Health Needs Assessment of Sex Workers in Bristol 2026

Public Health, Bristol City Council, 2026 (data provided up to and including January 2025)

Please note, due to unforeseen circumstances, there has been a delay in the publication of this report. Since the writing of this health needs assessment, both Bristol's Sexual Health Services and Substance Use Services have been recommissioned. The health needs assessment provides a snapshot in time from when it was written, providing available data and information up to and including January 2025. For further information on current service provision, please follow Sexual and reproductive health services and/ or Support for people who use drugs and alcohol

It must also be acknowledged that since the development of this report, a number of individuals who have been accounted for in the data have sadly passed away, emphasising the importance of recognising the health and service needs of sex workers. Our condolences are with all who knew them.

Contents

1. Executive Summary

This health needs assessment aims to quantify and map sex work in Bristol, understand the demographics and health needs of sex workers, and identify gaps and barriers to service access. The assessment focuses on adults aged 18 and over, including male, female[1], and LGBTQ+ individuals.

Key themes identified in this health needs assessment:

- **Demographics**: Sex workers in Bristol include a diverse range of individuals, with high representation amongst those accessing services from females, those of White British ethnicity, heterosexual individuals and those aged between 30 - 50. This suggests that there is need to locally explore health needs and support for other demographic groups who are under-represented in service data.
- **Multiple disadvantage**: Many sex workers face multiple disadvantages, including homelessness, substance use, disability, domestic abuse and sexual violence, and poverty.
- **Health**: Evidence and data indicate that sex workers experience poor health outcomes and health inequalities, compared to those not sex working in regard to physical and mental health. There are also health inequalities within the sex working community. There is high prevalence of chronic and co-occurring health conditions as well as high levels of health risk behaviours such as smoking and substance use.
- **Service access**: Barriers to accessing relevant services are highlighted and include stigma and service times. There is a need for trauma-informed, well-connected services that reduce stigma and build trust to improve access.

This health needs assessment puts forward a call to action and the areas for action are summarised below:

Local system and policy/ strategy: Ensure a multi-agency approach is taken to sex work in Bristol, with lived experience being central to this; develop a local strategy, ensure cohesion between local strategies and raise awareness amongst professionals.

Prevention and early intervention: Support prevention into sex work for young people at risk through improving shared understanding of risk factors and unmet need, providing alternative options. For those engaging in sex work, improve early access to primary care, prevention, mental health pathways and trauma-focused interventions.

Ensure all services meet the needs of sex workers: All services should ensure they are accessible to and meet the needs of sex workers including ensuring they are trauma-informed. Lived experience should be embedded in services, ensuring collaboration between health and non-health-related services, and a “My Team Around Me” approach for individuals with more complex needs/ experiencing multiple disadvantage. Innovative ways to engage such as peer networks and trusted groups should be utilised.

[1] The terms "woman" and "female" shall have the meanings attributed to those such terms contained within the Equality Act 2010

Improving sexual health outcomes: Improve sexual and reproductive health outcomes for sex workers by ensuring health services meet the needs of sex workers through a range of routes, ensuring that there are clear pathways between agencies.

Data and further research: Continue to work with existing systems and projects to further understand the needs of sex workers and evaluate and improve data recording practices. Conduct further research in terms of experience of domestic abuse and sexual violence, particular sub-groups identified and the online sex work industry.

This health needs assessment suggests that scoping and where possible implementing these areas for action could create a more supportive and accessible healthcare environment for sex workers in Bristol, better supporting their specific health needs, and the social challenges that influence their health and care access, reducing health inequalities in the city.

2. Acknowledgements

Author: Sophie England, Public Health Specialist (Protecting Health and Inclusion Health), Bristol City Council

Advisory Oversight: Sophie Prosser, Principal Public Health Specialist (Protecting Health and Inclusion Health), Bristol City Council

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- One25
- NIHR ARC West, University of Bristol
- The Nelson Trust
- The Homeless Health Service
- Broadmead Medical Centre
- Unity Sexual Health
- Terrence Higgins Trust (THT)
- Womankind
- Brigstowe
- Bristol Drugs Project (BDP)
- Changing Futures Bristol
- Beloved

Bristol City Council Colleagues

- Tiffany Wood, Senior Public Health Specialist
- Katie Porter, Consultant in Public Health, Inclusion Health
- Dr Joanna Copping, Consultant in Public Health, Population Health, Sexual Health and HIV
- Filiz Altinoluk-Davis, Principal Public Health Specialist, Sexual Health and Population Health
- Holly Mckeon, Senior Public Health Specialist, Sexual Health and HIV
- Sue Moss, Principal Public Health Specialist, Substance Use
- Katy Harris, Senior Public Health Specialist, Domestic Abuse and Sexual Violence
- Celia Marshall, Public Health Specialist, Protecting Health and Inclusion Health
- Ben McNamara, Public Health Apprentice
- Rachael Harrison, Public Health Registrar
- Magdalena Szapiel, Senior Public Health Specialist
- Joni Lloyd, Commissioning Manager for Homelessness and Rough Sleeping Services

3. Background

3.a. Aims and Scope

The aims of this health needs assessment are to:

1. **Quantify and map** real-world sex work in Bristol.
2. **Understand** the number of workers, their demographics, and working locations.
3. **Understand the health and service needs of sex workers**, including identifying what is working well, gaps, barriers to access, and cost-effective adaptations to improve access.

Within the scope of this health needs assessment are:

1. **Demographics:** Adults aged 18+ (the legal age for sex work), including male, female, and LGBTQ+ individuals. Under 18s are excluded from the needs assessment recognising Child First principles; anyone under the age of 18 would not be considered a sex worker but as a victim of child sexual exploitation.
2. **Geographical areas:** Bristol, with consideration for travel in/ out of area for sex work and service use.

The health needs assessment is not an in-depth services assessment but will offer areas for action based on evidence and identified gaps; the focus is on health over wider needs.

3.b. Abbreviations

The following acronyms/ terms may be used throughout the health needs assessment:

BDP: Bristol Drugs Project
BNSSG: Bristol, North Somerset, and South Gloucestershire
CIS: A synonym of “cisgender.” Cisgender is “used to describe a person whose gender matches the body they were born” (Cambridge Dictionary n.d.)
ECG: Electrocardiogram
EMIS: Egton Medical Information Systems
GP: General practitioner
GUM: Genitourinary medicine, a medical specialty that focuses on the diagnosis, treatment, and prevention of conditions affecting the urinary and genital systems
HIV: Human Immunodeficiency Virus
HNA: Health needs assessment
HPV: Human Papillomavirus
ICB: Integrated Care Board
ISVA: Independent Sexual Violence Advisor
JSNA: Joint Strategic Needs Assessment
LGBTQ+: Lesbian, gay, bisexual, transgender, queer/ questioning, and others
NICE: National Institute for Health and Care Excellence

NPCC: National Police Chiefs' Council
NUM: National Ugly Mugs
OHID: Office for Health Improvement and Disparities
OST: Opioid substitution therapy
PrEP: Pre-exposure prophylaxis
PTSD: Post-traumatic stress disorder
Script: A prescription for medication, typically for controlled substances such as opioid substitute treatment
STD: Sexually transmitted disease
STI: Sexually transmitted infection
SW: Sex worker
SWLO: Sex Work Liaison Officer
THT: Terrence Higgins Trust
UKHSA: UK Health Security Agency
VCSE: Voluntary, community, and social enterprise
WHO: World Health Organisation

3.c. Methodology

The following methods have been used to develop this health needs assessment:

1. Rapid review of evidence: This included relevant systematic reviews, UK studies, grey literature and health needs assessments from comparative areas in the UK.
2. Analysis of quantitative data from services.
3. Qualitative data collection from a focus group with local street-based sex workers (from Bridging Gaps).
4. Qualitative data collection from conversations with service professionals.

Rapid techniques were used relevant to the scale and resources of the project. This is not a definitive list of literature or potential data sources.

All qualitative data collected (points 3 and 4 above) were thematically analysed.

A project group of stakeholders steered the project and wish to continue work on the project's areas for action following its completion.

4. Context

4.a. National Context

4.a.i. Defining Sex Work

Sex work spans a wide range of activities, but is defined in this health needs assessment as in Hester et al. (2019), as:

> "the provision of sexual or erotic acts or sexual intimacy in exchange for payment or other benefit or need."

4.a.ii. Selling Sex: UK Law

In England and Wales, selling sex is legal, but related activities like soliciting in public, kerb crawling, pimping, and managing a brothel are illegal (National Police Chiefs' Council, 2024).

Detailed discussions of the development of law and policy around sex work in the UK are available, for example McCarthy, Caslin and Laite (2014) and Sanders (2017). Early legislation such as the 1824 Vagrancy Act (UK Parliament, 1824) and the 1864 Contagious Diseases Acts (UK Parliament, 1864) are examples of key developments. The 1956 Sexual Offences Act (UK Parliament, 1956) and the 1959 Street Offences Act (UK Parliament, 1959) introduced penalties for brothel-keeping and street solicitation. Modern legislation, including the 2003 Sexual Offences Act (UK Parliament, 2003) and the 2009 Policing and Crime Act (UK Parliament, 2009), focused on exploitation and demand reduction. Recent debates have considered the Nordic Model, which criminalises buying sex but not selling it (Vuolajärvi, 2023).

The NPCC is developing guidance[2] which highlights how the lack of clarity and outdated nature of some national legislation creates uncertainty around how to police sex working within the existing arrangements. The new guidance aims to "aid interpretation of the complexities of sex work, recognise the key indicators and risk factors of adult sexual exploitation, and improve national consistency in policing's approach to sex work, while focusing on enforcing against those who exploit" (NPCC, 2024). It emphasises the role of Sex Work Liaison Officers (SWLOs) in building trust, investigating crimes, and coordinating responses. In Bristol, SWLOs work closely with local specialist organisations to support and reengage sex workers, aiming to avoid prosecution that could lead to more sex work. In 2012, the Home Office funded the National Ugly Mugs scheme to improve sex worker safety by allowing the sharing of information between sex workers about dangerous individuals and providing support to victims of crime (Hodson, 2023).

4.a.iii. Why People Sex Work

In 2019, a team of researchers at the University of Bristol were commissioned by the Home Office and the Office of the South Wales Police and Crime Commissioner to report on the current "nature" and "prevalence" of prostitution among adults aged 18 or over in England and Wales (Hester et al., 2019). The authors summarise:

[2] The National Police Chiefs' Council's guidance went out for consultation in 2024 and the final guidance has since been published and can be found using this link Sex-work-national-police-guidance-2025.pdf

> “We recognise that there are many individuals in prostitution who are subject to acute exploitation and serious and sustained harm. Some identify selling sex as a pleasurable and lucrative career choice, or as a therapeutic vocation. Our sense from the data that we have collected and from reviewing existing research is that a substantial proportion of individuals (mainly women and trans women) are selling sex to get by financially, given different constraints in their lives around caring responsibilities, physical and mental health, lack of access to social security benefits and support services, workplace discrimination, or other reasons. Their situation is compounded by stigma and managing safety, and many find that the longer they sell sex, the harder it can be to leave completely. This moves beyond individual ‘choosing or ‘not choosing’ and recognises the structural economic and social context in which choices are narrowed: or in the case of those coerced in to selling sex, choices removed.”

The NPCC guidance on sex work in the UK which went out for consultation in 2024 uses levels of autonomy to estimate risk, to operationalise police efforts to reduce harm faced by sex workers:

> “At one end of the spectrum are those who perceive commercial sex to be inherently exploitative, harmful and a form of male violence against women, and demand that it should be robustly challenged at every level. At the other end of the scale are those who adopt the ‘sex as work’ standpoint and view a person’s involvement in sex work as something of personal choice. For many, however, their perspectives are much more nuanced and reflect various aspects of the different ends of the debate.” (National Police Chiefs’ Council, 2024)

They note that whilst there is debate around the extent to which any sex worker operates with true autonomy and self-determination, it is possible to recognise that some sex workers have greater freedom, choice and autonomy than others. These can be categorised into the following:

> **Survival sex**: engage in commercial sex because they see no alternative.
>
> **Sex workers**: don’t necessarily choose to work in the sex industry but due to their circumstances engage in commercial sex because it appears better than the alternatives.
>
> **Sexual entrepreneurs**: have chosen to engage in commercial sex as a career choice and for whom sex working is not necessarily a temporary arrangement that they seek to exit.
>
> (National Police Chiefs’ Council, 2024)

They describe how this model is used as a tool to address harm and vulnerability holistically, “combining law enforcement with social justice- and community-based approaches”, allowing policing to focus on tackling exploitation and serious sexual offences (NPCC, 2024).

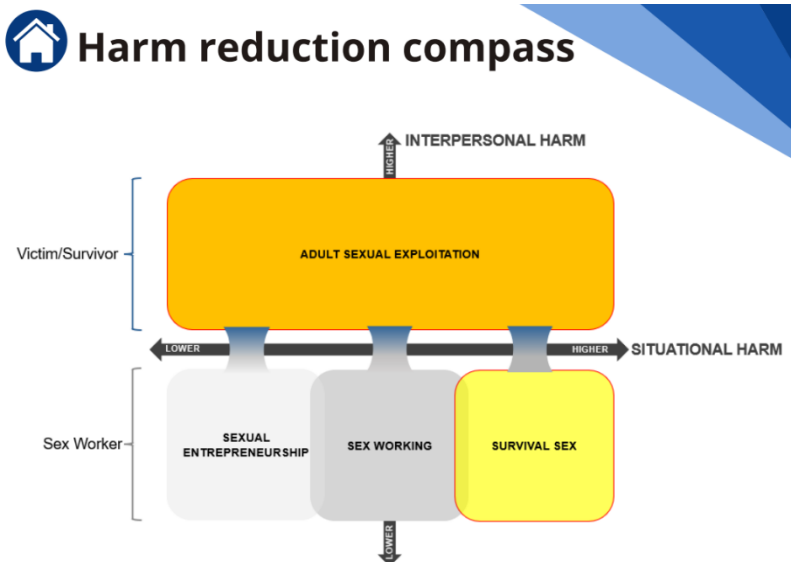

Figure 1. The Harm Reduction Compass
(National Police Chiefs’ Council, 2024)

Figure 1. shows the Harm Reduction Compass. It highlights how victims and/ or survivors of adult sexual exploitation are likely to experience higher interpersonal harm compared to sex workers (sexual entrepreneurs, those sex working and those engaging in survival sex work). It shows that those engaging in survival sex are likely to experience higher situational harm than those sex working, and sexual entrepreneurs.

