the impact of ceasing funds from the UK's Foreign and Commonwealth Office (FCO), and the Department of International Development (DfID). Although there may be different visions between companies, particularly with the pharmaceutical industry, '*you can't say no to that*', and there is a need to fight and negotiate, especially for the allocation of funds. Mechai reported, it is '*the pharmaceuticals [that] are kind of filling these gaps where it used to be international funding and now it's not there*'. Mechai shared that it is easier to secure funds when they are health-related, for example with HIV; so, for '*decriminalised populations or criminalised behaviour*', he must position '*it from a public health angle*'. Therefore, the work draws on '*civil society engagements'*, such as spreading current HIV messaging and '*understanding of U=U*[7] *in the region*' (ibase, 2021).

[7] U=U is part of an international campaign to raise awareness and share the message that undetectable viral load (achieved through adhering to ART regimens) means HIV is not transmissible (ibase, 2021).

The organisation's focus crosses multiple levels from international, national, and local communities. Their work centres on HIV and sexual health, primarily in gay men, MSM, and transgender populations, '*to advocate for the country national strategic plans for HIV*', through research, resource allocation, and campaigns. The organisation disseminates messaging and advertising of their services, mainly that of HIV testing, through social media; then, as the organisation is community led, they communicate with the community through peer-to-peer training, ensuring service users trust that '*the information will be secure and that they will get [a] very good service*'. As the organisation has grown and spans across the Asia Pacific region, connecting 200 community-based organisations across Asia Pacific, Afghanistan, Pakistan, and the Pacific Islands, there are country specific strategic plans to tackle local infection rates. Young, gay men currently drive HIV and STI transmission in the area, with '*90% of all new HIV infections…in key populations and their partners*'. HCPs that are part of the community led service, train staff to provide testing, treatment (ARTs) and preventative tools (PrEP, condoms, and education). With COVID-19, Mechai explained how they would then be able to migrate these services online.

The two other main areas of attention for the organisation in the region are the criminalisation of same sex relationships (with the exception of New Zealand) and drug use. To achieve sustainable improvements, they direct their efforts onto '*research education, community empowerment, strengthening community networks and then stuff like the research advocacy as well*'.

HIV testing campaign

The organisation's work has gained traction, and Mechai described how they are now well known for their '*fantastic testing campaigns*'. They were incredibly successful as they strategically assessed how '*information can be delivered differently and how*

communit[ies] can be empowered to use new technology' at the same as '*com[ing] up with their own testing campaign*'. He explained how high-level bodies normally lead campaigns from a top-down approach, yet this testing campaign began internally. The campaign targeted young gay men through their online social media presence and use of gay dating apps. The aim was to '*normalise HIV testing, normalise talking about sex, [and] being sex positive*'. The messaging centred on overcoming individuals' fear and resistance to test, '*even if it's their first time [and they] might be worried about it…getting HIV testing is not the worst thing that can happen in your life*'. He expressed how at first, funders met this approach with resistance, yet now with hindsight, it was the obvious direction to move in.

To execute a successful and sustainable campaign, Mechai needed to keep it on the ground. He started by deciphering specific target audiences, stakeholders, concepts, branding, and how the team would disseminate the messaging. Once formulated, Mechai shared the ideas with different communities that they worked with. He laid out the process, starting with Thailand as the first location:

> *'So people travel in the region, so we had to stay in the region, and everyone comes to Bangkok, right? So what kind of information that would be useful for those that are coming to say, "OK, where can I get tested", and they can't do that in their own country, because it's much more liberal than many other places around the region. And you know what would be catchy?...Then in the region it becomes something much more well known, and you know once there's a lot more people talking about it, then yeah, it's normalised.'*

When presented to funders, the campaign, '*at the time…was quite controversial*', particularly the taglines. Mechai conveyed how hypocritical he thought this was. For Mechai, the crux of the campaign, to access more vulnerable individuals, was that the messaging needed to reflect the individuals who would be testing. They needed to '*see themselves and not some other models coming in and being like, "who's that?"*

you know? Like, if you can imagine a HIV test campaign with white people...that just wouldn't work'.

The campaign was so successful that organisations in Washington, Jakarta, Manila, Mongolia, and Hong Kong have replicated the model. Mechai credits it to the strengthening of health systems and reaching the most vulnerable populations in hot spot areas, which undoubtedly appeals to respective governments.

Decriminalisation of sex work and law enforcement

For Thailand, Mechai believes that the '*decriminalisation of sex [is] going to be very difficult'* as still, '*there's a lot of people who get some benefit from it*'. He described the '*conservatism around sex work*', the use of drugs, and '*anti-homosexuality*' sentiment, that Singapore and countries that '*still have the British law*' observe. Mechai emphasised the heart of the issue is not necessarily with the law but around protection of sex workers and GBV. Sometimes, '*police are the perpetrators, particularly targeting transgender sex worker for example or using, say condoms in examples as evidence for sex on premises and then using that as [a] bribe to get money*'.

According to Mechai, the community organisation Service Workers in Group (SWING), have been working with the police to change the '*Sin City*' image of Pattaya. However, this led to law enforcement displacing TGSWs from where they solicit transactions. While there is a need to '*relationship build*' with the police, when restrictive policies are applied, negotiating with the police '*become[s] much more difficult…we've seen periodic levels of discrimination and harassment by the police*', with tourist and sex worker areas specifically targeted by law enforcement, particularly during COVID-19. An issue that was also raised by Liz, Ping Pong, and Mai (case study 6).

Sex tourism

Although '*[sex tourism] is on [their] radar*' it does not impact their '*day to day work*'; however, Mechai did explain how COVID-19 has had a substantial impact on the industry. Without tourists, '*sex workers are not getting work*', so they cannot provide for themselves or their families. Furthermore, other community organisations in Thailand are '*being contacted by the most vulnerable…[be]cause they don't go to the government based services, they come to the communities but we don't have the resources to do that*'. Instead, organisations, such as SWING, are pushing existing messages of '*100% condom promotion*' and STI prevention as well as distributing kits that contain '*wet wipes and sanitisers*' and information saying, '*this is what you do before having sex with clients*'. However, Mechai highlighted that the Thai government do not fund STI screening and treatment.

A newer trend that has emerged in Thailand is chemsex (Hibbert et al., 2021).[8] They are currently looking at how to effectively meet '*the changing needs of the community*', which Mechai reported was proving a challenge, as those that take part in chemsex are '*much more difficult [to reach] than other groups*'. Usually, they would launch a campaign, but Mechai explained that the issue requires further research, trust building, education, and harm reduction, so that they can initiate conversations around the likes of PrEP and other HIV prevention tools. The day

[8] Chemsex is a form of sexualised drug use whereby '*men engage in sex with other men for long periods of time with multiple sexual partners, typically taking one or more of crystal methamphetamine, γ-hydroxybutyrate/γ-butyrolactone (GHB/GBL), methedrone, cocaine and/or ketamine immediately before or during sex to facilitate and enhance the sexual experience. Chemsex has become a public health issue over the last decade*' (Hibbert et al., 2021, p. 1).

before the interview, Mechai's organisation had published a harm reduction chemsex resource document for gay men, transgender women, and transgender men. It is currently in Thai but there was already demand for an English translated version.

The conversation shifted to sexuality and gender identity. I referenced my conversation with George and Korn (case study 3), and the four accepted genders in Thailand: men, women, transgender men, and transgender women. Similar to the two other case studies, Mechai agreed: '*to be trans is not recognised in Thailand*'. While you '*can change your name to be female sounding*'…'*you cannot change your gender on your official document*'. This has significant implications on stigma, discrimination, lack of social protection, and employment opportunities for the transgender community, '*that's why there's a lot of transient sex workers*'.

Similar to George and Korn (case study 3), Mechai also described how Thailand's TGSWs are '*not just sex workers, they're performers*' on mainstream television. The phenomenon has spread through Thailand, with *RuPaul*-esque competitions such as, "Thailand Drag Race", with '*slapstick…comedic undertone[s]*'. From a different perspective to the previous case studies, there are now some '*openly transgender women in Parliament*'. Furthermore, there is a TGSW organisation, Sisters, based in Pattaya, which is transgender led, and conducts key sexual health and preventative outreach work, as well as supporting negotiations and relationships with law enforcement.

Referring to Mechai's previous comment regarding using social media and apps to access a wider audience, I asked if he was able to target the most vulnerable in society. He explained how social media has moved people, such as '*money boys*', to use websites and apps. This is emphatic of the international reach that online

platforms provide to sex workers, who use social media as an advertising tool to work on the streets and cater to tourists, whether in brothels, massage parlours or saunas. However, going online is '*obviously…not going to reach everybody*'. At the same time, organisations such as SWING are '*very much are on the ground*', and have working relationships with bar owners, go-go places, and restaurants, specifically in the LGBTQ+ areas. Between the outreach from SWING, and online and social media communications, Mechai believes community organisations in Thailand have reached a wide range of individuals. However, he did identify that those '*between them…they will not be covered*', and gave the example of '*sex workers that are migrants from neighbouring countries*'. For those that are in Thailand illegally, they experience great difficulty in accessing employment and community-based services, mainly due to language barriers. Although Mechai stated that '*Global One has also tried to do some more work around migrant workers access to health services as well in Thailand'*, he acknowledged it is '*nowhere near enough*'.

Finally, we spoke about recommendations for international sexual health. Regarding prevention messaging for tourists travelling to Thailand, Mechai stated that he has seen information regarding human exploitation in airports, and thought, '*why can't I put my sexual health message there as well, right?*' Alternatively, he added that airports could distribute sexual health leaflets with landing cards, concocting the tagline, '*Enjoy yourself but protect yourself!*' On top of this, Mechai emphasised the need for further research into different populations. Of note, he highlighted the TGSW community in the context of international tourism, exploring how they market themselves to various clients and audiences, whether street-based or online. He stressed the necessity to investigate their specific health risks, from accessing sexual health services, testing, and understanding the range of STI and HIV prevention methods. Finally, Mechai identified the need for policy level changes for

(transgender) GBV. The industry requires a structural, multifaceted approach utilising institutional collaboration, with vital input from the police and government, to effect substantial change.

4.8 Naw – 'I would consider transgender women [as a] very vulnerable population as a sex worker, especially…in [the] context of Thai police'

Previous interviews had discussed the transgender community in Thailand, their place in Thai society, and identity terminology. A colleague put me in touch with Naw. Over email we realised we had similar, overlapping research interests. Naw focuses on transgender health experiences, '*healthcare barriers and inequity, particularly primary care, HIV/AIDS prevention strategy, and…SOGI*[9] *data collection*'.

Naw is a medical doctor at the Thai Red Cross in Bangkok, providing sexual health services and conducting research. Qualifying five years ago, she currently provides services specifically for transgender and gender diverse individuals including counselling, HIV and STI testing, ART provision, hormone therapy and treatment, gender affirming guidance, post-surgical examination, and vaccination services.

As I did not have much time with Naw, my questions were more structured and direct than the previous interviews. My opening comment '*so I've heard people say that transgender is recognised as a third gender…[but then also]…I've heard that there are four recognised genders [in Thailand]*' was immediately clarified by Naw. She stated that Thailand does not recognise non-binary genders '*under law*' and similarly, '*when you go to the hospital you have just like tick box for male or female, that's all*'. She

[9] Sexual Orientation and Gender Identification

added that NGOs may include transgender male and transgender female categories and in '*social circumstances…people here in Thailand, we [are] recognised as you said, like male, female, trans male, trans female*'. In relation to legal rights, if an individual is undergoing gender affirmation therapy, they are unable to change their name, and even after gender affirmation surgery (GAS)[10], their '*gender marker cannot change*'. As a transgender woman herself, Naw shared that '*in my passport, I'm still mister…*' Similar to sex workers in Thailand, '*we are not fully accepted…we [are] tolerated*' and '*in terms of law or legislation, we don't have anything to protect us*'.

Due to the lack of legal recognition, there is no official spelling for transgender identities. I mentioned '*katoey*' and Naw corrected me: '*you know that this term is not really polite, right?*' I explained that I had recently learnt of the derogatory connotations (from George and Korn, case study 3). The accepted terminology directly translates as "female or male '*come across'*", therefore, acknowledging the transitional process. When utilised in health services, Naw described how Bangkok has gender sensitive services due to plentiful high-risk populations in the area. Therefore, the Thai Red Cross '*encourage all staff to make sure that they [attend] gender sensitivity course[s] before they start working*'. For transgender patients, the clinicians allow them to direct the conversation and '*say how they identify themselves*'.

Although Naw reported that HIV prevalence is reducing in Thailand, those that acquire HIV are '*gender diverse…including men who have sex with men or gay and transgender people*'. Concurrently, those '*who receive PrEP and PEP [are] increasing*

[10] During the interview, Naw corrected the term 'sex reassignment surgery' to 'gender affirmation surgery', which will be used for the remainder of the thesis.

like every year as we have many campaign[s] or a lot of like funding to support this campaign for PrEP'. Naw explained how Thai citizens could receive two free HIV tests a year. In her experience, transgendered people, particularly those engaged in sex work, have negative associations with hospitals due to the lack of '*gender recognition legislation*' and '*gender sensitivity*'. The transgender community, therefore, prefers to attend community healthcare services for testing, PrEP, and PEP, which international and Thai organisations such as the Thai Red Cross, SWING, Tangerine, and Rainbow Sky currently fund.

According to Naw, Thailand's sex industry namely operates in '*Pattaya, Bangkok, and Phuket*'. For Naw, there are two types of sex workers, both of which generally use protection during transactional sex. Those that are based in nightclubs and bars, and those who work '*freelance*' and '*are looking for clients on like application[s] or online platform[s]*'. For those in nightclubs, Naw described how the owners of the venue are responsible for '*encourag[ing] sex worker[s] to make sure that they check [for] HIV and syphilis regularly*'. She continued, detailing how the Thai law does not protect sex workers, and that police and law enforcement expend violence and abuse on their community. The transgender community receive even harsher treatment, '*especially [for] transgender women*', who historically were '*only able to work as a makeup artist or sex worker*' due to lack of societal acceptance. '*I would consider transgender women [as a] very vulnerable population as a sex worker, especially…in [the] context of Thai police'*.

To conclude the conversation, I asked what the international response should be to reduce disease transmission in the backdrop of the COVID-19 pandemic. Whilst Naw emphasised that international collaboration was important, she went onto say that the greatest need would be to enact '*some law to protect sex workers*' and make it '*mandatory for them to have like regular [checks] for HIV [and] syphilis*'. Naw believes

that if Thailand enforces such policies, it would reduce domestic and international HIV transmission.

Chapter 5: Discussion

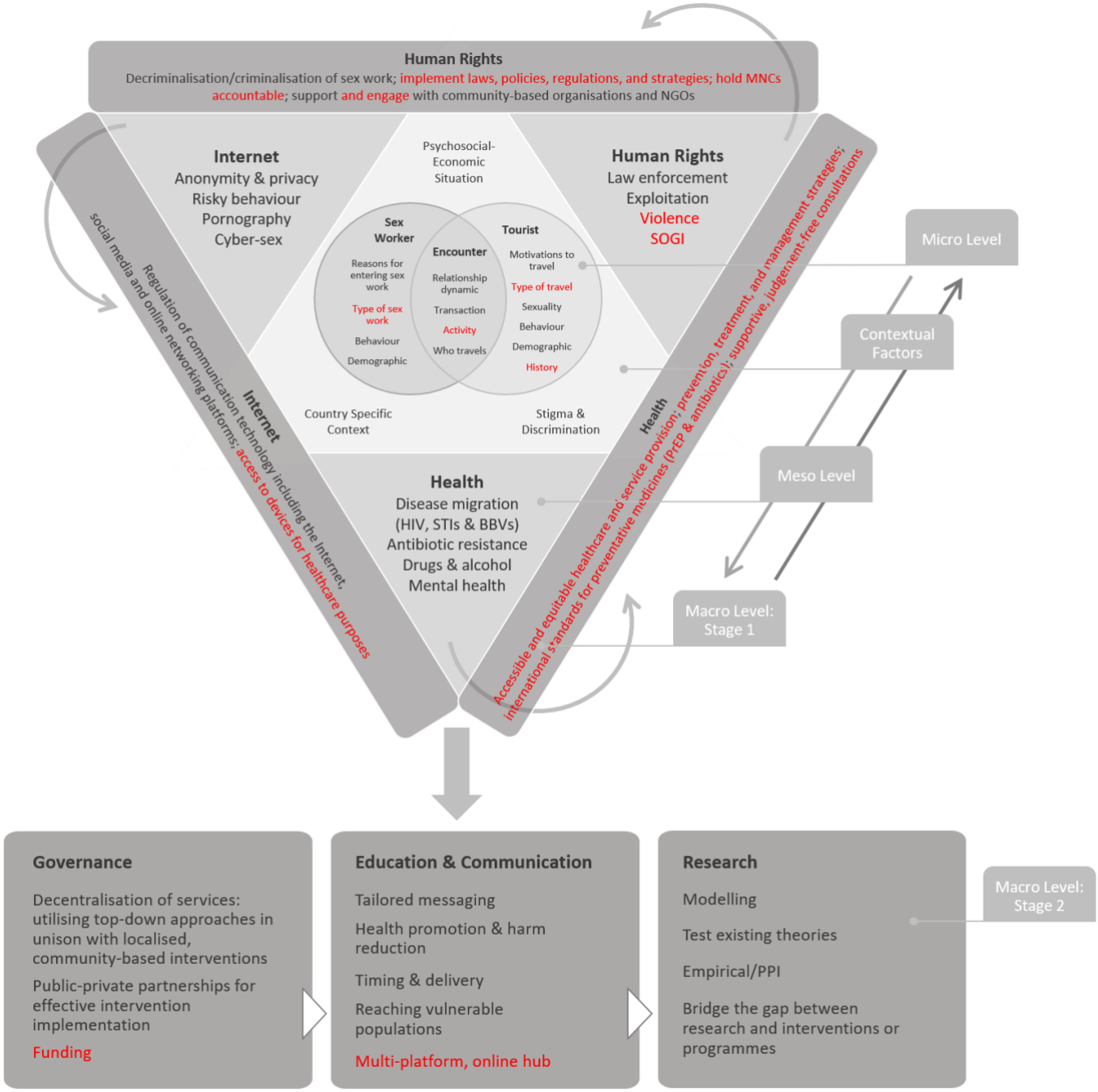
Following on from the case studies, this chapter will draw together the findings and analysis from the previous chapters. The principal aim of this thesis was to map out and create a new innovative contemporary sex tourism model. To achieve this, this chapter scrutinises and refines the initial model presented in chapter 2 in light of the findings from the interviews and subsequent case studies, with the resulting adapted model presented in the following section. Cultural normative gender and sexuality issues were thread throughout the case studies and highlighted in the revised model. This aspect is pulled out and elaborated on in the context of feminist and intersectional literature. The chapter then translates these into a sexual health pathway for tourists that can be used to inform service provision and future public health interventions. Utilising the generated deductive and inductive themes, the pathway and respective discussion addresses access to services, patient conversations with HCPs, prevention strategies, diagnosis and treatment, harm reduction education, and messaging. Within this, recommendations have been drawn and presented in boxes throughout. Finally, the chapter concludes with the limitations of this thesis as a whole, combined with reflections on the research process, and recommendations for future research directions.

5.1 Refining the model

The initial conceptual model was scrutinised and refined by using the findings from the critical analysis of extant literature combined with the case study and thematic analyses in the previous chapters. This section addresses each level of the adapted model separately, highlighting distinctions between the initial and final models. The levels are presented both visually in Figures 4 to 8 (the greyscale Figures include the

adaptions in red font for contrast and clarity), and through further discursive exploration of the domains and elements within the model. The reader must note that the model, although extensive in nature, is not exhaustive, as sex tourism continues to change in line with globalisation and has different attributes dependent on the country specific context.

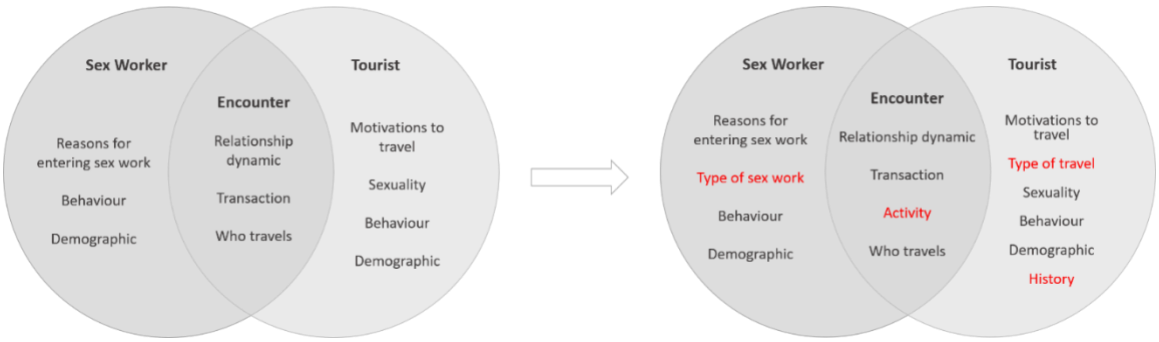
Figure 3: Final conceptual sex tourism model with adaptions



Key: MNCs – multinational corporations; HIV – human immunodeficiency virus; STIs – sexually transmitted infections; BBVs – blood borne viruses; PrEP – pre-exposure prophylaxis; SOGI – sexual orientation and gender identity; PPI – patient and public involvement

5.1.1 Micro level

Figure 4: Micro level adaptions



As can be seen in Figure 4, four elements have been added to the micro level: 'type of sex work', 'type of travel', 'history', and 'activity'. These new elements will be discussed first, followed by further details pertaining to the remaining elements that have not been altered since the initial model.

Firstly, the sex worker circle of the Venn diagram has the additional field, *type of sex work*, which may include online or street-based sex work, or sex work based in nightclubs, brothels, and ping-pong shows (Travelling Jezebel, 2020). The type of sex work can be reflective of both the individual and their contextual factors such as their psychosocial situation, level of stigma experienced, and view on sex work (sex positive and abolitionist), which are elaborated on in the contextual level. It is important to acknowledge these aspects, to provide the individual with the most relevant and tailored interventions. In the tourist circle, while the motivations to travel are considered subjective attributes (for example escapism, relaxation, or sex-seeking), it is the *type of travel* that has been added to the domain, and is distinguished by its objectivity. It details the purpose of travel, which is how most

literature labels tourists, and may include whether the holiday is short or long-term, business-related, medical, cultural, a volunteering project, or for migrating purposes, where the individual may frequently return home and have sex with a regular partner (Oppermann, 1999; Dessie, case study 1). Interestingly, participants in this research noted the large number of businessmen (comprising of some British businessmen, but with the majority travelling from Japan, Korea, and China), who travel through Thailand, engage in the sex industry, and are well informed of the public health risks (Richens, 2006). Additionally, interviewees in the present case studies, requested that HCPs should take note of previous and future travel plans where the patient has or may have sexual encounters as well as documenting the types of encounters and the patient's sexual history in relation to travel over the course of their lifetime, during consultations. According to the HCPs interviewed, consultants or nurses only enquire regarding the previous three or six months of sexual history. It is for this reason that the tourist circle now contains a *history* label to document the individual's sexual health, general health, and travel history, for healthcare and service provision purposes. *Activity* now complements the existing labels of 'relationship dynamic', 'transaction', and 'who travels' within 'Encounter' domain or the intersection of the circles. Although similar to the relationship dynamic, it will include more nuanced descriptions of the encounter such as voyeurism, online sex, and sex shows (Travelling Jezebel, 2020).

