Promoting Community Health among People who Trade Sex in the Baltimore's Brooklyn, Curtis Bay and Baltimore Highlands Neighborhoods

Final Report (October 2020 - May 2021)

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*This report is part of a larger report and reflects a set of recommendations specific to the service area of the Greater Baybrook Alliance (Brooklyn and Curtis Bay communities)

Overview of the Current Study

The Greater BayBrook Alliance (GBA) and the Southeast Community Development Corporation (Southeast CDC) are local nonprofit organizations that listen to the needs of Baybrook and Highlandtown residents, respectively, and partner with other organizations to develop, revitalize, and provide services to their communities. In response to resident concerns about the prevalence of street-based sex work in their neighborhoods, the two organizations partnered with one another to hire a paid Community Health Fellow from October 2020 to May 2021, as funded by the Open Society Institute grant. **The Fellow was tasked with 1) reviewing the literature on sex work, 2) gathering feedback from local stakeholders, 3) centering the perspectives of community members who trade sex on the street, and 4) developing tailored recommendations to move the community forward.** Munazza Abraham, M.A., was selected as the Community Health Fellow, supervised by GBA's Public Safety Director.

Community Health Fellow Background

Munazza Abraham is a Clinical and Community Psychology Ph.D. Candidate with mental health and research experience. Her work focuses on supporting the equitable well-being of individuals and communities harmed by the criminal legal system. With a social justice orientation, Ms. Abraham developed a community health plan informed by the following actions: she conducted a literature review on topics surrounding sex work and community initiatives, she met with stakeholders and organizations from in and outside of the community to responses to sex work and service provider capacities to serve individuals who trade sex, she consulted with key peer-led organizations that serve women who trade sex (notably, Power Inside and SPARC), and she developed a qualitative study to gather interview data from individuals involved in trading sex on the street. The primary goals of the community health plan are to improve the health equity of each full community by developing actionable recommendations to improve the quality of and access to resources for individuals who trade sex and other marginalized community members. Details of the Community Health Fellow's methods and results are described below.

Methods

The Community Health Fellow began her work by researching and memoing relevant literature concerning sex work and community interventions (see: link for full literature review; and briefing papers promoting the end of human trafficking and promotion of public health and safety among people who trade sex). The GBA Public Safety Director then provided the Fellow with a contact list of local partners, relevant organizations and meeting groups that would provide insight into developing the community health plan. The Fellow attended multiple community meetings each month for the full length of the 7-month fellowship (virtually due to the COVID-19 pandemic) to understand community needs, perspectives, and current efforts to address sex work concerns. The Fellow also facilitated 1x1 meetings with representatives from key outreach organizations and service providers to inquire about their capacity to serve people who trade sex and explore potential areas for partnership and capacity building. Upon learning about potential community training needs, the Fellow emailed a Google Forms survey to local stakeholders (contact list provided by GBA Public Safety Director) to assess interest in free trainings on sex work 101, trauma, and community health equity. And lastly, considering marginalized community members, namely individuals who trade sex, were not present at community meetings or trainings to share their ideas and experiences, the Fellow then leveraged connections with local

outreach and service organizations to recruit interview participants with lived experience in trading sex.

Interview Eligibility: To be eligible for the interviews, participants had to be adults 18 years old and older with recent experience (within the past 12 months) in trading sex on the street for money, drugs, housing or other needs in or near the Curtis Bay, Brooklyn, and Highlandtown areas of Baltimore, MD. All genders and sexual orientations were explicitly welcomed. Limited exceptions were made to include community members who were affiliated with individuals who trade sex or whose experiences commonly intersect with the sex trade, such as individuals experiencing extreme poverty, drug use, and homelessness.

Interview Format: The interviews were semi-structured and followed a written interview guide. Interviews were facilitated in-person, by video conference, or by phone (audio only). Interview participants selected their preferred interview format to accommodate accessibility and optimize their sense of safety and comfort. Interview participants were not required to provide their full names or any identifying information unless they requested to be contacted in the future to lead or participate in a "community health initiative" supporting individuals who trade sex. Interview data was stored separately from identifying information and participants were assigned a Participant ID to protect confidentiality. Interviewers explained the informed consent form and provided all participants with a copy. Prior to beginning the interview, participants either signed the informed consent or provided verbal consent (due to participant's limited technology access and limited in-person contact in accordance with CDC guidelines for the COVID-19 pandemic). Interview questions were read aloud and explained as needed to each participant. Interview questions collected demographic data and centered on:

- Top resource needs of participants who traded sex and what resources were missing in the community
- Barriers to community resources
- Participant perceptions on how they were treated by resource staff and neighbors
- The impact of the COVID-19 pandemic
- What community resources were accessed and where
- Whether participants were interested in additional resources: peer support groups and virtual sex work workshops (as an alternative to street-based sex work)
- Participant thoughts on how to improve the community
- And whether participants were interested in leading or participating in a community health initiative to support other individuals on the street who trade sex.

Interview Length: Interviews typically lasted 30-60 minutes. The interview guide was piloted twice with GBA's peer-led consulting partner, Power Inside's Executive Director, and a paid Power Inside participant with previous sex work experience. The interview guide was also piloted with GBA staff and interns. The Fellow integrated feedback and revised the interview guide accordingly.

Compensation: Interview participants were compensated with an activated $40 Visa Gift Card which was delivered directly to each participant. The compensation amount was endorsed by GBA's consulting partner, Power Inside. Participants also received localized resource sheets to address basic needs.

