Spectra

Peer services, improved lives

Sex Worker Health Inclusion Report

A community-led overview

Spectra CIC

October 2023

Contents

Content Warning: Assault and abuse of SWers in 'Key issues for Spectra's service users', 'Strengthening Access to Harm Reduction'. Assault and stalking in 'Options for a high-quality NHS SW service'.

Acknowledgements

This report was developed through funding from UKHSA via a UCLH commission. This report does not necessarily reflect the views of UKHSA or UCLH. Thank you to UKHSA and UCLH for commissioning and funding this piece of work.

Thank you to all who took part in the CPGs and interviews to source information for this report.

Lastly, thank you to the staff at Spectra who continue to provide this essential service.

Note on terminology

'Sex Worker' is used throughout this report since this is the appropriate terminology for non-sex workers to use in this discussion. Sex workers themselves may use different language which is not appropriate for external parties. To encourage sharing of this report with professionals who may not be sex workers, this in-group terminology has not been included to set a standard for respect.

'Client' is used throughout this report to indicate a person who is a client of a sex worker.

'Service user' is used throughout this report to indicate a person who is accessing health services from Spectra and other similar organisations.

'Bookings' is a term used to describe shifts sex workers arrange with clients.

'Peer-led' is used to describe when a service or organisation is run by the inclusion group which it is also designed to support. For example, at Spectra our peer-led service is run by and for sex workers.

'Trans' is defined in this report as any person whose gender identity is not the same as that which was assigned to them at birth.

'Cis' defined in this report as any person whose gender identity is the same as that which was assigned to them at birth

'Disabled' is used rather than 'persons with disability' to reflect how individuals are disabled by their inaccessible surroundings, rather than their condition.

'Racialised' is used rather than 'race' to describe the process of being assigned a race, rather than supporting the idea of race as a biological fact and division.

'Ethnicity' is used to indicate the combination of racialisation and citizenship, for example Black British.

List of acronyms

ALEX – Advocate with Lived EXperience

AFAB – Assigned Female At Birth

AMAB – Assigned Male At Birth

CPGs – Community Participation Groups

HIV – Human Immunodeficiency Virus

HPV – Human Papillomavirus

HSV – Herpes Simplex Virus

KPI – Key Performance Indicator

MSM – Men who have Sex with Men

NHS – National Health Service

PEP – Post-exposure Prophylaxis

PIP – Personal Independence Payments

PrEP – Pre-exposure Prophylaxis

SMT – Senior Management Team

STI – Sexually Transmitted Infection

SW – Sex Work

SWer – Sex worker

SWL – South West London

SWLSHC – South West London Sexual Health Consortium

UCLH – University College London Hospitals

UTI – Urinary Tract Infection

Summary

This report collates the experience and research of Spectra CIC in the field of health inclusion, services, and outreach for sex workers (SWers) in London.

A series of staff interviews and two community participation groups (CPGs) were conducted by Spectra to represent the overlapping voices of service provision and use, with an emphasis on hearing the voices of SWers from within and outside of Spectra's staffing body. We hope that the insight which we have presented in this report may go some way to improving the health inclusion by and for SWers in a deeper and broader manner than is currently offered.

Over the course of this document we aim to first give readers an overview of current pressing issues for SWers, including common barriers to accessing related services. Then, the report outlines Spectra's provision for SWers. This includes our commissioning model, remit, operational model, and examples of our work in vaccination, harm reduction, and testing and treatment. Following this broad perspective on Spectra's work, the report will next move onto insights from the CPGs regarding the health provisions that they want, have, and would improve.

One: Needs of the SWer community

This section of the report outlines contemporary healthcare issues for SWers by discussing results from the staff interviews and CPGs.

The key issues to emerge are as follows:

- SWers having to choose between privacy of personal information, and identification of high-risk status and treatment
- Lack of credible information around where and how to test or access treatment
- Lack of information about communicable diseases such as Hep-C
- Lack of resources for SWers with latex allergies
- Discrimination and uninformed medical professionals
- Restrictive locations and opening hours of health services
- Gendered eligibility for vaccines such as MPox and HPV
- Intersectional discrimination and barriers to health resulting from housing difficulties, precarious immigration status, lack of disability support and being transgender

Data collection method

Before discussing insights from the session, the method of data collection is outlined here. Since this was a positive experience for participants the process is detailed to serve as a reference for similar future activities.

Staff members were interviewed to source information on recurring health-based issues in service users (see Appendix 2.1 and 2.2). The interviews were semi-structured, in that some variance off the script was allowed to enable flow of conversation but all topics listed were covered. The interviews were recorded, transcribed and then incorporated into the following section alongside insights from the CPGs.

During two CPGs in October 2023, Spectra held discussions with SWers and lived experience health inclusion professionals to explore the field of health services, outreach and inclusion for SWers. Spectra hosted one online session for access and convenience, and one in person session to bring outreach resources and provide food, drink and socialising. In both sessions all participants were paid £50 for 2 hours as community experts, and all facilitators of the sessions were SWers with experience and training in social research. For the in-person session there was a counsellor with SW experience in attendance, this was for the possibility of triggering conversations, so participants could take some time out with a counsellor to work through anything that may have come up. The questions used in the session are detailed in Appendix 2.3, these were designed with a trauma informed approach where Spectra was not asking people to divulge details about painful experiences under pressure where they may not actually want to share this with researchers or a group.

Attendees were invited to take part via a poster (Appendix 1.1) which was distributed through personal networks and not social media. The goal of this method of distribution was to encourage sharing across multiple groups, and encourage more privacy to individuals than would be afforded if the project and cash reward was published online. Individuals applied to be part of the session using an online form which took their basic demographic characteristics and details about their sex work. From a pool of 67 individuals, 60 people had signed up exclusively for one online session. Not every applicant could be invited because each person needs space to speak in a CPG. 20 people were selected and attended the zoom session. Participants were chosen because they were all in-person current SWers and then for a

balance of venues where they worked, type of SW which they did, and demographics such as racialisation, gender, disability. All persons who applied to join the in-person session were invited to participate in a smaller group. A full dashboard showing the demography of applicants and participants is available in Appendix 3.

Upon confirmation of their place on the session all participants completed a consent form regarding their data privacy and indicated their preferred method of payment between bank transfer or an e-voucher. All video recordings taken during the zoom were deleted immediately after the session, and all audio recordings across both sessions were deleted after transcription. The names of participants were deleted from our records after the sessions, and their emails will be deleted one month after they have been paid. Participants were informed of this process prior to the CPG and during the CPG so they had the opportunity to ask any questions.

After the CPGs all participants were emailed an estimation of their payment date, a signposting pack to resources on a host of topics such as housing, mental health as well as SW specific links, and a link to a brief anonymous feedback form. Overall, Spectra received very positive feedback for our model of CPG organisation and delivery:

> ***"You obviously planned this well and I think it was constructive, interesting and worthwhile doing"***
>
> ***"[I enjoyed] the breakout sessions where we could freely talk. [I would] add more fun games in between the sessions [to improve]"***
>
> ***"[I] Just wanted to say thank you to everyone for hosting the space. I really appreciated getting to be vocal and be a part of sharing our experiences and pushing for change and hope to be considered for these spaces again in the future."***

This report summarises the conversations at the CPGs in reference to Spectra's brief for the report. For a more general overview of what was discussed, two miro boards were utilised throughout the CPGs. One facilitator would add stickynotes to the board while the discussion was happening, and participants could add their points with this facilitator rather than interrupting the conversation. Two mind maps of each session were created, zoom session here and in-person session here.

Key issues for Spectra's service users

The SW team at Spectra provides support for a range of health-related problems. This could include information about where to access testing or treatment, asking for a test from our team, or referral to counselling. SWers approach us with these queries as part of their regular check, to obtain a certificate for shooting porn, or after they have been assaulted and/or stealthed (non-consensual removal of a condom during sex). Health services can be reluctant to give cis-women or AFAB people PrEP and PEP because SWers feel unsafe telling the service about their profession, and rarely know the risk profile of the people they are having sex with. The health services often therefore refuse PrEP on the basis that these individuals are not high-risk, but in the process often do not ask the SWers about the type of sex which they are having (e.g. group sex, anal sex) that could elevate their risk dramatically and not

require them to share their profession. Our team coaches and advises SWers on which clinics are SWer friendly, and what to say in order to access support.

We also encounter issues which are not strictly health-related but have health implications. These issues are commonly associated with employment and housing instability, stalking from clients, disability, mental health, and other intersecting obstacles SWers are handling other than their profession itself.

One example is assistance with making an application for personal independence payments (PIP). Disabled SWers make up a sizable portion of our service users, the team believes that some disabled people turn to SW so they can work on their own terms and still have some independence compared to other careers which are less flexible and thus more inaccessible. For disabled people the application forms and bureaucracy required when applying for PIP can make the process itself inaccessible. Our team can go through that process with them via casework advocacy. This not only supports their mental health by limiting the impact of overwhelming processes, but also secures the payment quicker so the SWer can support their own wellbeing for example by paying for food, medical supplies or housing.