Secondly, the 'reasons an individual enters sex work', 'behaviour' (such as drug and alcohol use), and 'demographic' information remain unchanged in the sex worker circle. The tourist circle continues to provide details regarding 'motivations to travel', 'sexuality', 'behaviour', and 'demographic' information. Whilst the labels of 'behaviour' and 'demographic' were justified during the creation of the initial model, the findings from the interviews and case studies add to the wider knowledge base regarding both

elements in the tourist circle, as well as wider discourse on power dynamics. Most participants in this research grouped tourists based on their ages. Existing literature does not distinguish age-specific tourism (Suttikun et al., 2016), apart from those that vaguely focus on age-related motivations to travel, such as evidencing senior, mature, and cultural tourists (Batra, 2009), and youthful, backpacking tourists (Jariyachamsit, 2015; Bishop and Limmer, 2018). Furthermore, participants in this present study portrayed the image that the younger generation travels to Thailand and has sex with multiple partners. Due to the volume of sexual partners, HCPs agreed that this behaviour could be classed as sex-seeking, and is a trait specific to Thailand as a holiday destination, with tourists' averaging at least one new sexual partner a day (Dessie, case study 1). Other participants supported this notion, proving easy access to multiple partners, notably when visiting Bangkok, through dating apps and the LGBTQ+ nightlife (George, case study 3). Grönvall, Holmström and Plantin (2021) found similar behaviours in their Swedish cohort, who travelled for excitement and pleasure, having sex with multiple sexual partners, including sex workers while abroad, to explore their sexuality. They described the phenomenon as a balance between the commercialisation of women and the need for tourists to obtain intimacy in a bid to reach their sexual goals. Undoubtedly, this is a very male-centric voice but corresponds to the narrative provided by the participant interviews.

The interviewees described two different, intersectional power dynamics (racial and gender-based), which should be added to the theoretical analysis of the literature around agency and power in the transactional relationship. Firstly, participants depicted the historic stereotype of women from impoverished backgrounds who seek to elevate their social status and economically survive, through entering relationships with Western men. With the perception of a powerful global North dominating Southern countries, sex tourism fosters racism and continental

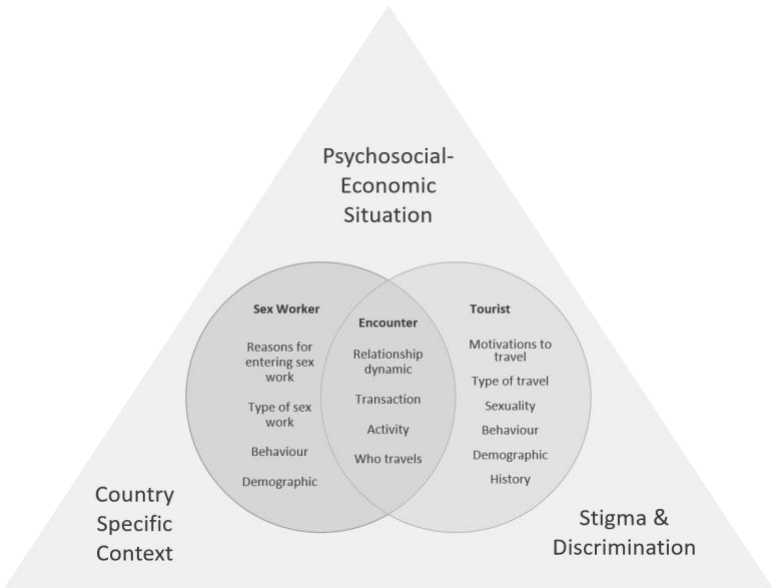
stereotypes, predominantly with people from the Caribbean, African countries, and Eastern territories (Pruitt and LaFont, 1995; Kempadoo, 2001; Nyanzi et al., 2005; Phillips, 2008; Weichselbaumer, 2012; Bandyopadhyay, 2013; Bauer, 2014; Spencer and Bean, 2017). Literature hyper-sexualises and deems sex workers from the South as 'exotic' in the eyes of white Westerners (Wonders and Michalowski, 2001; Padilla et al., 2010), who in turn socially ostracise sex workers while paying for their services (Dorfman, 2011, p. 18). Cyclically, it is Westerners who perpetuate the stereotype, believing that Thai women are attracted to, or want a relationship with white, affluent men (Bishop and Limmer, 2018; Scuzzarello, 2020). Therefore, it is systemic racism and historic stereotypes that contribute to these relationships as opposed to the negative connotations associated with the Thai sex industry (Dorfman, 2011). Participants, most notably the Thai nationals, argued that there is insufficient evidence to identify the nuances surrounding the antagonistic theories. During the interviews, they reiterated that longer-term relationships are not transactional, and constitute a small segment of society. Interestingly, the participants also delivered a sub-narrative of reverse orientalism, in that Thai locals fetishised and romanticised foreigners. Conversations highlighted the appeal of pale skin, with accounts of bleaching and wearing white powder to achieve the desired skin tone. Thus, drawing attention to the level of respect that Thai men (as opposed to Western, white men) have for women (regardless of intersectional factors such as race and ethnicity).

The second dynamic discussed was between female sex workers and their male clients. Thai sex workers detailed how their customers may believe they have the power in the relationship, yet it is the sex workers who are in control of the situation (Liz, Ping Pong, and Mai, case study 6). From this, they obtain empowerment and agency. An abolitionist feminist would dispute that this view is naïve and that the women are only in that situation due to circumstances outside of their control (Farley

and Barkan, 2008). Conversely, Western literature emphasises feminist and neoliberal discourse, encouraging sex positivist agendas, which argue that sex workers do not need protecting as they have their own agency (Lankenaua et al., 2005; Weitzer, 2005; Sanders, O'Neill and Pitcher, 2009). Therefore, there is a need to understand the binaries of power and choice through non-Western contexts (Strega, Shumka and Hallgrímsdóttir, 2020). Subordination and one's ability to change or embody their circumstances, breeds agency (Strega, Shumka and Hallgrímsdóttir, 2020). With participants in this research describing the dehumanisation of sex workers, and even more so in relation to the transgender population in Thailand. By reframing the phenomenon, it '*provides sex workers with the necessary grounds by which they become wholly realized subjects; subjects who hold the socially mediated capacity to act*' (Strega, Shumka and Hallgrímsdóttir, 2020, p. 9).

5.1.2 Contextual level

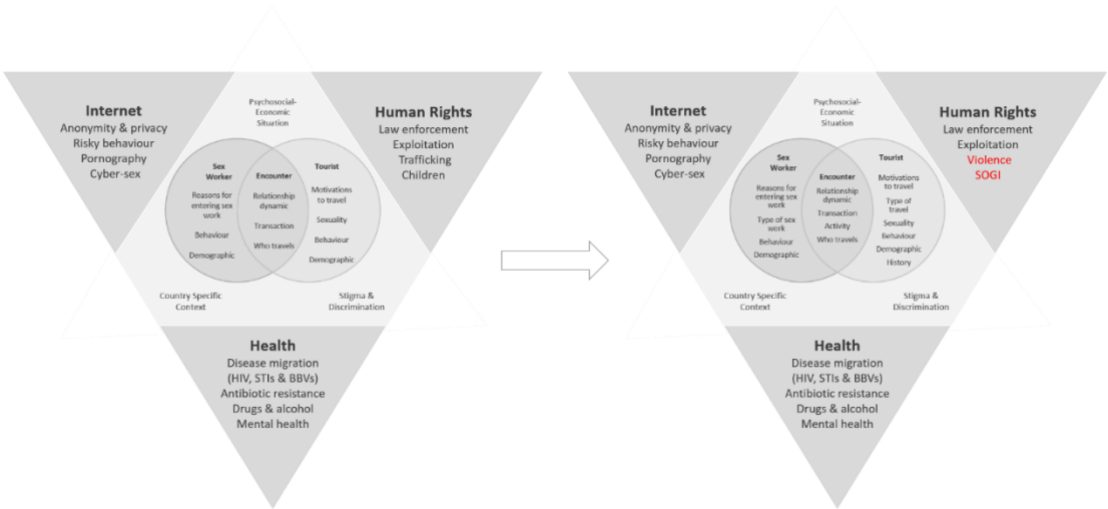
Figure 5: Contextual level adaptions



The refinement of the model did not alter the labels used in the contextual level of the model (see Figure 5 above). However, the case studies did shed new light onto the wider context of sex tourism in Thailand, particularly the role and status of women in Thai society (George and Korn, case study 3). In Thai culture, younger generations and women are responsible for caring for older generations within the family (Reyes, 2015). Traditionally, Thai women are culturally and religiously subordinate to men and punished for presenting themselves in society as sexual beings. This is because Buddhism preaches celibacy; yet, at the same time, 75% of Thai men have paid for sex (Keene, 2019). However, globalisation and urbanisation are encouraging Thai women to enter higher levels of education and employment. As women continue to maintain their domestic home, Thai society refers to them as '*Plastic Bag Housewives*', which George pointed out in case study 3. Interestingly, the female Thai participants did not feel oppressed, did not agree with the concept of patriarchy, and believed that society socially constructs gender roles (Liz, Ping Pong, and Mai, case study 6). From a health perspective, it was evident that accessing healthcare settings is problematic for women. Particularly in rural regions in Thailand, as gynaecological and women's health issues continue to be sensitive topics and carry taboo, causing further stigma and discrimination.

5.1.3 Meso level

Figure 6: Meso level adaptions



From the findings of this research, no adaptions were made to the 'Internet' and 'Health' domains. In the 'Human Rights' domain, analysis identified gaps in the initial model. Four changes have occurred (see Figure 6 above). Firstly, where the model originally used the labels of 'trafficking' and 'exploitation', Liz, Ping Pong, and Mai (case study 6) influenced the terminology change to solely 'exploitation'. Secondly, the initial model originally listed the term 'children', which is now incorporated under the element of 'exploitation'. Thirdly, following conversations with Thai sex workers and community organisations, *violence* has been added and may include sexual assault, GBV, IPV, and common assault. Finally in case study 8, Naw emphasised the need to bring sexual orientation and gender identity (SOGI) issues and data into higher structural levels, and so *SOGI* has also been added to the domain. 'Law enforcement' is the only element that has remained unchanged. The relationship and

the role of the police with sex workers has been previously discussed and confirmed during the interviews with participants.

Regarding the first new addition, sex workers experience high rates of violence, which inevitably impact on their health, well-being, and safety (Armstrong, 2018; Benoit et al., 2018). Sex workers fall within a vicious cycle of stigma, whereby social norms have historically rejected and expelled sex workers, influencing how they are treating, and ultimately perpetuating violence towards them (Armstrong, 2018). Literature reports that street-based sex workers experience higher levels of violence than those operating indoors (Church et al., 2001); and in general, clients are notoriously violent towards sex workers (Deering et al., 2014). Although sexual health risks such as pregnancy, HIV, and STIs are of concern to sex workers, financial pressures, fulfilling family obligations and avoiding violence from clients, the police and brothel managers, are of greater priority (Busza, 2005). Furthermore, since COVID-19, sex workers are putting themselves in increasingly vulnerable positions, and are at a higher risk of violence and exploitation (Hurst, Martinez and Monella, 2020).

Secondly, sexual orientation has been extensively explored throughout this thesis, with the case studies supporting findings from the initial critical analysis of the literature. Additionally, and aligned to the gender identification elements of 'SOGI', transgenderism in Thailand was raised on numerous occasions by the participants. Whilst there is some level of *social* acceptability, Thai law and policy are not *legally* accepting of the transgender community (Chokrungvaranont et al., 2014). Mechai in case study 7 aptly summarised that while Thai society may appear to accept transgenderism, it should be considered as tolerated: '*there's a lot more visibility and vocalisation of transgender issues and rights that are being denied*'. This is specifically the case where individuals are unable to change their gender marker, name, or

passports, leading to implications for employment opportunities, and generating even greater stigma and discrimination (Kabir and Ahsan, 2021).

> '*Policymakers and law enforcement agencies routinely operate outside the law to violate the rights of transgender and sexual minority people. Among the abuses reported by transgender persons are blackmail, extortion, public humiliation, and physical and sexual violence. If policies to socially integrate transgender and gender diverse peoples are not implemented, the state of the transgender community in Asia will not improve*' (Kabir and Ahsan, 2021, p. 1).

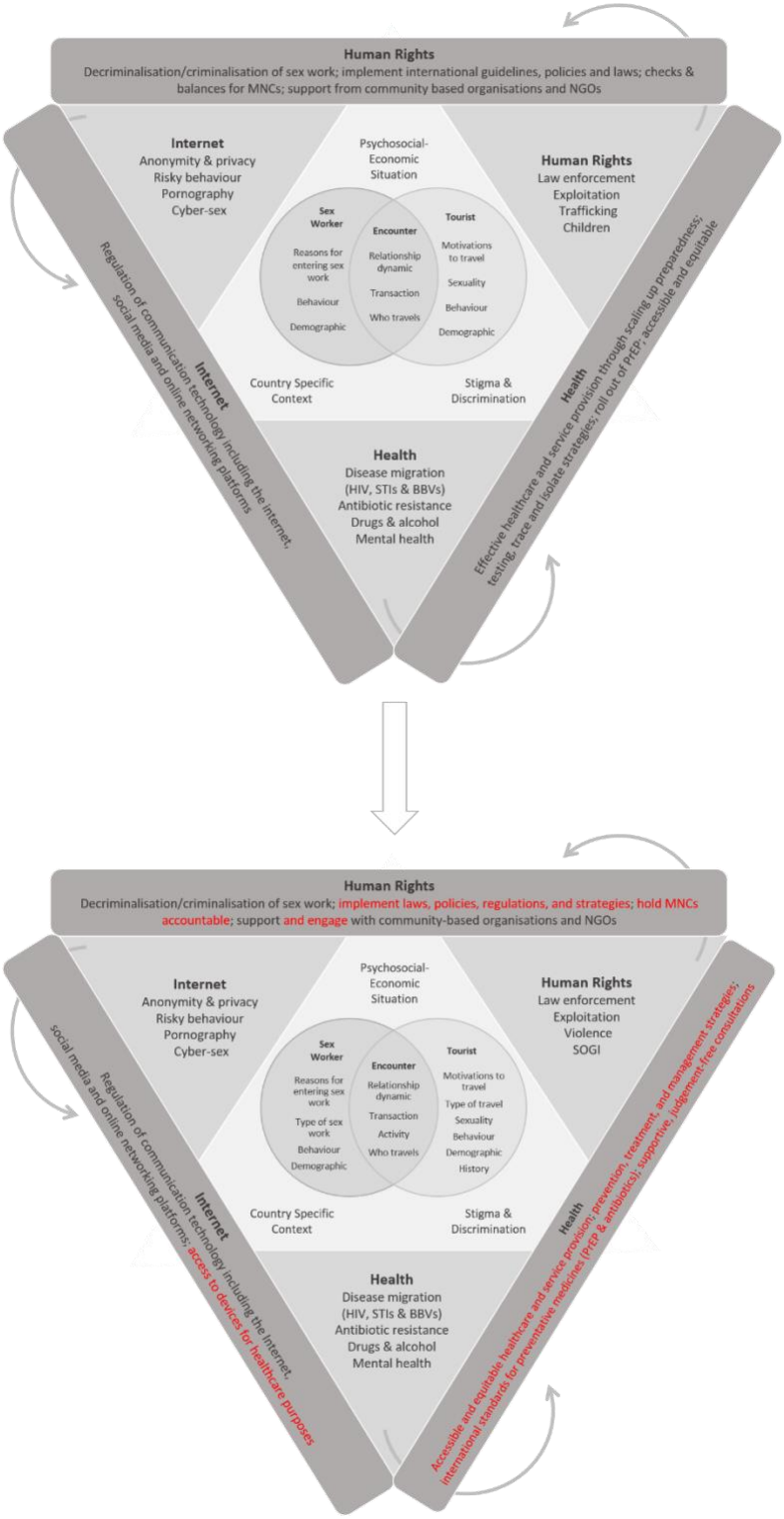
It is also worth noting that for the element 'exploitation', further details arose from the analysis. During COVID-19, sex work organisations shared that exploitation groups have dispersed, presumably due to lack of demand, but they are expecting them to re-emerge with the reopening of borders, due to financial necessity, and as sex tourism continues to operate in illicit environments, facilitated by the shift to accessing the industry online. The interviews depicted how child exploitation largely remains underground, with recruitment through debt bonds, emotional and physical abuse, financial promises, and grooming (Bah and Artaria, 2020). While the system has improved in surveillance, monitoring, and reporting exploitation claims through the Ministry of Social Welfare and Human Development in Thailand, large cohorts of tourists opportunistically source children.

As mentioned, the elements within the 'Internet' and 'Health' domains did not alter. Yet from a health perspective, it should be highlighted that the interviewees did not discuss generic use of drugs or consumption of alcohol for either sex workers or tourists, which is surprising given that literature frequently makes the association in relation to tourism (Darrow et al., 2005; Geibel et al., 2008; Jones et al., 2014; Shokoohi et al., 2019). However, the interviews raised the topic of chemsex, which is considered in relation to drugs and alcohol. Specifically, chemsex reflects the

changing needs of Thai communities, which were supported by UK HCPs noting a correlation between patients on PEP and patients engaging in chemsex. They observed how drug use and chemsex reduce adherence of PrEP, in turn placing vulnerable people at greater risk of HIV and STI transmission. In contrast, longitudinal studies have found that chemsex is not a barrier to PrEP persistence and adherence among gay men, bisexual men, or MSM (O'Halloran et al., 2019; Anato et al., 2021). Regardless, future research must investigate high-risk populations, most notably tourists, engaging with chemsex and the sex tourism industry in an effort to reduce STI and HIV transmission (Maxwell et al., 2020).

5.1.4 Macro level: Stage 1

Figure 7: Macro level: Stage 1 adaptions



Stage 1 of the macro level has seen the most changes following investigation. For 'Human Rights', namely the wording of the elements has changed, reflective of the nuances expressed during the interviews with participants. 'Implement international guidelines, polices and laws' has changed to '*implement laws, policies, regulations, and strategies*'; 'checks and balances for MNCs' has changed to '*hold MNCs accountable'*; and 'support from community-based organisations and NGOs' now has an engagement aspect: '*support and engage with community-based organisations and NGOs*'. In the 'Internet' domain, the label '*access to devices for healthcare purposes*' was added to acknowledge the widening socio-economic disparities that existed before and were exacerbated by the COVID-19 pandemic. For 'Health', additional health-related findings from the case study and thematic analyses provide ample evidence for the four revisions made to the domain. Firstly, the 'roll out of PrEP' changed to '*international standards for preventative medicines (PrEP and antibiotics)*', since the approval of PrEP in the UK. Secondly, to move away from a COVID-19 focus and to ensure longevity, 'scaling up preparedness' was reprioritised to, '*accessible and equitable healthcare and service provision*'. Thirdly, for similar reasons, and to encourage collaborative national and international sexual health planning, 'testing, trace and isolate strategies' was altered to '*prevention, treatment, and management strategies*'. Finally, the domain has seen the addition of '*supportive, judgement-free consultations*' following HCP and CW interviews.

All participants broached the subject of the decriminalisation of sex work. Interviews evidenced the activism taking place across the world. Specifically in the case of Thailand, participants emphasised obstacles in the abolition of sex work such as the military government, benefactors, and religion. Taking a more protectionist approach, the case studies supported the decriminalisation models that New Zealand and some States in Australia currently implement, which make STI and HIV testing

mandatory for sex workers to operate legally (Platt et al., 2018). Participants in this present study extended these measures to include employers or venues where sex workers operate. Placing these perspectives into the broader sex work debate, Strega, Shumka and Hallgrímsdóttir (2020, pp. 1-2) argued that the polarised opinions found in the literature limit the discourse; '*Within the prohibitionist [or abolitionist] literature, agency is discussed primarily in the context of exiting, while within prosex work/empowerment perspectives, the effect of structural constraints on agency is minimized*'. It is therefore necessary to position the sex work debate, as Benoit et al. (2018, p. 458) have done, by understanding sex work as a '*continuum of occupational experiences, ranging in degree of empowerment/choice to oppression/exploitation*'.

If the government overturns the abolition law, sex workers should have greater access to healthcare, be within the protection of other laws, have equal respect as other citizens in Thai society, obtain independence (as individuals and as a collective), experience less stigma and violence, and work towards an encompassing welfare state in Thailand. Minichiello, Scott and Callander (2013; 2015) not only agree with these declarations but also add that the criminalisation of sex work challenges disease surveillance and the implementation of health initiatives. Yet, research should move away from positioning sex workers as vectors of disease (Strega, Shumka and Hallgrímsdóttir, 2020), as they use condoms, attend regular HIV and STI testing, and access same day ART, if necessary; in contrast to tourists, who are reluctant to access health services in Thailand and the UK (Croughs et al., 2016).

