SEX WORKERS & SEXUAL HEALTH: PROJECTS RESPONDING TO NEEDS

BRIEFING FOR SEXUAL HEALTH TEAM, DEPARTMENT OF HEALTH

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1.1 ABOUT THE UK NETWORK OF SEX WORK PROJECTS (UKNSWP)

The UK Network of Sex Work Projects is a voluntary sector umbrella organization to which projects providing support services to sex workers can affiliate. UKNSWP is a charity which facilitates; networking and the sharing of good practice in the provision of support services for sex workers. The aim of the UKNSWP is:

“To promote the health, safety, civil and human rights of sex workers, including their rights to live free from violence, intimidation, coercion or exploitation, to engage in the work as safely as possible, and to receive high quality health and other services in conditions of trust and confidentiality, without discrimination on the grounds of gender, sexual orientation, disability, race, culture or religion”.

UKNSWP has 60 members projects, and 20 associate members (individuals). Member organizations include key projects for sex workers in many towns and cities with a visible sex industry where specialist services are commissioned. They are staffed by professionals striving to deliver quality services informed by good evidence based practice. Our member projects are offering frontline support services to female and male sex workers throughout the UK, they have direct weekly contact with thousands of sex workers in the UK.

Member organisations are diverse and include; those located and managed within primary care trusts, voluntary sector projects, local authority projects, children’s charities, sex worker led organisations, agencies with a faith based ethos and/or harm reduction and human rights. Some member organisations have sexual health and HIV prevention as a major focus for their work, others have a drugs, sex worker rights, or wider health remit. Protection from violence, promoting safety, housing support, education, alternative lifestyle choices, exiting and the sexual exploitation of young people are also addressed. Many adopt a holistic approach to health and social care needs. Whilst projects have varying remits and work with a range of client groups in different sectors of the sex industry, the majority offer some element of sexual health promotion or care.

Amongst our Associate members are some of the most renowned academics researchers on sex work in the UK.
1.2 WHY TARGETED SEXUAL HEALTH SERVICES FOR SEX WORKERS?

Sex workers’ sexual and health behaviour varies enormously. For some involvement in commercial sex entails no risk of morbidity compared to the general population, and UKNSWP urges organisations not to reinforce stigmatising stereotypes which increase social exclusion and reduce contact with health services. However both research and the experience of targeted services shows that many sex workers do have heightened risk in relation to certain aspects of sexual health. Some also experience other vulnerabilities such as violence, rape and sexual assault, homelessness, drug and alcohol problems which may impact on sexual health needs.

There is a need for targeted specialist services because sex workers still face barriers to accessing mainstream services some of these are listed below:

- Criminalisation: the criminal legal framework surrounding sex work in the UK can make sex workers wary of accessing mainstream services and of disclosing sex working to health services and “authorities”.
- Criminalisation, and associated enforcement, directly impacts on the delivery of health services for sex workers and provides an adverse and challenging context within which to provide such services.
- Stigma and prejudice: fear of judgmental attitudes from health professionals and discriminatory actions can result in non-disclosure of sex work or drug use, so that all appropriate services may not be accessed. For example one project in a major Northern city report that their main GUM clinic recently reported that in 10 years only 23 people using the clinic had identified themselves as sex workers. Others may be deterred from accessing services at all. This is especially so for those who also belong to other socially-excluded groups, such as drug users, the homeless, migrants, and the under-18s
- Cost of travel, rigid opening hours and appointment systems can make access difficult. These factors can be particularly a problem for those people living chaotic lives dominated by drug and alcohol dependency.
- The daily difficulties faced by sex workers who experience problematic drug and alcohol use such as high levels of homelessness can make it difficult for people to access services
- Night-time working and/or the long hours demanded in some indoor establishments may also limit access to “9-5” services.
- Lack of knowledge about free and confidential services: this may particularly affect migrant sex workers who may not have access to service information in their own language.
- Some sex workers who are controlled/coerced/trafficked and or experiencing domestic abuse may be prevented from accessing services
- Previous experience of poor practice
The World Health Organisation (WHO) Sex Work Toolkit (2004) stresses that is important to target sex work settings with HIV prevention and care initiatives. Rationales include:

- In many places, underlying economic and socio-cultural factors cause vulnerability to HIV. These factors may operate indirectly, related to the low status of women, a lack of educational or economic opportunities, and local attitudes to sex and sexuality which create a market for sex work whilst simultaneously stigmatizing those involved in it.
- In addition, the social and legal status of sex work can create situations in which sex workers have little control over the conditions in which they work, and presents barriers to the use of health and social welfare services. At the same time, the stigma and fear commonly associated with HIV contribute to a reluctance to come forward for HIV-related services.
- The internal structure of the sex industry may also increase vulnerability to HIV and hinder sex workers' ability to protect themselves. Sex work can be competitive and isolated, making it difficult to maintain social or family links. Working conditions can be highly exploitative, leaving individual sex workers with limited power over their lives. Vulnerability is highest where sex workers are isolated from mainstream society and where they lack internal solidarity and their own social support networks. In such circumstances the capacity for community action around health and other issues may be low.

1.3 CURRENT SEXUAL HEALTH SERVICE NEEDS OF SEX WORKERS

UKNSWP member projects identified a wide range of sexual health needs amongst the sex workers they work with including:

- Up to date sexual health information and advice: including amongst other things safer sex information and negotiation skills re condom use
- Access to condoms, lubricants and other safer sex supplies
- Access to free and confidential screening and treatment for HIV and all other sexually transmitted infections. Projects noted a range of current presentations they are seeing at sexual health clinics. These included bacterial vaginosis, pelvic inflammatory disorder, urinary infections, increased oral Chlamydia and gonorrhoea, latent and new syphilis cases, Hepatitis B infections both infectious and dormant, increased HIV positive results for transsexuals. Whilst not a sexual health matter Tuberculosis B dormant and active is being presented. One male sex work project noted that currently amongst symptomatic male sex workers the most common conditions were genital warts, non specific urethritis, fungal infections and genital herpes
- Vaccinations for Hepatitis A & B
- Needle exchange services and safer injecting information
- Access to full contraceptive services including; contraceptive pill, injectable methods and implantons
- Information and support to deal with condom breakages
- Access to PEP after broken condom or exposure with client, casual partner
- Access to emergency contraception for female sex workers
- Appropriate sexual health and other support following rape and sexual assault ensuring crisis workers and Independent Sexual Violence Advisors’ (ISVA’s) and Independent Domestic Violence Advisor’s (IDVA’s) trained in issue relating to sex workers. And/or work in partnership with sex work support services.
- After rape or sexual assault, need PEPS immediately at SARC (in SARC area) or other facility as sex workers may not access local GUM clinic or A&E to receive it
- After rape or sexual assault, offer HEP A & B vaccinations at SARC (in SARC area) or other facility as may not access local GUM clinic or GP’s to receive it
• Access to antenatal care for female sex workers
• Access to termination of services for female sex workers
• Access to cervical smear testing
• Need for cap fitting for indoor sex workers indoors to deter the use of sponges and other items when working during menstrual period

1.3.1 MIGRANT SEX WORKERS

The proportion of Migrant sex workers in the UK sex industry varies across regions of the UK, project client monitoring data ranges from 0% of migrants to over 80% for some London based projects. Indeed the highest proportion of migrants reported is in London, with some projects reporting a majority of migrants amongst their service users. The majority of migrants are in the off street sex industry but in some areas of the UK there are cases where migrants are working on the street yet are a minority amongst their UK counterparts. The general trend across the UK is for those projects that deliver services to off street sex workers have found an increase in migrant sex workers in recent years, but the extent of this increase varies.

