Left out in the cold

The extreme unmet health and service needs of street sex workers in East London before and during the COVID-19 pandemic

EXECUTIVE SUMMARY

Introduction

> **"It would be nice to go somewhere to feel normal and not be judged or looked at differently as a non-member of society. I'm still human, my choices might not be to everyone's liking, but at the end of the day, I'm not hurting anyone. I'm doing what I am doing because I am on drugs."**

Sex workers are identified as a priority population for addressing health inequalities in the UK, but they often report widespread stigma in health services and are rarely consulted in their development, despite growing emphasis on community involvement in health. Some sex workers, particularly those who work on the street, rely heavily upon specialist health and support services that can respond to their needs and schedules on their terms. In recent years, such services have faced extensive cuts, increasingly replaced by 'exiting' services, which prioritise stopping selling sex. These cuts have been made against a backdrop of more sweeping austerity cuts to housing and welfare and ongoing police and immigration enforcement targeting sex workers.

Recent research carried out by the London School of Hygiene and Tropical Medicine (The East London Project: https://eastlondonproject.lshtm.ac.uk)found that women who sell sex on-street in East London experience intense enforcement and high rates of violence from partners, clients, police and others, such as strangers and residents, but have little access to justice. They also experience stark inequalities in physical and mental health compared to other groups of sex workers and the wider population.

In 2019, a long-standing specialist sex worker health and support service lost its funding to work with street sex workers in the London borough of Newham – a service that many had described as essential to securing support to deal with these needs. That same year, Doctors of the World UK (DOTW), a medical charity that works to ensure access to healthcare in the UK and abroad, relocated its East London clinic to the area. DOTW commissioned research to ascertain the impact of the specialist service's closure, and the health and service needs of street sex workers in Newham.

The purpose of research

The study reported on here used a participatory, qualitative approach led by two academics – one of whom has lived experience of street-level prostitution – to identify participants' health and welfare needs and priorities as they saw them and drive action. It sought to identify, from participants' perspectives:

- **their unmet health and support needs**
- **current and required service accessibility, acceptability and quality, and related social/ structural barriers**
- **and models of service delivery that would support them to access health and social support services, including through advocacy and referral.**

Method of data gathering and analysis

Researchers conducted a qualitative consultation exercise to investigate the health and welfare needs of women who sell sex on street in Newham. They used qualitative methods to generate rich data about participants' needs, priorities and realities.

Interviews took place on seven occasions between September and November 2019. To find participants, the research team drove along Romford Road between 12-6am – when street sex workers were most likely to be there – approaching women working on the road and asking them if they were willing to participate in the study. They interviewed women they had met during previous research in the area, as well as some they had not met before. Women received £40 for participating and information on local services.

On a separate occasion, short interviews and a small informal focus group were held with four women by arrangement with an earlier participant. These interviews were complemented by consultations with representatives from a small number of health and support services that women mentioned, formerly and currently working with sex workers in Newham.

A month after the main report was submitted, with publication imminent, the UK went into lockdown due to the COVID-19 pandemic, and it was deemed necessary to produce a COVID-19 related addendum. In October 2020, one of the researchers carried out additional consultations with women while conducting outreach with a DOTW nurse, to assess how their needs had changed since the pandemic had begun.

Overview of findings

In total, researchers carried out 37 consultations with women who sell sex on-street in Newham – 17 women during the research in 2019 and 20 on outreach in 2020, 11 of whom took part in initial consultations. In 2019, they also consulted with five people who currently or had recently provided health and social support services to them.

Although the researchers did not set out to focus exclusively on women, everyone they consulted with identified as such to them. No participants described themselves as trans or talked about gender-affirming healthcare.

Ranging in age from 21 to 51, participants broadly reflected the racial and ethnic diversity of the borough, with Asian British, Black African, Black British, East European, Irish Traveller and white British women represented. Most had grown up in or near London. Many were mothers but none was currently living with their children.