Recommendation Box 1: Input of government departments and services

Legislative reform

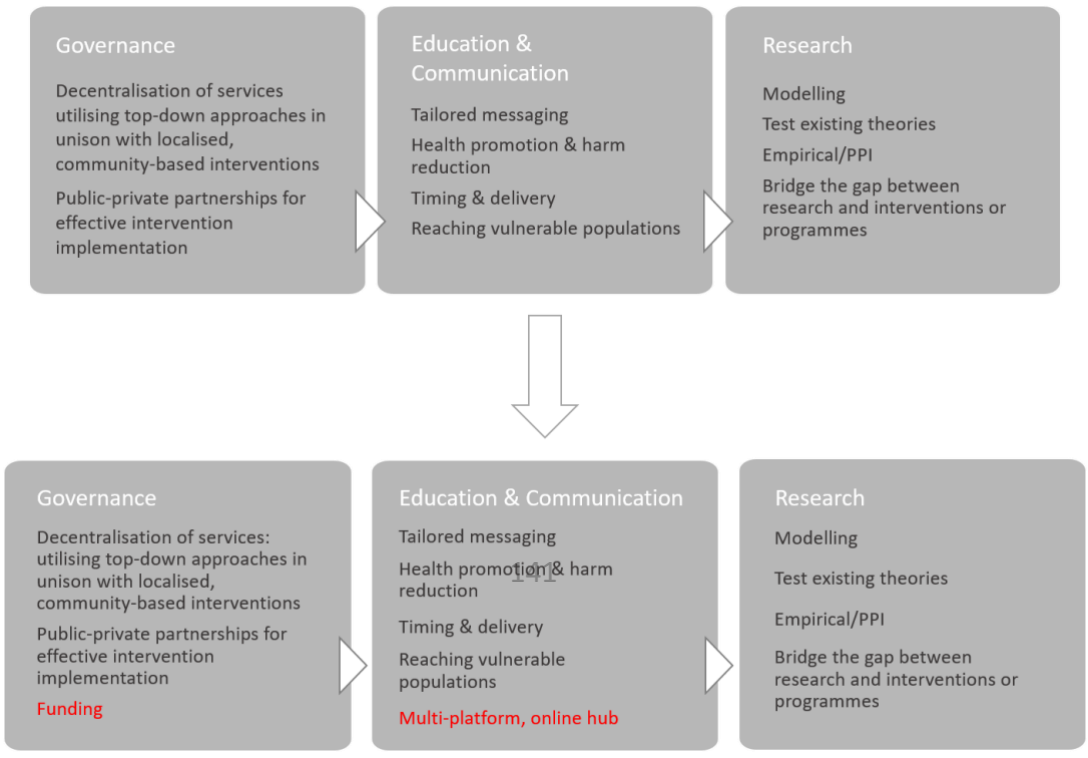
- Legitimise systems and allocate services to tackle child exploitation
- Improve treatment of migrant and sex workers
- Recognise sex work as a profession in law, policies, regulations, and societies
- Increase reach of protectionist policies to support all individuals in the sex industry
- Encourage the empowerment, independence, and agency of women in society
- Continue to develop and update national and international guidelines to address all forms of violence
- Create recognised medicine standards to manage AMR and international provision of supply
- Consider including provisions to technology in future benefit and welfare offerings

Law enforcement

- Hold police forces and law enforcement accountable for preventing, detecting, and prosecuting cases of corruption and violence
- Cooperate with the sex worker community
- Encourage, enable, and empower sex workers to report crimes without fear or threat of arrest or detention
- Collaborate with law enforcement on local, regional, national, and international level, for example INTERPOL

5.1.5 Macro level: Stage 2

Figure 9: Macro level: Stage 2 adaptions



For the second stage of the macro level, 'Governance', now contains a '*funding*' element, which is explored below, and 'Research' has received no adaptions. The 'Education & Communication' domain includes a '*multi-platform, online hub*' element. This reflects how the sex industry is diversifying online, with many sourcing their information from online platforms, whilst community organisations work with international bodies to create national and regional strategic plans through evidence-based research to deliver campaigns that raise awareness and address issues around HIV and sexual health, particularly among MSM and the transgender population. Multilaterals (such as the UN and Global Fund), MNCs, pharmaceutical companies, and donor development agencies, fund community organisations to implement the work. This allows grassroot organisations to allocate specific working groups to enact sustainable change. Part of the negotiations with private or hybrid companies is to meet fixed outcomes. For example, in case study 7, Mechai described how pharmaceutical companies have a '*civil society engagement*' protocol that is required for '*their funding allocation processes*', such as updated HIV messaging; and for multilaterals, the likes of peer-to-peer monitoring, service delivery, and advocacy pieces are the types of initiatives that are highly funded.

Recommendation Box 2: Travel-related interventions

- Disseminate marketing and harm reduction materials in national tourism campaigns, on airlines, with boarding and landing cards, on public transport to and from airports or border crossings, or at airports
- Distribute testing kits in airports that travel to and from high-risk destinations
- Target people before they travel in settings that people attend for information and vaccinations such as travel clinics and general practitioner (GP) surgeries
- Prescribe short-term PrEP and antibiotic courses for those travelling or at high-risk of HIV and STI acquisition
- Offer online, email, or phone access to UK-based clinic, allowing HCPs to conduct risk assessments from other countries

Disogra, Mariño and Minichiello (2005) identified that public organisations such as human rights groups and LGBTQ+ organisations can play an integral role in communicating with, and supporting, the sex worker community. They have the potential to act as a balancing force and linchpin through liaising with local governments, the criminal justice system, and communities to offer support, education, and information programmes to those in need as well as help them to adopt public health strategies that result in safer sex (Mariño, 2000). Community organisations such as these are respected within the sex worker community, and are pivotal to protecting and promoting the health of sex workers and their clients (Disogra, Mariño and Minichiello, 2005). In Disogra, Mariño and Minichiello's sample of male sex workers in a sexual health clinic, the structural barriers experienced in relation to safe sex strategies were the length of waiting time (70.4%), opening times (41.4%) and cost of services (24.1%; Disogra, Mariño and Minichiello, 2005). Other factors included negative attitudes from HCPs and the location of practices. From the same sample, 67.7% agreed that there was a need for sex worker organisations to address their issues as well as to achieve the decriminalisation of sex work, provide alternative work options, and reduce prejudices. Utilising Browne and Minichiello (1997) initial work in Australia using state funded sex worker organisations, Disogra, Mariño and Minichiello (2005) offered the suggestion of advocacy groups that would employ previous sex workers as outreach CWs to provide support and education.

The Global Network of Sex Work Projects (NSWP) is an example of this type of organisation. Uniting more than 160 sex worker led groups across 60 countries (AVERT, 2018), the (NSWP, 2014a; 2014b) reaffirms the rights of female, male, and transgender sex workers across the world. They claim that due to their participation in the global HIV response, they were largely responsible for the term sex worker replacing prostitute, which this thesis has observed throughout. NSWP (2014a,

paragraph. 3) state that this was '*more than mere political correctness, this new language moved global understandings of sex work toward a labour framework which provides solutions to many of the problems faced by sex workers*'. Furthermore, it addresses the stigma and discrimination of sex workers, thus representing greater recognition of sex workers as right bearers. The second example, the Sex Workers Outreach Project (SWOP; 2019), is Australia's largest community-based, peer education sex worker organisation specialising in HIV and STI transmission prevention, health promotion, and education. Since its establishment in 1990, there have been no reported cases of HIV transmission from sex worker to client. Interestingly, SWOP (2019) believes that it was the decriminalisation of the sex industry in New South Wales that enabled the organisation to achieve their goals. By taking an innovative and holistic approach that works alongside sex workers, they have been able to obtain effective improvements for the health and human rights of sex workers and their clients. The final example is the formalised partnership between the police and sex workers, SWING, which was created in Thailand in 2004 (AVERT, 2018), and has been previously mentioned. The group aims to foster legal and regulatory practices with the intention of protecting the rights of those involved and offers wider sexual health and HIV support. Police trainees interact with sex workers in a controlled, neutral environment to obtain a mutual understanding from both parties. Since its creation, there have been fewer reported arrests and a reduction in harassment in Bangkok (AVERT, 2018).

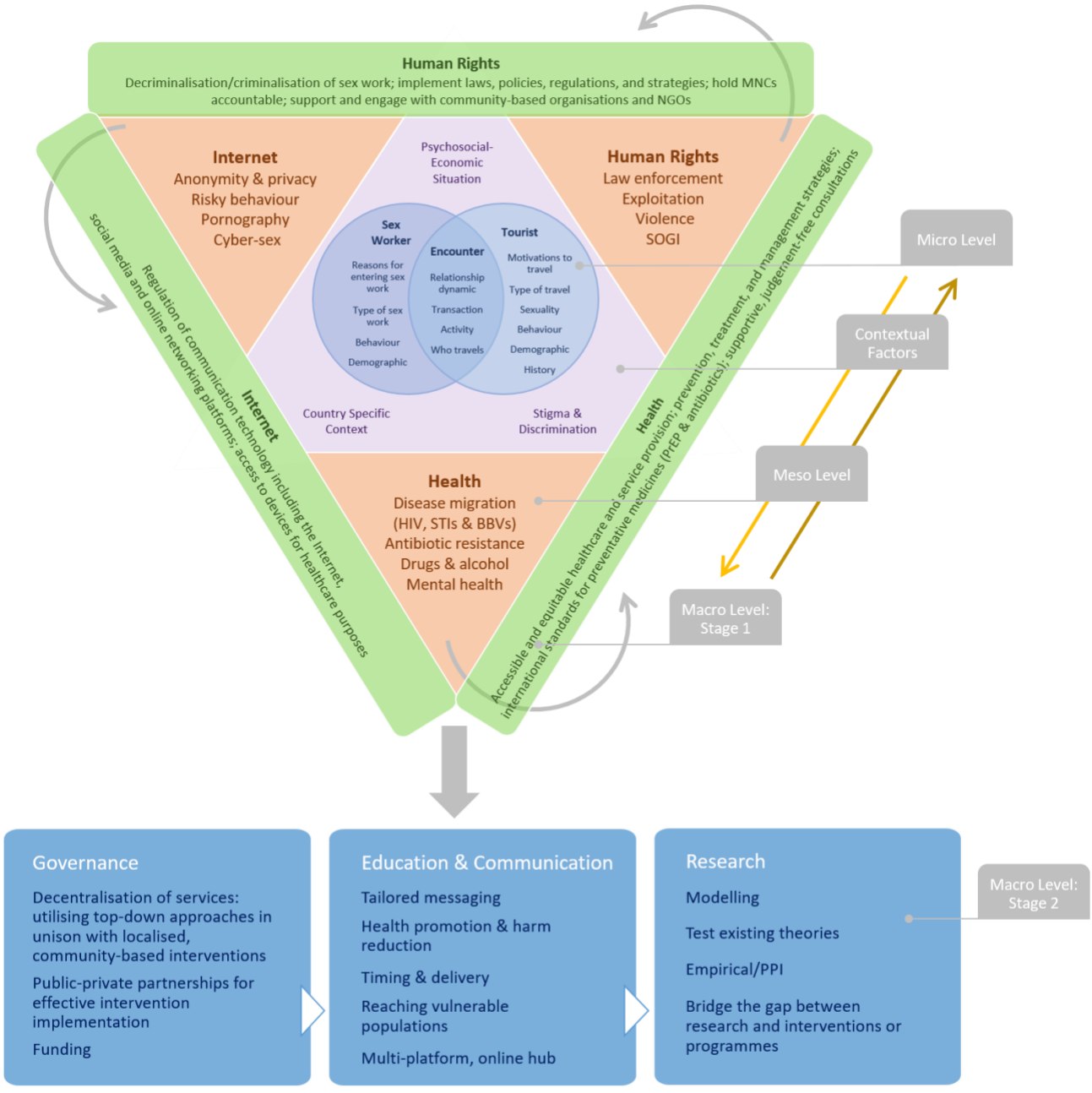
At the same time, the international funding landscape is changing and becoming a challenging environment, as funding is finite, and resources are more constrained, with little to no government funding for social and community-led initiatives. More recently, MNCs have withdrawn their funding due to COVID-19, disrupting supply chains but still requesting their branding to be on display. The UK has a comparable

situation, with multiple charities '*competing for a small pot of funding*' (Adam, case study 4), which Dessie (case study 1) described as '*the brutality of globalisation*'. Therefore, there needs to be continuous '*civil society mobilising voices, particularly around human rights*' to make it sustainable and provide longevity (Mechai, case study 7). Most notably in the aftermath of COVID-19, funders should prioritise local organisations to ensure the rejuvenation of healthcare systems and to bridge the widening socio-economic disparities.

Based on the changes made to the model in the previous sections, Figure 9 depicts the final, refined, and adapted model below.

5.1.6 Final conceptual sex tourism model

Figure 9: Final conceptual sex tourism model



Key: MNCs – multinational corporations; HIV – human immunodeficiency virus; STIs – sexually transmitted infections; BBVs – blood borne viruses; PrEP – pre-exposure prophylaxis; SOGI – sexual orientation and gender identity; PPI – patient and public involvement

5.2 Faux-feminism, female individualisation and citizenship

The case studies reflected existing cultural ideas of normative gendered assumptions, which became problematic to analyse due to differing forms of global feminist agendas. In the West, early waves of feminism took strides in combatting gender inequalities from the 1970s to the 1990s. Yet, McRobbie (2008, p. 46) rightly stated that this progress, '*has contributed to an occlusion of concern with the re-instatement of gender inequality and with the existence of new forms of gender regulation, in favour of a post-feminist gender settlement organised around choice and consent*'. Although the likes of Beck and Beck-Gernscheim (2001) disregard prevailing gender hierarchies and the continuous reproduction of hegemonic masculinity, the case studies in this research emphatically evidenced perpetuating power dynamics between genders and sexualities, which should be recognised as a resurgence of patriarchalism (McRobbie, 2008; Adkins, 2002).

In reference to sex workers' agency, it was previously argued that there is a delicate and nuanced spectrum between 'choice' and 'exploitation' (Scoular, 2004; Sokoloff and Dupont, 2005; Benoit et al., 2018). Yet McRobbie (2008), deliberating the limitations of female emancipation, shrewdly stated that '*choice is surely, within lifestyle culture, a modality of constraint*' and by bringing in an intersectional perspective, draws attention to the '*evasion…of social and sexual divides, and of the continuing prejudice and discrimination experienced by black and Asian women*'. Although this attempts to bridge the stark gaps within global feminist discourse, it does not appreciate the different stages of the feminist journey in relation to the geographical context, which presented itself in the case studies. The interviews described how Thai women in today's society are liberated and are able to act according to their own will, evidenced by the label of '*Plastic Bag Housewives*' used

to describe married and employed Thai women. Here, the subtle or unexplored cultural differences become evident.

Building on this, the Thai sex workers explained that feminism did not exist in Thai society as we know it in the West. To them, the injustices and inequalities are not borne from gender power imbalances, but rather from structural restrictions enforced by the government, political system and existing judicial regulations. Legal restrictions are the prevailing concern for most, as Thai citizens believe that they are socially equal in society. This was a recurring theme throughout the Thai interviews: from the role of women in society, to the decriminalisation of sex work and the legal recognition of transgendered people. In these scenarios, the individual's citizenship is being contested, culturally and historically because of dominant (male) groups legally represented at the expense of marginal (namely those from sexual and gender minority) groups (Hines, 2007). Early feminist literature models citizenship on employment rather than domestic duties in pursuit of equal universal rights (Hines, 2007; Lister, 1997). However, based on McRobbie's arguments, these achievements have led society to change its definition of citizenship in relation to the role of a woman (McRobbie, 2008). Furthermore, if this same narrative is applied to Thailand, specifically transgender sex workers in contemporary Thailand, Thai citizens are still yet to achieve the 'successes' of Western first wave feminism, especially when their employment and financial independence is inextricably dependent on white, Western, male tourists. However, again, this is from a perspective and theoretical positioning of Western feminism, which does not fully appreciate the lived experiences and realities of Thai women and transgender women. If anything, these notions reinforce the prejudices that were initially discussed regarding the attrition of feminism in the West. At the same time, it exacerbates racial prejudices through disarticulated post-feminism

discourse, as '*the only logic of affiliation with women living in other, non-Western cultures, is to see them as victims*' (McRobbie 2008, p. 26). These sentiments are precisely the response that I was met with during initial communications with those at EMPOWER (case study 6). Sex workers and those involved in the Thai sex industry should not be viewed as victims. The fact that they are perceived in this light is, in itself, a regression of modern global feminism:

> '*Young women are encouraged to conceive of themselves are grateful subjects of modern states and cultures which permit such freedoms unlike repressive or fundamentalist regimes*'…*'women who are deemed to be less fortunate both mimics and distorts discussions within feminism and anti-racism around difference*' (McRobbie, 2008, p. 27).

5.3 Implications for sexual health provision and public health interventions

The future implications for UK sexual health provision and public health interventions will now be discussed in order to address one of the main objectives of the thesis, to 'identify the unmet needs of UK tourists in the domains of public health, social policy, clinical practice, and sexual health programmes'. A broad approach will be taken to trace the patient, sex worker or tourist's journey through UK and Thai health systems, by utilising the findings and focusing on access to healthcare; conversations with HCPs; prevention tactics (condom use, testing, PrEP, PEP, and antibiotics); diagnosis and treatment; and harm reduction, education, messaging, and communication. Combining these aspects, Figure 10 presents a sexual health pathway, specific to the UK and Thailand. The diagram highlights the typical pathway taken by the tourist within a healthcare setting before and after a sexual encounter with high-risk

exposure and includes suggested recommendations to improve the overall experience of tourists from prevention and treatment perspectives.

5.3.1 Access

The participants in this study discussed healthcare access among all populations. In Thailand, three access issues arose. Firstly, although Thailand has UHC for sexual and reproductive health (WHO, 2020a; 2021d), participants reported that sexual health services are scarcely available in rural areas. Secondly and as already mentioned, women's health and sexual health remain taboo. Finally, access is a significant barrier for sex worker, migrant, stateless, and LGBTQ+ populations. Participants shared similar experiences in the UK. In both countries, the health systems have begun to establish specialised clinics to cater for specific needs, which in turn reduces discrimination levels.

For sex workers in Thailand, access is predominantly through community-based organisations, such as EMPOWER and Nightlife. They operate at all levels of society, running STI and HIV testing campaigns, targeting key populations, and providing a full range of services from prevention (education, PrEP, PEP, and condoms) to testing, diagnosis, and treatment with ARTs and antibiotics. They also offer translation services to help individuals, patients, staff, and larger services, integrate into the area through healthcare. Some cooperate with the government, advocating for the decriminalisation of sex work in a bid to gain equal respect for women. However, the organisations' resources are finite, and need to act in alignment with frontline staff in government-based services to provide optimum care (Hillis et al., 2020b). In contrast, UK services effectively collaborate with European and international institutions to provide quality leadership through the publication of guidelines and networks such as IUSTI (2021). Arguably, the most impactful outcome of these types

of campaigns is the dialogue that is created between HCPs and patients, leading to referrals to other sexual health services as well as supporting local community groups to generate demand for HIV services. Of note, one CW described effective peer-to-peer mentoring and outreach. A recent PrEP study conducted by Hillis et al. (2021a, p. 8), highlighted the need for community navigators, '*targeting those with lower socio-economic status*', to '*disseminate high, quality, updated messages tailored to communities, and act as multi-level touch points to PrEP-related services provided in various settings*'.

Sexual health structures have undergone significant changes during COVID-19 with services remaining closed, channels of access reduced, and funding cuts. Recent literature identifies a marked decline in PEP requests (Junejo et al., 2020; Sánchez-Rubio et al., 2021); supporting concerns that attendance at clinics depends on the urgency of the patient's clinical symptoms and conditions (Chow et al., 2020). Yet the actual impact of COVID-19 on sexual health services is undocumented as the full extent remains unknown. Technology, in terms of online booking systems, self-testing kits, the posting of medication, and phone triaging, have become an unseen benefit of the pandemic. Specifically for Thailand, health services have extended PrEP prescriptions from three to six months, effectively use telehealth for consultations, and have couriers for PrEP prescriptions to ensure access continuation for key populations (UNAIDS, 2021a). UNAIDS (2021a, p. 76) emphasises that '*these kinds of adaptions are largely sustainable and support the wider use of a differentiated service delivery model for PrEP*'. These provision changes are particularly important as whilst technology has been a lifeline to many during the pandemic, health services cannot rely on them as the only access channel for patients due to socio-economic disparities.

Therefore, the pandemic has removed an individual's choice regarding accessing healthcare, and so governments must consider including provisions to technology in future benefit and welfare offerings, acknowledging that '*the most vulnerable people have been hit the hardest*', and '*deep-seated inequalities*' have been exacerbated (Dessie, case study 1). In response to the current situation, a UK campaign, (Build Back Better, 2021, paragraph. 1) has drawn up a manifesto that reframes the outlook in taking the present situation as an opportunity to '*rest the clock and build back better than before*', to '*protect public services, tackle inequality in our communities, provide secure well-paid jobs and create a shockproof economy*'. In a similar fashion, countries must first look internally at national and political levels, to overcome the weaknesses that COVID-19 has exposed.

Recommendation Box 3: Access to healthcare services

Bridging inequality gap

- Target vulnerable, high-risk, hidden, and hiding populations through multiple health and non-health related channels
- Offer free sexual health and HIV services to the most vulnerable populations
- Tailor healthcare for women and gender diverse populations
- Avoid removing physical access options to patients; maintain multiple routes of access including retaining both walk-in and appointment systems

Human resources and support networks

- Train and decentralise services to CWs (such as navigators, educators, and mentors)
- Ensure equitable distribution of HCPs by geographical area
- Raise awareness of available services in local regions

Consultations and service provision

- Implement online and phone triaging systems to handle symptomatic and asymptomatic cases; signpost patients to relevant services; conduct risk assessments
- Create a supportive environment for marginalised populations by taking practical considerations around language, histories, and physical examinations
- Strive for removal of stigma and discrimination by conducting conversations in a non-judgemental manner
- Provide access to medications through various convenient and accessible frontline services (such as pharmacies, GPs, accident and emergency, and supermarkets)
- Prescribe short-term PrEP and antibiotic courses for those travelling or at high-risk of HIV and STI acquisition
- Provide services that deliver testing kits and medication to patients' place of residence
- Encourage patients who do not perceive themselves at risk, to test and engage in healthcare
- Offer online, email, or phone access to UK-based clinic, allowing HCPs to conduct risk assessments from other countries
- Scale up preparedness for future surges in STI and HIV transmission

5.3.2 Patient conversations

A recurring topic throughout the case studies was the use of gender and sexuality sensitive language during consultations. As mentioned, Thailand HCPs at the Thai Red Cross have mandatory gender sensitivity training, and during consultations, the

patient states how they identify themselves, without being offered specific or binary options (Naw, case study 8). Similar pathways in the UK advocated for the correct use of language and terminology to build rapport and trust with patients. There is a distinct need to create a supportive environment, particularly for marginalised populations within sexual health. This requires practical considerations around language, histories, and physical examinations (Algeria, 2011).

Interestingly, during consultations, UK HCPs tend not to ask about sex in other countries; sexual encounters abroad; who they have had sex with (for example transgendered people); or sexual history over the patients' lifetime (criteria and guidelines currently state the previous three to six months; Una, case study 5). One HCP noted this significance, as they were concerned with the behavioural changes that take place over prolonged periods and are reflective of shifting societal attitudes, particularly regarding same-sex relationships. Unsurprisingly, different generations perceive judgement in varying degrees, with the younger generation comfortable being asked standardised sexuality and gender-related questions (Dessie, case study 1). The same can be said for culturally sensitive communications, and with sex tourism and global healthcare, HCPs must hold awareness of their own positionality as well as the cultural values, beliefs, and attitudes of their patients (Brooks, Manias and Bloomer, 2019).

Concurrently, UK HCPs shared that they must objectively decipher the truth in the claims made by the patient or appreciate that some patients will be concealing information. With the stigma associated with sex tourism and transactional sex, patients may potentially hide the full extent of their activities. Therefore, HCPs must provide care based on the evidence, patient history, experience, and instinct. Combined, these views support how clinicians conduct their consultations and

choose specific language and terminology to interpret the type of sex that patients have engaged in during their travels.