Interviewers: The Community Health Fellow and Dr. Cora Frantz (a, then, PhD nursing student who was interning with GBA) conducted the interviews. The Fellow facilitated trauma-sensitive interview trainings with Dr. Frantz to ensure relative consistency in interview

protocols, how to use the interview guide with reflexive listening and probing questions to achieve the goals of the study, and to relay relevant resources following each interview.

Recruitment method: The Fellow sent emails and made announcements during community meetings (i.e., Baltimore Highlands Task Force meeting and the Brooklyn COVID-19 Coordination Call, etc.) with partnered community organizations to request warm referrals to the interviews and to post or distribute the recruitment flyer. The following community organizations were also directly contacted for recruitment support considering their frequent service to marginalized individuals: The Well, City of Refuge, Transformation Center, Concerted Care Group, Family Health Centers of Baltimore, Our Lady of Pompei church, and Baltimore Safe Haven (who has begun outreach in the Highlandtown areas since late March 2021).

Results

Meetings with Local Organizations & Community Members Who Do Not Trade Sex

Local meetings included the Baltimore Highlands Task Force (led by Councilmember Zeke Cohen), Baybrook COVID-19 Coordination Call (formerly led by GBA, then by the United Way), the Brooklyn Task Force (formerly led by Delegate Robbyn Lewis), Brooklyn Community Advisory Meeting (led by the Concerted Care Group substance use program), and Community of Practice on Homelessness (state-wide meeting led by Maryland's Healthcare for the Homeless). Community meeting attendees included residents, district political leaders, police leadership on occasion, service providers, and local organizations.

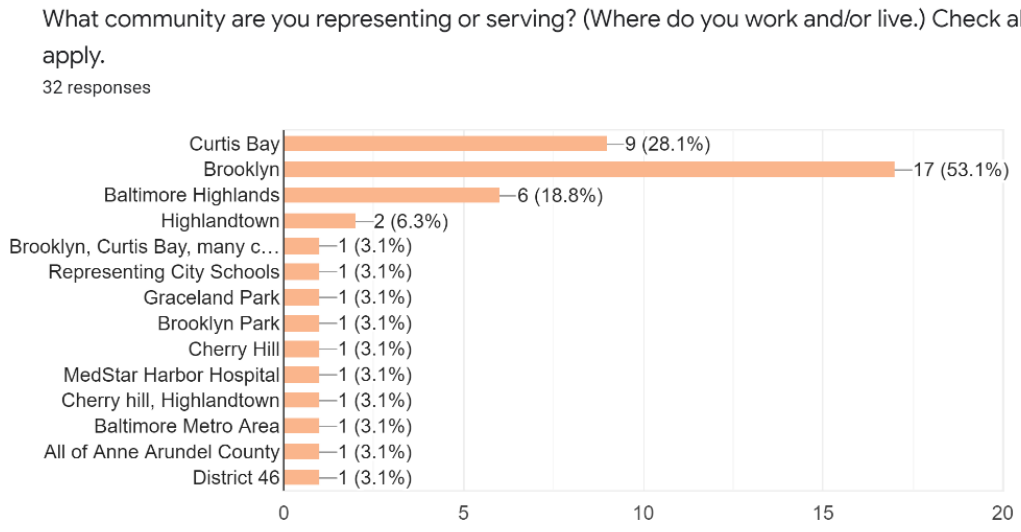
The meeting results largely aligned with the previous literature. Conversations with stakeholders **consistently yielded a concern for the perceived low morality and overall visibility of sex work in the neighborhood. Some residents and police leadership endorsed the myth that sex work causes more crime.** Some residents expressed deep concerns following police leadership's recent announcement that they would no longer make arrests for "prostitution" (not arresting sex workers or clients). Resident concerns ranged from believing that police should arrest "the johns" for soliciting women on the street to believing police should still respond to calls to remove sex workers from standing on corners or trading sex near their homes, schools and neighborhoods.

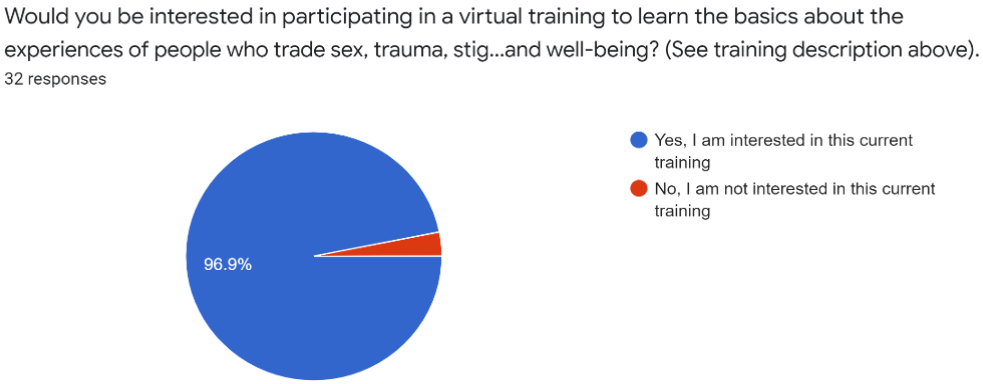
During community meetings, there was a clear marginalization of people who trade sex in the Baybrook community. This marginalization is clear in the language used during community meetings when **attendees would discuss "residents and sex workers" as if sex workers were not also residents and community members**. **Some meeting attendees wanted to "help sex workers"**, while **others demonstrated a *not in my backyard* mentality, desiring sex workers to be removed or less seen, which contributes to their invisibility and vulnerability to violence** (Krüsi et al., 2016). Specifically, in the Highlandtown areas, there is a lack of outreach and lack of overall service engagement with people who trade sex on the street. This lack of outreach is compounded by issues of stigma and a lack of community inclusion (noted by the absence of less privileged residents at community meetings), further marginalizes individuals who trade sex and decreases overall community health equity.