Housing is an issue spoken about often by service users. SWers can have difficulty being outed to landlords, housemates, or family members who they live with. Housing instability arises from this stigma, as well as reasons like: SWers struggling to provide proof of a consistent income, unaffordable rents, gaps on their CVs creating issues applying to other jobs, and migrant SWers being unsure of their own status for right-to-rent or right-to-work. SW is regularly linked to complications with employment and income instability; both factors are exacerbated in the struggle for many SWers to find housing. SWers who come to Spectra for support can be in exploitative housing situations where they may be having sex with their landlord for rent, living in a brothel, moving in with clients, or travelling long distances nationally in order to secure bookings. These housing arrangements are likely to be unsanitary, isolating and abusive. Not only does this environment result in poor mental health of the SWer, but they are also unlikely to be able to choose safer clients or be supported in their sexual health.

Key issues for SWers in CPGs

To begin both CPGs we conducted a poll to gage participants' knowledge about TB, HIV, Hep B, Hep C, STIs and other vaccine-preventable diseases. The results of this poll are displayed in full in Appendix 4.

Of all the key issues suggested by the brief, participants in both sessions were most sure on their knowledge of HIV. The discussion followed that people felt there had been a strong educational campaign for HIV over the last generation, and as a result were reassured about their knowledge on the matter. There were participants who shared with the group that they were HIV positive, but this was not framed as a pressing issue for any individual during the CPGs rather more context of their own circumstances. Participants agreed that they had a good awareness of PrEP and PEP, some saying that they have learnt from their trusted peers about these topics rather than approach healthcare professionals first.

> ***"The knowledge that I acquired through my community is what I brought to health professionals in the sense that [I] was like, OK, I heard about this. Can you explain [it to] me more?"***

Hep B had a higher level of knowledge in both groups rather than Hep C. 86% of CPG participants said that they had some knowledge of Hep B, compared to 71% with Hep C, the majority of both figures being made up of individuals who only knew a little (57% of participants overall for both types). In the online CPG this provoked a discussion about if participants knew the difference, and no one seemed to have this information. The online group agreed that they didn't know about the symptoms or treatment for Hep C, and that it was unclear to them who was eligible for Hep B or C vaccines or where to access them. The in-person CPG had a similar conversation with the knowledge disparity which developed into participants sharing that they were unsure how many doses of which vaccines they had had, for Hepatitis or other diseases. In-person participants were generally hesitant to request this information from healthcare providers since they wanted to remain anonymous where possible, stated that they often found it hard to remember follow-up vaccination appointments with no reminders, and that having to return to the same clinic for all doses was obstructive when they needed to travel for work. The in-person group shared the sentiment that as a result of these barriers to vaccinations they were under-informed and under-vaccinated.

It is worth noting that in the cases where there was low knowledge of diseases in the CPGs, participants did not add any experiences of having such infections. This could indicate a low incidence of these diseases *or* possible undiagnosed cases, it is unclear from the information we have here. Aside from our list, other communicable diseases which were mentioned by SWers as important for outreach, treatment and/or vaccination where possible were:

- MPox
- HPV
- HSV
- Covid
- Flu
- Trich (Trichomoniasis)
- UTIs
- Thrush

Common barriers to accessing health services for Spectra's service users

During interviews, opening hours were mentioned by multiple staff members as a key access barrier for SWers. Drop-ins are much preferred by SWers for accessing health services, vaccinations and testing. Drop-ins can be difficult to find, the information online may be out of date, or the opening hours are limited to a few hours on one morning a week. A few hours in the morning is both an unsociable time for SWers due to late working hours and a small window to be available during what can often be a last minute and busy schedule. Drop-ins are preferred to appointments for service users because they don't require a registration process with personal details, and they require less prior planning than making an appointment where a last-minute client booking will take priority. A long drop in window makes it far easier for SWers to reach medical help at a time which suits their working schedule.

> ***"I constantly see SWers putting earning income over […] their health and […] over medical appointments."***

A second access barrier is the lack of latex-free products in sexual health services. Latex-free condoms and gloves are important for SWers because they are at an elevated risk for a latex allergy. SWers have

a high exposure to latex, a material which increases its potential for reaction over repeated contact (click here for more information). Most sexual health services do not offer latex-free alternatives thus forcing SWers to work through reactions to the material, from rashes to open wounds and scabbing. In addition to allergies for the SWers, clients will often claim to have a latex allergy in order to have unprotected sex with a SWer. In this scenario, the SWer must choose between no income, unprotected sex and possibility of infection, or insisting on the latex protection and risk of violence. Not offering latex-free products in these contexts is the equivalent of not offering protective services at all.

Common barriers to accessing health services in CPGs

CPG participants were forthcoming when discussing access barriers to health services. Aside from incurring issues with anonymity and knowledge of medical records as in the previous section, eligibility for vaccines was also mentioned by multiple participants across both sessions. SWers in these groups appeared to be struggling with standard eligibility criteria because they did not want to share that they were SWers in order to be recognised as high risk and did not know of anonymous SW-only drop-in services for the vaccinations. An older SWer shared that he wanted to access the HPV vaccination but thought that since he was over 45 years-old he would not be eligible. Similarly the HPV and MPox vaccinations were raised in this conversation because participants thought often to access these you need to be of a particular gender, AFAB for HPV and AMAB or often MSM for MPox. These criteria are likely related to non-SW levels of risk, but the participants were quick to note that HPV and MPox affect all genders yet not everyone has access to preventative treatment. Lastly, a trans man confided in the group that he had wanted to access the HIV vaccination trial but was declined due, he felt to his genitalia and an assumption that he would not be having anal sex. In all of these cases, SWers found access barriers to vaccinations they had sought out because they were not considered to be a priority for the preventative treatment. In-person participants felt that this access barrier would have been relieved had a SWer-only drop in vaccination service been available, complete with cards similar to Covid-19 to record details of their doses.

> ***"[When I went to get my Mpox vaccine I had] to use a lot of like sex worker group chats to know which clinic offers it, what to say, where to go, and like it actually turns out that a lot of places offer it to sex workers. But it wasn't necessarily made explicit on their websites or when you would call them."***

Participants felt that they had experienced barriers to accessing health services just because they were SWers. The term 'whorephobia' was brought up in both sessions to describe the moral outrage and discrimination SWers had encountered when opening up about their professions to healthcare workers. Hostile behaviour such as lecturing service users on their own self-esteem has dissuaded participants of both CPGs to be honest about their activities when accessing health services, and often choosing peer-support in SW-only spaces instead. Participants in both CPGs also mentioned concerns around anonymity and medical records. SWers said that they felt unsure about how their information was being stored, and didn't know how integrated the UK medical system is – if they confided in a nurse in one hospital that they were a sex worker, would that be on their record forever and subject them to further discrimination or even legal action? Discrimination, uncertainty about data, alongside unsensitive behaviour such as calling out individual names before seeing them for treatment caused a number of the CPG participants to state then when they have to access health services they often lie. SWers do not want to share information with healthcare providers that they fear will worsen their circumstances, and can resort to saying whatever information that will encourage the healthcare professional to give them the treatment they seek. For resources such as menstrual sponges both CPGs

agreed that sponges were rarely available and they knew SWers who had been shamed for using them by medical professionals when they asked for help. This is consistent with the experience of Spectra's peer-led team during their outreach shifts. Another access barrier which supports Spectra's experiential advice is that of making appointments. Participants in the in-person CPG commiserated with each other about the difficulty of not only remembering to book an appointment, but also getting to the appointment without last-minute cancellations in a fluctuating and busy work schedule.

> ***"[I] just want medical professionals who don't get scared by the realities of my life. Even when they're normal. […] Just people who are not easily surprised would be really nice. Or if they're surprised then keep your poker face."***

Intersectionality within the SW community

Aside from their experience as SWers, other intersectional demographic characteristics within the CPGs were mentioned as barriers to accessing health services. Non-UK nationals in both groups said that they have experienced a sense of distrust around accessing health services in the UK, because there were times when they were unsure about their immigration status and didn't know if healthcare providers would report them to the Home Office intentionally or systematically. Neurodivergent SWers in both CPGs opened up about feeling that healthcare professionals relate to them differently once they know that they are neurodivergent, which makes them feel uncomfortable. Another individual also described the experience of healthcare spaces as overstimulating, with bright lights and loud indistinguishable sounds, and physically inaccessible using examples of no lifts and long waiting times. Transphobia was mentioned by trans men and women in both groups. They stated a desire for medical professionals to ask about what terminology they preferred, because too often they had experienced jarring language such as 'front hole' rather than 'vagina' and acknowledge that everyone has different preferences when describing their own body. Other individuals said that what they had experienced was simply transphobia, that healthcare providers didn't understand their body or needs and as a result they received poorer treatment than their cis peers. In the online CPG racialised participants added experiences of racism to transphobic concerns, multiple individuals agreeing with this intersectional experience of discrimination.