Post-travel, tourists return to sexual health clinics in the UK with extreme anxiety and fear of exposure. Their anxieties derive from their own risk assessments, which do not correspond to the risk assessment of HCPs, regarding the tourists' number of partners; type of sex they have had; if the partner was a tourist, sex worker or high-risk individual; and preventative actions such as the use of condoms or PrEP (Dessie, case study 1; Una, case study 5). HCPs in this present thesis concluded that patients do not hold consistent logic between partners, which is worrying, as in Thailand, there are high HIV rates in commercial sex workers (Nemoto et al., 2012; UNAIDS, 2015; AVERT, 2017; 2021). Further research needs to be conducted on how individuals assess their risk regarding sex, and how tourists can use this information before, during, and after they travel.

5.3.3 Prevention

5.3.3.1 Testing

Thai citizens have the right to two free HIV tests every year; however, Thailand's UHC does not allow for regular free screening. Testing through community organisations is, therefore, funded by NGOs, international companies such as the pharmaceutical industry, or charities. In contrast, UK STI and HIV testing is free at the point of care, and for those on PrEP, patients must test every three months. When abroad, tourists are usually in the testing windows periods (the length of time required for an infection to appear on a test). Best practice for HIV window periods, is a fourth-generation serological test outside of 45 days (Palfreeman et al., 2020; Whitlock and Scarfield, 2020), and for STIs it is two weeks (Solent NHS Trust, 2021). Additionally,

participants noted discrepancies in the types of tests used between countries, with LMICs using third-generation or Point of Care (POC) tests, which have different sensitivities and longer window periods; 60 and 90 days, respectively (Palfreeman et al., 2020). In practice, window periods are not common knowledge. If someone tests within the window period, they may receive a negative result but still be carrying an infection or virus, which they are able to pass on through unprotected sex to other sexual partners. Furthermore, one UK HCP in this piece of research confirmed that if an individual has unknowingly acquired HIV and is within the window period, they would be at a viral load peak, facilitating transmission within the destination country as well as on return to the UK, at an even greater rate (Una, case study 5). As emphasised throughout, tourists are reluctant to access sexual health services before, during or after travelling (Croughs et al., 2016), leading to patients presenting in clinic up to six months after exposure, and potentially unsuspectingly, living with a systemic illness (Rogstad, 2004).

Before the COVID-19 pandemic, UK sexual health clinics were piloting self-testing services as patients requested immediate results, and to complete their own tests in a private and anonymous environment such as their own home (Baraitser et al., 2019). Clinics obtained funding and implemented these facilities in response to COVID-19, and HCP participants in this study reported that online testing and home testing kits were an effective alternative once the government ceased face-to-face consultations. As home testing led to new patients accessing wider services, UK HCPs are wanting the online aspect to remain in place to cover more patients, including those who have continued to have high-risk sex during the pandemic (Pampati et al., 2020). However, as Baraitser et al. (2019) warned, self-testing and self-sampling must be used adjunct to regular clinic-based services, as the importance of choice in accessing sexual health is now paramount due to heightened vulnerabilities, and

social and health disparities. Ideally, both types of testing will be implemented moving forward as community-based testing initiatives, developed by and for the community, easily gain momentum with localities and have the possibility to expand rapidly. Furthermore, these types of ventures normalise discussing sex and sexual health (Hillis et al., 2020a; Hillis et al., 2020b), accentuated through HCPs training CWs to carry out testing in localities and neighbourhoods.

5.3.3.2 Condom use and PrEP

The case studies identified that those who experiment abroad, tend to express anxieties of exposure upon return to the UK, particularly if it is the individual's first time having condomless sex or being with a sex worker, and subsequently become fearful of exposure to STIs and HIV. In some situations, patients do not consider condomless sex to be high-risk in the UK but their opinion differs when a similar sexual encounter has occurred in Thailand. It was apparent across the interviews, that tourists undertake a decision-making process relating to condom use and that the decision is based on instinct as opposed to a substantiated risk assessment. At the same time, some HCPs now prefer the use of PrEP as a HIV prevention strategy, with condoms proactively used more by sex workers than tourists. With COVID-19, sex workers now use condoms as a tool for negotiations around payment, safe sex, and health, will now include PPE and sanitation measures (Wheeler, 2020).

The use of PrEP and PEP is increasing in Thailand due to community-based organisations' funding and campaigns, which make both freely accessible. If UK tourists are planning to travel to Thailand or high HIV risk countries, HCPs have begun to place them on short-term PrEP prescriptions. Dating app profiles, such as on Grindr, allow tourists to search for potential partners and learn about their PrEP status before meeting in person. However, as discussed, when on holiday, tourists

are less likely to adhere to their chosen PrEP regimen or use a condom, and more likely to consume alcohol or drugs; therefore, putting themselves and others at risk of contracting HIV and other STIs. At the same time, participants reported sharing PrEP pills between friends at parties in the UK, so it would be conceivable to assume that this is taking place abroad too. During COVID-19, parts of the UK observed a continued demand for PrEP. However, services were unable to sustain daily functionalities, and some patients took themselves off PrEP. As services begin to return to some form of normality, HCPs are preoccupied with how to restart patients safely and effectively on PrEP, especially now it is available on the NHS. Clinics, if possible, are preparing harm reduction and combination prevention messaging for HIV and STIs. Therefore, future research should ascertain the normative aspects and social dimensions of PrEP and explore how interventions could directly target tourists travelling for sex (Brown et al., 2012), to promote earlier STI and HIV diagnosis (Rice et al., 2012), and allow for continued surveillance of sex as well as STI and HIV transmission overseas (Tanton et al., 2016).

5.3.3.3 PEP and antibiotics

The case studies reported that tourists initiate courses of PEP while abroad in Thailand. HCPs described the process as problematic, as on return to the UK, tourists provide minimal information and rarely have knowledge of the prescribed drug brand or name. Due to varying medicinal standards between countries as well as differing drug availability and resistance patterns in other countries outside of the UK, international HCPs may prescribe only a portion of the required course to tourists, with some countries solely operating on a syndromic basis. Therefore, UK HCPs must either complete the PEP course (if the tourists know the PEP brand consumed) or restart the course entirely upon their return to the UK. Unfortunately,

the effectiveness of PEP is reduced due to the high possibility that days were missed between exposure to HIV and completion of PEP. The interviews with participants documented how this led to some cases of seroconversion. Since COVID-19, HCPs also observed a significant drop in PEP requests and prescriptions, even though many continued to engage in high-risk sex. Policy-makers should, therefore, align and adhere to the WHO (2019b; 2021a) Global Action Plan, endorsed at the World Health Assembly in 2015, which consists of improving awareness of AMR, strengthening surveillance and research in the area, reducing infection incidence rates, optimising the use of antibiotics, and ensuring sustainable investment in tackling it.

5.3.4 Diagnosis and treatment

In Thailand, sexual curiosity, experimentation, changing behaviours such as chemsex, and poor sex education, has led to increases in HIV incidences (APCOM, 2021a). Although the HIV epidemic is in decline in Thailand, new diagnoses are occurring in gender diverse people (40%) and 10% of sex workers (AVERT, 2021; Jose et al., 2021). Studies recommend harm reduction techniques as well as multi-level tailored programmes and the continued roll out of PrEP to control the transmission (Gedela et al., 2020; Jose et al., 2021). For example, Thai-based CWs described how local services test, and upon diagnosis, provide same day ARTs. In instances where Thai sex workers seroconvert, they are quickly placed on ARTs. Similar to UK practices, patients are then referred to health advisors, particularly if they also present with issues such as sexual assault, GBV, or IPV.

According to UK HCPs, during the COVID-19 pandemic, sexual behaviour in general, reportedly did not change, leading to an increase in STI transmission (Hyndman et al., 2021). A London-based sexual health clinic surveyed 814 UK-based HIV-negative high-risk MSM in August 2020, of which 76% continued to be sexually active, 75%

were using PrEP and having sex outside of their household, 28% received an STI diagnosis, and 19% had engaged in chemsex during lockdown (Hyndman et al., 2021). These data are specific to London, and in fact, during the same period, the British HIV Association (BHIVA) and BASHH 2021 conference reported that in the UK, 90% of citizens did not have intimate contact with persons outside of their household or 'bubble' (Sonnenberg et al., 2021). Interestingly, participants reported that MSM organisations were advising people to have sex online. The International Society for the Study of Women's Sexual Health (ISSWSH) postulated that '*the new "really safe" sex in many cases may require 'e-sex'*' (ISSWSH, 2020, paragraph. 5), while scholars referred to the online move as '*disease prevention behaviour*' (Döring, 2020, p. 2768).

Taking these factors into consideration, the similarity of management strategies of both COVID-19 and sexual health (Appendix 1), aligned to the principles of epidemiology of control and infectious disease, should be adhered to as part of a great global strategic response in tackling international sexual health challenges (Hall et al., 2020; Hillis et al., 2020b).

5.3.5 Harm reduction, education, messaging, and communication

In the UK, there currently are no active sexual or public health campaigns, or specific guidelines directed at tourists. However, HCP participants emphasised that education and messaging should inform decisions as opposed to eliminate sex (Ward and Plourde, 2006); especially as current messaging only reaches a small percentage of the travel community (Berdychevsky, 2017). The case studies reported that tourists namely access information through the Internet. Yet, sourcing information online reduces attention and critical analysis of sources, leading to the acceptance of misinformation, ill healthcare decisions, and poor self-diagnosis (Ryan and Wilson, 2008). For sex workers, Thai community-based organisations provide preventative

and harm reduction resources and messages that target key populations and connects them with frontline services. Additionally, guidelines are invaluable resources nationally and internationally. Thailand produces their own versions for the LGBTQ+ community on specific areas such as chemsex, aimed at the transgender population (Mechai, case study 7); while the UK have established networks, professional bodies, and organisations (BASHH, BHIVA, IUSTI, and ECCG), which review and publish guidelines, on topics such as resistant gonorrhoea and herpes (Dessie, case study 1). Other suggestions for effectively accessing relevant information include peer education (Sriranganathan et al., 2010), hotlines (Parisi et al., 2018), and community groups (Hillis et al., 2020b).

5.3.6 Recommendations

The 'Recommendation Boxes' placed in the relevant sections of the Discussion, outline suggestions for public and sexual health interventions that will improve the public health approach in tackling key issues related to the international sex tourism industry. The boxes group the recommendations into four core themes: 'input of government departments and services'; 'travel-related interventions'; 'access to healthcare services'; and 'harm reduction education, messaging, and communication'.

A further four overarching factors place the recommendations into a wider public health context. Firstly, evidence highlights the urgent need to reduce inequalities by creating accessible touchpoints to healthcare. In turn, this will allow for greater access to services for those most vulnerable, and will ensure that appropriate messaging reaches all corners of society. Secondly, the call for legislative reform in the practice of decriminalising sex work is louder than ever. The global abolition of sex work laws will encourage social and cultural changes towards women and

transgender people, reducing stigma and discrimination, and empower those within the industry. It will indirectly improve health outcomes, as sex workers will have access to prevention, treatment, and management healthcare services at the same time as observing a reduction in violence towards the most vulnerable populations. Thirdly, the COVID-19 pandemic exacerbated existing issues and problems, with countries now having to prioritise internal challenges and rebuild national health systems. However, they must remain cognisant of the international risks involved when travel is reinstated, focusing on prevention and harm reduction strategies that will control current and future infectious disease migratory patterns. Finally, following the discussion and the presentation of the final conceptual model, there is a clear need to generate a sexual health pathway for UK tourists. In doing so, policy and decision-makers alongside the scientific community, can monitor the tourists' journey through the healthcare system, abroad and in the UK, undertake surveillance, and enact tailored prevention interventions, when necessary.

Recommendation Box 4: Harm reduction education, messaging, and communication

Education

- Update school curricula with latest sex education information to include preventative strategies (PrEP, condoms, and regular testing); sexual activities (chemsex); and harm reduction messaging that informs decisions as opposed to rejects sex
- Provide online education for the public that is run by workforce who understand the local epidemiology and community

Accessing information

- Provide updated information across multiple platforms in print and online
- Advertise sexual health and HIV services in healthcare settings as well as non-health related settings such as bars and nightclubs, community venues, social media, dating or hook up apps, or banners on websites
- Train individuals to disseminate information through peer education, hotlines, and community groups

Reaching vulnerable populations

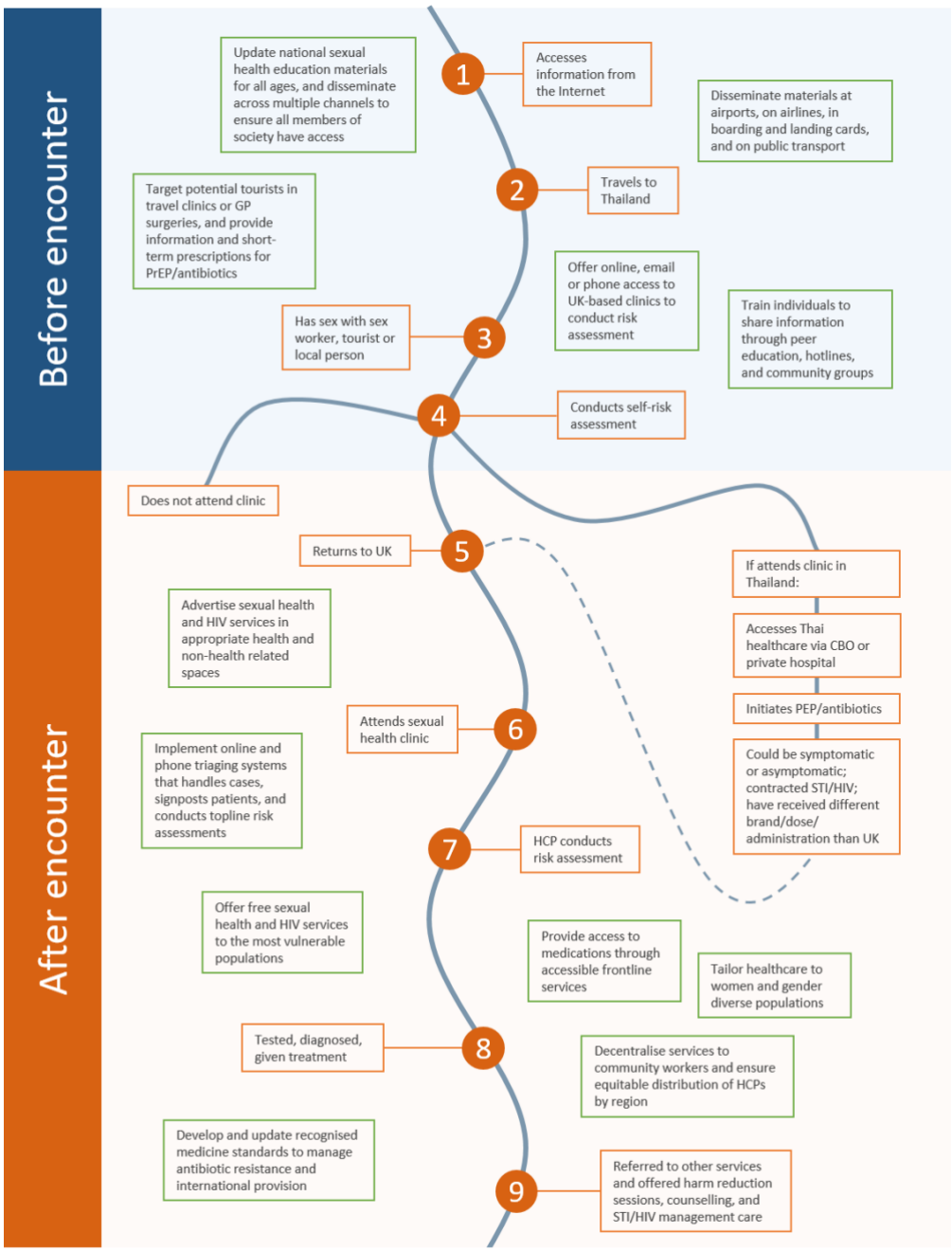
- Tailor messaging to specific age groups and demographics
- Disseminate information through national campaigns
- Reframe the narrative of sex workers as vectors of disease

Messaging

- Convey updated sexual health, HIV, and harm reduction messaging (such as U=U and chemsex)
- Verify that all messaging and communications utilise gender and sexuality sensitive language that is all inclusive
- Produce international guidelines focused on travel, for different therapy areas, diseases, and viruses, and for different activities (such as sex tourism, chemsex, and encounters with sex workers)

5.3.7 Sexual health prevention, intervention, and treatment pathway for tourists

Figure 10: Sexual health prevention, intervention, and treatment pathway for tourists



Key: GP – general practitioner; CBO – community-based organisation; PrEP – pre-exposure prophylaxis; PEP – post-exposure prophylaxis; STI – sexually transmitted infection; HIV – human immunodeficiency virus; HCP – healthcare professional

Figure 10 depicts the 'sexual health prevention, intervention, and treatment pathway for tourists'. To ensure that the pathway is robust, it is based on a hypothetical case, devised from an amalgamation of this study's participants' descriptions of tourists at the greatest risk of HIV and STI transmission. The fictitious tourist is 20 to 30 years old, male, of any sexuality, engaging in sex-seeking behaviour, on a short-term holiday (as opposed to those looking for long-term relationships or a businessman), and willing to have transactional sex. While specific to the UK and Thailand, most countries will be able to use, apply, and adjust the pathway to their needs. As described in the interviews, the pathway highlights the typical steps taken by the tourist before and after a sexual encounter with high-risk exposure (orange boxes), and suggested recommendations to holistically improve the experience (green boxes). The recommendations have been directly drawn from the Recommendation Boxes, which are specific to the pathway. Other recommendations, including meso and macro level responses, should also be considered in policy and decision-making processes related to sexual health service provision, such as bridging the inequality gap (Recommendation Box 3) and legislative reform (Recommendation Box 1).

Steps 1 to 4 of the pathway detail the movements of the tourists before a sexual encounter has taken place. Typically, they access information from the Internet, travel to Thailand, have sex, and then conduct a self-risk assessment based on their activities. Arguably, step 4 could be placed at any point in the 'before encounter' section. The recommendations here relate to developing and disseminating materials in airport settings, improving sexual health education, targeting populations before they travel, and training community advocates. From step 4, tourists could take three routes. Firstly, they do not attend clinic in either the destination or home country, in which case they become a possible vector of disease. Secondly, they seek healthcare or medication in Thailand, initiate PEP or antibiotics

and return to the UK. This is problematic for disease transmission in the UK, as the tourists could be asymptomatic; have contracted an STI or HIV but have tested abroad inside the window period and receive a negative result; or receive different antibiotic brands, dosages, or administration, which increases the chances of spreading AMR. The third route is that tourists return straight to the UK (steps 5 to 9), they attend a sexual health clinic, where the HCP conducts a risk assessment. They are then, if necessary, tested, diagnosed, given treatment, and referred to other services such as harm reduction education sessions, counselling, or STI and HIV management care. Post-encounter recommendations suggest streamlining, scaling up, and tailoring services to ensure they reach and capture the majority of those requiring healthcare, as well as the need to decentralise services to allow for equitable distribution of resources.

Whilst the pathway has mapped out the touchpoints between the tourist and sexual health services, these should be considered as a minimum level of healthcare. Arguably, if there are more accessible touchpoints between healthcare systems and tourists before travelling, such as through innovative messaging and communication or at travel clinics and GPs, then there is the potential to reduce risks further down the pathway, once the encounter has taken place (step 3). In taking these preventative measures, acute and costly interventions will not be required from step 5, as tourists will be travelling with the latest information, prevention techniques and knowledge to create safer surroundings and experiences when abroad.

5.4 Limitations, reflections, and further research

5.4.1 Limitations

Whilst this study has added to extant literature on sex tourism, there are limitations. Some of the limitations have already been addressed in the Reflection Boxes positioned throughout the thesis, including the impact of COVID-19, the study design and methodology, the interviews and case studies, and ethics. The conceptual model's validity was arguably tested to some degree through the empirical qualitative study. The study design required in-depth sifting and analysis of the data, with comparative techniques used throughout. In conducting the interviews, transcribing them, writing case studies, iteratively coding the transcriptions, and recoding prior to thematic analysis and write up, the inductive and deductive findings and overall rigor of the process has led to a final model that can be considered as robust. However, for greater generalisability of the findings, further research needs to be conducted that uses different approaches, particularly quantitative or mixed method designs, that will allow for larger sample sizes and gather more extensive data that goes beyond the resource restrictions observed within a PhD. Due to the complexity of sex tourism, one particular angle would be to test the model using an implementation science based approach, which holistically considers the social context and setting in which the model is being applied to as well as focusing on the multi-layers of risk, gender, and sexuality-based discrimination (Moore et al., 2014). This is of particular importance as the socio-economic disparities are experienced in varying degrees depending on contextual factors that can disturb the intricate cultural, social and health systems within sex tourism (Hawe, Shiell and Riley, 2009; Van Hout et al., 2020). Another suggestion would be to expand the research team. Interestingly, Oppermann (2020, p. 143), one of the original sex tourism framework

authors, recently published a short methodological article, which spoke to '*female interviewers potentially obtaining a very different set of responses from male tourists than male interviewers*'. Ideally, future sex tourism research should involve male researchers conducting interviews alongside female researchers, noting differences and similarities between the researcher and participant experiences.

The model was intended to have an overarching, all-encompassing international function, with policy and decision-makers adapting it where and when necessary. However, those who would utilise the model must adapt it to the needs of the specific country or region under investigation, especially when applied to LMICs due to the fragility of their developing health systems and political structures. This limitation was highlighted in the peer review feedback during the process of publishing the conceptual model editorial (Appendix 3). The larger problem that may be experienced by policy-makers, is the notion that sex tourism is undefinable. While a transactional definition has been provided for the purposes of this research, the actual phenomenon does not have boundaries and is continually expanding and evolving alongside, and as a product of, globalisation. Given this, the model must be continually re-evaluated to ensure that significant changes are incorporated in future versions, and its elements (particularly the meso and macro levels) are integrated in interventions and frontline programmes.

Recruitment and the inclusion criteria accounted for women, transgender, and non-binary populations to volunteer for the qualitative research. As mentioned, participants included women, men, and a transgender woman where discussions focused on sexual encounters between a male tourist and a female or transgender sex workers. Although questioned about different gendered or non-binary partners, the answer was usually limited and the conversations returned to mainly heterosexual relationships. Only George (case study 3), Mechai (case study 7), and

Naw (case study 8) provided more general anecdotes relative to sexually minoritised communities. The contextual level of the model explores female and romance tourism, and the sexualisation of male bodies (Weichselbaumer, 2012; Johnson, 2016; Jeffrey, 2017; Spencer and Bean, 2017), yet these concepts did not emerge in the interviews.