4.a.iiii. Challenges of Estimating the Prevalence of Sex Work in the UK

Hester et al. (2019) highlight the significant challenges in estimating the prevalence of sex work in the UK due to the hidden and transient nature of the industry. Stigma, legal issues, the private nature of these activities, and many not knowing or considering themselves a sex worker, make data collection difficult. They emphasise the complexity and multifaceted nature of sex work, noting that people often move in and out of the industry, and of services and settings, which further complicates obtaining accurate data. Additionally, the diversity of “actors” involved in the sex industry, from NGOs to government bodies, leads to inconsistent data collection practices, as data is not held by a single organisation. As a result, they note that any estimates or generalisations about this population must be approached with caution, understanding their limitations (Hester et al., 2019).

Hester et al. (2019) collated estimates for the prevalence of sex work in the UK. For example, Abramsky and Drew (2014) estimated there were 58,000 “prostitutes,” extrapolating from estimates in London which may not be representative of the UK. Pitcher (2015) estimated that there were 85,714 sex workers (indoor and street) in

the UK, conducting surveys with service providers, with the limitation being that it excludes groups less connected to services. Hester et al. (2019) state “it should be noted that currently in the UK, no source of data allows for the production of representative population estimates for this group.”

4.a.v. National Policy and Strategy

The National Framework for NHS – Action on Inclusion Health aims to address health challenges faced by socially excluded groups, including sex workers, people who experience homelessness, and people with drug/ alcohol dependence (NHS England, 2023). These groups often avoid NHS services due to poor experiences, for example stigma, leading to worse health outcomes. The framework emphasises equitable access, excellent experience, and optimal outcomes, with cross-sector collaboration to address health determinants. Specific health risks for sex workers include high mortality, drug use, PTSD, and barriers to healthcare access (NHS England, 2023).

Figure 2. shows a graphic included in the framework that outlines 5 inclusion health principles: 1) Commit to action on inclusion health, 2) Understand the characteristics and needs of people in inclusion health groups, 3) Develop the workforce for inclusion health, 4) Deliver integrated and accessible services for inclusion health, and 5) Demonstrate impact and improvement through action on inclusion health.

Figure 2. Principles for action on inclusion health (NHS England, 2023)

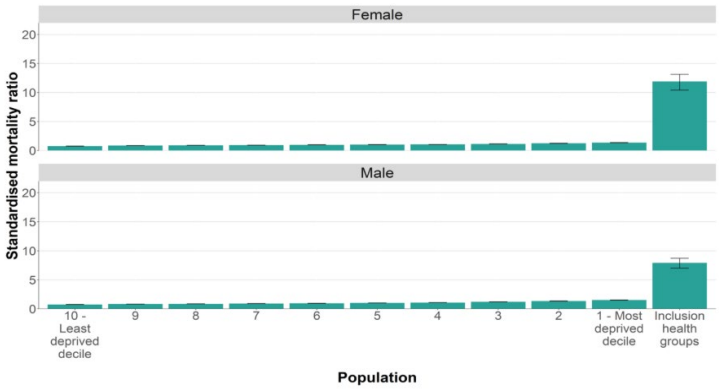

Figure 3. Standardised all-cause mortality ratio for inclusion health groups, compared to the general population by deprivation decile (NHS England, 2023 – Source: OHID, 2022)

The graph in Figure 3., included in the NHS “action on inclusion health” framework, shows how mortality ratios for inclusion health groups are disproportionately higher when compared to all deprivation deciles, and with an even greater disparity for females.

The Office for Health Improvement and Disparities (OHID) suggests that senior leaders can play a role in improving health outcomes for inclusion health groups, for

example by understanding their characteristics and needs and promoting a coherent local approach to inclusion health (Public Health England[3], 2021).

'Core20Plus5' is an approach set out by NHS England to support the reduction of health inequalities at national and system level (NHS England, n.d.). Core20 refers to the most deprived 20% of the national population. PLUS population groups include inclusion health groups which, by definiton includes sex workers. The 5 refers to five clinical areas of focus which are asthma, diabetes, epilepsy, oral health and mental health.

4.b. Local Context

4.b.i Local Policy and Strategy

Bristol's One City Plan[4] aims to reduce health inequalities (Bristol City Council, 2023a), further developed in the Multiple Disadvantage Strategy (2023-2026) (Bristol City Council, 2023b) aligning health and care efforts to support those facing multiple disadvantages. The Joint Local Health and Wellbeing Strategy 2020-25 envisions a city with reduced health outcome gaps and children free from adverse childhood experiences (ACEs) (Bristol Health and Wellbeing Board, 2023).

4.b.ii. Prevalence of Sex Work in Bristol and Where is it happening?

Hester et al. (2019) outline a range of best practice methods that could be used to estimate the prevalence of sex work locally; this may be useful for future updates of this assessment. For this project we are seeking information and data from local services to give us a picture of sex workers accessing services but noting the limitation that Bristol's sex workers who are not linked with services will not be captured, such as those who do not view themselves as sex workers.

Local service providers told us of challenges they face identifying sex workers. For example, one professional noted that many individuals involved in transactional sex don't see themselves as sex workers, making engagement difficult, and another, that many women, often exploited or trading sex for drugs, don't recognise their involvement. Demographic data collection by services can deter people from accessing services, so often services choose not to collect this unless necessary. Data collated from services about sex workers they work with will be an incomplete picture of the population, but it will give some insight to a certain degree, to give a sense of who sex workers are in Bristol.

The information gathered regarding outdoor sex working locations outlined below is for females only.

Outdoor sex working locations: Locally, we are told that the main areas for street sex work are in inner city and east (exact locations are withheld for safety reasons). Key support services in these areas include One25, Nelson Trust Women's Centre, BNSSG Integrated Sexual and Reproductive Health Service, and The Homeless

[3] In 2021, Public Health England was abolished and transferred all functions into the UK Health Security Agency and the Office for Health Improvement and Disparities (Department of Health and Social Care, 2021)

[4] Bristol's One City Plan was updated for 2025, and the 2025 version can be found using this link About the One City Plan - Bristol One City

Health Service. Overall, service locations are likely to be in close proximity to outdoor sex working locations in central Bristol, however, some street-based sex workers may be a further distance from support services. The One25 outreach van can take support to them, potentially highlighting the importance of ensuring the range of support that can be offered via this service is maximised.

Note: Service provision locations were accurate at the time the report was written. Since then, due to recommissioning of certain services, some services and their locations may have changed.

Indoor sex working locations: Due to not being routinely inspected, the number (and locations) of indoor sex worker venues is hard to estimate. Records from Bristol City Council Regulatory Services (as of August 2025), show that there are 27 premises with the primary usage recorded as “massage parlour.” This is indicative and not all premises whose primary usage is “massage parlour” may be providing sex work and these records are unlikely to represent a true, current picture of the number of indoor locations offering sex work, with some premises possibly closing down and new ones opening up (however, this is hard to research, due to the private nature of the industry). The same challenge is found when estimating the prevalence of home-based sex workers. This makes it challenging to gather an accurate picture of the distance indoor sex work locations are from support services. During Covid-19 lockdown, there was some shift to online sex work, recognising that many would have continued in-person sex work (Purves, 2020).

It must also be noted that “pop-up brothels” can exist. A pop-up brothel is a setting which will set up “for days or weeks in a hotel or short-term apartment let before swiftly moving on to other locations” (Skidmore, 2017). Due to the nature of pop-up brothels, they are hard to identify and locate and therefore, we are uncertain of the current number of pop-up brothels in Bristol.

4.b.iii. Local Services

Key health service provision for sex workers in Bristol and the organisations who provide these services are outlined below.

One25 is a Bristol-based charity supporting marginalised women, especially those in street sex work, operating from the Grosvenor Centre. One25 provides:

- **A health hub:** open Monday-Wednesday, 12:30-3:30 pm, offering GP services, liver and hepatitis C screening, opioid substitution therapy, sexual health services, and essentials such as sanitary products and food bags.
- **A night outreach van** which provides food, clothing, condoms, safety alarms, and harm reduction support to women. The van is out on the beat area 7 nights a week as well as an early morning every Wednesday.
- **Specialist caseworkers** who provide one-to-one support for mental health, housing, addiction, and domestic and sexual violence issues.

In 2023, services had to be reduced, including the closure of the drop-in centre and the Peony[5] and Pause[6] programmes, refocusing on support for women actively street sex working, co-commissioning an Independent Sexual Violence Advisor (ISVA) service, researching trauma-informed approaches, and continuing to host the Bridging Gaps Group which is a group of women with lived experience, working to improve access to primary care for women experiencing multiple disadvantage.

Beloved is a charity which supports female indoor sex workers (online, massage parlours, home settings, and other indoor venues) in Bristol and the surrounding areas. Beloved provides:

- **Outreach** to indoor sex work settings and offers monthly meetings within massage parlours or in the community, and online contact such as via WhatsApp & Zoom.
- **Gift bags** with toiletries/ safety information and distributes personal attack alarms.
- **Signposting to local organisations** such as specialist sexual health clinics, debt advice, housing support, mental health services, and community groups.
- **General support** such as with accommodation, emergency financial assistance, CV writing, job applications, and accessing benefits.
- Support for **younger women**, particularly **students** who they notice turn to the sex industry for short-term financial provision without recognising the potential risks.

Unity Sexual Health, the free Integrated Sexual and Reproductive Health Service in Bristol, North Somerset and South Gloucestershire provides[7]:

- **STI testing and treatment:** e.g. testing for chlamydia, gonorrhoea, HIV, and syphilis, providing free home testing kits and clinic appointments. Individuals at high-risk receive rapid testing and vaccinations.
- **HIV prevention:** pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEPSE) as free NHS treatments.
- **Contraception advice and services:** various contraception options, free condoms, and support for contraception issues.
- **Pregnancy advice and support:** pregnancy tests, advice on options, and support for those considering adoption.
- **Vaccinations:** hepatitis A, hepatitis B, and HPV vaccinations.
- **Vending machines:** dispenses free STI test kits and HIV point-of-care tests.

[5] "Peony was a holistic wellbeing service for women in recovery to overcome trauma, build resilience and learn life skills to thrive in the community. Peony was for women facing multiple disadvantages (at least three of: domestic and sexual violence, removal of children, addiction, homelessness, offending, mental health issues and street sex work). It included a programme of therapeutic and meaningful activities, specialised group work and one-to-one support. 20 women were supported through Peony in the year before the service closed in May 2023." (One25, 2024)

[6] In 2017, Pause Bristol was launched. It was a programme supporting women who had two or more children permanently removed from their care. It offered 18 months of intensive, tailored support to help women break destructive cycles, develop new skills, and to avoid further trauma. During 2023-24, 39 women participated in the two programmes. Pause Bristol ended in August 2023 (One25, 2024)

[7] Sexual health services in Bristol were recommissioned in April 2025. For more information, follow this link Sexual and reproductive health services

- **Information on abuse and sexual violence:** referrals and information.
- **The specialist sexual health nurse at One25's Health Hub** for female street-based sex workers.

The Homeless Health Service provide healthcare and support to homeless individuals in Bristol and South Gloucestershire, providing:

- **The female sex worker specific GP service** at the One25 Health Hub.
- **Medical care**: a team of doctors and nurses, offering health advice and treatment including services for those who are rough sleeping or living in temporary accommodation.
- **The Health Link Team**: specialist advice and guidance helping homeless individuals navigate health-related services. They advocate for the healthcare rights of homeless people who are entitled to healthcare without a permanent address. The service connects them with medical and housing services, such as the Broadmead Medical Centre walk-in clinic.

Terrence Higgins Trust (THT) Bristol provides outreach services as part of the BNSSG Integrated Sexual and Reproductive Health Service and offers sexual and reproductive health services and support for people living with HIV in Bristol, South Gloucestershire, and North Somerset (BNSSG), providing:

- **STI and HIV testing** at the BNSSG Integrated Sexual and Reproductive Health Service and East Trees Health Centre.
- **One-to-One support and wellbeing groups**
- **Community outreach:** focus on LGBTQ+ community, sex workers, people who use substances, and minoritised groups.
- **Training and consultancy** conducted at colleges and universities.
- **A weekly walk-in clinic:** STI testing, advice, free condoms, and lube.
- **Monthly sex worker breakfasts:** social space with food, sexual health supplies, and mutual aid opportunities.

Brigstowe is a Bristol-based charity supporting individuals living with or affected by HIV across BNSSG. Brigstowe provides:

- **Advice & support** for health, housing, benefits, and re-engagement with care.
- **Peer support:** one-to-one mentoring and support groups.
- **Migrant & asylum support** for those with HIV.
- **HIV awareness:** training to reduce stigma and promote understanding.
- **Community engagement** e.g. Common Ambition Bristol[8] to increase HIV testing and reduce stigma with African and Caribbean communities.
- **Health services:** support for long-term conditions such as Type 2 diabetes.

