

Substance Use and Health Related Needs

of Migrant Sex Workers and Women Trafficked into
Sexual Exploitation in the London Borough of Tower
Hamlets and the City of London



Cutting Crime  **TOGETHER**
The Tower Hamlets Partnership



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Research and Development Unit
Programme Service
The Salvation Army United Kingdom Territory with the
Republic of Ireland
101 Newington Causeway
London SE1 6BN
Tel: 0207 367 4859

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The views expressed in this report are those of the individual authors, and not necessarily those of The Salvation Army, the London Borough of Tower Hamlets or the City of London.



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Authors

Rebecca Dibb
Tamsin Mitchell
Gayle Munro
Elizabeth Rough

With additional material from Dr Mike Emberson

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Tower Hamlets Partnership

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Executive summary

Introduction

This report presents the findings of a research study into the substance use and health needs of migrant sex workers and women trafficked into sexual exploitation in the London Borough of Tower Hamlets (Tower Hamlets) and the City (City). Research was conducted over a period of approximately four months, November 2005 - February/March 2006. The aims of the study, as laid out by the commissioning body, were:

- To map the incidence of the trafficking of women and girls into sexual exploitation in Tower Hamlets and the City, identifying country of origin and trafficking routes
- To identify the nature and extent of safety, substance use and health related needs of trafficked and migrant women working in the sex industry.

The study was largely funded by the London Borough of Tower Hamlets Safer and Stronger Communities Fund with additional funding from The Salvation Army. The research findings aim to inform the programme to be offered by a women-only drugs service, due to open in Tower Hamlets in the summer of 2006.

Methodology

Recognising the hard to reach nature of the target group, the researchers adopted a multi-methodological approach to ensure that all potential sources of data were examined. The methods included:

- A comprehensive literature review
- A mapping exercise of commercial sex sites across the two research areas, including: a website search for commercial sex premises; collection of telephone numbers from cards advertising sexual services in telephone boxes and the windows of newsagents; a telephone survey of sites identified
- Distribution of flyers, advertising the study and calling for participants, to service users from the target group through 17 direct service providers
- Use of an advertisement calling for participants in a local weekly newspaper
- Researchers accompanied staff from a sexual health agency on street outreach
- Attendance by a researcher at a central London sexual health clinic for sex workers.

The methods detailed above led to:

- Interviews with 65 service providers/organisations
- Interviews with seven migrant sex workers
- Interviews with five maids working in off-street commercial sex premises
- Interviews with two managers of lapdancing/strip clubs
- Case studies drawn from interviews with migrant sex workers and service providers.

The study was approved by The University of Kent's Research Ethics Committee and The Salvation Army's Medical and Ethics Advisory Committee.

Access to such a vulnerable, hard-to-reach and hidden population proved problematic and despite the multi-methodological approach adopted by the researchers, barriers involved in the research study proved to be multiple. Levels of co-operation from the various service providers and agencies varied widely. It is likely that had the research period been of a longer duration and allowing time for full NHS ethical approval to be secured, a more comprehensive study could have been carried out.

Summary of key findings

Presence of migrant sex working population in Tower Hamlets and the City

As one of the main areas for street prostitution in London, the on-street sex market in Tower Hamlets has been discussed in previous literature (Brewis, 2003; Dickson, 2004b; Safe Exit Tower Hamlets, 2006; Skidmore, 2005). While the majority of women working on-street in Tower Hamlets are British, the current study indicates that migrant women and girls have been identified working on-street in Tower Hamlets and surrounding areas (particularly Newham and Kings Cross), in much smaller but increasing numbers. This study did not find any indication of migrant women working on-street in the City.

Much less is known about the off-street commercial sex market in Tower Hamlets. The telephone survey of off-street premises in East London conducted for the current study indicated a higher number of premises in Tower Hamlets than cited in existing sources.¹ The survey identified 71 premises as operational overall (with a total of 114 women working in them), 21 of these located in Tower Hamlets (30 women). Eleven lap dancing, strip or 'gentlemen's' clubs were also identified in Tower Hamlets in the course of the

¹ Including Dickson, 2004b and Lilley, 2005a

research. Although these clubs generally maintain that entertainers are not involved in selling sex², a local sexual health service provider reports seeing women who work in dance clubs and who supplement their income by working in flats. The majority of women who work in off-street premises in Tower Hamlets would appear to be migrant.

In contrast to Tower Hamlets, the telephone survey conducted as part of this study found the City to have fewer off-street sites than indicated by other available sources. Only eight establishments were identified as lying within the boundaries of the City (eight women). It can be speculated that this disparity may be due to differences in the visibility and marketing/advertising strategies of brothels in the two boroughs. Research for the study also found that there are at least five lap dance/strip/'hostess' clubs located in the City. As noted above, some women who work in these establishments may also work in prostitution.

The City's sex trade appears to be mainly off-street. Police intelligence suggests that some premises in the City belong to small 'chains' of brothels with sister establishments owned by the same individual located elsewhere in the City or other parts of London, and some women working in different premises of the 'chain' on alternate days. Local police believe that the off-street market in the City is growing. As in Tower Hamlets, the vast majority of women working in the off-street sex industry in the City are migrant.

The telephone survey carried out for the current study indicates a slightly lower proportion of foreign nationals than did Dickson (2004b), but a greater number of ethnicities/nationalities. Of the 114 women working in 71 premises found to be operational in Tower Hamlets, the City and surrounding boroughs³, only 29 women (25.44%) could be positively identified as nationals of the British Isles (the UK and Ireland). 85 women (74.56%) were identified as being other ethnicities/nationalities. 40 other (non British Isles) ethnicities/nationalities were identified.

Overall, the most common regions were: British Isles (25%), Eastern Europe (18%), Western Europe (14%), Southeast Asia (14%), Other (10%), Caribbean/Americas (7%) and Asia (subcontinent) (4%).

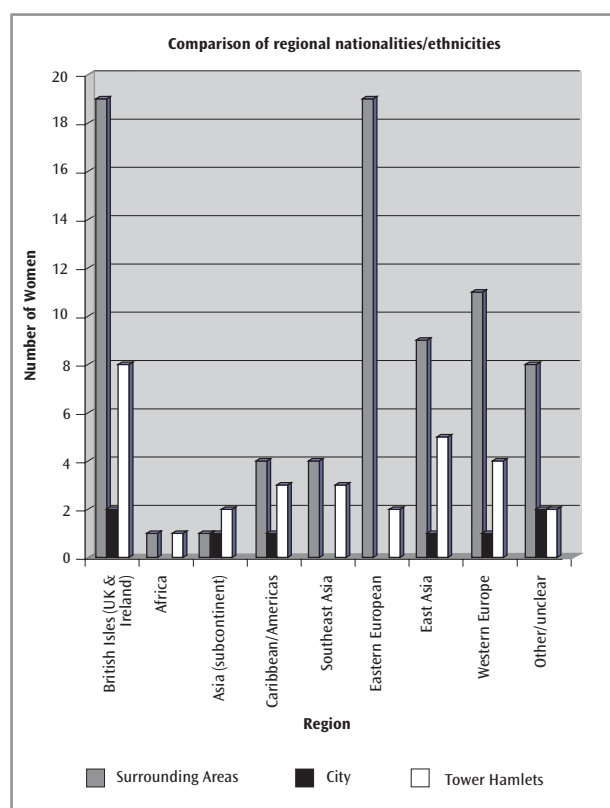
The City was found to have eight off-street premises with eight women. Two women were from the British Isles. The other six women were identified as the

following ethnicities/nationalities: Black; French Caribbean; German; half Greek/half English; Indian; Singaporean. There were no women identified from Eastern Europe.

Tower Hamlets was found to have 21 off-street premises with 30 women. Eight women were from the British Isles. The other 22 women were identified as the following ethnicities/ nationalities: Brazilian; Burmese; Chinese; Czech; Egyptian; half Indian/half Bengali; Hong Kong; Indian; Italian; Japanese; Oriental; Polish; South American; Singaporean; Spanish; Thai.

Compared to the City and the survey overall, Tower Hamlets showed a considerably larger percentage of women from Southeast Asia (17%) and a larger percentage of women from East Asia (10%). Unlike the City, a small percentage of Eastern Europeans were registered in Tower Hamlets (7%) although this figure is considerably lower than in surrounding boroughs.

The chart below shows a comparison of the nationalities/ethnicities of women identified in the City, Tower Hamlets and surrounding boroughs. One-quarter of the women working in surrounding boroughs were identified as Eastern European, whilst 26% were from the British Isles and 14% were from Western Europe.



2 Interviews with the managers of a lap dance club in the City and a strip bar in Tower Hamlets.

3 'Surrounding boroughs' included Barking & Dagenham, Camden, Hackney, Lambeth, Newham, Redbridge, Waltham Forest and Westminster. Some numbers proved to be outcall, while the location of some other premises was unknown. As the focus of the telephone survey was Tower Hamlets and the City, mapping of sites in surrounding boroughs was incidental and therefore can only present an incomplete/partial picture of those areas.

Similarly, PunterNet⁴ 'field reports' for Tower Hamlets, the City and surrounding boroughs since 1999, describe the vast majority of women as being other than British/English, where ethnicity or nationality is mentioned. Of a sample of 76 of these non UK women, 34 separate ethnicities were identified:

The most common regions were:

- *Eastern Europe*: 27 women (35.53%)
- *South East Asia*: 15 women (19.74%)
- *Asia subcontinent*: 13 women (17.11%)
- *Western Europe*: 11 women (14.47%)
- *The Americas*: 6 women (7.89%)
- *Other*: 4 women (5.26%).

Cases of women trafficked into sexual exploitation

The current study revealed only a few confirmed cases of women who had been trafficked into sexual exploitation in the UK with links to the two boroughs and the immediate area. However, it also found several unconfirmed/possible cases of trafficked women and a number of confirmed cases of girls and young women trafficked or coerced into sexual exploitation. It should be borne in mind that these are only the cases identified by service providers to date. This, added to the fact that the majority of confirmed cases of trafficked women are from the main regions of origin for migrant sex workers detailed throughout the report, and supporting evidence from other sources, suggest that the problem of sex trafficking in the local area is likely to be larger than the number of confirmed cases imply.

Identifying the numbers of women trafficked into sexual exploitation in the areas under research proved problematic given the reluctance on the part of some service providers, particularly sexual health projects, to positively identify migrant women who do fit international definitions of the term as being 'trafficked'.

It is recognised that trafficking can take many forms and trafficked women may fall into a wide spectrum of trafficking situations. However, it is also difficult to ignore the fact that if an agency chooses not to identify a woman as 'trafficked', it is also absolving itself of responsibility to report/refer that case to the appropriate authority/care provider. In the UK, an agency may choose not to identify a woman as trafficked because of a lack of appropriate care provision for victims, a fear that no assistance would be available or that the trafficked woman would ultimately be deported. Nonetheless, it could be argued that care provision is unlikely to be extended without a fuller picture of the scale of trafficking, which can only result

from wider reporting. By extension, if a 'trafficker' is defined as a 'facilitator', this may weaken the case for any potential prosecution.

A number of sexual health service providers seemed to believe that the only valid use of the term 'trafficked woman' was when the woman defined herself as such and that any other use of the term would be 'disempowering'. Initial contact with a service provider is unlikely to reveal the full extent of a woman's experiences. An agency's insistence on 'empowering' women may conversely be denying that woman access to the appropriate care or treatment. There is evidence from the literature (Zimmerman, 2003 & 2005) to suggest that a trafficked woman's health care needs may differ from those of a migrant sex worker.⁵ Any reluctance to identify a service user as having been 'trafficked' may therefore result in an incomplete or inaccurate needs assessment.

It was also interesting to note that many of the sexual health agencies who place emphasis on 'empowering' women were often the same agencies who did not agree to permit their service users to decide for themselves whether they wished to participate in the study and declined to facilitate even the most limited level of access, in the form of flyer distribution. As a result, research access to the target group in the areas of study was limited and the research findings were compromised.

Substance use amongst the target group

Despite assertions at the beginning of the study made by several service providers that 'problematic' drug and alcohol use amongst the migrant sex working population in London is 'non-existent', the research has revealed evidence of substance use amongst migrant sex workers (both on- and off-street) and women trafficked into sexual exploitation which may require the provision of either immediate or future treatment. Case studies in the report which revealed substance use by trafficked women all involve women who have accessed services after leaving the trafficking situation. No details were available from service providers or through direct researcher access of substance use by women who are still in the trafficking situation.

For many women from the target group, the first point of contact and a potential gateway into other services is likely to be through sexual health projects. Difficulties of assessing the drug and alcohol care needs of women in the non-confidential setting of sexual health outreach have been highlighted among several service

4 PunterNet: website on which punters post 'reviews' of the women they have paid to have sex with in the form of 'field reports'. The website can be searched by date, woman's name, location, author, establishment or report number.

5 As a result of, among other things, possibly higher levels of violence and/or psychological stress.

providers. Migrant women who do not present for clinical assessment are therefore not likely to be directly assessed on drug or alcohol use by service providers. The provision of drug and alcohol training, specifically around assessment and referral procedures, for sexual health service providers, relevant NGOs and mental health agencies is therefore one of the recommendations of this report.

Alcohol use has been highlighted as particularly difficult to assess. Alcohol use by maids and women in flats, driven by boredom when business is slow, was raised in service provider interviews. However, interviews with maids in four out of five different establishments, conducted as part of the telephone survey, reported no drug or alcohol use during working hours. Use of alcohol as a coping mechanism has been highlighted in interviews with service providers, in an interview with a maid as well as in an interview with one migrant sex worker.

Cocaine use amongst migrant off-street sex workers was highlighted in interviews with service providers and migrant sex workers. Interviews with sexual health service providers however indicated that staff would categorise the majority of drug and alcohol use amongst migrant women working off-street as 'recreational' or 'non-problematic'. An interview with the manager of a City lap-dancing club, where 'the majority' of their dancers are migrant women, indicated that problematic drug or alcohol use has only been observed amongst their British dancers. When asked to define 'problematic' most service providers stated that the service user's self-identification of whether her drug use was a problem would be the basis on which they would consider referring her for treatment. Staff also stated that in most cases there would be physical signs of 'problematic' drug use, through the woman's appearance or behaviour. In one case reported by a sexual health service provider however, a migrant woman approached staff following attendance at a drop-in session to request help for her heroin addiction. Staff had not previously been aware of any drug use by the woman. Such an example further reinforces the need for comprehensive drug and alcohol training of 'gateway' provider staff.

Other health needs

The majority of the health concerns reported as part of this study were sexual health related. This is perhaps not surprising given that a) interviews with service providers who report the most direct contact with the target group were sexual health projects and b) the majority of interviews with migrant sex workers were carried out within the setting of a sexual health clinic.

Most sexual health service providers interviewed for the current study reported that migrant sex workers, who mainly work off-street, are generally health-conscious. Some of the sexual health service providers interviewed reported that the health needs of their service users reflect those of the population at large; the problem is that barriers to accessing care mean that those health problems often go untreated and as a result further complications arise.

Physical health concerns, highlighted through the interviews conducted with service providers and migrant sex workers, included:

- Sexually transmitted infection (STIs) e.g. chlamydia, genital warts, gonorrhoea, herpes, human papilloma virus (HPV), syphilis and trichomonas vaginalis (TV)
- Blood Borne Viruses (BBVs) e.g. human immunodeficiency virus (HIV) and Hepatitis B and C
- Pelvic inflammatory disease (PID)
- Chronic pelvic pain
- Infertility and associated distress
- Ectopic pregnancy
- Malignancies associated with STIs such as cervical cancer
- Complications arising from terminations
- Amenorrhoea (absence of menstruation)
- Respiratory difficulties and asthma
- Insomnia
- Generally weak immune system
- Skin complaints
- Problems with teeth
- The physical effects of violence
- Generally poor 'self-care'
- Thrush
- Pain on intercourse
- Long-term unspecified gynaecological problems.

In connection to the above incidences of STIs, findings from the study indicated inconsistent condom use, especially for oral sex. 'Exceptions' to condom use were widely mentioned, most of which are economically motivated: if women are desperate for money due to a lack of clients, especially if the client looks 'clean' or is a 'regular', or if the client offers to pay more. Interviews with local service providers indicated that the cost of sex in central London has gone down over the last four to five years, for example the price of anal sex without a condom was £80-£90 but can now be bought for £40-£50.

In addition to physical health needs connected to both sexual and non-sexual health, two areas appeared to be of particular concern with this target group: levels of violence and mental health.

Concerns around disproportionate levels of violence faced by both the sex-working populations in general and women trafficked into sexual exploitation were raised by several service providers and agencies.

Mental health seems to be a significant issue for many migrant women. Being foreign, isolated, lonely and away from support networks of family and friends tends to exacerbate any mental health problems. Depression was mentioned by the majority of the migrant sex workers interviewed for this study and was also a concern highlighted in interviews with maids and service providers. Anxiety and stress, often related to sex work, were also frequently mentioned.

Barriers to accessing existing services

The majority of barriers to accessing existing services, identified during the course of the study, related to limited access to primary health care due to the service user's immigration status and (lack of) recourse to public funds. Access to care would seem to depend not just on general policy but rather on a) geography and b) the individual service provider. Health care providers interviewed in different parts of London, for example, list varying services which are available free of charge to service users without recourse to public funds. A telephone survey of GP surgeries in Tower Hamlets also revealed the disparity in policies around registering migrants who present without valid immigration documents.

Other barriers identified included:

- Language barriers
- Personal freedom to access health care
- Confidentiality concerns
- Perceived stigma and associated shame.

Gaps in service provision

Gaps in service provision were highlighted in the areas of sexual health (specifically around opening hours and access to interpreting services), drug and alcohol treatment, housing, legal advice, services for younger women and opportunities to exit sex work. It is interesting to note that several of the women interviewed for this study are travelling some distance outside of their area of residence or work to access services, even when there are other agencies offering similar services in the more immediate area.

Many of the identified gaps in service provision were linked to the barriers to accessing health care associated with current policy and immigration laws surrounding the legal rights and entitlements of migrants.

A shortage of accommodation, together with lack of recourse to public funds, have been identified by service providers as the two crucial factors which operate to impede access to other services, especially drugs services. Accommodation for sex workers, particularly sex workers with no recourse to public funds and trafficked women is significantly lacking in Tower Hamlets and the City. This is a gap that impacts upon the uptake and effectiveness of other services as well as making the women more vulnerable to health and substance use risks.

There is a significant gap in comprehensive free of charge NHS health service provision for non-EU nationals, which has a clear impact upon migrant sex workers and women trafficked into sexual exploitation from outside the EU. A lack of recourse to public funds and the subsequent inability to access specialist health services has the potential to put the health, welfare and lives of migrant sex workers and trafficked women at a greater risk than the general public. NHS agencies will continue to struggle to overcome this inequity unless there is a shift in policy at the national level.

Limitations of the research

It is without doubt that the research findings would have been enhanced by greater numbers of interviews with migrant sex workers and trafficked women. Some service providers expressed reluctance to encourage women to contribute to a research study which they felt would not bring any 'practical benefits' to the participants. The view held by several service providers was that migrant sex workers and women trafficked into sexual exploitation do not present with 'problematic' substance use. As a result those agencies were reluctant to encourage any research which aims to inform the tailoring of drug services for these client groups. Research into the wider health needs of migrant women was also considered by some service providers to be of limited practical value, given the barriers to accessing mainstream health services posed by the irregular immigration status of some of their migrant service users. Asking questions around health needs of women who cannot access treatment for those needs was considered to be unethical by many potential interviewing agencies; access to interview women identified as being from the target group was in those cases also not facilitated.

Summary of key recommendations

In light of the findings outlined above, it is recommended that the following points are considered when devising drug and alcohol service provision for

female migrant sex workers and women trafficked into sexual exploitation^{6 7}:

Access

- Direct access to the service should be offered as well as via referring agencies.
- In acknowledgement of the transitory nature of the target group, information-sharing networks and referral systems need to be developed with services in other boroughs across London.
- In recognition of the above and the working hours of women in the sex industry, services should be offered to non-borough residents who work in the area.
- The service and any referral procedures should be widely publicised among other relevant service providers.
- Strategies for raising awareness of the service among the target group need to be carefully developed.
- Opening hours should be ‘user friendly’ and reflect the lifestyles of the group the service is to be aimed at, i.e. not 9-5.
- The service needs to consider its policy on access to the treatment/waiting area by men (e.g. partners of service users) and any possible implications on other service users’ readiness to engage with the service.
- Immigration status is likely to be a real or perceived barrier to accessing services for many women. If the service is going to be offered regardless of status this should be well publicised.
- The effects of any security procedures, such as double-gated access or police monitoring, on potential service users need to be considered.

Staffing

- Staff should have expertise in asylum and immigration issues and to be aware of appropriate referral agencies working in the relevant fields.
- The potential implications of male staffing and any possible effects on female service users, some of whom are likely to be suffering from the consequences of violence at the hands of male clients, pimps or traffickers need to be carefully considered.

- It is important to ensure that there are sufficient resources to meet demand once referrals begin. Many service providers when discussing the current system referred to their frustration at not being able to secure access to a service when a woman is ready to engage with and access treatment.
- Services need to be offered in multiple languages. If the service is receiving multiple referrals from one particular nationality/ethnicity, consideration needs to be paid to employing a first-language speaker.

Nature of service provided

- The needs of diverse groups of women need to be considered and a comprehensive needs assessment to be carried out on presentation to the service.
- The service will need to consider women’s multiple care needs in order to offer a holistic service.
- There is a current gap in services for sexually exploited young women and girls who present with drug and alcohol problems. A service which offers provision for younger women needs to consider the nature of that service, including timing of sessions and separate clinics for younger service users.
- It is recommended that the service include a ‘safe room’ or a ‘rest room’ where women would be able to sleep, rest, wash and eat.
- The service needs to consider whether there will be an enforceable ‘drug free’ policy on site or whether service users will be able to use drugs within a specific area of the building.
- The service should consider the use of a freephone helpline number, staffed by multiple language speakers.
- In order to take into account the needs of service users with children, the provision of a creche/play area, together with possible staffing implications, should be considered.
- A flexible appointments system needs to be offered along with both drop-in and outreach services, available in multiple languages.

Referrals

- The service should have links to a range of different service providers and advice agencies.

6 Many of these recommendations will also apply to services for non-migrant sex workers.

7 Some of the recommendations are offered in the form of suggestions to consider.

- Staff need to be aware of which agencies will accept service users without recourse to public funds.

Other

- As the first point of contact with migrant sex workers and trafficked women is often sexual health service providers, appropriate training of staff working in these services and others, such as mental health services and NGOs, needs to be in place to ensure that the drug and alcohol needs of women and appropriate referral routes are being identified.
- Protocols should be established on the level of protection, confidentiality and anonymity women will receive. These protocols need to be effectively communicated to service users.
- Assessment targets (of service outcomes) are likely to be quantitative. Qualitative outcomes assessment of services working with this target group are more likely to be valid.
- A protocol around identifying trafficked women needs to be established using internationally recognised definitions.

Introduction

Background to the study

In response to a perceived need amongst migrant sex workers and women trafficked into sexual exploitation, Tower Hamlets Drug Action Team wished to investigate and plan service engagement with these particularly vulnerable groups within the borough. The Salvation Army was therefore commissioned, following a competitive tender process, to undertake this research study in October 2005.

Fieldwork and data collection ran for a period of approximately four months (November 2005 - February/March 2006). The research team consisted of four female researchers (two full-time and two part-time) with research backgrounds in human rights and migration. The work of the researchers was supported by a steering group made up of experts in sex work, drug and alcohol use, mental health, wider health issues and working with vulnerable women, together with an internal Salvation Army advisory group. The study was largely funded by the London Borough of Tower Hamlets (LBTH) Safer and Stronger Communities Fund with additional funding from The Salvation Army.

Demographics of the research areas

The estimated 206,600⁸ residents of Tower Hamlets comprise a diverse ethnic population. Over 33% of the Tower Hamlets population are Bangladeshi, while 6.5% are Black or Black British and a further 2.5% are from mixed ethnic backgrounds (Census, 2001). It is estimated that there are 15,688 Somalis in the borough, although there is no reliable census figure of this (Clancy and Al-Kaisi, 2004). One third of 16-74 year olds hold no qualifications and in 2001 the unemployment rate in the borough stood at 6.6% of all economically active people aged between 16-74 (Census, 2001). These figures are reflected in the Indices of Deprivation 2004 which ranks Tower Hamlets as the fourth most deprived borough in England out of a total of 354 local authorities (ODPM, 2004).

In contrast, the City of London has 8,000 residents, a figure which reflects the small size of the borough and its less residential nature. The population of the City is not as ethnically diverse as Tower Hamlets. Over 84% of residents described themselves as White, 6.83% as Asian or Asian British and 2.56% as Black or Black British (Census, 2001). In 2001, the unemployment rate in the City was 3.6% while less than 10% of 16-74 year olds had no qualifications. In the Indices of Deprivation 2004, the City was ranked 226 out of 354 local authorities in England, placing it in the top 40% least deprived local authorities (ODPM, 2004).

Structure of the report

The report is organised into thirteen main sections: aims of the report and methods used; definitional problems; a review of the available literature on trafficking routes to the UK, along with relevant data from interviews; a review of the scale of migrant sex work and trafficking for sexual exploitation in the UK and a review of current literature by relevant theme, policies around prostitution and trafficking and a history of sex work across the two boroughs under research. A review of current service providers in Tower Hamlets and the City as well as key organisations from surrounding areas is then presented along with a summary of any agency contact with the target group. The migrant sex-working population in Tower Hamlets and the City is profiled, sexual, physical and mental health concerns of the target group discussed and cases of substance use presented. The report closes with an analysis of barriers to accessing health services; gaps in service provision; conclusions and recommendations.

8 Mid-2003 population estimate - www.statistics.gov.uk; last accessed 21 March 2006.

Definitions and scope of the study

Use of the term ‘trafficked’

Despite the existence of a widely accepted international definition of ‘trafficking’ (see boxed definition below) practical applications of the terms ‘trafficking’ and ‘trafficked woman’ remain problematic.

The research highlighted the reluctance on the part of some service providers to apply the term ‘trafficked’ to a woman believed to have been coerced, abducted or deceived into sexual exploitation. ‘Facilitated’ is a term preferred by many service providers, especially sexual health, on the grounds that this term can encompass a wide range of situations and circumstances in the trafficking spectrum, from, for example, a woman in ‘consensual’ debt to a ‘facilitator’ but otherwise with freedom of movement, to a woman in a more ‘extreme’ situation of having been deceived and under complete control of her trafficker with very little or no freedom of movement.

Possible implications of this use of terms are discussed in the closing summary. For the purpose of this report, the researchers employ the definition of trafficking in persons as outlined below:

- a) ‘Trafficking in persons’ shall mean the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs.
- b) The consent of a victim of trafficking in persons to the intended exploitation set forth in subparagraph (a) of this article shall be irrelevant where any of the means set forth in subparagraph (a) have been used.
- c) The recruitment, transportation, transfer, harbouring or receipt of a child for the purpose of exploitation shall be considered ‘trafficking in persons’ even if this does not involve any of the means set forth in subparagraph (a) of this article;

- d) ‘Child’ shall mean any person under eighteen years of age.

Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, Supplementing the United Nations Convention Against Transnational Organized Crime (2000)

Use of the term migrant

For the purpose of this study, the researchers adopted a multi-dimensional definition of the term ‘migrant’, encompassing women who may fall into one of the following categories (the term ‘migrant’ or ‘Black and Minority Ethnic’ (BME) is used depending on which seems more appropriate in each case):

- Non-British national: usually referred to as ‘migrant’
- British national whose country of origin is not the UK (for example, a woman who has been given British nationality since living in the UK, i.e. first generation migrant): referred to as ‘migrant’ or ‘BME’
- Women belonging to second (and subsequent) generations of migrant families: usually referred to as ‘BME’.

The rationale behind expanding the usual definition of ‘migrant’ is to highlight the barriers to accessing health care that women who fall into the second and third of the above categories may also experience. BME women, as migrant women, face many of the same problems around exclusion, for example: language difficulties; marginalisation; lack of knowledge of the ‘system’. However, BME women do not usually face the same vulnerabilities and barriers to accessing health care that may be experienced by some migrant women with irregular immigration status. (See section below on barriers to accessing health services for sex workers).

Sex work vs prostitution

An analysis of the use of the terms ‘sex work’ vs ‘prostitution’ has not been the focus of this study.^{9 10} For the purpose of this report, women working in the sex industry are referred to as ‘sex workers’; women known or believed to have been trafficked are referred

9 For such an analysis see for example Anti-Slavery International, ‘Redefining Prostitution as Sex Work on the International Agenda’, available at: <http://www.walnet.org/csis/papers/redefining.html>

10 On the debate around the use of both terms see Kelly (2002).

to as 'women trafficked into sexual exploitation' or 'trafficked women'. Young women under the age of 18 are referred to in the report as 'sexually exploited young women/girls'.

Area focus

The two areas under research, as outlined by the commissioning body, are the London Borough of Tower Hamlets (LBTH) and the City of London (the City). Each area is defined by its borough boundary.

The research indicates that some women are accessing services outside of both their borough of residence and their borough of work. This implies that:

- Women who reside outside the immediate research area are accessing services or may potentially access services within LBTH and the City
- Women who reside within the immediate research area are accessing services outside the two boroughs (some are even travelling considerable distances across London to a service).

Therefore, although the main focus of the study has remained within these two boroughs, consideration has also been given to services provided in neighbouring boroughs and some relevant pan-London services.

Victim

Whilst acknowledging the debate in the literature over the term 'victim' (Kelly, 1987) and the possible implications of women's lack of empowerment and control, the view taken in this study is that many women in a trafficking situation are not empowered and are not in control of their situation. For this reason the researchers have not avoided using the term 'victim' for women who have been trafficked into sexual exploitation, where it seemed appropriate.

Clients and punters

Both the terms 'client' and 'punter' have been used in the report to describe a man who pays for sexual services.

Brothel

The term 'brothel' has been used to refer to an off-street site offering commercial sex. References are also made to the 'off-street' and 'indoor' sex markets.

Substance use

The term 'substance use' is used by the researchers to refer to any use of drug or alcohol by the target group.

The National Treatment Agency defines substance misuse as: 'drug or alcohol taking which causes harm to the individual, their significant others or the wider community. By definition those requiring drug or alcohol treatment are substance misusers'.¹¹

However, definitions of substance use become more complicated in the case of trafficking victims. Zimmerman (2003) refers to drug 'abuse' as the way perpetrators force women to take drugs or alcohol. In comparison, the term 'misuse' refers to voluntary use at harmful levels. Most service providers interviewed for the study emphasised that they would consider drug or alcohol use to be 'problematic' only if the client herself defined it as such.

In the absence of clinical assessment of some of the drug or alcohol using women cited in the report, the researchers have therefore avoided the terms 'misuse' and 'abuse' as it has not always been possible to determine the extent to which:

- the drug use can be considered 'harmful' or
- the drug use is 'involuntary' or coerced.

11 National Treatment Agency: <http://www.nta.nhs.uk/>

Aims and methodology

Aims

The aims of the study, as laid out by the commissioning body, were:

- To map the incidence of the trafficking of women and girls into sexual exploitation in Tower Hamlets and the City, identifying country of origin and trafficking routes; and
- To identify the nature and extent of safety, substance use and health related needs of trafficked and migrant women working in the sex industry.

The research findings aim to inform the programme to be offered by a women-only drugs service, due to open in Tower Hamlets in the summer of 2006 and also to inform future commissioning strategies.

Methodology

The challenges and complexities posed by conducting research in the field of human trafficking are widely acknowledged (EU, 2004; Laczko and Gramegna, 2003; Kelly, 2002). Research by the London School of Hygiene and Tropical Medicine (Zimmerman, 2003) on the difficulties of researching the health of trafficked women identify four 'dimensions of sensitivity' that need to be considered when devising a methodology and conducting the research:

- Practical dimensions (including the vulnerability and marginalisation of this hard-to-reach and diverse group)
- Cultural sensitivity (recognition of ethnic, religious and socio-economic differences, differences in personal history and differences in the stigmatising nature of experiences)
- Ethical concerns (physical and psychological safety and human rights standards)
- Political sensitivity (policy and legal implications, including immigration and media attention)

The processes around researching migrant sex workers are subject to many, although not all, of the same challenges of researching trafficked women. Careful attention was paid by the researchers to the ethical considerations of researching both groups (see ethics section below).

