Marked as Contagious

Sex Work and the History of Moral Blame

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COVER IMAGE:

Source: Dalma Ubitz
Via Canva
Veiled under the labels and diagnosis, there lies a woman

Disclaimer

This essay uses both the terms sex work and prostitution. While prostitution is now widely understood as outdated and derogatory, it is used here in historical contexts where it reflects the language and social frameworks of the period being discussed. The term sex work is used in contemporary contexts to acknowledge its current, more inclusive understanding. (UN, 2016) (Body + Soul, 2021)

Sex work has captivated society for generations. Though sometimes referred to as the "oldest profession," it tends to be seen as nasty, immoral, and a path that women pursue out of desperation (Pritchard, 2021). Throughout history, women have disproportionately borne the stigma and blame for perceived declines in public health and morality (Professor Philippa Levine, 2003), facing social ostracization for earning a living (Weitzer, 2011). Contemporary discourses frequently oversimplify the historical realities of sex work. While some present it as a destructive force that must be eradicated, others characterize it as entirely exploitative or, conversely, an empowering choice. The truth lies within the complex spectrum of social, legal, and economic systems that have shaped sex work, and the surprisingly recent invention of its association with disease (Weeks, 2005).

It is often said that to understand ourselves, we need to understand our past. So why do sexually transmitted infections (STIs) still carry such stigma? When people encounter a ‘shocking’ STI statistic or receive their own diagnosis, their emotions likely circle around shame. It can feel like a private, painful sense of moral failure. The shame attached to STIs was constructed before medicine understood disease transmission, and it persists not because of individual prejudices, but because institutional structures continue to reproduce it. Yet, these feelings are not natural responses to infection. They are inherited scripts, written over centuries by systems that needed to make certain bodies ‘dangerous’ in order to regulate all sexuality.

Dancing and holy worship of the past.
Source: Dalma Ubitz, Canva

Making of the Dangerous Body

Societal beliefs and scripts are written over centuries (Jones & Hannem, 2018). For a long time, powerful systems, for example the state or church have controlled certain bodies, especially women’s in sex work, casting them as ‘dangerous’ for their control. The ideas from the past persist and continue to shape a lot of our understandings around health, morality, responsibility, and our sense of self.

In 2400 BC Sumeria, perceptions seemed to be different. Historians found prostitution to be spiritual forms of worship done by men and women for the gods of fertility, love, and war (Rosaria Vignolo Munson, 2013). The Ancient Greeks and Romans had other practices, but they also did not legalize or hide prostitution. They saw it as a social inevitability, allowing brothers to be operated out in the open, even under state regulation sometimes. While not considered socially good, men’s needs were seen as an unstoppable force that normalized the need for prostitution. As a double standard, women were seen as uncontained and morally deviant. These beliefs would further multiply.

At first, humanity had little knowledge about the microbial world, explaining the transmission of illness through cosmology and moral frameworks. When disease appeared, many beliefs intersected to blame sexually active women: imbalance, impurity, and divine retribution caused sickness. Since it was seen as the cause of moral failing, those who were most morally questionable needed to be blamed. The popular belief was that if deities chose to punish them, why should not society? (Porter, 1999) (Rosenberg, 1992)

The moral framing of venereal disease developed through deeply gendered assumptions that treated women as sources of contagion and men as expected participants in sex. Historical records consistently describe male sexuality as natural and inevitable, while women’s sexuality was marked as suspect and in need of supervision. This logic shaped policy, leading authorities to name, register, examine, and monitor women while leaving male clients largely invisible to regulation. The emergence of syphilis in early modern Europe makes this pattern especially clear, as the disease spread widely across classes, genders, and institutions, including courts, armies, and religious communities. Even under these conditions, public health responses focused on surveilling sex workers rather than addressing shared transmission networks. This approach protected men by preserving their sexual behavior as socially neutral and locating risk in women’s bodies. Disease functioned as a justification for enforcing existing sexual hierarchies rather than as a guide for equitable health policy.

Where did this leave prostitutes? Throughout European history, they were symbolically associated with excess and transgression. People were terrified of the unknown, and sadly resorted to scapegoating. Prostitutes were perfect explanatory figures for such unpredictable times (Gilman, 1988).

Symbolically, they represented all things wrong in the world. Society could project their fears about decay and disorder freely, staying distracted from holding governments and other ruling bodies responsible for outbreaks. While prostitutes were not demonstrably more infectious, they were occupying a morally unacceptable space, making placid blame more plausible. First, the label of ‘dangerous body’ was made, and afterwards, medical knowledge brought the vocabulary that could further the assumptions with better labels.

The mystery around sex work actively makes it easy to scapegoat
Source: Dalma Ubitz, Canva

Institutionalizing the Gaze

The British Contagious Diseases Acts of 1864, 1866, and 1869, implemented both in Britain and across its colonies (Walkowitz, 1980). Framed as public health measures, the Acts were designed to protect military efficiency by reducing STIs among soldiers.

However, soldiers were the very population the Acts claimed to protect, were never subjected to comparable scrutiny. Their bodies were presumed healthy by default. Resistance to the Acts, most notably led by Josephine Butler, exposed the gendered cruelty of this system and its tenuous relationship to health. As we have seen before, these medical policies did not just happen to disadvantage women, but were mechanisms of social control disguised as healthcare.

