

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

A report for *Doctors of the World UK*

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Background

The UK's 'Inclusion Health' agenda, which advocates social justice approaches to health inequalities, identifies sex workers as a priority population (1). However, current commissioning guidelines do not fully account for sex workers' diverse needs and the structural factors that compromise their health (2). Sex workers report widespread stigma in health services but are rarely consulted on their development, despite growing emphasis on community involvement in health (3). Some sex workers, and 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, amid frequent stigma and stringent requirements in mainstream services (4-8). In recent years, specialist services have faced extensive cuts, increasingly replaced by 'exiting' services that prioritise stopping selling sex (9). 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 (6, 7, 10).

Doctors of the World (Médecins du Monde) is an independent international movement that aims to empower excluded people and communities to claim their right to health through innovative medical programmes and evidence-based advocacy, while fighting for universal access to healthcare. *Doctors of the World UK* (DOTW) is part of the *Médecins du Monde* network, which has expertise and experience in supporting sex workers across the world. DOTW has been a registered charity in England and Wales since 1998 and runs clinic and advocacy programmes that provide medical care, information, and practical support to people unable to access NHS services, opening its first clinic in London in 2006.

In July 2019, DOTW relocated its clinic to Stratford, in the East London borough of Newham, and began operating fixed-site and mobile clinics in this and other parts of London. Aware of the cuts mentioned above, DOTW commissioned a consultation with sex workers in the area, to identify unmet healthcare needs and inform efforts to fundraise for any new service required. Through these consultations, we 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.

In April 2019, a long-standing specialist sex worker health and support service lost its funding to work with street sex workers in Newham, having lost funding to work with indoor workers in the borough in 2017. Six years earlier, the service had conducted an assessment of the needs of street sex workers in the borough to inform a then-new outreach and case management service. They identified two communities in need of their services: British women who were primarily homeless and used heroin or crack, and Romanian women (16% of whom were Roma) who were precariously housed and typically did not use drugs (11). The primary concerns they identified for the former group were homelessness, violence (by strangers and partners) and drug use, whereby a lack of housing was,

'systematically entrenching women in Newham in violent and chaotic situations' (11, p.15). The assessment stressed the need for service flexibility around women's lives and schedules, and case management – meeting women in community environments, accompanying them to health services and advocating for improved care and treatment.

For the Romanian women they worked with, lack of proof of address made it challenging to access GPs and other health services, but during the assessment two women had been supported to access a GP service locally, in one case through referral to DOTW's Project London. This group of women was also keen to take up sexual and reproductive health services at clinics run by the service in local hospitals. A number of women had reported incidences of violence at work via *National Ugly Mugs* (NUM), a charity that supports sex workers to report violence and crimes against them, anonymously if they wish, and to receive warnings about violent perpetrators. Women also described the detrimental impact that violence, financial insecurity and pressures, and constant police enforcement had on their mental health (11).

Women who sell sex on-street in East London continue to experience high rates of violence by partners, clients, police and others (6, 7). They have little access to justice, experience intense enforcement, and stark inequalities in physical and mental health (compared to other groups of sex workers and the wider population) (6, 7). Since funding was cut, women in Newham no longer have access to the specialist service described above – one that many have described as invaluable in securing support to deal with these needs (6).

Because of our awareness of this situation and the new location of DOTW's clinic, the decision was made to focus these consultations on the experiences and needs of street sex workers operating in Newham. We used a participatory 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 to drive action (12-14). Participatory methods can help to ensure that communities are involved in shaping knowledge-generation and actions that affect them. It can also provide insights into issues that members of marginalised communities may not be willing to share with researchers with whom they do not have shared lived experience. We sought to move beyond the polarised debate surrounding the meaning and governance of sex work/prostitution to focus on the lived experiences and expertise of women selling sex, through a lens of social justice (13).

Methods

We conducted a qualitative consultation exercise to investigate the health and welfare needs of women who are engaged in street-level prostitution¹. We used qualitative methods to generate rich data about participants' needs, priorities and realities. Although we did not set out to focus exclusively on women, everyone we interviewed identified as such to us. We did not ask participants directly about their gender identity but none of the women we interviewed described themselves as trans nor did they talk about gender-affirming healthcare. In our recent research, we have met very few trans women, and no men (cis or trans) or non-binary people, selling sex on street in the borough.

We conducted a series of interviews (typically 30-60 minutes) with women, over seven occasions between mid-September and late November 2019. On six late nights/early mornings (12-6am) – the

¹We decided to use the term 'prostitution' here, after considerable discussion between us about the controversy around its use, for two reasons. First, this is the term that women often used themselves during interviews, so its use keeps the report as close as possible to women's narratives. Second, author RS seeks to reclaim the word 'prostitute' from those who use it to denigrate women selling sex in person. At other points in the report, we use the terms 'sex work', 'sex worker' and 'selling sex', which some participants also used.

times at which we had seen and met most street sex workers in our previous research – two researchers (RS together with PG or one of two other freelance co-researchers) drove along Romford Road in Newham, approaching women working on the road, telling them about the consultation and asking them if they were willing to participate. We had budgeted for face-to-face interpreting, particularly anticipating the need for Romanian language skills. However, we did not ultimately meet any women who wished to be interviewed via translation (see 'Participants in these consultations' for further discussion).

We contacted women while they were working because, in our previous research, participants had been receptive to being interviewed during quiet periods and we had little success arranging interviews during the day due to their competing priorities. To build on our existing links and to make the best use of the resources and time available, we began by interviewing women we had met during our previous research in the area (East London Project <https://eastlondonproject.lshtm.ac.uk/>). As we progressed, we started to meet women we had not encountered before. On a separate occasion, we conducted short interviews and a small informal focus group with four women on a weekday afternoon, arranged by an earlier participant who contacted RS because of her desire to find help for herself and her friends.

All interviews and the focus group were conducted in a nearby fast-food restaurant by RS, with PG or one other freelance co-researcher present. We bought women a meal and soft drink of their choice, explained the project and sought their verbal consent (or written consent if they preferred) before beginning the interview, taking care to sit at a quiet table where the conversation could not be overheard. We sought verbal consent to avoid completion of written consent forms being off-putting given the time pressures women were under, and we assured women of the anonymous nature of the consultations. We offered participants £40 in recognition of their time commitment. We also offered them information about DOTW and other appropriate health and social support services in the area, drawing on resources compiled and connections made during our previous research in the area. We offered to accompany women to any health or support services they needed and/or put them in direct contact if they wished. These consultations were conducted per safety and ethical guidelines that we and others have developed for conducting outdoor night fieldwork with people who sell sex (6, 7, 15).

During interviews, we asked women about their health and related social support needs, and experiences of accessing healthcare and welfare services, recently and in the past. Led by women's narratives, this variously generated discussions around their physical, mental and dental health; drug use; violence, abuse and trauma (recent and historical); housing, welfare, social services, food, justice and legal advice. We also asked women directly what they thought DOTW and other services for sex workers should comprise, who should deliver such services and in what setting. We audio-recorded interviews with participants' consent and took detailed notes from the recordings (time and budget constraints precluded transcribing interviews verbatim in full). We organised notes into key themes with linked illustrative quotes (verbatim), using Microsoft Excel and Word. After each fieldwork session, RS and PG debriefed to discuss any pressing ethical and safety concerns and participants' referral needs, and the main emerging themes. Participants' names in this report have been replaced with pseudonyms to protect their anonymity. In some places, we refer only to 'participants' or 'women', without pseudonyms, to avoid deductive identifiability based on the extent of detail provided about participants' experiences.

Over the same time period, PG conducted consultations (30-60 minutes) with representatives from health and support services that women mentioned, formerly and currently working with sex workers in Newham.

This consultation exercise received ethics approval from the London School of Hygiene & Tropical Medicine (LSHTM) ethics committee.

Participants in these consultations

We interviewed 17 women who sell sex on-street in Newham and consulted with five people that currently or have recently provided health and social support services to them. Broadly reflective of the racial and ethnic diversity of the borough, interview participants included two Asian British women, one Black African woman, one Black British woman, three women of East European ethnicities, one Irish Traveller and nine white British women. Most of the women who took part in these consultations were raised in East London (7) or surrounding counties outside of London ('Home Counties') (7). Three women had grown up overseas, two in East Europe and one in West Africa². Women's ages ranged from 22 to 45 (median age: 33 years).