> ***"I feel like I'm being treated different because when I try to explain to the healthcare workers that I'm black […], I'm non-binary, and then I'm a sex worker they look at me all confused like maybe I do not know what I'm saying. […] I feel like there's a certain way that I'm being treated which is different from the way others are being treated."***

> ***"I'd like them not to assume anything. It's better to ask and then know than to just assume."***

These CPGs are not a comprehensive scoping exercise for the SWer population in London or the UK. However, what we can see from Spectra's data (Appendix 3) is the SWer population is made up of people with many different life experiences and intersectionalities. A key takeaway from this insight is that any SWer service must also cater to the needs of people of all ages, genders, racialisations, (dis)abilities and migration status. Barriers for SWers are not just due to their profession but also due to the other intersectionalities they encounter in their lives as well.

Two: Spectra's Service

This section of the report summarises Spectra's SW service structure including its emphasis on lived experience, and finishes with Spectra's examples of vaccination, harm reduction and testing and treatment.

Commissioning

Spectra's services for SWers is primarily funded by the South West London Sexual Health Consortium (SWLSHC) under the general theme of sexual health. The consortium is made up of six boroughs in South West London, two of which support our commission. These are Richmond and Wandsworth with the latter acting as the contract lead. The team at Spectra provide quarterly KPI and narrative reports on the work.

Remit

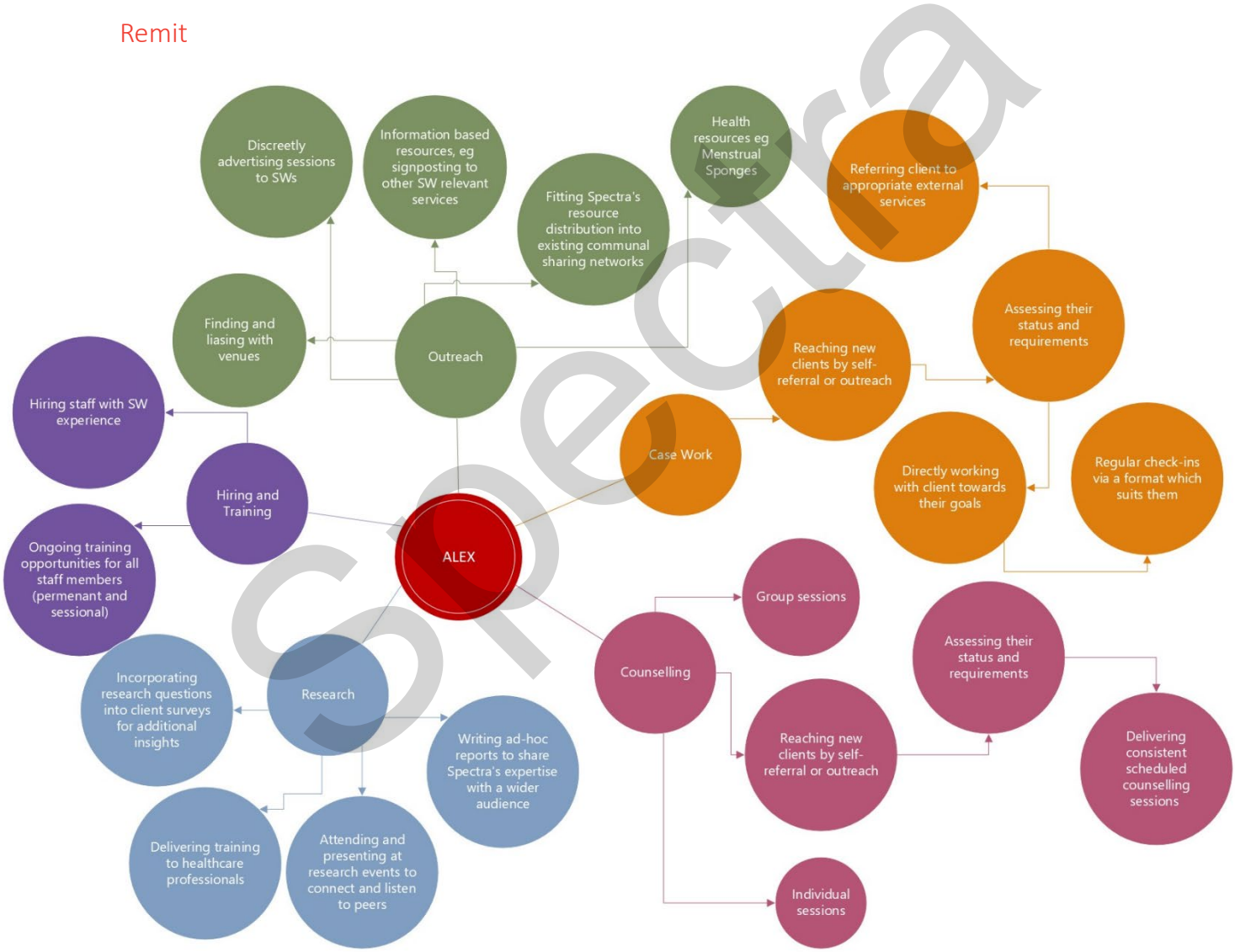

Fig. 1 summary of Spectra CIC's SW service

Spectra's SW service is targeted health inclusion for SWers who are over 16 years old in Richmond and Wandsworth to meet their health needs. Our definition of SW is intentionally broad and inclusive, encompassing online as well as in-person work in various types of venues such as street work, brothels, agencies, dungeons or bars and clubs. All staff from Spectra who are involved in the service delivery

summarised in Fig. 1 have lived experience of sex work. The priority of peer-led service is central to our work, to make our service users more comfortable and likely to reach out to us for help.

Spectra's outreach sessions are foundational to the SW service, offering a one-stop-shop for friendly, professional informal conversation, resources (see Appendix 1.1) and signposting to our own and other services. Examples of signposting can be to case work, counselling, peer-support groups, or externally with issues such as housing. We also offer HIV and STI testing on-site, and will guide service users through sign-ups which they would usually need to complete in their own time for example to register their home test kits online.

These outreach sessions largely take place in known and trusted SW-only safe spaces, to support the existing network of SWers and build trust and reputation for our organisation within the community. Since our funding is from the Wandsworth and Richmond boroughs, our work for SWers at Spectra primarily targets those who live and work in these areas. In order to do so however, it is important to travel since SWers are known in the community to travel across the city for bookings. Often even when SW-only events are not within SWL, many of the SWers who attend them are. Over the coming months we will be expanding our outreach from these spaces and hosting more sessions within our commissioned boroughs.

Spectra is pioneering a new brothel outreach strategy, working with key contacts in each brothel to agree bespoke visits where the SWers are able to decide who attends, when, and with which supplies. This approach puts the brothel SWer in charge of how they interact with outreach, building trust and agency rather than simply being confronted by unknown health professionals at their door.

In addition to outreach, Spectra currently provides one-on-one counselling, advocacy case work, and therapeutic groups. Often our referrals to these services come through our outreach sessions, but they are also open to individuals who self-refer. As Spectra offers more therapeutic groups the team will be working on integrating our outreach and casework services into these events to provide as much as possible to a busy group with difficult schedules.

As Spectra gains more experience and staff in the SW field, the organisation is increasingly able to attend conferences and trainings as an in-house expert on sexual health. This facet of the service connects to advocacy service on a broader level, rather than individual advocacy.