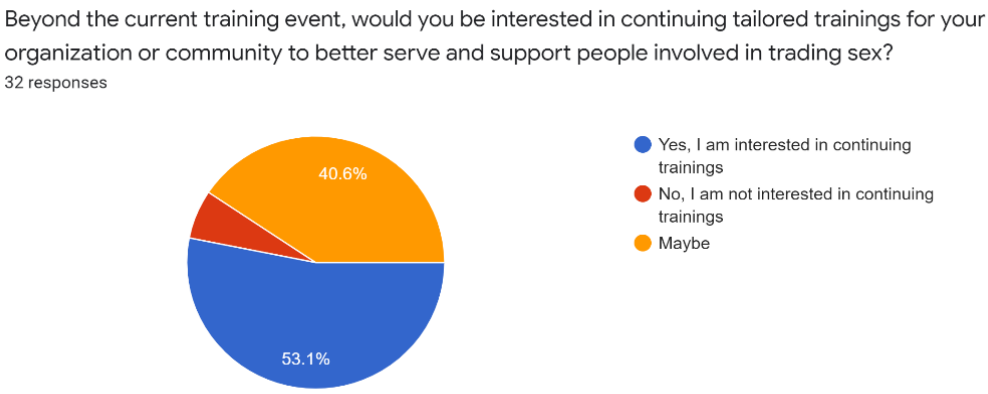
Despite the varying outreach capacity levels between the Baybrook and Highlandtown areas, **leaders of both Baybrook and Highlandtown community meetings acknowledged the need to include marginalized groups and individuals with experience trading sex at the meetings**. However, in initial meetings without peer-led outreach organizations, both leaders **were unsure of how to reach and extend warm invitations to individuals on the street**.

There was also general **uncertainty around how to facilitate inclusive problem solving** with more privileged and less privileged community members, which implies there is a need for experienced facilitators to moderate the challenging conversations and mediate any conflicts.

Several service organizations also expressed uncertainty on how to tailor services and improve their quality of care for individuals who trade sex on the street. All service organizations who attended 1x1 meetings with the Fellow endorsed wanting training to better serve individuals who trade sex on the street. The Fellow polled additional service providers, organizations, and residents, (a total of 62), who served the Baybrook and Highlandtown areas to assess interest in a free training on trauma, sex work 101, and community health equity. Out of 62 individuals contacted, 32 individuals responded to the poll. The table below displays the areas poll respondents were from. Respondents were able to select from a list of neighborhoods or write it in. Most respondents were from Baybrook areas. Respondents represented the following organizations, as written in by respondents: Maree G. Farring EMM, Baltimore city council district one, United Way of Central MD / Bay Brook EM School/ Ben Center (n = 3), The Partnership for Children Youth and Families, MedStar Harbor Hospital, UWCM, Friends of Garrett Park, Southeast Community Development Corporation (n = 2), MD Division of Parole & Probation (n = 2), Highlandtown Community Association, No organizational affiliation (n = 2), The Transformation Center, The Well / Hon's honey, Enoch Pratt Free Library Brooklyn Branch, Boys and Girls Club of Metropolitan Baltimore, CCBB, and CASA. The figures below display that 96.9% (n = 31) of respondents reported that they would be interested in the initial training and only 3.1% (n = 1) said no. However, when asked whether they'd be interested in continuing trainings beyond the one initial training, 53.1% (n = 17) said yes, 40.6% (n = 13) said maybe, and 6.3% (n = 2) said no.







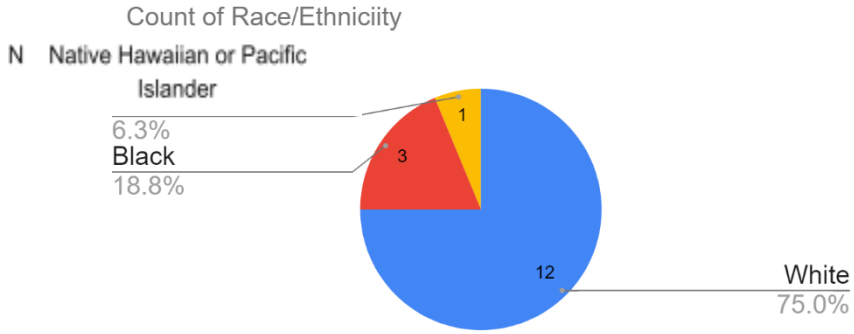
The last question on the training poll asked whether respondents had any particular concerns or questions they'd like the training to address. One eager respondent commented that they were **"particularly interested in how to support equity and well-being in community."** Another respondent asked practically, "How will this training be converted to use in the community?" Another respondent was interested in criminal charges against sex work clients; however, they also expressed interest in welcoming diverse ideas for collaboration: "**Can we talk about enforcement for the johns? We talk a lot about sex workers and have had several meetings about the topic with a variety of people. I'm curious to see how this training will differ and how everyone can work together with a variety of different ideas to address concerns**." This response might be endorsing the arrest of sex work clients, which, according to the literature, is not an effective means of protecting sex workers or ending sex work (Fehrenbacher et al., 2020; Landsberg et al., 2017). And the last respondent clearly endorsed wanting to "help", "save" or "change" individuals by encouraging or requiring a different career path: **"How do you retrain prostitutes for [a] different career?"** Overall, the training poll results endorsed some common myths surrounding sex work, such as "End Demand", yet **respondents displayed a strong interest in learning more**.