Although a more extensive study would have generated more in-depth knowledge, these consultations provide insights into the experiences and needs of a diverse and highly marginalised group of women with extreme unmet health and support needs, most of whom have sold sex and/or lived in the area for many years (see below). We provide an overview of participants' needs as they described them to us and the related services that they recommended and needed. We also summarise broader information that women chose to share with us about their lives because it offers critical current, historical and inter-generational context to their health and wellbeing. We include women's descriptions and direct quotes about their experiences of extreme structural and direct violence, including abuse, loss, physical and sexual assault, trauma and suicide.

Sometimes researchers opt to exclude such details out of concern that they could be gratuitous or further 'other' street sex workers. However, we decided to include women's narratives of these issues because they voiced them in discussions around their most pressing needs and concerns. It is crucial that participants' narratives are not misused to advocate for or justify policies that are harmful to them and to other sex workers, such as those that criminalise them, their clients or their workplaces (6, 7, 16), or that render service access conditional upon leaving sex work (see below) or mandatory so as to avoid criminal justice involvement (17) – the damaging effects of which fall most heavily on street sex workers (6, 7, 16).

Qualitative methods aim to identify *diversity* of experiences rather than how *representative* these experiences are within a particular community. Where we state how many women described a particular experience, this should be taken as an indication of how often participants talked about these experiences, not as statistically representative of women selling sex on the street in Newham (or elsewhere). Furthermore, because women's narratives led us during interviews, we did not ask all participants directly about all needs reported on here.

It is also important to note that this consultation exercise reflects a 'snapshot' in time and space, for one group of women selling sex on the street in this borough. It does not reflect the vast diversity of needs, priorities and realities among people who sell sex across different locations and sectors (6, 7, 18-20), nor does it capture changes in street sex work environments and communities over time. For example, during consultations we saw very few women working on a street just outside of Newham where previously many of the women we had met were migrants. This followed intensive, sustained police, immigration and local-authority enforcement on this particular street (6, 7).

²We do not specify home country to avoid deductive identifiability.

Since we were tasked with identifying the most pressing health and support needs that participants were experiencing, this is where we place most emphasis in the report. However, this emphasis does not mean that the experiences or needs of those mentioned by a minority of participants, or needs that may be less severe or pressing, are not also extremely important.

COVID-19 Context Addendum Prepared by Rachel Stuart

A month after the main body of the report was submitted, with publication imminent, the UK went into COVID-19 related lockdown, and it was deemed necessary to delay publication of this report until a COVID-19 related addendum could be included. Therefore, over a period of four nights in mid-October 2020, a small team of two, one of the original researchers (an academic with a history of sex work and addiction) and a nurse employed by DOTW were contracted to conduct outreach with women working on Romford Road in Newham, to assess their current needs and inform DOTW's ongoing and future service provision. During outreach, we conducted 20 consultations and gave everyone we encountered condoms as well as offering them an opportunity to engage with the services offered by DOTW. The outreach nurse then followed up with the women we met and coordinated medical assistance where they were willing and able to engage. As per the original consultations, women received £40 in recognition of their time commitment.

Given that the fast-food restaurant we had previously used for interviews was closed because of COVID-19, we conducted the majority of consultations on benches outside the restaurant, per DOTW protocols on COVID-19 secure working. This arrangement was less physically comfortable than the restaurant environment, and also offered less privacy. The warmth of the restaurant meant that women would linger, and we were better able to explore the highly personal and often profoundly distressing experiences they shared with us. Consulting with women outside the restaurant meant that we were often interrupted by other people living on the street and passers-by, and it was more challenging to explore some of the more harrowing aspects of women's lives that were captured in the initial consultations. We also conducted three consultations in a hostel that was housing single homeless women and where a number of the women who took part in this research lived, again per DOTW COVID-19 secure working protocols. Despite these challenges, we were still able to gather essential information about women's current needs, primarily because of the ongoing relationships the original research team has developed with the community, which DOTW is attempting to assist.

As with the initial consultations, we encouraged women to discuss issues they were experiencing rather than responding to specific questions. We synthesised the information gathered in the same way as the initial consultation exercise.

Similarly to initial consultations, the women we spoke to broadly reflected the racial and ethnic diversity of the borough, including three Asian British women, one Black African woman, one Black British woman, three women of East European ethnicities (Romanian and Romanian/Roma), one Irish Traveller and 11 white British women. Women's ages ranged from 21 to 51 (median age: 31 years). Mothers were significantly represented: half of the women mentioned they had children, and in total, they had 21 children. The three Romanian women had six children between them, all being cared for by their families in Romania whilst they earned money to send back to support them and other family members. The other 15 children were either in the care system or with women's family members; none was currently domiciled with their mothers.

This is not a longitudinal report with the women that were interviewed previously; we consulted with women we encountered as we walked and drove along Romford Road. However, 11 women had taken part in the initial consultations and they have been further anonymised by being given new pseudonyms to avoid deductive identifiability.

It is important to note that like the original consultations, this addendum reflects a 'snapshot' in time and space, for one group of women selling sex in one location, over the space of a week. It does not reflect the vast diversity of needs, priorities and realities among people who sell sex across different locations and sectors (6, 7, 18-20). Once again, women led the discussions; we sought to identify the most pressing health and support needs that they were experiencing, and this is where

we place most emphasis in this addendum. Therefore, we begin the addendum findings with a brief overview of women's overall health and the affordances that COVID-19 has had on housing. We then explore the issues that women mentioned as being most pressing and having the most impact on their health and wellbeing, namely policing and a lack of outreach support (see 'Findings, Addendum').

Findings

Changing landscape of specialist sex worker health and support services

It is essential to place these consultations in context. As described above, a long-standing specialist sex worker health and support service in Newham lost its funding in 2019. In June of that year, an organisation that specialises in working with women who have experienced violence but had not previously worked with sex workers was commissioned to work with people who want to 'exit' sex work. At the time of the initial consultations, the new service had not begun outreach except accompanying homeless and drug and alcohol services to inform them of their new service, having been occupied thus far with recruitment, training and planning. Although the service now describes recognising the need to work with people who sell sex whether or not they want to 'exit', a number of the women we spoke to mentioned missing the previous specialist service and said that this had not been replaced at the time these consultations were being conducted.

[The new service] is an outreach, but they aren't as good as [the previous service] were.

[The previous service] would come round with condoms, hot food and drinks. With [the new service] it's a two-minute conversation... [The previous service] felt friendlier. [The new service] got funding before they got staff and they don't do food. — **Abbey**

Commenting on their experience of supporting street sex workers who used drugs and wanted to stop selling sex, one service provider was critical of services that focused singularly on 'exiting' without understanding or supporting what women needed and wanted in order to make this possible:

So much needs to be in place to be able to [stop selling sex], if they [women selling sex] want or are able to. If you've got nothing to base a recovery on, an outreach worker who says they will help you exit – can they get you clothing, a warm bed to sleep in that night? — **Service Provider**

A number of women talked explicitly about the high financial cost of their drug use. The two women who did not use drugs were migrants who had recently been studying at university or would soon start doing so, one talking directly about working to fund her studies. A few women talked about how, if they were not working to pay for drugs, they would either stop working or would opt to work indoors, for example in flats or saunas, which one woman had done previously but described her Class A drug use as preventing her from doing so now. It is also important to note that leaving sex work is not necessarily a singular moment or linear process (21); sometimes people transition in and out, and sometimes they alter how much they work depending on other sources of income, commitments, needs and so forth.

Women also talked about a now-closed drop-in service that had been specifically geared towards their needs. They described how vital that service had been to them and how they missed it now that such a facility was not available for them to access.