The Nelson Trust addresses substance use and multiple disadvantage through community-based women's centres, residential rehabilitation, and hub enterprises including in Bristol. The Nelson Trust provides:

[8] Common Ambition Bristol | Improving Sexual Health

- **Women's centres:** trauma-informed, gender-responsive support with one-to-one sessions, group work, educational courses, workshops, wellbeing groups, and facilities like creches, showers, and cafes (Protheroes House, Bristol).
- **Residential rehabilitation:** 12- or 24-week programmes offering trauma-informed care, counselling, and therapeutic activities like art therapy and yoga.
- **Hub enterprises:** community projects teaching long-term employability skills, reducing stigma, and supporting recovery through therapeutic activities, life skills training, and education.

Womankind is a Bristol-based charity supporting women's mental health, focusing on disadvantaged women who have experienced trauma or abuse. Womankind provides:

- **Individual counselling:** one-on-one sessions for mental health and trauma.
- **Group psychotherapy** (facilitated group support).
- **Befriending:** emotional support from trained volunteers.
- **Helpline and webchat:** confidential support with around 5,000 calls annually.
- **CADA:** specialist trauma counselling for girls and young women aged 16 to 18.
- **The Safer Women's Project:** counselling for refugees, trafficked women, and asylum seekers.
- **Support for deaf and hard-of-hearing women:** counsellors trained in British Sign Language.
- **Advocacy and collaborations** with sexual violence and abuse agencies to promote gender equality and support women.

Unseen UK is a charity dedicated to ending modern slavery and exploitation, offering support for survivors providing:

- **A modern slavery Helpline** (24/7) offering advice, support, and a safe way to report concerns.
- **Safehouses:** secure accommodation and support for survivors.
- **Outreach and advocacy:** work with businesses, governments, and communities to raise awareness and prevent slavery.
- **Training and consultancy**, educating organisations on how to identify and combat modern slavery.

The Bridge Sexual Assault Referral Centre (SARC) supports individuals who have experienced rape or sexual assault, providing:

- **Medical care:** immediate and follow-up attention for physical health needs.
- **Emotional and psychological support:** trauma-informed therapy.
- **Practical assistance:** guidance with legal processes and safety planning.
- **Forensic examination:** evidence collection without police involvement.
- **Psychology and counselling:** 8 sessions for recent assaults with follow-up.
- **Trauma-informed training** at events and for university staff.
- **SARC tackle barriers for sex workers** e.g. concerns about police involvement.

For other domestic abuse and sexual violence services in Bristol such as Next Link, Safe Link and SARSAS see Domestic Abuse Needs Assessment

The newly commissioned drug and alcohol services, Horizons, is due to launch on the 1st of April 2025. **For current substance use services in Bristol** see Support for people who use drugs and alcohol

Challenges and risks to health services used by sex workers in Bristol: Service representatives highlight funding risks from short-term contracts, reduced funding, and shifting priorities which can decrease service capacity. They can limit client interaction time making it difficult to build the trust required to work through complex and entrenched problems.

5. Summary of Existing Evidence

To explore available evidence, a search for systematic reviews was conducted to find recent, rigorously reviewed and collated evidence from studies that synthesise large bodies of evidence.

References were snowballed[9] from the systematic reviews and manual online searching was used to find studies in Bristol and the UK with more flexibility on date range to capture more place-specific research.

Manual online searching and snowball techniques were used to locate relevant, recent grey literature. This section helped capture the voices of sex workers and specialist organisations that represent them, proving helpful for hearing the voices of subgroups such as male and migrant sex workers who are underrepresented in published research, and who we did not locate locally. A table which summarises and provides links to the grey literature identified and reviewed can be found in Appendix 1.

Below outlines short summaries of the evidence found; please note, due to the project time constraints and capacity, we outline key studies, however, do not explore strengths and limitations. Please refer to the studies themselves to explore this.

5.a. International Evidence

Service access and design: **Vimpere, Sami and Jeannot (2023)** explored the effectiveness and sustainability of cervical screening programmes for female sex workers and found the strategies to be the most effective and sustainable were the screen and treat approach (treating a patient immediately after a positive, primary screening test), introducing cervical screening in existing STI services in drop-in or outreach clinics, HPV-DNA self-sampling and integrating sex-worker specific services in public health facilities. A main challenge identified was rates of loss to follow-up in this group being high.

Johnson et al. (2023) found interventions to be of benefit for sex workers were multicomponent and those which had a focus on empowerment and education. Effective interventions included those which used peer design and delivery, with outreach or drop-in possibly being beneficial in some contexts. The researchers recognise that there is limited data for male, transgender and indoor-based sex workers, and access to services needs to be improved for sex workers of all genders and those new to an area, with a need for future research on developing interventions for the diversity of sex workers and their wider health and social needs.

Turner et al. (2022) found that current evidence as it stands (despite lacking evidence of good quality) suggests that improving the wellbeing of female street-based sex workers can be achieved using peer health initiatives; use of diary-based methods of collecting real-life behavioural information could increase self-esteem and behaviour change intentions.

[9] Snowballing refers to using the reference list of a paper or the citations to the paper to identify additional papers (Wohlin, 2014)

Intersectionality and multiple disadvantage: **Tweed et al. (2021)** investigated the health outcomes associated with the overlap of life experiences including sex work substance use, homelessness, imprisonment and severe mental illness. Despite there being limitations and gaps within the data (including little number of studies found involving sex work), overall, it was found that individuals who are affected by "multiple exclusionary processes" experience significant health disparities and a co-ordinated, multi-agency approach is required to address their experienced health needs.

Health outcomes and health risk behaviours: **Alareeki et al. (2023)** found that the pooled mean seroprevalence[10] for HSV-2[11] was 12.4% in "general populations" in Europe and 63.2% amongst female sex workers, concluding that there is a need to invest in HSV-2 vaccine development and sexual and reproductive health services.

Lavelanet et al. (2022) despite concluding that evidence is fairly limited, found that themes which emerged related to values and preferences of sex workers particularly in regard to contraception included perceived effectiveness and safety and impact on the sexual experience (perceptions and concerns). Benefits of the female condom were found including discretion, however there were also some concerns/ difficulties referred to including the physical attributes of this contraception method and stigma.

Segosebe, Kirwan and Davis (2023) found that there are barriers to condom use in female sex workers and inconsistent use, which is a concern, due to the increased risk of transmission of STIs and HIV. The barriers identified were around "alcohol consumption and drug use before sex, venue stability, socio-economic status vulnerability, violence and gendered power dynamics, trust of regular clients, and age" (younger age is an additional barrier). Regarding venue stability, due to female street-based sex workers having no permanent working location, they may have no place to store condoms for future use. Outdoor female sex workers may move around to avoid police and to meet new clients and therefore may be less likely to negotiate for condom use, more likely to experience physical abuse, and less likely to be paid if they attempt to negotiate for condom use, compared to indoor female sex workers. The use of substances was also found to affect condom use. They concluded the need for initiatives to promote the use of condoms amongst this group and people who have contact with female sex workers; other options to prevent HIV (e.g. PrEP) need to also be promoted.

Wider policy context: **McCan, Crawford and Hallett (2021)** note through the systematic review they conducted that findings from included studies suggest that sex workers in legalised and decriminalised countries demonstrate "greater health outcomes, including awareness of health conditions and risk factors".

5.b. UK Evidence

A study by **Emanuel et al. (2023)**, through exploring the Unlinked Anonymous Monitoring Survey of people who inject drugs (PWID) found that between 2011-

[10] the level of a pathogen in a population, as measured in blood serum (Collins n.d.)
[11] "Herpes simplex virus (HSV), known as herpes, is a common infection that can cause painful blisters or ulcers." "Type 2 (HSV-2) spreads by sexual contact and causes genital herpes." (World Health Organisation, 2025)

2021, 31% of women and 6.3% of men who inject drugs report having ever engaged in sex work, with 14% of women and 2.2% of men engaging in the past year. Sex workers were more likely, than non-sex workers (between 2018-2021) to report symptoms of an injection-site infection in the past year, report an overdose, or amongst men, report having HIV, overall concluding that PWID and whom are sex workers are a distinct population whom experience overlapping risk factors and disproportionate vulnerability; tailored, inclusive and low-threshold interventions are required.

Martin-Romo, Sanmartin and Velasco (2023) found there to be a high prevalence of "mental health problems" among sex workers, with psychological problems such as anxiety, substance use and suicidal ideation being high; the most common identified mental health problem amongst sex workers was depression. Work related risks to mental health included high-risk sexual behaviours and violence and in alignment with findings from other studies, they recognised a number of barriers which sex workers face when accessing health services, concluding that there is a need to focus on prevention, to promote good wellbeing amongst this group.

Potter, Horwood and Feder (2022) found two services to be largely inaccessible to street sex workers (general practice and mental health services) and 3 main challenges found were inflexible services, services being under-resourced and services not being trauma informed. Healthcare access for street sex workers in the UK is variable. Seamless partnership working, peer-involvement, a range of provision (e.g. outreach, community spaces and fast-track access to mainstream services), trauma-informed and gender sensitive services, having a welcoming environment, flexible and responsive appointment and drop-in systems and consistent clinicians were examples of best practice which the authors say need to be systematically implemented and evaluated.

Platt et al. (2022) found differences in experiences of ethnically/ racially minoritised and LGB-identifying sex workers regarding violence and enforcement compared to counterparts. Examples of areas where differences were found were in regard to police encounters, recent arrest, past imprisonment, police extortion, rape and emotional violence.

Grenfell et al. (2022) found that across a number of services, sex workers lives were disciplined, and services put the responsibility of sex workers health on the sex workers themselves; defunding of specialist services which were lived experience orientated were also found, with the impact most felt by marginalised and minoritised cis and trans women. Street-based sex workers who used drugs, were migrants, or non-white were especially targeted by police, often ignored when they reported violence, and hit hardest by cuts to support services. Participants wanted funding to be moved away from policing and instead used to fund respectful, peer-led services.

5.c. Local Bristol Evidence

A local study by **Jeal and Salisbury, 2004a** concluded that street-based sex workers experience worse inequalities (health and social) than any group highlighted in the 'Tackling Health Inequalities Review 2002' and these seem cross generational, with the potential for continued unmet needs. This includes chronic health problems,

substance use, STI's, sexual abuse and still-birth as well as risk behaviours such as sharing injecting equipment and having unprotected sex.

Jeal and Salisbury (2004b) through a local study found that female street-based sex workers in Bristol frequently used health services but had poor use of preventative health care and inconsistent use of services more generally, with GPs found to be their main source of care, but many not disclosing their work. This likely made it harder to provide appropriate care as well as pose practical problems. Depression or anxiety, substitute prescribing for opiate addiction and obtaining a sick note were the most common motives for needing to go to the GP and low rates of STI screening, cervical screening, and hepatitis B vaccination were found; antenatal contact was also found to be late and inconsistent.

Regarding barriers to services, themes around the appointments themselves, waiting times and fear of being judged/ being stared at by other patients were raised, with women wanting an integrated service which not only provides healthcare but also addresses the needs of basic living. Overall, the study found that sex workers having appropriate care is made difficult due to a number of factors including not disclosing sex work to professionals and poor attendance at follow up – these may contribute to poor health outcomes. Although sex workers were found to have contact with services often, there are missed opportunities.

Jeal and Salisbury (2007) found through a local study that indoor sex workers and street-based sex workers had different experiences in terms of risk-taking behaviour and use of services, therefore tailored services in different settings are required for the two groups. Differences in experiences included reporting of chronic or acute illness, GP registration, STI and cervical screening, use of contraception, antenatal care, the use of heroin and crack cocaine and injecting drugs, with parlour-based sex workers found to have more favourable outcomes in regard to these areas compared to street-based sex workers. There were also differences recognised wider than health including social background, reason for entering sex work and service provision needs.

Jeal et al. (2017), through a local study found that experiences of sex workers in drug treatment included feeling unable to discuss sex work in group settings, stigma relating to the disclosure of sex work, and adverse encounters with male service users. Not feeling able to disclose prevented them from discussing unresolved trauma issues and having mixed treatment groups meant that participants felt it was not appropriate to discuss trauma, due to often, experiences involving perpetrators who are men. Of street-based sex workers in recovery, despite stopping sex work and drug use a while ago, trauma-related symptoms still continue and impact their lives. Services for street-based sex workers only and having female staff were found to be crucial to effective care, with the loss of trusted staff and loss of street-based sex worker only treatment services reported as lowering the chances of engaging with drug services. Lack of continuity of care and reduced time with staff were referred to as barriers to having an effective relationship. Overall, it was found that street-based sex workers encounter barriers in accessing effective drug treatment services. Ways to improve this are by having street sex worker-only groups, ensuring continuity of care with staff and having female staff (with lived experience). The

detection and treatment of trauma-related symptoms may also improve service engagement and outcomes.

Potter et al. (2024), implemented service improvements to improve GP access for people experiencing severe and multiple disadvantage locally. This built on work which found that "continuity of care, developing trusting relationships, and being proactive are of particular importance in providing care to people with severe and multiple disadvantage." To note, **Potter et al. (2024)** found key themes from data to be:

- "protecting resource to enable cultural shift to proactive relationship-based care"
- the benefits to marginalised patients, services, and professionals of having collaborative space to develop positive changes"

The Bridging Gaps Forum were involved in this project along with healthcare staff, women with lived experience of severe and multiple disadvantage and One25 **(Potter et al. 2024).** The methodology used included service improvement meetings, interviews and a focus group, and data was thematically analysed. As a result of this, changes to services were made including patient prioritising through an inclusion patient list (more flexible access), a care coordinator, and a micro-team (consisting of clinicians) to provide continuity for individuals being seen; an information sharing document was developed. A trauma-informed approach was also promoted and a "personal snapshot document" was developed. It was found that the project process and outcomes produced "improved connections within and between general practices, support organisations, and people with severe and multiple disadvantage."