Operational model

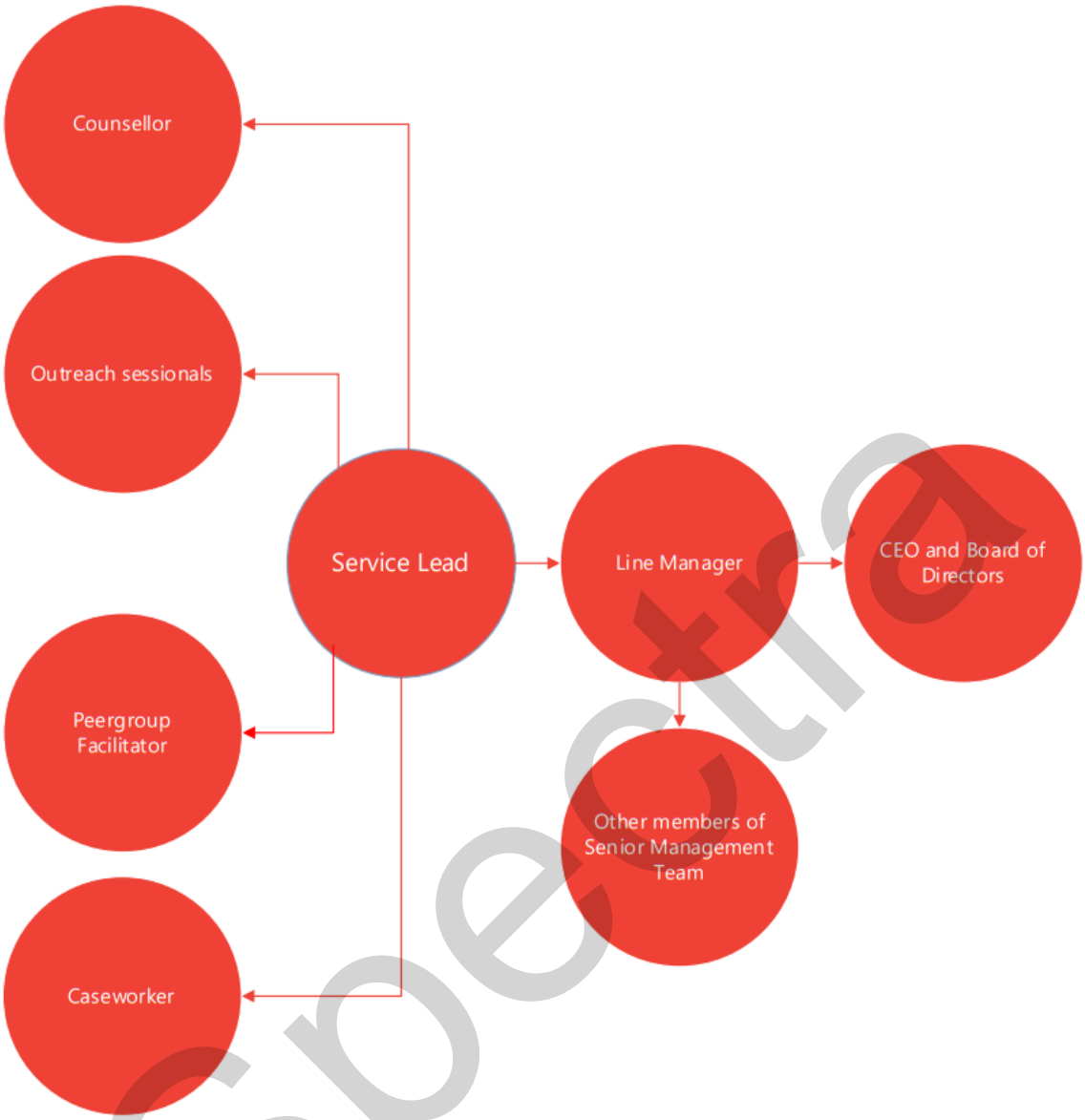

Fig 2. The staff structure of Spectra CIC's ALEX team

The Service Lead at Spectra is a pivotal member of the team. The Service Lead is a mid-point in the organisation between service users, the core operations of the SW service, and the Senior Management Team (SMT), CEO of Spectra. The Service Lead conducts three CPGs per year with service users to critically evaluate and plan Spectra's SW services going forward. The Service Lead is responsible for recruiting, training, onboarding and outreach shift allocation of all other staff members in the SW service. They also coordinate bi-weekly steering meetings amongst staff to discuss pressing and emerging issues and proposed solutions to the service internally. The Service Lead writes quarterly narrative and numerical reports for funders and SMT, attends meetings for funding bids, and develops the brand of the SW service at Spectra at external professional events such as conferences. The Service Lead was the first employee on the SW project at Spectra and has been responsible for developing the service model, social media, and brand promotion over the last year. This work is carried out over a 4-day working week, a 0.8 FTE post.

The other staff in the SW service are as follows:

- Counsellor (0.2 FTE)
- Case Worker (0.4 FTE)
- Peer Group Facilitator (0.4 FTE)
- Outreach sessionals (casual contracts)

Advocacy casework holds three to four clients at one time, scoping and mapping potential signposting pathways is also a recurring task. Counselling holds 4 client slots per week, and peer group services run sessions one day per week. Outreach sessionals deliver three sessions per week on average. Depending on the week Spectra holds at minimum one weekly outreach session in West London, and often a couple of other shifts in SW-only spaces.

The SMT level line manager oversees the delivery KPIs of the service, ensuring that it meets contractual obligations and service workplans. This is done through regular supervisions, and meetings between the line manager and CEO.

Peer workers

All staff in the frontline SW service team have lived experience of SW. This does not necessarily include the SMT.

Roles which require professional qualifications on top of lived experience, e.g. counsellor and caseworker roles, were recruited with these skillsets. During the recruitment process, lived experience of SW is considered obligatory for staff members in the SW service, and is accounted for alongside any other qualifications. Gaps in CVs which are common for SWers are not judged as an issue for the application process to Spectra's SW service, nor will they be asked about in an interview for a SW service position. In addition, there is no requirement for a degree or formal higher educational qualifications provided that the individual has sufficient experience for the specific role they are applying for. This includes voluntary and activist experience. Applicants do not need to provide references for their previous employer, because their previous employer may not know that they are a SWer. Other references are accepted, for example from voluntary or activist organisations. Offering to speak with applicants before they apply can also provide reassurance, especially if the applicant has had issues with gaining employment in the past or aren't aware of Spectra's emphasis on peer-support. The SW service benefits from the same accessibility support as the rest of the organisation, for example being mindful that language used in job listings is kept to non-specialist vocabulary and questions for the interview are provided in advance for all shortlisted candidates. This supports autistic and neurodiverse applicants in particular.

When hiring for lived experience at Spectra the equality and diversity form is anonymised and separated from the application itself. This means that unless an individual states their lived experience in their application, Spectra may not be aware of it even if that data has been collected elsewhere. An enhanced DBS check is essential prior to Spectra's onboarding process, and we are able to use Sensitive DBS checks. The sensitive option circumvents the issue of connecting a SWers profession, legal name and address where they may not want those facts to be associated in any official capacity outside of Spectra. Spectra chooses this DBS option to protect the safety of its employees with lived experience. When joining Spectra, staff members are advised to choose a different name to engage with colleagues, and thus protect their own privacy. Another possible consideration as lived-experience staff enter the workplace is the importance of offering an advance on salaries. SWers are often living

hand-to-mouth lifestyles and the possibility of receiving and advance in the early stages of their role would be beneficial for their stability.

Trainings are available for staff members once they work for the organisation, often being specific to their role. For example, outreach sessionals will receive training on administering point of care and other tests and carrying out assessment exercises after they are appointed to a role. Training which is required for a role is mandated by Spectra. The comprehensive Staff Handbook sets out other key parameters such as Code of Conduct, boundaries, confidentiality, data protection, safeguarding protocols, and HR processes. Training on elements of this document are compulsory. General trainings are available for all staff once part of the Spectra organisation. These are opt-in only trainings. Staff in the SW service have utilised these opportunities for trainings about facilitating focus groups, intersectionality in therapy, the needs of trans sex workers, adult safeguarding, and sexual health. These trainings have been provided by the Trans Learning Partnership, Trans Actions, and the e-learning portal via the NHS amongst others. The variety of training opportunities at Spectra reflects the breadth of the organisation itself, with each service bringing a new focus and expertise to the table. To encourage staff to take advantage of these skill-sharing opportunities. A new organisation would benefit from scheduling paid time for staff to take part in trainings such as these.

All services at Spectra prioritise staff members with relevant lived experience, and as such the support structures for each service are similar. Service leads, caseworkers, and counsellors have external supervisions organised by Spectra with an external provider once a month. The external provider can be chosen by the individual or by Spectra, and can be a licensed clinical supervisor (mandatory for counsellors) and/or an individual who has the same lived experience. Part of the selection process for supervisors is to ensure that they are informed about the nuances of the staff's lived experience, but they are not part of the same social or professional circles. Staff members who have existing therapists and counsellors have been allowed to keep the same person as their clinical supervisor, this time covered by the Spectra budget. Outreach sessionals do not have an external supervisor. Larger organisations should consider offering counselling to frontline outreach roles as well as casework or counselling since these employees often encounter the same difficult conversations.

Aside from clinical supervision, staff have monthly structured meetings with their line manager and an internal peer support group which takes place approximately bi-weekly. The frequency of both these meetings depends on availability of all persons and can fluctuate with annual leave.

An important support structure mentioned by SW service staff is the support they receive simply by working with people who share the same lived experience as them.

> ***"Everyone that works [at Spectra] has been really helpful. […] whenever I've asked someone a question, they've come back to me pretty much immediately with an answer, so I don't feel that peoples' metaphorical doors aren't open to me if I […] need to bounce and idea off them or find something out."***

> ***"There were people at Spectra who had already done sex work who hadn't disclosed it to other people at Spectra […] who have now started to do that and so that's been really positive for me, […] just knowing that they have felt safe to do that."***

"[I would recommend Spectra's model of hiring based on lived experience] based not just on my own experience, of how positive it's been for me working amongst my peers, but based on what I know to be desirable from the point of view of service users who would much rather talk to someone who has lived experience that is similar to theirs because they don't fear being judged [and] they don't have to explain themselves."

Having a team which is entirely made of those with lived experience has been beneficial for the organisation as well as the individuals. Not only are staff members happier in themselves due to high quality peer-support, but also the service has access to SW-only spaces where service users are more understood and open. The lived experience of staff does not just ease social relations, but it is highly practical. Our SW service team are experts on the nuances which needed to be added to our processes when Spectra began this service. For example, all our surveys and outreach materials (Appendix 1.1) have been created by and for the SW service. Information about what supplies were wanted, how to describe SW venues, and different types of SW were all sourced from the SW service staff themselves. A second example is that the risk assessments for outreach were previously not optimised for outreach with SWers. There was previously no acknowledgement of the risk of police presence, the risk of gang activity, the risk of weapons, the risk of staff members being outed publicly, or the risk of staff members' stalkers tracking them to the organisation and office. These considerations came along with the SW team, and help Spectra's interest in providing support to the community.