There used to be something just up the road. We went there religiously every Monday and Wednesday. They had a change of clothes, showers, food, someone to talk to about housing and drug issues. It was only for a few hours, but all the girls went there. If you wanted to sleep for a couple of hours, you could do your washing, and no men were allowed. — **Gemma**

There was a drop-in centre in Capital House that opened at nine at night and closed at 12am, and every single working girl was in there. They lost the funding, and they closed it down. It was condoms, showers, clothes, and it was bloody brilliant. — **Becky**

A number of service providers stressed the importance of offering women support on their own terms, based on what they expressed as their most pressing needs. On outreach, the previous specialist service had provided condoms, hot food, drinks and, where possible, clothes and sleeping bags. They had also supported women to access mainstream health and support services, for example, liaising with the borough's transitional care team to secure access to GPs the morning after outreach visits and accompanying women to their appointments (see 'Access to Primary and Secondary Care'). This system had worked well when services accommodated drop-in appointments at short notice but less so in those with fixed, advanced-booking appointment systems such as hospital-based antenatal care. Crucially, the previous specialist service had also supported women to access housing, benefits, drug and alcohol services, dental care, independent sexual violence advice, fast-track referrals for partner/domestic violence support, legal and immigration advice, and support through the criminal justice system, including making reports to National Ugly Mugs (NUM). They had also worked in collaboration with a local drug and alcohol support service to help women access the treatment they wanted, and provide integrated drop-in services at 'hubs' in the area, where women could also see healthcare staff – a service that several participants described as being of particular benefit. Without this arrangement, access to drug and alcohol services was now restricted by fixed appointment times that did not necessarily accommodate women's schedules (see 'Drugs and Addiction' and 'Access to Primary and Secondary Care'). At the time of these consultations, the new specialist service for sex workers was not working with NUM in the way that the previous specialist service had done.

A service provider we spoke to from the borough's transitional care team noted that they no longer saw the women they knew to be street sex working now that the previous specialist service no longer accompanied them to the GP practice (see 'Access to Primary and Secondary care'). The team had not yet had contact with the new specialist service, and other service providers noted that the organisation had not been evident thus far. The new service was commissioned in an apparent effort to 'amalgamate various support services that already existed in Newham... [into] one provider offering support around... domestic abuse, sexual violence and sex working' (Service Provider). However, women selling sex on the street were left with very little access to support over at least a five-month period, a concern that we were told had even been raised by police locally. This loss of services was mentioned frequently but its impact was articulated particularly starkly by Becky when she shared that 'if it wasn't for you guys, we would just be forgotten about'. While driving around searching for participants, we distributed condoms to whomever we encountered working. The women who took part indicated that, at that the time of these consultations, there was very little outreach work being undertaken.

These changes occurred against a far broader range of local authority cuts to housing, domestic violence support and other services. One service provider's account highlighted how an argument often used to oppose the provision of harm reduction supplies (e.g. that giving condoms to sex workers 'promotes' sex work (22)) was being extended to homelessness. A participant at a recent 'homeless prevention strategy meeting' had voiced a concern that handing out tents and warm clothes

might 'promote rough sleeping' (Service Provider). Pointing out that specialist services were increasingly voluntary-sector funded, one service provider made a case for renewed and increased public spending: 'if there were [greater local authority] funds available for this work, it would more than pay for itself'.

Before we describe women's health needs and recommended service provision in more detail, we summarise what they told us about other aspects of their lives that provide important context to their current needs.

Childhood, parenting, the care system and multigenerational trauma

Many of the women we interviewed described their and/or their children's experiences of being taken into care. They detailed how the intervention was related to violence and trauma. Six of the women we interviewed mentioned that they had themselves been through the UK care system at some point, and one woman³ described a traumatic adoption.

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].

My mum is a working girl, and I was raised by my nan from [when I was a baby]. I went into care [when I was a young teenager]... cos my nan couldn't handle my behaviour.

I was sexually abused by my real dad [for 10 years, from being a young child to a teenager]... He got seven years in jail... Then I met my kid's dad and went on to suffer 10 years of physical, emotional and sexual abuse from him.

Although qualitative research does not aim for statistical representativeness, this is clearly disproportionate relative to the estimated less than 1% of children in England in care in 2017 and 2018 (23, 24) – statistics that themselves mask extreme inequalities between poor and wealthy families and areas (25, 26). When coupled with the number of women (seven out of 17) who described family abuse during their childhood, it became clear that many of the women we interviewed had experienced severe trauma in their early years.

Interviews also 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. Twelve of the women we interviewed were or had been parents, one describing having suffered multiple neonatal deaths. For 11 participants, their children were either in the care system (five women), being cared for by family members (three women), or a combination of the two (three women). Several women mentioned that, although they were able to have visits with their children, they were not currently doing so because of concerns about their children's wellbeing. In total, the women we interviewed had given birth to 28 children, none of whom were currently in their custody. Three women had children whose family life was impacted further because siblings were separated from each other, as well as not living with their birth mothers. Three women described having one or more children in care and/or adopted, and one or more living with their father or her mother. One woman described the intense pain she feels having learned that her daughter had been suffering from family sexual abuse similar to that which she had experienced as a child:

I found out last year that my [very young] daughter was abused by her grandfather [for several years]... It's the worst pain I've experienced in my life. It's why I smoke the white. I can't deal with what's in my head when I think about her because I handed her over to him because of what was going on in my life.

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

One service provider mentioned a project that works with women who have experienced the trauma of having multiple children removed from their care. The service provider described this as a tailored

³Where we do not use pseudonyms, this is to avoid participants being deductively identifiable.

service that works with women in Newham and other areas to meet their diverse health, support and welfare needs, but that also asks them to commit to long-acting, reversible contraception while they are engaged in the project to allow 'time to put the right things in place' (Service Provider). They also mentioned that some midwives had been reluctant to engage women in such discussions soon after birth, conscious of how distressing this might be. None of the women we interviewed mentioned this service nor talked in detail about contraception, so we do not know their perspectives on the project. It is vital that women are offered information on and can access appropriate contraceptive options, including long-acting forms, with sensitivity to the trauma of having children taken away that they may have experienced. It is also vital that there are equivalent services available for women who do not wish to take up long-acting contraception.

Violence in adulthood

In light of our previous research in the area (6, 7), we anticipated that women were likely to be experiencing high levels of violence. Not wishing to traumatise participants, we allowed conversation to develop naturally and discussed only what they felt comfortable sharing. Nine women disclosed that they had been victims of violence perpetrated by people with whom they were not intimately involved. In the previous week, one woman had been threatened physically by another sex worker's boyfriend. Several other women discussed violence that they had experienced while working or in connection to their drug use, by clients and/or dealers.

I was working in a flat a while back. I had a gun put to my head and was put in the boot of a car. 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, having been homeless for the majority of her pregnancy and left with no accommodation once she agreed to have the baby adopted.

I had a baby... I was raped on-road, and she was the result of that. I didn't exactly know if she was my boyfriend's or from the rape. I carried her anyway... Social services came in four hours after I gave birth and took her off me. They could not even wait a day... I was homeless for the first seven months of the pregnancy and then social services paid for a hotel. They let me stay there until I signed the adoption papers.

Eleven women also mentioned violence by an intimate partner. One woman's children had been taken into care earlier that year because of the violence that she sustained from her partner, and which her children had witnessed. Another woman detailed that she had suffered extreme violence that worsened after leaving her partner:

I was with someone for a year. I have only just got out of that with him. He would give me proper beatings... He was beating me, raping me and stamping on me. He was beating me when I was with him, but then when I left him, that's when I properly got it. He used to intimidate me so much that I would have sex with him so that he wouldn't beat me.

Three women, all of whom had grown up in or near London, described how partners had used violence, manipulation and abuse to coerce money from them, which they had earned selling sex.

My boyfriend, who was saying that he loved me but was being a sly pimp... I didn't do what he wanted one day, and he beat me up... It all went wrong, and I ended up [with life-altering injury].

My ex-partner used to send me out to fund both of our habits. He is still about. When I see him, I hide. I was with him for 15 years.

The accounts of several women demonstrate how homelessness can exacerbate the vulnerability of women who are experiencing partner violence. One woman, for example, describes how not having a stable address meant that she was unable to open a bank account. She was therefore still in contact with and dependent upon a former partner who had been both physically violent and emotionally abusive:

My benefits go into my ex's account cos I haven't got my own bank account, so he has control of my money... he has control over me.

Few women talked about reporting the violence that they had experienced or having received any counselling for this. During previous fieldwork, women we met working on the street had often lacked access to the internet and/or smartphones to make reports directly to NUM and relied on specialist services to support them to do so.