The individuals who were recruited, were wide-ranging in their roles within sex tourism. The response-driven and snowball sampling recruitment techniques resulted in the diversity and broad context of the findings that were beneficial to the model and the wider scope of the research. Those that were recruited, fell into four distinct categories of HCPs, CWs, tourists, and sex workers as depicted in Figure 10. Each category in Figure 10 includes sub-categories, as well as other research groups that should be recruited in future studies.[11] While data saturation was reached, recruitment saturation was not feasible for this particular study. While the sub-categories that were recruited for this thesis have been shaded grey, there is certainly scope for future research to continue to work with these groups on a larger scale. For example, the original protocol intended for community organisations to act as gatekeepers to participants as well as for research engagement with bars, pubs, and social venues but COVID-19 curtailed these plans. The 'new' sub-categories are suggested recruitment target groups for upcoming studies; although it should be noted that these do not constitute an exhaustive list, they should be considered as recommended participants in impending sex tourism research designs.

[11] 'Family members*' in Figure 10 refers to the recruitment of family members of both tourists and sex workers.

Figure 11: Future recruitment groups

5.4.2 Reflections on a "hiding" research population

During the research process, I found discrepancies between *my* perceptions of sex workers and tourists, and *their* perceptions of themselves. So much so, that my supervisors, a colleague who has previously published on this topic, and I, wrote a short editorial on the subject, which is currently in development (Appendix 15). The editorial describes how the thesis has shown that existing research judges sex workers as a vulnerable, marginalised, and stigmatised group, as well as considering them as hidden and hard to reach. Yet feminist agendas and sex positivism denotes that sex workers' empowerment is embodied in their knowledge and understanding of their own contexts, allowing them to assert power and agency into relationships with clients (Grenfell, Platt and Stevenson, 2018). The case studies have evidenced how sex workers are active members of communities and regularly participate in research, informing public health agendas. Yet, Liz, Ping Pong, and Mai (case study 6)

expressed how they have become resentful of researchers using sex workers' stories without acknowledging their role, speaking on their behalf and thus, indirectly, silencing them. In reality, they are carving out their own path as working activists, collaborating with NGOs, charities, and advocacy groups to fight for their rights to stimulate legislative reforms, such as the decriminalisation of sex work and the legitimation of '*sex as work*' (Strega, Shumka and Hallgrímsdóttir, 2020).

On the other hand, feminist discourse emphasises that hegemonic masculinity is a core reason for male tourists to engage with the sex industry. This narrative rests on three assumptions as put forward by Strega, Shumka and Hallgrímsdóttir (2020). Firstly, men perceive themselves to be consumers of, and are entitled to, sex workers' bodies, thus, justifying any associated violence; secondly, the sex industry is the only way that these men receive sex; and thirdly, they believe they are offering a public service to women that they deem helpless. Concurrently, an adverse by-product of hegemonic masculinity is the shame that is associated with engaging with a sex worker for sexual fulfilment. Therefore, it is unsurprising that tourists, who travel for transactional sex, remain anonymous and separate their activities abroad from their home lives (Ellard-Gray et al., 2015).

During the thesis, tourists were a particularly difficult population to recruit, and I found myself continually reflecting and questioning my use of language, and its appropriateness, through the research process. In the early stages, I voiced to my supervisors that prospective participants may not identify with labels such as 'sex tourists', especially as self-identification can '*vary greatly across race, culture, age, political affiliation, education level, and geographical region*' (Ellard-Gray et al., 2015, p. 2). We coined the term, 'people who travel for sex (PWTFS)'. This is the reason why the website and ethics applications state 'PWTFS'. However, people do not believe or may not want to accept, that they fit this criterion. Furthermore, if people

are recognised in research as belonging to a particular group, have a stigmatised identity or are involved in risky and/or criminal behaviour, their reputation, social status, and privacy may be jeopardised; or they may become vulnerable to stigma and discrimination (Ellard-Gray et al., 2015). At the same time, those whom researchers would historically consider as 'sex tourists' are in a temporary state or identity while they are abroad. Similar to one's sexual and gender identity, cultural labels are fiercely important to the majority of people.

As the labels of PWTFS and sex tourist were used in some of the initial social media campaigns, recruitment proved to be a significant challenge. I believe it is for this same reason that many of the traditional and even the more innovative recruitment methods were unsuccessful, did not gain any traction, and were exhausted. From my own ideas, experiences, readings, and recommendations from participants, I searched comment boxes at the bottom of online articles; emailed bloggers, authors, and profiles; sent targeted, direct, and sweeping social media messages; leveraged all recruitment assets that LJMU subscribes to; networked and reached out to existing contacts and friends; and revisited old projects. Without actually travelling to Thailand and approaching a person who I (judgementally) perceive to be a (sex) tourist, recruitment was near impossible.

Furthermore, due to tourists' covert nature, as the project went on, it was clear that they are not a hard to reach or hidden population as they are not stigmatised, marginalised or vulnerable (except as a consequence of experiencing shame); but they are, in fact, hiding. Who would want to take part in highly sensitive research while they are on holiday? Whilst some tourists reportedly travel with friends, those who consciously plan to purchase sex on holiday tend to operate alone. Their solitary movements make them harder to access as a population and conduct peer level research. Yet, to target them, I continuously searched, tracked, and located

individuals and organisations online; incessantly trying to make connections that could possibly lead to potential participants, and subsequently, interviews. By adopting such an online strategy, I entered into a grey ethical space. Colleagues Germain et al. (2017) have already published on this topic, identifying that by encroaching on people's private and safe, albeit virtual environments, online recruitment methods of this nature are distorting the lines between academia and investigative reporting or journalism, where no ethical approval is required.

5.4.3 Future research

Future international health-related research can practically engage with both sex workers and tourists through adjusting study methodologies, recruitment tactics, and participant involvement. The research process must reflect these revised understandings of the positionality and agendas of sex workers and tourists. Public health research with sex workers requires tailored study designs, adapted for the subgroup of sex workers under investigation, to understand them as a diverse and heterogeneous population. Typically, advocacy organisations, social services, healthcare, and police, collect data on sex workers; yet, not directly from sex workers themselves, with data likely obtained from those in crisis, victimised and powerless (Bungay, Oliffe and Atchison, 2016). This is reflective of the broader dimensions and power dynamics whereby theoretical concepts present participants as statistics, restraining their role and relevance in sex tourism research, thereby further limiting access to their lived realities. This approach diminishes the tenets of in-depth exploration, stripping participants of their identity and context, which should be at the core of the qualitative researcher's intentions.

For tourists, future public health research requires '*targeted sampling…to penetrate the local networks of the stigmatized population*' (Shaver, 2005, p. 296). This can be

achieved through establishing access to 'hiding' populations, including through screening and testing, and by locating these services in non-clinical settings, such as in red light districts, as it can reduce sexual and gender stigma, which is commonly reported in healthcare services. Due to resources and then COVID-19, recruitment for this thesis remained online and in the UK. Ideally, greater sample sizes would have been achieved and more effective recruitment strategies carried out through on-site fieldwork, gatekeepers, or privileged access research (Johnson and Richert, 2016; Bishop and Limmer, 2018; Pawelz, 2018). Once researchers have access to a group, they must obtain social acceptance to maintain contact with the chosen network through building rapport, trust, and a reciprocal, non-exploitative relationship with potential participants over a substantial period of time (Bengry, 2018).

By not understanding those I am aiming to target in their entirety, I am doing a disservice and carrying out an injustice to those populations. Moving beyond colonialization, future research designs must not reflect historical biases, perceived power hierarchies, but incorporate a nuanced approach, tailored to the individual and their position and agency in society. This approach will ensure that future public health strategies are informed, appropriate, and targeted, as well as supported by public health policies and practices, and legislative structures that are respectfully inclusive of the majority of populations, with coverage of contrasting experiences and perspectives.

Chapter 6: Conclusion

This thesis has achieved its overarching aim of mapping out sex tourism by developing a new contemporary sex tourism model. It undertook an in-depth qualitative investigation to explore the operation of the Thai sex industry and the impact that sex tourism has on UK sexual health service provision. In doing so, the research has attained a greater outcome in realising the progressive ways in which the world is moving in, at the same time as starkly shining a light on persisting human rights issues that envelope it. Due to the extensive analysis of existing literature, models and interpretations of sex tourism in contemporary society, the findings are novel in the field and should be further tested, expanded upon, and utilised in future sexual health and HIV programmes, policies, and interventions.

One of the most notable findings from this research is the demonstration of how women in the Thai context are empowered individuals with agency and autonomy. The interviews and case studies are woven through with sex positivity, which feeds into the recommendations for the entire project. However, women's roles in communities are dependent on the backdrop of their country's religion, culture, and socio-economic and political landscape. Across the world, women are constantly compared and juxtaposed against their male counterparts. In the sex industry, this is emphasised within the sexual encounter, from Western perspectives, and between the global divisions experienced in tourism settings.

Globalisation ties together the other core findings of thesis. With the reported increasing use of apps for sex-seeking as well as advertising, social media, and online platforms playing a significant role in the sex industry from providing agency to sex workers, as well as fuelling the sexual exploitation of women and children. Women, children, and gender diverse populations appear extremely vulnerable to sexual

health risks, in terms of transmission of diseases as well as violence from the police. The decriminalisation of sex work is being called upon from every angle; yet, to ensure sustainable and effective change, all stakeholders need to be supportive of the reforms, including the police, law enforcement, businesses, and governments. Education and funding are key to impactful change. Through corporate social responsibility of MNCs, such as the pharmaceutical industry and NGOs, decision-makers must evaluate the contextual level of the people they are trying to target. By establishing where people and communities receive information, more of the population will be able access harm reduction messaging and subsequently appropriate healthcare services. Finally, COVID-19 has highlighted and exacerbated the widening social, economic, and health disparities between communities and countries. From a disease migration perspective, international collaboration is now required to prepare for surges in STIs and BBVs, through leveraging existing and proven prevention, monitoring, and treatment strategies.

This thesis demonstrates how sex tourism epitomises fundamental human rights issues, and how they affect individual, community, and global health. Grassroot activism must create foundations that will enact behavioural and cultural change within societies. Furthermore, these foundations need to be firmly in place so that when institutional and systemic shifts occur, such as the removal or adaption of harmful and discriminatory political structures, those most vulnerable will be relieved from the arduous stigma and marginalisation that they currently experience. The thesis and model should be interpreted as a call to action to scale-up preparedness, learn from our mistakes, and equip ourselves for future public health challenges so that we continue to work towards permanent eradication of health inequalities across the world.

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Appendices

Appendix 1: Sex tourism, disease migration and COVID-19: lessons learnt and best practices moving forward

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7499778/

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Perspective

Perspective

Sex tourism, disease migration and COVID-19: lessons learnt and best practices moving forward

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Tolson[1] broadly defines sex tourism as 'travel for the purpose of engaging in sexual relations' due to the nuanced ideas between sex tourism, and sex and tourism. Approximately 20–34% of international travellers engage in casual sex (https://wwwnc.cdc.gov/travel/yellowbook/2020/travel-for-work-other-reasons/sex-and-travel). Yet, based on the given definition, the number of sex tourists in the world are unknown, as many remain anonymous. Sex tourists are a source of many international sexual health issues, due to high-risk behaviours such as condomless sex with multiple partners or sexualized drug use whilst abroad. Those who engage in high-risk sex when travelling are prone to sexually transmitted infections (STIs) and blood borne viruses (BBVs) such as viral hepatitis and human immunodeficiency virus (HIV).[2,3] Condom use is dependent on the choices made by sex tourists and sex providers, with usage ranging from low to up to 75% (https://assets.researchsquare.com/files/rs-26585/v1/a105f3aa-99d5-46e9-8884-ad195ea411b9.pdf). This has led to HIV transmission in male sex workers being as high as 50%; and 40% of gonorrhoea diagnoses in Asia having become antibiotic resistant and circulating around parts of Northern America.[2,4] Tourists are generally reluctant to access sexual health services before, during or after travelling.[5] Furthermore, sex tourists have reported using pre-exposure prophylaxis (PrEP), a biomedical HIV prevention tool, on an event-based regimen, as it reduces the perceived threat of HIV acquisition.[6] There is mixed evidence in relation to risk compensation, whereby PrEP use may potentially increase risky sexual behaviours and therefore STI transmission. Yet, as primary HIV infection has been shown to be the leading STI contracted by travellers who are not living with HIV, PrEP would play a substantial preventative role for high-risk tourists.[3] It is these risky sexual behaviours that pose significant threats to the international, domestic and community transmission and migration of diseases.

With over 22.9 million confirmed COVID-19 cases and 797,918 deaths worldwide at the time of writing, we have witnessed the devastating human and economic consequences of this globalized virus (https://www.worldometers.info/coronavirus/?utm_campaign=instagramcoach1?). It has led to the closure of national borders and cancellation of the majority of commercial flights, halting global trade across all industries, including sex tourism. With the international travel of people severely restricted, global populations are changing social and health behaviours in order to adapt to the current situation.

With domestic lockdowns and social distancing measures in place for the foreseeable future, the physical sex tourism industry is currently non-existent. As sex work is criminalized in most countries, sex workers are struggling to survive as they are unable to access government relief responses to the pandemic (https://www.euronews.com/2020/04/16/it-s-a-contact-job-sex-workers-struggle-amid-the-coronavirus-crisis). A number of sex tourists and sex workers have therefore moved online to the 'surface' and 'dark' web. The online sex tourism industry was occurring before COVID-19. Websites and technology-based applications increasingly facilitated the seeking of offline and cyber-sexual activities. Furthermore, those who sought sex online reported to have riskier interactions when the relationship moved offline.[7]

At this stage of the pandemic, we cannot say exactly what the repercussions will be regarding health risk behaviours on return to normality or even quasi-normality. After restrictions ease and with the waning of the pandemic, it would be reasonable to

expect a surge of offline sex-seeking behaviours and high-risk sexual activity, potentially reigniting the cycle of international to domestic and community transmission of BBVs and STIs. Behaviours such as sexual gratification through technology may become permanent in the industry, intensifying sexual exploitation, online grooming and human trafficking. For example, one sex worker has described how moving online to work during COVID-19 has led to being 'constantly abused' with 'dozens of violent messages every week. The abuse by this kind of person has increased tenfold' (https://www.euronews.com/2020/04/16/it-s-a-contact-job-sex-workers-struggle-amid-the-coronavirus-crisis).

COVID-19 is having a significant detrimental impact on international sexual health progress. For example, Zimbabwe is now unable to provide consistent antiretroviral treatment to the 14% of their population living with HIV (https://www.aljazeera.com/news/2020/03/survive-health-woes-deepen-zimbabwe-covid-19-fear-200 323 065 933 020.html). However, there are key lessons that can be learnt from the international strategic responses to COVID-19, which can be applied to the sexual health scene and, by proxy, the sex tourism industry. These include effective communication, decentralization of services and 'test, treat and isolate' programmes. Senegal used learnings from HIV, Ebola and malaria to develop simple communications around isolation and case-finding tactics to prepare for COVID-19. These were disseminated by service managers to community-based actors and patients using social media and telephone hotlines (https://www.unaids.org/en/resources/presscentre/featurestories/2020/june/20200603_senegal). It is this effective decentralization of services that utilizes top-down approaches in unison with localized, community-based interventions, which should inform the reopening of the sex tourism industry post-COVID-19. Of note, staff who understand the epidemiology of the infectious and sexual diseases within their locality should be consulted on the delivery of surveillance, testing and monitoring schemes for localized HIV and STI management. Furthermore, the World Health Organization, based on their own experiences of prior epidemics, recommended a similar approach with the 'test, treat and isolate' COVID-19 strategy as well as encouraging local lockdowns to counter second spikes. Through strong elimination tactics, the likes of New Zealand, Iceland, Rwanda and Taiwan have successfully contained the virus, in contrast to countries such as the United Kingdom, the United States and Sweden.

When borders do begin to open, global migratory patterns supporting the sex tourism industry will resume, and with it, an inevitable flux of disease. Flexible 'test, treat and isolate' strategies must be urgently scaled-up internationally, nationally and regionally, alongside the decentralization of services and mobilization of communities, to target not only the resurgence of COVID-19 and other coronaviruses, but to also address sexual migration flows. There is a clear need for increasing awareness of the impact of COVID-19 on the sex tourism industry, and how new learnt behaviours will perpetuate risky activities, with additional emphasis to be placed on safe sex due to increased vulnerability for all involved. State communication and education is key. Public health messaging must include the most vulnerable and be accessible to all, disseminating communication materials that pay particular attention to the most exposed populations, in a bid to reduce social and health disparities. Research needs to be conducted to understand the real-life experiences of COVID-19 on those within the sex tourism industry, so we can look at adapting public health strategies to accommodate the significant changes taking place. This is therefore a call to action to scale-up preparedness, learn from our mistakes and equip ourselves for the future diversification of infectious and contagious diseases, be they coronaviruses, BBVs or strains of antibiotic-resistant gonorrhoea.

Author Contributions

All authors worked collaboratively to draft, edit and review the manuscript.

Conflict of Interest

None declared.

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Appendix 2: Comment on sex tourism in the era of COVID-19

https://academic.oup.com/jtm/article/28/4/taaa234/6054202

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Comment on sex tourism in the era of COVID-19

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This comment provides a critique on the authors' argument about the post-pandemic development of sex tourism. It acknowledges the need for more research on real-life experiences of sex tourism workers but argues that we need to differentiate between sex as a tourism product and as a motivation for travel.

This comment refers to the article 'Sex tourism, disease migration and COVID-19: lessons learnt and best practices moving forward' by Hillis *et al.* (2020).[1]

I would like to thank the authors for their contribution. A discussion on sex tourism, impacts of COVID-19 and the post-pandemic realities of sex as a tourism product is welcomed and needed, given the non-existence of sex tourism at the moment[2] and unclear post-pandemic perspectives for its development. Although I agree with the authors that further research is needed to study the real-life experiences of COVID-19 on those within the sex tourism industry, we first need to focus more on the nature, context and realities of sex tourism in order to understand and anticipate the inevitable changes in the post-pandemic era.

First, we need to acknowledge there is a difference between sex tourism as a niche form of tourism and sex as a potential part of tourist consumption and their behaviour.[3] Considering social distancing measures, border closures and imposed self-isolation, travelling for a very specific purpose to engage in a sexual act is highly unlikely. The 'test, treat and isolate' strategic approach already implemented in a number of countries is a general measure to prevent the spread of coronavirus among the community and help local authorities to deal with the pandemic. The access to an approved vaccine can potentially encourage the revival of international travel and tourism but not specifically to prioritize a distinctive niche of tourist activity such as sex tourism. Further research is needed to explore the strategies for sex tourism recovery in those countries where sex tourism (as a specific market segment) plays a significant role in their tourism economies, but sex workers have no access to any government income support (e.g. Thailand).[4]

Second, I fully support and endorse the perspective that further empirical research is needed to explore the adaptation of public health strategies in the post-pandemic era. It is inevitable that sex will again comprise a major part of tourist activity, but the current situation implies that significant changes need to take place to manage and control its promotion and resurgence, particularly in the countries in the developing world.

Author Contributions

The author is the sole contributor and drafted, edited and reviewed the entire manuscript.

Conflict of Interest

None declared.

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Appendix 3: Sex tourism in an era of globalisation, harm reduction and disease migration: a new conceptual model

https://www.emerald.com/insight/content/doi/10.1108/TR-04-2021-0184/full/html

Sex tourism in an era of globalisation, harm reduction and disease migration: a new conceptual model

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Abstract

Purpose – *This paper aims to contribute to sex tourism literature by placing it into a contemporary context of globalisation, harm reduction and disease migration.*

Design/methodology/approach – *The paper takes a public health and social science approach to map sex tourism, drawing on sex worker and tourist situations alongside global forces including technology, human rights, law enforcement and health.*

Findings – *A new, holistic conceptual model is presented, containing interacting, multi level associations. Whilst the separate micro, contextual, meso and macro levels are versatile, decision makers and practitioners will be equipped to understand sex tourism in its entirety.*

Originality/value – *The paper's originality is found in the proposed conceptual model.*

Keywords *Sex tourism, Sexual health, Disease migration, Model, Globalization, Harm reduction*

Paper type *Conceptual paper*

全球化、减害和疾病迁移时代的性旅游：一种新的概念模型

设计/方法/途径：该论文采用公共卫生和社会科学方法，利用性工作者和旅游者的情况以及包括技术、人权、执法和健康在内的全球力量，分析了性旅游的状况。

目的：本文将性旅游文献置于全球化、减少危害和疾病迁移的当代背景下，为性旅游文献做出了贡献。

结果：本文提出了一个新的、整体的概念模型，包含相互作用的多层次关联。虽然单独的微观、背景、中观和宏观层面是多变的，但决策者和从业者将可以全面的了解性旅游。

原创性/价值：该论文的独创性体现在提出的概念模型中。

关键词 性旅游，性健康，疾病迁移 全球化，模型，减少危害

文章类型：研究型论文

El turismo sexual en la era de la globalización, la reducción de daños y la migración de enfermedades: un nuevo modelo conceptual

Objetivo : *Este artículo contribuye a la literatura sobre el turismo sexual situándolo en el contexto contemporáneo de la globalización, la reducción de daños y la migración de enfermedades.*

Diseño/metodología/enfoque : *El documento adopta un enfoque de salud pública y ciencias sociales para delimitar el turismo sexual, basándose en las situaciones de los trabajadores del sexo y los turistas junto con las fuerzas globales, como la tecnología, los derechos humanos, la aplicación de la ley y la salud.*

Conclusiones : *Se presenta un nuevo modelo conceptual holístico que contiene asociaciones interactivas de varios niveles. Mientras que los niveles micro, contextual, meso y macro separados son versátiles, los responsables de la toma de decisiones y los profesionales estarán equipados para entender el turismo sexual en su totalidad.*

Originalidad/valor : *La originalidad del artículo se encuentra en el modelo conceptual propuesto.*

Palabras clave : *Palabras clave Turismo sexual, Salud sexual, Migración de enfermedades, Globalización, Modelo, Reducción de daños*

Tipo de artículo : *Investigación*

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Introduction

Sex tourism research since the 1980s has investigated tourists' motivations for travelling, in a bid to define the phenomenon (Graburn, 1983; Hall, 1992; O'Connell Davidson, 1996; Ryan and Kinder, 1996; Oppermann, 1999). Oppermann (1999) departed from traditional definitions of sex tourism as travelling for commercial sex, exploring the relationship between the tourist and sex worker. Ryan and Kinder (1996, p. 507) described the overlapping *liminality* of sex work and tourism – separate behaviours that *operat[e] at social thresholds*, whilst Bauer and McKercher (2003) and others discussed how sex and tourism are symbiotic (Bender and Furman, 2004; Eaglen and Maccarrone-Eaglen, 2005; Garrick, 2005). Reflective of globalisation expanding at the start of the Millennium, sex tourism interpretations widened to incorporate pragmatic global relationships, with literature turning to the growing production and consumption of sexual services (McMichael and Beaglehole, 2000; Wonders and Michalowski, 2001; Guise, 2015). Once sex tourism was recognised as an intricate and complex phenomenon, research began to tackle it from specific angles, focussing on travel for intentional and planned sexual experiences and emphasising the exploitative nature and economic inequalities (Bauer, 2014; Tolson, 2016; Brooks and Heaslip, 2018; Xu, 2018; Kock, 2020).