Conversely, working in a peer-led team can come with its difficulties. Staff were open about fears of letting their community down, feeling tired and like they weren't doing enough. In addition to this, when the onus is on staff with lived experience to represent their community in the workplace this additional burden can leave them feeling isolated and tired-out. On one hand, between colleagues who have lived experience of SW it can feel difficult to maintain professional boundaries, especially when they have shared social circles prior to working for Spectra. On the other hand, some employees can feel relations between the SMT with no lived experience and staff in peer-led services are sometimes challenging. Not every element of lived experience is embodied in the SMT, and balancing what lived experience is prioritised within the staffing body is an ongoing process. This can lead to some staff feeling that their experience or other skill-based contributions to their work is misunderstood.

There is a short history of public funding to support SWers, and indeed much of the public structure in the UK goes toward criminalisation and isolation of SWers and their support networks. The stigma toward sex work leads to a limited quantity of funding being made available for the work of Spectra and other similar organisations. It is widely accepted that SWers are underprovided for in terms of inclusive and appropriate services. The current service provision at Spectra is not as comprehensive nor widely available across London as we would wish. There is more work to be done as the organisation gains experience, contributes to the evidence base and evolves its offer. For larger organisations such as the NHS which may have access to health inclusion funds, lived experience needs to be centred within the planned and delivered provision, with SWers providing paid input at all levels.

Examples of good practice

An example of good practice at Spectra is our SW team's ability to enter the SW-only spaces directly to offer support. For many, this removes any barriers of needing to seek out resources, signposting or referral, because the SW service at Spectra will go to them and complete this process on-site. People who would otherwise be unlikely to reach out to us have been supported this way.

During our outreach sessions we distribute a variety of resources such as condoms, lube and sponges for SWers (Appendix 1.1). We ensure that SWers can take an appropriate supply for themselves, as well as their networks. This is because mutual aid is a lifeline in the SW industry, especially in spaces such as brothels where some workers are a lifeline for their more isolated colleagues. One notable case of resource sharing amongst SWers is one individual who approached Spectra in a SW-only space, they shared their free condoms with co-workers but this was resulting in them running out of supplies for themself. To cover the cost of providing their own medical supplies this individual was having to do more unprotected SW. The risk of contracting an infection would not only create instability in their life with potentially less income, but also SWers who they support with resources and other SWers who share the same client. When offered enough supplies for themself and their co-workers the individual was visibly relieved, saying they could now negotiate more of the services they offer to use protection. Our ability to adapt our service to meet needs as they are encountered is key to offering services that are appropriate and trusted, and not reinforcing another service model that does not meet the actual needs of SWers.

> ***"Thanks so much for the condoms – I've let all the workers I've been on shift with so far know they can help themselves to them from my box in the brothel at any time […] so hopefully [this] eases some of the financial strain for them too."***

When an issue is outside the remit of Spectra, our staff refer service users to other organisations which have a history of supporting sex workers and provide a good service. These include:

- Open Doors drop-in service for SWers, this drop-in also offers food for SWers
- Ambrose King sexual health centre
- Positive East HIV and STI testing, this service can also assist with referrals to PEP and PrEP
- Mortimer Market
- Archway CLASH/SHOC
- Spires Centre is good for street worker drop ins and sensitive outreach in the area

With all these services a 'good service' is when a SWer can go at a time which suits them, they are seen quickly and taken seriously without judgement or moral lectures, and finally they receive testing and treatment for the issue which they arrived with.

Strengthening access to vaccination

Spectra does not currently offer vaccination sessions, although this is a project which is underway partnering with Falcon Road clinic. This session will be a drop-in vaccination clinic offering vaccines such as MPox which are hard to access for AFAB SWers and a common issue in the community with unsanitary conditions in brothels and other similar venues.

Spectra outreach staff will also sit with a service user to register their vaccination appointment during our in-person sessions, and our caseworker has the capacity to organise a similar conversation with clients if desired.

Strengthening access to harm reduction

Spectra's resource distribution to SWers is our main form of harm reduction. The resources which Spectra distributes include internal and external condoms, lube, and menstrual sponges, as well as written information about our ALEX service and other Spectra services (see Appendix 1.1).

Menstrual sponges are difficult to buy in mainstream stores or with health providers. Menstrual sponges are required by sex workers who have a menstrual cycle to absorb the blood whilst allowing them to continue working. This is not just for in-person full service SWers, but also for online camming where the community guidelines of many platforms prohibit showing blood. If a SWer does not use a menstrual sponge they risk having to offer non-vaginal services they don't usually offer to clients and aren't comfortable with, violent repercussions or assault from clients who feel slighted, or loss of income and financial precarity. Where sanitary menstrual sponges are not available SWers have been known to use scouring pads, upholstery foam, or baby wipes. Beyond elevating the risk of infection through using the wrong material, SWers can also struggle to remove the menstrual sponge themselves and can use unsuitable means such as metal tongs or tweezers leading to tearing and abrasions. The SWer will likely need to continue working through these injuries to continue earning income.

Not only is it very difficult and expensive to source sponges for SWers, but also SWers often find medical professionals are unaware of the existence of sponges. This can lead to embarrassment when SWers do venture out for support for infection, tearing and removal, and possibly disapproval from a medical professional who does not have lived experience or know the safe and sanitary manner to use a sponge.

The SW service at Spectra distributes menstrual sponges in SW-only spaces and discusses safe ways to use and remove sponges with service users who are unsure. This method of harm reduction is in direct contrast to SW experiences of sexual health services which have not been tactful or educated in this regard. In one case our team was contacted for an urgent sponge by a service user, and our staff were able to promptly meet the service user in a space where they were comfortable to give them the supplies.

Strengthening access to testing and treatment

Spectra's outreach team offers rapid HIV and STI tests in SW-only spaces without the targeted health inclusion group needing to change their routine or enter an unfamiliar space. The STI test kits which Spectra offers are home test kits where our staff walk the service user through the testing process to ensure they feel comfortable taking the sample themselves. Spectra staff also have devices with them on the outreach shift and offer the amenity of registering the STI testing kit online with the service users in the moment. Delivering this next step while we have contact with the individual goes some way to remove the additional barrier of registering the kit in their own time and space. If requested by the service user, they can hand the testing kit back to our team with the sample and we will post it on their behalf. In this sense, Spectra removes as many of the travel, admin, and postal fee-based barriers as possible. This level of support would not be available if the service user was not comfortable with our staff or if we simply distributed the testing kit as a resource with no additional advice.

A specific case of Spectra strengthening access to testing and treatment comes from our caseworker who was able to offer a rapid HIV test conducted from our office. They then signposted to two clinics: cliniQ which has services specifically for trans people, and Dean Street which has services specifically for sex workers. Because our staff had already researched and contacted these facilities, they were able to promptly provide targeted information about referral pathways and up to date contact information to make it as easy as possible for the service user to choose the clinic that would best meet their needs, and make contact without having to search for information. This was one of many successful outcomes for this service user, who emailed to thank our caseworker for not giving up on them.

Three: Further Planning

This section brings together insights from the CPGs to outline preferences and recommendations from SWers for healthcare inclusion, outreach and services.

The key recommendations are:

- Resource distribution is a priority for outreach
- A variety of outreach locations appeal to a range of SWers. Including in-person and online but not in spaces where SWers are working
- Almost universal preference for peer-led outreach and services
- Educated and non-judgemental staff without lived experience are acceptable for some but not all SWers
- More availability of walk-in centres
- Longer opening hours for SW-only services
- No requirement to share personal information or verify SWer status to healthcare staff
- There is demand for a wide variety of health services which prioritise SWers, not just STI and HIV testing
- Introduce SW-specific crisis services, such as support for SWers after assault or rape
- More intersectional and holistic services to support general wellbeing

SWer preferences regarding outreach and engagement

According to the poll Spectra conducted in both CPGs, participants rated in-person outreach as more important than online outreach (full results in Appendix 4). One example which came up in both sessions was that people thought some online outreach was untrustworthy, when organisations contacted them on adultwork and similar sites where they are working they don't take the health service seriously. In the in-person CPG one participant mentioned that Controlling Chemsex on Grindr was an exception to this rule - they liked that this outreach profile was a consistent and reliable resource on Grindr and felt that they could contact Controlling Chemsex as and when they needed to.

The highest priority from the outreach poll was resources. SWers wanted free and discreet access to legal rights resources, condoms of all sizes, menstrual sponges, and individually packed dental dams amongst others. Casework advice was also considered an important resource for outreach. It appeared that there was a general expectation from prospective service users that outreach should have a similar capacity as a caseworker, resolving complex issues and offering referrals in the moment.

In the online CPG there was a discussion about outreach and testing in social spaces e.g., public bars. Some participants felt that it was a positive form of outreach, saying they felt more relaxed there, it opened up a conversation, and reduced stigma towards HIV. Others found outreach in social spaces anxiety-inducing because they were unsure about their safety and didn't want to speak openly about their experiences.