Homelessness and sleep deprivation

Fourteen of the women we interviewed described themselves as homeless, predominantly street homeless and sleeping rough. Vulnerability, abuse, trauma, and homelessness were closely connected: of these 14 women, 10 mentioned having experienced partner violence, and 13 having either grown up in care or had abusive childhood experiences. Nine women reported each of these experiences alongside being homeless. Two women were in precarious housing, one was living in a refuge following partner violence, and another moves from hostel to hostel. Three women, Halley, Kelly and Lisa, were living in rented accommodation.

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. Gemma described having bandages stolen from the tent where she sleeps. Candy had all her clothes stolen and was wearing flip flops when we interviewed her on a cold October night. Halley described not having anywhere to store possessions when she was homeless: 'I've lost so much stuff cos I hide it behind bins and the bin men take it.' Ten women mentioned that they only possessed the clothes that they were currently wearing, an issue exacerbated by the weather becoming colder.

I've got my blanket with me, and I've got two or three jumpers on. In some of the stairways, it's quite warm, but some of them are really cold. — **Jane**

One of the service providers described how this left those with ulcers and open wounds nowhere to store dressings; they highlighted a need for services to provide secure storage facilities that women could use.

Many women described intense sleep deprivation. Erin was frightened to sleep because, in the past, she has not only had possessions stolen but had also been violently attacked while sleeping. Sleep was an issue mentioned by 11 women; for some, like Gemma, drug use meant they were awake for extended periods: 'I will stay awake for four days then sleep for 24 hours in the tent or a punter's house.' One woman had not slept adequately since she had come out of prison four days ago, an experience also described by another woman who had been homeless since being released from prison nine months previously: 'I will find a block and just sit in the bin sheds.' For Ellie, Nicky and Paula, nightmares about abuse and trauma meant that they avoided sleep:

Sometimes I don't sleep for days till the point that I feel so ill that I fall asleep walking. Sometimes I am so tired, but I don't want to sleep cos I have bad dreams. Like now, I am so tired. — **Ellie**

I have these dreams about my kids and wake up crying my eyes out. — **Nicky**

When I go to sleep, I get nightmares... I wake up crying and shaking. — **Paula**

The impact of a profound lack of sleep on health has been well documented, particularly for rough sleepers (27). Sleep deprivation is associated with diseases such as obesity, heart disease and diabetes; it also affects the immune system and the body's ability to heal itself (28). Homeless women in England and Wales experience extreme health inequalities and an average life expectancy of 43 years, compared with 45 years for homeless men and 81 years for women in the general population (29).

A number of women described housing and clothing as top priorities. One service provider described how previous cross-borough service agreements had helped to get women 'housed locally and onto a script'. However, when funding was restricted to women with perceived low and medium needs, women they worked with who sold sex on the street began to be housed further away, at times in different cities. Many ultimately came back to Newham, because that was where 'everyone they knew was' (Service Provider) and started sleeping rough again. The service provider discussed how conditional access to housing also left some of the women they worked with 'set up to fail, by the system, even one that's supposed to be supporting them'. One of the women, as part of her service-level agreement with a hostel, had to agree that she would not go to the location where she had been selling sex and ultimately lost her accommodation because she had carried on working. The woman's key worker in the hostel had told the service provider 'she doesn't want your condoms, you don't need to work with her anymore' but the woman herself had explained 'I'm still working, just not telling them' (Service Provider).

Drugs and Addiction

Fifteen of the women we interviewed described themselves as using crack and/or heroin addictively and daily. Several women also described using other drugs such as illegally-purchased benzodiazepines and pregabalin.

I'm using day and night constantly. I'm on 150 [pounds] a day minimum... crack, heroin, weed, benzos, pregabs everything. — **Candy**

Women described long-term drug use, generally starting in their mid-teens. Thirteen of the women who described using addictively were homeless, 12 had grown up in care and/or had an abusive childhood, and 10 had experienced partner violence; nine had all of these experiences. They talked about their dependence on using as a coping mechanism that allowed them to function and live with longstanding and on-going trauma, homelessness and violence. They also talked about the debilitating effects that using had on their physical health, and the emotional pain of subsequently losing children and relationships.

If I don't have heroin, I struggle to do things. I need heroin to function like a normal person. — **Abbey**

I am ready to die. I can't stop using. I chose drugs over my children. I am so guilty for leaving my kids. My hygiene is terrible. When I do a proper toilet, I have blood coming out my bum. I'm so not well. — **Debbie**

Women talked about how they felt their using 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.

I get banged up for breaking CBO ['criminal behaviour'] orders. I'm not allowed in certain areas. I'm not allowed to carry paraphernalia. I've breached it four times. I got sent to prison last week for having a crack pipe on me. I got six days and walked out homeless. Why would I want to be drug-free out here? Why would I not want to be out of my face?

I haven't got my own place, but I have somewhere I stay sometimes. I think if I didn't have crack or drugs, I wouldn't be there very long. It's not a crack house, but I benefit him. Mentally he is very abusive.

Women who described having drug addictions reported being in poor physical health and attributed certain conditions directly to chronic drug use, such as hepatitis, abscesses and, in the case of two women, heart attacks. Some women, such as Gemma, also described using to self-medicate for trauma, emotional and physical pain.

The nature of the interviews – conversational rather than questioning – meant that we did not ask women directly if they wished to stop using drugs because we did not want to appear judgemental or imposing. Instead, we asked women about the services and support that they wanted and needed. Because one of the researchers (who conducted the interviews) is a recovered addict who is also a former street prostitute, women were remarkably frank in describing their drug use, how it had affected them and what they would like to do about it, if anything. Six of the women we interviewed did not want to give up using but wanted to be able to control their using and stated that they would like to get onto a methadone script. Just one woman described currently taking methadone regularly. For some women, they had tried this and felt that it had not worked for them. Three women described wanting to try a detox, and nine women mentioned that they would like to go to rehab.

A number of women talked about their prior experiences of drug treatment and accessing drug and alcohol services. Fiona, for example, described being unable to get onto a methadone script because of her life being 'so chaotic'. Paula described how the schedule of her drug use and sleep stopped her being able to attend her appointments at a local drug service. Abbey felt that her previous experience of rehab had not worked because the service had not been able to address her concurrent mental health problems. Service providers emphasised the importance of supporting women to access substance use services and treatments that they wanted and felt ready for, on their own terms.

The previous specialist service's collaboration with the local drug service that Paula described had helped women to access drug and alcohol services by accommodating their schedules and co-locating drop-ins (see 'Changing landscape of specialist sex worker health and support services'). One service provider also described how one woman they had worked with had felt 'harassed, pressured and bullied' by another drug service, which continually contacted her to monitor her whereabouts and timing. Service providers described the lack of services equipped to address concurrent substance use and mental health problems, which we discuss in more detail below (see 'Mental health').

Two of the women we interviewed did not use any drugs except for nicotine.

Mental health

Most of the women we 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, and suicidal ideation and attempts. Women linked these primarily to trauma, loss, violence, and homelessness, and often described their drug use as self-medication.

My drug use and homelessness have caused a lot of mental health issues. I never used to be like this, running around on nervous energy. — **Halley**

Women who sleep rough suffer high rates of mental ill-health, and women who experience mental health issues are also more likely to rough sleep for sustained periods or repeatedly (30, 31). One woman, who experiences auditory hallucinations, described how she first became homeless 20 years ago in her late teens when her mother died. Another woman, who described feeling suicidal, was currently sleeping in the tent city and had been homeless for 15 years. One woman described how her anxiety increased when she was unable to use in prison. Two of the migrant women we interviewed 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 these consultations, none of the participants were receiving any help to deal with the intense anxiety, stress, and depression that they described suffering from:

I would like counselling because when my anxiety creeps up on me, and I don't know how to deal with it, I get really bad... Three years ago, I got sectioned. — **Becky**

Eight women mentioned previously having been prescribed medication for mental health conditions, including anti-depressant, anti-anxiety, and anti-psychotic drugs, but none were currently taking these. Just three women mentioned having received counselling, two in a drug service, but this was typically one-off or short-term. Many women said that they would like to receive counselling, but this would need to be gradual and ongoing. One woman, for example, worried about having to confront painful memories of violence and trauma. None were currently receiving any mental healthcare.