In addition to the training poll and meeting results, the Fellow also discovered that **some formal and informal Brooklyn organizations have conducted past community research regarding local resources and the experiences of people who trade sex.** However, **research results were frequently not accessible** or not widely distributed to the public or key stakeholders. The Fellow attempted to contact individuals who were involved in these research efforts, however,

not everyone responded. It was apparent that a few meeting attendees would work independently to explore and address neighborhood concerns, rather than fully collaborate and share information with other stakeholders. The Fellow was able, however, to directly request and attain some prior research articles authored by Power Inside and SPARC leadership (i.e., the SAPPHIRE [Footer et al., 2019] and Window studies [McLean, Robarge, & Sherman, 2006]) as well as conduct an independent literature review to find one neighborhood assessment of resident attitudes and beliefs surrounding sex work concerns and appropriate responses (Shdaimah et al, 2014). However, despite some recent publications, the actual studies were 5-16 years old and did not significantly explore the perspectives of individuals who traded sex in Highlandtown areas. Unfortunately, the Fellow also had difficulty reaching this population in Highlandtown.

Interviews with Community Members Who Trade Sex and Affiliates

Demographics



The majority of participants identified as women (n = 12, 75%) and one quarter identified as men (n = 4, 25%). The average age was about 42 years old, the youngest participant was 26 years old and the eldest participant was 59 years old.

Nearly all participants were living in Brooklyn, MD at the time of the interview or recently moved from Brooklyn. One participant was from Cherry Hill, one was from Arbutus and previously lived in Brooklyn, and another one was from Highlandtown who also previously lived in Brooklyn. The average length of time participants lived in their primary community was about 15 years; the maximum was 50 years, and the minimum was 1 year.

Twelve participants endorsed staying in a house or apartment, typically with family, a friend or a significant other. One participant endorsed staying in both a house and a tent and 2 participants endorsed staying in a tent, frequently referred to as “Tent City” or “the Tent Community” in Brooklyn. Nearly all participants indicated that there was no limit to the length of time they could stay in their living arrangements.

Over half of the participants (n = 9, 56%) were referred to the interviews by a flyer posted at the Concerted Care Group in Brooklyn, while 6 (37.5%) were referred by previous interview participants, and 1 (6.3%) was referred by The Transformation Center in Brooklyn, MD.

Due to the nature of the referral and interview format, all participants had access to a phone with call and text capabilities. Though some participants' data was limited, the majority of participants had full smart phone capabilities, including internet access. However, some participants disclosed they had difficulty navigating the internet and video conferencing features. No participants owned a laptop or computer.

History Trading Sex

Participants average history of trading sex was about 12 years, the maximum was 37 years and the minimum was 2 years. Five participants reported that they no longer traded sex at the time of the interview whereas 9 participants were still active. When participants were active in trading sex (n = 14), 4 participants (29%) reported trading sex every day or multiple times a day; 5 (36%) reported trading sex weekly, 2 (14%) reported trading sex 1-2 times a month (normally when the rent was due), and 3 (21%) generally reported trading sex whenever there was a need to earn extra money. Specifically, one of these participants stated, she trades sex whenever she needed "money, drugs" or when she "didn't want to be alone". While another participant stated she trades sex "rarely" in *addition* to her traditional job when she "needed something for the household".

The last time participants traded sex on average was about 141 days from the interview date; the maximum was 720 days ago and the minimum was 0 days (indicating the participant traded sex the same day as the interview. Notably, 2 out of the total 16 participants (2 out of the 4 men interviewed) reported that they had never traded sex but struggled with substance use, mental health, poverty, and were affiliated with individuals who trade sex. These 2 participants were referred by previous participants from the Concerted Care Group who were active in trading sex. Due to the warm referral and their intersecting marginalized status (i.e., individuals who trade sex often use substances), the interviewer continued the interview with these two participants to listen to their perspectives on the community and their access to resources.

Participants often reported trading sex for money, food, drugs, and housing, which is consistent with previous literature.

Community-specific Needs

All participants reported their top three needs. Participant responses in order of popularity included: 1) Housing, 2) Money/employment, 3) Food, 4) Mental health/substance use care, 5) Medicine/physical health care, 6) Transportation, 7) Legal documents (i.e., ID and social security, etc.), 8) Childcare & Child Support 9) Drugs, and 10) a place to Shower.