Acknowledging in advance the difficulties and sensitivities involved in studying a group of particularly vulnerable women, the researchers adopted a multi-methodological approach. Methods adopted are discussed below along with details of their varying success/response rates. It is hoped that by providing

details of the various methods used, the research may help to inform methodological strategies of future studies in the field.

Literature review

A review of literature was undertaken covering the following themes:

- Sex work in the UK
- Extent and nature of trafficking to the UK
- Methodology of researching hard to reach and hidden populations
- Trafficking routes
- Substance use amongst sex working populations
- Health needs of sex workers
- Health needs of trafficked women
- Barriers to accessing services for these groups

Interviews with service providers/ organisations

An initial scoping exercise (via the Internet, literature review and advice from the steering group) identified a total of 263 agencies and organisations that were each sent an introductory letter outlining the study and requesting an interview. Interviewees were approached not only for their experience of direct service provision but also for their knowledge of the wider picture surrounding migration, health, substance use, criminal justice, and other key issues. Organisations and agencies were contacted and interviewed in the following fields:

- Drug and alcohol services
- Health (both sexual and non-sexual health)
- Children and young people's services
- BME community groups and migrant and refugee community organisations
- Housing and homelessness services
- Immigration
- Legal advice and representation
- Police and crime reduction agencies
- Social services and other local government departments

- Central government
- Specialist domestic violence services
- Women's groups
- Others.

Of the 263 introductory letters sent, a total of 173 responses (66%) were received. Many of these were not as a direct result of the initial letter and key agencies received follow-up calls from the researchers. Of the 173 responses, a total of 111 (42% of total contacts made/64% of total responses) replied to state that they did not wish to participate in the study; 65 (25% of total contacts made/38% of total responses) agreed to participate and were interviewed by one of the research team. A few of the interviews, particularly with key service providers, required a follow-up interview, usually conducted by the same researcher.

The principal reason given for not wishing to participate in the study was that the potential interviewee had no contact with/no knowledge of the research group and therefore felt that s/he would have little of value to add to the study. Other respondents declined to participate on the grounds that the study did not have ethical approval from an NHS body (see ethics section below); a few respondents declined to participate but gave no reason.

A questionnaire template was devised for semi-structured interviews with service providers. However, given the diverse nature of the services offered by the agencies interviewed, combined with their varying contact with the research target group, this original template was, in practice, found to be most useful/relevant for direct service providers, particularly sexual health projects.

Where the organisation interviewed had direct contact with migrant or BME sex workers, staff were asked whether the organisation would be in a position to facilitate contact or interviews with their service users. 17 requests were made to organisations. Most did not agree to facilitate direct contact, but the majority did agree to distributing flyers to women from the target research group (see section below). One sexual health clinic agreed to allow a researcher to attend clinic sessions to request interviews with consenting service users.

For further details on interview access, see section on barriers/challenges.

Flyers

A flyer advertising the research study was produced and copies distributed via consenting agencies from the following sectors:

- Drug and alcohol services (number of agencies: 3)
- Sexual health services (6)
- Other health services (2)
- Homelessness services (3)
- Police (1)
- NGOs (1)
- Women's groups (1)

Women interested in participating were asked to call or text the number of a mobile telephone allocated for this purpose. Each participant was offered £20 for the interview. One agency requested that the financial incentive be offered in the form of vouchers to the value of £20 in lieu of cash and an amended flyer was produced for distribution via this agency.

The researchers made follow up phone calls to agencies to enquire on the interest and uptake amongst service users. Positive/encouraging responses were given from several agencies but of the approximately 350 flyers sent to agencies only one response was received (see Appendix C: case study: Amely).

Interviews with sex workers

Interviews were conducted with seven women: one as a response to the flyers distributed; one as a response to direct research calls to flats/saunas and five as a result of attendance by a researcher at a sexual health clinic. Six interviews were face-to-face, carried out at the site of the introducing agencies. A Salvation Army site was identified as a potential alternative interview location.

In the case of face-to-face interviews, informed consent was obtained prior to each interview; each participant was distributed with an information sheet on the research study and referral information in the form of a pocket-sized leaflet. The questionnaire was devised and interviews planned in accordance with the World Health Organization's guidelines for interviewing trafficked women (Zimmerman & Watts, 2003); Department of Health guidelines on research in health and social care (2005b); Anti-Slavery International's report on the identification of trafficked people (2005) and on advice from steering group members. Researchers ensured that contingency plans were in place should a trafficked interviewee have requested immediate assistance.

Recognising the practical and ethical difficulties of obtaining informed consent before an interview conducted by telephone (see telephone survey section

below), a revised, shortened questionnaire was devised for the purpose of the telephone survey.

Advertisement

An advertisement, in the same format as the flyer, was produced and placed in one issue of a weekly local newspaper in Tower Hamlets. There were no responses.

Outreach

Two of the researchers accompanied staff from a sexual health agency¹² on street outreach in Tower Hamlets and Newham on two separate evenings in January 2006. Whilst recognising that it was relatively unlikely that the researchers would meet on-street migrant sex workers, the researchers hoped to meet and engage with the women in the presence of outreach workers to establish whether any of the women knew or were aware of migrant sex workers in the off-street sector.

Eight sex workers were seen across the two outreach sessions, all of whom were British.

Clinic attendance

With prior agreement, researchers attended the clinic of a sexual health agency¹³ for sex workers on three separate occasions. The researcher sat in the waiting room of the clinic and spoke to women either while they were waiting for their appointments or while they were purchasing condoms. Flyers were distributed and brief introductions to the research study were outlined. Any women who agreed to be interviewed were then interviewed in a separate room, on-site and in confidence (in accordance with the procedure outlined above under the heading 'Interviews with sex workers').

The location of the clinic was in Soho and therefore outside of the two boroughs under study. However, interviews with agency staff of this sexual health provider (and another in West London) highlighted cases of women travelling from several boroughs (including in East London) to access services in Central London. Unfortunately, no corresponding service provider in either Tower Hamlets or the City was willing to facilitate a similar level of access.

Interviews with five women were undertaken. Clear advantages to this method of access are the secure location of the interviews and the degree of trust established by the introducing agency.

Case studies

Case studies of women included in the report were drawn from:

- Interviews with migrant sex workers
- Interviews with service providers

The confidentiality and anonymity of each case was guaranteed by the researchers. Each woman interviewed by the research team was given a list of the most common names for women and asked to choose an alias. Case studies provided by agencies are published with the agency's consent. As it was not possible for the women concerned to choose a non-identifying alias it was decided, although acknowledging that this is far from ideal because of the de-personalising effect this may have, that in order to guarantee anonymity, to allocate each case a number, i.e. Case 1, Case 2, and so forth.

Mapping exercise

Internet search and local newspapers

A search of websites advertising commercial sex and adult entertainment was undertaken by researchers to collect data on the nationalities/ethnicities of women, locations of establishments and telephone numbers. The most extensive amount of data was gathered from PunterNet's 'field reports'.¹⁴ A search by location revealed 638 field reports in East London dating back to 1999. Researchers read through each report to identify possible nationalities/ethnicities and the number of women at each establishment. A database of telephone numbers of establishments where it appeared as though women from the target group were working was created (see following sections).

Local newspapers were also collected and searched for establishments advertising commercial sex and telephone numbers recorded on the database.

Telephone box carding and newsagents windows

The areas of the two boroughs under research were divided between the four members of the research team who then each spent two afternoons collecting telephone numbers from cards advertising sexual services in telephone boxes and the windows of newsagents. The numbers were added into the database (mentioned above) and doubles were deleted (see telephone survey below). It is acknowledged that this collection of numbers can only represent a 'snapshot' of the total numbers available and the researchers do not claim to have made a definitive

12 U-Turn

13 CLASH

14 PunterNet: website on which punters post 'reviews' of the women they have paid to have sex with in the form of 'field reports'. The website can be searched by date, woman's name, location, author, establishment or report number.

search. Whilst attempts were made to ensure that as much ground as possible was covered during the time allocated it is also acknowledged that there will be several areas which, due to time restrictions, have not been included.

Efforts were concentrated on areas around major transport hubs as these had the highest concentration of telephone boxes and areas suggested by agency staff and outreach workers.

Telephone survey

At the end of the collection of telephone numbers from the sources listed above, the database had 209 numbers. 35 numbers were deleted after being identified as outside of the area of research or as being sites where only British women were working. In a process similar to that employed by Dickson (2004b), two male volunteers called the 174 numbers posing as potential punters in order to establish whether sex was for sale at the establishment and the number and nationalities/ethnicities of the women working on the premises.

Following the results of this initial telephone survey, the female researchers made follow-up phone calls to the 71 sites identified as operational and where migrant sex workers were known to be present to request research interviews. As a result of these calls, telephone interviews were conducted with five maids and one migrant sex worker at six different establishments.

Interviews with club/ bar managers

As a result of the mapping exercise, a list was drawn up of lap-dancing and strip clubs (where their addresses were available) in the two boroughs and a letter requesting a research interview was sent to the manager of each establishment. 45 clubs were approached via letter and two agreed to be interviewed.

Interviews with convicted traffickers

A London Prison was approached as an establishment known to be holding convicted traffickers. A request was made to interview these prisoners. The researchers followed the procedures as laid out by the Home Office for requesting research access to any of HM Prisons. Staff at the Prison agreed to ask the two identified traffickers for their consent to be interviewed. Unfortunately neither prisoner consented to participate in the study.

Methods not used

Whilst aware of the need to utilise multiple methods in order to gain as full a picture as possible of the area under research, the researchers were mindful at all times during the study of the need to ensure that any methods employed were ethically sound and did not at any time jeopardise the health, safety and well-being of either the participants or the researchers. For this reason, the researchers rejected the suggestion proposed by one advisor of posting letters/flyers through the letterbox of flats identified during interviews, as locations where trafficked women may have been present. For the same reason the suggestion of sending male researchers posing as punters to these locations was also rejected.

Ethics

The study was approved by The University of Kent's Research Ethics Committee and the Salvation Army's Medical and Ethics Advisory Committee. The short timeframe of four months meant that it was not possible to secure NHS ethical approval before commencing fieldwork. This had some adverse effect on gaining access to the full range of service providers and to the data shared by some service providers.

Barriers/challenges

It was acknowledged from the outset that conducting research within such a highly politicised environment would be challenging. Access to such a vulnerable, hard-to-reach and hidden population is problematic and despite the multi-methodological approach adopted by the researchers, barriers involved in the research study proved to be numerous.

Restrictions of time and resources meant some routes were unable to be followed up. It is likely that had the research period been of a longer duration thus allowing sufficient time for full NHS ethical approval to be secured, a more comprehensive study could have been carried out.

Levels of cooperation from the various service providers and agencies varied widely. The implications of some of these barriers are discussed further in the concluding sections.

Trafficking routes to the UK

Published intelligence on specific trafficking routes to the UK is scarce. Kelly and Regan (2000) present a summary of trafficking routes to the UK:

- South America (particularly Brazil) via Lisbon
- South East Asia (particularly Thailand, Philippines, Malaysia, Hong Kong, Singapore) directly by air to Heathrow or via mainland Europe and then by Eurostar
- Central & Eastern Europe (particularly Lithuania, Hungary, Ukraine and Belarus) by various trans-Europe routes, particularly through Greece, the Balkans, Italy and then to the UK
- East and West Africa (particularly Nigeria, Ghana, Kenya and Uganda) directly by air or via mainland Europe.

Four 'waves' have been identified as trends in global trafficking. The 'first wave' being women from South East Asia in the 1970s, the 'second wave', women from Africa in the early 1980s and Latin American women representing the 'third wave' also in the 1980s. The fourth wave is described by Malarek (2004) as being women from Eastern Europe, starting in the early 1990s.

It proved impossible for the current study to show that Tower Hamlets and the City of London are receiving areas for women being trafficked along all of these routes. Interviews with service providers revealed little information on trafficking routes. A few direct service providers intimated that women would talk to them about the journeys they had taken en route to the UK, but when questioned service provider interviewees were not forthcoming with further details.

The following sections therefore review the available literature on specific trafficking routes along with any relevant data collected via interviews.

Africa

The United States Department of State, Trafficking in Persons Reports for the years 2003-5 (US Department of State 2003, 2004, 2005) show the following African countries have used the United Kingdom as a destination country: Cameroon, The Gambia, Nigeria, Liberia, Malawi, Sierra Leone, Tanzania, Zimbabwe and West Africa in general.

Possibly the most authoritative recent overview of trafficking in Africa is Adepoju (2005). Trafficking to the UK for the purposes of child labour exists from Benin, Ghana, Nigeria, Mali, Burkina Faso, Mauritania and Togo. Women are trafficked for sexual purposes to the UK from Ghana (see also ILO 2003a and 2003b). Ghana

is also a transit country for Senegalese and for Nigerian women and children trafficked to the UK.

Perhaps the event that brought African trafficking to the UK into the limelight was the realisation in the late 1990s and the early 2000s of a significant problem concerning the arrival, and subsequent disappearance, of unaccompanied minors in the country from West Africa.

Somerset (2001) notes the reports of Scott (1998), Kelly and Regan (2000), Ayotte (2000), Ayotte and Williams (2001) and Stickler and Anderson (2001) and reports on the conclusions they come to concerning the trade in West African girls, particularly Nigerians, to the UK from West Africa and the trafficking of West African girls and women through the UK to Italy. She highlights the belief that over 10,000 West African children are living with strangers in the UK.

Concerns about the continued problems of unaccompanied minors entering the country led to the mounting of Operation Paladin Child by the authorities. Its report, *Paladin Child* (2005), details the monitoring of unaccompanied minors into the UK during a set period. The results revealed further evidence of suspected child trafficking into the UK from Africa. Of the unaccompanied minors who arrived in the country, 38% were from Africa. The top 20 sending countries for unaccompanied minors included Nigeria, South Africa, Ghana, Zimbabwe, Malawi, Zambia and Kenya. 51% of the arrivals from the top 20 countries were African females.

Furthermore, according to the evaluation of the Poppy Project by Taylor (2005), the UK receives women trafficked from West Africa and also suggests its role as a transit country. Taylor (2005) also provides some quantitative information that is of value: during the period from March 2003 to July 2004, 169 referrals were made to the Poppy Project and of these 14% were described as African. Taylor (2005) notes that the African countries of origin were: Cameroon, Democratic Republic of Congo, Egypt, Ghana, Ivory Coast, Kenya, Liberia, Mauritius, Nigeria, Sierra Leone, Sudan and Uganda.

The following nationalities of women from Africa were arrested, between 2003 - 2005, as part of the CO14¹⁵ led Operation Kon Tiki¹⁶

Table 1¹⁷

| Country | 2003 (300 arrests made) | 2004 (113 arrests made) | 2005 (38 arrests made) | No. of trafficking claims |
|--------------|----------------------------------|----------------------------------|---------------------------------|---------------------------------|
| Kenya | 0 | 1 | 0 | 0 |
| South Africa | 4 | 3 | 0 | 0 |
| Cameroon | 4 | 0 | 0 | 0 |
| Gambia | 1 | 0 | 0 | 0 |
| Ghana | 2 | 0 | 0 | 0 |
| Ivory Coast | 1 | 0 | 0 | 0 |
| Nigeria | 2 | 0 | 0 | 1 |
| Rwanda | 1 | 0 | 0 | 0 |
| Uganda | 2 | 0 | 0 | 0 |
| Total | 17 | 4 | 0 | 0 |

These statistics suggest that women from Africa are present in the off-street sex industry in London, although in smaller numbers compared to other nationalities (see below). The statistics also suggest that, in addition to West Africa, women are coming from countries in East and Central Africa as well as from South Africa. One trafficking claim was made by a woman from Nigeria, which supports the reports mentioned above, concerning trafficking of women and girls from West Africa to the UK.

Dickson (2004b) notes that 2% of women who were working off-street and in escort agencies in London in 2003 were of African origin.

In the mapping exercise for this study, it was noted that out of the sample of 76 women in the PunterNet field reports, none were identified as African. In the telephone survey of the indoor sex industry in the boroughs and surrounding, none (out of 114 women) were reported as coming from Africa (see profile of sex working population below for further information).

The Americas

Although there is a lack of data on trafficking in and from the Americas (Casa Alianza, 2003; IOM, 2001; Langberg, 2005), the trafficking of both women and children from the region is considered to be a significant problem (IOM, 2001). Many of the women are known to be trafficked into sexual exploitation (IOM, 2001). There is some evidence of Russian and Eastern European mafia involvement in prostitution and sex trafficking to and from numerous Latin American countries (Bagley, 2001). Less information is available on the destiny of trafficked minors, although it is known that in Guatemala many children are trafficked under the guise of adoption abroad (Casa Alianza, 2003).

As noted above, Latin American women represented the ‘third wave’ of trafficking for sexual exploitation, starting in the 1980s. Then, as today, major source countries for the Western Europe market were Brazil, Colombia and the Dominican Republic (Kelly, 2002), for women as well as for children (Carballo and Mboup, 2005).

More common destinations for women trafficked from the Americas would appear to include the USA, Canada, Central America, South East Asia, Japan and Spain (IOM, 2001; International Human Rights Law Institute (IHRLI), 2002; ILO, 2005). In Spain, a large proportion of migrant sex workers are Latina (del Amo et al, 2005; Rodriguez Arenas, 2002). Ehrenreich and Hochschild (2003) cite Guatemala to Spain and Colombia and Brazil to Western Europe as routes of migration for Latin American sex workers.

Today Latin American women are present in the sex industry in the UK, although in lower numbers than women from other regions such as Eastern Europe and Asia.

Only a small minority of known cases of trafficked women in the UK are from the Americas. The late 1990s saw some major prosecutions in the UK involving trafficked Brazilian women and Brazil to the UK via Lisbon is a known trafficking route (Kelly & Regan, 2000). Of the 169 women referred to the Poppy Project between March 2003 and July 2004, only three were from Jamaica and one was from Ecuador. Of the 43 women accepted on to the scheme in the same period, only 2% were from Jamaica (Taylor, 2005).

15 CO14: Clubs and Vice Branch Metropolitan Police Service.

16 Operation Kon Tiki is a CO14 led operation, involving the Metropolitan Police Service (MPS) and the UK Immigration Service (UKIS) visits to saunas and brothels in London. The focus of the operation is to identify and help trafficked and sexually exploited women.

17 Data from Operation Kon Tiki, 2003 - 2005, accumulative totals, CO14.

The following nationalities of women from the Americas were arrested, between 2003 - 2005, as part of the CO14 led Operation Kon Tiki:

Table 2 ¹⁸

| Country | 2003 (300 arrests made) | 2004 (113 arrests made) | 2005 (38 arrests made) | No. of trafficking claims |
|--------------|----------------------------------|----------------------------------|---------------------------------|---------------------------------|
| Brazil | 20 | 17 | 1 | 0 |
| Colombia | 0 | 1 | 0 | 0 |
| Jamaica | 5 | 3 | 0 | 0 |
| America | 1 | 0 | 0 | 0 |
| Argentina | 1 | 0 | 0 | 0 |
| St.Lucia | 1 | 0 | 0 | 0 |
| Total | 28 | 21 | 1 | 0 |

The above statistics, for the years 2003 and 2004, suggest that Brazilian women are the main group of women from the Americas, who are involved in the off-street sex industry in London. With a significantly smaller number of arrests made in 2005, only one woman from the Americas (Brazil) was arrested. No trafficking claims were made from women from the Americas for any of the above years.

Interview data from service providers also suggested that Brazilians are one of the main groups of women in the London sex industry today. Venezuelans and Colombians are also present in smaller numbers.¹⁹

Dickson (2004b) identified 10% of women working off-street in London in 2003 to be from the Americas (6% South American, 3% Caribbean, 1% North American), and 11% of women working for escort agencies (8% South American, 2% Caribbean and 1% North American).

In the mapping exercise for this study, it was noted that out of the sample of 76 women in the PunterNet field reports, six (8%) were reported as coming from the Americas. In the telephone survey of the indoor sex industry in the boroughs and surrounding areas, seven women (6% of 114 women) were noted as coming from the Americas. (See profile of sex working population below for further information).

Asia

Asia constitutes a region often described as a hub of trafficking in persons, particularly for the purposes of sexual exploitation (Piper, 2005). Establishing accurate data on the number of trafficking cases from the region is as problematic in Asia as in any other region.

The most widely quoted figure estimates that between 200,000 to 250,000 women and children are trafficked annually from South-East Asia (Asian Migration News, 2000 in Skeldon, 2000 and Richards, 1999 in Derks, 2000). This estimate is now over five years old and refers specifically to South-East Asia and not Asia as a whole. It is argued that there is a regional bias to the Asian trafficking data due to the enormous activities of donor and UN agencies in South-East Asia and their limited involvement in trafficking research in North-East Asia (Piper, 2005). Similarly, it has been asserted that there is an absence of information about trafficking in South Asia. Bangladesh, Nepal and Sri Lanka have been identified as source countries (Masud Ali, 2005) but no data or discussions regarding India as a sending country are available (Asian Development Bank, 2003 in Masud Ali, 2005).

These data limitations reflect the dynamic and complex nature of migration in Asia, which, over the past two decades, has been characterised by the rapid growth of a market driven intraregional migration (Lee, 2005). It is argued that the numbers of illegal migrants leaving Asia are 'tiny' compared with the numbers moving within Asia itself. It is estimated that intraregional migration to major regional cities in South-East Asia accounts for 60% of all Asian trafficking (Richards, 1999 in Derks, 2000).

South-East Asia is also reported to be a common stopover for trafficked persons, from which migrants can be moved through Central Asia or Russia to Eastern and Western Europe (Skeldon, 2000).

¹⁸ Data from Operation Kon Tiki, 2003 - 2005

¹⁹ Interview with Praed Street Project.

The following nationalities of women from Asia were arrested, from 2003 - 2005, as part of the CO14 led Operation Kon Tiki:

Table 3 ²⁰

| Country | 2003 (300 arrests made) | 2004 (113 arrests made) | 2005 (38 arrests made) | No. of trafficking claims |
|--------------------|----------------------------------|----------------------------------|---------------------------------|---------------------------------|
| China | 4 | 8 | 2 | 0 |
| Korea | 1 | 0 | 1 | 0 |
| Malaysia | 8 | 0 | 14 | 0 |
| Pakistan | 0 | 0 | 1 | 0 |
| Thailand | 48 | 23 | 10 | 9 |
| Vietnam | 0 | 0 | 1 | 0 |
| Bangladesh | 0 | 1 | 0 | 0 |
| Indonesia | 0 | 1 | 0 | 0 |
| Malaysia | 0 | 6 | 0 | 0 |
| Mongolia | 1 | 1 | 0 | 0 |
| The Philippines | 1 | 0 | 0 | 0 |
| Total | 63 | 40 | 29 | 9 |

Women coming from Asia generated the second largest group of trafficking claims made in Operation Kon Tiki. All the nine trafficking claims made throughout the three years were by Thai women.

Data published in 2004 by The Poppy Project (Dickson 2004a) reported that only one of a sample of twenty six women accommodated by Poppy was trafficked from Asia (Thailand).

Of the 44 trafficking cases that were referred to the IOM in 2004 one woman identified herself as Thai and four cases involved women from Pakistan. Comments made by Open Doors indicated that whilst many of the women they meet on outreach do not self identify as trafficked, certain population groups, most notably Thai women, do.

Kelly and Regan (2000) note that Thailand, Singapore, the Philippines, Malaysia and Hong Kong were identified as the key countries in Asia sending women to the UK. The women were routed via air direct into Heathrow or mainland Europe and by rail via Eurostar. These nationalities correspond with the information gathered from the mapping exercise carried out for this study.

Dickson (2004b) notes that of the women working in the indoor sex industry in London in 2003, 13% were from South East Asia and 5% were from the Indian Subcontinent. Furthermore, she notes that in escort agencies, there were 13% from South East Asia and 2% from the Indian Subcontinent.

As part of the mapping exercise for this study, it was noted that out of the sample of 76 women in the PunterNet field reports, 28 (37%) women were reported as being of Asian origin (it is not possible to know if these women are first or second generation migrants). In the telephone survey of the indoor sex industry in the boroughs and surrounding areas concerned, 24 (21%) women (of 114 women) were noted as being of Asian origin. (See profile of sex working population below for further information).

Europe

Whilst it is recognised that other Western European states are also source countries for both trafficked women and migrant sex workers in the UK, data gathered from interviews for this study suggest that by far the most common European region of origin is Central and Eastern Europe (CEE)²¹.

Economic transition, ethnic conflicts and their aftermath have contributed, in several of the CEE states, to appalling abuses of women's human rights. Corrin (2005), in her analysis of trafficking in women from and through CEE identifies 'compounding variables [of] certain criminals, military personnel and 'business' people [who] view women and children as valuable commodities to exploit in terms of prostitution'. Despite World Bank²² (2005) claims of a 'significant decrease in poverty' in the region since the Russian financial crisis of 1998-99, more than 60 million people are still living on less than \$2 a day and the CIS-7 countries of Armenia, Azerbaijan, Georgia, Kyrgyzstan, the Republic of Moldova, Tajikistan and Uzbekistan are particular targets for development (Corrin, 2005).

Several studies support the claim that women from poorer countries and certain ethnic groups such as Roma are more likely to be trafficked to the West

²⁰ Data from Operation Kon Tiki, 2003 - 2005

²¹ For the purpose of this report CEE includes the countries of: Albania, Armenia, Azerbaijan, Belarus, Bosnia & Herzegovina, Bulgaria, Croatia, Czech Republic, Estonia, Georgia, Hungary, Kosovo, Kazakhstan, Latvia, Lithuania, Macedonia, Moldova, Montenegro, Poland, Romania, Russian Federation, Serbia, Slovakia, Slovenia, Tajikistan, Turkmenistan, Ukraine, Uzbekistan.

²² World Bank: <http://www.worldbank.org>

(Corrin, 2005; IOM, 1995; Limonowska, 2002; Scanlan, 2002). Evidence from the Praed Street Project would support this theory. When discussing women who were more likely to be in a trafficked group subject to the highest degree of control by traffickers and with the least amount of physical freedom, factors suggested for these women's particular vulnerability included level of education and region of origin (urban vs rural).

Corrin identifies two main trafficking routes from the region where the major sending countries are: Moldova, Romania and Ukraine through Romania, Serbia, Bosnia & Herzegovina and Croatia. A second route is through Kosovo, Albania, Macedonia and Montenegro to Italy and then on to other Western European countries. Malarek (2004) refers to two main routes from the CEE region: the first, the 'Eastern route' trafficks women from Russia, Ukraine, Romania, Latvia, Lithuania and Estonia through Poland, into Germany and then on to other countries in Western Europe and beyond; the second, the notorious 'Balkan route' corresponds to routes identified by Corrin.

The following nationalities of women from Europe were arrested, between 2003 - 2005, as part of the CO14 led Operation Kon Tiki:

Table 4 ²³

| Country | 2003 (300 arrests made) | 2004 (113 arrests made) | 2005 (38 arrests made) | No. of trafficking claims |
|----------------|----------------------------------|----------------------------------|---------------------------------|---------------------------------|
| Albania | 15 | 7 | 1 | 0 |
| Czech Republic | 9 | 3 | 0 | 1 |
| Estonia | 2 | 0 | 0 | 0 |
| Hungary | 4 | 0 | 0 | 0 |
| Kosovo | 24 | 10 | 1 | 1 |
| Lithuania | 41 | 5 | 1 | 3 |
| Moldova | 16 | 3 | 0 | 1 |
| Poland | 16 | 1 | 0 | 1 |
| Romania | 16 | 3 | 3 | 1 |
| Russia | 22 | 10 | 0 | 1 |
| Slovakia | 7 | 0 | 0 | 0 |
| Ukraine | 7 | 2 | 0 | 2 |
| Latvia | 7 | 0 | 0 | 0 |
| Total | 186 | 44 | 6 | 11 |

23 Data from Operation Kon Tiki, 2003 - 2005

The statistics suggest that the largest number of women arrested and trafficking claims made for the three years were women from Lithuania. Kosovo generated the second largest number of arrests and Russia third, with only one trafficking claim made for each country. Women coming from CEE generated the largest number of trafficking claims across the three years, in comparison to the other regions analysed in this report.

Of the 44 applications made to IOM London by victims of trafficking since June 2004, the following number of nationalities were from CEE: Albania (3), Lithuania (23), Czech Republic (1), Slovakia (1), Russia (3), Moldova (1), Romania (1), Bulgaria (1) and Poland (2).

Dickson (2004b) notes that in 2003, 25% of women who were working in the indoor sex industry in London were from Eastern Europe.

In the mapping exercise for this study, it was noted that out of the sample of 76 women in the PunterNet field reports, 27 (36%) were reported as being of Eastern European origin. In the telephone survey of the indoor sex industry in the boroughs and surrounding areas, 33 (29%) women were noted as being of Eastern European origin. (See profile of sex working population for further information.)

The Middle East

Within the trafficking context, the Middle East is primarily a destination region for women and children who are trafficked both for the purposes of sexual exploitation and forced labour. There is little evidence to suggest that the Middle East is a source region, although Baldwin-Edwards (2005) notes that certain countries in the region are transit points for illegal migration for entry into Europe. Morocco, Tunisia and Libya in North Africa and Lebanon and Turkey in the East provide transit stops, mainly for individuals from sub-Saharan Africa, en route to arrival areas such as the Canary Islands, the Gibraltar Strait and the Sicily Islands.

The annual US Department of State Trafficking in Persons Report (TIP) (2005), highlighted that Egypt and Turkey are transit countries for women and girls trafficked into sexual exploitation, with Europe being one of the destinations. Iran and Morocco are source and transit countries for trafficking into Europe and beyond. Algeria is another transit country for trafficking into Europe (US Department of State, 2005).

Specific information about the UK as a destination country is not mentioned in the review of the above countries. However, this does not eliminate the

possibility of women being trafficked to the UK from these countries.

Operation Kon Tiki of CO14 has not made any arrests (2003 - 2005) of any women originating from the Middle East.

Of the 44 applications made to IOM by victims of trafficking since June 2004, the following number of nationalities was from the Middle East: Turkey (1).

Dickson (2004b) notes that women from the Middle East constituted 1% of the indoor sex industry in London in 2003 and that no women from this region were identified as working for an escort agency.

As part of the mapping exercise for this study, it was noted that out of the sample of 76 women in the PunterNet field reports, no women were reported as being of Middle Eastern origin. In the telephone survey of the indoor sex industry in the boroughs and surrounding areas, two out of 114 women were noted as being of Middle Eastern origin. (See profile of sex working population below for further information.)

Scale of migrant sex work and trafficking for sexual exploitation in the UK²⁴

Demand for commercial sex in the UK is on the increase. A 2005 study found that the number of men who report paying for sex has more than doubled in the last 10 years, from 2% in 1990 to 4.2% in 2000, the main group being young unmarried men aged between 25-34 and living in London (Ward et al, 2005). A 1997 study in the United Kingdom estimated that 10% of London's male population paid for sex (Brown, 2000, cited in Raymond, 2004).

Meeting this demand are some 80,000 people engaged in sex work in the UK (Home Office, 2004). Approximately 85% of these are women (Safer London Committee, 2005a), working mainly off-street. Estimates of the number of young people under the age of 18 involved in prostitution in the UK vary from 2,000 to 5,000 (Hester and Westmarland, 2004). In London there are estimated to be at least 730 off-street sites selling sex, on average 18-19 per borough (with the exception of Westminster, which has 138), with an estimated total of 2,952 - 5,861 women working in them (Dickson, 2004b).

Most sex workers in London are non UK nationals. According to Ward et al (2004), the percentage of foreign-born sex workers in the UK increased from 25% in 1985 to 63% in 2002. Dickson (2004b) found the percentage of migrant sex workers to be significantly higher at 81%, and considered it a low estimate. This figure is not disputed by the Metropolitan Police (Safer London Committee, 2005a²⁵). Dickson found the most common regions of origin to be Eastern Europe, South East Asia and Western Europe (Dickson, 2004b).