In practice, they authorized the forced examination, detention, and incarceration of women suspected of prostitution in garrison towns and port cities (Biswas, 2020). Suspicion alone was sufficient grounds for intervention. Women could be subjected to weekly invasive examinations and confined and locked in hospitals without trial.

Religious rescue narratives

Alongside legal regulation, Christian moral frameworks reinforced the association between disease and female sin. Sex workers were cast as ‘fallen women,’ figures who required rescue and redemption rather than rights or resources (Mahood, 2013). Illness functioned within this narrative as both punishment and proof, a visible sign of internal moral failure. These stories that individualized blame obscured the truth: structural factors such as poverty, coercion, and lack of alternatives kept women in this profession.

This framework proved enduring because it translated easily into institutional practice. By teaching society to interpret disease as revelation of character rather than consequence of circumstance, it legitimized punitive interventions while appearing compassionate. The language of rescue softened the reality of control. Healthcare became conditional upon moral reform, a dynamic that continues to shape access and treatment today.

Visual propaganda

By the late nineteenth and early twentieth centuries, public health campaigns began to circulate visual representations that crystallized these ideas. Posters depicted sex workers as skeletal figures, shadowy threats, or conduits of death, their bodies exaggerated as sites of contamination (Brandt, 2020). Messaging emphasized fear of women’s sexuality rather than shared responsibility for sexual health. These images reflect stigma, but they also produced it, teaching viewers whom to fear and why.

Two young men are approached by a prostitute; a clothed skeleton holding a made-up mask in front of her face, representing syphilis.
Source: Jean-Jacques Grandville, 1830, Lithograph

This imagery persists as emotional residue. Today, contemporary audiences encounter STI statistics or experience infections themselves and feel a sense of unease towards themselves or targeted at certain populations. This is a clear example of how historical messages have been passed down and live collectively in our social understanding. People are responding to associations forged through decades of visual conditioning. Society had to believe in a story. And the story was that the danger resides in sex workers. Lupton (2012)

How Surveillance Becomes Internalized

The HIV/AIDS crisis of the 1980s showed how long the faulty framework could last. Once again, rather than focusing on behaviors or structural conditions, institutions searched for identifiable “risk groups.” Sex workers, gay men, and people who used drugs were framed as vectors, delaying effective responses that could have mitigated widespread transmission. Moral panic shaped policy as much as epidemiology. (Singer et al., 2017)

Harm reduction strategies eventually emerged, accompanied by a shift in language from “risk groups” to “risk behaviors.” Yet the underlying logic remained body-centered. Certain populations continued to be read as inherently risky, their presence standing in for danger itself. The repetition was not accidental. It revealed a system more comfortable policing identities than confronting inequities.

Contemporary Realities

History is not confined to the past as sex workers continue to report discrimination in healthcare settings, including coerced testing, breaches of confidentiality, and denial of care (WHO et al). Criminalization drives work underground, reducing access to regular screening and treatment and increasing vulnerability to infection. The resulting disparities are then cited as evidence of inherent risk, completing a self-fulfilling cycle. Stigma itself produces the conditions it claims to address. (The Lancet HIV, 2024)

In 2024, twelve sex workers in Mumbai were detained under the Immoral Traffic Prevention Act, ostensibly to prevent STI transmission. This justification echoed 19th century logic almost precisely. The sessions court later ordered their release, noting the lack of public health basis for the detention (Hindustian Times, 2025). Yet the incident revealed how containment of bodies framed as protection of society remains a viable state practice. The resulting disparities from such interventions are then cited as evidence of inherent risk, completing a self-fulfilling cycle. Stigma itself produces the conditions it claims to address.

The shame surrounding STI testing is a learned response, a product of medical systems designed to surveil rather than heal (Foucault, 2012) (Lupton, 2016). Consequently, public health data is persistently misread: higher infection rates among stigmatized groups are cited as proof of moral failure instead of being recognized as evidence of structural barriers to care (Columbia Law School, 2017). The statistics are not the profile of risk they want to be, but a blueprint of exclusion.

When people see headlines about STI rates among sex workers and feel an automatic distancing; a sense that this is about those bodies, not theirs, they are experiencing the success of a disciplinary system designed to make exactly that distinction feel natural.

The complex social intricacies that form who we are represented by broken glass and echoes of the past
Source: Dalma Ubitz, Canva

Refusing the Framework

Meaningful change cannot be achieved through moral reframing alone. Moving beyond binaries that cast sex work as either empowerment or exploitation, effective public health requires structural shifts: decriminalization, voluntary and confidential testing, and barrier-free access to prevention tools such as PrEP. Evidence from New Zealand, where sex work was decriminalized in 2003, demonstrates improved health outcomes when sex workers can access care without fear of arrest, deportation, or judgment. STI rates among sex workers there declined, while rates of condom use and regular testing increased, not because attitudes changed, but because barriers were removed. (New Zealand Prostitutes Collective, 2025)

De-stigmatization is not about moral approval. It is recognition that systems built on surveillance and punishment generate the harms they claim to prevent. When healthcare is accessible without judgment, transmission decreases across all populations. The benefits extend beyond sex workers: when anyone can seek testing without shame, public health improves broadly (Dijkstra & Tydeman, 2025).

Shame after an STI diagnosis comes from history, policy, and public health systems that learned to govern sex through blame. These systems made certain bodies and sexual choices visible as risky long before biology explained infection, teaching people to read diagnosis as moral meaning. A rights based approach treats STIs as ordinary medical events and shifts attention from individual guilt to the structures that shape vulnerability.

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