When asked what resources are missing in their community, **participants frequently named housing and transportation as missing resources in their community**. One participant stated:

> *"I do know that a lot of us that are down there…behind the McDonalds, called Tent City or whatever…They often need more tents because they're making their own shelters and it's causing more problems because people are getting hurt…They're not very clean.* ***We need more tents or shelter places...[We also need Drop-in Centers] to sit down, eat chill, shower****…****and rehab centers that don't require ID or support you in attaining ID****…We need more places to help people to get the help they need while they're getting set up with insurance and ID. I'm currently on CCG's [Concerted Care Group] program where you need an ID to get in there…"*

Some participants also labeled the following resources as missing in their community: **job placement support, 24/7 food bank, a local Needle Exchange center, childcare, and supportive services to aid people in seeing their children again**.
Four additional responses included the following:

> *"Housing and a social security office [is missing]. They used to have a fair once a year like a job fair but for getting IDs and your social security card or job help, but I haven't seen that in a few years."*
>
> *"I feel like **the big things we need out here is social services for IDs and food stamps** and stuff like that, 'cause you have to take a bus to that."*
>
> *"Housing and **mental health care** [are missing], especially for schizophrenic people on the streets"*
>
> *"There should be more in-patient methadone clinics (vs outpatient) -at least 30 days to get them off the streets…There should be more places for pregnant people; a safe place for them to live and sleep **[supportive housing and in-patient substance use treatment, especially for pregnant women like the Center for Addictions and Pregnancy through Bayview** (CAP).]… used to be a unit at the Bayview Hopkins where you can have 7 days in patient to get on the medication (like methadone) then continue doing 3 groups a day outpatient 9am-12pm daily in order to get the medication (like methadone), provide parenting classes, 1x1 counselors, etc. …Women can continue going there for 6 weeks after child is born…A pediatrician is also on site…I continue going for my son…Now it's a temporary shelter…There needs to be more places like that because it's such a small program…It should be in every borough…I know a lot of people it saved…It's the first place I got clean for 5 years…I hate seeing pregnant women on the street, and there's a lot of them on the street tricking and doing drugs"* (a woman who trades sex from Highlandtown).

<u>Barriers to Community Resources</u>

Transportation was the most commonly reported barrier to accessing resources. However, it is important to note that when interviewers asked, "what gets in your way of accessing the resources you need", despite most participants being without transportation, not all initially named transportation as a barrier until directly asked in a follow-up question. A couple of participants initially answered **"nothing really gets in [their] way", referring to their willingness to walk or request a ride to where they need to go or simply do without. These initial responses speak to participants' resiliency as well as the chronic nature of their circumstances - to have to adapt and do without a necessity (or what more privileged individuals perceive as necessity)**.

Another participant initially named **"my drug use" as their first barrier to accessing resources** prior to being prompted about transportation. This participant was referring to the fact that **substance dependence can be debilitating and shift an individual's priorities from fulfilling any other basic need to satisfying their addiction**. In contrast, two participants clearly stated that they **perceived no barriers to accessing resources due to a reliable social support system** (i.e., family or a significant other).

For some participants with and without a reliable social support system, it was clear that **even those who had been long-term residents of Brooklyn, were unaware of local resources that could address their basic needs**. For example, multiple participants who sought job placement support were unaware of the local United Way program that provides job readiness training, job placement support, and free education-to-employment programs such as the

CNA-to-Nursing degree program. Some of the local resources and programs were relatively new, and partially due the COVID-19 pandemic, street outreach and promotions were limited.

As another example, one participant reported that she cannot access free food distribution sites because she has no transportation, and so she "trades sex for food…not drugs…only for food". However, the Fellow (who's not from Brooklyn) was aware of a food distribution site just 2 blocks from the participant's residence. The Fellow learned of this food distribution site through attending virtual community meetings, which rarely, if ever, was attended by individuals who trade sex. This highlights the importance of ensuring marginalized groups and individuals who trade sex on the street are included in such community meetings. After the Fellow shared the nearby food resource with the participant, they further discussed the participant's concerns of walking alone for the 2 blocks to the food distribution site. The participant expressed intense fears of being assaulted as she had been in her past, including while sitting at a neighborhood bus stop. This participant also disclosed that **because she had to walk to access resources, not having a coat and warm clothes during cold or storming weather was an additional barrier**. Fortunately, the Fellow and the participant were able to connect with City of Refuge for the participant to secure a coat and food multiple times a week during City of Refuge's outreach schedule.

Several other participants also reported transportation barriers and expressed an unawareness of which organizations offered wrap-around services to meet their basic needs. For example**, a participant may go to an organization for food, yet not be informed that the same organization also offers clothes or additional resources**. One local organization acknowledged that **individuals may be responsible for vocalizing each of their needs, which may be several, rather than staff proactively inquiring about common needs or offering wrap-around services on a person's first visit.** While this organization may be known for a particular set of services, they may also offer obstetric and gynecological care, substance use treatment, mental health counseling, social services, dental care and more. Thus, **participants' lack of awareness of wrap-around services may be an opportunity for organization staff training on proactive comprehensive care as well as an opportunity for intentional advertisement in accessible formats to people on the street.** Acknowledging that not all individuals have phone or internet access to review organization websites and their menu of services, the Fellow ensured that as each interview concluded, the interviewers handed out resource sheets and clarified what and where wrap-around services were available.

During the interviews, multiple participants **named safety as a "missing resource" and a lack of safety was named as a barrier to accessing community resources**. Participants reported being worried for their personal safety as well as the safety of their children and families, which is consistent with other resident concerns discussed at community meetings in both Brooklyn and Highlandtown. Three participants discussed safety concerns below.