Migrant sex workers have many of the same sexual health needs of UK sex workers but there are some particular current sexual health issues and consideration. Projects identified some of these as:

• Language and communication: require translation and interpretation, project information and sexual health promotion resources in various languages
• Isolation and lack of networks/support
• Significantly higher rates of STIs and HIV in some host countries
• Mistrust of authorities and professionals due to visa status
• Self medication
• Increased pregnancy and requests for termination
• Difficulties accessing migrant women to termination and lack of access for undocumented migrants: e.g. in one city where their termination referral pathway relied on the GP route if the client does not have any form of ID for a specific address then a GP will not register them. None GP referral termination in this city costs £575 and often the time taken to seek abortion leads to a later termination
• “Backstreet abortion” and antibiotics: 4 projects flagged up their serious concerns about cases where women have sought abortions outside of referral pathways, with projects uncertain where they have accessed termination. Also women administering their own medical termination. A number of women have then encountered problems following termination and required health care.
• Those migrants who are victims of trafficking may have only limited control and agency in relation to safer sexual practices and sexual health.
• Migrant sex workers who become victims of rape and or sexual assaults need to be able to access SARC (where available) or other facilities without fear of immigration being the primary issue. After the victims care, safety and wellbeing, the potential evidence and intelligence should be prioritised over the criminalisation and implications re status. This of obvious importance if the person is also a victim of trafficking for sexual exploitation.
1.3.2 MALE AND TRANSGENDER SEX WORKERS

Male and transgender sex workers share some of the sexual health service needs of female sex workers but projects noted a number of particular key issues and considerations:

- Access to sexual health services out of hours (evening/weekend)
- Appropriate sexual health promotion information, advice and resources
- Access to PEP, especially out of hours
- Access to supportive/understanding GP, especially for migrant workers
- Regular routine sexual health checks for asymptomatic guys as part of their occupational health every 3 months
- Monthly STI certificates for men working in the adult film industry.
- Access to support from appropriately trained health professionals re: steroid use, and also hormones for transgendered clients
- Need for wider sexual health needs such as smoking, alcohol, mental health to be addressed. The focus for male sex workers has been on HIV and sexual health, but ignores wider determinants of health
- Appropriate sexual health and other support following rape and sexual assault ensuring crisis workers and ISVA’s and IDVA’s trained in issues relating to male and transgendered sex workers

1.4 GOOD PRACTICE PROVISIONS & PRINCIPLES

The summary of good practice provisions and interventions outlined here are drawn from recent consultation with UKNSWP member projects and existing good practice guidance relating to sexual health service provision for sex workers.

Principles which should inform good practice are that services should:

- Be confidential and respectful of sex workers’ privacy and human rights
- Be non judgmental
- Be inclusive
- Be accessible and flexible: e.g. targeted outreach, clinics at times and locations desired by sex workers
- Be comprehensive: clinical services should address all areas of sexual health
- Recognise that sex workers are usually highly motivated to improve their health and well-being,
- Involve sex workers and build community capacity
- workers;
- Recognise and adapt to the diversity of sex work settings and of the people involved.
- Adopt a community based approach: taking services to sex working communities including mobile unit, community based clinics and drop-ins

continued
1.4 GOOD PRACTICE PROVISIONS & PRINCIPLES continued

Principles which should inform good practice are that services should:

- Target the whole sex work setting, including clients and third parties, rather than only sex
- Locate sexual health needs within a wider holistic approach to sex workers health and social care needs: many projects, even those that originated from HIV prevention funding, have adopted a holistic approach. Projects stress that sexual health care is related to wider physical and mental health and well-being. Jeal and Salisbury (2007) recommended the need for specialist health interventions for sex workers as part of wider integrated multi-agency services.
- Do no harm and not reinforce stigma.


Provisions that have been identified as good practice include:

- A health promotion approach which uses outreach as an indispensable method
- Distribution of safer sex supplies e.g. condoms, lubricant, finger cots, dams and latex gloves
- Drop-in centres: to create accessible, comfortable and safe space for sex workers to access services
- Community based integrated sexual health clinic with STI screening treatment and contraceptive services: appropriate opening i.e. with evening sessions
- Accessible mainstream GUM and family planning/contraceptive services. GUM forging partnerships with sex work support projects attending outreach (e.g. dedicated nurse on outreach where possible to build trust and ease access into services), offering formalised fast tracks to services, joint delivery of clinics, specialist GUM staff known to sex workers, need for a dedicated link nurse in GUM service, dedicated sex worker sessions/clinics within GUM services.
- Community based screening in outreach and drop-in settings as a gateway to accessing mainstream clinical services: a number of projects provide some level of screening in outreach and drop-in settings. Some projects offer Chlamydia screening as part of their local Chlamydia screening program, others report offering the dual NATS gonorrhoea and Chlamydia. One project offered Oral swabs for HIV, Syphilis, Hep B and Hep C and self-taken Chlamydia/gonorrhoea swabs. All who offer such screening flagged up the popularity of such screening amongst their clients.
- Rapid HIV tests
- Easily accessible Hepatitis B vaccination program; some projects offer such screening in an outreach setting
- Hepatitis Support groups/clinics
- Access to vaccination program for HPV
- Provision of full range of contraceptive choices for sex workers
- Provision of free pregnancy testing
- Provision of or rapid access to free emergency contraception
- Provision of or rapid access to PEP
- Fast track arrangements for termination services
Provisions that have been identified as good practice include:

- Ante-natal care particularly for female street and survival sex workers with problematic drug and/or alcohol use: fast track arrangements, specialist midwives liaises with projects, midwives on outreach, weekly drop in Midwifery clinic with sexual health promo
- Up to date and relevant sexual health information and promotional campaigns/resources: participatory approaches which use media and community arts to produce promotional materials, sexual health training delivered to women on short informal courses e.g. workshops on breast awareness, cervical cytology, STIs and Contraception
- Assertive sexual health promotion on outreach and in other settings
- Monthly STI certificates for men working in the adult film industry.
- Needle exchange and information and harm reduction related to drug use, needle exchange and safer injecting information
- Support for victims of rape and sexual assault: provisions of, or supported pathways to, appropriate sexual health care, support through the criminal justice system and counselling/emotional support
- Interventions to address violence and promote safety
- Legal information
- Sex workers in Prison Initiative: cascade training to prison staff to raise awareness about sex worker and their service needs including sexual health
- Multi-lingual resources for migrant sex workers
- Formalised arrangements for translation and translation initiatives e.g. Palm Pilot
- Awareness raising re sex work and sex workers service need for health care professionals including reception staff; training and awareness raising for medical staff around sensitivity towards examinations and info gathering
- Advocacy to enable sex workers to access mainstream services and receive equitable treatment

Members commented that there is some good practice guidance in existence for addressing the sexual and wider health needs of sex workers, but this needs updating and in some cases customising for UK context.
1.5 CURRENT KEY CHALLENGES

1.5.2 Delivering sexual health promotion and care services in a context of stigma and criminalisation: projects report this is a key issue with a conflict between health promotion and criminal justice agendas having a real affect on frontline service provisions

Examples (N.B all these are recent):

- Projects in some areas report increased difficulty in accessing off street settings, with those in flats and parlours suspicious and fearful following more sustained policing of indoor settings. This has been heightened in some areas in the wake of anti trafficking operations such as Pentameter 1 & 2. A number of projects report that establishment they have previously accessed and delivered a range of health promotion & care are now unwilling to permit access or are permitting only limited access.

- Services working with street sex workers describe challenging circumstances for contacting clients delivering interventions in the wake of intensive policing operations to enforce the soliciting, kerb crawling or anti social behaviour legislation with street sex working clients working more illicitly, with dispersal to new areas, working later hours or simply wishing to keep “below the radar” and not even access or be seen to specialist confidential services. To address this some projects have where possible have changed outreach hours to try and make contact, this often means outreach sessions taking place late into the night/early morning). Projects in Scotland reported significant disruption to the delivery of health services in the wake of the introduction of the Prostitution (Public Places) (Scotland Act) in 2007. These projects report ongoing difficulties of delivering services to sex workers now dispersed over wider areas and facing higher levels of vulnerability to violence. Some projects in the UK report periods in which female street sex workers may shift to crack houses due to intensive policing and become out of touch with services, one project reported that following such a period a number of women began to reappear of the streets and had poorer health status, their was an increase in STI rates amongst this group of socially excluded women.