McGeown et al. (2023) found that when people who have experienced trauma are involved in co-production, processes may need to be adapted; trauma and the impacts of it need to be understood. The importance of partnership working, flexibility, being mindful of the transparency of power dynamics and long-term funding were found. Co-production is well-suited for trauma-informed services, but it is important to carefully consider how people share their experiences, create safe and honest spaces, and manage the balance between empowerment and safety.

6. Data from Services

6.a. Demographic Data

Due to the often 'hidden' nature of sex work and this assessment using data provided by local services, the local demograpic data is very likely to be an underestimation of the true picture of sex work in the city. Some sex workers will be in contact with multiple services so may be counted more than once within this data section. The section below is broken down by service/ provider and provides data available on the demographics of the individuals using the service. Percentages where possible, are expressed to 2 decimal places.

One25, who work with street-based sex workers, supported 260 women in 2023-24; to note, not all 260 women have demographic data recorded, so may not be included in the data below.

Of those where demographic data had been recorded:

Ethnicity[12]**:** 70.75% were recorded as White British, and 11.56% were recorded as unknown, with the remaining service users recorded as White Eastern European (4.08%), Dual Heritage (4.76%), Asian (0.68%), Black (6.12%), or from 'other ethnic group' (2.04%).

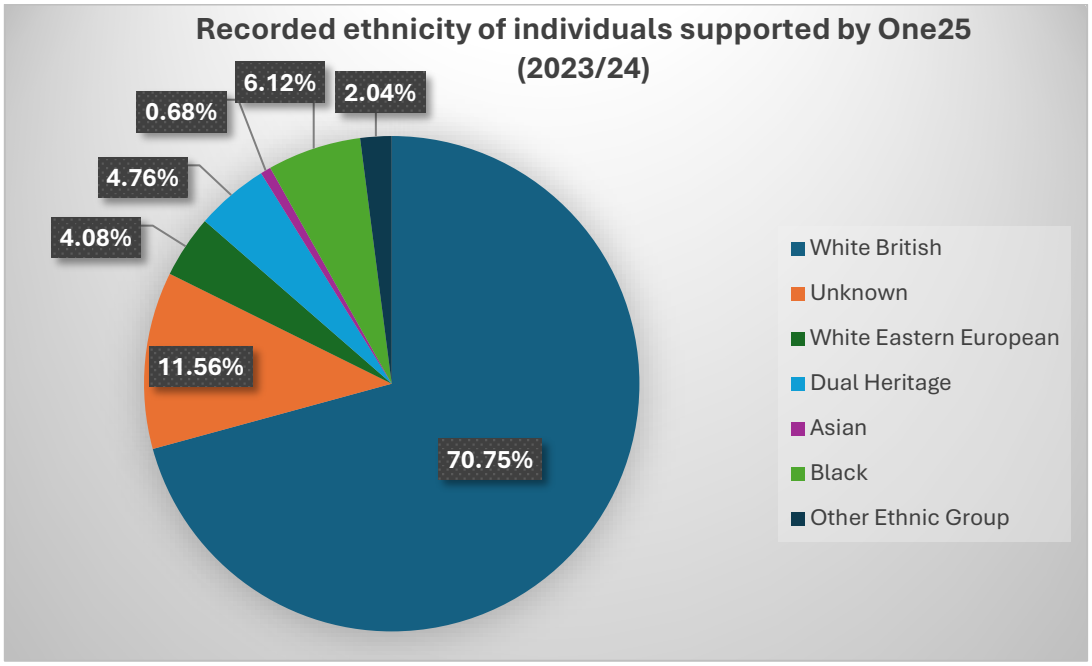

Figure 4

Disability[13]**:** 28.57% were recorded as having a disability, 47.62% as not having a disability, and 23.81% were recorded as it being not known whether they had a

[12] Ethnic categories are the same as used in Bristol's Multiple Disadvantage Needs Assessment (Changing Futures, 2023)

[13] Disability was defined, as in Bristol's Multiple Disadvantage Needs Assessment (Changing Futures, 2023), as a "physical or mental health impairment that has a substantial and long-term negative

disability. The Bristol's 2021 census found that 17.2% of the total population of Bristol had "long-term physical or mental health conditions or illnesses whose day-to-day activities are limited" (17.5% in England and Wales) (Bristol City Council, 2021), suggesting rates of disability among this group may be higher than the average population.

Sexual Orientation: 70.75% were recorded as heterosexual, and 19.05% as not known, with the remaining services users recorded as gay/ lesbian (0.68%) or bisexual (9.52%).

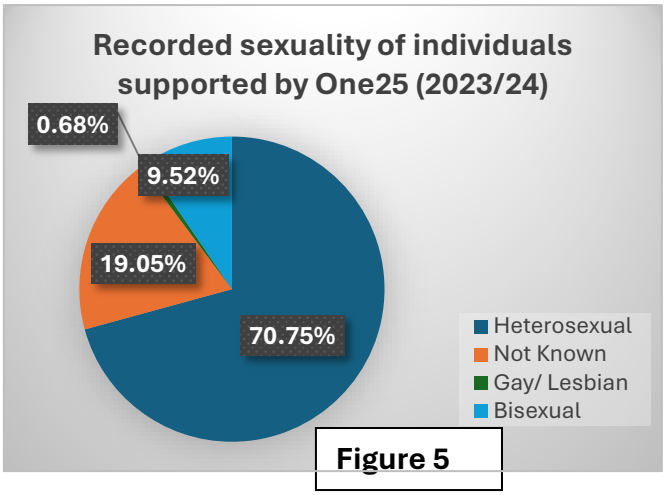

Figure 5

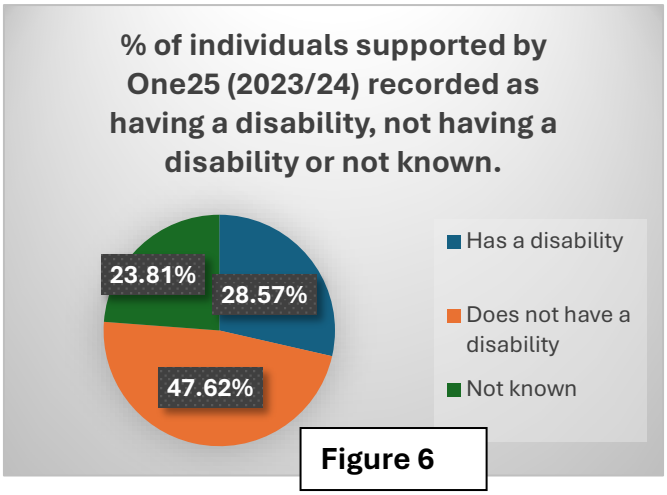

Figure 6

Age: Majority were aged 31-40 (45%), followed by 27% being aged 41-50. Smaller proportions were aged 21-30 and 51-60 (both 9%). 1% were recorded as aged 16-20 and 9% had no record of age.

Where people live: Data was not available at the point of writing this needs assessment and it was recognised that women's living situation can change frequently.

Homeless Health provide the GP service at One25's Health Hub, and other health services in Bristol used by sex workers. Patient's details are recorded on EMIS (the GP record system). Between January 2024-January 2025, 75 sex workers were recorded as having accessed Homeless Health Service.

Of those where demographic data had been recorded:

Gender[14]: The majority were female (96.00%), with the remaining 4.00% being male.

impact on your ability to do normal day to day activities," as used in the Equality Act 2010 (UK Parliament, 2010).

[14] Categories "male" and "female" were recorded under "gender," in raw data, however we recognise that these categories are in reference to an individual's sex.

Ethnicity: 52.00% were recorded as White British, 36.00% were recorded as ethnicity not stated, with the remaining patients recorded as either Black, Mixed Ethnic Background, White Other, or Other (see below Figure 8 for detail).

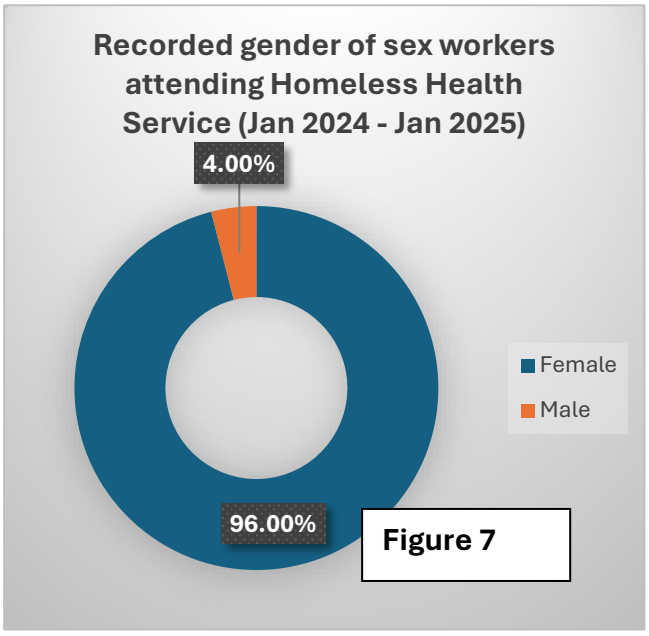

Figure 7

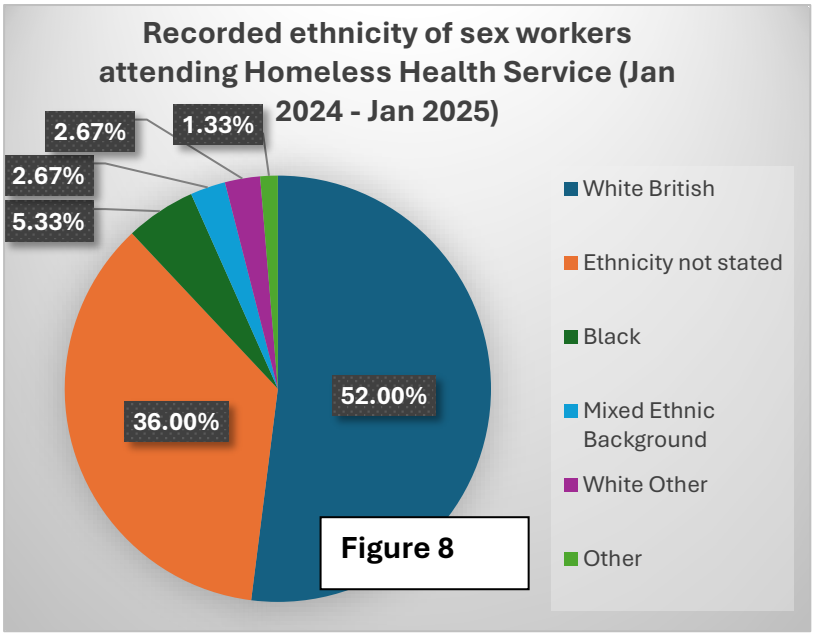

Figure 8

Age: Majority were recorded as being between 40-49 years old (42.67%), followed by 30-39 (34.67%). 9.33% were recorded as being aged 20-29, with the lowest number of sex workers falling within the age categories 50-59 and 60+ (both 6.67%).

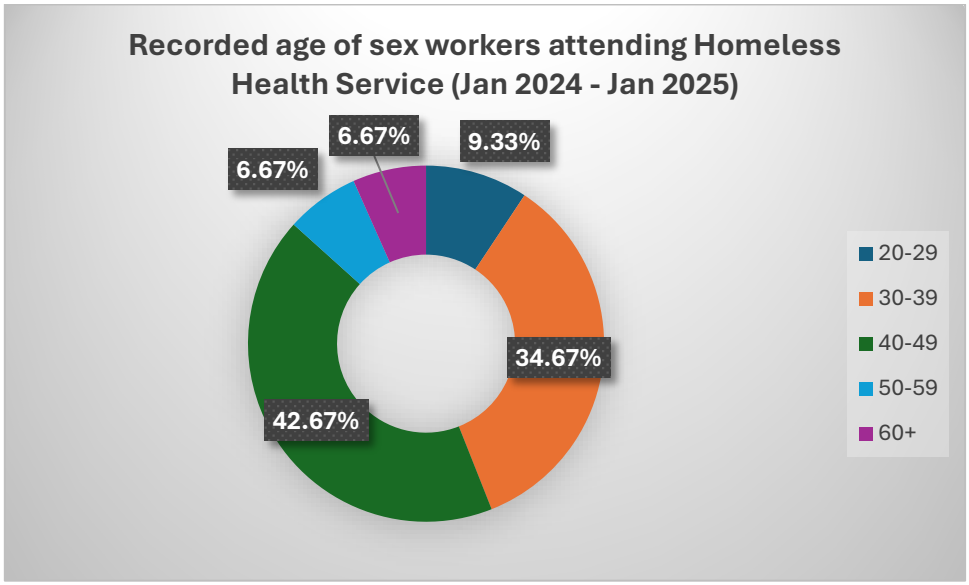

Figure 9

Homeless Health provide substance use services in Bristol. A team member shared insights about sex workers they see, noting a small number of male sex workers currently use their service, with many not disclosing their work due to stigma. They outline how these men often face insecure housing, criminal justice involvement, trauma, and mental health issues. They also mentioned non-stereotypical cases,

such as a successful man 'willingly' involved in chemsex[15]. Their service is for those 18 and older, but they note that many report starting sex work at around age 14, often as children who have been in care who have experienced abuse and addiction.

Terrence Higgins Trust (THT) provide sexual health information and advice, testing for STIs and HIV, and run monthly events called Sex Worker Breakfasts with 10 people attending each one on average. Across their services, THT note sex workers are:

- predominantly female (up to 90%), and those assigned female at birth.
- predominantly white.
- There is a high representation of LGBTQ+ people, and of individuals who may be early in their gender transition, or who express complex or non-binary gender identities and presentations, including some trans men whose presentation may reflect evolving gender expression.

A professional from THT noted that male sex work is largely happening/ facilitated online or via apps like Grinder. They were involved in a project in 2018 that mapped underserved sex working groups, attempting to find street sex working men, but they did not find any. They found a small number of trans women (noting there were no doubt more) who were street sex working, in a similar way to cis women.