> *"I'm afraid of the area now, especially being disabled…My sister went through a hard time there [in Brooklyn]…She felt threatened…I don't want to go back to Brooklyn for anything."*
>
> *"Safety, because there's a lot of murders here and a lot of girls getting the shit beat out of them and their money taken away after they do services because they jump in and out of cars and mess with drug dealers.*"
>
> *"… I go to clinic and home…I don't feel safe going outside anywhere…Don't want to risk my sobriety and my life [in Highlandtown]. I'm afraid someone is going to rob me…"*(Participant MMW75). This participant added *"…I couldn't be around Highlandtown and get clean, I got clean in Brooklyn".* Though sex work and substance use is prevalent in both Highlandtown

and Brooklyn, this participant may have been referring to her social connections in Highlandtown that made it difficult to maintain sobriety and/or the lack of community resources in Highlandtown compared to Brooklyn. The participant continued her response regarding her personal safety concerns, *"It would be a lot safer if it [sex work] was legal…People would have to be clean and security would prevent abuse and people taking advantage of the girls [in legal brothels]…People look at you like you're nasty [but] people are going to do it regardless…It's just sex.*"

In addition to safety concerns, **stigma was also endorsed as a barrier to accessing resources**, which is consistent with prior literature. Stigma is further discussed in the next section on Perceptions of Community Attitudes and Judgement.

In summary, lack of transportation, lack of appropriate clothes for the weather, lack of awareness of services, substance dependence, lack of safety and stigma are significant barriers to accessing community resources among this sample of individuals who trade sex and/or use substances.

Perceptions of Community Attitudes and Judgement

Interview participants who trade sex sensed the **"divide" and lack of unity in the community**. Two participants reported:

"Sometimes the community is not very happy because they don't know what Is going on or they don't understand, but if they knew what was going on and educated themselves, they'd feel better about it. But they don't because it is so secretive… The community doesn't like when the resources (shower, harm reduction supplies, etc.) are near [their neighborhood] because they think it attracts people on the street coming from other areas, but the people are already there [in the community] just hidden till the resources are visible/available."

"Feels like the community sees us [people who trade sex or use substances] as the problem, 'cause of drugs and violence and bad things in the community…The community looks down on us…People don't usually understand till it's one of their own…The community needs to be more together than apart."

Some interview participants noted being **treated as "addicts" and seen as "less than"** by neighbors as well as hospital staff, Department of Social Services, and "government" affiliated service providers. Five participants reported:

"When I was out there [using substances and trading sex on the street], I was raped. At the hospital, I was treated so bad…I was on drugs… awake for 6 days…I was delirious…they were smacking me to keep me awake…The hospitals were rude…Some police officers were rude…The ambulance was rude…I would stay up 'cause I wouldn't have a place to sleep…I had pneumonia and heart infections…The ambulance treated me so bad, they thought I was messing around, they were very mean...I asked for their names, but because of how I looked they didn't give me their names. Just because I was doing that stuff, I wasn't a bad person."

"They treat you like you're a piece of shit…No respect or dignity, like they don't seek to understand why you're using drugs…They look at you different. It hurts…I feel downgraded. They're supposed to make you feel secure and comforted. It's like they want to break you down, not bring you up...Feels like they just care about money."

"Government ran places don't take the time to sit there and talk, they just throw it [resources] out in the street and leave (like gear, bags, and let people throw clothes everywhere)..Like if you walk through the alleys in Brooklyn you'll see ripped bags of clothes and can't use it by the time you get there."

"I feel like I get treated really good most of the time by staff [referring to Concerted Care Group]. But social workers and doctors and stuff have been judgmental about the drug use and the sex work, so I don't share about the sex stuff anymore."

"Generally, judgement is bad. I don't get many services 'cause I don't tell anybody anything [including about trading sex]" (a man who trades sex).

When interviewers asked participants, "Do you worry about being seen or judged by others in community when visiting local services", the majority of participants were not worried. One participant proudly stated:

"It feels good for people to see me now. Back then, I used to pick my face till it hurt…scabs all over my body. I was 97 pounds. Since I've been clean, I've gained 100 pounds."

Although the majority of participants were not concerned about how neighbors viewed them, a few participants were impacted by community perceptions and stigma associated with trading sex and/or using substances. One participant disclosed:

"I feel down a lot in public…depressed…I still have problems thinking sometimes…This is why I work all the time" (a man who uses substances and does not trade sex).

Another participant, one of the two men who trade sex, replied:

"...I don't tell anyone anything, so nobody knows to judge anything."

In contrast**, participants frequently reported "kind", "friendly", "respectful", and "great" experiences with community nonprofit organizations such as the Concerted Care Group, City of Refuge Baltimore, and local churches in Brooklyn, MD**. This emphasizes the importance of community-based resources and the need for harm-reduction and trauma responsive training for some service providers.

Impact of COVID-19 Pandemic

In addition to the aforementioned barriers to accessing resources, the majority of participants noted that the COVID-19 pandemic further disrupted their access to legal documents, food stamps, reduced the amount of clients and slowed money streams from trading sex, and hindered additional employment. Four participants reported:

"Everything shut down; everything stopped. Right now [May 7, 2021], I'm trying really hard to get insurance, but still can't. They also stopped my food stamps a couple months because they shut the place down. Thank God I had some good resources because of my program at CCG [Concerted Care Group in Brooklyn]."

"It's been hard to get documents like SSN card and ID. This will be my 3rd attempt to get ID and docs through the mail from MVA. Had to start over with nothing when I got clean. On the other hand, the stimulus checks helped for income."

"It [COVID-19] really messed me up. When I even call for stuff, I don't get real people. I just get answering machines and then nobody calls back. I still have my same clients though because they know me, but a lot of girls have had less money sometimes. And there's more people on the streets because of evictions and losing their jobs and all that."

"There's not as much clients, so I don't get as much sex work as I used to. It's harder to get the money I need."