The UK is recognised as a major sex trafficking destination (Malarek, 2004). However, as on the global and European level, the exact scale of the problem is unknown. Existing estimates are generally considered underestimates. The main reference point remains the Kelly & Regan (2000) study for the Home Office, which suggested that between 142 and 1,420 women are trafficked into sexual exploitation in the UK per year, based on figures for 1998. Many, including the Home Office, believe the real scale of the problem to be much greater (Home Office, 2003). No official police estimates are currently available. However, the National Criminal Intelligence Service (NCIS) recognises that the numbers of trafficked women identified across the UK have continued to rise and that sex trafficking is a nationwide problem (NCIS, 2004-2005/ 2005-2006). In

2004-05, UK police carried out 353 operations against traffickers, making 1,500 arrests and seizing £3.5m in assets.²⁶ At the time of writing, 53 suspected traffickers had been arrested and 14 trafficked women 'rescued' in little more than a month under the police's counter trafficking operation, Operation Pentameter, launched in February 2006.²⁷

A 1999 estimate by health workers suggested that at least 5% of prostitutes in London were trafficked (Kelly & Regan, 2000). However, subsequent research suggests that the true figure may be significantly higher. Although Dickson (2004b) does not prove the scale of sex trafficking in London, there is an established correlation between off-street sex sites, where non UK nationals are in the majority and which tend not to be monitored by the police, and a prevalence of trafficking (Kelly & Regan, 2000). Dickson substantiates this link through qualitative evidence, such as the fact that practically all of the trafficked women interviewed (all clients of the Poppy Project) had worked alongside other trafficked women (Dickson, 2004b).

The Kelly & Regan estimate of the scale of sex trafficking cited above did not include children (Kelly & Regan, 2000). Somerset (2004) comments that almost a decade after the first known case emerged in the UK in the mid 1990s, little is known about the scale or modus operandi of child trafficking. According to UNICEF, in 2003 at least 250 children had been identified as trafficked by statutory bodies and NGOs in the previous five years. However, it believes that the real numbers of children trafficked to the UK each year are in the 'hundreds, if not thousands' (UNICEF, Stop the Traffic! End Child Exploitation Campaign, cited in Women's Commission for Refugee Women and Children, 2005; Somerset, 2004). Somerset notes that the vast majority of cases will go unreported (Somerset, 2004).

In the past, trafficking victims tended to be identified mainly in South East England but news reports reveal that they are now being found across the UK, including Wales, Scotland and Northern Ireland (BBC News, 2006b, 2006c, 2006d; McEwan, 2006). At the time of writing, police raids under Operation Pentameter included South Wales, Manchester and Southampton.²⁸ Service providers also report an increasing number of victims in rural as well as urban areas (WCRWC, 2005, citing interview with Refugee Arrivals Project).

24 Note on referencing system: literature is referenced Harvard style; data from interviews are referenced as footnotes.

25 CO14; local police

26 Reflex figures quoted in conference presentation by Stephen Webb, head of Organised and Financial Crime Unit, Home Office: CHASTE, 10 March, 2006.

27 Source: NCIS

28 *ibid.*

Review of current literature on migrant sex work and trafficking in the UK

Scale and nature of migrant sex work and trafficking for sexual exploitation

Kelly & Regan (2000) is a Home Office-commissioned exploratory study into the extent of trafficking of women for sexual exploitation in the UK and law enforcement responses to the phenomenon. As mentioned above, the study is often cited for its estimates of the number of women trafficked into the UK per year (142-1,420), based primarily on police data on trafficking cases in 1998. This is still considered the only valid estimate available, despite the fact it is considered to be an underestimate even by the Home Office and that the data is now over five years out of date.

Somerset (2001) was the first study into trafficking of children into the UK for sexual purposes. Based on interviews with officials (immigration and police), NGOs and 'observers' (academics, journalists and lawyers), the study establishes the existence of trafficking of children to the UK for sexual purposes and the use of the UK as a transit point for other European countries. However the study does not provide any estimate of the numbers involved.

Building on her 2001 research, Somerset (2004) examines the levels of awareness and experience of dealing with child trafficking among London social services. It concludes that while London social services are aware of the issue they are not always well informed or sure about how to address it, meaning that cases may not always be identified. Recommendations include: the provision of safe and secure accommodation for trafficked children; training on child trafficking for social workers and immigration services; better cooperation and information sharing within teams, across teams and across boroughs; checks on 'hot addresses'; reporting of child trafficking cases to the Department of Education and Skills; and improved cooperation from the police.

Singer (2003) relates the pattern of disappearances of young asylum seeking West African girls from social care in West Sussex which emerged in 1996 and the resulting Operation Newbridge. It describes the work the charity National Missing Person's Helpline has since done to try to locate missing girls suspected to be victims of trafficking in cooperation with the police, social and immigration services and other statutory and non governmental bodies. Information is provided on the foundation of the cross-sector Counter Trafficking Steering Group in 2001-02, which, among others has lobbied for legislative change.

Dickson (2004b) maps the extent and nature of commercial sex across London boroughs and the presence of foreign born women within the industry, based on data gathered in the latter half of 2003. Looking at off-street premises, escort agencies, lap dance clubs, on-street sex work and chat lines, it finds that migrant women are in the majority in the first two categories (see discussion above). The report suggests links between off-street sex work and organised crime and trafficking. It outlines responses to off-street sex work and trafficking by statutory bodies and sexual health outreach providers, and makes a number of recommendations to improve these. Dickson highlights the pressing need to explore and address the demand for sex.

Policy on prostitution and trafficking

UK government policy on tackling prostitution is set out in the consultation paper *Paying the Price* (Home Office, 2004) and in the resulting *A Coordinated Prostitution Strategy* (Home Office, 2006). Government policy on tackling human trafficking is outlined in the White Paper *Secure Borders, Safe Haven* (Home Office, 2002), and subsequently elaborated in the 'Crime Reduction Toolkit' (aiming to raise awareness of trafficking among relevant agencies and advise them on how to identify and deal with trafficking victims) (Home Office, 2003), and in *Paying the Price*. A consultation process to develop the strategy further, entitled *Tackling Human Trafficking - Consultation on Proposal for a UK Action Plan* was launched in January 2006 (Home Office/Scottish Executive, 2006).

Published prior to the development of the UK government's proposed strategy on prostitution, Bindel & Kelly (2003) compares and contrasts policy and legislative approaches to prostitution in four countries (Australia, the Netherlands, Ireland and Sweden) to inform the debate on prostitution in the UK. The main, brief, report on the UK outlines the history of prostitution legislation from the early nineteenth to the late twentieth century, barriers to discussion and debate and current knowledge of the sex industry. It concludes that the case for complete legalisation of prostitution is 'weak and unsubstantiated'.

As part of a wider European study, Candappa (2003) looks at the measures statutory, non governmental and interagency bodies in the UK are taking to prevent and combat trafficking on a national as well as regional and international level. It provides a useful description of the respective roles, responsibilities and approaches of the different organisations. The main body of the study is preceded by an overview of how trafficking in the UK

came to light in the mid to late 1990s and of the current knowledge of the scale and nature of trafficking in the UK. A (now out of date) overview of the country's legislative framework is also given. Examples of coordinated and collaborative working across sectors and good practice are highlighted.

Kantola & Squires (2004) argue that the UK debate on prostitution and trafficking is dominated by a public nuisance discourse in relation to kerb crawling, influenced by community activists, and a moral order discourse in relation to trafficking, influenced by NGOs and IGOs. It is held that both of these discourses marginalise the 'sex work' discourse, and that the policy debate should be broadened to include discussion of approaches taken by other European countries.

Matthews (2005) examines changes in the policing of prostitution in England and Wales over the past decade, comparing two surveys of vice squads carried out in 1994 and 2004, and identifies emerging trends. Key findings include a move away from strict enforcement models linked to vice squads, whose number has halved (from 30 in 1994 to 15 in 2004); and towards multi-agency responses in collaboration with sex workers' support and interest groups. Matthews notes that the off-street trade has been relatively neglected and that its growth and links to trafficking, child exploitation and organised crime suggest that the police's 'blind eye' approach needs to change.

Munro (2005) compares the counter trafficking approaches of the UK and Australia and argues that their differences are the result of very diverse stances on the role and regulation of the sex industry at large. It is argued that the UK's response has tended to emphasise exploitation over consent and sexual exploitation over other types of labour exploitation, thus implicitly challenging the concept of prostitution as work. The UK continues to see prostitution as inherently exploitative and therefore morally condemns it. Australia, on the other hand, favours the concept of 'voluntariness' rather than exploitation and several states have decriminalised or legalised prostitution.

Since 2000, the United States Department of State has produced an annual report on foreign governments' efforts to counter 'severe forms' of human trafficking worldwide. The report is widely cited in the literature for its figures on the number of trafficking victims globally (600,000-800,000 in 2005). Also cited are its controversial 'rating' of countries into Tier 1, Tier 2, Tier 2 Watch List, and Tier 3 according to the level of progress the State Department perceives them to have made in the areas of prosecution of traffickers, victim protection and prevention initiatives (Tier 1 being best and Tier 3 worst). The bulk of the report comprises detailed country reports. In the 2005 report (US

Department of State, 2005a), the UK is ranked as Tier 1. The report praises the UK's new legislative framework criminalising human trafficking and introducing heavy penalties and its record of prosecution and prevention. However, it criticises the lack of uniformity in the UK's statistics on trafficking, the inability to accommodate the number of referrals of trafficking victims received and the lack of a residency permit system for victims.

Safer London Committee (2005b): the London Assembly's Safer London Committee, which ran between July 2004 and May 2005, carried out a review of prostitution and its impact on community safety in London via consultation with a number of statutory and non governmental bodies. The resulting report focuses on street rather than off-street prostitution, due to its visible nature, greater impact on the community and connections to drugs and the drugs trade. A series of recommendations for the Home Office are made, notably: reassessment of funding for out-of-hours drugs referral services and organisations providing care for vulnerable people including prostitutes; a review of the use of Anti Social Behaviour Orders (ASBOs) for sex workers; greater emphasis on drugs referral and exit programmes; better coordination of homelessness strategies across the London boroughs; and more effective barring of the telephone numbers given on cards advertising prostitutes' services.

Victim identification and protection

Pearson (2002) presents the results of a two-year multi country study looking at various protection measures in place for victims of trafficking in 10 sending or receiving countries, including the UK. The research found that the four countries most successful in prosecuting traffickers were those with the most comprehensive measures for assisting victims. These measures included temporary residency permits for those willing to testify against their traffickers, allowing them to access their human rights, recover from their situation and secure prosecutions of traffickers. Also highlighted is the importance of a 'reflection period' accompanied by specialised services providing housing, legal, medical, psychological and material assistance; witness protection schemes; safe housing; and legal representation, legal redress and compensation for victims. The report finds that in most cases, countries prioritise the needs of law enforcement over the rights of trafficking victims, and makes extensive recommendations for governments, law enforcement agencies, immigration services, NGOs and lawyers.

The Women's Commission for Refugee Women and Children (2005) provides a critique of the UK's treatment of trafficked women and children in the context of immigration control, and argues that victim

protection is inadequate. The report includes: a review of the international, European and domestic legislative framework relating to refugee, asylum and trafficking law; the demographics of trafficking in the UK; and UK efforts to combat trafficking, including victim, legal and physical protection and law enforcement efforts. It argues that in the absence of a specific protection system such as a reflection period or residence permit, victims are obliged to apply for asylum or humanitarian protection or discretionary leave to remain, which is made more difficult by an increasingly restrictive asylum system. There is also insufficient provision of services, including safe houses, for individuals recognised as trafficking victims. The report advocates for the British government to put the human rights abuses of victims rather than immigration control at the centre of any counter trafficking initiatives and makes some specific recommendations to this effect.

Anti-Slavery International (2005) is a manual aiming to provide a protocol for identifying and providing assistance to victims of trafficking, including a training kit, produced with input from Eaves Housing for Women in the UK, On The Road in Italy and the Police Academy and STV (Dutch Foundation against Trafficking in Women) in the Netherlands. The manual is aimed at front-line police and immigration officers, detention centre workers, service providers and others that may come into contact with trafficked people as part of their everyday work. An annex provides country reports on the UK, Italy and the Netherlands which detail background information on the development of knowledge of trafficking and related services, the legislative framework and the process currently used by agencies to identify trafficking victims in each country. The UK report is critical of the focus of and figures produced by Kelly & Regan (2000) and of the response of most statutory and non governmental agencies to the trafficking issue.

Health of trafficking victims

Zimmerman (2003) presents the results of a two-year multi-country study on the impact of trafficking on the health of women and adolescents trafficked to the European Union. The research process included interviews with health care and other service providers, immigration and law enforcement agencies, and women who had been trafficked in five source and destination countries, including the UK, where four trafficked women participated. There is no separate section on the UK (see below for a more detailed discussion).

Dickson (2004a) is a short report summarising qualitative data gathered over time from interviews

with 26 women trafficked to the UK and housed by the Poppy Project, 23 of whom were trafficked for sexual exploitation. The report covers the women's experiences of sexual and physical violence prior to and during the trafficking situation; how they were trafficked; their expectations of work in the destination country; factors leading to their decision, if applicable, to leave their country; their exposure to pornography; and the impact of trafficking on their health (see below for a more detailed discussion).

History of sex work in Tower Hamlets and the City

This short survey of the history of sex work in the research area draws only on secondary sources but aims to paint a picture of the historical and cultural background of the sex trade in the area.

Middle Ages

Shuckburgh (2003) reports that, in medieval times (1000 - 1500), Smithfields, on the edge of the City, was the centre of the London sex trade. Unable to decide whether to ignore it, condone it, regulate or punish it, the authorities dealt with the existence of brothels by alternately ordering them out of the City to the outskirts or restricting them to certain streets within the City. Unofficial brothels were physically dismantled in successive stages, partly with the idea of giving the owners a chance to repent and prostitutes were often punished.

According to Danziger and Gillingham (2003), in the twelfth century, the royal household normally sitting at the Palace of Westminster but occasionally installing itself in the Tower of London, in a similar fashion to other noble establishments, had its own brothel consisting of 12 licensed 'demoiselles' in order to regulate the trade and keep out an endless procession of gold diggers.

Tudor times

Writing on the Elizabethan period of London's history, Picard (2003) records that prostitution flourished in the City and provided an alternative means of earning a living for many women, the norm being domestic service. 'Stews', 'trugginghouses' or 'whorehouses' were found mainly in the poor quarters of the town and although Bankside in Southwark was the centre of the trade, brothels could be found in Spitalfields beyond Bishop's Gate, Shoreditch and parts of Whitefriars. A 1584 broadsheet puts the charge at a brothel at 40 shillings 'or better' although in the context of other Elizabethan prices this seems extremely expensive. That there was some stigma attached to the profession in those times is evidenced by court cases of individuals being sued for calling women 'whores' and alleging the exchange of sexual favours for goods.

Pre-Victorian times

In 1700, on the boundary of the City of London and the City of Westminster, a maze of dark alleys between the Strand and Drury Lane were the haunt of a variety of street prostitutes who plied their trade, states Waller (2000), by means of approaching and soliciting men or through a system of signals using their fans. The off-street sex trade was vibrant; letters of recommendation were provided for 'gentlemen' as a means of introduction from one brothel to another and in

elegantly furnished brothels men were offered the choice of 'rich City wives "who loathed their husbands and who loved the sport"', or a 'fresh-cheeked country girl'. A sexual encounter cost a guinea although there was a thriving trade in virgins for ten guineas. Dillon (2002) reports that in 1720, sex was heavily commercialised in London and a publication, *New Atlantis*, listed prostitutes by abode, attractiveness and 'qualifications'.

Perhaps the current definitive works on the period are Peakman (2004) and Rubenhold (2005). Peakman records a rich tapestry of sex work in London, including the City of London brothels. Street prostitution was rife and widespread but it appeared, in general, that the sex trade was geographically ordered with the 'better' class of activity occurring in the City of Westminster and the West of the town, the City of London holding the middle ground and the nascent East End of what is now Tower Hamlets occupying the 'lower' niches of the market.

The Victorian era

According to The Times (2005), there was an Albert Square in the East End until the Second World War and in the 1851 census nearly every householder in the Square described his employment as 'brothel keeper'. Even a cursory examination of texts such as Thomas (1998), Pearsall (1969) and Fisher (1997) reveal that this information should hardly surprise the reader. The sex trade in Victorian London was widespread.

Thomas (1998) also reflects the ambivalence with which the sex trade and sex workers were viewed. This is reflected in the series of confused regulatory approaches adopted to the issues such as the Contagious Diseases Acts of 1864 and 1866, The Bill for the More Effectual Suppression of Brothels in 1844 and The Bill for the Protection of Females in 1848 as discussed by Fisher (1997).

The 'Ripper' murders

The murders of prostitutes in East London in 1888, referred to as the 'Ripper' and Whitechapel murders, hold a fascination which continues to this day. The murders are inextricably linked in many ways to both past and present perceptions of sex work in the East End. There is a wealth of information on the Ripper murders perpetrated in 1888. The Ripper was never caught but has spawned an ongoing industry of speculation and investigation.

The Twentieth Century

After the First World War, the Limehouse region of London became linked with drugs, prostitution and the

activities of criminals of a Chinese ethnic background. As Kohn (1992) seeks to stress, many of the accounts of this era, which stretched from 1918 to the late 1930s, are sensationalised and racist with lurid tales of white slavery, opium and racially stereotyped images of cruel and inscrutable 'Orientals'. Yet it remains true to say that the area was rife with prostitution and that large elements of the sex trade, which was connected to the drug trade, was controlled by the ethnic Chinese. A series of oral history interviews were given by an Annie Lai in the mid 1980s and describe how she arrived in Limehouse in 1921 and her subsequent precarious life amongst the drug and sex trade. These records are held by the Tower Hamlets Borough Library Local History Collection as is a copy of Binder (1935), which relates the story of a 'white woman' and her descent into prostitution and cohabitation with the Chinese manager of a gambling den.

A further ethnic group to become linked to prostitution in Tower Hamlets were the Maltese as Brewis (2003) notes. Many Maltese men arrived in the UK following the Second World War and settled in the Stepney area of London. Certain elements of this group became involved in operating brothels and gambling establishments in Stepney, Cable Street, Whitechapel and surrounding areas. Police figures cited for the period 1951-1969 show significantly high percentages of Maltese men convicted of 'living off immoral earnings' per 100,000 of the relevant ethnic populations, as follows:

- 1951-54: 1% as opposed to 0.00012% of United Kingdom Nationals
- 1955-59: 1.7% as opposed to 0.00015% of United Kingdom Nationals
- 1960-64: 0.96 % as opposed to 0.0003% of United Kingdom Nationals
- 1965-69: 0.57% as opposed to 0.00033% of United Kingdom Nationals.

The sources examined in this short overview identify a dynamic geography of sex work across the City and the East End of London which has been in existence since medieval times and has persisted, albeit in modified forms, to the present day.

Review of current service providers in Tower Hamlets & The City (& surrounding boroughs)

In the course of this study, several hundred service providers in Tower Hamlets, the City and surrounding boroughs were contacted to scope their views and experience of the substance use and health related needs of migrant and trafficked women and girls in the local sex industry (see Appendix B). The organisations listed below are those where representatives who were interviewed reported contact with migrant sex workers and/or women trafficked into sexual exploitation in the City and Tower Hamlets. Additionally, some key organisations that did not report specific knowledge or contact are also described.

BME, community, migrant and refugee organisations

The researchers contacted 62 Black and Minority Ethnic (BME), community, migrant and refugee organisations in Tower Hamlets, the City and surrounding boroughs, in addition to several specialist organisations in other areas of London (see Appendix B). Of these, only Praxis, a refugee organisation based in Tower Hamlets, reported any contact with the target group, and this was via their satellite service at Health E1 (see Other Health Service Providers below).

Children

Barnardo's Young Women's Project (North London)

The project works with girls and young women from all backgrounds, up to the age of 18, who are involved in, or at risk of, being sexually exploited. The services provided include advice on benefits, drugs and alcohol, and sexual health. The project raises awareness among agencies, policy and decision-makers so as to ensure that attitudes, practices and policies are changed.

NSPCC Street Matters/Bfree Sexual Exploitation Service (SES) (Tower Hamlets & UK)

Street Matters and Bfree are sister projects operating from the same premises. The former works with young women up to the age of 18 who are involved in, or at risk of sexual exploitation, including those who are abused through prostitution. Street Matters is a non-residential social work based service, providing one-to-one key working to address issues around sexual exploitation and conducting advocacy work on the young women's behalf. The Street Matters team mainly works in Tower Hamlets and the young women they see have to prove an East London connection, such as being enrolled in a local school or living in the area. Within Street Matters, the 'There to Here' group specifically

helps Unaccompanied Asylum Seeking Minors (UASM), supporting the young women with HIV testing, immigration matters, exiting sexual exploitation as well as advocating on their behalf to social services. There are currently 13 girls in the 'There to Here' group, all from Africa.

Bfree works across London, and sometimes nationally, providing consultancy and training about sexual exploitation, especially to residential homes.

The young women and girls who are seen by NSPCC SES include non-UK nationals, children of mixed parentage with UK residency and UK nationals. Street Matters has had contact with young women who are using drugs and who have been sexually exploited through prostitution (see Case 8 in Appendix C).

Project DOST (Newham)

Project DOST offers specialist, individual and long-term support to children who have arrived in the UK as UASM. Workers from the team accompany the children on visits to solicitors, doctors and other service providers. Staff also carry out home visits, offer advice on health issues and education and encourage the child's empowerment at school, in sports and other areas.

Project DOST has come across unaccompanied minors who they suspect have been sexually exploited. The majority of these girls come from Africa. Three years ago Project DOST was aware of an influx of Ugandan girls coming to the UK and suspected that at least two of the Ugandan girls they had contact with had been trafficked for the purposes of sexual exploitation (see Case 7 in Appendix C).

Domestic violence

Ashiana (Surrounding boroughs)

Ashiana provides refuge accommodation for young women from South Asia, Iran, Turkey and countries with a similar culture who are suffering domestic violence or who are at risk of forced marriage. There are two refuges, one for each group. The organisation also does outreach work; one-to-one and group counselling for women who have left or are considering leaving their situation; schools talks and projects; an in-house counselling service; and a support group for women from all backgrounds/nationalities who are suffering abuse. Ashiana accepts referrals from statutory and non-statutory agencies as well as self-referrals. Most referrals come from the police and GPs in East London.

The organisation reported three recent cases of suspected sexual exploitation of young women after

they had escaped from their situation of domestic violence or forced marriage. The women concerned were British-born Bangladeshi, British-born Pakistani and Middle Eastern.

Hackney and Tower Hamlets Asian Women's Aid (Hackney and Tower Hamlets)

Hackney and Tower Hamlets Asian Women's Aid provide refuge accommodation, advice and counselling services for Asian women and children experiencing domestic violence in the two boroughs. Most clients are suffering domestic violence within a steady relationship. However, the organisation does receive occasional referrals of women who fit into the target group (see Cases 11, 12 and 13 in Appendix C).

Southall Black Sisters (Surrounding boroughs)

Southall Black Sisters is an organisation based in West London that aims to highlight and challenge domestic violence against Asian and African-Caribbean women at the local and national level. It runs a resource centre for women experiencing violence and abuse, offering specialist advice, information, casework, advocacy, counselling and self-help support services.

The organisation occasionally comes into contact with women who have been involved in forms of sex work and/or sexual exploitation. Two main scenarios were outlined: a woman's husband forcing her into having sex with other men, usually his friends or possibly within the family; and women being brought into the country to work in 'entertainment' who are highly controlled and under pressure to have sex with their agent or other men. Of the two scenarios, Southall Black Sisters reported that the first scenario has probably been more common. The organisation has come into contact with three or four women in these situations in the same number of years. These women have all been Indian and based in West London.

Tower Hamlets Social Services - Adult Protection (Tower Hamlets)

As a statutory body, Tower Hamlets social services has a legal duty to ensure the welfare and protection of vulnerable adults²⁹, including women with needs related to mental health, disability or domestic violence. A spokesperson within adult protection services confirmed that they have received two referrals of trafficked women, both recent cases, one of which was ongoing at the time of writing.

Women Against Rape (WAR) (Surrounding boroughs)

Women Against Rape offers support, counselling, legal advice and information for women and girls who have been raped or sexually assaulted. The organisation assists women with reporting attacks, legal action, testifying in court, health referrals, re-housing, claiming benefits and compensation. Clients include immigrant wives facing domestic violence and rape survivors seeking asylum.

WAR was aware of four trafficked women from Africa being detained in Yarl's Wood Removal Centre in December 2005. According to WAR, the women did not fit with the Poppy Project's referral criteria (see below) and therefore could not be accepted by them.

Drug & alcohol

Addaction Gateway Day Programme (Tower Hamlets)

The Addaction Gateway Day Programme is a Tier 3 therapeutic service designed to encourage clients to change their behaviour through teaching them new ways of thinking. The programme complies with the requirements of Drug Testing Treatment Orders³⁰ and the majority of clients are referred by criminal justice workers. Most clients are male, although the programme reports seeing increasing numbers of female clients and opened a women-only group in late 2005.

Since 2000/01 the programme has had contact with three or four BME, mainly Asian, female sex workers who may have been first or second generation immigrants. These women were all heavy users of drugs, particularly opiates.

Addaction Tower Hamlets Community Drug Team (THCDT) (Tower Hamlets)

Addaction THCDT is a Tier 3 community drug service offering advice, support and counselling to drug users over 18 who are resident in Tower Hamlets. Services include key working, shared care prescribing³¹, a drop-in for assessment, primary healthcare, mental health support, referrals for inpatient detoxification and rehabilitation and other specialist services. The current client base is approximately three-quarters male and the majority are Bangladeshi or White British. A small number of male clients are Afro-Caribbean, Vietnamese, non-British White European and Somalian. Sex workers account for a significant minority of female clients

29 A vulnerable adult is a person aged 18 years and over who is or may be unable to take care of themselves, or unable to protect themselves against significant harm or exploitation.

Source: <http://www.medway.gov.uk/index/socialcare/adults/3796.html>; Last accessed: 31 March 2006

30 The Drug Treatment & Testing Order is used for offenders who have drug misuse issues that require treatment. The order lasts between 6 months and 3 years. The offender receives regular drug testing and treatment in the community and is supervised by the Probation Service. Source: <http://www.youth-justice-board.gov.uk/> Last accessed: 31 March 2006

31 'The joint participation of specialists and GPs (and other agencies as appropriate) in the planned delivery of care for patients with a drug misuse problem' (Department of Health, 1999).

(approximately one quarter to one third) and are mainly White British, although some are Bangladeshi. No migrant women are known to access the service.

Adolescents Specialist Addictions Treatment Service (ASATS) (Tower Hamlets, Hackney and Newham)

ASATS is a service for young people under the age of 19 with drug and alcohol use issues associated with addiction and/ or mental health problems. It provides a range of specialist services and interventions to young people who have developed severe or problematic drug use causing a significant impairment to their ability to function in an age appropriate manner. Referrals are received from a range of sources including other Child and Adolescent Mental Health teams, youth offending teams, voluntary sector agencies and hospital paediatric liaison teams. ASATS operates in Tower Hamlets and Hackney and via outreach in Newham.

Angel Drug Services (Surrounding boroughs)

Angel Drug Services provides advice, information and support for people with drug-related problems, as well as services for their partners, families and friends. It runs an advice line, drop-in service, outreach service in North London, women's service, counselling, health care, complementary therapies, crack users' group, and a daily needle exchange operating from a van at Kings Cross.

The organisation reported some limited contact with women believed to be Eastern European and sex working via the needle exchange van at Kings Cross. These women have only asked for condoms, not needles and do not appear to be (injecting) drug users.

Drug and Alcohol Service for London (DASL) (Tower Hamlets and pan-London)

DASL is a community based charity providing a Tier 2 alcohol treatment service for adults in Tower Hamlets and some targeted substance use services in the wider London area. DASL runs services which target the Bangladeshi community, including a Bangladeshi alcohol project and a 'girls talk' project to raise awareness of substance use among young Bangladeshi women. DASL also runs a London-wide gay and lesbian youth service. Services are free, confidential and open to all.

To its knowledge, the organisation has minimal contact with sex workers. However, there is anecdotal evidence, gathered via outreach work, of Bangladeshi girls being coerced into sex work via a boyfriend, partner or family member, with some exchange or payment in drugs involved.

Odyssey Trust/City Roads (Surrounding boroughs)

The Odyssey Trust offers a range of services for people with substance use problems, particularly heroin and

crack, including advice, information, support, structured day programmes, aftercare, residential treatment, detoxification, education and employment support, counselling and group work. The Tier 4 City Roads programme offers a three-week residential drug detox programme for people who are facing a life-threatening crisis because of their substance use and who are a resident of a London borough.

The Odyssey Trust reported some limited contact with migrant sex workers: of 18 women who declared they were sex workers in the last year (2004-05), three were non UK nationals but were 'settled' in the UK.

Specialist Addiction Units (City and Hackney and Tower Hamlets)

The Specialist Addiction Unit (SAU) is a Tier 3 drug service and is part of the East London and City Mental Health NHS Trust. It provides specialist secondary care to people with complex drug related problems including multiple or chaotic drug users, pregnant drug users, those with complex physical health needs and users with mental health problems. The SAU is accessed via referrals from GPs and other primary care agencies.

The SAUs were not aware of any contact with migrant sex workers.

Housing/homelessness

Providence Row (City and Tower Hamlets)

Providence Row is a faith-based charity providing emergency and long-term help to those in poverty and distress, regardless of religious beliefs. There is a dedicated women's service which provides advice on healthcare, counselling, training, accommodation, education, basic life skills and mentoring. Many service users are homeless and vulnerable women, including sex workers. A women's group drop-in service is run twice a week as well as a homeless women's group. The Providence Row's women's service aims to build relationships with hard-to-reach women via the support and advice services it offers and referring on to relevant specialist services if necessary.

Around 50% of Providence Row's women service users are currently involved in sex work, but over 90% have been involved in sex work at some point in their lives. Most of these women are from the local area. However, within the last six months, Providence Row has seen two migrant sex workers accessing their services, one from Eastern Europe and one from Argentina.

Whitechapel Mission (Tower Hamlets)

The Whitechapel Mission is a faith-based organisation providing free services for poor, homeless and excluded people. Services are open to all and include the provision of a hot breakfast, showers, laundry, clothing,

pastoral care, advice and assistance with accommodation, benefits, identification documents and basic numeracy and literacy. Some 150-200 people attend the centre every day, the majority male.

The organisation reports that one of the fastest growing groups attending is Eastern Europeans (particularly from Lithuania, Russia and Latvia). Approximately 50-60 Eastern Europeans have been seen during 2005, some 10% of them women, who are believed to be sex working. Teenage Asian girls, believed to be sex working, also attend.

Immigration

Immigration and Nationality Directorate, Home Office (National)

In the course of the research, contact was made with the Home Office Immigration and Nationality Directorate. Researchers requested permission to approach for interview any migrant sex workers or alleged trafficking victims who were being held at 'reception' and removal centres in the London area (Oakington, Tinsley House and Yarl's Wood Immigration Removal Centre). The request was directed to the Home Office's Enforcement Policy Unit (EPU). After a number of communications, and referral of the matter to 'Ministerial level', the request was declined. Several reasons were given: the request came within the 'climate' of the launch of Operation Pentameter; the short timescale and 'impact on staff'; and concerns around the protection of the identities of those being detained. Finally, the Home Office did not believe that trafficking victims would be found in detention centres:

[...] The Home Office has established procedures for the identification and referral of those who may have been victims of trafficking to the POPPY scheme which will mean that individuals who claim to have been trafficked should not be held in places such as Yarl's Wood and we do not believe that individuals who match your specific criteria would be identified [*sic*]. I am aware of the events following the Birmingham brothel operation last year and the comments of some NGOs at Tuesday's Operation Pentameter launch that the UK routinely detains victims, but it is felt that the events in Birmingham were exceptional and the set of circumstances surrounding it were equally unusual meaning that this would be unlikely to reoccur.³²

It should be noted that this view is in direct contradiction to information from sources such as CO14 (see below), Women Against Rape (see above) and the Poppy Project (see below), who all report direct contact with women who allege to be trafficked and who are held in detention centres.