6.b. Health and Service Needs

The table below breaks down each service and provides data on the experienced demands on the service. For information on what each service provides, please refer to **Section 4.b.ii. Local services.**

One25	One25 worked with: **271** women in 2022-23 (May 2022 – April 2023) (One25, 2023). **260** women in 2023-24 (May 2023 – April 2024). Some of these will be the same women and some will be new. One25 report that they saw **7 women enter street sex work** and **13 women return to the streets** in 2023-2024 (One25, 2024). For 2023-24, One25 saw a **12% increase** in visits to their outreach van from the previous year, which they indicate in their report is due to increasingly severe challenges that the women face and compounding factors emerging from the pandemic and the cost-of-living, with a **76% increase** in the number of women accessing their van since 2021-22, up from 94 women to 165 in 2023-24 (One25, 2024). 82 women used the health hub in 2023-24, with the average number of women attending per session staying stable compared to the use of the drop-ins in the previous year (average 5.1 women per session compared with 5.4 in 2022-23). They have seen an 83% increase in the number of visits to their General Practitioner (GP).

[15] Chemsex most commonly refers to the use of specific drugs, used specifically during sex, often but not exclusive to men who have sex with men (MSM) (BDP, n.d.).

	One25 saw more women exit street sex work in 2023-24 (up 24%), and an increase in the number of women returning to the streets (One25, 2024).
The Nelson Trust	The Nelson Trust worked with **14** women selling sex in 2024, inclusive of women who practitioners know or suspect to be sex working.
Beloved	In 2024, Beloved supported 49 women engaging in the indoor sex industry. Within that year, Beloved reached 80 women through outreach and received 20 referrals for support.
Unity Sexual Health	The below data was provided by UHBW who were commissioned to deliver the BNSSG Integrated Sexual Health Service under the brand Unity. The data relates to sexual health provision at Central Health Clinic, Tower Hills Bristol. Data shows that between July 2023-June 2024 there were **232 attendances** from sex workers, inclusive of male and female sex workers, at Unity Central Health Clinic. This includes all attendances of individuals coded as "SW" (Sex Worker) at their initial appointment. Due to coding inconsistencies, this may be an underestimation of the true number of attendances by sex workers attending the Unity Central Health Clinic.
Homeless Health	Homeless Health ran a data report[16] on all sex workers attending their services between January 2024-January 2025. **75** sex workers used their services.

Statistics below are in reference to the numbers being supported by each service stated above (or the individuals which this specific data has been recorded for) and are expressed to the nearest whole percentage.

General needs: Of the street-based sex workers One25 worked with in 2023-24, 89% had chronic health needs. Of the women involved in sex work whom The Nelson Trust worked with in 2024, 86% had health needs, with 93% having 4 or more needs (inclusive of health and wider needs).

Domestic abuse, sexual violence and childhood abuse: Of the street-based sex workers supported by One25 in 2023-24:

- 98% had experienced domestic or sexual violence
- 54% had disclosed childhood abuse

Of the women involved in sex work whom The Nelson Trust worked with in 2024, 86% had experienced domestic abuse and/ or rape and/ or sexual violence.

[16] They note they cannot guarantee the consistency with which clinicians will have coded patient's records.

Mental health and wellbeing and co-occurring mental health and substance use: Of the street-based sex workers supported by One25 in 2023-24, 94% had significant mental health needs. Of the women involved in sex work who worked with the Nelson Trust in 2024, 43% had needs around attitudes, thinking and behaviour.

Of sex workers attending Homeless Health services between January 2024-January 2025, 48% were coded for depression, 32% for anxiety and 12% for post-traumatic stress disorder (PTSD). Smaller proportions were coded for mental health conditions such as personality disorders, schizophrenia, self-harm, and a drug-induced mental health disorder. 79% of those coded with opioid dependence were also coded with a mental health condition (45 of 57).

Patients were coded with medical conditions, drug misuse and/ or dependency, mental health conditions and social issues (such as safeguarding or risk of domestic violence). 24% of all sex workers attending Homeless Health Services had up to 3 of these coded, 36% had 4-6, 13% had 7-9 and 21% had 10 or more, highlighting complexity.

Substance use and smoking: For the street-based sex workers supported by One25 in 2023-24, 98% were recorded as addicted to drugs or alcohol. Of the women involved in sex work who The Nelson Trust worked with in 2024 (who practitioners know or suspect to be sex working), 71% had substance use needs.

For all sex workers attending Homeless Health services between January 2024-January 2025, 76% were coded as having opioid dependence. Smaller numbers were coded as having dependence on cocaine, benzodiazepine and alcohol and generally “drug misuse”. The substances with the highest usage under “Last 5 drugs use” were heroin, crack and, alcohol. 36% of sex workers attending Homeless Health were coded as using 1 substance, 29% were coded as using 2 substances, and 12% for using 3+ substances. 45% of sex workers attending Homeless Health were coded as intravenous drug users, 8% for sharing injecting equipment, and 44% for smoking drugs.

Of female sex workers accessing Homeless Health Services, 49% were coded as smoking, and 51% were coded as not smoking; No males were coded as smoking. According to Bristol City Council’s Smoking JSNA Health and Wellbeing Profile 2025/26, 12.7% of Bristol adults smoked in 2023, similar to the national rate of 11.6% (Bristol City Council, 2025a[17]). With nearly 4 times the rate of tobacco use in the female sex worker population, it highlights the importance of ensuring stop smoking support services are accessible to sex workers.

Finance and debts: Of the women involved in sex work who worked with the Nelson Trust in 2024, 64% had needs around finances, debt and benefits.

Family and children: Of the women involved in sex work who worked with the Nelson Trust in 2024, 79% had needs around children, families and relationships.

Healthy weight: Of sex workers attending Homeless Health Services between January 2024 and January 2025, 15% had a body mass index (BMI) (a quick and inexpensive way to screen for underweight, overweight, or obesity) in the

[17] Since the writing of this report, a 2025-26 JSNA Data Profile for “Smoking” has been published, and 2024-25 Data Profile has been replaced and is no longer available online, therefore, data has been updated to reflect the 2025-26 data profile.

underweight range, 37% in the normal weight range, and 36% had no BMI recorded. A smaller portion were in the overweight (8%) or obese (4%) ranges. In England (2022), 2% of men and women were underweight, 31% of men and 37% of women were normal weight, 39% of men and 31% of women were overweight, and 28% of men and 30% women were obese (Statista, 2025[18]), suggesting that where among the general population obesity is the most pressing need with regards to healthy weight, for this cohort, being underweight may be of greater concern.

Long-term and other conditions: At Homeless Health Services, patients were coded with over 50 different "medical conditions". The graph below highlights the most commonly occurring conditions for sex workers by percentage, with 41% coded for hepatitis C (a cause of liver disease), 24% for asthma (in 2018, 17% of men and 18% of women had ever had asthma diagnosed) (NHS Digital, 2019) and 21% for deep vein thrombosis.

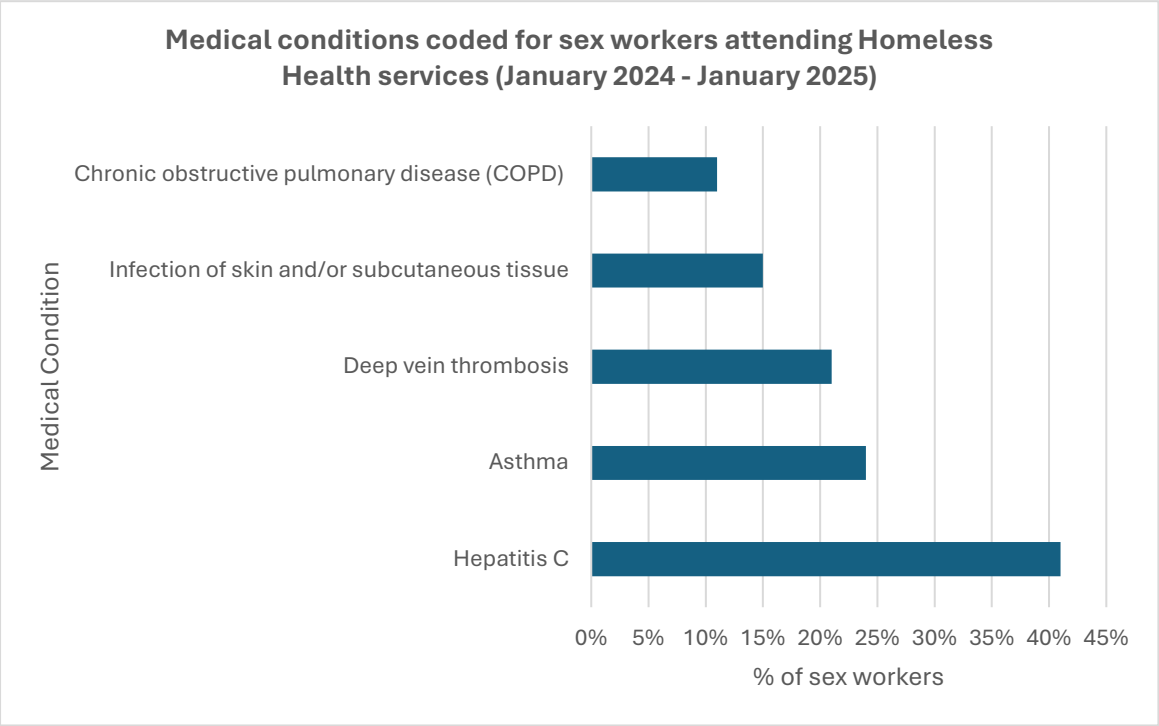

Figure 10

Other conditions patients were coded for include skin infections, chronic obstructive pulmonary disease (COPD), pulmonary embolism, injuries, type I and type II diabetes, vitamin D deficiency, urinary incontinence, and cirrhosis of the liver. 20% were coded for 4-6 medical conditions, 9% for 7-9, and 8% for 10 or more.

Environmental determinants: Of the street-based sex workers who were supported by One25 in 2023-24, 74% had experienced homelessness and 100% were living in poverty. A similar percentage was seen with sex workers supported by the Nelson Trust in 2024, with 79% having an accommodation need. However, of sex workers attending the Homeless Health Services, 13% were coded as experiencing homelessness, and 87% were not coded as experiencing homelessness.

[18] Since the writing of this report, data was re-published in 2025 (2024 version no longer available) therefore, 2025 data source used.

In Bristol, there is a recognised gap in data collection on women's homelessness, where their experiences may differ from men's, which may may be affecting funding and service planning for vulnerable women. In order to address this, the Women's Rough Sleeping Census explores the experiences of women rough sleeping. Despite the census not having a sole focus on women involved in sex work, the 2025 census involved women working with services such as One25. With permission from the Rough Sleeping Homelessness Commissioning Team (Bristol City Council), findings from the 2025 Women's Rough Sleeping Census have been shared and can be found in Appendix 2.

Additional Information: To note, all figures relating to sex workers supported by One25 in Section 6.b and their health and wider needs have increased from the previous year (2022-2023) except for the number disclosing childhood abuse which reduced by 1%. One25 believe this is in part driven by contextual factors such as Covid-19 and the cost of living crisis, reflecting greater need of the women they see, and partly reflects their service refocus towards women actively street sex working and therefore having greater needs than those at risk of, or who have exited, street sex work, who they previously also worked with.

6.b.i A Spotlight on the Sexual Health of Sex Workers in Bristol

As found in the existing literature, sex workers are at increased risk of having poor sexual health, hence, below, we have provided additional information and service data regarding the sexual health of sex workers in Bristol.

Spotlight on cervical cancer

Incidence rates for cervical cancer are highest in females aged 30 to 34 in the UK. There are around 3,300 new cervical cancer cases in the UK every year; that is around 9 every day (2017-2019). Since the early 1990s, cervical cancer incidence rates in females have decreased by a quarter (25%) in the UK (2017-2019) (Cancer Research UK, n.d.).

One of the most important risk factors for developing cervical cancer is increased exposure to infection with human papillomavirus (HPV), which is predominantly transmitted through sexual intercourse (NICE, 2025). To note, the HPV vaccine helps protect against human papillomavirus (HPV). It's recommended for children (boys and girls) aged 12 to 13 years old and people at higher risk from HPV (NHS n.d.); the HPV vaccination in boys and girls can help protect against certain cancers, as well as for boys, helping to reduce cervical cancers in women (Vare, n.d.)

Risk factors for acquiring HPV infection include:

- Early age of first sexual intercourse
- Multiple sexual partners or a high-risk sexual partner
- History of sexually transmitted infection (STI)
- Lack of use of barrier methods of contraception, such as condoms

Factors which increase the risk of progression to cervical cancer include:

- Co-infection with other STIs
- Smoking (increases the risk of developing precancerous lesions and squamous cell carcinoma)
- High parity (more than five full-term births) and being a young age at first birth (less than 17 years of age)
- Conditions causing immunocompromise or immunosuppression, such as HIV infection

(NICE, 2025)

No cervical screening attendances amongst sex workers (from June 2023 – May 2024) were recorded at Unity. Unity explained “smears [cervical screening] are normally done at the patient’s GP practice as Unity only has very small capacity for complex smears [cervical screening].” This may be problematic for this cohort of whom many have difficulties accessing GP services. Research highlights how female sex workers experience additional risk.

Appointment type: Of the 232 attendances of individuals coded as sex workers (using code “SW” at their initial appointment) at the Unity Sexual Health Service, between July 2023 – June 2024:

- 90 appointments were for face-to-face genitourinary medicine (GUM) conditions such as sexually transmitted infections (STIs).