This section provides an overview of women's needs as they described them to the researchers, and the related services that they recommended and needed. It offers two snapshots in time and space for a group of women selling sex on the street in Newham. It does not reflect the vast diversity of needs, priorities and realities among people who sell sex across different locations and sectors, nor does it capture changes in street sex work environments and communities over a long period of time.

September-November 2019 findings

Changing landscape of specialist sex worker health and support services

Women described feeling less supported since the long-standing specialist service had lost its funding. They also discussed a now-closed drop-in service that had been specifically geared towards their needs, describing how vital it had been to them and how they missed it.

A service provider noted that they did not see women they knew to be street sex working now that the previous specialist service no longer accompanied them to the GP practice.

While the former service was defunded in an apparent effort to amalgamate various support services that already existed in Newham, the replacement service had not previously worked with sex workers and was commissioned with an emphasis on helping people who want to 'exit' sex work.

The new service had not begun regular outreach at the time initial consultations were conducted, which left women selling sex on the street with very little access to support over at least a five-month period, a concern that researchers were told had even been raised by police locally. As a result, women described no current provision for their most basic and immediate necessities, including condoms and food.

These changes occurred against a far broader range of local authority cuts to housing, domestic violence, and other services.

Childhood, parenting, the care system and multigenerational trauma

Many of the women interviewed during the initial consultations described their and/or their children's experiences of being taken into care.

Interviews revealed a strong theme of sustained, multigenerational trauma and loss, as women who had experienced trauma, violence, and the care system in their childhood – and some who had not – had their own children removed from them by social services.

> **"I was in care my whole life. I was born in Newham, but I was taken away from my family [as a very young child] ... My mum ran away [two years earlier] ... my dad is a paedophile, and I was abused by him and his brother [from then onwards]."**

Twelve out of 17 women were or had been parents, one describing having suffered multiple neonatal deaths. None of their 28 children was currently in their custody.

Just four women mentioned having good relationships and regular contact with their families, and many described feeling very socially isolated.

Violence in adulthood

Nine out of 17 women disclosed that they had been victims of violence perpetrated by people with whom they were not intimately involved. Several had experienced violence while working or in connection to their drug use, by clients and/or dealers.

> **"I was burnt from head to toe with cigarettes by dealers I owed money to. I have never had counselling. I write poems and stuff to get it out of my head."**

One woman described how inhumanely she felt treated by social services after she was raped and gave birth.

Eleven women also mentioned violence by an intimate partner. One described how this had resulted in her children being taken into care, and three described how partners had used violence, manipulation and abuse to coerce money from them, which they had earned selling sex. For some, their homelessness exacerbated their dependence upon violent (ex-) partners.

Few women talked about reporting the violence that they had experienced or having received any counselling for this. During previous fieldwork, the researchers had found that women working on the street often lacked access to the internet and/or smartphones to make reports directly to charity National Ugly Mugs (NUM) and relied on support services to help them do so.

Homelessness and sleep deprivation

Fourteen out of 17 women described themselves as homeless, predominantly street homeless and sleeping rough. Only three had stable (rented) accommodation. Vulnerability, abuse, trauma, and homelessness were closely connected. Of these 14 women, 10 mentioned having experienced partner violence, 13 having either grown up in care or had abusive childhood experiences, and nine women reported all of these experiences alongside being homeless.

The women who were homeless slept in a variety of places, such as doorways, stairwells, bin shelters and, for five women, 'tent city' – a collection of tents behind a local shopping centre. Sleeping rough presented many problems for women, one of which was theft, and many only possessed the clothes they were wearing, despite the cold weather. Housing and clothing were described as top priorities.

Many women were suffering from intense sleep deprivation, which they attributed to drug use, fear of theft or attack, and nightmares about abuse and trauma they had experienced.

Drugs and addiction

Fifteen out of 17 women used crack cocaine and/or heroin addictively and daily. Several women also used other drugs such as illegally purchased benzodiazepines and pregabalin. Just two of the women interviewed, both migrants, did not use any drugs except for nicotine.

Participants described long-term drug use, generally starting in their mid-teens. They talked about their dependence on using as a coping mechanism that allowed them to function and live with longstanding trauma, homelessness, and violence. They also discussed the debilitating effects that using had on their physical health, and the emotional pain of subsequently losing children and relationships.