An interview was also requested with a Home Office representative to discuss the Home Office's policy on dealing with women who claim to have been trafficked for sexual exploitation as well as information on joint police and immigration raids on brothels in East London. However, this request was also turned down.

International Organisation for Migration (IOM)

The International Organisation for Migration (IOM) in the UK implements two voluntary return programmes: Voluntary Return and Reintegration Programme (VARRP) and Assisted Voluntary Return of Irregular Migrants (AVRIM).

The VARRP programme is open to asylum seekers, rejected asylum seekers and those with temporary protection in the UK. VARRP offers advice on travel documentation, as well as air ticket and reintegration assistance in the country of origin, worth up to £3000 per person.

The AVRIM programme is open to those who have overstayed their visa and those who have been smuggled or trafficked into the UK and who have not made in contact with the UK authorities. The programme offers advice on travel documentation and buying a ticket home but does not include re-integration assistance.

IOM UK assists victims of trafficking to return voluntarily under both programmes, depending on their status in the UK. Since June 2004, IOM has received 44 applications from victims of trafficking, of whom 25 returned home.

Legal Advice

Asylum Aid (Tower Hamlets)

Asylum Aid is an independent charity which works to support vulnerable and disadvantaged people seeking asylum in the UK. Clients are given free legal advice and assistance with their asylum application. The organisation has a Refugee Women's Resource Project, which aims to enable women fleeing serious human rights violations to gain protection in the UK. Outreach is carried out at Positively Women, Traumatic Stress Clinic, Holloway and Bronsfield Prison. Asylum Aid reported seeing clients who have been trafficked for sexual exploitation and estimated that, on average, they see fewer than ten cases annually. Referrals are received from trafficked women themselves, their friends, CLASH, the Poppy Project, SHOC, Women's Aid and the Police. Occasionally they also receive calls from maids worried about women. Asylum Aid were unaware of any specific cases arising in Tower Hamlets, or cases that had a Tower Hamlets connection.

³² Personal communication, 28 February 2005.

Police & law enforcement

City of London's Crime and Disorder Reduction Partnership (CDRP)

The CDRP was set up as a result of the 1998 Crime and Disorder Act. It aims to reduce crime, disorder, antisocial behaviour and substance use in the City. It is accountable to the government. Partners include residents groups, business associations, the Corporation of London, City police and City and Hackney Primary Health Care Trust. Activities include information provision and sharing and the coordination of crime reduction activities between partners.

The CDRP does little work on sex work. However, in 2005 the CDRP produced a report on sex workers in the City, based on police data, for the City Drug Action Team (City CDRP, 2005).

City of London police: Bishopsgate division

Bishopsgate division covers the eastern part of the City. The main policing activity in relation to sex work is countering carding (cards advertising sex workers' services, generally left in telephone boxes). Other activities in relation to sex work include disruption and/or closure of brothels, often in response to reports of nuisance premises.

Until 2006 brothel raids only took place once or twice a year, but raids on nuisance brothels have now been stepped up with a view to closing premises down. Some raids were conducted at the same time as, but independently from, Operation Pentameter in February 2006. Bishopsgate police has no plans to conduct these raids as joint operations or to conduct any raids under Operation Pentameter, although there may be some consultation with Metropolitan police units specialising in dealing with trafficking victims and other vulnerable women such as CO14 and Sapphire (see below). At the time of writing, the division was investigating a small chain of brothels with two premises in the City and one in Covent Garden with a view to prosecuting the owner under the Proceeds of Crime Act (2002).

City of London police: Snow Hill division

Snow Hill division covers the western part of the City. At present, Snow Hill does not believe sex work to be a problem in the area. Bishopsgate and Snow Hill divisions do not coordinate their response to sex work. The division maintains a 'watching brief' and responds to any reports of nuisance premises from the public.

Metropolitan Police Clubs & Vice Unit (CO14) (Cross-borough)

CO14 has been addressing trafficking in women and children for sexual exploitation within its wider remit of monitoring London's sex industry since 1999. The unit's primary concerns are to rescue women and children from exploitative situations, to prosecute offenders and

seize assets. CO14 is a proactive vice squad. Its approach starts from the premise that it is unrealistic to expect trafficking victims to come forward to the police or to be able to testify, therefore investigations must be intelligence-led. It is a small unit, with 13 core officers working on off-street prostitution and much of its resources and work are based in central London.

At the time of writing, CO14 was carrying out raids on brothels under the nationwide Operation Pentameter to identify victims of trafficking. As of mid-March 2006, raids had taken place in Westminster where two women were found who said they were working against their will. When CO14 identifies a trafficking victim, she is placed into temporary hotel accommodation before being referred on, either to the Poppy Project, to the International Organisation for Migration (IOM) or immigration services. If referred to immigration services, the woman is held in a detention centre.

CO14 conducts regular operations on both on- and off-street sex work in Tower Hamlets in conjunction with the local police, and is understood to have undertaken some preliminary work on brothels in the Whitechapel area. However, no further information on this work or on future raids to be undertaken under Operation Pentameter was publicly available.

Operation Maxim (Cross-borough)

Operation Maxim is the Metropolitan police force's response to organised immigration crime, a multi-agency initiative which, like Reflex at the national level, brings together police, immigration, passport and prosecution services. Maxim is a 'proactive' unit, i.e. intelligence-led. Maxim's contact with victims of trafficking to date appears to be limited (Anti-Slavery International, 2005; Mitchell, 2005).

Maxim was not aware of any trafficking cases having arisen in East London. However, it confirmed that it is due to set up a dedicated human trafficking unit within the next few months, with the aim of coordinating the Metropolitan police's work on trafficking. Although details are yet to be finalised, it is likely to be a reactive service acting as a first point of contact for the most 'extreme' trafficking cases in London and will work closely with other related units, such as CO14.

Tower Hamlets police

There is no vice unit in Tower Hamlets. Sex work in the borough is mainly dealt with by the Safer Neighbourhoods Team based at Brick Lane. The police in Tower Hamlets are part of the Safer Exit Tower Hamlets forum, a multi-agency partnership project established in 2004 to coordinate agencies engaging with sex workers in the area. A female police liaison officer has recently been appointed to develop links between the police and sex workers.

Since the establishment of Safe Exit Tower Hamlets the police have focused on the demand side of on street sex work and have carried out kerb-crawling operations in conjunction with CO14. Off-street sex work is only addressed if a 'problem premises' has been identified, i.e. if complaints are received about an establishment or if an allegation of vulnerable women has been received. Occasional brothel operations are carried out, also in conjunction with CO14.

The representative was not aware of any direct contact with migrant sex workers or trafficked women.

Tower Hamlets Sapphire Unit

Sapphire units are borough-based police units dedicated to investigating rape and serious sexual assault. Like most Sapphire units, Tower Hamlets Sapphire is reactive. Sex workers and trafficking are not a specific part of Sapphire's remit, but they do occasionally deal with related cases. Referrals can be made by anyone, although the majority of women self-refer. A small minority of the Tower Hamlets unit's cases have involved foreign nationals, two of whom have been known or suspected to be sex workers in the last year. There had been one recent referral of an East European woman who alleged to have been trafficked (see Case 10 in Appendix C).

Sexual health

Ambrose King Centre (Tower Hamlets)

The Ambrose King Centre is a sexual health clinic based at the Royal London Hospital in Whitechapel. The Centre is open to all, including clients with no recourse to public funds, and offers a free and confidential service. It is primarily a walk-in clinic, but a limited number of appointments are available. The Centre provides services and advice on:

- Sexually transmitted infections
- HIV testing and counselling
- Vaginal or urethral discharge
- Herpes, warts or other skin infections of the genitals
- Emergency contraception
- Sexual Assault Clinic
- Psycho-sexual problems
- Hepatitis B screening and immunisation and Hepatitis C testing
- Free condoms and lubricants
- Gay men's sexual health
- Services for women working in the sex industry
- Access to special clinics for HIV patients
- Limited family planning for under 25 year olds

Every Friday, there is a clinic specifically for sex workers where they can access sexual health services as well as a psychologist who offers crisis intervention sessions. In addition, women who work in the sex industry can attend any drop-in service and they will be fast tracked. Amalgamated cases of trafficked women seen by the psychology service at Ambrose King, where all individual identifying characteristics have been changed, can be found in Appendix C.

Barts Sexual Health Centre³³, St Bartholomew's Hospital (City)

Barts Sexual Health Centre is a walk-in clinic and individuals are seen on a first come first served basis. The Centre offers advice and services on the following:

- Sexually transmitted infections
- HIV testing and counselling
- Vaginal and urethral discharge
- Herpes, warts or other skin infections of the genitals
- Emergency contraception
- Sexual assault
- Psycho-sexual problems
- Hepatitis B screening and immunisation and Hepatitis C testing
- Access to special clinics for HIV patients
- Limited family planning for under 25 year olds.

Naz Project London (West and East London)

The Naz Project provides sexual health and HIV prevention and support services to targeted Black and Minority Ethnic (BME) communities in London. Naz exists to ensure that these communities have access to care, support and culturally and linguistically appropriate information. Its main offices are based in West London, with a smaller office in East London.

In East London, the Naz project is aware of 25 Somalian women who are engaging in sex work, 16 of whom are in Tower Hamlets.

The Haven³⁴ - Whitechapel (Tower Hamlets)

The Haven is a Sexual Assault Referral Centre. The centre offers a confidential service with a dedicated team of specially trained NHS doctors, nurses and other healthcare professionals including counsellors and psychologists as well as forensic examinations and full aftercare services for women, children and men. Referrals are by telephone, self-referrals or any third-party referrals.

Women's and Young People's Service at the Sylvia Pankhurst Centre - Mile End Hospital (Tower Hamlets)

The Women's and Young People's Service provides family planning and sexual health services to women, young people, lesbian, gay, bisexual and transgender

³³ Service provider not interviewed.

³⁴ Service provider not interviewed.

young people. The service accepts self or agency referral, including through a GP, local family planning clinic or the Ambrose King Centre. Services are either drop-in or appointment based and include:

- Cervical smear tests
- Contraceptive counselling for clients of all ages and emergency contraception.
- Pregnancy counselling and abortion service, including early medical termination.
- Psycho-sexual counselling
- Young people's service provides advice and contraceptive supplies for those aged 16 and under.

In addition to the clinics run from the Sylvia Pankhurst Centre, the Women's and Young People's service also operates from multiple health centres across the borough. The Sylvia Pankhurst Centre reported that they do not see many women who disclose their sex working background. However, they have received information from service providers who work with sex workers who have told them that this group does access their clinics.

Services for sex workers

Central London Action on Street Health (Westminster)

Central London Action on Street Health (CLASH), based in Soho, works with clients who are at risk of HIV and sexual health problems. They work with multiple client groups, one of which is female sex workers. CLASH runs sexual health clinics for female sex workers, providing full sexual health check-ups and treatments, HIV testing, vaccinations and contraception. CLASH also operates a twice weekly condom shop. The women's team go on outreach to flats in the area to provide information and advice and to distribute condoms.

CLASH has contact with migrant sex workers through their outreach work in off-street premises, although not in Tower Hamlets or the City. It must be noted however, that CLASH's services are well known among the migrant sex working population and women working in East London are known to be accessing the services at CLASH in Westminster.

Door of Hope (Tower Hamlets)

Door of Hope is a faith-based organisation providing support to on-street sex workers in Tower Hamlets. Outreach workers go out twice a week, focusing on the areas around Spitalfields and Bethnal Green Road, with the aim of building relationships and providing information about services in the locality. They also

provide condoms and discuss sexual health issues and services with women. Door of Hope runs a drop-in service where women can participate in different activities, receive drugs and alcohol advice, one to one support, and counselling and advice on practical issues. The service is also a point of referral for solicitors and doctors. Staff can accompany a woman to an appointment if she wishes.

Door of Hope has come across a number of migrant sex workers on outreach over the last few years. Contact with these women has been brief and usually one-off. Since 2004 Door of Hope has seen three Eastern European women working on the street. Approximately ten other migrant women from the US, Canada and Australia have been seen since 2004.

Open Doors (City, Hackney, Newham and Tower Hamlets)

Open Doors, based in Hackney, provides outreach and clinic-based services to sex workers in East London. Their outreach work primarily targets flats and saunas and their clinic operates from the Ambrose King Centre at the Royal London Hospital and Newham General Hospital. Their services are open to clients with no recourse to public funds. On outreach, Open Doors distribute condoms and lubricants and discuss general safety issues with women. They provide information about the sexual health services women can access as well as referrals to other services that women may need.

Open Doors see a large number of migrant women on their outreach work. Currently 32 flats are visited on outreach, of which 10 are in the City and three to four are in Tower Hamlets. On average 135 - 155 'contacts' are made a month. 'Contact' refers to the number of times a woman is seen, not necessarily the number of different women seen. The migrant sex workers Open Doors have contact with are usually Eastern European (Polish, Lithuanian, Russian, Romanian, Albanian), as well as Spanish, French, Portuguese, Brazilian and Thai women.

Praed Street Project (West London)

The Praed Street Project provides sexual health services to women working in the sex industry, with a focus on empowering women to make their own choices. The Project provides outreach and run drop-in clinics where they put together holistic care plans for the women, encompassing not only sexual health, but also wider health needs. A three hour drop-in session is run three times a week as well as a daily appointment-based clinic, both from St Mary's Hospital in Paddington. Outreach takes place on one afternoon and one evening per week. The nature of this service is dictated by client need and changes as the client profile changes.

Approximately 90% of the women Praed Street see are migrant sex workers. Their most recent statistics indicate that they see women of 82 different nationalities, although the majority of women are from Brazil and countries in Eastern Europe.

Sexual Health on Call (Haringey)

Sexual Health on Call (SHOC), based in Haringey, provides support services to on-street and off-street sex workers through both outreach work and a drop-in sexual health service. At the drop-in, women can access a medical service with full sexual health screening, Hepatitis B vaccinations, condoms and sexual health advice and referrals. The SHOC team also has a substance misuse worker and provides a needle exchange service.

SHOC has had contact with migrant sex workers through their outreach work in flats, although the women have not reported living or working in the City or Tower Hamlets.

U-Turn Project (City, Tower Hamlets & surrounding boroughs)

U-Turn is a charity based in Tower Hamlets which offers support, information and practical intervention to women engaged in on-street sex work. They provide advice on sexual health, safer drug use, safety, housing and offer guidance on the services of other agencies. U-Turn distributes food and contraception to the women via their outreach work and are also setting up a new women's centre in 2006 which will offer health services for drug users, sexual health check-ups, housing and benefits advice, facilities for personal hygiene and laundry, a kitchen where the women can cook and a clothing bank.

U-Turn has occasional contact with migrant sex workers and estimate that they see three non UK national women per month on outreach in Newham and fewer in Tower Hamlets. The nationalities of non-UK women have included Romanian, Albanian, Nigerian, Brazilian and Kenyan. A representative from U-Turn had previously had contact with a Brazilian woman, trafficked for labour and sexual exploitation, while working at another (now closed) Tower Hamlets agency (see Case 14 in Appendix C).

Other health service providers

East London and the City Mental Health NHS Trust (ELCMHT) (Tower Hamlets and the City)

The ELCMHT provides mental health services across the City of London and the boroughs of Tower Hamlets, Newham and Hackney. The trust runs psychiatric hospitals in all three boroughs and provides services in

each area in the form of community mental health, assertive outreach and early psychosis teams. There is psychiatric representation at the Accident and Emergency (A&E) Departments in the three boroughs. The Trust also runs the two Specialist Addiction Units based in Tower Hamlets and Hackney. Access to most of the Trust's services is through referral from a GP or from self-referring at the A&E Departments. If individuals are considered to be a high risk to themselves or others, they may be sectioned and immediately admitted to the psychiatric hospitals. In other situations, the individual will receive an appointment with a Community Mental Health Team (CMHT) for a first assessment from which the client may be referred onto other agencies in the Trust or remain under the care of the CMHT.

Health E1 (Tower Hamlets)

Health E1 is a GP practice providing Personal Medical Services for people who are homeless, living in hostels or temporary and insecure accommodation. The service is open to clients with no recourse to public funds. Health E1 runs a drop-in service every morning and offers appointments on Monday, Wednesday and Friday for patients who are receiving methadone treatment and for patients who need interpreters or may have other requirements and needs. The practice has two GPs, one drugs nurse, one mental health and drugs nurse, one part-time psychologist and one healthcare assistant.

A significant proportion of Health E1's drug-using female patients are sex workers or have been in the past. Most of these women are White British and chaotic drug users. Health E1 has had contact with one heroin-using migrant sex worker in the last six months.

Medecins du Monde (Tower Hamlets)

Medecins du Monde is an international humanitarian aid organisation. In January 2006, the charity launched 'Project London', a clinic based at Praxis' headquarters. The service is intended for vulnerable individuals in the area, including sex workers. A doctor, nurse and two support workers are present at every session to provide information, advice and practical assistance on how to access mainstream health services. Basic medical healthcare is also provided on-site.

Services for trafficked women

Poppy Project³⁵ (Cross borough/national)

Initiated by the women's charity Eaves Housing for Women in 2001, the Poppy Project provides specialised housing and support to women trafficked into sexual exploitation in the UK. In 2003 Poppy was extended into a Home Office-funded project to provide a supported accommodation service for trafficked women.

35 Service provider not interviewed.

Poppy's services include supported accommodation, language, health and legal services for 25 women who meet the Home Office's eligibility criteria: they must be over 18, have been forced to work as a prostitute in the UK in the last 30 days, and be willing to cooperate with the authorities. These criteria have been widely criticised for automatically excluding from protection and support minors, women who have been exploited in other countries but not yet in the UK or who escaped more than a month ago, and those unwilling to testify. A common concern is that the project prioritises law enforcement and immigration control over victim assistance and protection (see, for example, Taylor, 2005).

The project accepts referrals from a wide range of sources including NGOs, police and immigration services and also accepts self-referrals. However, the project has only been able to accommodate a fraction of referrals to date (Mitchell, 2005; Taylor, 2005). This is due to its small capacity, exacerbated by the fact that, although the official maximum stay is 16 weeks, the majority of women stay for more than six months, often due to asylum claims and lack of move-on accommodation (Taylor, 2005).

Unfortunately, the Poppy Project failed to reply to requests to participate in the current study.

Women's groups and other local groups

Safe Exit Tower Hamlets (Tower Hamlets)

Safe Exit Tower Hamlets is a multi-agency partnership established in 2004 to bring together different service providers, agencies and organisations in the borough. The aim of Safe Exit Tower Hamlets is to ensure that information is shared across the partnership to address the multiple perspectives of the problems surrounding sex work and to reduce the level of sex work in the borough.

The Women and Girls Network (pan London)

The Women and Girls Network (WAGN), established 18 years ago, assists women who are victims of physical and psychological violence. WAGN provide different treatment options in the form of counselling and also have a telephone helpline providing information and advice on legal and medical issues. WAGN provides individual counselling and art therapies are offered to women who have negative views about counselling. Two counsellors currently work on trafficking issues. Most of the women they see who have been trafficked are referred from the Poppy Project. Others are referred from social services and homeless teams. They particularly see women from Eastern Europe, Thailand, Nigeria and Ghana.

Profile of the sex working population in Tower Hamlets & The City

Tower Hamlets

On-street

Tower Hamlets is one of the main areas for street prostitution in London (Dickson, 2004b; Skidmore, 2005), particularly in the E1 postcode area (Spitalfields and Whitechapel) (Brewis, 2003). Estimates of the number of women involved in street sex work vary widely, from 120³⁶ to 250³⁷ or 300 (Skidmore, 2005). Obtaining accurate estimates is difficult due to street work being spread over a 1.5-2 square mile area rather than a defined 'red light' district³⁸, women spending more time in crack houses (Brewis, 2003), often used as brothels³⁹, and Anti Social Behaviour Orders (ASBOs) which are displacing many sex workers, often temporarily, from nearby areas such as Kings Cross, Newham, Paddington and Haringey; there is no corresponding outflow as Tower Hamlets has a policy of not issuing ASBOs to sex workers.⁴⁰ The prevalence of street prostitution in Tower Hamlets has been linked to it being an area of high poverty and deprivation in close proximity to an area of great wealth, the City of London (ibid.).

Most street working women in Tower Hamlets are in their late teens or early twenties, although ages can vary as much as from 13 to 67 (ibid.). The sex market in the borough is characterised by high rates of drug use, in particular crack cocaine and heroin, and 'survival sex' (i.e. women just managing to fund their drug habits and/or meet their basic needs rather than making a profit) (ibid.). While the majority of women say that they do not work for a pimp, many are working to supply their partner's drug habits as well as their own (ibid.).⁴¹ The majority of street sex workers in the area are homeless or in a temporary or vulnerable housing situation, for example staying in squats or crack houses or 'sofa surfing' (Brewis, 2003; Safe Exit Tower Hamlets, 2006).⁴² Most are White or Black British⁴³, from the East End⁴⁴ or other areas of London and the UK, such as Scotland and Yorkshire, with a large amount of movement of women in general, with different women seen on weekdays and weekends.⁴⁵ A small but

apparently increasing number of street workers are migrant and black and ethnic minority (BME) women, as will be seen below.

Off-street

Much less is known about the off-street sex market in Tower Hamlets. There are no official figures on the number of premises being used for commercial sex. Local police have limited knowledge of the off-street market as they rarely deal with it, but believe premises to include flats, massage parlours, saunas and crack houses.⁴⁶ Occasional operations are carried out by CO14, but data from these was not publicly available.⁴⁷

Dickson (2004b) shows Tower Hamlets to have a low number of brothels: 11 sites (compared to an average of 18-19 per London borough not including Westminster), with some 50-100 women working in them (Dickson, 2004b). The only organisation providing sexual health outreach work to off-street premises in the area, Open Doors, visits only three or four flats in Tower Hamlets (as opposed to 10 in the City) (Lilley, 2005a), and is unable to provide an estimate of how many women it sees in total.⁴⁸ The Ambrose King centre reports that 67 women came to its walk-in clinic and 66 women to the Open Doors clinic in the second half of 2005 although it notes that many of these women came to both services and usually more than once.⁴⁹

A telephone survey of off-street premises in East London conducted for the current study indicates a higher number of premises in Tower Hamlets than the sources cited above. The survey identified 71 premises as operational overall (with a total of 114 women working in them), 21 of them located in Tower Hamlets (30 women). Eleven lap dancing, strip or 'gentlemen's' clubs were also identified in Tower Hamlets in the course of the research. Although these clubs generally maintain that entertainers are not involved in selling sex⁵⁰, Open Doors says that it sees women who work in dance clubs and supplement their income by working in flats.

36 U-Turn

37 Brick Lane police

38 ibid.

39 ibid.

40 Brick Lane police; Safe Exit Tower Hamlets (SETH)

41 Door of Hope

42 ibid.

43 Providence Row; Door of Hope

44 Providence Row

45 Door of Hope

46 Brick Lane police; Tower Hamlets Sapphire Unit

47 CO14; Brick Lane police

48 Open Doors

49 Ambrose King centre, pers. comm. (28 March 2006)

50 Interviews with the managers of a lap dance club in the City and a strip bar in Tower Hamlets

The majority of women who work in off-street premises in Tower Hamlets appear to be migrant; nationalities/ethnicities are detailed below.

Demand

According to local police (City of London Crime & Disorder Reduction Partnership -City CDRP, 2005) and Door of Hope, many of the men who frequent prostitutes in Tower Hamlets work in the City, an assumption which would appear to be supported by the fact that one of the busiest times is said to be 5-6am on weekdays (City CDRP, 2005).

However, police data on 69 men arrested for kerb crawling in the period August 2004-January 2005 revealed a more diverse profile. The men had a wide variety of occupations, from unemployed and manual labourers to white collar professionals. 59% had London postcodes and 29% were from Tower Hamlets. The vast majority (81%) were aged 21-40. More than half were Asian (55%), with black and white men more or less similarly represented (20% and 18% respectively) (Skidmore, 2005).

The City

On-street

The number of on-street sex workers in the City is not known, although it is thought to be considerably lower than in Tower Hamlets (Lilley, 2005a; City CDRP, 2005). City police report that on-street prostitution in the borough is rare⁵¹, one interviewee attributing this to the traditionally non-residential nature of the area and the fact that the police in the City are better resourced than in the Metropolitan area.⁵²

Both police and service providers believe that where on-street sex work does occur it tends to involve isolated incidences, mainly on the boundaries with Tower Hamlets, around Middlesex Street, Commercial Street and Commercial Road (City CDRP, 2005; Lilley 2005a).⁵³ However, Lilley (2005a) suggests that street workers have also been sighted at a number of locations well within City boundaries. There are signs that on-street sex work is growing (City CDRP, 2005), thought to be largely due to an 'overflow' of street sex workers from Tower Hamlets and neighbouring boroughs which issue ASBOs (Lilley, 2005a; City CDRP, 2005). It is therefore likely that the profile of street sex workers in the City in terms of ethnicity, substance use and housing status closely resembles that outlined for Tower Hamlets above. The limited information

available would also appear to support this (Lilley, 2005a; Lilley, 2005b).

Off-street

The City's sex trade appears to be mainly off-street.⁵⁴ More information is available from existing literature and service providers on this sector than for Tower Hamlets. Dickson (2004b) mapped 10 sites selling sex in City, with around 20-50 sex workers. Open Doors currently visits 12 premises in the City: two saunas with two-four women in them and 10 flats with one-two women (i.e. 14-28 women) (Lilley, 2005). However, the organisation estimates that there are a further 10-20 flats operating in the City area around Smithfield, Holborn, Clerkenwell and Farringdon (ibid.). Similarly, Bishopsgate police are aware of around 30 off-street premises, all unmarked flats, with one or two women working in them, suggesting at least 30-60 women are working in the brothels on any given day. Women tend to work in different flats on a rotating basis. Police intelligence suggests that some premises in the City belong to small 'chains' of brothels with sister establishments owned by the same individual located elsewhere in the City or other parts of London, and some women working in different premises of the 'chain' on alternate days.⁵⁵ (Numbers of sex workers attending the Ambrose King centre are detailed above in the section on Tower Hamlets).

In contrast to Tower Hamlets, the telephone survey conducted as part of this study found the City to have fewer off-street sites than indicated by other available sources. Only eight establishments were identified as lying within the boundaries of the City (eight women). It can be speculated that this disparity may be due to differences in the visibility and marketing/advertising strategies of brothels in the two boroughs. Research for the study also found that there are at least five lap dance/ strip/ 'hostess' clubs located in the City. As noted above, some women who work in these establishments may also work in prostitution.⁵⁶

Local police believe that the off-street market in the City is growing. Several possible reasons for this were suggested: saturation of the sex market in the West End of London and discovery of the potential of an 'untapped market' in the City; and changes in the City, which have seen the borough become both more residential (with more places to open brothels and more potential clients), and more of a nightlife spot, with businesses increasingly opening at the weekend as well as during the week and visitors drawn from other parts of London and the UK.⁵⁷

51 Bishopsgate police; Snow Hill police

52 Bishopsgate police

53 ibid.

54 ibid.

55 ibid.

56 Open Doors

57 Bishopsgate police

As in Tower Hamlets, the vast majority of women working in the off-street sex industry in the City are migrant; this is discussed below. However, Open Doors suggests that the City market, in comparison to Tower Hamlets and other East London boroughs, represents the upper end of the spectrum, attracting City workers as their clientele. According to Open Doors, full sex in City flats can cost £70 compared to £30 in Tower Hamlets and Stratford; this price difference seemed to be borne out by the data obtained from the telephone survey. Open Doors reports that the women working in the City premises are more autonomous, see more clients and can therefore afford to be more selective. As the flats are more 'high profile', customers are more likely to complain if women are abused.

Demand

Most City sex workers' clients are assumed to be businessmen from the City (Lilley, 2005a; City CDRP, 2005⁵⁸), which may be borne out by the fact that City brothels are said to mainly operate Monday to Friday only (City CDRP, 2005). Given the off-street nature of the City sex trade, no police data on clients was available as it was for Tower Hamlets. A local lap dance bar also reported that its clientele mostly comprised City workers, bankers and financiers based around Liverpool Street, the average age group being late 20s.⁵⁹

Presence of migrant sex workers and women trafficked into sexual exploitation in Tower Hamlets, the City and surrounding boroughs

On-street

While the majority of women working on-street in Tower Hamlets are British, the current study indicates that migrant women and girls are now being seen working on-street in Tower Hamlets and surrounding areas (particularly Newham and King's Cross), in much smaller but increasing numbers. Contra Lilley (Lilley, 2005a), the study did not find any indication of migrant women working on-street in City.

Migrant women in Tower Hamlets are seen sporadically, service providers reporting a frequency of between one per month⁶⁰ and one per year.⁶¹ There is some suggestion that migrant women are seen more often in surrounding boroughs, particularly Newham, than in Tower Hamlets.⁶²

Service providers report recent contact in Tower Hamlets with migrant women from the following countries: USA, Canada, Australia⁶³, Spain, France, Ireland⁶⁴, Nigeria, Kenya⁶⁵; and in King's Cross: Ireland, Belgium, Portugal and Germany⁶⁶. Drug and alcohol use and homelessness were only mentioned in connection with a minority, and the former largely concerned the Irish women. Two women (Spanish and French) were mentioned as having mental health issues. Pimps or control were not mentioned in connection with this group. Different organisations all mentioned different nationalities, suggesting no particular trend.

The main group cited by street outreach organisations, however, was Eastern European women and girls. Nationalities mentioned in connection with Tower Hamlets include Lithuanian (uncertain), Czech, Polish, Slovakian, Romanian and Albanian; in Newham: Russian and Eastern European (unspecified). Most of these women were said to be in their twenties, with the exception of two 18-19 year olds in Newham⁶⁷ and one interviewee who was 47.⁶⁸

Some of the street working Eastern European women were addicted to drugs and/or alcohol, and display similar behaviour and health problems as their British counterparts⁶⁹ (see section on substance use below), while others - apparently the majority - did not present as substance users, and indeed often stood out as fit and healthy in comparison to their British counterparts.⁷⁰

A number of these Eastern European women were known to be homeless, some drug using⁷¹ and others non drug using.⁷² Their situation must be seen in the context of the growing numbers of Eastern Europeans, particularly Poles and Lithuanians, homeless or rough

58 Open Doors

59 Interview with the owner of a City lap dance bar

60 Whitechapel Mission; Angel Drug Services

61 Door of Hope women @ the well

62 U-Turn; a local service provider

63 Door of Hope

64 women @ the well

65 U-Turn

66 New Horizon

67 A local service provider

68 Case study: Amely

69 Door of Hope; Providence Row; a local service provider; Amely

70 Whitechapel Mission; women @ the well; Angel Drug Services

71 Door of Hope; Amely

72 Whitechapel Mission

sleeping and without recourse to public funds reported to be coming to the notice of service providers in the last few years.⁷³ Some have substance use or mental health issues or learning difficulties.⁷⁴ Although women are in the minority in these groups, their numbers are on the increase, and their vulnerable position may lead them to consider ‘clipping’⁷⁵ or sex work as a less risky option than petty crime such as shoplifting.⁷⁶

Although these Eastern European women are often from countries which are known trafficking source countries, it is not known whether they have been trafficked. To date trafficking into on-street prostitution is not a pattern that has been identified in the UK, although it does occur in Europe, notably in Italy (Aghatise, 2004).⁷⁷ One service provider thought that the Eastern European women seen on the street in East London are unlikely to be trafficked since street sex work would offer too many opportunities for escape.⁷⁸ However, there were suggestions that a number of the women may have been controlled by pimps and/or that they displayed high levels of fear.⁷⁹

Some service providers suspected that for the non drug using Eastern European women sex work is primarily economically motivated, rather than a ‘lifestyle’ as it has become for many drug using British street workers.⁸⁰ Several organisations commented that Eastern European women only tend to be seen on the street a few times, in contrast to British women⁸¹, and some speculated that street work is a temporary stage before they move on to other work, either ‘regular’ employment or indoors sex work (where foreign nationals predominate).⁸² One service provider also suspected that some of the women already worked indoors and were on the streets to attract men to the premises.⁸³

Off-street

Despite the above evidence of migrant women working on-street, they are present in far greater numbers off-street. Sexual health organisations report a noticeable shift since the late 1990s/early 2000s in the ethnicity of

the women working in flats, saunas and massage parlours, from predominantly British born to predominantly foreign born (Lilley, 2005a)⁸⁴. This trend has been shown to be true of London as a whole (Dickson 2004b).