- 34 were telephone triage (on the day calls where patients phone up and need a clinical assessment, mostly STI related).
- 31 were self-testing kits sent to or collected by a patient.
- 18 were for PrEP (pre-exposure prophylaxis to prevent HIV infection) and 8 were for bloods to be taken (such as for PrEP monitoring and STI testing). Unity noted that PrEP appointments were mostly for male sex workers which could indicate a local gap.
- 17 were health advisor appointments for STIs or PrEP.
- 15 were visits to the One25 Sexual Health Nurse.
- Other attendances were for gonorrhoea treatment, vaccinations, contraception, and psychosexual support.

Unity says that sex workers tend to have face-to-face appointments due to complexity and/ or attend specific sex worker clinics.

Contraception: Upon analysing the reasons for attendance received from Unity, it was noticed that contraception appointments were low (<1%) for patients coded as a sex worker. It was further noticed that face-to-face attendances for STIs were proportionately high (39% of all recorded attendances). This is in line with our findings from exploring the literature; female sex workers, particularly street-based, can have low rates of contraception use (Jeal, 2007). Further investigation through conversations with Unity found that when female sex workers attended for a face-to-face GUM appointment, they were often asked about contraception, however the appointment was not coded to reflect this. This means that individuals may be accessing contraception through Unity, but this is not clear from the data provided. It is also not clear from this data whether they are accessing contraception elsewhere.

It is challenging to draw conclusions about need and access, where coding practices include inconsistencies, where health needs and treatments of interest are not specifically coded, and where we cannot see where sex workers have accessed services elsewhere, such as at their local GP practice or pharmacies. Future collaborative work could seek to develop:

- more consistent coding practices at health services, including sexual health services.
- codes that aid deeper understanding, for example, code for contraception discussed (not in patient notes which is time consuming to search), code for contraception prescribed/ used, and which type.
- improve data access/ sharing across organisations.

Unprotected sex and STI's: Of sex workers accessing the **Homeless Health Service**, 8% of patients were coded for unprotected sexual intercourse. Low numbers were coded for genital herpes, gonorrhoea, trichomonal vaginitis, chlamydia, and as HIV positive. 55% were coded for contraception and 45% had no code for contraception, however it is not clear whether these are for conversations about contraception or relate to prescriptions/ fitting/ use. 16% were coded for "uses contraceptive sheath" (condom), and 12% for oral contraceptive. Smaller proportions were coded for depot contraception (injection), the 'morning after' pill, and IUD contraceptive (coil).

Sexual health service preferences: In 2023, Bristol City, North Somerset, and South Gloucestershire Councils (BNSSG) conducted targeted community engagement to understand sexual health service access needs from underrepresented communities including sex workers. These findings will inform the redesign of integrated Sexual Health Services across BNSSG, set for recommissioning in April 2025. The unpublished report, shared with permission from Public Health BCC Sexual Health Team, includes data from an anonymous survey and in-person focus groups. 6 sex workers, all from Bristol were involved.

The consultation found that female sex workers in Bristol wanted easier and more regular access to STI/ STD testing and results. They stated preference for online access to contraception services, in-person and walk-ins for free condoms, STI testing kits and HIV prevention/ testing, in-person pre-booked appointments for STI treatment and abortion/ pregnancy options, and a wider availability of walk-in clinics for sexual health services generally. Telephone access was not preferred for any services. Regarding availability times, weekdays (9am-5pm) was most popular[19] with weekends (9am-5pm) second most preferred. Preferred channels to receive information about sexual health were (in order of preference) online (social media), mobile and email, and Bristol Sex Workers Collective (BSWC).

Regarding sexual health service access preferences, reducing stigma around sex work was stated as a way to improve accessibility; preferences were stated for sexual health services to be evenly split between local sexual health clinics and trusted community venues. Local clinics were preferred for contraception and STI services, and community venues were preferred for HIV prevention/ testing and free condoms.

A summary of sexual reproductive health needs amongst sex workers is provided below:

1. Unprotected sex is high, especially amongst street-based sex workers, increasing risk of STIs and HIV.
2. Risks for street-based sex workers are higher than those working indoors.
3. Sex workers often will not disclose their status due to stigma or fear of being reported to authorities which makes it difficult to interpret local data on access.
4. Screening for STIs is low relative to level of risk.
5. The use of alcohol and drugs whilst working amongst street-based sex workers is high.
6. Numbers of sex workers accessing PrEP in Bristol is low, relative to likely need.
7. Access to routine contraception via sexual health services appears low, suggesting low use of reliable contraception.
8. Cervical screening rates are low, with a significant proportion of women being overdue for their cervical screening. It appears that female sex

[19] This is contrary to information found across other areas of this report, for example across the HNAs, Mon-Fri 9-5 availability hours were reported as not well suited to this group. It could indicate a difference in preference among female SWs in Bristol, relative to other areas or may result from the small sample size.

workers are not currently receiving cervical screening via sexual health services, suggesting a gap in access.
9. Vaccination uptake for hep B is low.
10. Vaccination uptake for HPV is unknown locally for sex workers.
11. Access to sexual health screening certification for those in the porn industry appears to be an issue for some in Bristol, with a proportion choosing to access via London.

6.c. Deaths of Sex Workers in Bristol

Between 2020-2024, One25 recorded 21 deaths among their service users. From 2020-2024, the highest numbers of deaths we recorded in 2021 (8 deaths recorded) and in 2023, they recorded 6 deaths.

Of the 21 individuals recorded as having died between 2020 and 2024:

Ethnicity: 76% were recorded as White British, and the remaining deaths were recorded as Black British, Black African, White Other, or recorded as unknown (all <10%).

Age: The age of death recorded was between 25 and 59 years old. 32% were aged between 45-50 years old (the age category with the highest frequency), with the mean and median being 43 years. Aware that One25 worked with 260 street-based sex workers in 2023-24, using data over 5 years (2020-2024), there was an average of 4.2 deaths per year and the average age of death amongst the 21 individuals who died was 43 years; with the average age of death for deaths registered in 2020-2024 being 80.2 years old for females in Bristol (averages have been calculated using the data from the Primary Care Mortality Database provided by NHS England), the data indicates that the apparent risk of premature mortality is high amongst street-based sex workers, compared to the general population, with the limitation that we are relying on a small sample size.

Reported cause of death: 63% were recorded as unknown cause or “TBC”. The remainder were recorded as the result of cardiac arrest, overdose, suicide, cancer, kidney problems or unexplained/ not suspicious.

One25 note that women’s needs were often multiple and complex making it challenging to identify a single cause of death. They feel more information about the needs of service users, and reason(s) for their death, would help to better support their most vulnerable service users.

Bristol is launching the Avon Real Time Surveillance System (RTSS) for suspected drug and alcohol related deaths and suspected deaths by suicide. Anyone can submit a notification of a suspected drug and alcohol related death in Bristol using the Bristol City Council webform Report a drug or alcohol related death. Similar webforms exist to report Non-Fatal Overdose and Substances of Concern. Drug and alcohol related deaths (DARD) are analysed to identify themes and trends and associated learning to inform preventative action.

7. The Voice of Bristol's Sex Workers

In July 2024, a focus group was conducted with members of the Bridging Gaps group, a group of women from Bristol who have experienced trauma and who experience complex needs, many of whom sex work or have sex worked. They work to improve access to health services for women experiencing multiple disadvantage. Notes were thematically analysed and have been written up under themes below.

It must be noted that an assumption cannot be made that the views below are representative of all sex workers in Bristol, due to data being collected from one focus group and all individuals being part of Bridging Gaps. All members who were in attendance at the session had experience of street sex work.

7.a. Health Needs of Sex Workers as reported by Bridging Gaps

General health: Representatives from Bridging Gaps told us that women often have multiple, unaddressed conditions due to barriers accessing care: "By the time they present, it's dire-sclerosis, heart problems. By the time they seek help it's too far gone." They noted fear of going to doctors: "Once you start to look into things, you're worried it might unravel."

Mental health and dual diagnosis: Representatives from Bridging Gaps noted that mental health is a massive issue for this cohort, where multiple layers of trauma require specialised mental health services. Bridging Gaps members highlighted that "the dual diagnosis issue continues" where service users can't access mental health support if they have substance use needs, creating "a huge barrier to women accessing mental health support".

Sexual and reproductive health: Representatives from Bridging Gaps noted how delayed symptoms of STIs can result in severe health problems. "Many STIs don't present until later down the line, by which time you may face infertility or a multitude of problems."

Substance use: Representatives from Bridging Gaps highlighted long-term health issues that can arise from methadone treatment such as impacts on teeth and the heart. They stressed the need for harm reduction services for this group such as needle exchange.

7.b. Health Services: Current Access, Barriers and Opportunities as reported by Bridging Gaps

Flexible services with drop ins are valued: Representatives from Bridging Gaps highlighted that drop-in services are valued for improving accessibility: "There used to be open access…would be good to have an open access place."

Stigma and lack of trust is a barrier to disclosure: Representatives from Bridging Gaps expressed desire for a better understanding from practitioners about the complexities of sex work and multiple disadvantages. "People assume you're a sex addict. They don't understand you're doing it to support a habit." Representatives from Bridging Gaps highlighted that stigma and lack of trauma-informed practice in services deters access: "If you've been assaulted, smears [cervical screening] are

really hard." They highlighted that seeing different doctors hinders building trust: "I have trust issues, I might not trust a new GP as I'm feeling judged."

Services that are trauma informed and inclusive are valued: Representatives from Bridging Gaps told us that this group may not go to services they need due to fear of encountering perpetrators at services: "Sometimes [they] can't go to places cos of perpetrators, [they] don't feel comfortable." They expressed a strong, unanimous desire to bring back valued programmes like Peony and Pause: "With Peony I had a life again!"

Representatives from Bridging Gaps talked of potential solutions to make services more accessible to sex workers, including separate phone lines to trained professionals for individuals with complex needs so they don't have to go through to the main reception, data sharing practices to avoid repeated storytelling ("Snapshot gives service provider a brief history, so you can just present whatever is happening that day, not have to recount your whole history"), self-testing kits to reduce the need for in-person visits, educational videos (being trialled at One25) to help women understand medical procedures ("providing info in different ways it can help people to process things in their own time"), and creating a non-judgmental, empathetic atmosphere: "a hug in a mug at the entrance! Chocolate with marshmallows!"[20]

Sex workers have multiple and complex health needs which need to be taken into account by services: Representatives from Bridging Gaps emphasised that GP appointments are too brief for complex needs where they "are often quick interactions so it's hard to have conversations in such a short time". They highlighted challenges in making and attending appointments due to chaotic lifestyles and lack of consistent contact methods: "Sometimes the chaos of the day, even if I have reminded myself, I can still forget".

Services need to be responsive to needs when presented - timeliness is important: Representatives from Bridging Gaps noted how a swift response is needed when individuals are ready to engage: "When people have cleaned up [from addiction], all their ailments come to the fore, so that when you want to get help, you have multiple needs. And when I'm ready, I need the support then."

[20] Something offered at One25 to welcome their service users who visit.

8. The Voice of Service Professionals

We identified a sample of local services who work with sex workers around health in Bristol. We spoke with a representative from each organisation to capture their views on issues that impact the health and service access of sex workers locally. This was thematically analysed and written up under themes below.

8.a. Health Needs of Sex Workers as reported by service professionals

Dental health: Professionals spoken to as part of this health needs assessment stressed that access to dental care is a significant issue. A lot of women are in constant pain which can increase the risk of drug use to self-medicate.

Mental health and wellbeing: Professionals spoken to highlighted that "mental health is the biggest need…[clients] often want counselling to help them process what's going on for them," though long waiting lists and other barriers to access such as language can prevent timely support. A GP explained:

> "Many of our women face significant mental health issues, some due to biological factors and others due to trauma. They all need substantial mental health support, which they often don't receive because of their addictions or the chaotic nature of their lives."

Sexual and reproductive health: A local GP commented that it is difficult to access patient records from the local sexual health service as they are separate, so it can be challenging to find out what procedures a woman needs. They noted that it would be ideal to do cervical screening at the same time as sex workers visit sexual health services, and to operate better patient data sharing to join up care.

Service providers and colleagues within Bristol City Council have commented on recent rising numbers of unplanned pregnancies and children being taken into care among women facing multiple disadvantage in Bristol. A GP highlighted the huge cost, both financial and the impact on people's lives, associated with unplanned pregnancies among this group. They note that prevention is a far better approach, and more cost effective. Looking to understand why contraception usage rates are low among this group, and looking for ways to increase uptake, could have health benefits for sex workers and their children, and the costs associated with meeting needs around unplanned pregnancies.

Substance use: Professionals noted how substance use can interact with and exacerbate underlaying general health conditions: "We secured funding for an ECG machine as we needed to monitor patients on high-risk medications like methadone."

Professionals noted that many individuals involved in transactional sex for rent or drugs don't label themselves as sex workers, leading to challenges in service engagement: "Some people may not admit to themselves that's what they're doing due to this stigma associated with the label."

Professionals commented that there is a long-established need for comprehensive, gender-responsive services for women including those engaged in sex work. BDP

runs a women-only morning in Bristol with childcare that's been running for 28 years. BDP work in partnership with One25 and Brisdoc, however, it was noted that these have not been comprehensive.

A substance use service provider further noted that women often report being targeted for exploitation when accessing support (e.g. at drugs services when picking up their script). They may not feel comfortable to tell staff that it's happening, but many women report that there can be 'informal' swapping of sex for drugs, for access to opioid substitution therapy (OST), and for housing and protection on the street. Professionals told us, "Women say they see workers/ professionals who have bought sex from them, as well as other service-users which can be a huge barrier." Similar findings were noted in the Yorkshire and Humber Public Health Network Webinar (2024) where it was mentioned that female sex workers noted bumping into clients working in services including the police.