Women who described themselves as having drug addictions reported being in poor physical health generally but attributed certain conditions – such as hepatitis, abscesses and, in the case of two women, heart attacks – directly to chronic drug use. They explained how this also impacted their ability to be selective about their customers and increased their exposure to violence, exploitation, and police enforcement.

> **"It's not safe out there. I don't know whose car I am jumping in. If this man is going to kill me. You just don't know... I've been strangled, taken to a spot where five men jumped out. I've been raped, and that affected my using badly."**

Most women were interested in stopping or controlling their drug use. A number had previously tried drug treatment and described difficulties accessing drug and alcohol services.

Mental health

Most of the women interviewed described untreated and often concurrent mental health issues, including depression, anxiety, panic attacks, paranoia, post-traumatic stress, personality disorder, fits and hallucinations, self-harm, suicidal ideation, and attempts. Women linked these primarily to trauma, loss, violence, and homelessness, and often described their drug use as self-medication.

The two women who did not use drugs described experiencing some level of stress, anxiety and/or depression, one profoundly so.

Despite high levels of trauma, experienced both historically and at the time of consultations, none of the women interviewed were receiving any help to deal with the intense anxiety, stress, and depression that they described. Every service provider that researchers consulted with noted a severe lack of services to address mental health needs and substance use concurrently.

> **"I'm alright when I am on medication, but I haven't been on it for a long while. Because of domestic violence, I fled from [hometown] and came here...I see things, hear things... I want to go to sleep and not wake up anymore. Twelve months ago, I tried to hang myself."**

Physical health

Most women said their physical health was poor. Fourteen out of 17 described multiple severe conditions, some of which had been diagnosed before they became homeless, including severe osteoarthritis, Parkinson's Disease, and epilepsy. Others described concerns they considered less debilitating such as benign tumours and polycystic ovary syndrome. Just two women, neither of whom used drugs, described their physical health as good.

Aspects of women's lives and histories mean they could be vulnerable to tuberculosis (TB) and 10 women mentioned respiratory problems. Given that Newham has the highest rate of TB in London and London has the highest rates of TB in the UK, there is a need for prompt action.

Many of the women interviewed also reported hunger and malnutrition and were very thin with several describing significant weight loss. Ten mentioned that they did not menstruate, which could be connected to poor nutrition, low body weight and stress, particularly given the age range of participants.Several women had not eaten for between one and four days, while others predominantly ate snacks rather than meals. Few had access to any cooking facilities, and two women mentioned that they relied on food handed out by homeless charities.

Access to primary and secondary care

Although many of the women interviewed mentioned having a GP or having visited one within the last few years, most had not seen a doctor recently and/or were unable to make appointments because they conflicted with the timing of their drug use and withdrawal. Five out of 17 women did not currently have a GP in the UK.

Women described challenging encounters with mainstream health and social services and the incompatibility of rigid appointment systems with their schedules, and a lack of outreach services – all of which the previous service in Newham had helped them to navigate before losing statutory funding.

A number of women described disliking and/or avoiding mainstream healthcare services because of feeling judged by doctors and other staff – amid broader blame by, and exclusion from, mainstream society – and often did not access such services as a result. Several women mentioned Accident and Emergency as their most recent contact with healthcare.

> **"The doctors judge as much as the police do... they don't say anything, but it's their whole demeanour, they are a bit off. You can tell they are thinking if you hadn't put yourself in this situation, it wouldn't have happened. It's like you deserve it. You bought it on yourself. They don't necessarily say it, but you know that's what they are thinking."**

Few women mentioned accessing sexual healthcare in recent months and four said they had what they considered or suspected was an STI. Given that no outreach in the area currently offers STI testing, and a number of women mentioned a lack of access to condoms since the previous service's outreach had ended, there are concerns that existing conditions will worsen based on previous experiences. None of the women interviewed talked about medication to prevent or treat HIV.