All service providers that we consulted with noted a severe lack of services to address mental health and substance use needs concurrently. Mental health services would only accept patients once their drug use was 'stable', until which point they would be seen in substance use services. By contrast, drug and alcohol services were unable to support women with mental health diagnoses since their 'primary need was mental health' (Service Provider). One service provider felt that this would best be addressed by strengthening referral pathways between these services, but that this would only be successful if coupled with a service like the previous specialist sex worker health and support service that had strong relationships with women and could accompany them to appointments.

Eleven of the women we interviewed explicitly mentioned having ever felt suicidal or attempted suicide, despite not being asked about this directly. Seven of these women were homeless, used drugs daily, and had experienced abuse or the care system in childhood and partner violence in adulthood. A number of women said that they had 'given up' or were 'ready to die':

I am ready to die; I'm like a saggy old lady. I am absolutely disgusting; blokes stop and drive off. I want to go home. — **Debbie**

I've had Hep C for 16 years. I'm turning yellow from time to time. I think I've given up, to be honest. — **Gemma**

One woman, who was currently homeless having fled partner violence, described having attempted suicide after her mental health dramatically deteriorated when she was not on medication.

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 see people who aren't there. I get to the point where I can't take it anymore; I want to go to sleep and not wake up anymore. Twelve months ago, I tried to hang myself.

One woman described having attempted suicide by taking four boxes of paracetamol. Another talked about having overdosed several years ago on paracetamol and, accidentally, on zopiclone.

Four years ago, I took an overdose of 48 co-codamol. They are paracetamol based, and they said I had caused a lot of liver damage and may need a transplant. Before that, I took an accidental overdose of zopiclone, so I was already fragile.

Given high levels of violence, abuse and trauma experienced by women who have become homeless (32), it is vital to consider how a lack of treatment for these traumatic events may impact on women's mental health, including overdose and suicide. Recent national statistics estimate that overdose and suicide accounted for 40% and 12% of all deaths among rough sleepers in 2018, respectively, and a 55% increase of drug-related deaths since 2017 (29). Given that it is difficult to ascertain with certainty whether death by drug overdose is accidental or intentional, the rate of suicide among people experiencing homelessness may be higher.

Physical health

Most of the women we interviewed said their physical health was poor. Fourteen women described multiple severe conditions, some of which had been diagnosed before they became homeless, including severe osteoarthritis, Parkinson's Disease and epilepsy, while others described concerns they considered less debilitating, such as benign tumours and polycystic ovary syndrome. Just two women, both migrants who did not use any drugs except nicotine, described being in good health.

A number of women reported chronic pain and/or health issues that they linked to their diet (see below), being homeless, a lack of opportunities to wash, and drug injection, including skin ulcers, abscesses and infections, and Hepatitis C. Most women were not receiving regular treatment for these conditions.

Women made frequent references to chest and respiratory issues. Again, it should be noted that we conducted interviews in a semi-structured fashion and encouraged women to discuss issues they were experiencing rather than responding to specific questions. Ten women specifically mentioned respiratory health problems.

I am coughing up black stuff on a regular basis. In the morning, it is pure black and thick... last year I was lying on my back sleeping and my lungs filled up with mucus, and I couldn't breathe, I called an ambulance, and they put me on a nebuliser for an hour, which broke it up. When I coughed it up, it was disgusting. I feel like there is something seriously wrong with my lungs. — **Nicky**

My phlegm is black. when I wake up in the morning, I am always coughing up blood. — **Paula**

Now the weather is getting colder it's not going to be good for my chest. Last year I got sharp pains in my back and chest. — **Candy**

Aspects of women's lives and histories also meant that they could be vulnerable to tuberculosis (TB) (33): of the 10 women who mentioned current respiratory health problems, six women were homeless, identified themselves as addicts and had been in prison, and four women mentioned two of these factors. Of the seven women who did *not* mention current respiratory problems, all mentioned at least two of these factors, and two mentioned all three. One woman who sleeps in the tent city voiced a direct concern about this:

I found out from the nurse that comes out that one of the men in the tent city has got out of hospital with live TB. He looks grey; it's going to spread.

Tuberculosis is contagious and airborne and among the leading causes of death internationally (34). TB is exacerbated by poverty, malnutrition and food insecurity. People who inject drugs experience elevated TB prevalence due to factors such as poverty, homelessness, imprisonment, HIV infection, malnutrition, and lack of access to healthcare (33, 35). Given that Newham has the highest rate of TB in London (36) and London has the highest rates of TB in the UK (37), there is a need for prompt action.

Many of the women we interviewed also reported hunger and malnutrition:

I haven't eaten today (Sunday). I haven't eaten since I came out of prison on Wednesday. — **Becky**

A number of women had not eaten for between one and four days and – except for those in rented accommodation – many others predominantly ate snacks (such as crisps, chocolate and sweets) rather than meals. Few had access to any cooking facilities, and two women mentioned that they relied on food handed out to people experiencing homelessness by charities in Stratford. Many of the women we interviewed were very thin, and several described significant weight loss. One woman, for example, had lost over five stone in the past three years and now weighed seven stone. Another woman mentioned having lost half her body weight over two years to 40kg. Ten women mentioned that they did not menstruate. While some linked this to their drug use, amenorrhea can also be connected to poor nutrition, low body weight and stress (38), particularly in the age range of participants.

Access to primary and secondary care

Most of the women we interviewed mentioned having a GP or having visited one within the last few years. However, most had not visited them recently and/or were unable to make appointments because they conflicted with the timing of their drug use and withdrawal. A number of women considered the care they received to be inadequate or of poor quality, and some described attending only to collect repeat prescriptions or supplies for wound care.

Five women did not currently have a GP, one of whom had attended recently in her home country but would like a GP in the UK. Six women mentioned having attended one of two GP practices in the borough run by the transitional care team, for people unable to get registered with a GP for any reason. One service provider described how sex workers' access to this practice has been impacted by the loss of funding for the previous specialist sex worker health and support service in Newham, with whom they used to work in collaboration.

The biggest change is that we see very, very few sex workers now... almost always when we were working with [the previous specialist service] we would only see the sex workers when they came in with a [previous specialist service] key worker... Often it was at the drop of a hat, so we'd get a call in the morning when they'd often picked them up on a night round and tried to persuade them to wait until the morning to come and see a GP... We just had a regular day... and we'd just block off a few spaces in the morning so that if

they did come in with someone, we could see them straightaway... Often what we found, even if they came in and we were booking them for appointments later in the day or another day, they just wouldn't attend again after that, so we had to do it like a drop-in clinic, and that worked well for a good while... but since they [the previous specialist service] pulled out of Newham, it all stopped. — **Service Provider**

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.

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. — **Abbey**

Several women mentioned Accident and Emergency (A&E) as their most recent contact with healthcare, with one woman explaining that she had fled when told that her leg would need to be amputated because of the extent of her ulcer. A number of women described particularly bad experiences in mainstream hospital services and A&E:

My leg was really bad, so I went to the hospital; I hadn't slept for a few days, and I knew I had to get it sorted. I kept falling asleep. I had fashioned my own dressing, but they couldn't get off. It was really hurting me, and because it was hurting, I was screaming. The doctor got the hump and pulled it off. I crashed out cos I had been awake for days. They got security to throw me out. I had been awake for days, and they said you are just there to sleep. I couldn't believe it.

Although 10 women described their sexual health as good or did not mention any particular symptoms or issues, few women mentioned having accessed STI check-ups in recent months, and some described the difficulty of attending fixed-site clinics:

I had a check recently, and that was bloody hard work. I haven't got a doctor in the area. The nearest sexual health clinic to here is Newham General. It's not like there is anywhere local. It's Plaistow, not that far really, but it is when you ain't got no money to get there.

Four women mentioned that they had what they considered or suspected was an STI, two explicitly mentioning BV (bacterial vaginosis) because of what they described as an unpleasant smell. Given that no outreach in the area currently offers testing for STIs, and a number of women mentioned a lack of access to condoms since the previous specialist service's outreach had ended, there are concerns that existing conditions will worsen based on previous experiences (9, 39, 40). None of the women we interviewed talked about medication to prevent (PrEP) or treat (anti-retrovirals) HIV.