Most of this section discusses migrant women working off-street in the two boroughs together rather than separately for a number of reasons. The main sexual health service providers in the area see women from both (and other) boroughs without necessarily knowing where they work or live.⁸⁵ It is widely acknowledged that women commonly work in different areas of London and beyond on different days of the week⁸⁶, to meet demand for ‘new faces’, and in some cases to create the impression that the women only work part-time or occasionally.⁸⁷ Thus women working in East London will access health services in other areas of London, and vice versa.

Note on nationalities/ethnicities: It should be borne in mind that it is common practice for both women and the establishments where they work to lie about nationalities/ethnicities, for a number of reasons. In some cases this is to mask illegal immigration status, for example Albanians claiming to be Italian (Dickson, 2004b)⁸⁸ and, by the same token, it seems likely that a Latin American nationality might be changed to Spanish or Portuguese. In others it seems to be in order to avoid the ‘stigma’ of trafficking victim or ‘sex slave’ attached to certain nationalities: for example, maids in two separate flats in Tower Hamlets emphasised that they did not have any Eastern Europeans or ‘Albanians’.⁸⁹ Sometimes nationalities seem to be altered simply to make the women sound more enticingly exotic.

Prevalence and nationalities/ethnicities of migrant sex workers (off-street)

There are no official estimates on the number of migrant sex workers in Tower Hamlets and the City. However, police in the two boroughs state that they do not dispute the figures presented in Dickson (2004b) that suggest that up to 81% of sex workers in off-street

73 Providence Row; Whitechapel Mission; Angel Drug Services

74 Providence Row

75 A term used to refer to someone who accepts money for a sexual service which he or she does not intend to provide

76 Angel Drug Services

77 Safe Exit Tower Hamlets

78 U-Turn

79 women @ the well; Providence Row; U-Turn; New Horizon

80 Whitechapel Mission; Providence Row

81 U-Turn; women @ the well; Door of Hope; Angel Drug Services

82 Providence Row; U-Turn

83 women @ the well

84 Open Doors; Ambrose King clinic; Praed Street

85 Open Doors; Ambrose King

86 Praed Street; CO14. Nicole estimated that she had worked in approximately 20 different flats across London in the two years that she has been a sex worker.

87 CO14

88 SHOC

89 Interviews with two maids

commercial sex premises in London are non UK nationals.⁹⁰ Dickson (2004b) recorded 21 women of 14 different ethnicities in Tower Hamlets, and four women of four different ethnicities in the City.

Telephone survey

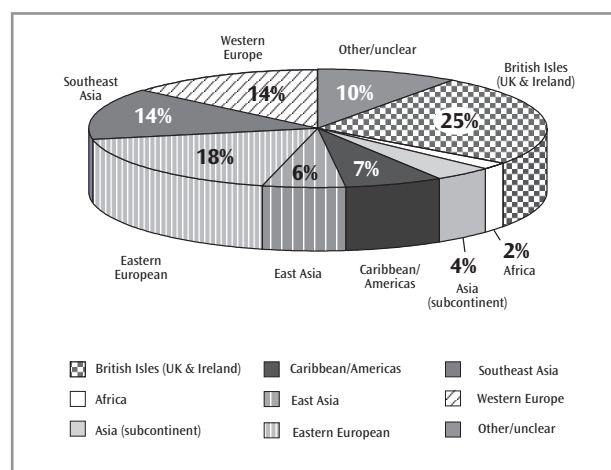
The telephone survey carried out for the current study indicates a slightly lower proportion of foreign nationals than did Dickson (2004b), but a greater number of ethnicities/nationalities. Of the 114 women working in 71 premises found to be operational in Tower Hamlets, the City and surrounding boroughs⁹¹, only 29 women (25.44%) could be positively identified as nationals of the British Isles (the UK and Ireland). Six ethnicities/nationalities referring to the British Isles were identified (Black British, Black English, British, English, Irish and UK).

85 women (74.56%) were identified as being other ethnicities/nationalities. 40 other (non British Isles) ethnicities/nationalities were identified, as follows:

- Africa (continent): Egyptian; Moroccan
- Asia (subcontinent): Indian; half Indian/half Bengali
- Caribbean/ Americas: Black French Caribbean; Brazilian; French Caribbean; half Caribbean/ half USA black; South American; Venezuelan
- East Asia: Chinese; Hong Kong; Japanese
- Eastern Europe: Czech; Eastern European; Estonian; Lithuanian; Polish; Russian; Slovakian
- Southeast Asia: Burmese; Malaysian; Philippines; Singaporean; Thai
- Western Europe: German; Italian; Norwegian; Portuguese; Spanish; Swedish
- Other/unclear: Asian; Black; European; half Asian/half Caribbean; half Greek/half English; half Indian; half Russian/half Italian; half Spanish/half English; Oriental

Chart 1

Telephone survey: nationalities/ethnicities identified in the City, Tower Hamlets and surrounding boroughs

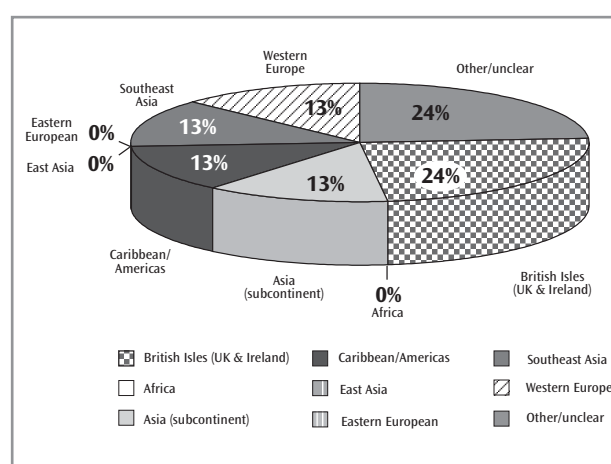


Overall, the most common regions were: British Isles (25%), Eastern Europe (18%), Western Europe (14%), Southeast Asia (14%), Other (10%), Caribbean/ Americas (7%), East Asia (6%) and Asia (subcontinent) (4%) (see Chart 1).

The City was found to have eight off-street premises with eight women. Two women were from the British Isles. The other six women were identified as the following ethnicities/nationalities: Black; French Caribbean; German; half Greek/half English; Indian; Singaporean.

Chart 2

Telephone survey: nationalities/ethnicities identified in the City by region



⁹⁰ Bishopsgate police

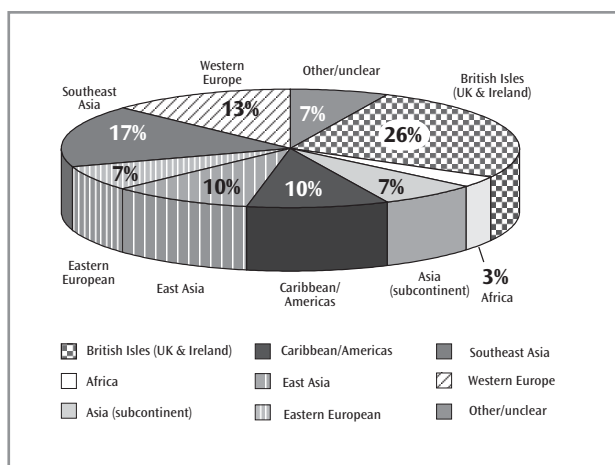
⁹¹ 'Surrounding boroughs' included Barking & Dagenham, Camden, Hackney, Lambeth, Newham, Redbridge, Waltham Forest and Westminster. Some numbers proved to be outcall, while the location of some other premises was unknown. As the focus of the telephone survey was Tower Hamlets and the City, mapping of sites in surrounding boroughs was incidental and therefore can only present an incomplete/partial picture of those areas.

Compared to the overall survey (Chart 1), the City shows a similar percentage of women from Western Europe (13%), The British Isles (24%) and Southeast Asia (13%), but many more from the Caribbean/Americas (13%). There were no women identified from Eastern Europe (Chart 2).

Tower Hamlets was found to have 21 off-street premises with 30 women. Eight women were from the British Isles. The other 22 women were identified as the following ethnicities/nationalities: Brazilian; Burmese; Chinese; Czech; Egyptian; half Indian/half Bengali; Hong Kong; Indian; Italian; Japanese; Oriental; Polish; South American; Singaporean; Spanish; Thai.

Chart 3

Telephone survey: nationalities/ethnicities identified in Tower Hamlets by region



Compared to the City (Chart 2) and the survey overall (Chart 1), Tower Hamlets showed a considerably larger percentage of women from Southeast Asia (17%) and a larger percentage of women from East Asia (10%). Unlike the City, a small percentage of Eastern Europeans were registered in Tower Hamlets (7%) although considerably lower than in surrounding boroughs (see Chart 4, below).

Chart 4

Telephone survey: nationalities/ethnicities by area

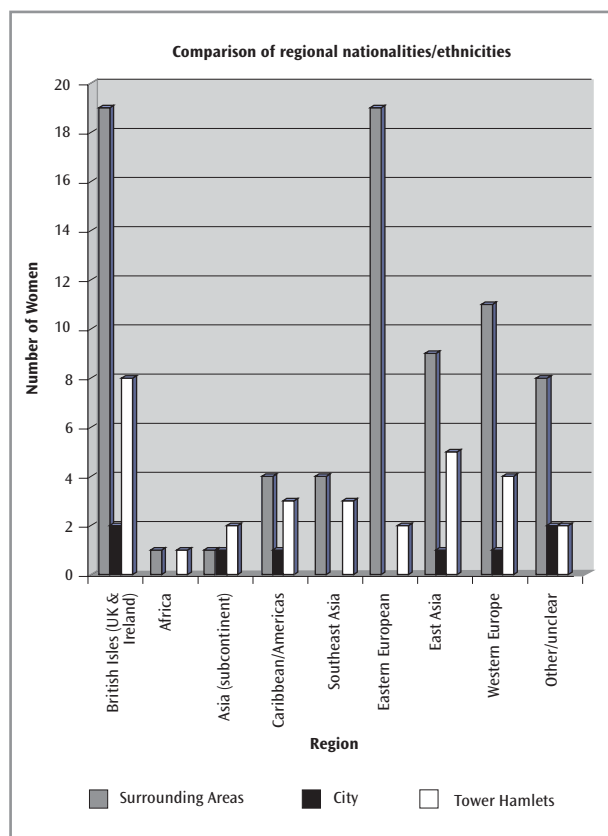


Chart 4 shows a comparison of the nationalities/ethnicities of women identified in the City, Tower Hamlets and surrounding boroughs. One-quarter of the women working in surrounding boroughs were identified as Eastern European, whilst 26% were from the British Isles and 14% were from Western Europe.

PunterNet

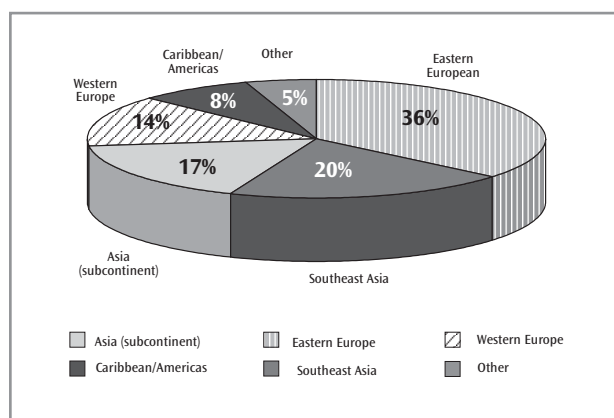
Similarly, PunterNet 'field reports' for Tower Hamlets, the City and surrounding boroughs since 1999, describe the vast majority of women as being other than British/English, where ethnicity or nationality is mentioned. Of a sample of 76 of these non UK women, 34 separate ethnicities were identified.

The most common regions were:

- Eastern Europe: 27 women (35.53%)
- South East Asia: 15 women (19.74%)
- Asia subcontinent: 13 women (17.11%)
- Western Europe: 11 women (14.47%)
- The Americas: 6 women (7.89%)
- Other: 4 women (5.26%).

(See Chart 5 below).

Chart 5
PunterNet: nationalities/ethnicities identified in East London by region



Interviews with service providers

Interviews with service providers with direct contact with migrant sex workers in the area⁹² mentioned regularly seeing clients of 20 different nationalities/ethnicities, as follows:

- **Western Europe:** English, French, Finnish, Italian, Portuguese, Spanish, Swedish, UK
- **Eastern Europe:** Albanian, ‘Eastern European’, Lithuanian, Polish, Romanian, Russian;
- **The Americas:** Argentinean, ‘American’, Brazilian, South American;
- **Southeast Asia:** Singapore, Thai

However, the regions most commonly mentioned by local sexual health organisations were Eastern Europe, Brazil and Thailand.⁹³ This pattern was mirrored in the Praed Street clinic in Paddington, despite it seeing a higher proportion of migrant women from a wider variety of nationalities (90% migrant women of 82 different nationalities).⁹⁴ Interviews with police⁹⁵, maids, lap dance and strip bar managers⁹⁶ and sex working women also confirmed the prevalence of women from these three regions in Tower Hamlets and the City.

The prevalence of Eastern European and South East Asian women in the sex industry has been identified as a London trend (Dickson 2004b). The same pattern appears in statistics from the joint CO14 and Immigration Services Operation Kon Tiki, which show that the majority of foreign sex workers arrested between January 2003 to September 2005 were from these regions (although with an increasing focus on South East Asian women across the period).⁹⁷ Of 44 women referred to the IOM from June 2004 to March 2006, 37 were from Eastern European countries (Albania, Bulgaria, Czech Republic, Lithuania, Moldova, Poland, Romania, Russia and Slovakia) and two from Thailand.⁹⁸

Immigration status

The immigration status of the migrant sex workers in Tower Hamlets and the City is generally unclear. One interviewee from Open Doors stated that most of the women they see in the flats in Tower Hamlets and the City are illegal immigrants. However, according to another interviewee from the same organisation, flats in the City are more visible and so unlikely to take risks with those they employ: they will tend to ensure the women are in the country legally (although they may not have a legal right to work). According to CLASH, in central London there has been an influx of migrants from the EU Accession states in Eastern Europe, meaning that most of the women they deal with now are in the country legally. However, CLASH suggested that a lower police presence outside central London may attract more sex workers with illegal immigration status to these areas.

Ages

According to Open Doors, the ages of the migrant women range from 18-30, but most are in their early twenties. Similarly, interviews with migrant sex workers, other service providers, maids and club owners, the telephone survey and a review of PunterNet’s ‘field reports’ for the area showed that most women are in their early to mid twenties, the youngest described as 18 or late teens and the oldest generally late forties, with one woman described as in her fifties.⁹⁹ (See note on minors, below).

92 E.g. Open Doors; the Ambrose King clinic; Providence Row.

93 Open Doors; Ambrose King clinic

94 Praed Street

95 Bishopsgate; CO14

96 One lap dance club in the City and one strip bar in Tower Hamlets

97 Source: Operation Kon Tiki

98 Source: IOM

99 Providence Row

Living arrangements

According to Open Doors and the Ambrose King clinic, the migrant women that they see usually live elsewhere than their workplace. Women working in Tower Hamlets and the City tend to live with other working women or a partner and away from the area in which they work, often further east towards Stratford, Newham, and on the borders of Essex.¹⁰⁰ One interviewee suggested this distancing may be to reduce the possibility of being recognised by clients.¹⁰¹

Presence of women trafficked into sexual exploitation in Tower Hamlets and the City

The current study revealed only a few confirmed cases of women who had been trafficked into sexual exploitation in the UK with links to the two boroughs and the immediate area. However, the study also found several unconfirmed/possible cases of trafficked women and a number of confirmed cases of girls and young women trafficked or coerced into sexual exploitation (see separate subsections below). It should be borne in mind that these are only the cases identified by service providers to date. This, added to the fact that the majority of confirmed cases of trafficked women are from the main regions of origin for migrant sex workers detailed above, and supporting evidence from other sources, suggest that the problem of sex trafficking in the local area is likely to be larger than the number of confirmed cases imply.

Confirmed cases of sex trafficking

Below is a summary of the confirmed cases of women trafficked into sexual exploitation; more specific details relating to substance use, health and security are covered in the relevant chapters below. (See Appendix C for full case studies).

Two women trafficked into sexual exploitation in London, with mental health issues as a result of their trafficking experience (referred to an NHS agency) (**Cases 4 and 5**)

A Thai woman trafficked into sexual exploitation, who is HIV positive and pregnant (referred to an ante-natal care clinic) (**Case 6**)

A woman from Asia (subcontinent) trafficked into sexual exploitation in the UK, whose child has been sexually abused and taken into care (referred to a local service provider) (**Case 9**)

A Southeast Asian woman trafficked into sexual exploitation (referred to Hackney Asian Women's Aid) (**Case 11**)

A Brazilian woman sold into domestic labour in the UK, where she was sexually exploited both as part of her original work and, following her escape, via prostitution (referred to the now closed Maze Marigold Project in Tower Hamlets) (**Case 14**)

A 22 year old Eastern European (non-EU) woman who was trafficked to the UK, escaped and went back home and then returned to the UK voluntarily to work in saunas and flats (**Case 1 - amalgam**)¹⁰²

A 25 year old Thai woman who was initially trafficked to the UK but has now paid off her 'contract' and is working voluntarily to send money to her family back home (**Case 2 - amalgam**).¹⁰³

Unconfirmed/possible cases of sex trafficking

Sexual health service providers

Interestingly, only one of the above cases came from a service for sex workers and none at all from sexual health service providers, despite the fact that such organisations have in all probability the most direct and frequent contact with migrant sex workers. There may be a number of reasons for this lack of reported cases, including these organisations' primary focus on sexual health; respect for patient confidentiality; the time needed to build up the necessary trust to divulge sensitive information; and a lack of time to devote to the latter, due in part to limited resources. Another important reason, however, is likely to be the reluctance of the sexual health organisations interviewed to employ the term 'trafficked' at all. As seen above, the preferred terms tend to be 'facilitated' or 'bonded'.¹⁰⁴

Nonetheless, Open Doors did note that certain groups do readily identify themselves as 'trafficked', for example Thai women. Open Doors estimated that at least a third of their 'contacts' are Thai, and that 95% of the Thai women were trafficked. These Thai women pay

¹⁰⁰ Open Doors; Ambrose King clinic

¹⁰¹ Ambrose King clinic

¹⁰² Source: Psychology services at the Ambrose King centre. This is an amalgamated case where all individual identifying characteristics have been changed.

¹⁰³ *ibid.*

¹⁰⁴ See Definitions section

between £24,000- £30,000 to be trafficked to Britain and are usually aware that they will be working in the sex industry.¹⁰⁵ Praed Street also said that the majority of Thai women have some kind of debt bondage but may have entered into this debt willingly and see it as a contractual debt to be paid off.

According to Open Doors, it is much harder to identify Eastern European women as trafficked. Both Open Doors and one interviewee from the Ambrose King clinic believe that most of the Eastern Europeans they see come to the UK voluntarily. However many, even those from accession countries, still pay a 'trafficker' to transport them to Britain and are consequently sex working to pay off their debt.¹⁰⁶ Sometimes Eastern European girls will come out of a 'trafficking' or 'debt' situation and decide to stay and continue working in the sex industry.¹⁰⁷

Open Doors said that it had not come into contact with a woman who had been 'completely duped' about working in the sex industry in the UK. The majority of women they see knew that they were coming to work in the sex industry, although sometimes women are told that they will be working as lap/pole dancers in clubs, rather than in flats.¹⁰⁸ It should, however, be noted that such a situation falls within the internationally recognised definition of trafficking (see Definitions).

An interviewee from Open Doors also mentioned that some of the women the organisation sees have to work seven days per week, often for 12-18 hours a day, and see up to 30-40 clients per shift. Given that the highest number of clients per shift mentioned by other service providers or sources was 10 (see section on health below), this information, if correct, would also seem to suggest that Open Doors is seeing women who are in a trafficking situation but who do not necessarily identify themselves as such.

Similarly, Praed Street says that the majority of the women they see know that they are coming to work in the sex trade, but may not be aware of the full picture. However, every month or two months they see a woman who 'worries' them or who causes them severe concern for her well-being. For example:

A Polish woman working in London as a nanny accepted her boyfriend's offer of a job in his bar to

earn more money to pay for her father's operation back home. She ended up doing sex work locked in a flat, and he now accompanies her to the clinic, monitors her phone calls and her mobile number is regularly changed.¹⁰⁹

Police

None of the law agencies approached were aware of any sex trafficking prosecutions having arisen from the City, Tower Hamlets or East London as a whole.¹¹⁰ However it should be pointed out that policing in Tower Hamlets, like most forces in the UK (Kelly & Regan, 2000; Matthews, 2005, etc.), is not currently geared up to monitor off-street prostitution. Brick Lane police said that if a trafficking case arose, it would refer it to CO14 due to a lack of resources and know-how. As for City police, Snow Hill division admits off-street prostitution is not 'on the radar'. The other division, Bishopsgate, appears to be now actively gathering intelligence on off-street prostitution and conducting raids on brothels. City police are independent from the Metropolitan force, and are not obliged to seek advice or assistance from the latter's specialist units dealing with trafficking.¹¹¹

However, Tower Hamlets Sapphire unit had a relevant case referred to them in late 2005:

An Eastern European woman discovered in a brothel raid by CO14 who alleged she had been trafficked and raped in a sauna in Bethnal Green. However, she failed to substantiate the claim or to turn up for appointments with Sapphire in order to follow up on the case (**Case 10**).

PunterNet

In a number of Punternet.com 'field reports' on East London, men comment on their perception of the women's attitude to sex work, and a few comment on their perceived lack of freedom or reluctance/unhappiness. For example:

'A choice of about 10 or so girls ranging from a couple of slave blondes through to afro caribbean [*sic*]'¹¹²

'It felt like entering a prison, steel barred gate at top of stairs and then a bare room with a bed and maybe

105 Open Doors

106 Open Doors

107 Ambrose King clinic

108 Open Doors

109 Praed Street

110 Brick Lane police; Tower Hamlets Sapphire; Bishopsgate police; CO14; Maxim; personal communication with Crown Prosecution Services (23 and 26 February 2006)

111 Bishopsgate police

112 Punternet.com field report no. 57892 (29 September 2005)

a small table.” “A Philipina [*sic*] girl, vere [*sic*] unhapy [*sic*] and sullen-looking¹¹³

‘Czech. Very little English. [...] her look and general “feel” of reluctance gave me the distinct feeling that she was not there by choice [...] this was the only time I have ever felt anything like this’¹¹⁴

‘Black French Caribbean [...] defiantly [*sic*] got the picture that she did not want to be there [...] the Man looked like he was Albanian or something and I had serious words with him on the way out’¹¹⁵

BME women in sex work in Tower Hamlets and the City

A separate section is included here on women from BME communities, given the frequent difficulty of determining whether they are first, second or third generation immigrants (see the section on definitions above). There is uncertainty in the literature and among local service providers regarding the extent to which women from BME communities are involved in sex work in the area. Skidmore suggests that the fact that ethnic minority groups, such as the Bangladeshi community, are not visible in sex work in Tower Hamlets is likely to indicate that they are involved in different systems of sex work not identified by agencies, rather than their absence from sex work (Skidmore, 2005), a view also shared by Safe Exit Tower Hamlets. The current study suggests that this is indeed the case.

Women from the Asian (subcontinent) community

The interviewee from Addaction Tower Hamlets Community Drug Team, which currently has some Bangladeshi women among its sex-working clients, believed that the presence of Bangladeshi women in sex work in the borough is fairly well established. Little is known about the phenomenon, he thought, because the women are very shielded by their pimps and the sex industry moves on very quickly.

However, various other service providers confirmed past contact with Asian women involved in sex work in the area, both on and off-street. Addaction Gateway Day Programme and Health E1 both reported previous limited contact with Asian sex workers, all heroin and/or crack users. An interviewee from the Ambrose King clinic said she had seen two Bangladeshi women who reported sex

working indoors, and a few Bangladeshi women who were working on the streets. U-Turn reported a one-off sighting of an Asian woman in traditional dress on a street corner in Whitechapel, who said she was trying to sell sex to get her jewellery out of pawn.

In addition, Open Doors had heard of flats, to which they have no access, providing sex specifically to the Bangladeshi community. One Asian interviewee from another organisation was aware of a number of ‘members’ clubs’ in Newham frequented mainly by Asian men where striptease and lap dancing and presumably prostitution take place. The women at one such club - which also has rooms - are either Asian or, in recent years, Eastern European.

Women from the Somalian community

A number of service providers commented on the difficulty of accessing the sizeable Somalian community in Tower Hamlets. As part of the study, a large number of organisations catering to the Somalian community across London were contacted. Most reported that they had no knowledge of sex work within the community; only one specialist BME sexual health organisation, the Naz Project, confirmed its existence.

The Naz Project is aware of 25 Somalian women involved in sex work, 16 in Tower Hamlets and 9 in Newham. Most are in their 20s, the youngest being 19, the oldest 42, and are a mixture of first and second generation Somalians. Most of the women are single, although some have been married and are separated.

This sex work is very hidden, because of the stigma attached to sex outside marriage in the Somalian community. The women all work off-street, the set-up varying from an informal exchange of sex for company or khat, to women working together in a house, sometimes belonging to one of the older women, where the transactions are purely financial. In the latter scenario, the women charge around £30 for sex and split the money with the owner of the house. In both scenarios the sex work tends to be tied up with khat, which is used by all 25 women.

According to the interviewee, unemployment is very high among the Somalian community, partly because of a lack of English language skills, and for many the sole source of income is state benefits. In his view, sex work among young Somalian women is on the increase.¹¹⁶

113 Punternet.com field report no. 53645 (7 June 2005)

114 Punternet.com field report no. 29201 (23 March 2003)

115 Punternet.com field report no. 8695 (12 May 2001)

116 Naz Project

Presence of minors in the sex industry in London

Although Open Doors and the Ambrose King clinic do not report seeing girls and young women under the age of 18, other service providers confirmed that minors are being sexually exploited through prostitution in East London (see cases below).

Underage sex tends to take place in closed places.¹¹⁷ According to one interviewee from CO14, children are not generally found in saunas and massage parlours, but rather are picked up from children's homes and befriended by someone who slowly reels them into the sex industry¹¹⁸ (an example of this is Case 8, below).

However, sexual health service providers in other areas of London do report seeing minors in the sex industry¹¹⁹, although their real ages can take time to establish. Police statistics concur. Statistics from Operation Kon Tiki show that 17 juveniles (defined as children under 18) have been found in brothel raids from January 2003 to September 2005, albeit in dramatically falling numbers (10 in 2003; five in 2004; two in the first nine months of 2005). The minors were all Eastern European, bar one Chinese girl.¹²⁰ Similarly, the ages of women found during overt visits by CO14 to 46 flats in a specific area of Soho on 27 October 2005 ranged from 16-30.¹²¹

Girls of other cultures vulnerable to sexual exploitation, including through prostitution

A recent briefing for Barnardos (Kartalozzi, 2006) suggests factors that may make young women from other cultures particularly vulnerable to sexual exploitation. These include the conflicting cultural values of refugee (and by extension migrant) parents and their children being brought up in the UK, trafficking, and the vulnerability of unaccompanied asylum seeking minors. The report states that 'any breakdown of social structure leads to children receiving less protection and being more susceptible to ending up in the sex industry' (ibid.). The cases of girls and young women in sex work in Tower Hamlets and surrounding boroughs, identified in the course of the research, appear to fall into these same categories.

Girls and young women with parents of different cultures

While most NSPCC Sexual Exploitation Service (SES) clients are not being sexually exploited through prostitution, a small minority have been exploited in this way (approximately two out of 100). One recent case stands out:

A 15-year-old British born mixed race girl has been involved in exchanging sex for crack cocaine and other drugs in crack houses, flats and cars in Tower Hamlets and other boroughs. Police are treating the case as part of a paedophile ring targeting children's homes and vulnerable young people in London¹²² (Case 8).

It is interesting to note that the majority of NSPCC SES clients who are part of the 'Street Matters' group are the British born children of migrants, have parents of different nationalities, or are themselves foreign born. The interviewee suggested that this could be seen as a reflection of Tower Hamlet's ethnic diversity, but speculated that the children of migrants find assimilating difficult and associated problems such as confusion about their identity could make them more vulnerable to sexual exploitation.¹²³

The Whitechapel Mission reported seeing about six Bangladeshi girls (probably second generation) who are involved in sex work and had been using the centre over an 18-month period (2004-2006). These girls, mainly teenagers of 16 or 17 but some apparently as young as 14 or 15, are homeless and appear to live in cars with their pimps, who keep a very strong control over the girls, including their access to the centre. Both the girls and their pimps are drug users. The interviewee also commented that these girls seem to be confused about their identity, not seeing themselves as either English or Bangladeshi.¹²⁴

Kartalozzi (2006) notes that in many refugee or migrant communities, boyfriends and sex outside marriage are taboo. Parents feel torn between two cultures and find it difficult to establish a balance between their traditional culture, which they may recognise as overly

117 CLASH

118 CO14

119 Praed Street; CLASH; SHOC

120 Source: Operation Kon Tiki

121 Source: CO14

122 NSPCC Sexual Exploitation Service (SES)

123 NSPCC SES

124 Whitechapel Mission

restrictive traditional culture, and British society, which they tend to view as overly permissive. Young Bangladeshi women in particular are highly controlled by their families and forced marriage is a major issue of concern for them. Girls for whom the pressure is too much might run away, ending up homeless, destitute and vulnerable to drugs and prostitution (ibid.).

An unaccompanied asylum seeking Ugandan girl trafficked to the UK was raped in transit and contracted HIV. She was referred to Project DOST, which believes her to have been sexually exploited in the UK thereafter (**Case 7**).

Ashiana reports three cases of young girls apparently entering sex work or multiple situations of sexual exploitation after or as a result of escaping from domestic violence or forced marriage since 2003-04. The girls in question were British born Bangladeshi, British born Pakistani and first generation Middle Eastern.¹²⁵

Unaccompanied asylum seeking girls

According to recent UK research, social services in 32 out of 33 London boroughs are currently concerned about trafficked children in their care (ibid.). Of the NSPCC SES group for unaccompanied asylum seeking girls, all are African and the vast majority have been trafficked. One was brought into the UK as a domestic slave; the others were all brought into the country after being sexually exploited in their country of origin or in transit and/or for the purposes of sexual exploitation in the UK. Sometimes exploitation is part of the 'deal' for the child to be brought to the UK; sometimes they are told they will get 'legitimate' jobs, such as modelling, in the UK. Although some of the girls may still be in contact with their traffickers, none are currently involved in selling sex, as far as NSPCC SES knows. However, one past case was highlighted:

One African girl who was brought into the UK and abandoned on arrival was forced to work in street prostitution in central London for three months before being referred to NSPCC SES.¹²⁶

Project DOST also reported a number of cases of confirmed or suspected sex trafficking. For example, two Nigerian teenage girls had recently been trafficked into the UK for the purposes of sexual exploitation. In 2003 there was an influx of Ugandan girls coming to the UK, at least two of whom were also believed to have been trafficked for sexual exploitation. For example:

125 Ashiana

126 NSPCC SES

Extent and nature of substance use amongst the sex working population of Tower Hamlets and the City ^{127 128}

Much of the literature to date (Barnard, 1993; May et al, 1999; Church et al, 2001; Hunter et al, 2004) on the links between substance use and sex work has tended to focus on the on-street commercial sex market.

Possible reasons for this literature focus could include:

- Drug and alcohol use which comes to the attention of treatment providers and researchers is more 'obvious' in the on-street sex industry
- Negotiating access (from the point of view of both researchers and service providers) is less problematic than in the off-street sector
- 'Gateway' service providers such as sexual health agencies are reporting more problematic drug and alcohol use amongst on-street sex workers
- The evidence shows that substance use among off-street sex workers is less 'problematic' than that for women working in the on-street sector.