Most women did not have a dentist, but many felt that they needed dental care. Thirteen described substantial dental health problems, often accompanied by pain, which is likely to indicate severe dental problems given most used heroin daily.

October 2020 findings

Health and housing

As with the initial consultations, most women consulted with after the COVID-19 pandemic had begun described chronic physical and mental health concerns and pain. Again, they often linked these to drug injection, trauma, loss, violence and homelessness.

Respiratory issues were once again raised frequently, with 13 women describing symptoms that worried them. None of the women reported having had COVID-19. However, one woman had been told that she could not get treatment for a chronic health condition until the pandemic had passed.

The COVID-19 lockdown has somewhat altered women's living situations. Only three of the 14 women who described themselves as homeless during initial consultations were still sleeping on the street. Although most were not rough sleeping, accommodation was precarious, with only one woman in secure and long-term accommodation.

Hunger was also still an issue; six women described not having eaten in the past 24 hours. Others were only able to access food through food banks, prison, or customers.

Although the affordances of temporary accommodation meant that women housed in hostels did not describe suffering from issues around sleep deprivation that had been featured so significantly in the earlier findings, the accommodation they were temporarily housed in was problematic, exposing them to violence and others' drug use while trying to stop using, and negatively impacting on their mental health.

Policing

All the women mentioned that they had either observed or directly experienced much higher levels of policing since lockdown had begun. This is corroborated by police data, which shows higher levels of policing for 'anti-social behaviour' in Newham and surrounding boroughs at this time. Women reported that the overall policing they were experiencing was very intense and, on occasion, led to incarceration.

One woman described being fined twice for being out during lockdown, despite being homeless, and on the day she was consulted with, had been stopped and searched by police for no apparent reason other than they knew her to be a drug user and a sex worker.

Two migrant women described particularly harsh and discriminatory policing. One described how she was stopped by the police and asked if she was being trafficked; when she said no, they arrested her for soliciting. Another told researchers that the police had called her a "bitch" and told her to go home.

Three women had been imprisoned during COVID-19 but for very short periods. Given that prisons have been severely impacted by the pandemic, the use of prison for sentences that are so short (indicating a lack of perceived severity on the part of the judiciary) and for women who have so many underlying health issues needs to be redressed urgently. Women also mentioned they had observed police officers not wearing face masks during their interactions.

Violence

Thirteen out of 20 women mentioned that they had recently been the victims of violence, ranging from interpersonal violence from partners to rape by customers and attacks by members of the public.

Despite heightened levels of policing, the focus remained on the misdemeanours and relatively petty offending women undertook. This resulted in women being the victims of much more severe crimes but feeling unable to report them because of mistrust of the police or the sense that they will not be taken seriously.

Outreach services

The most recurrent issue that women mentioned at this time was a lack of adequate outreach. Fourteen out of 20 women had had no contact with any outreach services either since the COVID-19 pandemic had begun or for a considerable time before that. Four women mentioned that they had not seen anyone since the previous service had lost its funding.

Current service provision was described as intrusive, bringing women into contact with the criminal justice system unnecessarily, and removing their agency. For several women, the service offered did not cater to their actual needs but instead catered for their perceived needs.

The situation around women's ability to access sexual health advice, check-ups and condoms has worsened considerably since the initial consultations. Fifteen out of 20 women said that they would like to have a sexual health check as a matter of urgency. Two women, both migrants, requested immediate reproductive health advice to deal with unwanted pregnancies, and two women were experiencing symptoms of possible STIs after sexual violence by customers.

Service recommendations and priority needs

The extreme unmet health and social support needs identified in this report demand intense and rapid cross-sectoral service action, to overcome the exclusion experienced by street sex workers and improve the health and wellbeing of women who are already highly marginalised.

Participants in the initial consultation exercise provided detailed recommendations for the services that they would like to be able to access. These were echoed by women consulted with since the onset of the COVID-19 pandemic and have been outlined in more detail below.

- **A peer-led approach**

  The importance of being able to speak openly with someone with shared experience, and without being judged, was mentioned often by the women interviewed.