For a number of women, including three of the eight women who had ever had a cervical smear test⁴, the only time they accessed sexual healthcare was when they were in prison.

I last had a smear test when I was in prison [eight months ago]. I have had abnormal cells and laser treatment when I was in prison before.

⁴Three women mentioned never having had a smear test.

Thirteen women described substantial dental health problems, often accompanied by pain. Given that 12 of these women used heroin daily, the fact that they could still feel this pain is likely to indicate severe dental problems (41). Most women did not have a dentist, one woman directly noting that she could not afford to see one, but many felt that they needed dental care.

COVID-19 context addendum - Prepared by Rachel Stuart

Health and housing

Similarly to the initial consultations, the majority of women we consulted with since the pandemic had begun described their physical health as poor. A number of women reported chronic pain and/or health issues that they linked to drug injection, including skin ulcers, abscesses and infections, and Hepatitis C. Eight of the women described having longstanding medical conditions, including sciatica, asthma, ADHD, Asperger's, COPD, carpal tunnel, autism, severe osteoarthritis, septic arthritis, partial blindness and heart abnormalities. Most women were not receiving regular treatment for these conditions. Women were still also experiencing ongoing respiratory issues, as highlighted of concern in the initial report, thirteen women describing symptoms they were worried about. None of the women reported having had COVID-19. However, one woman described having been told that she could not get treatment for a chronic health condition until the pandemic had passed.

Again, similarly to the initial consultations, the majority of women we interviewed described having untreated and often concurrent mental health issues, including depression, anxiety, self-harm, bipolar disorder, personality disorders, suicidal ideation and attempts. Women linked these primarily to trauma, loss, violence, and homelessness, and often described their drug use as self-medication. Women also linked these mental health conditions to their drug use because while they were using they were also exposed to trauma and violence. Of the 20 women that we interviewed, 17 identified as addicts and were working to support their drug use. The three women who took part in these consultations and did not identify as addicts did not describe experiencing issues with their mental health or anything other than routine health issues.

Women's living situations had somewhat altered since the pandemic had begun. Of the 20 women interviewed, only three were still street homeless. While the majority of women were no longer rough sleeping, accommodation was precarious. Two women were living with a parent; one woman was being housed in a hotel; nine were living in hostels. One woman had a council property in a county near East London, however, she was scared to go home because her ex-partner was there and she was frightened of him, and so she was sofa surfing and on occasion sleeping rough. Three women, all Romanian nationals who did not use drugs, were renting in the private sector. Only one woman had secure and long-term accommodation. She resided in a neighbouring borough and was a former rough sleeper who had been housed with the help of a homeless charity in direct response to the COVID-19 pandemic. Hunger was also still an issue; six women described not having eaten in the past 24 hours. Two women mentioned that they were getting food from food banks, one woman had started to eat regularly because she was staying with a customer, and two had been able to eat regularly because they had been in prison until very recently.

The affordances of temporary accommodation meant that women did not describe suffering from issues around sleep deprivation that had been featured so significantly in the earlier findings. However, the accommodation they were temporarily housed in was described by a number of women as problematic. At the start of lockdown, Kirsty was provided with temporary accommodation in a local hotel but within a few days of arrival, she had been badly beaten by a drug dealer who was also temporarily housed in the hotel. Consequently, Kirsty was moved to a hostel as a safety precaution. Several days later, the same man was moved into the hostel and Kirsty had to be moved again, this time to an all-women hostel. Kirsty described how the man was eventually evicted for hitting another woman.

Frankie described how she lived in a hostel that was home to several other addicts; being in such proximity to people who are continually using made her fear that she would never be able to 'get clean'. This dependency threatens her residency; the staff have threatened her with eviction because she is not engaging with them. She felt so desperate about her situation that several months ago she attempted suicide. Etta was housed in a local hostel three months ago, as a consequence of contracting pneumonia. Although the police had moved her on numerous times throughout lockdown – she had been sleeping in a local phone box – no attempt had been made to house her until she was hospitalised. Despite now being temporarily housed, her mental health is very poor. On a number of occasions, she has told us about a horrific gang rape she suffered in the past.

The three women who described themselves as street homeless told us they had been sleeping rough throughout the lockdown; one of the women had been moved into a local hotel well-known as a place where sex is sold, but she described the conditions as so 'squalid' that she has moved from the hotel into a van that is parked in an alley. Zara described being so tired that she had passed out on a piece of grass locally during the day in August, tending to sleep at this time because it was safer (the day before we met, her trainers had been stolen as she slept). She got such bad sunburn that she was hospitalised; the area where she had fallen asleep was by a very busy public road, but she had not been approached or offered help and had to call an ambulance herself. She has yet to be offered even temporary shelter, despite having resided in the borough for the requisite two years demanded by the local council before they will consider her for housing.

Policing

All the women that we spoke to mentioned that they had either observed or directly experienced much higher levels of policing since lockdown had begun. Higher levels of policing for 'anti-social behaviour' are documented in Newham and surrounding boroughs in publicly available police data (42). This gives a sense of how much policing has intensified since the lockdown and other COVID-19 measures were introduced.

Six of the women we spoke to described being given written dispersal orders. The police told them that the written warnings they were given by hand were anti-social behaviour orders (ASBOs) and if they were stopped three times, they would be liable to arrest; a consistent theme that all the women who had received the orders described. The legitimacy of these orders is unclear; the women we spoke to were adamant that they were ASBOs. However, ASBOs were abandoned in 2014 in favour of several other dispersal and community order legislations (43). One woman we spoke to, Frankie, described being given an ASBO and a community protection order within the space of a week. She was informed by the police that she is no longer allowed on Romford Road between 6pm and 8am, despite needing to use this road to reach her home; all the women who had been given written warnings had been told the same thing.

Frankie claimed that the ban was for a year. The police told her that the third time they see her, they would arrest her. Jade told us that although she had been given three orders, the police did not seem to log them into their system because they were unaware that she had been issued a warning previously. Two migrant⁵ women described particularly harsh policing. Teela had been stopped by the police and was asked if she was being trafficked; when she replied in the negative, they arrested her for soliciting. She was the only woman who mentioned being arrested for

⁵We do not specify nationality here to avoid deductive identifiability.

soliciting since the COVID-19 pandemic had begun. Stelah told us that the police had called her a bitch and told her to go home.

Women reported that the overall policing they were experiencing was very intense and on occasion, led to incarceration. Jade described being fined twice for being out during lockdown despite being homeless. The day we interviewed her, she had been stopped and searched by the police for no apparent reason other than the police knew her to be a drug user and a sex worker. She described the humiliation of being forced to empty her bag, which contained condoms, in the middle of a busy shopping area. Three of the women had been imprisoned since the pandemic began; these incarcerations were for very short periods; in the case of Kirsty, she received an eight-day sentence for breaching her tagging order. Leah was given a 14-day sentence for failing to surrender but ultimately served four days. Given that COVID-19 has impacted prisons severely (44), 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. Another issue women mentioned was that police did not appear to be observing government guidelines when interacting with them; six women mentioned that they had observed police officers not wearing face masks during their interactions.

Violence

Given the graphic nature of the violence that women described previously and the lack of mental health provision for women at present, we decided to keep the consultations focussed on the current issues that women were experiencing. Thirteen 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.

I got attacked by a bloke the other night, one of the smokers who hangs around waiting for the girls to come back with money. He asked me for business, and I said no to him, and he attacked me right outside [major supermarket]. It was five o'clock in the morning, just getting light, people were at the bus stop, nobody even done anything, not even picked up the phone. Look my eye's not healed, he fucked me up good and nobody done anything, not even picked up the phone. I don't know how you could make it safer for girls when we ain't supposed to be doing it. — **Helen**

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.

I was out of it on zopiclone and pregabs. I was knocked out, and I came round, and the geezer was in me, and I was like 'what the fuck are you doing', and he just ignored me. He is a schizophrenic, and he was scaring me, I was like 'get off me please' and he wouldn't get off till he had finished. I told the staff at the hostel where he was living, and the police come, but I got scared cos it had been more than 24 hours, and I had washed myself so many times that there was no DNA left, and because he is schizophrenic, they aren't really going to take my side are they? I'm a working girl, that's what I thought.