Professionals note the value of long-acting injectable buprenorphine to this group. Buvidal is a prolonged-release injection, administered weekly or monthly for treating opioid dependence (NICE, 2019). To overcome problematic opioid use, traditional forms of opioid substitution therapy, such as methadone and oral buprenorphine, have become valuable tools, but these methods do not work for everyone, for example, one barrier to success is the need to attend a clinic or pharmacy every day, or every few days, to obtain the substitute. Long-acting injectable buprenorphine is administered via an injection either weekly or monthly and therefore may have the ability to overcome this barrier. A local professional highlights "we recognise that the current daily prescribing method isn't working for people who are most disadvantaged, who are opioid dependent and homelessness or [at] risk of homelessness" and note they feel long-acting injectable buprenorphine provides a solution to many of the barriers experienced by this group in accessing current treatment options.

The newly commissioned drug and alcohol services, Horizons, is due to launch on the 1st of April 2025, and is collaborating with the Nelson Trust's Women's Centre to offer comprehensive services in a women-only space (from harm reduction interventions such as needle and syringe provision to comprehensive assessment, groupwork and other psychosocial and pharmacological treatment).

8.b. Health Services: Current Access, Barriers and Opportunities as reported by service professionals

Flexible, trauma informed services with options for drop in are valued: Professionals note that women face a range of barriers when accessing drug treatment. For women who sex work (typically work throughout the night/ early morning and sleep in the day), it can be challenging to access services that only operate during 9am-5pm and have strict procedures around missed appointments (such as GP surgeries). They note that there are some excellent examples of trauma-informed flexible care in Bristol (including Wellspring Surgery's open doors appointments for people who face multiple disadvantage). BDP does outreach and relationship building at the Sex Workers Breakfast run by Terrence Higgins Trust (offering naloxone, needle and syringe provision, advice and information, and

onward referrals) which “has been successful as it's at a time or place that works for them.”

One local organisation which supports people involved in street sex work suggested that “having a service running on Friday, for example, would be a great benefit,” and also commented that clients “can’t get down before 3:30.” One professional recommended that “a full-time doctor available at the Health Hub and an additional clinical room” would improve care and availability. It was also highlighted that further opportunities for healthcare being delivered by outreach should be explored, for example by having more than 1 GP outreach session per month; the outreach model used in Leeds was mentioned and could be explored.

Importance of trust and reducing stigma: Professionals note the importance of trust in building relationships with professionals to facilitate healthcare access. Professionals note that service users can prefer specialised services over mainstream healthcare due to feelings of being judged or not listened to in traditional healthcare settings. Professionals told us, “To reduce stigma, it is essential to hear the experiences of service users directly.” Specialists, such as police officers, benefit from hearing about the lived experiences of individuals to improve their approach and understanding of clients’ needs.

Local professionals highlight an awareness of an issue also identified by the Women’s Budget Group (2019) around negative interactions with the police and note how local approaches aim to support women and not criminalise them “as this just leads to more sex work”.

Integrated, joined up, holistic services are desired: Professionals highlighted the importance of integrated and coordinated care to prevent service users falling through gaps: “Clients discharged from the hospital may have to wait days to see a GP for an OST script which can result in them taking drugs again. [Clients] express that although they could go elsewhere, they don’t like to due to risks of meeting pimps and perpetrators.” They also noted the benefit of specialist roles such as Case Coordinators being highly effective for sex workers, to provide tailored support and coordinate responses from various agencies. One local organisation which supports people involved in street sex work have stressed how effective they feel it would be to have housing officers based at their service to support women when they come in.

A whole systems strategic approach to sex work is required: One local organisation which supports people involved in street sex work highlighted the potential local benefit of a joined up, strategic approach, echoed by another professional who noted organisations are currently working separately for sex workers in Bristol and there could be benefit from a more coordinated approach. Several partners referenced the need for a culture change across the system through awareness raising, for example, of the risks faced and needs of sex workers. It was suggested that this should be at an operational level, however awareness also needs to be raised amongst senior leaders, for example, through training opportunities. A cultural shift and knowledge raising, could allow for better data and good practice sharing across services, such as Local Authority, the Integrated Care Board (ICB) and provider services as well as lead to the development of a local strategy which can be used to monitor and deliver improvements to the system to support sex workers.

Peer support is welcomed: Professionals highlighted the power of peer influence among sex workers: “Sex workers love a group chat. Negative experiences of services can spread quickly, as can positive ones.”

Services need to be responsive to needs when presented - timeliness is important: Professionals expressed that when service users arrive, they need to be able to support as many needs as possible in that moment, as they never know when or if they will see them again.

There are missed opportunities to make every contact count. STI certificates should be processed rapidly: Conversations with professionals and other area HNAs suggest opportunities may be missed to make every contact count when sex workers attend sexual health services for STI testing, particularly around the certification process required by the porn industry to show employers that they are clear of STIs.

8.c. Intersectionality, Multiple Disadvantage and Wider Determinants of Health as reported by service professionals

Poverty is a key driver for sex work: Professionals highlight that “transactional sex work behaviour is a symptom of poverty. Addressing those needs is part of addressing health inequalities”, and many clients turn to sex work out of economic necessity: “There is an increasing number of women, including students and mothers, engaging in sex work to make ends meet due to the cost-of-living crisis.”

Ethnicity and immigration: Professionals told us that migrant and trafficked women face additional vulnerabilities. A Women’s Rights organisation explained that they work with a lot of women trafficked in for sex particularly from Eastern Europe. Language barriers and cultural expectations hinder many women from seeking timely medical help: “They have expectations from their home country that differ from the UK system, such as an immediate response causing frustration with NHS delays.”

Transgender sex workers are more vulnerable: Professionals noted “trans women are particularly stigmatised in today’s political climate and can find it difficult to get meaningful work.”

Underrepresentation of women experiencing homelessness: Professionals highlight how women who “make up part of Bristol’s hidden homeless population” and often stay in parlours or temporary accommodation, resulting in “a significant underrepresentation of women” in homelessness counts and limited housing support options for them.

Experience of domestic and sexual violence is high amongst street sex workers: Professionals spoke of a high risk of violence among sex workers, highlighting global research that suggests that “lifetime prevalence of any or combined workplace violence ranged from 45% to 75% and over the past year, 32% to 55%” (Deering et al., 2014) They note: “We have recently seen several cases of pelvic inflammatory disease, most likely the result of untreated STIs,” reflecting increased exposure to health risks among this group, such as clients removing condoms without consent. They also noted that indoor sex work was sometimes

considered safer for clients: “Some parlours have safety measures in place for [clients] such as security staff and panic buttons” which are not available to street sex workers. They note how abusive partners can intentionally prevent women from accessing health services.

Despite violence being recognised by studies found in the literature review, locally we are told violence may be less of a barrier to housing/ accommodation, as we have respite rooms. However, the Housing Team do have challenges around what is being offered not being suitable, for example, the area that the accommodation is based in or who else is residing there. With temporary accommodation, there are checks in the mornings to make sure residents used the bedspace and if found not to be there, the offer of accommodation can be ended. This is particularly difficult for street-based sex workers as they may not be back following being out at night but would want the bed to sleep during the day. They note despite the challenges, they do have good channels of communication and collaboration around housing which they don’t have with health services and is much needed.

Some local professionals suggest figures among Bristol’s vulnerable female sex workers experiencing physical and sexual violence are closer to 100%.

9. Call to Action

Areas for action identified through this health needs assessment are outlined below.

Local system and policy/ strategy

- Develop a local strategy to reflect the findings from this needs assessment and secure a multiagency approach to reducing inequalities faced by those with lived experience of sex work.
- Ensure that expertise through lived experience is central to strategy development and delivery.
- Create a culture change across the system, by raising awareness (e.g. through training) of the needs and risks faced by sex workers, amongst those working at an operational level and those working at a strategic level, ensuring lived experience voice at all levels.
- Ensure cohesion between different strategies developed locally. For example, strategies based on sexual health, domestic abuse, sexual violence, substance use, homelessness and Bristol's Multiple Disadvantage Strategy amongst others.

Prevention and early intervention

- Improve shared understanding of risk factors and unmet need to support early identification and evidence-based preventative interventions with young women and men at risk of abuse and sex work with the aim of avoiding entry into sex work and providing alternative options, ensuring we maintain a trauma-informed Child First principle/ approach for those aged under 18.
- Improve access to primary healthcare for sex workers, with focus on reducing inequalities in uptake of screening, immunisation, smoking support, physical health checks, contraception and dental care, with the aim of preventing chronic conditions developing and identifying risk early.
- Recognising the significant trauma experienced by some sex workers, ensure trauma-focused interventions and mental health care pathways are accessible, timely, flexible and able to meet the sometimes-complex needs of this group (including those experiencing co-occurring mental health and substance use issues) to reduce the impact of trauma or further mental health deterioration.

Ensure all services meet the needs of sex workers

- Lived experience expertise should, at a minimum, inform service design/ delivery, training and communication, including digital developments.
- Shared commitment to collaboration between healthcare providers, housing, social services, and support organisations to provide integrated care for this group, to prevent individuals falling through gaps and being lost to follow-up.
- For those with more complex needs/ experiencing multiple disadvantage, embed a "My team around me" approach.
- Peer networks and trusted groups should be utilised to share positive experiences and encourage engagement with services across sex worker communities.
- Health services should be flexible, inclusive, accessible, and responsive to the needs of people experiencing multiple disadvantage, including sex workers,

focusing on reducing stigma and building trust. This should include consideration of geographic service coverage, access to both general and specialist healthcare, and opportunities for co-located services.

- Services that address wider determinants of health, such as financial and employment support, should also be easily accessible, non-judgemental, and inclusive.
- **The local system should be trauma-informed, for sex workers (as well as other inclusion health groups), for example through:**
  - development and delivery of staff training on the realities of sex work to improve understanding of its impacts on health and healthcare access and ensure sex workers feel safe to disclose their needs (i.e. confidentiality and trust).
  - creating, sustaining and evaluating (in terms of sex worker needs) single sex spaces and services (particularly for females where trauma is linked to male perpetrators).
  - recognition of non-linear engagement – ensuring a person-led approach, easy routes back in, and not having to retell or start over again.
  - recognition of language, literacy and diversity of sex workers (requires individualised approaches) including the differing needs of male sex workers.
  - exploring and evaluating innovative approaches to service accessibility and delivery, incorporating the views and expertise of sex worker lived experience on inclusivity impact.

Improving sexual health outcomes

- Improve access to sexual reproductive health (SRH) services (including the proactive offer of preventative interventions) ensuring they are discreet and meet the needs of sex workers (outlined in the above section) through a range of routes including online, in person, outreach and walk-in provision.
- Ensure all SRH staff receive training (as outlined above) to support a compassionate, non-judgemental and trauma-informed approach to working with people with lived experience of sex work.
- Improve recording of “SW” status within the SRH service to enable better understanding of access, outcomes and needs, while maintaining confidentiality and trust.
- Review and strengthen current SRH outreach and specialist provision to ensure that it is responsive to the needs of the sex working population and is available in trusted community settings.
- Ensure clear pathways and collaboration between the SRH service and specialist voluntary and community sector organisations that support the sex working population.

Data and further research

- Continue to work with existing systems and projects to further understand the needs of sex workers and embed learning into practice; for example, learning from the real time surveillance system and the Women’s Rough Sleeping Census (understanding of how this group experience homelessness, and how

health and other services could be better designed using gender informed definitions of homelessness).

- Further scoping and research are needed to understand the impacts of high rates of domestic and sexual violence identified among this group, and its implications health, working with police/ SWLO's to continue developing supportive, not punitive responses.
- Evaluate and improve date recording practices for sex workers including on EMIS and Millcare, as well as continue to work collaboratively with stakeholders to identity new data sources that could contribute to understanding and monitoring the health and service needs of sex workers.
- Work with organisations to further research needs, service access and effective (including cost/ benefit analysis) interventions for sex workers, particularly for underrepresented groups such as transgender sex workers, those not in contact with services, males, migrants and those experiencing sexual exploitation. Draw on existing local research and best practice to aid this research.
- The health and service needs of individuals involved in online sex work should be further researched locally.

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Appendices

Appendix 1: Grey Literature Summary

Grey literature sources have been grouped under themes in the table below.

Title and Author	Link	Key Points
Impact of Covid-19		
Left out in the cold: The extreme unmet health and service needs of street sex workers in East London before and during the COVID-19 pandemic **(Stuart and Grenfell, 2021)**	Link	- Found health and social support need themes experienced by street sex workers around childhood, parenting, the care system and multigenerational trauma, violence in adulthood, homelessness and sleep deprivation, drug use, mental health, physical health and access to primary and secondary care. - Experience of feeling judged in mainstream services, inflexible appointment systems and lack of outreach were described experiences of street sex workers. - Recommendations include a peer-led approach, preferences for premises and services (e.g. a drop-in centre) and a trauma-informed, holistic approach. A "hub" consisting of multiple agencies to support various needs would be the ideal, with a "drop-in centre" being the next best option. Transparency of services is essential, and outreach (providing essential supplies) is important to complement fixed-site services.
The impact of Covid-19 on women who sell sex or are sexually exploited **Beyond the Streets and the Joint Public Issues Team (2021)**	Link	- Found that women who sell sex or who are sexually exploited faced significant difficulities in the pandemic. - Themes around trauma (experiences of the pandemic being "retraumatising"), deterioatring mental health and lessensing specialist support arose. Further themes which arose were around income loss and food poverty, housing, homelessness and isolation. - Calls made for a trauma-informed approach for sex workers including readily accessible trauma-specific therapy, long-term specialist support, non-specialist services understanding women's needs and the offer of realistic routes to exit poverty.