However, **a few participants who had a consistent sex work clientele and those with reliable social supports were able to maintain a sense of stability during the pandemic**. These few participants reported no impact of the pandemic on their ability to access the resources they needed.

Accessed Resources

Although significant barriers were identified, the majority of participants were able to access some resources from certain local organizations. The top responses included Concerted Care Group for its methadone clinic and substance use treatment (where most interview participants were referred from), City of Refuge, and local churches in Brooklyn for free food, including dog food, clothes, and drop-in showers. Participants often knew general locations, such as "off of 4th street" [which may be the Transformation Center], yet not the name of each church). One participant stated:

> ***"Churches help so when I don't have the money, I don't have to go on the street [to trade sex]."***

One participant specifically named The Transformation Center for free food, clothes, and hygiene products; another participant named The Well as an additional organization they visit for women-centered wrap-around services; one participant named the Baltimore Crisis Response for behavioral health care; and another participant named the SPARC van for harm reduction supplies (i.e., condoms, hand sanitizer, Narcan, etc.) and the Medstar van for mobile primary health resources.

Interest in Peer Support Groups

Out of the participants who traded sex, 8 (57%) reported that they were **interested in attending peer support groups related to their experience trading sex on the street.** Specifically, 4 participants explained why they would attend a peer support group:

> *"[The peer support group would] Probably help me as well as I can help them...we relate."*
>
> "Cause you're exposed to a lot of stuff; others who haven't gone through it wouldn't understand – to avoid feeling judged."
>
> *"I like that idea because people can share resources and support each other. I would do that or help run one of those. They have other types of ones already around*."
>
> *"Hell yeah, I would do that! I like helping out.*"

One participant (.07%) said "Maybe" and 4 (29%) said "No", they were not interested in a peer support group. Among the participants who replied "No", primary reasons included **discomfort and unwillingness disclosing their history of trading sex, no longer being active in trading sex, and feeling "too traumatized" to discuss their experience in a group setting**. One participant stated that she preferred one-on-one counseling to address her trauma, while another participant simply stated "I don't need it". Both men who trade sex were not interested in the peer support group related to trading sex. One of the men stated, "I wouldn't do the sex work one, 'cause **I don't talk about that part**." Instead, he preferred a support group for Narcotics Anonymous. The other man stated, **"I think it's a good idea for other people, but I won't go"**, and did not prefer any alternative peer support group.

Four other participants listed the following additional peer support groups that they would be interested in attending:

> "*One for people with incarcerated spouses, and like, people who have been incarcerated too. I get off probation tomorrow, but I'm not allowed to see my husband anymore because I brought him drugs in jail years ago. That's what I got the probation for, and I got banned from visitation too."*
>
> *"I think people need grief support groups for dealing with all the death going around; a lot of people don't know how to handle the grieving process."*

“I would be interested in peer support groups for drugs, PTSD or trauma”

"[A peer support group would be helpful] to get people fresh in recovery to do fun things for free or sponsored, like bowling…people who don’t have the finances but need to get out of the lifestyle [of trading sex].”

Faith-based vs. Non-faith-based Preferences

Half-way through the interview process, a later interview question was added to the interview guide inquiring whether participants preferred a faith-based or non-faith-based program for peer support groups and/or for supportive housing programs. This question was added in consideration of diverse populations along with the prevalence of faith-based nonprofit organizations that have a strong presence, especially in the Baybrook areas. At the time of the interviews, the majority of community resources that participants accessed were operated by faith-based organizations. **Among the participants who replied to the newly added question (n = 9), 5 (56%) participants preferred a non-faith-based program for peer support groups or supportive housing, whereas 2 (22%) participants preferred faith-based, and 2 (22%) had no preference**.

Interest in Virtual Sex Work Workshops

The majority of participants endorsed the need for workshops on how to use technology for virtual sex work as alternatives to street-based sex work. Among participants who answered this question (n=13), 8 (62%) (including one of the two men who trades sex) replied that they were interested in these virtual sex work workshops. Specifically, three participants replied:

"Yeah, I would do that. It would be more money, but it’s more personal too, like you have regulars. And you could get people who aren’t from this neighborhood" (Participant MPB0111 - a man who trade sex).

"Yes, that would be good because I could make more money and not have to do it as often. It would be safer too."

"Yes, I really like that idea! It would be safer, and I could probably make more money."

Five (38%) (including one of the two men who trade sex) replied that they were not interested in the workshops; however, they supported the idea for other individuals. Four participants stated:

"That would be good for a lot of people, but I wouldn’t go to that either."

"[No]…I think I’m too traumatized…”

"[No for me because I’m not still trading sex, but] ***that would be great for women who are still on the street to prevent trafficking and STDs and avoid trauma."***

"I think this is a really good idea, I would have done it for sure if I was still in the game."

Additional Thoughts on Improving the Community

When asked what other thoughts participants had about improving the community, many of the responses, justifiably, overlapped with community-specific needs and addressing missing resources such as supportive housing and transportation. One participant specified a need to have localized **transportation support specific to free food distribution sites to help individuals carry groceries home.** This participant emphasized the difficulty of needing food for herself and family, yet only being able to take what she can carry, if it’s not too heavy or too far from her home. Even if the participant had funds to take the bus to the grocery store, it was still a burden to walk and carry the groceries back to the bus stop and back home. The participant **suggested a van service in partnership with the food distribution site that can**

travel within a 5 mile or so radius to drive people who need help carrying food to their nearby homes.