Outreach services

The most recurrent theme in the second series of consultations was a lack of adequate outreach. Fourteen of the women we spoke to 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 specialist service had lost their contract to work with street sex workers in Newham, one woman mentioning that the only people she had seen giving out condoms were ourselves during consultations. Six women had engaged to varying degrees with the new service commissioned to work with street sex workers in June 2019. However, women who had encountered outreach workers described how they did not have any provision for supplying condoms and so had to buy them *ad hoc* for women who requested them:

I met a group of women who seemed helpful at the time. They said they were from... [the new service]. I met them outside Sainsbury's, and I randomly asked them if they had any condoms. They didn't have any, but they went into Sainsbury's and bought me a really expensive pack. — **Kirsty**

Other women, Wanda, Penny and Natalie, had encountered the new service recently but had not been offered condoms. Although the outreach worker who had engaged with Penny had asked if she used condoms, she had not offered her any.

Four women highlighted specific concerns about their encounters with the service. Kirsty described how the actions of certain service providers had caused her distress and had unnecessarily brought her into contact with the police.

I signed some paperwork they wanted me to sign. I just wanted to score, to be honest, and so I signed their paperwork, and I never saw them again. Then after a couple of weeks they started calling the hostel I was living in and when they couldn't contact me, they filed a missing person report to the police. I went mad. I want nothing else to do with them. If they are going to do things like that, I don't want to engage with them. It was inconvenient, and I was outraged. An outreach [worker] that had met me once and I never met again to do that; they only had my contact details cos I gave them my details. They spoke to the hostel who said they would pass on the message, so I am obviously alive and well. They didn't explain that to me when I signed their paperwork. If they had, I would not have signed. — **Kirsty**

Wanda told us about a similar experience; she had not been offered condoms and described her encounters with the service as intrusive:

I came out of prison a couple of weeks ago, and I am staying at my dad's house, so I gave her [project worker] my dad's number, and she was asking me if I feel safe there. She was asking me if I need to get away – why would you need to get away from your dad's house? She wanted me to say something negative about my dad, and that really upset me. I found that really negative. You should not say anything about my dad. They phoned my dad a few times, and they told him they were going to report me missing to the police. We had made this agreement that we were going to talk once or twice a week, and I didn't engage with them. When you report someone missing it's because nobody has seen them, and my dad told them he had seen me. You don't report me missing just cos I haven't kept up my agreement with you to speak to you twice a week. She was ringing me all the time, and it was driving me mad. I thought it was strange and scary. In the end, I went to [specialist support service in neighbouring borough] and got condoms from them. I miss

[previous specialist service in this borough]. [Previous service project worker] was awesome. — **Wanda**

For several women, the service offered did not cater to their actual needs but instead catered for their perceived needs.

I had to walk all the way to... train station [1.5 miles away] today to meet [project worker] cos she wanted to talk to me. So, I'm thinking this has got to be important, or it's something that's going to help me... I couldn't believe it, she just wanted to know things about me, she did ask me if she could do anything to help. I said yes, get me on a proper [methadone] dose, and she was like OK, I will see what I can do. She didn't even offer me something to eat. I am really, really badly needing a pair of shoes, and she said she would buy me some art stuff. I said listen, if you don't mind can we leave the art stuff, but would you mind just buying me something to go on my feet that would cost like 10 pounds, which is nothing really, instead of buying all this art stuff... I said that's going to come to a bit of money and she said no, no that's fine, I've got this. But she didn't give me nothing, no shoes, it's a fucking joke. I don't know what their service is supposed to be doing but it really didn't help me. — **Natalie**

Only three of the women we spoke to had been given condoms. As indicated above, on those occasions, condoms were purchased after women requested them instead of being offered.

I saw [the new service] once before lockdown about eight months ago, by Sainsbury's but not seen them since and I am out every night, but I've not seen anyone. — **Helen**

I've not seen anyone apart from you since [the previous service] stopped. [The new service] never comes out. I have run out of condoms. [The previous service], they used to bring sandwiches and hot drinks and condoms, and since [the new service] took over, I have never seen an outreach car, not once. — **Frankie**

Fifteen of the women said that they would like to have a sexual health check as a matter of urgency, and two women requested immediate reproductive health advice. The situation around women's ability to access sexual health advice, check-ups and condoms had worsened considerably since the initial consultations. Two migrant women we encountered requested help with unwanted pregnancies, and two women were experiencing STI symptoms after sexual violence by customers. One of these attacks was a rape, and one was a surreptitious removal of a condom by a customer.

I had a sexual health check three to four weeks ago because I was attacked, I was raped. The other girl that was raped by the same man caught gonorrhoea. I had the symptoms as well, and when I was tested, it came back negative, and I don't know how that can be true. I was given antibiotics anyway, but now it has started to smell a bit fishy.

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 consultations provided detailed recommendations of the services that they would like to be able to access. These were echoed by women consulted since the COVID-19 pandemic began. Below we outline key dimensions of these recommendations: peer-led staffing; premises and services; a trauma-informed, holistic approach; timescale and planning.

A peer-led approach

During this and previous participatory research in the area, engaging with a researcher with a shared history of street work and, for many of the women we interviewed, addiction, raised a wealth of experiences that women were keen to share. When we returned to conduct these consultations, we were met with an open enthusiasm by women we had met before. The importance of being able to speak openly with someone with shared experience, and without being judged, was mentioned often by the women we 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. — **Jane**

There is nothing worse than someone saying that they know what you are going through, but they do not. To me, it's patronising. You can empathise, but that is totally different to understanding. — **Abbey**

It makes a difference cos you know that person has an idea of what you are going through. — **Candy**

The opportunity to speak openly about health issues was of critical importance to participants, not least given the judgement and antipathy a number of women perceived when they encountered health professionals.

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 brought it on yourself. They don't necessarily say it, but you know that's what they are thinking. — **Abbey**

A number of women explicitly indicated that this shared experience was important to them in terms of whom they would like to deliver services. On this basis, and in order to avoid the tendency to view sex workers' diverse experiences and realities homogenously, we would recommend that a new service be delivered by a team of 'peer' outreach workers with similar lived experiences to the women they are working with, particularly of street sex work. This approach could draw on the successes and challenges of other peer-led advocacy, health and support services for sex workers and people experiencing homelessness, in London and other parts of the UK (45-48). A peer-led service, delivered with empathy and respect, may help overcome women's reticence when talking about issues that are either illegal or typically judged, and their fears of being judged as people in health and welfare services. A peer-led team could both connect sex workers to the numerous services that they need, and act as a known and trusted intermediary between 'service user' and 'service provider'. As women and service providers' accounts show, this team would need to find ways to maintain trusted,

supportive and regular contact with women in step with women's schedules and lives, in a way that does not feel intrusive or invasive to them.

Given that the environment where women work and use drugs is part of a wider street-based community, insider experience of life on the street and within the community would also help to inform how to negotiate other people encountered during outreach. The outreach team would 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 women had experienced, could help create a space for them to discuss their needs more intimately with the outreach team. As one service provider stressed, peer outreach 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 we interviewed voiced a preference for a dedicated drop-in centre, similar to those provided and facilitated by the previous specialist service, but from late afternoon or early evening onwards. As articulated by Gemma, this would need to be in or very close to the area where women worked: 'It would need to be here. If it weren't where you used and worked, people wouldn't go there.' A locally placed centre could help to address the difficulty Candy described accessing healthcare even relatively close to where she works, given her lack of funds to travel there.

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 services until unavoidable. The participant who was reluctant to be admitted to hospital when told that she would need her leg amputated is an important example of this.

Given that housing was one of 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. This is in a context where one service provider had been told to expect a five-year wait for her clients to be given social housing in the borough. Such a space would help to address the most immediate threats to women's health and wellbeing.