NOWHERE TO TURN: Sexual violence among women selling sex and experiencing sexual exploitation during Covid-19 **Changing Lives (2020)**	Link	- Found that through the beginning of the lockdown, as a result of the Covid-19 pandemic, women facing vulnerability (inclusive of individuals selling sex) across the North East, Yorkshire and the Midlands were "acutely exposed to sexual violence and repeat victimisation" with impacts on individuals including reduced self-worth, confidence and facing stigma and discrimination. - This is in addition to the multiple disadvantage that these women already face including homelessness, substance use and poverty; however, access to support such as to access accommodation is faced with difficulties and women feel unable to access justice. - The report calls for a number of actions including for a statutory duty on local authorities to ensure training of staff in understanding and responding to these women, adequate long-term funding for trauma-informed specialist services and ensuring women selling sex receive adequate protections under the law.
Sexual Health		
The Epidemiology of HIV Among Sex Workers Around the World: Implications for Research, Programmes, and Policy **Goldenberg et al. (2021)**	Link	- Highlights the need for tailored services for sex workers, who face a disproportionately high burden of HIV and are not benefiting from advances in treatment. - Barriers to engagement include stigma, criminalisation, migration, violence, policing and substance use. - Stresses the importance of addressing data gaps, especially regarding sex workers who are cismen or transgender. - Community empowerment approaches have been shown to reduce HIV risk; this, along with filling data gaps and national action are vital.
Written submission from the National AIDS Trust **National Aids Trust (2019)**	Link	- Identifies that across the world, sex workers are affected by HIV disproportionately, with there being some common experiences amongst sex workers of different sexualities, but also differences.

		- Trans women sex workers, due to a combination of factors, are at a disproportionate risk of contracting HIV compared to other sex workers, as well as cisgender male sex workers also being at higher risk. - The paper also discusses the harms associated with the criminalisation of sex work as well as measures to support people exiting sex work and to participate in safer sex work.
Health & Support Needs and Service Access and Design		
Fighting for Fair Treatment Sex Workers Share Insights to Inform Inclusion Health Initiatives **(National Ugly Mugs, 2023)**	Link	- Key issues identified for sex workers: stigma, inadequate staff training, poor communication (being clear about distinction from punitive services), inconsistencies in care (creating a postcode lottery), and the need to address intersectionality (calling for sex work to be included in equality and diversity considerations). - Recommendations include co-designed health programmes led by those with lived experience, improved training and guidelines, design of communication to include sex workers, and national guidance to support regional efforts.
Support needs of women involved in the UK sex industry: Learning from frontline services **Beyond the Streets (Collis and Thorlby, 2022)**	Link	- The top 3 themes of support needs of sex workers identified were mental health, family, friends and friendships and support service access, with an average of 7.5 support themes identified per assessment (mentioned in the initial assessments), demonstrating the complex situations of sex workers. - A multi-agency approach to support is needed and challenges need to be addressed, with clear pathways for referral, and signposting policies to ensure trust. - Non-judgemental, appropriate, trauma-informed services which breakdown isolation are vital.
SWARM Response to the Scottish Government's Equally Safe Consultation	Link	- Number one concern for sex workers accessing healthcare is confidentiality and fear of information sharing.

SWARM (2020)		- Poor experiences in accessing mental health support for sex workers is referred to and judgmental attitudes, intrusive questions being asked or the impression that professionals are gathering information to pass to the police can break down trust. - Co-production and extensive consultation are key to effective health and wellbeing services for sex workers, as well as confidential and non-stigmatised services. - Financial support to quit is referred to; this can be met by peer-led, well-funded support services. Secure housing, emotional support, financial support, and secure employment options are important for those experiencing financial uncertainty. - Women should be supported to exit sex work at a pace that works for them. - Barriers to access services include high travel costs, transport and restricted opening hours; online and in-person options should be provided. - SWARM state that full decriminalisation is the most effective policy approach to reduce harm of sex workers.
Women and Equalities Committee Inquiry into prostitution/sex work. **Women's Budget Group (2019)**	Link	- Harms of sex work stated are violence (e.g. rape and murder), mental health problems (e.g. PTSD), STI risk and substance use, with intersectionality exacerbating inequalities, and studies showing an overrepresentation of minority communities and those with uncertain migration status in the industry and in the most abusive/ exploitative contexts. - Other factors related to exploitation in sex work include homelessness, substance use and mental health problems; these are also shown to affect exit out of sex work. - The harms mentioned are intensified and exit barriers are created by the social security system, the housing crisis, cuts to and lack of funding for specialist services, immigration/ asylum legislation and legal status as well as cuts to services such as sexual health and drugs and alcohol. "Meaningful assessments of the equality impact of policy" should be carried out, to avoid many of the problems faced.
A public health approach to sex work across Yorkshire & Humber	Link	- Showcases a public health approach to sex work in the region, highlighting the diverse reasons individuals engage in sex work and the various settings they work in.

Yorkshire and Humber Public Health Network (2024)		- The webinar recognises significant health inequalities faced by sex workers, including physical conditions like COPD and thrombosis, and mental health issues such as depression and psychosis. - Experiences of trauma, including adverse childhood experiences, time in care, and abusive relationships are recognised, with a speaker noting an average age of death of 41 among 26 women, over five years. - Barriers to accessing support include stigma, financial loss from attending appointments, and encountering clients in healthcare settings. - The webinar emphasises outreach and strong partnerships.
The nature and prevalence of prostitution and sex work in England and Wales today **University of Bristol (2019)**	Link	- Highlights that sex workers in England and Wales can experience varied health and service needs shaped by a number of factors. - Many individuals enter sex work due to financial hardship, lack of access to benefits, discrimination, or health issues, and often face stigma, violence, and barriers to healthcare. - Stigma and managing safety compounds the experiences of sex workers. - Varying experiences relating to the identity and characteristics of sex workers are identified such as the experiences of migrant sex workers.
Other area health needs assessments	N/A	- Identifies increased risk of many health conditions/ concerns amongst sex workers, including mental health disorders, STI's, chronic conditions, self-harm, falls, drug use and death, and elevated hospital admissions; high rates of complex childhood traumas among female street-based sex workers identified. - Crime, harm or violence as a result of sex work is referred to often, with only a small proportion reporting to the police. - Drivers for sex work identified include the need to fund drug addiction and to cope with trauma and mental health issues; money (including financial discrimination), work opportunities and a fear of contacting government services (particularly for migrants) may keep people in sex work and deter them from seeking support. - Barriers to mainstream work alongside or instead of sex work, include disability and health, insecure housing, caring responsibilities, not being able to tell employers

		about time spent or skills gained while in sex work, lack of education, and pay not being enough to live on. - The HNA's emphasise streamlined, trusting, stigma-free, holistic services (e.g. One25 "one-stop-shop" model), with dedicated sex worker and women specific services, peer support and fast-tracking (long waiting lists) mentioned. - The importance of making every contact count to avoid missed opportunities, gender-differences in experiences and services, further research evaluating interventions for health (particularly with minority groups) and the importance of a city-wide strategy are referred to.
Inequalities		
Healthcare and Racialised Sex Workers in the UK **National Ugly Mugs (2024)**	Link	- Found barriers to racialised sex workers receiving "adequate and respectful" health interventions, including stigma, mental health bias, misunderstanding and medical racism, stemming from systemic issues in healthcare systems. - Many racialised sex workers feel that they cannot confide in or engage with health professionals and have a lack of faith in the system. As found in other sources, a resistance to disclose sex work due to concern of being discriminated against can mean going without medical care or receiving it late. A number of suggestions are made including around staff training and specialist services, cultural competence in mental health care, communication accessibility and anonymity and having a compassionate complaints process.
"I'll tell you what I want, what I really, really want" The health and wellbeing needs of male sex workers **Turner, Meyrick and Wood (2024)**	Link	- Found through a study that participants (UK based men (18+) who were active or had previous experience of accepting rewards for sex (with the age range being 25-72)), spoke about identity and language used when navigating and understanding experiences as well as "tools of the trade" which included performance/ image enhancers, alcohol and drugs and STI certificates. - Peer and mental health support were referred to, to support the health and wellbeing of this population. Despite being known as a "hard to reach" population,

		male sex workers are willing to engage in research based on their health and wellbeing needs.

Appendix 2: Further Information on the Women's Rough Sleeping Census

Data shared below is from the Women's Rough Sleeping Census 2025 (Bristol City Council, 2025b).

In Bristol, there is a recognised gap in data collection on women's homelessness, where their experiences may differ from that of men's. This gap may be affecting funding and service planning for vulnerable women. For example, they may experience violence and abuse, and hide themselves away, and therefore be hidden from support and statistics. Data driven funding streams and commissioning can then unknowingly neglect women's needs resulting in a lack of specialist services and accommodation for women, increasing their risks.

Work around the Women's Rough Sleeping Census explores this, using a gender informed definition of homelessness to tackle this problematic cycle.

Census homelessness definitions

Ministry of Housing, Communities & Local Government (MHCLG) definition: People sleeping, about to bed down (sitting on/in or standing next to their bedding) or actually bedded down in the open air (such as on the street, in tents, doorways, parks, bus shelters or encampments).

People in buildings or other places not designed for habitation (such as stairwells, barns, sheds, car parks, cars, derelict boats, stations, or "bashes" which are makeshift shelters often comprised of cardboard boxes).

Gender-informed definition: Having nowhere safe to stay at all:

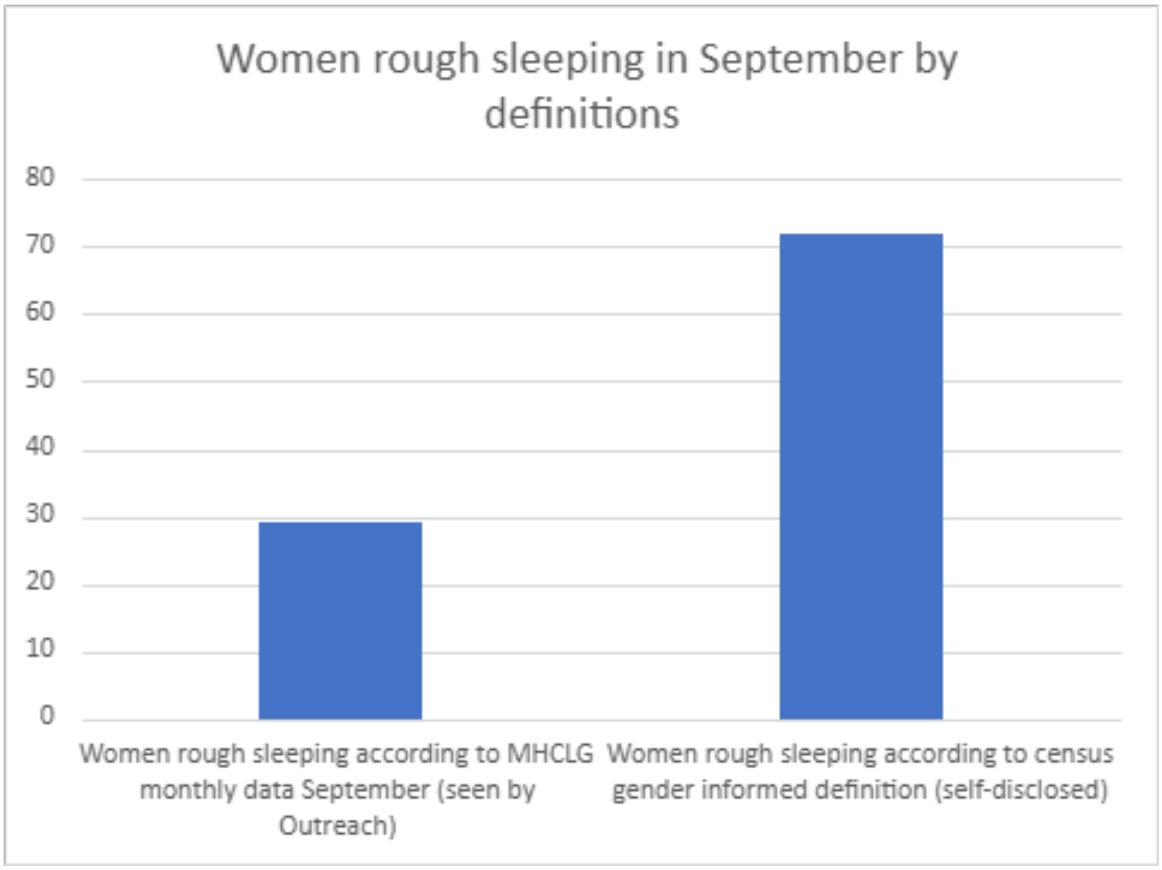
For example, sleeping outside on the ground or in a tent, sitting/sleeping in places which are open late or 24/7 (such as fast-food restaurants and hospitals), walking all night, sex working at night but not having anywhere to sleep during the day, using drugs in other people's accommodation at night but not having anywhere to sleep during the day etc.

Women may not do this every night, and rough sleeping may be interspersed with other forms of hidden homelessness such as staying in accommodation belonging to unsafe/ unknown people/ perpetrators, staying in 'cuckooed' flats or staying with friends/ family/ associates on a very insecure and transitory basis (e.g. nightly or weekly, or regularly being forced to leave immediately.)

Findings

The unpublished 2025 Women's Rough Sleeping Census, shared here with permission from the Rough Sleeping Homelessness Commissioning Team (BCC), found through a survey (conducted 22nd - 26th September 2025) asking about rough sleeping experience, that 102 women said they had some experience of rough sleeping. 88 women said they had experienced rough sleeping in the last three months and 72 within the last month. Appendix Figure 1 demonstrates hidden homelessness across September 2025.

Appendix Figure 1: Snapshot count of women sleeping rough in Bristol comparing use of the general definition of homelessness with use of the gender-informed definition (September 2025)



The top 3 places where women reported they had stayed or slept in the last 3 months were:

- Slept outside on the street (in a tent, park or carpark, or on the street)
- Walked around all night
- With a friend or partner

A number of services were asked to collate data for women who met the definition that they work with across July, August and September 2025; 281 women were captured through the insights data. Majority of women identified in the insights data were between 25-54 years old; no young women below the age of 18 were identified.

27% of women who fit the gender informed definition are potentially not accessing homelessness services.