At the beginning of the study assertions were made by several service providers that 'problematic' drug and alcohol use amongst the migrant sex working population in London is 'non-existent'. This section details any evidence of substance use by migrant sex workers that has come to light during the course of this research. This report does not attempt to make any conclusions concerning the treatment or care needs of women who use drugs or alcohol.

Substance use amongst migrant sex workers and trafficked women

Distinctions are made in the literature between on-street and off-street sex workers and the associated level and type of drug used.

In a survey examining violence against prostitutes in different work settings, Church et al (2001) reported that 78% of on-street sex workers acknowledged using heroin compared to 5% of prostitutes working indoors. Use of crack-cocaine amongst the surveyed group was lower, with 32% of on-street sex workers reporting crack-cocaine use, together with 4% of off-street workers. At the time of the survey, 49% of on-street sex workers reported injecting drugs during the past month, as opposed to 3% of the off-street sex workers. However, Church et al (2001) also highlight that 79% of

women working indoors reported using tranquillisers, compared to 37% of on-street prostitutes and that 30% of indoor sex workers also used amphetamines, compared to 11% of on-street sex workers. These findings suggest that drug use takes place in both the on-street and indoor sectors, but that the types of drugs taken in these environments differ. In the on-street sector substance use is more likely to involve 'hard', Class A drugs. In contrast, women working indoors reported minimal use of Class A drugs but a significant proportion were using other substances, particularly tranquillisers.

There is currently very limited evidence detailing substance use amongst migrant and trafficked women engaged in the sex industry. It should not be assumed, however, that this gap in the literature indicates that substance use is not an issue of importance amongst this group.

Substance use among migrant sex workers

Throughout this study, the researchers have recognised that migrant sex workers constitute a heterogeneous group. Evidence presented by service providers and agencies and gathered through interviews with migrant sex workers indicates that this group can be found working in both the on-street and off-street sectors and that cases of drug use have been identified in both sectors.

The following is a summary of cases identified as part of the research.

On-street

Door of Hope observed two women, believed to be Eastern European, whilst on outreach in 2004, who showed visible signs of using heroin. The two women were observed separately on two different nights and have not been spotted by outreach workers since that time. Neither of the women were keen to engage with outreach workers.

Providence Row had contact with two migrant sex workers during the last six months of 2005, one of whom, identified as Eastern European, was believed to be working on-street, and possibly off-street, and presented with 'a drink problem'. Providence Row was

127 The use of the term 'substance use' is discussed in the definitions section earlier in the report.

128 The two research areas of Tower Hamlets and the City have not been discussed separately in this analysis of substance use amongst the sex working population as much of the on-street sex working activity tends to take place along the borders of the two boroughs.

attempting to assist this woman (believed to be Lithuanian) with access to accommodation but this was proving problematic as she did not have recourse to public funds. The second woman, identified as Argentinean, did not present with any drug or alcohol problems.

A local service provider had contact with two migrant women, both aged between 18 and 19, who had a history of sex work and heroin and crack use. One woman was from Russia, the other was from an unspecified Eastern European country. The women came to the UK to escape their sex work situation and their heroin dependency, but both returned to using substances and sex working on arrival. One woman was injecting heroin whilst in the UK and was given a methadone script. The service provider reported that it was difficult to engage the women, mainly due to their chaotic, disorganised behaviour. The women have not been seen by the service provider since 2005.

Further anecdotes were presented during interviews of women believed to be drug-using 'Eastern European' women working on-street on the borders between Tower Hamlets and the City. These cases have not been substantiated, however, and when questioned further the claim that the women were 'Eastern European' seemed to be based on appearance alone.

The case of Amely (see Appendix C), who, until recently, was using heroin and crack-cocaine whilst working on-street in London, further confirms that some migrant women do work on-street and may use drugs whilst doing so. However, it is important not to extrapolate these findings and suggest that they are indicative of the behaviour of all migrant on-street sex workers. The Angel Drug Service needle exchange van, for example, cited instances of women, believed to be Eastern European, approaching their outreach van but only asking for condoms, rather than drug injecting equipment.

Off-street

Cases of drug use were also revealed amongst migrant women working in the off-street sector. Of the sexual health projects interviewed for this study who report engagement with migrant sex workers, each service includes questions around drug or alcohol use as part of an initial assessment when women present to clinics for treatment. All services highlighted the difficulties of questioning women about drug or alcohol use in the non-confidential setting of on- or off-street outreach. Migrant women who do not present for clinical assessment are therefore not likely to be directly assessed on drug or alcohol use by service providers.

Alcohol use has been highlighted as particularly difficult to assess. Praed Street indicated that migrant women working in flats might be using alcohol (and sometimes cocaine) with the client 'as part of their job' if the client requested it.¹²⁹ Open Doors, however, indicated that this scenario was more likely in West London and possibly the City; no similar reports have been received of women in Tower Hamlets. Alcohol use by maids and women in flats, driven by boredom when business is slow, was raised in service provider interviews. However, interviews with maids in four out of five different establishments, conducted as part of the telephone survey, reported no drug or alcohol use during working hours. An interview with the manager of a City lap-dancing club, where 'the majority' of their dancers are migrant women, indicated that problematic drug or alcohol use has only been observed amongst their British dancers. It is important to question the extent to which the telephone survey interviewees and representatives from lap-dancing clubs are describing the true picture, and if the 'house rules' differ from the working reality.

Use of alcohol as a coping mechanism has been highlighted in interviews with service providers, in an interview with a maid, who reported that women could 'choose to have a bottle of wine in the room' as well as in an interview with Lina (see Appendix C).

Lina usually drinks a glass of wine a day, in the evening, to 'help lift my spirits'. In addition, two to three times a week she will drink larger quantities of wine before working, at times when she feels particularly low or when she doesn't feel as though she 'could do it sober'. Lina says getting drunk makes her feel better in the short term but then often feels even more down afterwards. In Russia she would 'hardly drink', maybe once a week when out with friends.

(Interview with Lina, migrant sex worker)

An independent sex worker from Brazil, working in a flat in Tower Hamlets, also reported drinking alcohol, particularly wine, to get through the 'long days.' Case 15 stated that that the amount she drinks depends on the number of clients she sees; the more clients, the more alcohol she drinks. She regularly drinks a bottle of wine per shift. (see Case 15 in Appendix C).

Interviews with Megan and Nicole (see Appendix C) indicated (respectively) previous and ongoing cocaine

129 Praed Street reports that some women working in hostess clubs may be drinking up to a 'bottle of champagne a night, for five or six nights a week'.

use. For a four-month period at the end of 2005/beginning of 2006 Megan was a daily user of cocaine, which was supplied (and paid for) by a male Turkish friend. At the time of the interview Megan had not used cocaine for two months. She stopped using as she 'didn't like how it made [her] feel'. Nicole, who continues to use cocaine, classes it as a 'social activity' which she engages in 'occasionally'.

However, interviews with sexual health service providers indicated that staff would categorise the majority of drug and alcohol use amongst migrant women working off-street as 'recreational' or 'non-problematic'. When asked to define 'problematic' most staff stated that the service user's self-identification of whether her drug use was a problem would be the basis on which they would consider referring her for treatment. Staff also stated that in most cases there would be physical signs of 'problematic' drug use, through the woman's appearance or behaviour. In one case reported by Praed Street however, a migrant woman approached staff following attendance at a drop-in session to request help for her heroin addiction. Staff had not previously been aware of any drug use by the woman who has now been referred for treatment.

Substance use among women trafficked into sexual exploitation

A distinguishing feature of drug use among women trafficked into sexual exploitation, stated both in the literature and by service providers and agencies, is the extent to which trafficked women are coerced into taking drugs or drinking alcohol. Substance use may be through direct force from the trafficker to encourage the women to 'take on more clients, work longer hours, or perform acts they might otherwise find objectionable or too risky' (Zimmerman, 2003), or 'voluntary' to relieve stress and to cope with their situation. Zimmerman (2003) emphasizes that even where the use of drugs is argued to be voluntary, the woman's behavior must be seen within context of the coercive situation in which she finds herself.

A study by Dickson (2004a), based on information gathered from 26 trafficked women housed by The Poppy Project, indicated that five women had sought support for substance use once they had exited the trafficking experience. Women reported using alcohol, cocaine and marijuana 'to cope with their experiences' (Dickson, 2004a). Only one of the five women had used drugs prior to entering the trafficking situation.

Dickson's (2004a) findings are in line with those reported in Case 4 and Case 5 (see Appendix C). Both women had no history of substance use before their trafficking situation and stopped drinking and taking

drugs once they had exited sex work. Case 4 and Case 5 both used cannabis and cocaine and experienced varying degrees of coercion. Case 4 stated that, although the drugs were provided by the owners of the club where she worked, she was not forced to take them. In contrast, Case 5 was denied food by her traffickers and instead received supplies of drugs and alcohol. Together, the cases indicate that women trafficked into sexual exploitation may find themselves in a coercive environment which has the potential to lead to substance use. Substance use may be linked to the direct physical force of the trafficker or indirect force such as psychological control, which can compromise the woman's autonomy, decreasing her self-protective defences whilst increasing her levels of compliance.

The majority of interviews with direct service providers and agencies did not reveal any evidence of substance use among women who the services providers identify to have been trafficked. CLASH, the Praed Street Project and Open Doors had not come into contact with women who had been forced into taking drugs by their trafficker. CO14 reported that when they have entered off-street sites there have been no overt signs, such as the presence of drug paraphernalia, to suggest any drug use on the premises. However, the type of drugs that have been identified as used by off-street sex workers, including cocaine and cannabis, do not require much 'paraphernalia' and supplies may be small enough to be concealed on the person.

Several service providers and agencies indicated that in their experience traffickers do not need to use drug addiction as an additional 'hold' over women. Women are already frightened and vulnerable due to the traffickers' use of coercion and violence. A drug addiction would potentially risk the quality of the service provided and is therefore avoided.¹³⁰ Open Doors attributed the apparent absence of substance use among women trafficked into sexual exploitation to their precarious existence in the UK, which means that they cannot afford to partake in behaviour that may draw the attention of the authorities. Both CO14 and Open Doors noted that women may not have access to the funds necessary to be able to buy drugs, and in cases where they did, the huge debts they face act as deterrent from spending money on drugs.

However, a minority of direct service providers (in addition to the services accessed by Cases 4 & 5) had come into contact with women trafficked into sexual exploitation who had either been exposed to, or used, drugs. Case 14 details the instance of a Brazilian woman who stated that she had been trafficked into the UK and was referred in 2003 to the (now closed)

130 Interview with CO14

Maze Marigold Project, a service for young, vulnerable women in prostitution based in Tower Hamlets. The woman had been given cocaine by her pimp but did not present as having a drug problem (see Case 14 in Appendix C).

Hackney Women's Aid reported a case of a South-East Asian woman who was made to work in a flat after being promised a different job and had been drugged in the process (see Case 11 in Appendix C). Similarly, the Women and Girls Network (WAGN) had first hand contact with trafficked women who were substance users. Many of their trafficked clients are referred from the Poppy Project. Although WAGN recognised that some women use cannabis and crack-cocaine, they indicated that alcohol, and specifically cider, use is more of an issue than drugs among the trafficked women they see. Some of the women are seeking treatment and are in either detox or drug and alcohol treatment centres across London.

Ideally, clarity could have been added to service providers' mixed experiences of substance use among women trafficked into sexual exploitation through conducting interviews with women from this group. However, accessing women proved to be highly problematic and ultimately impossible (see Barriers/Challenges section). Consequently, while specific cases have illustrated that substance use is an issue among trafficked women, it is not possible to establish the extent of the phenomenon from the current evidence.

Substance use among sex workers from BME communities

This section looks at the specific case of khat use amongst first and second generation Somalian sex workers in Tower Hamlets. The Naz Project was the only service provider interviewed who had direct contact with, and knowledge of, this group of women. Sex work within the community is reported to be hidden due to the stigma attached to sex before or outside of marriage. However, Naz was aware of 16 women in Tower Hamlets, aged 19-40, who all use khat and who are engaged in some form of sex work.¹³¹

Somalian sex workers have been identified as operating under very different circumstances to the other migrant sex workers discussed in previous sections. Whilst the Naz Project did report instances of older and younger women working together in a house, which essentially functions as a brothel, there were other examples of 'informal' sex work where women exchange sex for 'favours' or for 'company'. To illustrate these exchanges, Naz gave the example of a man coming over to the woman's house to spend the evening with her and

bringing with him khat and alcohol. The evening would end with sex as a means of 'payment' for the khat.

Whatever the precise nature of the sex work, the motivations for Somalian women entering sex work, reported by Naz, included general survival (poverty), money to afford to chew khat or just to have company. This evidence suggests a clear link between khat use and sex work and highlights an alternative face of off-street sex work. However, the closed nature of the Somalian community makes it difficult to gauge how widespread this phenomenon is.

Girls and young women from BME communities: sexual exploitation and substance use

The sexual exploitation of minors (those under the age of 18) was raised during interviews with NSPCC Sexual Exploitation Service (SES), Project DOST, The Whitechapel Mission and Ashiana. Service providers did report instances where substance use was associated with exploitation. Case 8 (summarised in Appendix C) detailed the experience of a 15 year old British born mixed race girl who until recently was living in a children's home in Tower Hamlets. When she was 14 she began exchanging sex for crack cocaine and other drugs in flats/crack houses and cars in Tower Hamlets and other London boroughs.

Tower Hamlets social services eventually agreed to place Case 8 in a secure unit in February 2006. By this time the police had begun looking into the case as part of a wider investigation into a paedophile ring apparently targeting children's homes and vulnerable young people in London. The police have identified several Looked After young people sexually exploited by this group of adults. There is serious concern that other young people in care in Tower Hamlets and elsewhere in London are being sexually exploited by being coerced into serious drug misuse which they then have to repay in sexual services.

Ashiana reported one case from 2004 where a young, second generation Pakistani girl ran away from home, became involved with a gang, and was apparently paid to have sex with the men. During her stay at a hostel run by Ashiana the girl told staff that she 'smoked spliffs'. Staff also suspected that she drank alcohol.

The Whitechapel Mission is sporadically attended by six second generation Bangladeshi girls, aged between 14-17, who are homeless and are living in cars with a man believed to be their pimp. Both the girls and their pimps are drug users. NSPCC Street Matters also presented cases of young, sexually exploited women who use drugs. The Street Matters team works with young women, up to the age of 18, who are involved in,

131 Interview with the Naz Project

or at risk of, sexual exploitation, including those who are abused through prostitution. The Street Matters group includes one South American girl, one Middle Eastern girl and 11 other girls, most of whom have mixed nationality backgrounds. Amongst this group, girls do use drugs to some extent. In the past, girls have spoken about grass, skunk, heroin and cocaine. Street Matters reported that some girls consume alcohol, to the point of getting drunk, but that none of the girls have spoken about injecting drugs.¹³²

However, NSPCC SES emphasised that there is not always a clear link between drugs and sexual exploitation. Sometimes drugs may be completely absent from the relationship. Project DOST had contact with young Ugandan girls who had been sexually exploited but who came across as very 'clean-cut' and did not appear to be using substances. This example is supported by comments from NSPCC SES who noted that the unaccompanied asylum seeking minors they see as part of their 'There to Here' group are not drinking or using drugs. All the girls in this group are African from countries across the continent. The interviewee reported that girls from this group do not appear to be interested in drugs; instead they are focused on 'making a life for themselves' in the UK. NSPCC SES also highlighted that most cases of sexual exploitation involve girls being in a controlling relationship with men much older than themselves. The girls become trapped in the relationship and have sex for love/affection rather than for money or for drugs.

The evidence presented by service providers, particularly in the instance of Case 8, where sex was exchanged for crack cocaine and other drugs, does highlight that there are confirmed occasions where sexual exploitation of minors and substance use are linked. However, from the evidence gathered it is impossible to estimate how prevalent such cases are. Similarly it is not possible to establish the nature of the connection between substance use and sexual exploitation.

132 Interview with NSPCC Sexual Exploitation Service

Health needs of sex workers

Generic needs

Sexual and reproductive health

The sexual and reproductive health problems of sex workers are well documented (see for example: del Amo et al, 2005; Beyrer & Stachowiak, 2003; Cohan et al, 2005a and 2005b; Harcourt and Donovan, 2005; Lee D et al, 2005; Mak et al, 2005; Taylor D, 2003; Ward et al, 2003 and 2004). They include increased exposure to:

- Sexually transmitted infection (STIs) e.g. chlamydia, genital warts, gonorrhoea, herpes, human papilloma virus (HPV), syphilis and trichomonas vaginalis (TV)
- Blood Borne Viruses (BBVs) e.g. human immunodeficiency virus (HIV) and Hepatitis B and C

Sex workers also run a higher risk of long term complications relating to STIs and sexual trauma, including the following:

- Pelvic inflammatory disease (PID)
- Chronic pelvic pain
- Infertility
- Ectopic pregnancy
- Malignancies associated with STIs such as cervical cancer

However, one recent study showed STI infection rates to have sharply fallen within the London sex industry at a time when they have risen among the general population (Ward et al, 2004). Acute STI prevalence in the sex industry decreased by two thirds, from 25% to 8%, in the period 1985-2002. In contrast, among the general public gonorrhoea and chlamydia infections have doubled since the mid Nineties and there have also been outbreaks of syphilis. The authors attribute this decrease in STIs among sex workers to increased use of condoms with both clients and partners for penetrative (vaginal and anal) sex, although condom use for oral sex has declined (Ward et al, 2004). Use and perceived use of condoms by migrant sex workers in Tower Hamlets and the City are discussed below.

Sex workers' mental and physical health and exposure to violence seem to depend to a large extent on factors such as location of work, substance use and homelessness. These are discussed in the relevant sections below.

On-street sex workers

Working on-street is generally considered to be riskier than off-street. On-street sex workers are more likely to be arrested and suffer violence and are less likely to have access to health services (Shaver, 2005, citing: Benoit and Miller, 2001; Church, Henderson, Barnard and Hart, 2001, Chapkis, 2000, Whittaker and Hart, 1996).

The links between street sex work, substance use and homelessness in the UK are well established (for example, May et al, 1999). These links are true for street working women in Tower Hamlets and the City (as seen above in profile of sex working women in Tower Hamlets in the two areas) and many specific health problems suffered by on-street sex workers in the area relate to these factors.

Sexual and reproductive health

STIs and BBVs were mentioned as a major concern. For example, the Door of Hope outreach team have found that the women they see tend to have very limited knowledge of how STIs are spread; this was highlighted during a recent syphilis outbreak. Chlamydia is also a particular problem. Many of the women are very fearful of taking HIV and other tests. Women will tend to reserve condom use solely for paying partners and will not use them with their chosen (often heroin-injecting and not necessarily faithful) partner at home.¹³³ Other problems mentioned included Amenorrhoea (absence of menstruation), in the case of some women with high levels of drug addition, and unwanted pregnancies.

Physical health

Injecting drug users often suffer from abscesses and other infections, which can lead to septicaemia, as well as BBVs, collapsed veins and weight loss. Malnutrition and eating disorders such as anorexia and bulimia are common, and drug users often prefer to spend their money on drugs than food.

When Amely was sex working she would go without food for days, sometimes up to a week because she had 'no time to eat' and 'no money to eat': 'every money that you got was for heroin and coke'.¹³⁴

Other problems include:

- Respiratory difficulties and asthma (due to smoking crack and/or tobacco and living outside)
- Insomnia
- Weak immune system
- Skin complaints
- Problems with teeth (through heroin use and general decay)
- The physical effects of violence
- Generally poor 'self-care'

Mental health

Service providers frequently mentioned mental health problems in connection with on-street sex workers, often brought on by or exacerbated by substance use. These include depression and anxiety. The use of

133 Door of Hope

134 Amely

stimulant and suppressant drugs causes emotional states, chaotic, wild and noisy behaviour and impaired sleep patterns. A study comparing sex working and non sex working drug users found that the former are more likely to report adult physical or sexual abuse, to have attempted suicide, and to have depressive ideas than the latter (Gilchrist et al, 2005).

Exposure to violence

Although both on- and off-street sex workers are prone to violence, the risks are often said to be greater for those working on the streets. In their survey of street and indoor working women in three UK cities, Church et al (2001) found that street workers experienced significantly more violence from their clients than those working indoors (81% as opposed to 48%), half reporting violence from clients in the last six months. Street workers most frequently reported being slapped, punched or kicked. Work location (indoors or outdoors) was a more important factor in determining levels of risk of violence by clients than the city, drug use, length of time or start age of sex work. Street workers in Glasgow were six times more likely to suffer violence than indoor workers in Edinburgh (Church et al, 2001). There is also a high rate of murders among off-street sex workers, most committed by clients (Kinnell, 2001).

According to Taylor, growing crack use by clients is causing increasing levels of violence both on the street and inside crack houses, leading to rape, assault and strip searches, sometimes at gunpoint. Taylor notes that crack use by women also affects their security (Taylor D, 2003).

This pattern of high rates of violence would appear to hold true for street sex workers in Tower Hamlets and the City. According to a number of service providers, most women working on the streets in the area have been raped or attacked during their career and face additional risks associated to living on the street, such as being targeted by youth gangs (at one point particularly Bangladeshi youths fuelled by drug use¹³⁵), kicked or urinated on.¹³⁶ Through Safe Exit Tower Hamlets, Brick Lane Police has employed a dedicated woman police constable to work with women in prostitution with the aim of increasing the reporting of physical and sexual offences.¹³⁷

Off-street sex workers

As noted above, indoors sex workers are generally thought to be less at risk of violence than their off-street counterparts (Church et al, 2001; Taylor D, 2003;

Farley 2005). The presence of security measures in establishments such as cameras, CCTV, a receptionist/maid screening and even dogs is often mentioned as protecting women's safety (Lilley, 2005a; Taylor D, 2002).¹³⁸

However, although Church et al (2001) concluded that street workers were more at risk of violence than indoors workers, they nonetheless found that almost 50% of indoors sex workers had suffered violence by clients, and 25% had experienced some form of violence in the past six months. In a recent 'Ugly Mugs' report giving details of 13 incidents involving dangerous or suspect clients, 9 took place in flats as opposed to four on the street.¹³⁹

Generally without the homelessness and high levels of substance use often associated with street workers, the factor most affecting the health of indoors sex workers seems to be violence: sexual, physical and psychological. Some of the main documented violence-related issues for indoors workers in general are outlined here and are discussed further below under the section on migrant sex workers.

Sexual violence

Rape was the form of violence most frequently cited as suffered by indoor sex workers in Church et al (2001). C014 confirms that sex workers are 'often' raped by pimps. Sexual violence can also involve men intentionally removing condoms against the woman's wishes (Farley, 2005) or without her knowledge (Taylor D, 2003).

Physical violence

Physical violence against off-street sex workers may include attempted strangulation, forceful restraint, requests for bondage and acts of sadism (Farley, 2005); being beaten and burned¹⁴⁰; and experiencing attacks and robberies at flats, sometimes armed (Taylor D, 2003). Farley (2005) points out that the women suffering the highest levels of violence are trafficked women kept out of sight indoors and suggests that the social invisibility of indoor sex work can make it a dangerous environment as no one complains about it (Farley, 2005). The Church et al (2001) study showed that indoor sex workers are less than half as likely as street workers to report violence by clients to the police (Church et al, 2001). Indeed, given the policy vacuum surrounding prostitution in the UK until very recently, police have tended to observe a de facto policy of tolerating rather than monitoring brothels (e.g. Kelly & Regan, 2000; Matthews, 2005; Safer London Committee, 2005a).

135 Door of Hope

136 Providence Row; Door of Hope

137 Safe Exit Tower Hamlets

138 Open Doors; interviews with migrant sex workers and maids

139 Source: Ugly Mugs, April 2006

140 C014

Psychological violence

According to Farley (2005), the emotional violence suffered by sex workers, such as reliving of past or childhood abuse, Post Traumatic Stress Disorder (PTSD) including emotional volatility, and verbal abuse from clients, can be far worse than the physical violence. Farley argues that indoor and outdoor environments are similar in terms of levels of psychological violence against sex workers, and that women working indoors may even suffer a higher level of psychiatric symptoms.

Migrant sex workers

In line with Ward et al (2004), most sexual health service providers interviewed for the current study reported that migrant sex workers, who mainly work off-street, are relatively health-conscious.¹⁴¹ All of the migrant sex workers interviewed reported having regular sexual health check-ups (generally every two to three months). Maids in two flats in Tower Hamlets mentioned quarterly check-ups as a requirement. However, the women's long working hours may prevent them from accessing health services as often as they would like. Service providers also remarked that many of the migrant women seen on the street appeared incongruously healthy compared to other street workers¹⁴² (although this was only true of those who did not present as drug users, and may have been explained by their apparent newness to sex work).¹⁴³

Sexual health

Number of clients

An important variable affecting the sexual health and welfare of sex workers is the number of clients seen per shift (Harcourt and Donovan, 2005). The current study found that migrant women report seeing between three and 10 clients per day in a 10-12-hour shift, with one interviewee mentioning some women seeing 30-40 clients in a 12-18-hour day, seven days per week.¹⁴⁴ Interestingly, Zimmerman (2003) reports that a woman working in a flat in central London will often have to see 10 clients a day just to break even; an interviewee from C014 actually put the break-even figure even higher, at 14.¹⁴⁵ This discrepancy could suggest that migrant sex workers are either underreporting the number of clients to service providers or over-reporting them to the police.

Harcourt and Donovan (2005) point out that the health risks of having numerous sexual partners is greatly modified by consistent use of condoms and the sex worker's control over prices. They identify being illegal, immigrant, homeless, isolated, addicted to drugs or alcohol or gambling as factors that make sex workers less able to negotiate (Harcourt and Donovan, 2005).

Condom use

In their study showing a decrease in STI prevalence among London sex workers attributed to increased condom use for penetrative (not oral) sex, Ward et al (2004) note that this trend has coincided with the sex trade becoming predominantly off-street and peopled by migrant workers. Many migrant sex workers are well educated, motivated to improve their lives, rarely use drugs and see sex work as temporary work and a means of obtaining education and language skills, all of which makes it easier to convey health and safety messages to them (Ward et al, 2004). Most of the off-street sex migrant workers interviewed for the current study stated that they 'always' use condoms. It must however be borne in mind that there is a body of research suggesting that sex workers often tell researchers what they perceive to be the 'correct' answer (see, for example, Zimmerman, 2003).

The current study shows that, in line with Ward et al (2004), condom use in Tower Hamlets, The City and other parts of London has declined for oral sex.¹⁴⁶ However, contra Ward et al (2004) there seems to be considerably less consensus around consistent condom use for penetrative (oral or anal) sex. Sexual health service providers reported that only 'most' migrant sex workers use condoms for penetrative sex¹⁴⁷, a view confirmed by interviews with maids. The following examples illustrate the apparent inconsistency of condom use:

A Brazilian sex worker in Tower Hamlets interviewed said that she 'always' used condoms but commented (unsolicited) that she was aware that other migrant sex workers are engaging in unprotected sex and need information on how to deal with sex work safely.¹⁴⁸ A Romanian sex worker working in another area of London made very similar comments, adding that some women are aware of the risks but choose to ignore them as a way of making money more quickly.¹⁴⁹

141 Open Doors; Ambrose King clinic; Praed Street.

142 Whitechapel Mission; women @ the well; U-Turn.

143 U-Turn

144 Open Doors

145 C014

146 Ambrose King clinic; Open Doors; Praed Street; CLASH

147 Open Doors; Ambrose King clinic, CLASH; Praed Street.

148 Case 15

149 Nicole

A recent raid in the City identified a 20-year old Thai woman working in a flat where no condoms were found. Police speculated that this may have been because she was a recent arrival - she said she had only been in the UK for about two weeks - and had yet to receive any health advice.¹⁵⁰

'Exceptions' to condom use were widely mentioned, most of which are economically motivated: if women are desperate for money due to a lack of clients, especially if the client looks 'clean'¹⁵¹ or is a 'regular'¹⁵², or if the client offers to pay more.¹⁵³ Taylor holds that increased numbers of sex workers, many of them migrant, are causing increased competition and pressure to provide riskier services at lower prices (Taylor, D, 2003), a view echoed by some local service providers and CO14. According to the latter, the cost of sex in central London has gone down over the last four to five years, for example the price of anal sex without a condom was £80-£90 but is now £40-£50.¹⁵⁴

In the case of women who use drugs, some do not want to spend their 'drug money' on condoms and do not attend clinic regularly enough to have a free supply (Taylor, D, 2003)¹⁵⁵. For example, an Eastern European woman attempting to exit sex street sex work and drug addiction estimated she had used contraception only 50% of the time when working; when she was desperate to 'score' she would have sex without condoms.¹⁵⁶

Only one service provider suggested lack of education/awareness as a possible reason for inconsistent condom use.¹⁵⁷

Service providers did not report direct contact with migrant sex workers not using contraception as a result of coercion on the part of pimps. Open Doors does receive second-hand reports of particularly vulnerable women from their existing sex working clients, for example: Thai women being forced to have unprotected sex, a flat of East Europeans in Tower Hamlets which Open Doors does not have access to, and cases of women who want to pay off their debts faster.

PunterNet 'field reports' on sex workers in East London sometimes refer to 'specialist' services (i.e. anal sex, sex without condoms, etc.):

One PunterNet report describes a 'specials establishment' with a 'Chinese or Malaysian girl' [*sic.*]. The author states: 'I think she does every service' and then makes reference to having anal sex with her on his previous visit.¹⁵⁸ However, an earlier report on the same woman (this time identified as Thai), comments that 'many extras are on offer but no bareback'¹⁵⁹, it is an urban myth that Thai girls offer this service'.¹⁶⁰

Praed Street reported that condom use in 'specialist' contexts will largely depend on how 'empowered' the woman is to take her own decisions. One Open Doors interviewee thought that adverts for 'specialist services' are less frequent now than a few years ago. However, according to CLASH, girls may be expected to have unprotected vaginal and anal sex in less public places such as private members clubs.

Also contra Ward et al (2004), several authors hold that women are still less likely to use condoms with regular partners than with clients (del Amo et al, 2005; Cohan et al, 2005b; Taylor D, 2003). This too was confirmed by two service providers interviewed for the current study.¹⁶¹ Condom accidents are also frequent: for example, in a recent audit of women accessing the Open Doors sexual health services at Ambrose King, 50% reported having had a condom accident since their last sexual health screening.¹⁶² According to Open Doors, contraception use does not depend on the borough - there is no apparent difference between off-street establishments in City and Tower Hamlets.

Sexually Transmitted Infections (STIs)

Given the above, STIs were, not surprisingly, reported as a common problem by sexual health service providers in the area and beyond. In an audit of women attending the Open Doors sexual health services at Ambrose King (mentioned above), over a third (36%) were diagnosed with an STI in at least one of their attendances.¹⁶³

150 Bishopsgate police

151 Ambrose King clinic

152 Praed Street

153 Ambrose King clinic; CLASH

154 CO14

155 Praed Street

156 Amely

157 SHOC

158 Punternet.com field report no. 58422 (20 Oct 2005)

159 'Bareback' refers to sex without a condom. See <http://www.punterlink.co.uk/guide.htm> (accessed 30 March 2006)

160 Punternet.com field report no. 57631 (20 Sept 2005)

161 Open Doors; CLASH

162 Ambrose King clinic. Audit based on 64 women, who generated 162 attendances.

163 *ibid.*

Several cases of HIV were referred to during interviews. As mentioned above, Open Doors and the Ambrose King clinic had contact with two women from different work places, one Ukrainian and one Thai, testing positive to HIV in a week. Both said that a punter had violently torn off the condom during intercourse.¹⁶⁴ Praed Street also mentioned a case of an HIV positive Thai woman who died in hospital.

Other STIs commonly mentioned included Hepatitis B, syphilis and chlamydia. Open Doors commented that a recent pilot project offering Hepatitis B vaccinations via outreach had proved popular with maids as well as sex workers, since the former often come into contact with body fluids through cleaning toilets and rooms. As noted above, there is an ongoing outbreak of syphilis affecting both indoor and outdoor sex workers in East London.¹⁶⁵

Terminations

According to Open Doors, access to a termination service which is safe and free of charge is a significant problem for the sex workers it sees, especially for women with irregular immigration status, who have no access to free terminations via the National Health Service. Some health authorities are stricter than others about insisting that women present the correct documentation have immigration documents before treatment (Haringey, Newham and Enfield were mentioned). Sometimes a sympathetic GP might be able to help. Women in this situation may work more in order to save up to pay for a private termination, estimated to cost around £500.¹⁶⁶ Praed Street mentioned the use of back-street abortionists by women with irregular immigration status.