By concentrating on commercial sex tourism and taking a public health and social science approach, the commentary will map global issues such as exploitation, stigma and inequalities (Bauer, 2014; Xu, 2018). Whilst some literature discusses consensual, affirming and non-transactional encounters (Xu, 2018), we define sex tourism similar to that of the Centers for Disease Control and Prevention (2019), as a phenomenon involving tourists, planned or spontaneously purchasing sexual services or experiences.

Framework analysis

To date, five publications have depicted sex tourism (Oppermann, 1999; Ryan, 2001; Ryan and Hall, 2001; Bauer and McKercher, 2003; Eaglen and Maccarrone-Eaglen, 2005). Oppermann (1999) initiated the conversation, using six parameters to illustrate the tourist and sex worker relationship: the purpose for having sex, monetary exchange, length of time, the relationship dynamic, sexual encounter and identification of who travels.

Building on these foundations, Ryan (2001), Ryan and Hall (2001) and Bauer and McKercher (2003) constructed their own dimensions. All frameworks discussed the voluntary or exploitative nature of the relationship. Ryan (2001) and Ryan and Hall (2001) described the commercial or non-commercial transaction, whilst illustrating the impact on the self-image and integrity of involved parties. Bauer and McKercher (2003) used the work of Oppermann (1999) in demonstrating the motivation for travel, prioritising tourism as a facilitator of sexual activity, as it provides a setting for sexual encounters to take place.

Ryan and Hall (2001) progressed the narrative by analysing the dimensions through micro and macro perspectives, asserting that they are interdependent and interactive (Ryan and Hall, 2001). Eaglen and Maccarrone-Eaglen (2005) used a similar approach, placing sex tourism into a wider operational system, prescribing spatial, temporal and cognitive functionalities, through a dynamic "butterfly" configuration. They are also differentiated by *lo* (the self, personality and perceptions), micro and macro levels; yet the overall description of sex tourism was limited to listing attributes.

Undoubtedly, there is a well-developed body of sex tourism literature. However, there are no updated frameworks that conceptualise the multifaceted phenomenon within a contemporary worldview. Whilst existing papers broach elements including choice of destination, gender, sexuality, human rights and exploitation, these are not incorporated

into frameworks, which are predominantly constrained to the relationship between the tourist and sex worker.

New conceptual sex tourism model

The conceptual sex tourism model is presented in Figure 1. Its structure is underpinned by the analysis above and recommendations from Richter and Dragano (2018) and the World Health Organisation (WHO, 2002), who reiterate the importance of micro, meso and macro levels for social science and health-related concept models. Each level of the model builds upon the last. The micro level is the centre of the model, directly influenced by contextual factors (a separate level). The meso level draws on smaller-scale social arrangements and the macro level is comprising structural, institutional forces, the wider community and governance systems (Richter and Dragano, 2018).

Micro

As can be seen in the model, the sexual encounter between the tourist and sex worker constitutes the circles' intersection of the Venn diagram. For brevity, this commentary will concentrate on the relationship dynamics.

Agency and power in the relationship

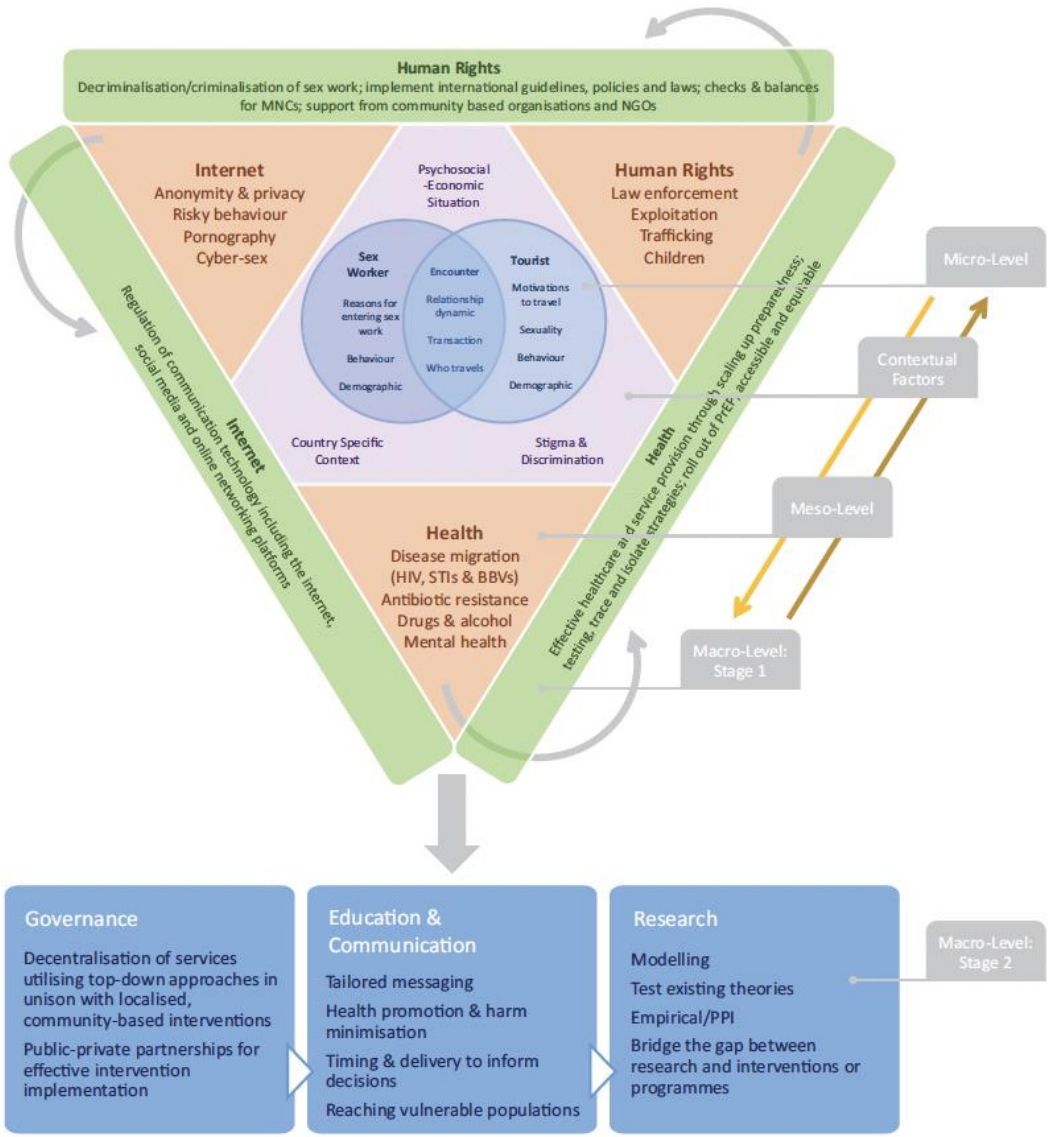
A dearth of literature draws on radical feminist discourse regarding sex workers, their agency and the subsequent power dynamics with clients (Gerassi, 2015). Abolitionist or prohibitionist theories view sex work as exploitative, derived from the understanding that society sits on patriarchal foundations (Comte, 2014), leading to violence, drug use, poor health and deprivation (de Graaf *et al.*, 1994; Kinnell, 2008; Sanders *et al.*, 2009; Shokoohi *et al.*, 2019; Zehnder *et al.*, 2019).

The second wave of radical feminism questioned the abolitionist perspective, which refused to acknowledge women's agency and decision-making power (Bell, 1994). Sex positivist feminists believe that sex workers recognise the constraints they face, proactively make conscious decisions and choose how they use their bodies (Lankenaua *et al.*, 2005; Weitzer, 2005; Sanders *et al.*, 2009). The theoretical underpinnings of sex work have, therefore, become dichotomised into "exploitation" and "choice" (Nguyen, 2017). In some societies, sex workers remain, culturally or socially unaccepted, particularly in lower socio-economic contexts. Consequently, risks such as gender-based violence (GBV), rape and murder persist (Kinnell, 2008), stigma prevails (Sanders *et al.*, 2009) and sex workers' circumstantial choices are restricted (Chapkis, 1997). Furthermore, male and transgender sex workers experience similar risks to female sex workers such as psychosocial, physical abuse and substance use (Nguyen, 2017). Men are *no longer the exclusive consumers of sex* (Minichiello *et al.*, 2015) and transgender sex workers *occupy the lowest stratum of the status hierarchy* [. . .] *fac[ing] greater difficulties than female or male prostitutes* (Weitzer, 2005). Regardless of gender, sex workers obtain agency through knowledge and understanding of their situation, allowing them to assert power into relationships (Grenfell *et al.*, 2018). Taking a more nuanced approach and considering contextual factors (gender, race, class or sexuality), sex work should be interpreted on a spectrum of choice (Scoular, 2004; Sokoloff and Dupont, 2005; Benoit *et al.*, 2018).

Contextual level

Richter and Dragano (2018) and Sauzet and Leyland (2017) identify how the context in which individuals live, directly contributes to health inequalities that lie outside their control. They are reflective of their originating country's historical political, health, socio-economic situation, which contributes to contemporary inequalities and power dynamics

Figure 1 A new conceptual sex tourism model



Notes: MNCs – multinational corporations; HIV – human immunodeficiency virus; STIs – sexually transmitted infections; BBVs – blood borne viruses; PrEP – pre-exposure prophylaxis; PPI – patient and public involvement

(Dorfman, 2011). Gender and tourism literature has begun to contextualise findings based on their geographical location, due to differing social boundaries between originating and destination countries (Bishop and Limmer, 2018; Brooks and Heaslip, 2018). There is a propensity to *conceptualise[s] women from the West as guests and women from the rest as*

hosts, reinforcing female marginalisation and postcolonial sentiments (Jeffrey, 2017, p. 1042). When considering gender tourism, literature typically sets the female tourist, who travels to destinations of lower socio-economic status, against the stereotypical male tourist laden with hegemonic masculinity, white supremacy and fear of sexual inferiority (Weichselbaumer, 2012; Spencer and Bean, 2017). Copious research implies that Euro-American males dominate *sex tourism* (Spencer and Bean, 2017), whilst female tourists embody *romance tourism*, providing financial support as opposed to direct monetary exchange (Weichselbaumer, 2012), with Pruitt and LaFont (1995) being the first to publish in respect to racial myths of Western women and male black bodies. This set the stage for studies investigating female sex tourism and *beach boys* in the Caribbean (Kempadoo, 2001; Phillips, 2008; Spencer and Bean, 2017), The Gambia (Nyanzi *et al.*, 2005), Costa Rica and Dominican Republic's *sanky pankies* (Bauer, 2014, p. 24). From the East, Bandyopadhyay (2013, p. 2) adds, *it is important and possibly more interesting to explore Asian tourists' sexual adventures in the West*. Other studies have also investigated female Asian solo travellers, who were found to be at greater risk of GBV and sexualised attention from their white, male counterparts, due to their ethnicity and the *erotic representation of Asian women in destinations where sex tourism prevails* (Yang *et al.*, 2019, p. 1050).

Although men also travel, to and from, different parts of the world to have sex, researchers should stress the intertwining intersectional factors such as race, gendered power relations and class, to challenge assumptions of sex tourism in the Global South, as the concept of *otherness* is *borne from a history of racism multi-faceted exploitation* (Spencer and Bean, 2017, p. 15).

Sexuality-based stigma

For this commentary, the authors focus on sexuality-based stigma (homophobia and transphobia) as it crosses multiple levels of the model and has a significant impact on health outcomes and public health responses.

Globalisation, technology and tourism have enabled the liberation of gender identities and sexual experimentation (Herdt, 2018), with heterosexually identifying people engaging in same-sex relationships when abroad (Minichiello *et al.*, 2015). However, homophobia and transphobia persist, exacerbated by stigma associated with sex work, sexually transmitted infections (STIs) and human immunodeficiency virus (HIV).

Travel for sexual experimentation can incite social stigmatisation (Monterrubio, 2018). Lesbian, gay, bisexual, transgender and queer (LGBTQ+) tourism advocates sexual diversity and markets based on sexuality *exemplif[y] contemporary queer theorisations of how the neo-liberal state sustains particular acceptable, non-threatening ideas of gayness – the homonormative* (Waitt *et al.*, 2008). The West continues to fashion heteronormative acceptances, masking the lived realities of those within the industry, heightening discrimination and persecution experienced by non-binary and transgender individuals in non-Western nations (Waitt *et al.*, 2008). In a study conducted in Bangkok, Thailand, more than half of the transgender participants reported experiencing transphobia, with 70% expressing they did not feel accepted in Thai society (Nemoto *et al.*, 2012). From a health perspective, there is ample research on the stigmatisation of LGBTQ+ people living with HIV [(PLWHIV) living with HIV (LWHIV)], with sex workers experiencing secondary, *layered or intersectional* stigma, which is internalised, self-deprecating stigma combined with enacted stigma from others that question social constructs, such as male sex workers LWHIV (Fitzgerald-Husek *et al.*, 2017).

Homophobia and transphobia are disseminated through the criminalisation of same-sex relationships (Fitzgerald-Husek *et al.*, 2017). Advocacy work continues to progress LGBTQ+ equality and legal protection. In international human rights law, the Yogyakarta Principles (2006, 2017), 2b, 6b and 33, declare each individual has the right to be free from

criminalisation regarding their sexual orientation, gender identity or expression and sexual characteristics. However, the International Lesbian, Gay, Bisexual, Trans and Intersex Association (ILGA) World Organisation, published a report stating *the polarizing trends that are taking place at a global scale mean that whilst more* [. . .] *of us have seen our rights legally recognized, more LGBTI people are also in greater danger of being discriminated, attacked, persecuted and even murdered* (ILGA, 2019). It remains illegal to have consensual same-sex sexual acts in 68 (35%) United Nations (UN) member states (ILGA, 2019).

Meso level

The meso level of the model identifies the structural elements that support contemporary sex tourism. Since the publication of previous frameworks, three main developments have been identified as influential to sex tourism: the internet, health and human rights (trafficking and exploitation).

Internet

The internet is a tool for anonymity, expression and sex-seeking, permitting sex workers and their businesses to advertise hyper-sexualised services (Ward and Aral, 2006; Minichiello *et al.*, 2013; Wang *et al.*, 2019). Mimiaga *et al.* (2008) ascertained that sex workers who find clients on the internet have inconsistent condom use, high rates of unprotected sex, low rates of HIV status disclosure and may not have screened for STIs. The internet accentuates the intention for risky behaviour, subsequently increasing the likelihood of HIV/STI transmission, if it is translated into physical actions (Liau *et al.*, 2006; Mimiaga *et al.*, 2008; Reisner *et al.*, 2008; Minichiello *et al.*, 2013, 2015; Wang *et al.*, 2018).

The migration of communicable and infectious diseases are symptomatic of globalisation and tourism, which are exacerbated through the internet. Notably, the current severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2 or COVID-19), has escalated risky sexual behaviours by intensifying sexual exploitation, online grooming and human trafficking (Lewnard and Berrang-Ford, 2014; Hillis *et al.*, 2020). In a statement by the Sex Workers' Rights Advocacy Network, sex workers are moving online. In European countries such as Ukraine, they are facing criminal prosecution as their work-related activities are deemed pornographic; in Russia, they are dealing with blackmail and amplified scapegoating online (SWAN, 2020). Yet, the COVID-19 pandemic is proving to be *countercyclical* as sex-related companies, sites and platforms have documented record traffic and sales (Barrica, 2020). Sex workers in the porn industry have gained autonomy and agency as they have been able to make personal connections with their clients, *something for which ethical and feminist directors have been striving for decades* (Barrica, 2020).

Health

It is observed that 62% of new HIV diagnoses in adults are from key populations (UNAIDS, 2020), including men who have sex with men, who *may increasingly transmit HIV and other STIs to non-sex work partners* (Mimiaga *et al.*, 2008, p. 55). Worldwide 1.7 million PLWHIV (UNAIDS, 2020) and sex worker transmission remain as high as 50% (Memish and Osoba, 2006). Condom use by tourists and sex workers can range from low to up to 75% (Bozicevic *et al.*, 2020), which is concerning as tourists are reluctant to access sexual health services before or after travelling (Croughs *et al.*, 2016). Tourists have reported using pre-exposure prophylaxis (PrEP), a biomedical HIV prevention tool, as it reduces the probability of HIV acquisition (Brooks *et al.*, 2018). Although risk compensation theory suggests that PrEP use may potentially increase risky sexual behaviours and STI transmission, primary HIV infection has been shown to be the leading STI contracted by tourists (Nouchi *et al.*, 2019).

Other health concerns relating to tourists and sex workers must also be considered, including mental health (Rössler *et al.*, 2010; Krumrei-Mancuso, 2017; Zehnder *et al.*, 2019); drug and alcohol use to lower the inhibitions and negotiation barriers in transactional encounters (Jones *et al.*, 2014; Shokoohi *et al.*, 2019); low self-esteem and depression (Geibel *et al.*, 2008) workplace violence; transgender-related health care; and social support access (Grenfell *et al.*, 2018). The micro level contains these issues in relation to individuals involved and they are addressed through organised responses in the meso and macro levels. If dealt with effectively, *such approaches would recognise sex workers as citizens with a right to health in the same way as other members of the public* (Grenfell *et al.*, 2018).

Trafficking and exploitation

Recently, there has been a shift in sex research to focus on human trafficking and more specifically, the commercial and sexual exploitation of women and children (Dewey *et al.*, 2018; Majic and Showden, 2018). According to US law, sex trafficking is when, *A commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such act has not attained 18 years of age* (Human Rights First, 2017). Human trafficking or forced labour is a transactional process that has claimed nearly 25 million victims across the world, of which 4.8 million have been sexually exploited (Human Rights First, 2017). Although men are forced into labour for commercial sex, women and girls constitute 71% of victims and of these, 25% are children (UNODC, 2016a, 2016b; Human Rights First, 2017, 2018). Current domestic abuse and violence activist agendas have led to legislative change (Majic and Showden, 2018). The UN Protocol to prevent, suppress and punish trafficking in persons, especially women and children, supplementing the UN convention against transnational organised crime (United Nations Treaty Collection, 2019), enforced in December 2003, was one of the most rapidly endorsed legal instruments in history (UNODC, 2016a).

However, since the COVID-19 pandemic, the number of child sexual abuse material (CSAM) referrals to Europol has increased from below 200,000 per month to over one million in March 2020, with the Internet Watch Foundation reporting nearly nine million attempts in accessing CSAM in April in the UK (Europol, 2020). The increase in online presence, sharing of CSAM and other abusive materials, is an emerging public health crisis. With desensitisation to content, the exploitation of vulnerable groups is of growing concern alongside mental health and sexual issues with those engaging in voyeuristic activities (Walker, 2008; Merdian *et al.*, 2013). It is the intersecting perspectives between sex tourism and trafficking that make modern slavery a contemporary global crisis, requiring urgent attention (Brooks and Heaslip, 2018).

Macro level

The macro level consists of institutional international, national and community responses, designed to address the inner levels of the model. The first "stage" envelopes and responds to the three core elements of the meso level, whilst the second "stage" is set aside from the main diagram as it incorporates the flow of responses. Although two distinct entities within the same layer, the "stages" remain interconnected and should be considered together in the development of interventions, programmes and policies.

Governance and legislation

To ensure the appropriate use of sex tourism models in implementing interventions, governments and international organisations must be aligned with community workers and frontline practice. Developing countries that experience epidemics have effectively decentralised services and used top-down approaches in unison with localised,

community-based interventions (Boland *et al.*, 2020). Notably, service providers should be regionalised, as they understand the epidemiology of infectious and sexual diseases within their locality, and consulted on surveillance delivery, testing and monitoring schemes, particularly for HIV/STI management.

Additionally, there is a need for judicial reformation to support the sex work community. Current state legislations are based on the selling, purchasing and organising of sex work (NSWP, 2020). Whilst selling sex is criminalised in the majority of countries, the purchase of sex is legal in most African countries, Central and South America, Eastern Europe and Asia. In some Australian states, there are controlled zones with obligatory condom use and HIV/STI testing. Full criminalisation is enacted in parts of the Middle East, South Africa and Argentina, with complete legalisation observed in Bolivia, Peru, Ecuador and Uruguay, and full decriminalisation practised in New Zealand (Platt *et al.*, 2018; NSWP, 2020). All countries criminalise coerced behaviour and child prostitution and most prohibit non-resident migrants to work legally or in a regulated environment (Platt *et al.*, 2018). However, regulation implementation remains controversial. In 17 countries that legalised some aspect of sex work, sex workers had a lower HIV prevalence than in countries that fully criminalise it (Reeves *et al.*, 2017). Conversely, although New Zealand has shown that sex workers feel more protected, many enter into sex work due to financial hardship and are likely to experience abuse and violence working outdoors (Schmidt, 2017). The Nordic Model, also known as the Sex Buyer Law or End Demand, advocates for the decriminalisation of sex work, whilst providing holistic support services such as housing, legal advice and health care (Nordic Model Now, 2020). However, the model declares that sex work is *inherently violent* and criminalises the purchase and advertising of sex online. Decrim Now (2021) a UK coalition of charities, non-governmental organisations, grass-roots activists and stakeholders such as Amnesty International UK, has written an open letter to the UK Government asking to terminate the legislation's introduction to Parliament as it *will only exacerbate violence against women, including those who are being exploited.* They claim, as the COVID-19 pandemic has shown, that when sex workers are unable to sustain income, they are pushed into poverty (Decrim Now, 2021).

Education and communication

Industry and national governments appear ambivalent to engage in sexual health education for tourists and sex workers, resulting in a lack of support and insufficient, inaccessible prevention services. Structural drivers must be leveraged to remove barriers to health education and care (Platt *et al.*, 2018). Community-based interventions encourage community empowerment (Cowan *et al.*, 2018; Silberzahn *et al.*, 2021), such as peer outreach for sexual health risk reduction and HIV prevention (Cornish and Campbell, 2009), and locally-tailored programmes, for instance, the Zimbabwean Adherence Sisters HIV programme (Cowan *et al.*, 2018).

Whilst communication should inform decisions as opposed to eliminating sex (Ward and Plourde, 2006), current messaging only reaches a small percentage of tourists (Berdychevsky, 2017). With hard-to-reach populations arguably the most vulnerable and in the greatest need of support, innovative communication strategies relating to sexual health risks are required to allow access to appropriate services, before and after travelling (Hillis *et al.*, 2020).