Additional suggestions on improving the community were to increase more accessible “showers” for individuals experiencing homelessness, increase “sanitation and trash clean up” (also endorsed by community meeting attendees) and increase/promote “recycling” in the neighborhoods.

Other participant responses re-emphasized developing “in-patient substance use clinics”, addressing “safety” and “protection”, “the slum lord issue”, and the “drug” and “violence” issues. Two participants suggested pushing for police to respond more efficiently to concerns about drugs and violence.

> *"You can’t even get in the store without drug dealers propositioning you every day…Cops are aware of it but cops don’t do anything...lazy cops...[To improve the drug issue] use the community, the neighbors, and local business owners to join in to help to all call the cops for the issue rather than one convenience store owner calling (since cops don’t respond to the store owner). Drugs makes the neighborhood look like crap" (a man who uses substances and does not trade sex).*
>
> *“[There are] a lot of drug deals…They’re selling drugs everywhere and cops let it happen…I’m afraid of my 14-year-old son walking to the corner. Right now, I’m standing in the store, and I count 4 drug dealers [actively selling drugs]” (a man who uses substances and does not trade sex).*

Other participants offered an additional community-powered approach to addressing violence and safety concerns, such as **women coordinating a carpool for other women on the street** who need transportation, especially at night. Another participant disclosed and suggested the following:

> *"I don’t even let my kids go outside or walk to the store alone...everywhere you go there is a shooting or stabbing…We need more police officers on the street* ***or a neighborhood watch to walk the streets more****...1-2 hour shifts of community members doing the walk...”*

This participant further expressed her concern about improving the community:

> *"It’s kinda hard to make the neighborhood better than what it is because parents are not raising their kids right... it ain’t the neighborhood, it’s the people in the neighborhood that has to change."*

And lastly, some participants emphasized that **“*legalizing* prostitution” would generate more safety** by having a secure and regulated location that supplies condoms and STD testing to prevent the spread of sexually transmitted diseases as well as offers physical and financial protection for the individuals trading sex. This reasoning is consistent with previous literature.

Interest in Participating in the Community Health Initiative

Among the 14 participants who trade sex, **11 (78%) confirmed that they would be interested in leading or participating in a community health initiative to actualize their suggestions and support the needs of peers who trade sex on the street.**

All results were synthesized into community-specific recommendations by centering the experiences, needs, and suggestions of individuals who trade sex on the street, then integrating community meeting feedback as well as evidence from literature to generate initial steps towards community health equity. The below recommendations were tailored to the communities serviced by the Greater Baybrook Alliance (GBA).

Key Recommendations for GBA - Baybrook

1) Improve access to and the quality of resources for marginalized community members, such as people who trade sex:

A. **Increase awareness of resources by establishing a local community calendar of events and resource distribution:** free clothes, food, and other free goods days/times/locations, updated digital/printable resources sheets and contact info of key organizations with wrap-around services. Also consider target low-income areas for flyer posts/distribution.
B. **Increase capacity of street outreach organizations.**
C. **Coordinate service provider trainings** to improve quality of services and resources for marginalized community members. May need to hire a facilitator experienced in trauma-responsive care, harm reduction, and sex work 101.
D. **Support development of peer support groups by requesting space (i.e., Library, Transformation center, Churches, open parks, etc.) and peer-led organization facilitators (i.e., Power Inside) for peer support groups and women empowerment groups for individuals who trade sex and related marginalized identities.**
E. **Increase resources for free and reduced cost transportation:** all women or single-gender community carpooling coordination, walking/bus stop companions for safety in numbers, connecting individuals to free bus passes, apply to local grants to enable nonprofit organizations to distribute transportation funds and resources, etc.
F. **Increase resources/capacity for permanent supportive housing,** to include substance use and mental health treatment as necessary, job readiness and employment support, and other social services. May utilize graduate program interns for expanding supervised counseling and case management in-house.
G. **Support development of local In-patient substance use clinics** with special attention to pregnant women, individuals with no ID or insurance, and vulnerable populations.
H. **Support individuals in obtaining legal documents and insurance.**

2) Increase the capacity of the community for *inclusive* community building and problem solving:

A. **Increase consistent and supported representation of peers who trade sex and other traditionally marginalized community members at community meetings** and engagement events (to address culture, marginalization, and solving community concerns together). Stipends, preparation, and direct support may be needed to accompany peers at meetings by a skilled facilitator to moderate a safe meeting space. Traditionally marginalized community members should also be intentionally invited (i.e., individuals experiencing housing insecurity, history of substance use, poverty, etc.). Special attention should be given to how these community meetings are promoted to ensure inclusivity: flyers posted in diverse and low-income areas, radio announcements, local websites, newspapers, hand-outs from outreach workers or at events, food distribution sites, etc.
B. **Coordinate community trainings and workshops** to increase awareness, empathy, and sense of agency to provide or support trauma informed, harm reduction for individuals who trade sex and other marginalized community members (i.e., individuals experiencing homelessness, substance use, etc.). May need to hire a facilitator experienced in trauma-responsive care, harm reduction, sex work 101, and community mediation.

C. **Develop, promote and expand the capacity of alternatives to police** to prioritize linkage to community resources and enhance a sense of community, empowerment, and safety.
D. **Develop Inclusive and Free community-building events** and activities paired with anti-stigma campaigning and promotion of alternatives to police.
E. **Develop a public shared database** for sharing local research results to avoid over-researching and re-traumatizing marginalized groups which expedite community initiatives and increase community partnerships through awareness of community initiatives.