  > **"I feel like people look at me and judge. I find it a lot better talking to someone whose been there. That's why I am finding it easy to talk to you. You've been there and know what it's like."**

  This team would need to find ways to maintain supportive and regular contact with women in step with their schedules and lives, in a way that does not feel intrusive or invasive to them. It would also need to be as embedded in the community as possible, to be approachable and not viewed with hostility or apprehension. A service staffed by women as opposed to men was described as preferential by many participants and, given the long history of male abuse that many participants had experienced, could help create a space for them to discuss their needs more intimately with the outreach team.

  Such work can be very emotionally demanding, particularly given the close relationships it involves developing. Trauma-informed, structured, and ongoing opportunities for debriefing and supportive supervision would therefore be essential for the team.

- **Premises and services**

  Most of the women interviewed voiced a preference for a dedicated drop-in centre like the services and hubs provided/facilitated by the previous service. Overwhelmingly it was agreed that late afternoon/early evening would be the most beneficial time for women to access a drop-in. Ideally, a drop-in centre would be part of a hub where it was possible to address the multilevel and often complex needs women described. There is a need to offer medical assistance to women whenever possible, because the combination of addiction, the need to avoid withdrawal symptoms and previous poor-quality care has rendered many women reluctant to attend mainstream health services until unavoidable.

  Given that housing was one of the women's most pressing priorities, it would be of greatest benefit if such a hub had some provision for women to sleep on a short-term basis while longer-term housing was arranged. Such a space would help to address the most immediate threats to women's health and wellbeing. It would also allow women a reprieve from constantly being in the cold and unable to relax because of the stress and dangers they faced on the street. It could also go some way to tackling the judgement and social isolation that women described feeling.

  While women voiced a strong preference for a drop-in, they also highlighted the importance of outreach workers who could connect with them where they work and provide basics such as warm clothing, food, drink, condoms, and hygiene-related items. Most felt that outreach should be by van (rather than on foot) and that this should either be unmarked or generically labelled without any reference to sexual health or sex work. Such outreach should run in conjunction with, not instead of, a drop-in.

A peer outreach team could make use of existing resources and infrastructure to provide medical treatment for acute health issues and offer confidential screening. This would need to be followed by more in-depth support to help women deal with the chronic health issues they described. This situation is likely to be best achieved by arranging to accompany women to a drop-in clinic in the first instance, from late afternoon onwards, or to other services where fast-track, short-notice access can be facilitated on a similar schedule. However, this is a bare minimum and would not address the underlying trauma, homelessness, substance use, violence and linked severe physical and mental health problems that women have described in these consultations.

- **A trauma-informed, holistic approach**

  Local-authority commissioning of services for women who sell sex has often focused on the sex-working aspect of their lives, whether from a sexual or public health perspective, or a singular focus on 'exiting' – without necessarily acknowledging women's broader needs, realities, and priorities. Similarly, other services are commissioned with a focus on substance use, violence and homelessness, respectively.

  Yet many of the women interviewed described these aspects of their lives in connection to unresolved trauma. The trauma that women often described medicating with drug use to alleviate emotional pain made it extremely difficult for them to access healthcare independently. This also contributed to further trauma as they were exposed to high levels of violence, in the course of street sex work, drug use and in their personal lives.

  Addressing women's expressed needs holistically and in collaboration with them presents an opportunity both to facilitate their access to good quality, respectful care and to support the healing process needed to halt the multigenerational trauma that many described. The high levels of trauma and abuse that women told researchers about should be addressed as a matter of urgency. Addressing their extreme mental health needs is also likely to give them the respite needed to address their drug use in the way that they decide, on their own terms.

  It would only be ethical to offer this if women also have a safe place to process their feelings. However, failure to address the trauma experienced by women is likely to do little to address the homelessness, addiction, pain, health concerns, and intergenerational trauma that they described. All health and support services for this community must be trauma-informed, unconditional, and led by women's own expressed needs and wishes.

- **Timescale and planning**

  Given the severe and urgent unmet health and welfare needs women described in these consultations, the ongoing cuts to specialist and wider services, and the decline that women have reported in their health throughout this and previous research, this work would need to start immediately. It will be crucial that any new service is carefully planned, with potential service users' input, and communicates clearly to them what it will be offering.