Research

Recently, promotive and preventative public health research has acknowledged the integral role played by public security and law enforcement (van Dijk *et al.*, 2019). There has been minimal progression on the part of law enforcement to promote public health measures in supporting sex workers, with exception of the recent establishment of the Law Enforcement and HIV Network (LEAHN), a ground-breaking initiative to centralise the role of police forces

in public health and HIV responses. Harm reduction strategies should be adopted by law enforcement to create an enabling environment, taking a multi-sectoral approach (van Dijk *et al.*, 2019; LEAHN, 2020).

We must incorporate recent political, social and economic developments so that decision makers have sufficient research at their disposal to execute programmes. Suggested research includes monitoring sexual behaviour trends and tourist activities; communicating international sexual health messages in pre-and post-travel settings (Tanton *et al.*, 2016); and conducting studies in collaboration with sex workers and tourists to provide greater representation in findings (Farley and Barkan, 2008). Most pertinent, is the need to test existing models through further empirical research. Whilst this commentary has developed a holistic model, it must be applied in a real-world setting to demonstrate validity and reliability.

Implications and future research

This commentary has taken a holistic approach using multi level associations to conceptualise sex tourism. Whilst the levels are versatile and not intended to be rigidly interpreted, researchers, decision makers and practitioners will be equipped to understand sex tourism in its entirety. By considering structural drivers for sexual health and HIV risk, legislation, policies and interventions can be reformed to remove barriers to health care (Platt *et al.*, 2018).

The model contributes to current legal and public health approaches in understanding sex tourism, targeted at multi-stakeholders. The micro level needs to be further deconstructed by gender (to consider female sex tourism and male and transgender sex workers), race and class. The contextual level should also consider stigma associated with GBV, health morbidities and low socio-economic status. At the meso level, it would be prudent to establish communication channel preferences (social media and websites), particularly for voyeuristic activities. Trafficking and exploitation were explored but should be considered under the umbrella of human rights as depicted in the model. Within this, further contextual scoping of rights to freedom, law enforcement, child exploitation and legislation is required.

Empirical research proving the validity and reliability of the new model is warranted. In-depth process evaluation would be necessary because of the sheer complexity of the phenomenon, particularly the multi-layers of risk, gender- and sexuality-based discrimination (Moore *et al.*, 2014). This is of particular importance as the socio-economic disparities are experienced in varying degrees depending on contextual factors that can disturb the intricate cultural, social and health systems within sex tourism (Hawe *et al.*, 2009; Van Hout *et al.*, 2020).

One of the distinguishing factors that set apart the model from previous frameworks is how sex worker and tourist situations are a focal point across the different levels. We argue that health should act as a linchpin for the majority of the acting forces discussed, from behaviour in the micro level to socio-economic status correlating with health outcomes in the contextual factors, and then broader entities found in the meso and macro levels. International and national decision makers should develop policies and programmes through a health care lens to effectively manage the greatest threats facing international sexual health.

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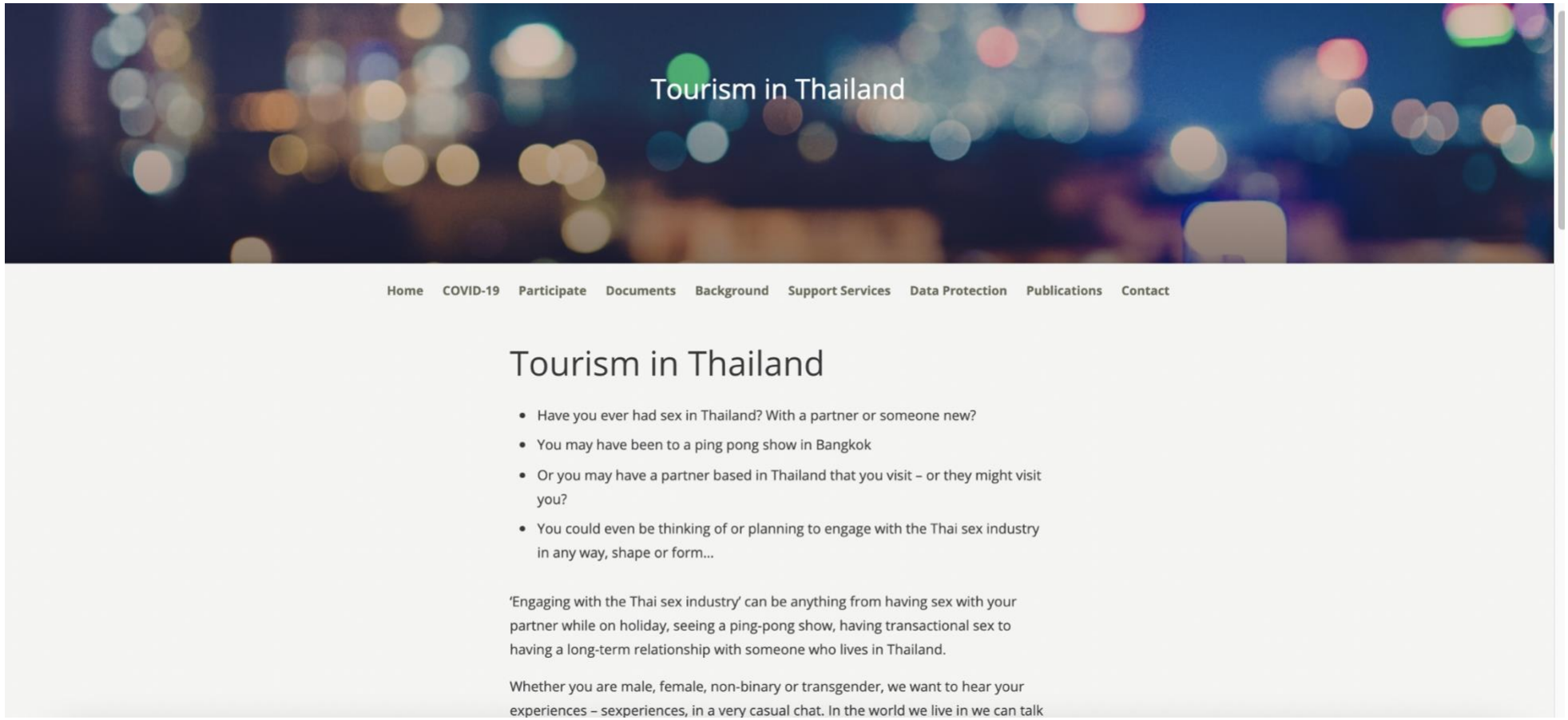
Appendix 4: Website

https://pwtfs.com/



COVID-19

COVID-19 has been classified as a pandemic, leading to the closure of 130 borders and cancellation of 90% of commercial flights, halting global trade across all industries, including sex tourism.

Writing at the end of June 2020, there are currently 8.1 million confirmed cases and 439,500 deaths worldwide.

With the international travel of people severely restricted, global populations are changing social and health behaviours in order to adapt to the current situation. However, we do not know what the repercussions will be regarding health risk behaviours on return to normality or even quasi-normality.

We want to know how COVID-19 might have changed your travelling habits.

- Have you been able to see your partners? How has this been done?
- Have your behaviours changed at all? Have you maintained social distance?
- Have you used technology or other methods to meet partners instead of travelling abroad?
- What do you think it will be like in the future?

We want to hear from you so that we can make travelling for sex safer in a post-COVID-19 world.

Participate

In the long term, the project hopes to create international policies to better protect people that travel. In order to do this, we are looking to interview people to learn about their past and current experiences. This means that all genders and sexualities will be considered for the study – men, women, transgender, LGBTQ, fluid or for people who don't self-identify.

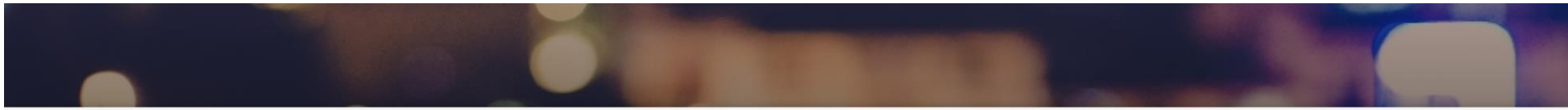
The only things that you need to consider before taking part is that you must be over 18-year olds, a UK resident, English speaking and meet **one** of the below:

- Have travelled to Thailand and had sex when abroad
- Engaged in any part of Thailand's sex tourism industry - this can be anything from ping-pong shows, other forms of visual entertainment, to paying for local kathoey
- Have intentions to do any of the above

Very informal chats will just consist of what your experiences or intentions are. They can take place over the phone, web chat (usually taking 30-60 minutes) or we can chat over email or face to face.

If you would like more information, are interested in taking part or would like to share any wisdom, please don't hesitate to get in contact.

This a piece of research as part of a PhD in Public Health at Liverpool John Moores University (LJMU). We are looking into the motivations, sexual behaviours and UK



Documents

Here you can download documents relevant to the research. Simply click on the blue buttons below.

If you are concerned about other people viewing the documents, remember to try to download them onto a personal computer instead of at work and remove them from your folders and trash after you have used them. You can always come back to this site to access them again!

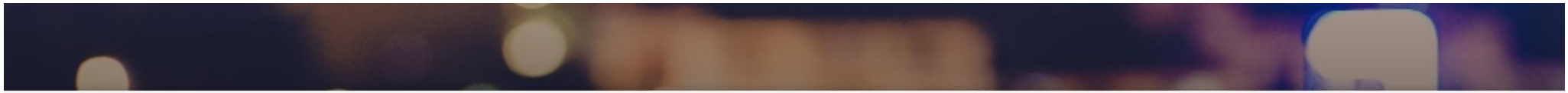
Protocol Download

Information Sheet Download

Consent Form Download

Poster Download

If there is anything you cannot find on the website or you are having trouble downloading the file, don't hesitate to contact the research team. All contact details can be found on the Contact page.



Background

The PhD will look to build upon existing knowledge by updating Opperman's (1999) multidimensional 'Sex Tourism Framework'.

However, since the framework was created, significant socio-economic changes have taken place. Globalisation has dramatically altered social norms relating to sexual exploration and the internet and geo-spatial apps have diminished geographical borders, changing the way people meet, shifting values and reaching hidden populations. These global changes are challenging disease surveillance and the implementation of health initiatives, as well as creating even greater stigma and discrimination. Therefore there is a need to modernise the framework and allow the findings to feed in to current and new policies.

To achieve this, the research team will explore the experiences of healthcare professionals (HCPs) and people who travel for sex (PWTFS). The study will target three areas in the UK: Manchester, Liverpool and London. The study will be completed by 2022.

Support Services

The research team have extensive experience with research projects, especially those that involve interviews concerning potentially sensitive topics. The lead researcher, Alice, who will be conducting the interviews, has experience working in sexual health and HIV clinics, conducting consultations and carrying out interviews for research.

However, if you feel uncomfortable at any point in time during the interview, you will be able to skip any question, take as much time as you want or stop the interview at any point in time. This will not effect any services you are wishing to or are currently receiving.

As we will be discussing your own experiences, some of which may be sensitive, the researcher team is appropriately trained and will respond accordingly. If you do make any disclosures during the interview, the research team will assess the situation and inform the respective 'gatekeeper' or support services if it is necessary.

Following the interview, you may want to speak to someone outside of the research if you feel like you need some support or more information on a certain topic. If you have joined the research through a 'gatekeeper' such as an NHS service, community organisation or charity, you can contact them directly and they will be have to speak whenever is convenient for you. Alternatively, you can find contact details and websites to support services by clicking the links below:

- Mind (Call 0300 123 3393 or text 86463)
- Samaritans (Call 116 123 or email Jo)
- Heads Together
- Terrence Higgins Trust (Call 0808 802 1221 or email THT)
- Terrence Higgins Trust Sexual Health Line (Call 0300 123 7123)

Data Protection

Study data collected will include contact details, signed consent forms and audio recordings of interviews. Minimal personal data will be collected, such as the your race, health, sex life and sexual orientation. Interviews will be recorded using devices only available to the research team. The recordings will be transferred to password protected LJMU computers and then deleted from the recording device. Consent forms will be transferred to locked LJMU filing cabinets at the earliest opportunity.

The transcripts will be anonymised and only accessible to the research team. Personal, identifiable data will be stored for 10 years, in line with LJMU codes of practice.

After publication and dissemination of the findings, we do not anticipate that you will be able to be identified in the research outcomes. This is because the main outcome will be an updated framework and recommendations for services, as opposed to investigating and reporting on your personal information and experiences.

Quotes may be used in other research papers following data collection and your interview, however they will be anonymised. Furthermore, it will be even more difficult to directly or indirectly identify quotes as recruitment is taking place across various centres, services and geographical locations.

Contact

If you are interested in taking part in an interview or would like further information, please do not hesitate to email Alice at:

PWTFS@ljmu.ac.uk

@AliceHillis

Remember, in order to participate you **must** be over 18-years old, a UK resident and English speaking.

#Thailandsexindustry #travel #sex #sextourism #PWTFS #peoplewhotravelforsex #research #sexualhealth

Appendix 5: Participant information sheet

LIVERPOOL JOHN MOORES UNIVERSITY

Participant Information Sheet for Participants

IRAS ID: 256202

LJMU's Research Ethics Committee/Sponsorship Approval Reference: 19LJMUSPONSOR004

NHS REC Reference: 19/NW/0253

YOU WILL BE GIVEN A COPY OF THIS INFORMATION SHEET

Title of Study: *The motivations, sexual behaviours and public health implications of people who travel for sex (PWTFS) to Thailand: a contemporary grounded theory framework*

You are being invited to take part in a study. Before you decide it is important for you to understand why the study us being done and what participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for taking the time to read this.

1. **Who will conduct the study?**

Study Team

Principal Investigator: Alyson (Alice) Hillis, PhD Researcher (a.hillis@2017.ljmu.ac.uk)

Co-investigator: Professor Marie Claire Van Hout, (M.C.VanHout@ljmu.ac.uk); Dr Stephanie Kewley (S.Kewley@ljmu.ac.uk); Dr Conan Leavey (C.Leavey@ljmu.ac.uk)

School/Faculty within LJMU: Public Health Institute, Faculty of Education, Health & Community

2. **What is the purpose of the study?**

This PhD is exploring your experiences, motivations and behaviours of travelling to Thailand for sexual intercourse.

3. **Why have I been invited to participate?**

You have been invited because you have been identified as a potential participant. Many other people have also been identified as potential participants and will be recruited to the research study.

To be eligible to participate in the study you must be over 18-years old, a UK resident, English speaking and meet one of the below:

- Have travelled to Thailand for sex
- Have had sex in Thailand with a new partner
- Have intentions to travel to Thailand for sex in the future

4. **Do I have to take part?**

No. It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. You can withdraw at any time by informing the investigators

without giving a reason and without it affecting your rights/any future treatment/service you receive.

5. **What will happen to me if I take part?**

You will be asked to take part in an interview with the researcher. The interview should last approximately one hour and will be conducted over the phone or face-to-face. The date and time of the interview will be arranged for your convenience. You will be asked to complete a consent form agreeing that you wish to take part in the research. The interview will explore your experiences, motivations and behaviours of travelling to Thailand for sexual intercourse. You will be asked if you would like the opportunity to review your interview as well as the final report, and if possible, refer any other potential participants for interview. Following the interview the researcher will not be in touch unless you agree to further communication or you would like to review your interview once it has been transcribed. You may contact the research team if you have any further questions.

6. **Will I be recorded and how will the recorded media be used?**

You are free to decline to be audio recorded. You should be comfortable with the recording process and you are free to stop the recording at any time.

The audio recordings of your activities made during this study will be used only for analysis. No other use will be made of them without your written permission.

Interviews will be audio recorded on a password protected audio recording device and as soon as possible the recording will be transferred to secure storage and deleted from the recording device.

7. **Are there any possible disadvantages or risks from taking part?**

If you are personally affected by participation in this research, you may wish to seek further support/advice. The below organisations all offer reputable services and would be happy to help:

- Mind - https://www.mind.org.uk/information-support/guides-to-support-and-services/; Call 0300 1233 393 or text 86463
- Samaritans - https://www.samaritans.org/; Call 116 123
- Heads Together - https://www.headstogether.org.uk/; Text 'SHOUT' to 85258
- Terrence Higgins Trust - https://www.tht.org.uk/our-services/services-your-area/support-people-living-hiv; Call 0808 802 1221

8. **What are the possible benefits of taking part?**

There is no direct benefit to taking part in the research.

9. **What will happen to the data provided and how will my taking part in this project be kept confidential?**

The information you provide as part of the study is the **study data**. Any study data from which you can be identified (e.g. from identifiers such as your name, date of birth, audio recording etc.), is known as **personal data**. This includes more sensitive categories of personal data (**sensitive data**). For the purpose of this study, the **personal data** that will be collected will include: your age, ethnicity, city of residence, gender identification, sexuality, relationship status, children, employment and highest level of education obtained.

When you agree to take part in a study, we will use your personal data in the ways needed to conduct and analyse the study and if necessary, to verify and

defend, when required, the process and outcomes of the study. Personal data will be accessible to the study team. In addition, responsible members of Liverpool John Moores University may be given access to personal data for monitoring and/or audit of the study to ensure that the study is complying with applicable regulations.

When we do not need to use personal data, it will be deleted or identifiers will be removed. Personal data does not include data that cannot be identified to an individual (e.g. data collected anonymously or where identifiers have been removed). However, your consent form, contact details, audio recordings etc. will be retained for 10 years.

Personal data collected from you will be recorded using a linked code – the link from the code to your identity will be stored securely and separately from the coded data.

You will not be identifiable in any ensuing reports or publications. We will use pseudonyms in transcripts and reports to help protect the identity of individuals and organisations unless you tell us that you would like to be attributed to information/direct quotes etc. After dissemination, it is not anticipated that participants will be able to be identified in the research outcomes. This is because the main outcome will be an updated framework of the 'contemporary' PWTFS alongside recommendations for supporting service provision, as opposed to investigating and reporting on personal information and experiences. Quotes may be used in other research papers following data collection, however they will be anonymised. Furthermore, quotes will not be directly or indirectly identifiable as recruitment is taking place across various centres, services and geographical locations, which further limits the ability to identify any participant.

With your consent, we would like to store your contact details so that we may contact you about future opportunities to participate in studies.

10. **Limits to confidentiality**

Please note that confidentiality may not be guaranteed; for example, due to the limited size of the participant sample, the position of the participant or information included in reports, participants might be indirectly identifiable in transcripts and reports. The investigator will work with the participant in an attempt to minimise and manage the potential for indirect identification of participants.

In certain exceptional circumstances where you or others may be at significant risk of harm, the investigator may need to report this to an appropriate authority. Depending on the risk, this may be discussed with you first. If this is the case, and you provide your consent, the interviewee will seek advice from the wider research team, documenting the reasons clearly, and the agreed appropriate actions will then be taken. In the case where consent cannot be obtained and the Investigator feels the need to breach confidentiality (such as to prevent serious harm and/or prevent, detect or prosecute a serious crime) then the Investigator will confer with colleagues and weigh up public and individual's interest in maintaining confidentiality against the public interest argument for disclosure. The Investigator will then seek advice from professional / regulatory / indemnifying body(s) and / or lawyers. In the event that the disclosure of activities took place or will take place in Thailand, the research team will contact the INTERPOL National Central Bureau and local law enforcement agencies.

11. **What will happen to the results of the study?**

The investigator intends to publish the results as part of their PhD, in journal articles and present the findings at conferences.

12. **Who is organising and funding/commissioning the study?**

This study is organised by Liverpool John Moores University and is self-funded by the PhD researcher, Alice Hillis.

13. **Who has reviewed this study?**

This study has been reviewed by, and received ethics clearance through, the Liverpool John Moores University Research Ethics Committee (Reference number: 19LJMUSPONSOR004), the NHS IRAS Ethics Committee (Reference number: 19/NW/0253) and has obtained a Research Passport (Number: xxx).

14. **What if something goes wrong?**

If you have a concern about any aspect of this study, please contact the relevant investigator who will do their best to answer your query. The investigator should acknowledge your concern within 10 working days and give you an indication of how they intend to deal with it. If you wish to make a complaint, please contact Dave Harriss, the chair of the Liverpool John Moores University Research Ethics Committee (researchethics@ljmu.ac.uk; 0151 9046467).

Please note, LJMU has arranged Public Liability insurance to cover the legal liability of the University as Research Sponsor in the eventuality of harm to a research participant. The coverage is provided through the management of the research by the University and activities conducted as part of this research are included within that coverage. This does not in any way affect an NHS Trust's responsibility for any clinical negligence on the part of its staff (including the Trust's responsibility for LJMU employees/students acting in connection with

their NHS honorary appointments). LJMU holds Professional Indemnity insurance to cover the legal liability of the University as Research Sponsor and/or as the employer of staff/students engaged in the research, for harm to participants arising from the design of the research, where the research protocol was designed by the University. LJMU's Public Liability and Professional Indemnity insurance policies provide an indemnity to our employees and students for their potential liability for harm to participants during the conduct of the research and the activities here are included within that coverage.

15. **Data Protection Notice**

Liverpool John Moores University is the sponsor for this study based in the United Kingdom. We will be using information from you in order to undertake this study and will act as the data controller for this study. Liverpool John Moores University will keep identifiable information about you for 10 years after the study has finished.

As a university we use personally-identifiable information to conduct research to improve health, care and services. As a publicly-funded organisation, we have to ensure that it is in the public interest when we use personally-identifiable information from people who have agreed to take part in research. This means that when you agree to take part in a research study, we will use your data in the ways needed to conduct and analyse the research study. Health and care research should serve the public interest, which means that we have to demonstrate that our research serves the interests of society as a whole. We do this by following the UK Policy Framework for Health and Social Care Research.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the study to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible.

You can find out more about how we use your information by contacting Tina Sparrow, the Liverpool John Moores University Data Protection Officer at DPO-LJMU@ljmu.ac.uk.

If you wish to raise a complaint on how we have handled your personal data, you can contact our Data Protection Officer who will investigate the matter. If you are not satisfied with our response or believe we are processing your personal data in a way that is not lawful you can complain to the Information Commissioner's Office (ICO).

Contact for further information

Alyson (Alice) Hillis (a.hillis@2017.ljmu.ac.uk) or Professor Marie Claire Van Hout, (M.C.VanHout@ljmu.ac.uk)

Thank you for reading this information sheet and for considering to take part in this study.

Note: A copy of the participant information sheet should be retained by the participant with a copy of the signed consent form.