When asked about experiences of outreach some SWers said that they don't encounter or use outreach at all. They prefer to approach services when they need to, and will only go to services which have a good reputation with other SWers.

> ***"Just the fact that it's another sex worker recommending does give me a bit of reassurance that they've had a look at the website, maybe they've met some of the staff there, maybe they have used the services there."***

Peer-led outreach came close to resources as the second most important element of outreach. The in-person session discussed how peer-led health professionals were less likely to be awkward or overly congratulatory when discussing their profession, and also would have more experience in the field and therefore more relevant advice. The online group agreed that peer-led outreach was very important. Individuals felt that other SWers would be less likely to discriminate and more relatable to talk to. One online participant mentioned that it would be valuable to have consistent staffing in addition to peers, so that service users can build relationships with those who run the service. This perspective was supported by a SWer at the in-person session who shared that they travelled across London to St Mary's Hospital for four years just because they knew they would be seen by the same nurse who was not a SWer but they felt was safe and non-judgemental. This SWer-specific clinic is now closed.

Both CPGs discussed outreach in SWer-only spaces, even though this was not listed on our poll. This type of outreach was what most of the participants had experienced before, and also where they were most comfortable. The SWer-only spaces offer the opportunity to socialise with friends not worrying about keeping their SW quiet. Both CPGs also agreed that an ideal outreach model would be the health service provider attending the SW-only space where they were already comfortable and relaxed. This way the SWers don't have to enter an unfamiliar space but can still access health inclusion and services if they would like to.

SWer perspective on peer-to-peer services

Peer-support was a recurring theme throughout both sessions, unprompted. Multiple participants in both groups echoed each other, saying that service delivery from other SWers was preferable over anyone else. People felt that because of empathy between peers their privacy would be more respected, and that they wouldn't have to give unnecessary information or risk police involvement. 'Experience' kept recurring in each group with the idea that because of another SWers history in the profession that they would have a deeper understanding and interpersonal skills to deliver a sensitive and friendly service. This point was repeated over the course of both sessions.

> ***"So I particularly use peer-to-peer groups. […] There's no, you know, shame. And I think that we have some kind of connection together […] so it's easier to access those services."***

Peer-led service design was also a familiar theme in both CPGs. Participants agreed that a SWer was more likely to know what was needed for a service: which spaces to approach and who to contact, what issues are the most important, and which resources the most appropriate. One individual during the in-person group added, each different type of SW has different required skills and resources, and poses different challenges. To have a peer-led service which is representative of those working in the SW sector, a variety of lived experience is required. Not all knowledge is transferrable within the sector. Another point from the in-person session was that when a service is designed by SWers it implies less of a power dynamic. The community itself has control over its own wellbeing, rather than being prescribed by an external medical professional who so often has the final say in treatment access and eligibility.

A few participants pointed toward nuances in the peer-led design and delivery of health services. An online attendee stated that they didn't need their health professional to be a SWer but wanted someone who wasn't judgemental or biased. During the in-person CPG a participant mentioned seeing advertising about a health service saying that it was non-judgemental. They thought that this was

bizarre and implied that SWers could and should be judged elsewhere, comparing it to if a supermarket was advertised as 'non-judgemental' it would be seen as strange – why would anyone be judged at a supermarket? The in-person CPG was split more equally in opinion as to whether they preferred a SWer to design and deliver their health services. For most, the health worker did not *have* to be a SWer, but they needed to be informed, up to date, have good interpersonal skills, and not easily phased or morally outraged. Participants agreed that these characteristics were far more likely to be found in a SWer, and because of these odds they would generally opt for a peer service unless it was recommended and approved by other SWers. The whole group did not agree, and some individuals maintained that even with this perspective they would only want to access healthcare services from another SWer, or otherwise would continue lying to professionals from whom they seek support.

Options for a high-quality NHS SW service

During the CPG exercise to design the ideal service provision, both groups agreed that staff with lived experience was important to them. For participants in our CPGs, a high-quality NHS SW service for them would be delivered and designed by their peers. In the absence of this, there was the suggestion from the CPGs to have a SWer on call to observe/support appointments with other medical professionals where requested by a service user. If SWer staff were present, but few, service users could also have the option to indicate their preference of lived experience (including gender) when they entered the service for treatment.

CPG participants were clear that to have a high-quality service, the professionals had to be knowledgeable about SW and its issues if hiring SWers themselves was not possible. Some online participants were reluctant to advise on how to design a service or which language to use. They were concerned that health professionals could be given a script to earn trust with terminology they don't understand and then let the service user down in the long-term. Both CPGs emphatically asked that health professionals engage in self-led learning on SW matters and learn for themselves which issues and terminology would be better.

The in-person group was more forthcoming, possibly due to the fact that this group had a higher number of SW health professionals in attendance. The terms 'victim', 'vulnerable', 'selling your body', 'exit', and 'complex needs' were resented amongst the group largely because they felt it painted SWers as helpless, morally corrupt and needing emancipation. 'Complex needs' was not universally disliked but around half of the group felt that this was a term often used to excuse medical inaction, that the individual was too complex to be supported. Another phrase which divided opinion was the idea of 'reduced reliance' rather than exiting SW, some participants felt this was still inappropriate and not required to support a SWers health needs.

A number of ideal characteristics were listed by participants in the brainstorming exercise to design the ideal service. Two models were suggested by the CPGs

Model 1: a discreet walk-in service with long opening hours and/or

Model 2: a mobile unit which operated out of multiple locations.

Participants from both CPGs indicated their preference for these services to be conducted out of existing SWer-only spaces and not NHS clinics. For both options the opening hours and information about how to access the services should be up to date and easily accessible online. Also central to most SWers model of health services is the absolute priority of privacy and anonymity. SWers asked

for no requirements to share personal information such as their NHS or National Insurance number and no information sharing with government departments such as the Home Office.

Participants wanted medical services to inform them of how their records were linked across medical institutions, and asked for their permissions before sharing data, even internally. According to the CPGs service users should be able to access the health services anonymously, using a self check-in system and not be asked for confirmation that they are a SWer during their time at the service. An anonymous complaints procedure was the final element of a service model.

In their ideal services participants included standard health services such as priority to quick testing and vaccines, with text reminders for follow up appointments, and PrEP and PEP monitoring. Services to benefit the wellbeing of SWers were also included such as advocacy and caseworkers on call, legal rights and union signposting, referrals to therapists, and treatment.

Two wellbeing services were mentioned in the in-person group as current gaps in health services for SWers: 1) support for SWers who are being stalked and 2) trauma informed rape crisis support for SWers. In the legal system SWers are forced to use their legal name when taking action against stalkers, which elevates their vulnerability by diminishing their privacy. Tailor-made support for SWers who have stalkers which allows them to keep their anonymity would be valuable for their wellbeing. SWers have also shared bad experiences with rape crisis centres amongst themselves, where the staff do not understand the concept of conditional consent or apply it to SWers. This too would be a welcome addition to existing health services for SWers.

In our exercise we wanted participants to consider how they would like to feel at the health inclusion service. From this conversation arose a more holistic approach to health and wellbeing. Participants wanted a calm space to socialise and have hot food, creches for their animals and children, and spaces to freshen up or get changed where they might not usually have access during the day. This idea evolved during the in-person session, to create a comfortable SWer-only environment where people could access healthcare and support, broadly defined in a non-clinical setting.

Access to resources featured in the exercises for ideal outreach and service visioning. Overall the guiding principle for resources was a high quantity and a large variety. Both CPGs envisaged the ideal health service for SWers as a one-stop shop for all the information, medication and protection they require. A needle exchange and over the counter treatments for Chlamydia infections or UTIs were enthusiastically requested, as well as maintaining the usual supply of STI self-test kits. Menstrual sponges were mentioned as important in both sessions as were a variety of lube (sachets, bottles, refills, silicone), condoms (all combinations of sizes, flavours, black colour, latex free), gloves (sizes, black, nitrile), and dental dams (latex and latex free, individually wrapped). According to the SWers that Spectra has consulted, these resources and the provisions discussed throughout this report have the potential to create a high-quality SW health inclusion service within and delivered by the NHS.

Appendix 1

1.1 Spectra's resources to engage with SWers

The following are our current resources at Spectra which we use to engage with SWers. They are distributed via social media and email, but also crucially through in-person outreach at SW-only spaces and interpersonal sharing in Whatsapp (and similar) groups.