Other sexual health/ reproductive problems

Other problems mentioned include:

- Thrush, sometimes caused by repetitive washing
- Unresolved PID
- Pain on intercourse
- Distress around fertility (after long-term contraception use)
- Long-term gynaecological problems, which may arise before or after arrival in the UK
- Chronic cystitis¹⁶⁷

Physical health

Several sexual health service providers mentioned poor diet as a major problem for migrant sex workers.¹⁶⁸ CLASH reported that some of the women it sees are anaemic and anorexic, and commented that although restricted food intake was often voluntary, in cases of 'severe exploitation' women do not have enough money to buy food (Case 5 is an example of this). Also, as noted above, drug using sex workers will tend to spend money on drugs rather than food (e.g. case of Amely). One interviewee mentioned dehydration as a problem: some women do not drink enough fluids as they want to avoid having to go to the toilet too much.¹⁶⁹

Other complaints included skin conditions, chest infections, stomach pain, teeth and hygiene problems and general primary health concerns. Praed Street mentioned complications resulting from plastic surgery undertaken in the country of origin (particularly women from Brazil). One-off health concerns included one woman with a blood clot on the brain and another with Parkinsons and Crohn's Disease linked to drug use.¹⁷⁰

Also highlighted was the situation of sex workers whose irregular immigration status means that they cannot be referred for treatment of chronic health problems (e.g. a woman with kidney problems)¹⁷¹, or that they delay treatment, exacerbating the problem.

A Thai woman suffering from pneumonia delayed going to hospital as she was frightened of being deported. She is now facing a hospital bill of several thousand pounds, in addition to any debts she may already have.¹⁷²

Mental health

Mental health seems to be a considerable issue for many migrant sex workers. Being foreign, isolated, lonely and away from support networks of family and friends tends to exacerbate any mental health problems.¹⁷³

Depression was mentioned by the majority of the migrant sex workers interviewed for this study. One East London maid stated that in her view some women in the flat where she worked needed psychological help because they start doing sex work, find it hard to deal with and want to stop but do not know how to get out of it.

164 Open Doors; Ambrose King clinic

165 Ambrose King clinic

166 Open Doors

167 Megan

168 Open Doors; CLASH; Praed Street

169 Open Doors

170 Amely

171 Open Doors

172 Praed Street

173 *ibid.*

Praed Street suggested that levels of depression tend to depend on whether the woman has been involved in sex work before (in her home country, for example). In the current study, one woman who had not done sex work in her own country described herself as being relatively happy with her job.¹⁷⁴ Two women who also started doing sex work in the UK reported suffering from depression which they attributed to the nature of their work.¹⁷⁵

Lina suffers from depression as a result of her work. She says she has a 'a lot of emotional problems', feels 'lost', as though she has no one to talk to, and says she feels she 'can trust nobody'. Although the women working for the same outcall agency in central London that she works for make plenty of money, 'they're so unhappy. How can anyone be happy doing this job?'

(Interview with Lina, migrant sex worker)

However, according to Praed Street, even women who are aware that they will be coming to the UK to work in the sex trade may find the reality of the situation far removed from their expectations: they may not have been aware that their freedom would be limited and that they would be earning far less than they were told.¹⁷⁶

In Amely's case, she linked her depression to doing drugs and sex work, although she has been diagnosed with bi-polar affective disorder (or manic depression), which she suggested runs in her family.¹⁷⁷

Anxiety and stress, often related to sex work, were frequently mentioned. For example, long working hours and whether the woman's partner knows about the work she does; according to one interviewee, both situations put a huge emotional burden on women. Women also worry about financial difficulties.¹⁷⁸ Migrant women tend to hold greater responsibility for their extended family than their British counterparts and will often be working to send money to their family

back home, for example for health treatment, education or living costs.¹⁷⁹ Migrant sex workers suffer from fear, of clients, violence and authorities such as immigration and police.¹⁸⁰

Other common mental health problems mentioned include:

- Symptoms of PTSD¹⁸¹
- Obsessive compulsive disorder, particularly around cleanliness and hygiene
- 'Self-identity'
- Difficulties with relationships with other sex workers, clients and partners

One-off problems included:

- Paranoia¹⁸²
- General emotional problems¹⁸³, bi-polar disorder, hospitalisation and attempted suicide¹⁸⁴ (related to drug use)

The physical effects of mental health issues were also mentioned, such as:

- Self harm¹⁸⁵
- Abdominal pain¹⁸⁶

Violence

As seen above, violence and the threat of violence are significant concerns for women working off-street, where most migrant sex workers are present. Open Doors reported that the women it sees face disproportionate levels of violence, from both clients and pimps/traffickers. Physical violence was mentioned, such as gangs raiding brothels to steal cash.¹⁸⁷ A recent issue of 'Ugly Mugs' showed that three out of 13 'incidents' published took place in flats in the City and one in the Old Street area, three of them involving robbery and two of these involving knives.¹⁸⁸

However, a great deal of the violence described by local service providers was sexual. The case of clients forcibly removing condoms during sex and infecting two migrant sex workers with HIV was mentioned above.¹⁸⁹ An 'Ugly Mugs' incident in Newham reports how a

174 Nicole

175 Case 15; Lina

176 Praed Street

177 Amely

178 Open Doors; Ambrose King clinic.

179 Praed Street; Jessie; Lina

180 Open Doors; Ambrose King clinic; case 12

181 Open Doors; Ambrose King clinic

182 Providence Row

183 *ibid.*

184 Amely

185 Open Doors/ Ambrose King clinic; CLASH

186 CLASH.

187 Open Doors/ Ambrose King clinic

188 Source: Ugly Mugs, April 2006

189 Open Doors/ Ambrose King clinic

woman was picked up on the street and taken to a flat in the Stratford area, where she was forced to strip and repeatedly perform oral sex over a seven-hour period.¹⁹⁰

Past sexual violence is also an issue for some migrant sex workers. Amely, a former street sex worker and heroin and crack addict from Eastern Europe (A8), said that she had been raped many times in both her country of origin and the USA, where she worked for many years (not in the UK, where she had recently arrived).¹⁹¹ Another Eastern European woman, also a crack and heroin user and suspected to be sex working, had a history of sexual abuse as a girl.¹⁹²

Women and girls trafficked into sexual exploitation

Very little information is available on the health of trafficked women in the UK. The main general study to date has been Zimmerman's multi-country study on the impact of trafficking on the health of women and adolescents brought to the European Union, including the UK, for exploitation (Zimmerman, 2003). Interviews were conducted with service providers and other agencies and 28 trafficked women, 25 of whom were trafficked into prostitution. Zimmerman concludes that the multiple and extreme violence and psychological stress experienced by trafficked women in the destination country pervade their work and personal lives. This has a profound impact on their physical, reproductive and mental health as well as on their wider wellbeing, including use of drugs and alcohol, and limits their access to health and other support services. The UK data is based on interviews with only four women and, since the analysis is thematic rather than country-based, the report does not include a separate section on the UK.

More UK-specific data is found in Dickson (2004a), a brief report summarising qualitative data gathered over time from interviews with 26 women trafficked to the UK from various regions and housed by the Poppy Project. 23 of the women were trafficked for sexual exploitation and 21 were involved in the sex industry before escaping. Data is provided on exposure to violence before and during trafficking and the impact of trafficking on the women's health. It is shown, in line with Zimmerman (2003), that these women experienced high levels of sexual, physical and psychological violence during (and frequently) prior to trafficking, with multiple lasting effects on their health, most

commonly on their mental health but also on their physical and sexual/reproductive health.

According to Zimmerman (2003), the health risks and consequences and barriers to services for trafficked women are similar to those experienced by other marginalised groups such as: migrant women; women experiencing sexual abuse, domestic violence and torture; women sex workers; and exploited women labourers. It is therefore not surprising that the health problems experienced by trafficked women are similar to those described above for off-street migrant sex workers, but are more extreme depending on the degree and means of control exerted over them by their traffickers/pimps.

Violence

In Zimmerman's study, physical and sexual abuse were the cause of the majority of injuries and illnesses reported by women in the destination country, and often exacerbated other pains and illnesses not directly caused by violence (Zimmerman, 2003).

Sexual violence

In Dickson (2004a), the trafficked 26 women studied who worked in the sex industry in the UK were exposed to a high level of violence, particularly sexual violence. Sexual violence included being forced to work long shifts seven days a week, see 20 or more clients per day, have unprotected penetrative sex and sex while menstruating. 43% were raped at least once in the UK, and 15% had been forced to have abortions or been beaten with the intention of bringing on a miscarriage.

The current study showed the following:

- As mentioned above, one interviewee from Open Doors referred to some women seeing 30-40 clients in a 12-18-hour shift, seven days per week. Given that most migrant sex workers report seeing a maximum of 10 clients per shift (see above), these conditions would seem to suggest these women are trafficked or 'bonded'.
- Violence in the form of rape takes place on a regular basis in trafficking situations in the UK¹⁹³
- Trafficked women, like other migrant women, frequently undergo terminations.¹⁹⁴ This can be especially traumatic for a trafficked woman, particularly if she is involved with a 'boyfriend' who manipulates her into thinking that she is in a loving long-term relationship. In this case, she may

190 Source: Ugly Mugs, April 2006

191 Amely

192 A local service provider

193 WAGN; CO14; Asylum Aid

194 Asylum Aid

believe that her pregnancy will be welcomed and may also see it as a way out of sex work. Being made to go through with a termination will bring home to her the reality of her situation.¹⁹⁵

Physical violence

In Dickson (2004a), 77% of the trafficked women interviewed had suffered physical violence, primarily involving being beaten with various objects.

The current study showed the following:

- Trafficked women in the UK undergo regular assault and beatings¹⁹⁶ (although CO14 pointed out that pimps/traffickers need to maintain the 'presentability' of the women).
- Case 4 suffered attacks as part of her trafficking experience, which she subsequently relived.
- Case 14 endured attempted strangulation at the hands of her 'partner'.

Psychological violence

According to Dickson (2004a), psychological violence used against trafficked women may include restrictions on women's freedom of movement, including imprisonment, confiscation of identity documents, being told they were indebted, verbal abuse and threats against themselves and their families, witnessing other women being attacked, restriction of food and voodoo, and unwanted exposure to pornography (Dickson 2004a).

The current study showed the following:

- While reluctant to identify women as trafficked, Open Doors commented that some women it sees have their movements controlled by their 'boyfriend', as did a number of sexual health service providers in other parts of London.
- According to WAGN, many of the trafficked women it sees have said that they were deprived of their clothes as a punishment, sometimes during the night so that they would feel cold.
- Case 5 was deprived of food by her traffickers, who instead provided her with drugs and alcohol.

Health effects of trafficking

Psychological health effects

Zimmerman (2003) reports that two-thirds of women asked about mental health reported having a high level of negative mental health symptoms during the destination stage as well as thoughts of suicide

(Zimmerman, 2003). In Dickson (2004a) the most common health effects of trafficking were mental/psychological. Nearly all (92%) of the trafficked women suffered mental distress, and more than half (54%) were diagnosed as depressed and treated with antidepressants or counselling. Almost all suffered from insomnia, nightmares and anxiety and fear. Many also experienced loss of appetite and problems controlling aggression, and some from panic attacks, memory problems, self-blame, distrust of others particularly men, flashbacks, thoughts of suicide, self harm and uncontrollable crying, among others (Dickson, 2004a).

The mental health impact of a number of the confirmed cases of trafficking identified in the current study also particularly stands out. For example:

- Case 4 developed severe and enduring mental health problems as a result of her trafficking experience. Following referral to an NHS agency, she was diagnosed as suffering from PTSD. Her symptoms included reliving her attacks, hypervigilance, compromised cognition, paranoia and self harm. She was also sleeping and eating poorly. Her treatment included taking a selective serotonin reuptake inhibitor (SSRI) anti-depressant and seeing a psychiatrist every three months or more often if necessary.
- Case 5 also suffered from mental health problems resulting from her trafficking experience, including regular nightmares, although the NHS agency she was referred to did not find her to be suffering from PTSD or to be clinically depressed.
- Case 2 (amalgam) was initially trafficked to the UK from Thailand but has now paid off her contract and is working voluntarily to send money to family back home. She misses her family and feels sad. She feels that the job 'makes you mad' and she has issues trusting others. She copes with these difficulties by prayer and the support of her friends.¹⁹⁷
- Case 1 (amalgam) was trafficked to the UK from an Eastern European country (non EU), managed to escape home, but then returned voluntarily to work in saunas and flats. She is having problems in her relationship with her regular boyfriend, feels quite depressed and is having trouble sleeping.¹⁹⁸
- Service providers working with unaccompanied minors trafficked into the UK, including into sexual exploitation, comment that the young people

195 CLASH

196 WAGN; CO14 ; Asylum Aid

197 Source: Psychology services at the Ambrose King centre. This is an amalgamated case where all individual identifying characteristics have been changed.

198 *ibid.*

commonly suffer from mental health related problems¹⁹⁹, including PSTD.²⁰⁰

Praed Street commented that for women who are the more 'extreme' end of the trafficking scale there are few or no temporary distractions from the stress associated with their sex work: for example, their lack of freedom means they cannot go out or socialise. This stress may be exacerbated by the effects of lack of sleep.²⁰¹ Other common complaints mentioned were anxiety and Compulsive Obsessive Disorders, which may cause insomnia, nightmares and eating difficulties.²⁰²

Physical health effects

The current study found that physical health problems suffered by trafficked women include:

- Restricted food intake, due to control by traffickers/pimps (see Case 2, mentioned above) or lack of money to buy food²⁰³, with resulting weight loss
- Eczema and other debilitating skin conditions
- Asthma²⁰⁴
- High blood pressure²⁰⁵
- Cirrhosis of the liver due to alcohol consumption²⁰⁶

65% of the trafficked women interviewed in Dickson (2004a) reported ongoing physical health problems, particularly headaches and pain from old injuries, and sometimes back pain, and stomach, skin and dental problems. According to NSPCC SES, the health problems of UASM girls who have been trafficked include: malnutrition; low weight; difficulties eating when first out of the trafficking situation; skin problems; insomnia; being 'jittery'; headaches; and toothache.

Sexual/ reproductive health effects

In Zimmerman (2003), it is noted that gynaecological complications were among the most commonly reported health problems and that exposure to rough sex increases susceptibility to STIs (Zimmerman, 2003). According to Dickson (2004a), 27% of the trafficked women interviewed had required treatment for STIs including HIV, and 23% needed treatment for cervical abnormalities or gynaecological problems, while 12% had suffered from heavy vaginal bleeding and very painful menstruation (Dickson, 2004a).

According to CO14, trafficked women provide unprotected sex because they are not given access to condoms and/ or because pimps can charge more for these services. Trafficked women and girls are therefore at higher risk of contracting HIV and other STIs, unwanted pregnancies and terminations. For example:

- A 23-year-old Thai woman, has tested positive for HIV and is currently pregnant. Part of her ante-natal care aims to avoid transmission of the virus from mother to baby (Case 6).
- A teenage girl trafficked into the UK (possibly for sexual exploitation) was pregnant as a result of being raped in transit and also tested HIV positive (Case 7).

According to Praed Street, traffickers often use back-street abortionists, partly in the interests of allowing the women as little access to British people as possible (to discourage women from learning English and to perpetuate unfamiliarity with their environment). As noted above, illegal terminations can carry a higher risk of health problems such as infertility.

BME women and girls in sex work/ sexual exploitation

According to Harcourt and Donovan (2005), sex work that is not recognised as such because it is covert, opportunistic, spontaneous or one-off, such as sex for drugs exchanges, can carry higher personal and public health risks than equivalent acts in the sex industry per se. Sexual health precautions are less likely to be taken and the consumption of alcohol and/ or drugs that often accompany such transactions cloud judgement at the time as well as recollection of behaviour as hazardous (Harcourt and Donovan, 2005). These heightened risks would also appear to apply to the Somali sex workers in Tower Hamlets and Newham described above, whose work ranges from informal exchanges to more organised sex work in premises functioning as brothels, but remaining highly covert.

Sex workers in the Somali community

Sexual health

The interviewee from the one service provider found to have contact with this group²⁰⁷ reported low use of condoms among the Somali community in general.

199 NSPCC SES

200 Project DOST

201 Praed Street

202 WAGN

203 CLASH

204 WAGN

205 *ibid.*

206 *ibid.*

207 Naz Project

There is strong stigma attached to using contraception because sex before or outside marriage is taboo. According to the interviewee, limited privacy in the Somali community means many are afraid that someone will find out if they use condoms, and so may choose to risk unprotected sex rather than shame. The Somali women involved in sex work are therefore at high risk of HIV, STIs and pregnancy. Indeed, two (out of 25) of the women with whom the interviewee is in contact are reported to have already contracted HIV.

According to the interviewee, these Somali sex workers are also at risk of physical and mental health problems linked to their use of khat.

Physical health

Chewing khat can induce insomnia and affects sleep patterns; suppresses the appetite, which can lead to poor nutrition; increases the risk of contracting tuberculosis, common in the Somali community (because of overcrowding, for example the enclosed environments of khat houses); and in the long-term can cause liver and kidney damage.²⁰⁸

Mental health

Khat also impacts on mental health because of sleep deprivation, which may cause paranoia and anger. Some khat users also suffer long-term mental health problems such as depression. They may be prescribed antidepressants but fail to collect them because of their nocturnal lifestyle and khat use.²⁰⁹

²⁰⁸ *ibid.*

²⁰⁹ *ibid.*

Barriers to accessing health services for sex workers

Barriers to accessing primary health care

For most people experiencing minor health problems their GP or local primary care clinic is their first point of contact for help and advice. A recent study examining the experience of health services amongst 71 female street-based prostitutes in inner city Bristol revealed that attending their local GP surgery was considered difficult by 80% of respondents (Jeal and Salisbury, 2004). Interviewees listed 'waiting for available appointments' and 'difficulty keeping appointments' as the two key factors impeding access.

Similar barriers to accessing primary health care were raised during interviews with service providers. The Praed Street Project reported that there was a four-week waiting list for appointments to their sexual health clinic, whilst the Women and Girls Network (WAGN) also acknowledged that there was a long waiting list to join the WAGN counselling programme. The opening hours of GPs' surgeries and of sexual health clinics have also been raised by several agencies, including Open Doors and Door of Hope, as inhibiting access for sex workers. Clinics are rarely open after 6pm, a time when many women are getting up and going to work. Similarly, if women are working until 6am, there is the potential to oversleep and miss appointments (Kurtz et al, 2005).

Difficulties keeping appointments have also been linked to the chaotic lifestyles of sex workers. A study examining the general health problems of inner-city, on-street sex workers in the United States hypothesised that the lifestyles of some sex workers operated to impede their interaction with services (Baker, Case and Policicchio, 2002). The chaotic lifestyles of sex workers have also been cited by service providers in Tower Hamlets as a barrier to accessing health services.

Language barriers

The inability to speak the local language has been identified as an important factor which can operate to inhibit a woman's ability to identify health care options, whilst 'disorientation' in a new country and cultural context can leave women 'overwhelmed at the thought of navigating the logistics of a place they don't know' (Zimmerman, 2003). Both Ashiana and Health E1 noted that migrant women (and men) are often completely unfamiliar with the UK health care system and how to access it, two problems which can be exacerbated by limited language skills. The Naz Project interviewee estimated that around 50% of second generation Somalians living in East London have

problems with English. Language barriers have also been identified by Praed Street as a major factor causing women to miss appointments. In some instances communication difficulties have led to women waiting in the wrong part of the hospital and missing their appointment in the clinic.

Personal freedom to access health care

The work patterns of sex workers may operate to further inhibit access to health services. If women are working a seven days a week they are left with very little 'free time' during which they can attend appointments. Open Doors reported that the 'bosses' of trafficked and migrant women do not like 'their' women taking time off work and consequently may be prevented from attending GPs or other health services. In some instances women may be accompanied to health services by their pimp or trafficker. Where sexual health clinics have a policy of not admitting men to the clinic, service providers reported instances where appointments are interrupted by 'bosses' constantly calling women to ask where they are.²¹⁰

The control of women by their pimps was also cited by the Addaction THCDT interviewee who presented anecdotal evidence that, to his knowledge, there are no agencies in Tower Hamlets specifically engaging with Asian sex workers, partly because they are 'very shielded' by their pimps. New Horizon Youth Centre also presented cases where the Angel Drugs Service needle exchange van has seen Eastern European women around Kings Cross but has been unable to approach them due to men of the same nationality (whom they assume to be their pimp/boss) 'hanging around.' New Horizon Youth Centre also reported that language barriers have made it difficult to speak to these women. Praed Street suggested that traffickers have an interest in allowing the women as little access to British people and services as possible. Denying contact not only discourages women from learning and speaking English, it also perpetuates unfamiliarity with their new environment.

A lack of freedom to access services is a complex issue and needs to be understood in terms of a continuum of freedom of movement. Whilst for many trafficked women 'not free' means that they are physically confined to a space, often through physical violence, it is also important to recognise the other mechanisms that traffickers use to isolate women and to take away their sense of self and power. A recent brothel raid by City (Bishopsgate) Police, where a Thai woman was

210 Open Doors

working, found no evidence of condoms on the premises, possibly indicating that the women who worked there did not have access to barrier methods of contraception. When asking trafficked women about access to condoms, Zimmerman (2003) found that 9 of 13 women stated that their pimps or owners were their sole source. Sexual health clinics and CO14 highlighted that while it used to be very rare for sex workers to provide services without using a condom, the pimps of migrant and trafficked women charge more for these 'specialist services.' It is also important to consider that women may not be able to negotiate condom use due to language barriers, depression and low self-esteem and may be forced by the pimp/trafficker, or the punter, to work without contraception.

Open Doors acknowledged that, due to resource limitations, as well as the inability to facilitate access to some flats, there are off-streets sites that they are not able to visit on outreach. Communication can remain a problem, even in cases where Open Doors sexual outreach teams are able to access women in their places of work; there may be surveillance cameras or the maid may be within earshot, preventing women from feeling able to talk about their 'true' situation. Praed Street also emphasised that flats are opening and closing all the time, making it difficult for their outreach teams to keep on top of where they are located. Together these factors mitigate off-street sex workers access to contraception.

Immigration status

Anna, an Albanian migrant sex worker, visited her GP when she had problems with her blood pressure. Anna and her Albanian husband are currently waiting for a decision from the Home Office on their asylum claim so they can only register temporarily with a GP.

(Interview with Anna, migrant sex worker)

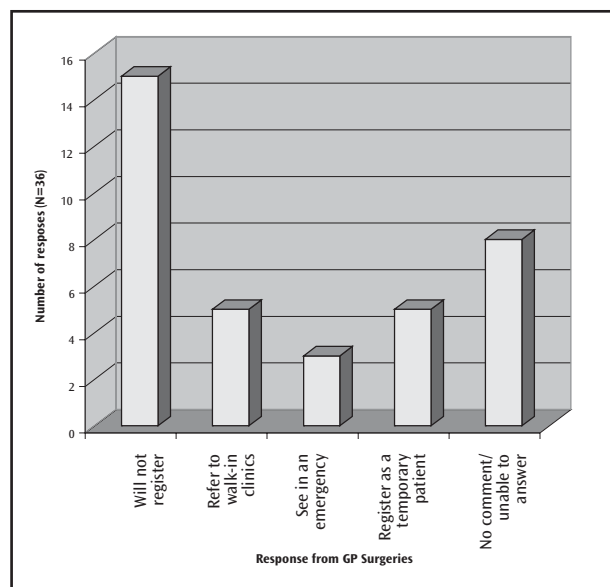
Many health service providers reported that non-EU nationals find it very difficult to register with GPs. As part of this research, phone calls were made to 39 NHS GP surgeries (36 practices in Tower Hamlets and 3 practices in the City) to establish their position on registering new patients. All surgeries reported that any patient wishing to register must present with proof of identity and proof of address. In Tower Hamlets, 23 of the 36 GPs surgeries went on to state that any individual from a non-EU country must also be able to prove that they have at least 6 months left on their visa, or that they are an asylum seeker with a Home Office case number. All 3 practices contacted in the City required non-EU nationals to present a passport with at

least 6 months left on their visa. If they were unable to clarify their immigration status the City practices stated that they would refer the individual to the Primary Care Trust (PCT).

The graph below represents how the 36 GPs surgeries contacted in Tower Hamlets stated that they would respond to an individual presenting with invalid documents when attempting to register.

Chart 6

What action do GPs in Tower Hamlets take if a non-EU national presents with invalid documentation when registering?



Over 41% of practices stated that they would not register the individual, 22% gave no comment, 14% would refer to a walk-in clinic, 14% would register the individual on a temporary basis and 8% would see the individual in an emergency.

If non-EU nationals are unable or not entitled to register with a GP they are effectively being denied access to more specialist services since access to the latter often depends on the former. For example, City and Hackney Specialist Addictions Unit (SAU) noted that they had not had contact with migrant sex workers. This may be because migrant sex workers do not experience addictions, but evidence presented in this report has suggested that this is not always the case (see 'Extent and nature of substance use amongst the sex working population' section above). In order to access the SAU the client must have been referred from a primary care agency, which is highly problematic in itself for people with irregular immigration status.

Open Doors has come across cases where receptionists at GPs surgeries have turned women away because they cannot understand them or because they think they are

‘unsuitable’ for the practice. This example highlights that there are instances where receptionists assess the individual’s ‘suitability’ in terms of appearance and character, rather than if they can meet the immigration and identification criteria. This finding suggests that moral judgements made by the ‘gatekeepers’ to primary health care may deny treatment to migrant sex workers, even in cases when they are legally entitled to register with a GP. Service providers stressed that migrant sex workers experience similar health complaints to the general public. Problems arise if women cannot receive treatment for the condition, exacerbating the issue and potentially leading to secondary problems.

A problem highlighted by Praed Street, Open Doors and CLASH is that sexual health providers are unable to help non-EU women with irregular immigration status, or refer them to more specialist services, if they present with a non-sexual health problem. This failure can cause the breakdown of a relationship, which has taken considerable time to build, between the woman and the service provider, even though they can still help her with any sexual health issues. This barrier to treatment is not specific to migrant sex workers, rather it is an issue for all non-EU nationals with irregular immigration status.

Establishing eligibility for free NHS treatment is a complex process. As a general guide, treatment which is always free of charge, regardless of immigration status, includes treatment given by hospitals in Accident and Emergency, compulsory psychiatric treatment, treatment linked to communicable diseases that have been identified as posing a public health risk if left untreated and family planning (sexual health) services. Testing for HIV and counselling following a test are both free of charge, but any necessary subsequent treatment may have to be paid for.²¹¹

Primary care is limited to walk-in clinics, whilst outpatient treatment would usually require payment. Accessing inpatient services, including treatment for chronic health problems and referrals to specialist services, would also prove to be problematic, if not impossible for non-EU sex workers with irregular immigration status, unless they were able to pay. In one known instance, a Thai sex worker, admitted as an inpatient to a London hospital, is currently accumulating a bill of several thousand pounds for her treatment, a debt which could limit her ability to exit the sex industry should she wish to.²¹²

There is a limited degree of flexibility surrounding the

treatments that are included under the banner of ‘public health.’ The Praed Street Project has been able to utilise the public health argument to ensure that women presenting with pelvic inflammatory disease (PID) can now receive treatment free of charge. Previously the Overseas Office at St Mary’s Hospital, Paddington charged non-EU patients who received consultation and treatment for PID. However, accessing health services and treatment for non-EU women remains extremely problematic.

Open Doors reported that accessing NHS abortion provision is a serious problem for undocumented migrant sex workers as it is not covered under the umbrella of ‘family planning.’ This has forced some health authorities to be particularly stringent in ensuring that patients present with the correct immigration documents. In an attempt to overcome this barrier, women may work extra hours in order to save enough money to afford a private abortion. These are often performed at ‘back-street clinics’ or through doctors in Chinatown, rather than through the NHS as a paying patient. Praed Street recognised cases where women were paying over the odds for this service. It was estimated that a private abortion can cost up to £500²¹³ and, in some instances, may be performed by ‘dirty-doctors’, placing the woman’s health and safety at risk.²¹⁴

Comments from Safe Exit Tower Hamlets, Door of Hope and Open Doors support Zimmerman’s (2003) finding that anxiety over immigration status can lead to a ‘fear of contact with outsiders, including health service providers.’ Confiscating legal documents is one example of the multiple mechanisms of psychological control that traffickers use to create an unsafe and unpredictable environment for women. The fear of deportation can mean that non-EU nationals will not approach services for assistance. The outreach team at Door of Hope noted that a woman of Eastern European appearance reacted very ‘jumpily’ to the team, and suggested that this response was linked to a general fear of police and/or immigration. Similarly, Open Doors highlighted that there had been occasions when women had reached the clinic, only to leave before entering after seeing a doctors car parked outside, which they mistook for the police.

In their discussion of undocumented Burmese sex workers in Thailand, Beyer and Stachowiak (2003) highlighted that a fear of deportation and arrest can also stem from migrant women’s negative experiences of the police and immigration services in their home country, where corruption can be rife. A lack of trust in

211 <http://www.adviceguide.org.uk/>: last accessed 20 March 2006

212 Praed Street

213 Open Doors

214 CWASU

the authorities, linked to a woman's experiences in her country of origin, may be a further reason why both Brick Lane police and Tower Hamlets Sapphire team stated that migrant and trafficked women, as well as sex workers in general, tend not to report sexual assault to the police. Establishing trust between the sex worker and the health practitioner is identified by many organisations as a crucial factor in the successful provision of health services for sex workers. Both St Mungo's, in reference to homeless people and Look Ahead, in reference to sex workers, noted that it can be difficult to work with these groups when many women have had very bad past experiences with service providers, which can hinder future engagement and uptake of services. The Praed Street Project also reported difficulties engaging with migrant sex workers.

Lack of recourse to public funds

Individuals who are subject to immigration control are unable to claim most state benefits, including Income Support, Jobseeker's Allowance, Housing Benefit, homelessness assistance, Child Benefit, disability allowances or Working Families Tax Credit. This is defined as having 'no recourse to public funds.' A number of agencies and service providers emphasised that a lack of recourse to public funds is a major obstacle to accessing services for undocumented migrant sex workers and trafficked women.

Housing service providers acknowledged that housing is a particular problem facing non-EU sex workers with no recourse to public funds. Although the Look Ahead Hostel at Dock Street has two beds for female sex workers, women must have identity documents, as well as recourse to public funds, in order to access the hostel. Therefore, only sex workers legally in the country, who are able to access benefits, would be entitled to become Look Ahead clients. St Mungo's stated a similar position to Look Ahead, while Providence Row Charity reported that an increasing number of night shelters are also requiring service users to have access to benefits.

Street sex workers do not fit the traditional homeless profile: they work at night, do not sleep regular hours and may sleep in crack houses (Brewis, 2003). Together these factors increase the likelihood of homeless sex working women being missed by the Official Rough Sleeper Teams, leaving them without a CAT number and thus limiting their access to hostel and night shelter accommodation. Amely was homeless at the time of the interview and had found out about services through other homeless people. She spoke about her experience of being homeless in London and how she had to move from one shelter to another each night.

It's just too bad that you can only stay one night in the Church, you have to go every night to a different church, I wish there was one place that you can go and stay.

(Interview with Amely, migrant sex worker)

A lack of accommodation has a serious impact upon other issues including substance use, health and security. The City Drug Team, for example, reported difficulties following up with clients who live on the streets, whilst the City DAT indicated that there were very few women accessing substance use treatment in the City through the arrest referral scheme. This gender imbalance was linked to the police's reluctance to pick up drug-using females, decreasing their access to treatment through this method of referral.²¹⁵

Without accommodation, some service providers indicated that drugs services are of limited use. Insecure accommodation, such as night shelters, may also be inappropriate for long term drug treatment programmes.