Appendix 6: Consent form

Participant consent form

LIVERPOOL JOHN MOORES UNIVERSITY
CONSENT FORM – Participants

School/Faculty: Public Health Institute, Faculty of Education, Health & Community

Name and Contact Details and status of the Principal Investigator: Alice Hillis, PhD Researcher (a.hillis@2017.ljmu.ac.uk)

Name and Contact Details of the Investigators: Professor Marie Claire Van Hout, (M.C.VanHout@ljmu.ac.uk); Dr Stephanie Kewley (S.Kewley@ljmu.ac.uk); Dr Conan Leavey (C.Leavey@ljmu.ac.uk)

1.	I confirm that I have read and understand the information provided for the above study (LJMU Participation Information Sheet NHS template v1 Feb'19 Version 5.0 date: 17/06/2019). 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 a reason and that this will not affect my legal rights.	☐
3.	I understand that any personal information collected during the study will be anonymised and remain confidential	☐
4.	I understand that the interviews will be audio recorded and I am happy to proceed	☐
5.	I understand that parts of our conversation may be used verbatim in future publications or presentations but that such quotes will be anonymised	☐
6.	I understand that relevant sections of my medical notes and data collected during the study, may be looked at by individuals from LJMU, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.	☐
7.	I agree to be contacted in the future for ethically approved studies	☐
8.	I agree to take part in an interview for the above study	☐

Name of Participant	Date	Signature
Name of Researcher	Date	Signature
Name of Person taking consent *(if different from researcher)*	Date	Signature

Note: When completed 1 copy for participant and 1 copy for researcher.

Participant Consent Form_v3.0_17.06.19
IRAS ID: 256202

Appendix 7: Poster

Appendix 8: Recruitment emails

Subject: PhD research: Motivations, sexual behaviours and public health implications of people who travel for sex (PWTFS) to Thailand

Dear [insert name of healthcare professional],

I hope this email finds you well. I am a PhD student at the Public Health Institute, Liverpool John Moores University. I am looking at how globalisation and technology have impacted on sex tourism and subsequently UK public health services, for the service provider and the service user travelling to Thailand.

As part of the research, I am looking for service providers to assist in facilitating interviews with people who travel for sex (PWTFS) or those who are intending to travel to Thailand for sex.

Secondly, your own professional insights would be useful in understanding the current and developing situation of sex tourism in relation to UK public health and services.

If you are able to act as a gatekeeper to PWTFS and/or as an interviewee, I have attached information sheets containing details for the different scenarios. Please do not hesitate to contact me if you have any questions. If you are willing to be interviewed, please do let me know by [insert date], and so we can arrange a mutually suitable time and date.

Many thanks in advance.

Best wishes

Alice

Alice Hillis
PhD Researcher
Public Health Institute
Faculty of Education, Health & Community
Liverpool John Moores University
3rd Floor, Exchange Station
Tithebarn Street
Liverpool, L2 2QP
Website: www.pwtfs.wordpress.com

Appendix 9: Social media posts

Appendix 10: PowerPoint slide

Appendix 11: Business cards

Appendix 12: Semi-structured interview schedule

Participant interview schedule post-COVID-19

Demographic questions

How old are you?

- What is your ethnicity?
- Where do you live?
- What gender do you identify with?
- What is your sexuality?

General questions

- What have your interactions been between with Western travellers when were you in Thailand?
- What are your perceptions, thoughts, experiences or observations of the sex industry in Thailand? How is it different in different parts of Thailand?
- What is the perception of travellers/holiday-makers in Thailand? What are they like – age groups/behaviour/activities etc.
- Do you think gender has a role?
- What are the main health concerns for people who have sex in Thailand?
- (This could be for people engaging in the sex industry as well as those who meet someone who is on holiday/longer stay. There does not need to be any transaction.)
- Who are the most vulnerable people/communities in Thailand's sex industry and why?
- Can you tell me a bit about katoey?
- Are there any other groups or communities that need to be considered or that I should be aware of?
- How do you think COVID-19 will impact the sex tourism industry in Thailand?
- Has technology changed the situation in Thailand?
- What do you think it will look like in the future?
- Are there sexual health services available to everyone who is having sex in Thailand? Are the services different if you are Thai to if you are a Westerner or travelling for business/pleasure?

- Do you have any recommendations for services, governance, programmes, policies or laws. These can be from any perspective such as: international public health, human rights, education etc.

HCP interview schedule post-COVID-19

Demographic questions

- Where are you currently working?
- What is your job title?
- How long have you been working in this therapy area?
- Have you always worked in this therapy area?

General questions

1. **Can you tell me a bit about your experiences of working or seeing people who travel for sex, if you know of specific examples to Thailand that would be great.**
   - What is the main demographic of people that travel abroad?
   - Is there any distinction between different groups or cohorts that travel abroad? (i.e. age)
   - What are some of your patients' reasons for travelling for sex?
   - Is there a difference in people's behaviours from at home to abroad? For example, riskier sexual behaviour or multiple partners?
   - Do patients tend to visit you before, after or both, travelling abroad?
   - Are you aware of patients accessing Thai sexual health services when abroad?
   - What are patients' main concerns when they come to see you?
   - If patients are worried, are their anxieties justified or are they ruminating on the wrong things?
   - Have things changed since PrEP has been made available on the NHS or even before, through the IMPACT trial?

2. **While you have been practicing, and more pre-COVID, have there been any significant changes have taken place with the sex tourism industry and for people travelling for sex?**

3. **Now we've been in a pandemic, borders sort of closed, locked down world, how do you think COVID has impacted the sex tourism industry?**
    - How frequent is breaking of quarantine
    - Have there been any new sexual health trends?
    - Have people been presenting in clinic after travelling abroad?
    - Are there any reports of online sexual activity and what does this mean? (For example, does technology, in terms of communication, the Internet and drug development, have an impact on sexual risk taking and increase in sex tourism?)
    - Do you think there are similarities between the spread of COVID and STIs?
    - Similar groups are vulnerable? What does this mean? Are sex providers marketing in a different way?

4. **Do you see the sex tourism industry changing in the future?**

5. **Can you describe the main patient pathways and processes for UK citizens planning to travel abroad for sex?**
    - What are the main barriers for patients accessing health and social services in the UK?
    - One of the main learnings from COVID is cross border transmission, and it's not too dissimilar from STIs or BBVs. Do you have contact with international sexual health teams, or anything along those lines, to protect those that do travel at the same time as working towards lowering numbers. And if not, would it work and how would you go about it?
    - Can you think of any recommendations to inform policy, practice and health professional training around sexual health or travel services in the UK?

6. **Recruitment**

Appendix 13: HRA ethical approval

IRAS ethical approval

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Professor Marie Claire Van Hout
Public Health Institute, Exchange Station
Tithebarn Street
Liverpool
L2 2QP

Email: hra.approval@nhs.net
HCRW.approvals@wales.nhs.uk

24 July 2019

Dear Professor Van Hout

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**The motivations, sexual behaviours and public health implications of people who travel for sex (PWTFS) to Thailand: a contemporary grounded theory framework**
IRAS project ID:	**256202**
Protocol number:	**N/A**
REC reference:	**19/NW/0253**
Sponsor	**Liverpool John Moores University**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

Important

If you are setting up NHS/HSC organisations from 5 June 2019 in ongoing projects, then you should prepare to use the UK Local Information Pack for these participating NHS/HSC organisations. This will mean that you will need to use Organisation Information Document(s) and **not** NHS/HSC SSI forms or Statements of Activities for the new participating NHS/HSC organisations.

If you have already created NHS/HSC SSIs (Scotland and Northern Ireland) and/or Statements of Activities (England/Wales) then you should transfer the information to the Organisation Information Document for inclusion in the UK Local Information Pack. There is no requirement to resubmit to the HRA.

Further information can be found at https://www.hra.nhs.uk/about-us/news-updates/launch-uk-local-information-pack-supporting-set-nhshsc-research-uk/

How should I work with participating non-NHS organisations?

HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?

Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **256202**. Please quote this on all correspondence.

Yours sincerely,

Amber Ecclestone

Approvals Specialist

Email: hra.approval@nhs.net

List of Documents

The final document set assessed and approved by HRA and HCRW Approval is listed below.

Document	*Version*	*Date*
Copies of advertisement materials for research participants	4.0	20 June 2019
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only)		16 July 2018
HRA Statement of Activities		
Interview schedules or topic guides for participants [Interview Schedule]	v2.0	18 April 2019
IRAS Application Form [IRAS_Form_03042019]		03 April 2019
Letters of invitation to participant [EMAIL TO HEALTHCARE PROFESSIONALS]	v2.0	18 April 2019
Letters of invitation to participant [EMAIL TO COMMUNITY ORGANISATIONS]	v2.0	18 April 2019
Other [Validation Queries]		18 April 2019
Participant consent form [Gatekeeper]	4.0	17 June 2019
Participant consent form [Healthcare Professional]	4.0	17 June 2019
Participant consent form	3.0	17 June 2019
Participant information sheet (PIS) [Gatekeeper information sheet highlighted changes]	v3.0	17 June 2019
Participant information sheet (PIS) [Gatekeeper information sheet clean]	v3.0	17 June 2019
Participant information sheet (PIS) [Healthcare Professional]	4.0	17 June 2019
Participant information sheet (PIS)	5.0	17 June 2019
Research protocol or project proposal	v4.0	25 March 2019
Schedule of Events or SoECAT	v4.0	25 June 2019
Summary CV for Chief Investigator (CI)		20 September 2018
Summary CV for student [Alyson Hillis]		12 March 2019
Summary CV for supervisor (student research) [Marie Claire Van Hout]		20 September 2018
Summary CV for supervisor (student research) [Conan Leavey]		16 April 2019
Summary CV for supervisor (student research) [Dr Stephanie Kewley]		16 April 2019

gmeast.rec@hra.nhs.uk <noreply@harp.org.uk> | Van Hout, Marie-Claire; Hillis, Alice; Sponsorship of research | 1 | 06/10/2020

IRAS PROJECT ID 256202, REC Reference 19/NW/0253 Confirmation of favourable opinion for substantial amendment

Follow up. Completed on 01 February 2021.

If there are problems with how this message is displayed, click here to view it in a web browser.

256202 REC FO Substantial Amendment 06102020.pdf
96 KB

Dear Professor Van Hout

IRAS project ID:	256202
REC reference:	19/NW/0253
Short Study title:	Sex tourism and public health in the UK: a grounded theory framework
Date complete amendment submission received:	16 September 2020
Amendment No./ Sponsor Ref:	19LJMUSPONSOR004
Amendment Date:	01 September 2020
Amendment Type:	**Substantial**
Outcome of HRA Assessment	**This email also constitutes HRA and HCRW Approval for the amendment, and you should not expect anything further.**

I am pleased to confirm that this amendment has been reviewed by the Research Ethics Committee and has received a Favourable Opinion. Please find attached a copy of the Favourable Opinion letter.

HRA and HCRW Approval Status

As detailed above, **this email also constitutes HRA and HCRW Approval for the amendment**. No separate confirmation of HRA and HCRW Approval will be issued.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/.

If you require further information, please contact me.

Kind regards

Amber Ecclestone
Approvals Specialist
3rd Floor, Barlow House | 4 Minshull Street | M1 3DZ
T. 0207 104 8009
E. gmeast.rec@hra.nhs.uk
W. www.hra.nhs.uk

Van Hout, Marie-Claire | Hillis, Alyson 03/12/2019

Fwd: IRAS PROJECT ID 256202, REC Reference 19/NW/0253 : Amendment acknowledgement and implementation information

You replied to this message on 03/12/2019 19:50.
If there are problems with how this message is displayed, click here to view it in a web browser.

Sent: Tuesday, December 3, 2019 7:10:15 PM
To: M.C.VanHout@ljmu.ac.uk ; sponsor@ljmu.ac.uk
Subject: IRAS PROJECT ID 256202, REC Reference 19/NW/0253 : Amendment acknowledgement and implementation information

New Site Amendment, Implementation Information

Dear Professor Van Hout

IRAS Project ID:	256202
Short Study Title:	Sex tourism and public health in the UK: a grounded theory framework
Date complete amendment submission received:	03/12/2019
Sponsor Amendment Reference Number:	1
Sponsor Amendment Date:	03 December 2019
Amendment Type:	Non-substantial
For new sites in Northern Ireland and/or Scotland:	Please start to set up your new sites. Sites may not open until NHS management permission is in place.
For new sites in England and/or Wales:	**This email also constitutes HRA and HCRW Approval for the amendment, and you should not expect anything further**. Please start to set up your new sites. Sites may not open until the site has confirmed capacity and capability (where applicable).

Thank you for submitting an amendment to add one or more new sites to your project. This amendment relates solely to the addition of **new sites**.

What should I do next?

Please set up the new site(s) as per the guidance found within IRAS. **Please note** that processes change from time to time so please use the most up to date guidance about site set up.

If your study is supported by a research network, please contact the network as early as possible to help support set up of the new site(s).

If you have listed new sites in any other UK nations **we will** forward the information to the national coordinating function(s) for nations where the new site(s) are being added. In Northern Ireland and Scotland, NHS/HSC R&D offices will be informed by the national coordinating function.

Note: you may only implement changes described in the amendment notice.

Who should I contact if I have further questions about this amendment?

If you have any questions about this amendment please contact the relevant national coordinating centre for advice:

- England – hra.amendments@nhs.net
- Northern Ireland – research.gateway@hscni.net
- Scotland – nhsg.NRSPCC@nhs.net
- Wales – HCRW.amendments@wales.nhs.uk

Additional information on the management of amendments can be found in the IRAS guidance

Appendix 15: Under the radar: A "hiding" research population in the case of sex tourism and imperatives of methodological and ethical redesign

Hillis, A., Leavey, C., Kewley, S., Germain, J. and Van Hout, M. C. (2021) Under the radar: A "hiding" research population in the case of sex tourism and imperatives of methodological and ethical redesign. [In progress]

Title: Under the radar: A "hiding" research population in the case of sex tourism and imperatives of methodological and ethical redesign.

Authors: Alyson Hillis MSc[1]*, Dr. Conan Leavey[1], Dr. Stephanie Kewley[2], Dr. Jennifer Germain[1] and Prof. Marie Claire Van Hout[1]

[1] Faculty of Health, Public Health Institute, Liverpool John Moores University, Liverpool, UK

[2] Faculty of Health, School of Psychology, Liverpool John Moores University, Liverpool, UK

* Corresponding author: Alyson Hillis – Faculty of Health, Public Health Institute, 3rd Floor Exchange Station, Tithebarn Street, Liverpool, UK L2 2QP; 01512314107; a.hillis@2017.ljmu.ac.uk

Sources of Funding

This work was not supported by any funding body.

Conflict of Interest/Disclosure

The authors have declared no conflicts of interest.

Key words: Tourist; sex worker; qualitative; methodology; ethics; hidden; vulnerable

Word count: 1,498 words

Abstract

Historically in sex tourism and health research, a population that is deemed 'vulnerable' or 'stigmatised' is classified as 'hard to reach' or 'hidden', concepts which determine recruitment strategies. Yet the main two groups explored in this field, tourists and sex workers, in essence the consumers and the providers of sex, require considerably different recruitment strategies. We discuss here the complexities around researching this phenomenon cognisant of the public health lens. Our commentary identifies the need to better understand and distinguish 'hiding' populations from the traditional hidden or covert populations. This is discussed with reference to tourists who wish to remain under the radar (hiding) and sex workers (hidden) who wish their voices to be heard and who want to be represented fairly in research. This will help ensure that policies, legislation, and governments can produce appropriate public health messages and responses to their given situation and positionality.

Introduction

Our public health research project investigating the dimensions of migration and disease, the processes of sex transactioning and the positionality of key actors in Thailand's sex industry, experienced significant methodological obstacles during operationalisation. The research sought to recruit tourists who consume sexual experiences, and sex workers who provide them. During the research process, we found discrepancies between *our* perceptions of sex workers and tourists, and *their* perceptions of themselves. We propose that a shift has occurred with the perceived vulnerablity of sex workers, and that of tourists in public health research, with tourists who engage in sex transactioning, actively 'hiding' as a population. This commentary advises how future international health-related research can practically engage with these unique cohorts through adjusting study methodologies, recruitment tactics, and participant involvement.

Sex worker empowerment

Historically, research has judged sex workers as a vulnerable, marginalised, and stigmatised group, considering them as hidden and hard to reach. Yet feminist agendas and sex positivism denotes that sex workers' empowerment is embodied in their knowledge and understanding of their own contexts, allowing them to assert power and agency into relationships with clients (Grenfell *et al.*, 2018). In some communities, sex workers remain socially ostracised and stigmatised; at risk of gender-based violence, rape and murder (Poppi and Sandberg, 2020). Evidence has begun to show that sex workers are active members of communities and regularly participate in research, informing public health agendas. Controversially, our project observed how sex workers have become resentful of researchers using sex workers' stories without acknowledging their role, speaking on their behalf and thus, indirectly, silencing them. In the meantime, sex workers are carving out their own path as working activists, collaborating with non-governmental organisations, charities and advocacy groups to fight for their rights to stimulate legislative reforms, the decriminalisation of sex work and the legitimation of '*sex as work*' (Strega *et al.*, 2020). Therefore, public health research is only one component of an existing progressive vehicle, supporting advocacy and driving change in human and health rights in the sex industry.

A 'hiding' research population

Traditional feminist discourse emphasises that hegemonic masculinity is a core reason for male tourists to engage with the sex industry. This narrative rests on three assumptions as put forward by Strega *et al.* (2020). Firstly, men perceive themselves to be consumers of, and are entitled to, sex workers' bodies, thus, justifying any associated violence; secondly, the sex industry is the only way that these men receive sex; and thirdly, they believe they are offering a public service to women that they deem helpless. Concurrently, an adverse by-product of hegemonic masculinity is the shame that is associated with engaging with a sex worker for sexual fulfilment. Therefore, it is unsurprising that tourists who travel for transactional sex, remain anonymous and separate their activities abroad from their home lives (Ellard-Gray *et al.*, 2015).

Our experience finds this particular population covert, difficult to access and due to lack of recruitment, created a void in our project. They are not hard to reach or hidden because they are not stigmatised, marginalised or vulnerable (except as a consequence of experiencing shame). They are hiding. As researchers, we should reconsider this cohort's agenda to understand their intentional or deliberate tactics to avert the attention of societies, communities and institutions, whilst acknowledging their significant impact on international public health, including cross border disease transmission, exploitation, and widening health disparities.

Practicalities of engaging with sex workers and tourists in research

The research process must reflect these revised understandings of the positionality and agendas of sex workers and tourists. Public health research with sex workers requires tailored study designs, adapted for the subgroup of sex workers under investigation, in order to understand them as a diverse and heterogeneous population. Typically, advocacy organisations, social services, healthcare, and police collect data on sex workers; yet, not directly from sex workers themselves, with data likely obtained from those in crisis, victimised and powerless (Bungay *et al.*, 2016). This is reflective of the broader dimensions and power dynamics whereby theoretical concepts present participants as statistics, restraining their role and relevance in sex tourism research, thereby further limiting access to their lived realities. Conversely, this approach diminishes the tenets of in-depth exploration, stripping participants of their identity and context, which should be at the core of the qualitative researcher's intentions. This more notably applies to sex workers, as previously discussed.

For tourists, public health research therefore requires '*targeted sampling…to penetrate the local networks of the stigmatized population*' (Shaver, 2005, p. 296). Literature recommends establishing access to 'hiding' populations, including through screening and testing and by locating these services in non-clinical settings, such as in red light districts, as it can reduce sexual and gender stigma, which is commonly reported in healthcare services. Recruitment through online communities; on-site field work; gatekeepers; or privileged access research using insiders in the case of gangs (Pawelz, 2018) and

drug users (Johnson and Richert, 2016), has also been documented with some success. Once access to a group is established, social acceptance is then required to maintain contact with the chosen network (Bengry, 2018). Researchers should build rapport, trust, and a mutual relationship with potential participants over a substantial period.

Additionally, scholars need to question the appropriateness of the language used throughout the research process. Prospective participants may not identify with labels used by researchers such as 'sex tourist', and thus, may not volunteer to participate in research; especially as self-identification can '*vary greatly across race, culture, age, political affiliation, education level, and geographical region*' (Ellard-Gray *et al.*, 2015, p. 2). Furthermore, if people are recognised in research as belonging to a particular group, have a stigmatised identity or involved in risky and/or criminal behaviour, their reputation, social status and privacy may be jeopardised or they may become vulnerable to stigma and discrimination (Ellard-Gray *et al.*, 2015).

Labelling populations as 'hidden', traditionally relates to a level of vulnerability, where the individual or group under investigation is out of reach of institutional or structural systems such as laws, health provision or policing (Bungay *et al.*, 2016). Yet throughout our research, tourists consciously choose to hide, and actively avoid engaging with researchers or organisations. Optimal public health research warrants a distinction between 'hidden' and 'hiding' populations. Once this has occurred, we recommend considering a revised definition, from a public health perspective, in all aspects of the research process, from ethical approval to data collection and analysis.

Finally, the shift in meaning of 'hiding' populations inevitably has ethical implications. To target these emerging groups in the research project, continuous searching, tracking and locating of individuals and organisations was required to gain traction with potential participants. Although travel with friends is reported, tourists who consciously plan to purchase sex on holiday tend to operate alone. Their solitary movements make it harder to access them as a population and implement peer level research. We recognise there may be online communities of individuals who purchase sex on holiday.

By adopting an online recruitment strategy, researchers arguably enter into a grey ethical space. Germain *et al.* (2017, pp. 1652-1653) identify that '*online forums provide an anonymous venue for those engaging in illicit activity to seek advice and share experiences that they cannot share offline*' however, recruitment through these environments, '*blur[s] boundaries between private and public space online*'. By encroaching on people's private and safe, albeit virtual environments, online recruitment methods of this nature are distorting the lines between academia and investigative reporting or journalism, where no ethical approval is required.

Conclusion

Public health researchers are charged with understanding a community and its actors from both literature and experts working with 'vulnerable' or 'hidden' individuals. We believe that there is an ethical duty, as public health researchers, to be aware of and sensitised to the transitional shift of societies' perceptions of sex workers and tourists' vulnerabilities. In our experience, sex workers are already using multiple platforms to voice their opinions. They are an accessible population, willing to participate, and like any other cohort, it is their right to directly express their situation through research. Contrastingly, tourists who engage in sex transactioning, are a covert group due to either their shame, criminal behaviour or their desire to maintain a 'double' life.

We therefore call for a revision of the terminology used to describe populations that are 'hidden' and consciously 'hiding', and at the same time, give a greater platform to those that have previously only be considered as 'vulnerable' due to prevailing stigma and discrimination. By not understanding those we are aiming to target in their entirety, we are doing a disservice and carrying out an injustice to those populations. Future research designs must not reflect historical biases, perceived power hierarchies and incorporate a nuanced approach, tailored to the individual and their position and agency in society. This approach will ensure that future public health strategies are informed, appropriate and targeted, supported by public health policies and practices, and legislative structures

that are respectfully inclusive of the majority of populations, with coverage of contrasting experiencing and perspectives.

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