Conclusion

The women who took part in these consultations are highly marginalised and described extreme unmet physical and mental health needs, in line with previous research and assessments. While most women consulted with since the COVID-19 pandemic had begun were no longer street homeless – compared with 14 out of 17 women in the initial consultations – most were precariously housed in temporary and often problematic hostel and hotel accommodation. It is highly likely that a change in COVID-19 regulations will mean that they will be sleeping on the streets once accommodation provisions end. For this reason, the findings from the initial consultations remain highly relevant.

All the women were involved in street-level sex work, and most described themselves as addicts. Each of these factors has implications for women's physical health, exposure to violence and mental wellbeing. In the context of experiences of unstable or abusive childhoods, partner violence, and separation from their children, many of the women described long-standing and unresolved trauma. They described judgement and inflexibility in mainstream services and an absence of adequate outreach since the former specialist service had lost its funding.

Immediate intervention is required. In the best-case scenario, this would be a hub where temporary housing was offered, and women could be assisted to access the help they needed from different agencies. This includes housing, drug services, physical and mental health services, domestic and other violence counselling, legal advice, and support to report violence/crimes against them via NUM, particularly for those who do not have internet and/or smartphone access to make reports directly.

The next best scenario would be a drop-in centre open at night and where women could access basics such as food, washing facilities and clothing, and securely store their belongings. This could act as a hub to coordinate the delivery of essential services.

In the context of heightened enforcement and women's experiences of current service provision as intrusive, it will be essential that service users are made fully aware of any requirements to report screening results to health authorities before they are offered testing, including in relation to COVID-19, particularly where there are concerns that such information could be shared with police.

The provision of fixed-site services would need to work in conjunction with an outreach service that could supply condoms, food, clothing, and other essentials. At the very minimum, there needs to be a shelter where women can take a break from the street and get access to food, warm clothing and washing facilities, talk to staff about their health needs and receive assistance in accessing good-quality, respectful health and support services.

Based on women's expressed preferences and the research team's experiences of participatory research with them, it is recommended that each of these services is staffed by a peer-led team with similar lived experiencesto those with whom they would be working. It will be essential to build on the experiences of other peer-led projects, and services such as the previous specialist service, that work with people who sell sex to address their most pressing health and support needs on their own terms. Given the high levels of trauma women described, it is essential that any new service is trauma-informed, unconditional, and led by women's own expressed needs and wishes.

Ongoing service development and advocacy

Building on these consultations, it is vital to establish ongoing opportunities for sex workers to participate in service development, monitoring and evaluation, through formats, at times and in spaces that are accessible and acceptable to them, and with adequate compensation. Assessing the languages most frequently spoken and hiring staff who speak these languages and/or working with appropriate interpreters will also be essential to assess the changing needs of women selling sex on the street in the area and ensure that the service is as accessible as possible.

There are also opportunities, through supporting women to meet their needs, to facilitate a space in which they can come together and have direct contact with health decision-makers and policymakers. The researchers urge DOTW to use these consultations and their ongoing engagements with people who sell sex and other service providers to advocate for adequately funded health and support services that respect sex workers as people, and listen to what they want and need unconditionally, as well as advocating against harmful policies, practices and discourses that criminalise and stigmatise sex workers and other marginalised communities to which they may belong.

There are many other groups of sex workers who may benefit from DOTW's services but whose needs are likely to be very different from those reported on here, including sex workers operating indoors, trans and male sex workers. It is essential that any future service development aiming to serve these communities occurs in full consultation and collaboration with them.

Executive summary prepared by Kimberley Vlasic on behalf of Doctors of the World UK, with support from report authors Rachel Stuart (University of Kent) and Pippa Grenfell (London School of Hygiene and Tropical Medicine).

To view the full report, Left out in the cold: The extreme unmet health and service needs of street sex workers in East London; Rachel Stuart (University of Kent) and Pippa Grenfell (London School of Hygiene and Tropical Medicine), visit:

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