The form Spectra uses to gather information from service users during outreach available here: https://forms.office.com/e/4LPEAVeKuC

This is a general resource file which is shared with any sex workers to read through in their own time, for their own use and interest, created by our Service Lead: https://tinyurl.com/spectrasw

Resources Spectra takes to outreach sessions:

- Home test STI kits
- Personal alarms
- UTI test strips
- Covid tests
- Lube
- Internal condoms
- Tampons
- Sanitary towels
- Menstrual sponge
- Pregnancy test strips HCG
- Dental dams
- Condoms (Regular, trim, large/king, XL/superking, extra safe, thin/naturelle, black, flavoured)
- Loose internal condom
- Information packs and leaflets

Ask for ALEX information packs and leaflets:

MSM pack

Indoor pack

Outdoor pack

Business card

General ALEX leaflet

Posters and invitations to our groups and events:

SWL Group

CPG/Focus Group

1.2 List of organisations by and for SWers

Name of organisation	*Area*	*What work do they do?*	*Links*
Bristol Sex Workers Collective	Bristol and surrounding areas	SW legal rights advocacy, decrim	Bristol Sex Worker's Collective (bristolswc.com)
Decrim Now	National	Campaign for decrim, mutual aid, support for workplaces	DECRIM NOW – National Campaign for Sex Workers' Rights
Hookers Against Hardship	National	Benefits assistance, decrim, housing advocacy	https://decrimnow.org.uk/hookers-against-hardship/
National Ugly Mugs	National	Personal Alarms, Leaflets, safety info & support for all SW	https://www.nationaluglymugs.org/
SAAFE	National	Info and screening for SW	https://saafe.info/main/index.php
English Collective Of Prostitutes (ECP)	National	Support for all SW inc rights and legal	https://prostitutescollective.net/
European Sex Workers Rights Alliance	International	Research opportunities & grants, studies and resources	European Sex Workers' Rights Alliance (eswalliance.org)
Sex Workers Advocacy and Resistance Movement (SWARM)	National	SW rights advocacy and meet-ups.	SWARM Collective
Sex Workers Breakfasts	National	Free condoms, clothes, hot food, social space for all genders and types of SW, every Wednesday 11am - 3pm in East London. Contact for address	http://www.xtalkproject.net/
Support Network For Adult Professionals	National	Resources, events, networking for adult industry content creators and performers	https://snaptogether.co.uk/
Umbrella Lane	National	Free condoms, clothes, hot food, social space for SW, every week in Glasgow. Run by NUM	HOME | Umbrella Lane

x:talk	National	Language lessons, support for migrant & other workers	http://www.xtalkproject.net/
United Sex Workers [branch of United Voices Of The World]	National	Sex Worker Union - inc strippers	https://www.uvwunion.org.uk/en/sectors/united-sex-workers/
Pineapple Support	International	Free support and therapy for those working in the online sex industry.	Pineapple Support - The Adult Industry Mental Health Support Network
The Dialtone Project	National	Gives second-hand phones to sex workers who need it.	The Dialtone Project - Phones for those who need them
The Global Network of Sex Work Projects (NSWP)	International	Membership organisation, collective of sex-worker led organisations globally	Who we are | Global Network of Sex Work Projects (nswp.org)

For more local projects click here

For more national projects click here

1.3 Other resources by and for SWers

Watch:

Ted talk by Juno Mac: The laws that sex workers really want

Read:

Revolting Prostitutes: The Fight for Sex Workers' Rights by Juno Mac and Molly Smith

Streethooker blog

Jack's Talks About Sex Work blog

South London Stories blog

Lydia Caradonna blog

Molly Smith blog

A Stripper's Case for the Full Decriminalisation of Sex Work article

Beyond the gaze reports on internet-based sex work in the UK

On Twitter / X

HAH Campaign (@HAHcampaign) / Twitter

United Sex Workers (@unitedswers) / Twitter

SWARM (@SexWorkHive) / Twitter

Jack Parker (@MxJackParker) / Twitter

The Dialtone Project (@DialtoneProject) / Twitter

National Ugly Mugs (@NationalUglyMug) / Twitter

DecrimNow (@ukdecrimnow) / Twitter

Audrey Whorne (@blacklodgewhore) / Twitter

Bristol Sex Workers Collective (@BristolSWC) / Twitter

PiscesDisco (@pisces_disco) / Twitter

SCOT-PEP (@ScotPep) / Twitter

English Collective of Prostitutes ♀ 🏧 (@ProstitutesColl) / Twitter

London Sex Worker Breakfasts (@ldnswb) / Twitter

ESWA (@sexworkeurope) / Twitter

Em (@grumpyhooker) / Twitter

Amélie 🦋 (@afrenchstripper) / Twitter

fa trophy coveter (@jeremywhorebyn) / Twitter

Basis Sex Work (@BasisSexWork) / Twitter

Sexquisite Events (@sexquisitevents) / Twitter

Jason Domino [SFW account] (@TheJasonDomino) / Twitter

UglyMugs.ie Public (@UglyMugsPublic) / Twitter

Labour4decrim (@labour4decrim) / Twitter

⚥ mother moses moon ☽☾ (@thotscholar) / Twitter

Whores of Yore (@WhoresofYore) / Twitter

Kate Lister (@k8_lister) / Twitter

marla cruz (@prolepeach) / Twitter

Ashley Lake (@AshleyLatke) / Twitter

Red Umbrella Fund (@redumbrellafund) / Twitter

Heather Berg (@DrHeatherBerg) / Twitter

Angela Jones (@drjonessoc) / Twitter

Dr Victoria Bateman (@vnbateman) / Twitter

SexWorkResearchHub (@sexworkreshub) / Twitter

Respect Inc QLD (@respectqld) / Twitter

SWAN - Sex Workers' Rights Advocacy Network (@SWAN_Network) / Twitter

NSWP (@GlobalSexWork) / Twitter

Black Sex Workers (@TheBlackSWC) / Twitter

Scarlet Alliance (@scarletalliance) / Twitter

National Network of Sex Workers, India (NNSW) (@NNSWIndia) / Twitter

SWOP Behind Bars (@swopbehindbars) / Twitter

SWOP Los Angeles (@SwopLosAngeles) / Twitter

Sweat (@SweatTweets) / Twitter

RUS - Red Umbrella Sweden (@RedUmbrellaSwe) / Twitter

SexWorkerSyllabus (@SWSyllabus) / X (twitter.com)

Appendix 2

2.1 Interview questions for the ALEX team

Background

Hi, how are you feeling today?

How would you summarise the Spectra SW service? (It's ok to be general! Just say what you know. Drill down if possible into the remit, model and commissioning depending on interviewees' knowledge level)

What is your role within the Spectra SW service?

What training did you receive before starting your role?

Are you receiving any training during your role?

What support is available for you at Spectra? (egs if lost – clinical supervision, access to free counselling, supervision with manager, peer support)

Do you feel supported when working at Spectra? Why/not?

Do you feel relaxed when working in your role at Spectra? Why/not?

What opportunities (if any) do you know are available for you at Spectra?

Healthcare support

What types of issues do people usually approach you looking for support? (egs from brief – homelessness, immigration, criminalisation)

- How do these issues (be more specific to what they have just answered if possible) relate to health services we provide?

In your role, have you seen any cases of clients encountering barriers to accessing health services for infectious diseases?

In your role, have you seen any cases of good practice where clients are accessing health services for infections diseases?

What challenges and barriers have you encountered in your work at Spectra (this can be personal, or challenging experiences with a client)

Peer-led work

On a scale of 1-5, with 1 being very negative and 5 being very positive, how have you found working with other SWers at Spectra? Why?

Would you recommend Spectra's model of hiring based on lived experience to other similar organisations? Why?

Would you change any element of how Spectra conducts outreach (and engagement)? What, and why?

If you could extend the reach of Spectra's SW peer-led support, what would you do? (eg introducing new services, or making existing Spectra services SW peer-led)

What do you think would be the benefit of expending the SW peer-led support in this way?

What do you think would be the challenge of expending the SW peer-led support in this way?

Do you think the existing model of peer-led SW support at Spectra is sustainable? Why?

Organisational landscape + priorities

What organisations are you aware of in the UK which are doing similar Sex Worker outreach and support? (Can clarify this isn't exclusive to health services – any support)

What resources do you think SWers want from organisations such as (any egs they have said)?

Which resources do clients use most/least during your role at Spectra?

Case Studies

Could you tell me about a time when Spectra has improved access to vaccination, (if relevant in a new manner compared to industry standards)?

Could you tell me about a time when Spectra has improved access to harm reduction, (if relevant in a new manner compared to industry standards)?

Could you tell me about a time when Spectra has improved access to testing and treatment, (if relevant in a new manner compared to industry standards)?

2.2 Interview questions for the Senior Management Team

What support mechanisms are there at Spectra for those with lived experience in the sex worker service?

Does Spectra provide opportunity to peer workers in the sex worker service? How?

Does Spectra provide sustainability to peer workers in the sex worker service? How?

Does support, opportunity and sustainability change when working with peer workers in the Sex worker service? Why?

Is there anything else on hiring peer workers which you would like to mention?

2.3 Focus groups' schedule

Arrival of attendees

Online: attendees arrive and are given 5 minutes to log into the session and connect audio.

In-person: attendees have 10/15 minutes to arrive after the beginning of the session to settle and take a drink/snack/seat.

Introduction

Facilitator 1 will introduce the session.