One experienced service provider proposed a way in which women's health and support needs could be addressed in a single location:

Set up somewhere where you would have the hook to bring women in – drop-in, food, clothes, get basics met, have a psychiatrist there who's in a position to start the assessment... if it's possible to have a timeline... where you can bring people in... blocked bookings... hopefully with the drop-in you're running. — **Service Provider**

Another service provider described how centring a service around women's immediate priorities, such as housing and benefits, could provide a platform to offer more comprehensive health services in one setting:

A key thing was that they [women] wanted to get their benefits sorted out... almost always they'd need a medical certificate and that would then... open up the doors to everything else they needed help with – their housing, access to benefits... Their health was pretty low down on their priority list, so they'd [previous specialist service] often sell their visit to the GP as being able to

get a sick note, so they'd then be able to get everything else sorted out there and then while they were there. — **Service Provider**

A health professional we interviewed noted that, while immediate basic health needs could be attended to in a mobile clinic, most would require care in fixed sites. In the context of elevated levels of TB in Newham and women's descriptions of their respiratory issues, an existing space, where women's broader physical, mental, sexual and reproductive health and welfare needs are being catered for, could also provide an opportunity for offering screening for these and other conditions.

A drop-in centre would need to work around women's timetable, which for those with addictions is dictated by their need to avoid withdrawing. Overwhelmingly it was agreed that late afternoon/early evening would be the most beneficial time for women to access a drop-in.

I don't get up early, and when I wake up, I am sick and have to sort out my habit. If you could do early evening, say 8-11pm. People go shoplifting at rush hour, but that finishes at about 8pm, but the traffic is too busy on Romford Road till about 10pm so the punters won't stop. — **Halley**

A drop-in centre would also allow women a reprieve from constantly being in the cold and unable to relax because of the stress and dangers they often faced on the street.

To get out of the cold, I sit in phone boxes or come into MacDonald's and drink a cup of coffee. I have a metal pin in my leg from a car crash when I was [a teenager]. The cold makes it really painful, and the other day I went to A&E. My leg was so painful I was crying.

An in-situ drop-in would also go some way to tackling the judgement and social isolation that women describe feeling, including as a result of being estranged and/or distant from family members.

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. — **Abbey**

My mum's moved from [nearby] to [town in county adjacent to London]. My son lives with my mum, and I have never been there in the eight or nine months she has lived there. I need enough drugs to survive up there, or I start withdrawing, and I can't afford for that to happen. — **Candy**

These recommendations also applied to the few women we interviewed who were not homeless and did not use drugs. They described how a drop-in centre would offer a space in which women could have a hot drink, talk, and receive information in relation to their health and other issues, such as legal and immigration advice, without judgement.

Although the women we interviewed 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 (e.g., wet wipes). A peer outreach team could make use of existing resources (e.g., mobile clinics) and infrastructure to offer medical treatment for acute health issues and community-based confidential screening, in collaboration with other services. Homeless health charity *Groundswell's* peer outreach workers, for example, work with University College London Hospital's Find and Treat service to provide community-based TB testing and treatment for rough sleepers in various parts of London (53). Most women 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.

The same team would need to coordinate healthcare and support and accompany women to services at times of day that accommodate their drug use, schedules, and other commitments. This would allow them to advocate for and with women for good quality, respectful and appropriate health and support services.

[If a drop-in is not possible] or even to take them over to Newham hospital where the psychiatrist's based, block out two hours where they could see women. They need case management, need to be linked into GP, some kind of follow up, someone's going to need somewhere to store medication, somewhere to live. — **Service Provider**

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 described.

A trauma-informed, holistic approach

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 we interviewed described these aspects of their lives in connection to unresolved trauma. The trauma that some women described as medicating with drug use to alleviate emotional pain, but which exacerbated homelessness, 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 to both facilitate their access to good-quality, respectful care and to support the healing process needed to halt the multigenerational trauma many described. The high levels of trauma and abuse that women told us about should be addressed as a matter of urgency. Addressing the extreme mental health needs that many women described is also likely to give them the respite needed to address their addiction in the way that they decide, on their own terms. It would only be ethical to offer the type of trauma therapy required if women also have a safe place to process their feelings. However, failure to address the trauma that women have told us about is likely to do little to address the homelessness, addiction, pain, health concerns, and intergenerational trauma that women described. All health and support services for this community must be trauma-informed (46, 49), unconditional, and led by women's own expressed needs and wishes.

Timescale and planning

Given the severe and urgent health and welfare needs women described, 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. As one service provider noted, and as is apparent from women's experiences of recent changes in service commissioning (see above), 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 (11, 50). Although 14 of the women we met during initial consultations were street homeless, the majority (15) of those we consulted with in the second phase were precariously housed in temporary and often problematic 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 we spoke to were involved in street-level sex work, most described themselves as addicts and many had had experiences of unstable or abusive childhoods, partner violence, separation from their children, and multigenerational trauma. They described highly judgemental encounters with mainstream health and social services, the incompatibility of rigid appointment systems with their schedules and a lack of outreach services – all of which the previous specialist service had helped them to navigate before losing statutory funding. Women reported that this service had not been adequately replaced, with no current provision for their most basic and immediate necessities, including condoms and food.

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 would need to include housing, drug services, physical and mental health services, domestic and other violence counselling, legal advice and support, including to help report violence and other 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 services such as basic primary care, sexual health and other confidential and voluntary screening (e.g., TB), substance use services, counselling, dental care, and support accessing housing, welfare, and legal advice and support. 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 essential supplies. 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, where they can 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 our experiences of participatory research with them, we recommend that each of these services is staffed by a peer-led team with similar lived experiences to those with whom they would be working. This could build on the experiences of other peer-led projects (45, 47), and services such as the previous specialist service in the borough, that work with people who sell sex to address their most pressing health and support needs on their own terms (46, 51). Given the high levels of trauma women described, any new service would need to be trauma-informed (46, 49), unconditional, and led by women's own expressed needs and wishes.

Ongoing service development and advocacy

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. Given that the women we met were keen to engage, there are also opportunities for DOTW, through supporting them to meet their needs, to facilitate a space

in which they can come together and have direct contact with health decision-makers and policymakers. We 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. We also urge them to advocate against harmful policies, practices and discourses that criminalise and stigmatise sex workers and other marginalised communities to which they may belong, including: cuts to housing and welfare; criminalisation and enforcement against sex workers, their clients and workplaces, and against people who use drugs and migrants; anti-harm reduction and anti-poverty discourses; and conditional service provision that does not acknowledge sex workers' diverse needs, realities and wishes (10, 16, 17). This would help to address the health inequalities and marginalisation that many sex workers face, and ensure their involvement in decision-making over health services for, with and led by communities, in keeping with a social justice approach (3).

The findings of this report relate to the experiences of a group of women who sell sex on the street and have extreme unmet health and welfare needs. These cannot be assumed to reflect the needs of all current street sex workers in Newham or other areas, not least given the rapid changes that can affect who sells sex where and when. We did not meet many migrants during this short piece of work, which we suspect relates in part to intensive policing in an area just outside of the study area (see 'Participants in these consultations'). By contrast, during our previous research in East London, we met a number of Romanian women working on the street (6, 7). An assessment seven years ago found that Romanian street sex workers in Newham were not typically homeless or using drugs (11) and so had quite distinct needs from those described by most of the women participating in these consultations. In our consultations, five of the six migrant women we interviewed were in temporary or rented accommodation and did not use any drugs except nicotine. They described their physical health as good, but two experienced some level of stress and anxiety (one profoundly). Assessing the languages most frequently spoken and hiring staff who speak these languages and/or working with interpreters, will be vital to assess the changing needs of women selling sex on the street in the area and ensuring that services are as accessible as possible. In order to maximise the space for, and dedicate most resources to, interviews with street sex workers, we only consulted with a small number of service providers. It will be necessary for DOTW to continue consulting and meeting with a broad range of health, support, advocacy and other agencies that work with and represent sex workers in and beyond this area.

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. Previous research, for example, indicated that migrant women selling sex indoors in London were often not registered with GPs in the UK (39). Furthermore, while those working indoors and online do not generally report the same levels of physical and health concerns as women working on the street (7), sex workers across sectors experience discrimination in mainstream physical and mental healthcare services (4, 52, 53). There is also a dearth of specialist health and support services in East London tailored to the needs of indoor-based and independent sex workers, and trans and male sex workers across all sectors, not least since funding cuts to specialist services in recent years. It is essential that any future service development aiming to serve these communities occurs in full consultation and collaboration with them.

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