- In both the above circumstances delivering quality health promotion, follow up health care and building trust is very difficult

- Condoms used as evidence of soliciting or that a premise is being used as a brothel: deters people from carrying/storing sufficient safer sex supplies and undermines health promotion

- Street sex worker arrested for carrying an offensive weapon: this “weapon” was a personal attack alarm distributed by the local outreach project and had been funded by the police force. Immediate action was taken by senior officers to ensure charges were dropped but other sex workers heard about the incident and for a time were reluctant to take these alarms

- Police cautioning or arresting sex workers immediately after they have accessed outreach/mobile/drop-in services: making people reluctant and fearful of accessing. One project reported that at the time of consultation police cars park near to their purpose built mobile unit.
Some projects report encouraging off-street sex workers and clients into services is more problematic, within the current climate in which there has been increased media coverage of raids of parlours and flats and associated court case and convictions for brothel keeping, and also of the potential legal change (including proposals to create laws to criminalise buying sexual sexual services). This climate is a disincentive for both sex workers and their clients wishing to access services and be open.

Some projects reported that some sex workers feel disempowered and less able to negotiate when they feel unsupported by the law. Sex workers are reported to increasingly fear blackmail and exposure in the media.

Many projects expressed concern that the changes in the Policing and Crime Bill will drive sex work further underground, heighten the vulnerability of sex workers and create a climate in which it will be even more difficult for health/support services to locate, visit and offer sexual health services. There is concern that immense harm could be done if section 20 “brothel closure orders” came into law. Health promotion projects have been able in the past to reach sex workers in indoor venues, build trust and maintain relationships in order deliver interventions. A climate of closures could lead to a more transient, less accessible sex industry with fewer incentives for responsible “managers” who have worked positively with projects.

Members fear that government policies will further marginalise migrant sex workers as they will be seen as more of a risk to employ in various sectors of the sex industry, meaning those who face additional barriers to access health case could further fall off the radar of health services.

Some projects are already reporting significant transience in certain sex markets due to saturated markets, increased police intervention/raids experienced as frightening and disruptive and proposed additional legislation. This has a direct impact on delivering healthcare as follow up is complex, longstanding relationships with specialist projects are impaired and increased risk in services offered due to competition and lack of clients. (E.g: A central London based project reported that two years ago they paid outreach visits to 40 stable flats in Westminster. At the time of reporting only 6 remain stable, this means outreach mapping must be re-done every two weeks as flats open and close, the consistent and reliable relationships with maids and working women have become fragmented. They report that follow up health care and building trust is severely compromised in these circumstances).

Variability of provision and limited funding resources: whereas some areas have funding to support best practice to address sexual health needs, this is not the case in many areas were adequate funding is not provided. Good practice is difficult to deliver with limited funding. For example, some projects reported a limited condom budget and no funding for other safer sex resources (e.g. lubricant, dental dams, sponges, finger cots). Some projects report that specialist clinics or specialist health professionals cannot be provided as regularly as needed e.g. specialist health clinic every other week rather than weekly, a Blood Borne Virus nurse attending clinic fortnightly rather than weekly. Another project had lost the services of an outreach Blood Borne Virus nurse and were struggling to find a new partner agency to provide this service and had no resource to employ a sessional nurse in-house. Some report specialist provisions under threat due to lack of funding and others that they can’t develop such provisions because there is no funding forthcoming. Some projects noted the lack of funding for resources for migrants was preventing them from developing materials. Similarly limited budgets restrict the number and frequency of outreach sessions, which mean projects in some areas feel they are not meeting the level of need. Some projects have minimal staffing levels which limit the extent and continuity of services.
• Some projects report that in a difficult financial climate for mainstream services they are losing of elements of targeted sexual health care for sex workers that have been previously delivered as partnership arrangements e.g. loss of Nurse who used to accompany outreach and deliver Hepatitis B vaccinations, GUM clinic no longer offering Hepatitis A vaccinations (clients have to pay for these at a travel health centre).

• Gaps in sexual health promotion and specialist outreach and support service provision: in some areas there is no targeted sexual health promotion for sex workers or support of any kind. More frequently, there is no provision aimed at indoor workers, areas where there may be a service commissioned to target female street workers but none for off street sex workers. **There are few dedicated projects for male and transgender sex workers.** There is no statutory obligation for the provision of such services.

• **Enduring judgmental attitudes amongst mainstream health professionals** reported in some areas are still identified as a key issue and **advocacy remains an important role for outreach and support projects.**