- This focus group is about health provisions for sex workers, as part of a piece of research which will reflect on existing provisions and work towards improving current sexual health services (SHS), outreach, and inclusion health groups.
- The research is being written by Spectra and will shared with external funders.
- Today we will collect peoples' thoughts and words only, by staying participants consent to this. If they do not want their ideas to be noted please clearly indicate at the time of sharing.
- Check all participants have signed and returned the consent form (sent in advance).
- Ask participants not to disclose anything that is being said within the focus group to others outside this group
- Any video, audio, or identifiable information will be disposed of once the transcript has been proofread and finalised.
- Throughout the session we will be updating a Miro board (online)/Sticky note board (in person) to create mind-maps of answers to each question. This mind map will also be kept for analysis after the session.
- Open invitation for participants to add sticky notes there if they would rather, compared to speaking, or online to enter their thoughts in the chat to also be included.
- Open invitation to take a break if they need to, and only share what they feel comfortable to do so. There is no pressure to produce a particular insight or conversation.
- In-person: invite them to help themselves to refreshments and use the fidget toys as desired.

Any questions about the research or privacy at this stage?

Recording started.

Focus group questions – Facilitator 1 to host first set of questions until the break

Q1 Rank the following issues from 'I know lots about' to 'I don't know about this'

- TB
- HIV
- Hep B
- Hep C
- Other STIs
- Other vaccine preventable diseases

Using pre-made cards in person, and a ('rank order') poll on zoom.

Facilitator will ask the group to expand on why they ranked the issues as they did, and if there are other important STI/STDs (eg MPox) which are not on this list.

The following questions 2-8, and 10-12, are all asked openly to the group for discussion. Responses will be collated onto a stickynote mind map as a poster in person, and online using a Miro board. Lara will ensure all points are added to the stickynote board, and that comments from the chat online are brought into the discussion.

Q2 What services do you currently use for health-based assistance?

Prompts: Sexual health centres, GPs, charities, online testing, Clinic Q, your friends and colleagues.

Encourage participants to say which services they use for *which health-based issues.*

Q3 What would you want to add to current service provision? What is lacking?

Prompts: services which were cut in the pandemic and not re-introduced.

Q4 Do you feel current sexual health services available are geared towards your specific needs as an individual?

Prompts: awkward service, knowledge gaps (sponges)

Q5 Do you experience any other barriers to accessing health services aside from your occupation as a sex worker?

Prompts: neurodivergence, disability, trans, ethnicity, age, parenting status, migration status

Emotional, practical and intersectional barriers.

Q6 If you could design your ideal sexual health service provision, what would it look like?

Starting prompts: What would make the *just mentioned* barriers go away?

Other prompts:

- What would feel good when accessing SHSs – eg Deans St. VIP Gold Card
- What issues do you want assistance with – and how
- What would make you want to engage with the SHS you're designing.
- Where do you want these provisions?
- Who are the staff-members?

Facilitator to keep a balance between societal critique and specific practical policy critique.

Participants are to split into small groups of 2-3 depending on how many attendees, for 10-15 minutes depending on timekeeping so far. After the smaller groups, a representative from each will speak to the wider group. Key points from the wider discussion will be noted on the stickynotes.

Online: these discussions will happen in breakout groups. Then when participants come back to the main group they will share highlights of their discussion.

In-person: groups will be given a large sheet of paper and some pens. They will be invited to draw out their ideal service provision, and then after the time alotted to groupwork they will present this to the group for discussion. These posters will ideally be kept for writing the report, unless participants do not wish them to be included.

Break – Facilitator 2 to host discussion after the break

Q7 What are your experiences of sexual health outreach?

Prompts: where and what was it like? online and in person, at events, in SW-only spaces, in wider spaces, resource distribution, testing pop-ups (eg find and treat NHS mobile van).

Definition of outreach: when organisations reach out to you, rather than you reaching out to them. Often to advertise options to you so you feel comfortable engaging again when you need to.

Q8 What are common experiences with SH outreach for sex workers?

Prompt: think best/worst, don't have to go into personal detail on terrible stories – it can be more general! Lots of people have difficulty with X, but often outreach can get Y right.

This question is to be answered in small groups again, very brief this time just 2/3 minutes to talk amongst themselves. Then, participants will relay their groups answer back to the wider group.

Encourage funny stories! And again emphasise, there is no pressure or requirement to dig up uncomfortable situations you don't want to discuss or think about here.

Q9 rank the following in order of most important to least important to you with outreach services

- Resource provision (condoms, sponges, gloves)
- Peer-led outreach
- In-person outreach
- Online outreach

Using pre-made cards in person, and a ('rank order') poll on zoom.

Q10 Facilitator to drill down on the results of Q9 poll.

Prompt: which resources are best? Why is X a top/bottom priority?

Q11 What messaging is important to you?

Prompts: what wording in outreach, not exit-ing, information on free resources/food, lived experience workers.

Q12 Why did you rank people with live experience as (high/low) in service provision/outreach?

Prompt: in a particular role, or all roles? Importance of lived experience, or not – and why.

Cool down

Facilitator 2 will summarise key points raised during the session, and open up the space in case there are any additional points participants feel must be said and were not touched on.

Recording stopped – session finished.

Appendix 3

A balance of CPG participants were chosen from the pool of applicants displayed below. Three disabled people applied in total, and all three attended the online session. Seven people selected 'Only past experience' when asked about their lived experience, and were automatically screened out of the selection process since we were only hosting discussions with current SWers.

Intersections are not shown here to preserve anonymity of participants, they are mentioned anecdotally in Section 3 when insights around peoples' intersectionalities were included in conversation. In each table below in-person applicants and successful participants are shown in the same column because all applicants were invited to the CPG for the in-person session due to lower numbers.

Ethnicity

	all online applicants	*online participants only*	*in-person applicants/successful participants*
Black British	31	7	1
Black Other	3	2	-
Brown British	8	4	-
Mixed race / heritage	5	2	-
White British	12	4	4
White Other	1	1	2

More non-white participants were selected for the online CPG because far fewer non-white people applied for the in-person CPG, the goal here was to achieve more of a balance of ethnicity overall. 'Brown Other' was an additional option on the application form but Spectra received no application from people with this ethnicity.

Gender

	all online applicants	*online participants only*	*in-person applicants/successful participants*
Man;	12	6	-
Woman;	31	6	5
Trans;	7	3	2
Cis;	8	3	3
Non-binary;	5	4	1
Fluid;	1	1	2

This question on the application form was a multiple choice question, for example participants could select 'Trans' and 'Man'.

Type of Sex Work

	all online applicants	*online participants only*	*in-person applicants/ successful participants*
Full service / escorting	37	13	7
Sugaring	6	2	4
Fetish (wrestling, BDSM etc)	18	12	3
Stripping/ dancing/ gogo	29	8	-
Adult performer	31	8	-
Massage	27	8	-
Remote sex work (phonelines, webcamming, sexting, content creation)	19	10	1

This question on the application form was a multiple-choice question, individuals could select as many as applied to their profession. Applicants who only selected 'Remote sex work' were automatically screened out of the CPG invitation since we were only hosting discussions for current SWers.

Venue of Sex Work

	all online applicants	*online participants only*	*in-person applicants/ successful participants*
Brothel	17	7	-
Dungeon	5	3	1
Incalls at own residence	22	8	1
Incalls at separate residence (flat/house, rented/shared)	31	11	3
Outcall to clients hostel or residence	30	11	7
Porn studio/filming location	14	7	1
Sex/kink club	19	6	-
Street, outdoors, cruising areas	19	6	-
Strip club	22	7	-
Remote from home (content creation / camming)	19	10	1

This question on the application form was a multiple-choice question, individuals could select as many as applied to their profession. Applicants who only selected 'Remote from home' were automatically screened out of the CPG invitation since we were only hosting discussions for current SWers.

Appendix 4

The following two sections summarise the CPG results of each poll.

Knowledge of key diseases

Not all participants chose to take part in each poll.

In-person group (headcount)	*I know lots*	*I know a little*	*I don't know*
TB	2	2	3
HIV	6	1	-
Hep B	1	5	1
Hep C	1	5	1
Other STIs	5	1	-
Other Vaccine preventable diseases	-	3	4

Zoom group (headcount)	*I know lots*	*I know a little*	*I don't know*
TB	3	9	2
HIV	11	3	-
Hep B	5	7	2
Hep C	2	7	5
Other STIs	9	5	-
Other Vaccine preventable diseases	1	11	2

Total across groups (%)	*I know lots*	*I know a little*	*I don't know*
TB	24%	52%	24%
HIV	81%	19%	-
Hep B	29%	57%	14%
Hep C	14%	57%	29%
Other STIs	67%	29%	-
Other Vaccine preventable diseases	5%	67%	29%

Important aspects of outreach

Not all participants took part in each poll.

In-person group (headcount)	*Very Important*	*A little important*	*Not important*	*Don't know*
Resource provision	4	1	-	-
Peer-led outreach	4	1	-	-
In person outreach	-	4	1	-
Online outreach	-	1	2	2

Zoom group (headcount)	*Very Important*	*A little important*	*Not important*	*Don't know*
Resource provision	12	3	-	-
Peer-led outreach	11	4	-	-
In person outreach	11	3	1	-
Online outreach	9	5	-	1

Total across groups (%)	*Very Important*	*A little important*	*Not important*	*Don't know*
Resource provision	80%	20%	-	-
Peer-led outreach	75%	25%	-	-
In person outreach	55%	35%	10%	-
Online outreach	45%	30%	10%	15%