When Amely first came to London she took drugs, including heroin, with the people she met at the churches [night shelters] she stayed in.

(Interview with Amely, migrant sex worker)

A condition of RAPT's community-based drug treatment day-care programme is that clients must have secure accommodation. Uncertainties surrounding the accommodation of migrant sex workers may be exacerbated through the issuing of ASBOs, preventing women from entering or soliciting in particular areas or boroughs. Brick Lane Police indicated that sex workers are entering Tower Hamlets, usually on a temporary basis, from Kings Cross, Paddington and Newham due to the issuing of ASBOs in these areas. The displacement of sex workers, initiated through the issuing of ASBOs, could potentially inhibit both continuity of care and the provision of services.

The findings indicate that a lack of recourse to public funds may severely limit undocumented migrant sex workers access to accommodation. This has the potential to limit the effectiveness of drug treatment programmes as well as increasing the risks to women's health and safety.

Workers registration scheme

Some service providers asserted that the 'Accession State Workers Registration Scheme' (WRS) placed migrant sex workers and trafficked women even more at risk of 'slipping through the system.' Since 1 May 2004, people from the eight accession (A8) countries of Central and Eastern Europe²¹⁶ have had to register under the WRS as soon as they find a job. A certificate is issued to them confirming that they can work in the UK but will become invalid if they lose their job within the first twelve months. In these cases the individual must renew their registration when they find another job and will not be entitled to claim any benefits in the interim period. After twelve months in continuous legal employment A8 nationals are entitled to work in the UK without restriction and access work-seeking benefits if necessary.²¹⁷

The introduction of the WRS has been criticised for making migrants more vulnerable. CLASH reported that legal migrants who are sex working find themselves in a grey zone where they remain invisible to the system. They cannot register as sex workers and so do not have the WRS certificate, leaving them unable to claim any benefits. This could potentially increase their dependence upon their boss or pimp whilst placing further restrictions on their freedom of movement and ability to exit the sex industry.

Socio-cultural barriers to accessing health care

Confidentiality

Service providers raised the issue of clients' worries about confidentiality as a barrier to accessing primary care, particularly through GPs. Ashiana reported that, in instances of substance use, older Asian GPs can be judgemental and 'tell women off' if they express concerns about their situation. This can leave women scared of discussing their problems with their doctor as they fear it will not remain confidential. The Naz Project reported that some Somali women find it easier to talk to people outside the Somali community because they feel freer to speak their minds.

Worries surrounding confidentiality appear to be consistent across age groups. NSPCC Sexual Exploitation Service (SES) reported that most of the young women they see do not go to GPs because they are concerned about confidentiality. Some girls, for example, have the same GP as their family and worry that, as a result, their family will find out about their relationship. NSPCC SES also commented that young women can feel uncomfortable discussing sexual health matters with

their GP, which operates as a further barrier to accessing health care.

Stigma and shame

Institutional barriers to accessing health care can also include providing culturally insensitive care, whereby there is a failure to recognise the 'cultural mores' surrounding health care, and sexual health care in particular (Beck et al, 2005). Beck et al (2005) studied the Bangladeshi community in Tower Hamlets to identify barriers to accessing sexual health care amongst this group. They reported that for a Bangladeshi to be seen approaching sexual health services by another member of the Bangladeshi community carries significant 'social stigma' and consequently would have a considerable impact on their standing in the community.

The Naz Project also identified similar barriers to accessing sexual health services amongst the Somali community in East London. Naz runs a sexual health project for young people in the Somali community involving talks at schools, community centres and social clubs. The project, however, does not target sex workers directly; sex outside marriage is taboo in Somali culture and consequently women would not readily identify themselves as sex workers. Naz highlighted that the shame surrounding sex before or outside of marriage also inhibits Somalis, including Somali sex workers, from using barrier methods of contraception. This presents a further deterrent to Somali women accessing sexual health services whilst increasing their risk of STIs and HIV/AIDS. Cultural norms and values can thus mediate the extent to which a community perceives sexual health services to be relevant to them and also increases the potential for sexual health promotion within the community to be viewed as 'culturally insensitive.'

'If you give out condoms it's like saying they're allowed to do it safely when our culture says no sex before marriage' (Interviewee from Beck et al, 2005).

Comments made at the 'Alcohol and Drugs - Improving Options for Women' conference in January 2005 indicated that there is also a significant degree of stigma attached to substance use amongst the Asian community. Speaking at the conference, Dipa Thakrar from Ethnic Alcohol Counselling in Hounslow reported that;

'Cultural norms meant Asian women fear losing the respect of their family and community if they were disclosed as a drinker by accessing services.' (Dipa Thakrar 2005).

216 The Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia and Slovenia.

217 <http://www.workpermit.com> Last modified:14 April 2004; last accessed: 16 March 2006.

It must be acknowledged that ethnic minority groups are a heterogeneous population comprised of several generations, all with differing values and attitudes. It is therefore important to treat any generalisations with some caution. However, the cultural constructs detailed in the literature were, to some extent, reflected in responses from service providers. The shame and stigmatisation surrounding substance use was raised by Ashiana and GLDVP²¹⁸, whilst Health E1 reported that patients have difficulty discussing stigmatised topics, including sex work and substance use, especially in close-knit communities where people can find it difficult to talk about their problems with ‘strangers.’

Comments made by Addaction THCDT indicate that cultural attitudes towards stigmatised issues are often cross-cut by an inherent gender bias. A lack of uptake of treatment by Bangladeshi women was linked to a fear of being seen at what is widely known to be a drugs service. Whilst it was recognised that Bangladeshi men are stigmatised for using drugs, the situation was believed to be worse for women, with a degree of ‘double standards’ recognised. In their study of illicit drug use among Bangladeshi women in Tower Hamlets, Cottew and Oyefeso (2005) highlight that one of the main barriers to treatment for Bangladeshi women is the fear of loss of custody over their children. Addaction Gateway Day Programme indicated that this fear is not limited to female Bangladeshi drug users, but to female drug users as a whole. They reported that, in general, women do not tend to access drug services because of childcare issues and worries about social services getting involved if they are seen to have a drug problem.

Cottew and Oyefeso (2005) also examined the concept of *izzat* (honour) amongst Bangladeshi women and found that whilst it is intended to regulate unacceptable behaviour, in practice it operates to create a climate in which women keep drug use hidden for fear of shaming both themselves and their family within the community. This strengthens a woman’s lack of readiness to present to services and can encourage a perception that her drug use is ‘non-problematic’, reinforcing her belief that she does not need help. A limited uptake of drugs services was also reported amongst the Somalian community in Tower Hamlets. Addaction THCDT has been trying to promote their service among the Somalian community, but with limited success. This lack of engagement with drug (and health) services may reflect the closed nature of the Somalian community and its relative isolation from the ‘mainstream.’²¹⁹

In reference to alcohol use, Drug and Alcohol Services for London (DASL), emphasised that not only does an alcohol problem take time to develop, it also takes time for the individual to recognise that they have a problem. In this respect, DASL suggested that a clinical service which is problem focused may not be the most suitable approach for migrant, transitory sex workers. However, it is difficult to envisage what type of intervention could prove to be more appropriate, particularly when it has already been established that this is a hard to reach group. None of the women seen on outreach by Open Doors have presented to them with substance use problems. However, outreach workers recognised that it takes time to build up the level of trust needed to disclose these, often stigmatised, problems. NSPCC Sexual Exploitation Service also noted that the young women that are referred to them tend not to see their relationships as exploitative or abusive when they first arrive at the service.

Individuals can thus, inadvertently, create their own barriers to accessing health care by failing to recognise that they have problem with which they need assistance.

Health E1 acknowledged that there are common misconceptions surrounding how service providers and GPs will react to an individual who presents with a substance use problem or an individual who discloses that they are, or were, a sex worker. Women may attempt to hide their background of sex work and/or drug use, believing it will increase their likelihood of receiving services (Kurtz et al, 2005).

[Megan] is registered with a GP but doesn’t feel as though she can disclose what she does for a living as she believes that would affect the treatment she would receive. She also believes that non-UK nationals get a different (worse) standard of service from health providers.

(Interview with Megan, migrant sex worker.)

Alternatively, misconceptions can encourage potential service users to assume that the service is not for them. Both scenarios can lead to ineffective care, either due to health providers remaining unaware of the clients’ greatest needs for care or due to failure to present. It should be noted, however, that interviews with migrant sex workers did raise one instance where a nurse at a sexual health clinic did not react favourably to the woman disclosing her background as a sex worker.

218 The Greater London Domestic Violence Project (GLDVLP) is not a direct service provider. It is an organisation providing policy, advocacy and training on the issue of domestic violence.

219 Naz Project.

Jessie had a bad experience at a West London GUM clinic: when the nurse asked her what she did for a living and Jessie replied 'working woman' the nurse reacted badly and did not want to treat her. That was a while ago but Jessie is still attending their clinic.

(Interview with Jessie, migrant sex worker)

These findings reveal the complex social and psychological factors that underpin Tower Hamlets BME communities' engagement with sexual and substance use services. The section has highlighted how institutional, structural, individual and socio-cultural factors interact to the extent that sex working women rarely face a single barrier but rather multiple obstacles impeding their access to health care services.

In this instance the nurse's reaction did not deter Jessie from returning to the clinic. However, the example illustrates that fears associated with disclosing a background of sex work are not unfounded. The example also emphasises the need for, and importance of, health professionals who do not discriminate between patients.

Potential service users may also have a general fear of accessing health clinics and hospitals. In a study examining off-street sex workers and their use of genitourinary medicine services two of the main obstacles for service use were identified as 'dislike of needles' and 'dislike of examinations' (Bell and Rogstad, 2000). NSPCC SES reported that the unaccompanied asylum seeking migrants they see can find tests for STIs traumatic. This problem is particularly acute amongst girls who have never been to a hospital before.

Migrant sex workers and trafficked women may come from countries where their health belief systems are not congruent with the Western 'biomedical' approach. Open Doors highlighted that they are able to refer women they see on outreach for psychological assessments if they believe this to be necessary. In cases where English is not the woman's first language, or where a woman comes from a culture where counselling is not recognised as a way of expressing problems, encouraging women to engage with the service can prove to be very difficult. To overcome this barrier a female psychologist from the Ambrose King Centre accompanies Open Doors on outreach once a fortnight so that the women can familiarise themselves with her. The aim is to ensure that the women feel more comfortable talking to the psychologist if they expressed a wish to see her when they came to the Ambrose King Centre for their appointment at the sexual health clinic. The Women and Girls Network also acknowledged that some of the women they see do not recognise 'verbal communication' as a means of dealing with their issues and offer art therapies as an alternative method of 'counselling.'

Gaps in current service provision

Interviews with service providers elucidated current gaps in service provision. In most instances these were linked to the barriers to accessing health care identified in the previous section. Whilst some gaps arise due to the practical barriers posed by limited resources, many of the gaps reported by service providers are directly related to current policy and immigration laws surrounding the legal rights and entitlements of migrants.

Sexual health

Sexual health services are available free of charge to migrant sex workers and trafficked women, whatever their immigration status. Current gaps in sexual health provision are predominately associated with the opening hours of clinics and their capacity to assist sex workers whose first language is not English.

A number of surveys have highlighted that access to sexual health clinics has worsened over the past decade, with demand far outstripping capacity.²²⁰ This is despite the fact that 'services have more than doubled their capacity through extensive modernization despite less than 10% increase in resource [*sic*].'²²¹ Sexual health clinics working with migrant sex workers and trafficked women face further pressures on their services. The Praed Street Project can only afford to pay for one interpreter at each clinic and so try to encourage women to come along to the appropriate session. Limited language resources are one reason why the clinic currently has a four week waiting list for appointments. A clear gap in service provision is the capacity to provide immediate, appropriate sexual health care for sex workers and women trafficked into sexual exploitation who do not speak English.

Sexual health outreach provides one method of filling the gap created by waiting lists and the inability of some migrant sex workers to access clinics. However, finite resources limit the scope of outreach and the number of premises visited. This gap is compounded by the underground nature of the off-street sector and the inability of service providers to negotiate access to some off-street premises. In addition, limited staff numbers amongst NGOs and NHS agencies can lead to outreach services being cancelled due to ill-health or unforeseen circumstances.

A further gap in service provision was highlighted by Safe Exit Tower Hamlets who reported that there is a lack of sexual health care available outside 'office hours' and specifically no night time drop in service for sex workers in Tower Hamlets.

Other health

There is a significant gap in comprehensive NHS health service provision for non-EU nationals, which has a clear impact upon migrant sex workers. A lack of recourse to public funds and the subsequent inability to access specialist health services has the potential to put the health, welfare and lives of migrant sex workers and trafficked women at a greater risk than that of the general public. NHS agencies will continue to struggle to overcome this inequity unless there is a shift in policy at the national level.

Drug/alcohol services, detox and treatment

Accessing NHS drugs services may be problematic for non-EU sex workers. Tower Hamlets offers a wide range of Tier 1-4 drugs services through NHS clinics, non-statutory agencies and NGOs but at present these services experience a limited uptake amongst BME groups and women. The key problem identified by drugs service providers is the lack of secure accommodation faced by women and, above all, sex working women with no recourse to public funds. Without secure accommodation, service providers have asserted that drugs services are of limited use and effectiveness.

City DAT identified the lack of a women's only service as a clear gap in current drugs service provision. Project DOST emphasised that it is crucial for some staff members at drugs services to have expertise in asylum and immigration issues so that they can offer a holistic service to migrant substance users.

Comments raised by service providers, and particularly sexual health services, have highlighted difficulties in assessing and establishing if a client has a substance use problem with which they need help. These difficulties indicate that service providers working with sex workers and women and minors trafficked into sexual exploitation may benefit from further training to identify the visible and non-visible signs of substance use in order to provide clients with the most appropriate care.

Housing

A shortage of accommodation, together with lack of recourse to public funds, have been identified by service providers as the two crucial factors which operate to impede sex workers access to all other services, especially drugs services. At present there is

220 For example, see Djuretic et al, (2001)

221 British Association of Sexual Health and HIV (BASHH) Modernisation Group cited in Ward and Robinson (2006)

very limited hostel provision specifically for sex workers in Tower Hamlets and the City (two beds at Look Ahead Dock Street hostel), which can only be accessed by individuals with recourse to public funds.

Housing services for vulnerable women were raised by Safe Exit Tower Hamlets and U-Turn as an area currently lacking in provision in Tower Hamlets and the City. GLDVP recognised that whilst there were approximately 68 domestic violence refuges for women across London, including 14 BME refuges, there are few services for women that have been trafficked. Ashiana indicated that women would be unable to stay in their refuges if they could not afford the rent, which becomes more problematic if the woman has no recourse to public funds. Both GLDVP and Ashiana highlighted that women presenting to refuges with substance use problems are likely to be refused accommodation as refuges do not have the resources to provide the high level support that substance users might need.

These findings show that access to residential domestic violence services for women, including sex workers, with no recourse to public funds and substance use issues is highly problematic. Door of Hope, in reference to on-street sex workers, noted that there is limited housing for sex workers who wish to live with a partner. Many of the women they have contact with would not consider going into a hostel as it would mean living on their own.

Accommodation for sex workers, sex workers with no recourse to public funds and trafficked women is significantly lacking in Tower Hamlets and the City and is a gap that impacts upon the uptake and effectiveness of other services as well as making the women more vulnerable to health and substance use risks.

Legal

Attention has already been drawn to the ways in which irregular immigration status and a lack of recourse to public funds impede non-EU sex workers' access to services, creating gaps in service provision. Statutory services will only be able to start to tackle such gaps if there is a change in policy towards these groups. Migrants from the eight EU accession countries (A8)²²² also experience gaps in service provision. Women who claim to have been trafficked from one of the A8 countries are left in a grey zone; they are not illegally in the country, they cannot claim asylum and, unless they have been registered under the Worker Registration Scheme (WRS) and have been in legal employment for 12 months, they are not entitled to

claim any benefits. As sex workers cannot register as such under the WRS they are left in a very vulnerable position, similar to that of non-EU sex workers with no recourse to public funds.

Services for younger women

Case 8, a client of NSPCC Sexual Exploitation Service (SES), is a 15 year-old British born mixed race girl who until recently was living in a children's home in Tower Hamlets. When she was 14 she began exchanging sex for crack cocaine and other drugs in flats/ crack houses and cars in Tower Hamlets and other London boroughs.

(Case 8)

The cases presented in this report of young women and girls who have been sexually exploited support the assertion made by Safe Exit Tower Hamlets that more prevention and intervention work needs to take place in schools. Agencies, including NSPCC SES and The Naz Project, are engaging in prevention work around sexual exploitation and substance use but awareness and understanding, particularly of the grooming process, needs to be raised and developed.

Project DOST reported a trend of unaccompanied asylum seeking minors entering the UK who have been raped in transit, such as in Case 7 detailed below.

Case 7 was 16 when she arrived in the UK from Uganda in 2003. For the first four months, Case 7 was held captive here. Details of her captivity are vague and not fully known. Case 7 was under the care of the asylum team of social services in East London. On her way to the UK, she had been raped in transit. She was pregnant as a result of the rape and social services organised the termination for her. She had at this point not been tested for HIV or STIs. When she was referred to Project DOST, Case 7 expressed concerns about this and, with the support of a project worker, she attended a clinic for comprehensive sexual health testing. Case 7 tested HIV positive.

(Case 7)

Despite their experience of sexual violence, on reaching the UK establishing the sexual health of these minors is not the first priority of Social Services. Project DOST

222 The Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia and Slovenia.

identifies this as a gap in service provision and believes sexual health screening should be a priority.

A further gap in the system highlighted by Project DOST, relates to unaccompanied asylum seeking minors who are aged 16-18 years. On their arrival in the UK this age group is placed by Social Services in semi-independent housing, usually with other young people. These properties are visited by a link worker on a fortnightly basis. However, Project DOST noted that the link worker is not always trained in how to deal with this group of children, making it more difficult for them to pick up on any signs of sexual exploitation. This example indicates the need for specialist, professional child protection training, such as that offered by NSPCC Bfree.

Opportunities for exiting the sex industry

Some services providers and agencies, including GLDVP, commented that more emphasis needs to be placed upon strategies to help women exit the sex industry if they so wish. The Praed Street Project noted that exiting the sex industry is raised by some of the women that they see during their drop-in sessions. Project DOST asserted that women wanting to leave the sex industry should be encouraged to aim high and look at further education, rather than going into jobs which assume a basic level of achievement. U-Turn emphasised that their new women's centre, opening in Tower Hamlets in 2006, will focus on exiting strategies, rather than solely upon harm reduction²²³. CLASH also reported that they would like to do more work developing exiting strategies with the women they see but that they currently do not receive funding to engage in this type of work.

Dickson (2004b) asserts that the majority of sexual health outreach agencies in London tend to focus on harm reduction rather than exiting strategies. To offer only exiting strategies could be seen as 'judgemental of women currently working in the sex industry' (Dickson, 2004b). However, both Dickson (2004b) and Bindel and Kelly (2003) suggest that harm reduction and exiting strategies work 'most effectively when applied together.' One way of combining both strategies, suggested by Dickson (2004b), is to build upon and integrate exit strategies with sexual health outreach services. However, this study has already shown that off-street sexual health outreach is unable to access an unknown number of premises in Tower Hamlets and the City due to a combination of limited resources and inability to negotiate access.

The establishment of Safe Exit Tower Hamlets means that Tower Hamlets is uniquely positioned to develop strategies to enable people to exit prostitution through its multi-agency approach. However, this needs to be supported by funding to develop the range of services required and also should take into consideration the specific situation and needs of migrant and trafficked women.

²²³ Harm reduction or minimisation involves helping women to be safer whilst they are working in the sex industry through the provision of health information, contraception and safe injecting.

Conclusions

The findings of this study are based on interviews with 65 service providers, seven interviews with migrant sex workers, five interviews with maids working in off-street premises selling sex, two interviews with club managers (one lap-dancing, one strip club), a comprehensive literature review and a mapping exercise of the sex industry covering the two geographical areas under research.

It is without doubt that the research findings would have been enhanced by a greater numbers of interviews with migrant sex workers and trafficked women. Barriers to securing interviews with the target group have already been touched upon in the methodology section. Some service providers expressed reluctance to encourage women to contribute to a research study which they felt would not bring any 'practical benefits' to the participants. The view held by several service providers was that migrant sex workers and women trafficked into sexual exploitation do not present with 'problematic' substance use. As a result, those agencies were reluctant to encourage any research which aims to inform the tailoring of drug services for these client groups. Research into the wider health needs of migrant women was also not considered by some service providers to be of practical value, given the barriers to accessing mainstream health services posed by the irregular immigration status of some of their migrant service users. Asking questions around health needs of women who cannot access treatment for those needs was considered to be unethical by many potential introducing agencies; access to interview women identified as being from the target group was in those cases also not facilitated.

Presence of migrant sex working population in Tower Hamlets and the City

As one of the main areas for street prostitution in London, the on-street sex market in Tower Hamlets has been discussed in previous literature (Brewis, 2003; Dickson, 2004b; Safe Exit Tower Hamlets, 2006; Skidmore, 2005). While the majority of women working on-street in Tower Hamlets are British, the current study indicates that migrant women and girls are now seen working on-street in Tower Hamlets and surrounding areas (particularly Newham and Kings Cross), in much smaller but increasing numbers. This study did not find any indication of migrant women working on-street in the City.

Much less is known about the off-street commercial sex market in Tower Hamlets. The telephone survey of off-

street premises in East London conducted for the current study indicated a higher number of premises in Tower Hamlets than cited in existing sources. The majority of women who work in off-street premises in Tower Hamlets would appear to be migrant. The City's sex trade appears to be mainly off-street. Police intelligence suggests that some premises in the City belong to small 'chains' of brothels with sister establishments owned by the same individual located elsewhere in the City or other parts of London, and some women working in different premises of the 'chain' on alternate days. Local police believe that the off-street market in the City is growing. As in Tower Hamlets, the vast majority of women working in the off-street sex industry in the City are migrant.

Cases of women trafficked into sexual exploitation

The current study revealed only a few confirmed cases of women who had been trafficked into sexual exploitation in the UK with links to the two boroughs and the immediate area.²²⁴ However, it also found several unconfirmed/ possible cases of trafficked women and a number of confirmed cases of girls and young women trafficked or coerced into sexual exploitation (see separate subsections below). It should be borne in mind that these are only the cases identified by service providers to date. This, added to the fact that the majority of confirmed cases of trafficked women are from the main regions of origin for migrant sex workers detailed throughout the report, and supporting evidence from other sources, suggest that the problem of sex trafficking in the local area is likely to be larger than the number of confirmed cases imply.

Identifying the numbers of women trafficked into sexual exploitation in the areas under research proved problematic given the reluctance on the part of some service providers, particularly sexual health projects, to positively identify migrant women who do fit international definitions of the term as being 'trafficked'.²²⁵

It is recognised that trafficking can take many forms and trafficked women may fall into a wide spectrum of trafficking situations. However, it is also difficult to ignore the fact that if an agency chooses not to identify a woman as 'trafficked', it is also absolving itself of responsibility to report/refer that case to the appropriate authority/care provider. In the UK, an agency may choose not to identify a woman as trafficked because of a lack of appropriate care

224 See confirmed cases of sex trafficking in profile of sex working population.

225 See section on definitions.

provision for victims, a fear that no assistance would be available or that the trafficked woman would ultimately be deported. Nonetheless, it could be argued that care provision is unlikely to be extended without a fuller picture of the scale of trafficking, which can only result from wider reporting. By extension, if a ‘trafficker’ is defined as a ‘facilitator’, this may weaken the case for any potential prosecution.

A number of sexual health service providers seemed to believe that the only valid use of the term ‘trafficked woman’ was when the woman defined herself as such and that any other use of the term would be somehow ‘disempowering’. Initial contact with a service provider is unlikely to reveal the full extent of a woman’s experiences and agencies’ insistence on ‘empowering’ women may conversely be denying that woman access to the appropriate care or treatment. It was also interesting to note that many of the sexual health agencies who place emphasis on ‘empowering’ women were often the same agencies who did not agree to permit their service users to decide for themselves whether they wish to participate in the study and declined to facilitate even the most limited level of access, in the form of flyer distribution. As a result, research access to the target group in the areas of study, Tower Hamlets and the City, was limited and the research findings were compromised.

Substance use amongst the target group

Despite assertions at the beginning of the study made by several service providers that ‘problematic’ drug and alcohol use amongst the migrant sex working population in London is ‘non-existent’, the research has revealed evidence of substance use amongst migrant sex workers (both on- and off-street) and women trafficked into sexual exploitation which may require the provision of either immediate or future treatment.²²⁶ Case studies in the report which revealed substance use by trafficked women all involve women who have accessed services after leaving the trafficking situation. No details were available from service providers or through direct researcher access of substance use by women who are still in the trafficking situation.

For many women from the target group, the first point of contact and a potential gateway into other services is likely to be through sexual health projects. Difficulties assessing the drug and alcohol care needs of women in the non-confidential setting of sexual health outreach have been highlighted among several service providers. Migrant women who do not present for clinical

assessment are therefore not likely to be directly assessed on drug or alcohol use by service providers. The provision of drug and alcohol training, specifically around assessment and referral procedures, for sexual health service providers, relevant NGOs and mental health agencies is therefore one of the recommendations of this report.

Other health needs

The majority of the health concerns reported as part of this study were sexual health related. This is perhaps not surprising given that a) interviews with service providers who report the most direct contact with the target group were sexual health projects and b) the majority of interviews with migrant sex workers were carried out within the setting of a sexual health clinic.

Some of the sexual health service providers interviewed reported that the health needs of their service users reflect those of the population at large; the problem is that barriers to accessing care mean that those health problems often go untreated and as a result further complications arise.

In addition to physical health needs connected to both sexual and non-sexual health²²⁷, two areas appeared to be of particular concern with this target group: levels of violence and mental health.

Concerns around disproportionate levels of violence faced by both the sex-working populations in general and women trafficked into sexual exploitation were raised by several service providers and agencies.

Mental health seems to be a significant issue for many migrant women. Being foreign, isolated, lonely and away from support networks of family and friends tends to exacerbate any mental health problems. Depression was mentioned by the majority of the migrant sex workers interviewed for this study and was also a concern highlighted in interviews with maids and service providers. Anxiety and stress, often related to sex work, were also frequently mentioned.

Barriers to accessing existing services

The majority of barriers to accessing existing services, identified during the course of the study, related to limited access to primary health care due to the service user’s immigration status and (lack of) recourse to public funds. Access to care would seem to depend not just on general policy but rather on a) geography and b) the individual service provider. Health care providers interviewed in different parts of London, for example,

226 Cases are discussed in detail in the sections on substance use and Appendix C.

227 See Health needs of sex workers section.

list varying services which are available free of charge to service users without recourse to public funds. A telephone survey of GP surgeries in Tower Hamlets also revealed a disparity in policies around registering migrants who present without valid immigration documents.

Other barriers identified included: language barriers; personal freedom to access health care; confidentiality concerns; perceived stigma and associated shame.

Gaps in service provision

Gaps in service provision were highlighted in the areas of sexual health (specifically around opening hours and access to interpreting services), drug and alcohol treatment, housing, legal advice, services for younger women and opportunities to exit sex work. It is interesting to note that several of the women interviewed for this study are travelling some distance outside of their area of residence or work to access health services, even when there are other agencies offering similar services in the more immediate area.

Many of the identified gaps in service provision were linked to the barriers to accessing health care associated with current policy and immigration laws surrounding the legal rights and entitlements of migrants.

A shortage of accommodation, together with lack of recourse to public funds, have been identified by service providers as the two crucial factors which operate to impede access to other services, especially drugs services. Accommodation for sex workers, particularly sex workers with no recourse to public funds and trafficked women is significantly lacking in Tower Hamlets and the City and is a gap that impacts upon the uptake and effectiveness of other services as well as making the women more vulnerable to health and substance use risks.

There is a significant gap in comprehensive free of charge NHS health service provision for non-EU nationals, which has a clear impact upon migrant sex workers and women trafficked into sexual exploitation from outside the EU. A lack of recourse to public funds and the subsequent inability to access specialist health services has the potential to put the health, welfare and lives of migrant sex workers and women trafficked into sexual exploitation at a greater risk than the general public. NHS agencies will continue to struggle to overcome this inequity unless there is a shift in policy at the national level.

In light of the findings outlined above, it is recommended that the following points are considered when devising drug and alcohol service provision for female migrant sex workers and women trafficked into sexual exploitation^{228 229}:

228 Many of these recommendations will also apply to services for non-migrant sex workers.

229 Some of the recommendations are offered in the form of suggestions to consider.

Recommendations

Access

- Direct access to the service should be offered as well as via referring agencies.
- The current study indicated that some migrant sex-working women are travelling considerable distances across London to access services in boroughs other than their place of residence or place of work. Some women in the sex industry move (or are moved) frequently to various locations, often working in flats in different areas on different days of the week. In acknowledgement of the transitory nature of the target group, information-sharing networks and referral systems need to be developed with services in other boroughs across London.
- In recognition of the above and the working hours of women in the sex industry services should be offered to non-borough residents who work in the area.
- The service and any referral procedures should be widely publicised among other relevant service providers, including: housing agencies, women's groups, refugee community organisations, BME groups, sexual health and other health service providers, legal advice agencies and domestic violence organisations.
- Strategies for raising awareness of the service among the target group need to be carefully developed, for example, leaflets advertising the service could be distributed at multiple locations where the target group is likely to spend time, i.e. hairdressers, language schools, etc.
- Opening hours should be 'user friendly' and reflect the lifestyles of the group the service is to be aimed at, i.e. not 9-5.
- The service needs to consider its policy on access to the treatment and waiting area by men (e.g. partners of service users) and any possible implications on other service users' readiness to engage with the service.
- Immigration status is likely to be a real or perceived barrier to accessing services for many women. If the service is going to be offered regardless of status this should be well publicised.
- The effects of any security procedures, such as double-gated access or police monitoring, on potential service users need to be considered.

Staffing

- Staff should have expertise in asylum and immigration issues and need to be aware of appropriate referral agencies working in the relevant fields.
- The potential implications of male staffing and any possible effects on female service users, some of whom are likely to be suffering from the consequences of violence at the hands of male clients, pimps or traffickers need to be carefully considered.
- It is important to ensure that there are sufficient resources to meet demand once referrals begin. Many service providers when discussing the current system referred to their frustration at not being able to secure access to a service when a woman is ready to engage with and access treatment.
- Services need to be offered in multiple languages. If the service is receiving multiple referrals from one particular nationality/ethnicity, consideration needs to be paid to employing a first-language speaker.

Nature of service provided

- The needs of very different groups of women should be considered and a comprehensive needs assessment carried out on presentation to the service, including:
 - Off-street sex workers
 - On-street sex workers
 - Migrant sex workers
 - Women who have or may have been trafficked into sexual exploitation
 - Non sex-working women
 - Domestic violence victims
 - BME women
 - Asylum seekers and refugees
 - Younger women who are being or at risk of being sexually exploited.
- The service will need to consider women's multiple care needs, including those around:
 - Housing
 - General health
 - Sexual health
 - Mental health
 - Legal advice
 - Immigration
 - Strategies for exiting sex work

- There is a current gap in services for sexually exploited young women and girls who present with drug and alcohol problems. A service which offers provision for younger women needs to consider the nature of that service, including timing of sessions and separate clinics for younger service users.
- It is recommended that the service include a 'safe room' or a 'rest room' where women would be able to sleep, rest, wash and eat.
- The service needs to consider whether there will be an enforceable 'drug free' policy on site or whether service users will be able to use drugs within a specific area of the building.
- The service should consider the use of a freephone helpline number, staffed by multiple language speakers.
- In order to take into account the needs of service users with children, the provision of a creche/play area, together with possible staffing implications, should be considered.
- A flexible appointments system needs to be offered along with both drop-in and outreach services, available in multiple languages.
- Protocols should be established on the level of protection, confidentiality and anonymity women will receive. These protocols need to be effectively communicated to service users.
- Assessment targets (of service outcomes) are likely to be quantitative. Qualitative outcomes assessment of services working with this target group are more likely to be valid.
- A protocol around identifying trafficked women needs to be established using internationally recognised definitions.

Referrals

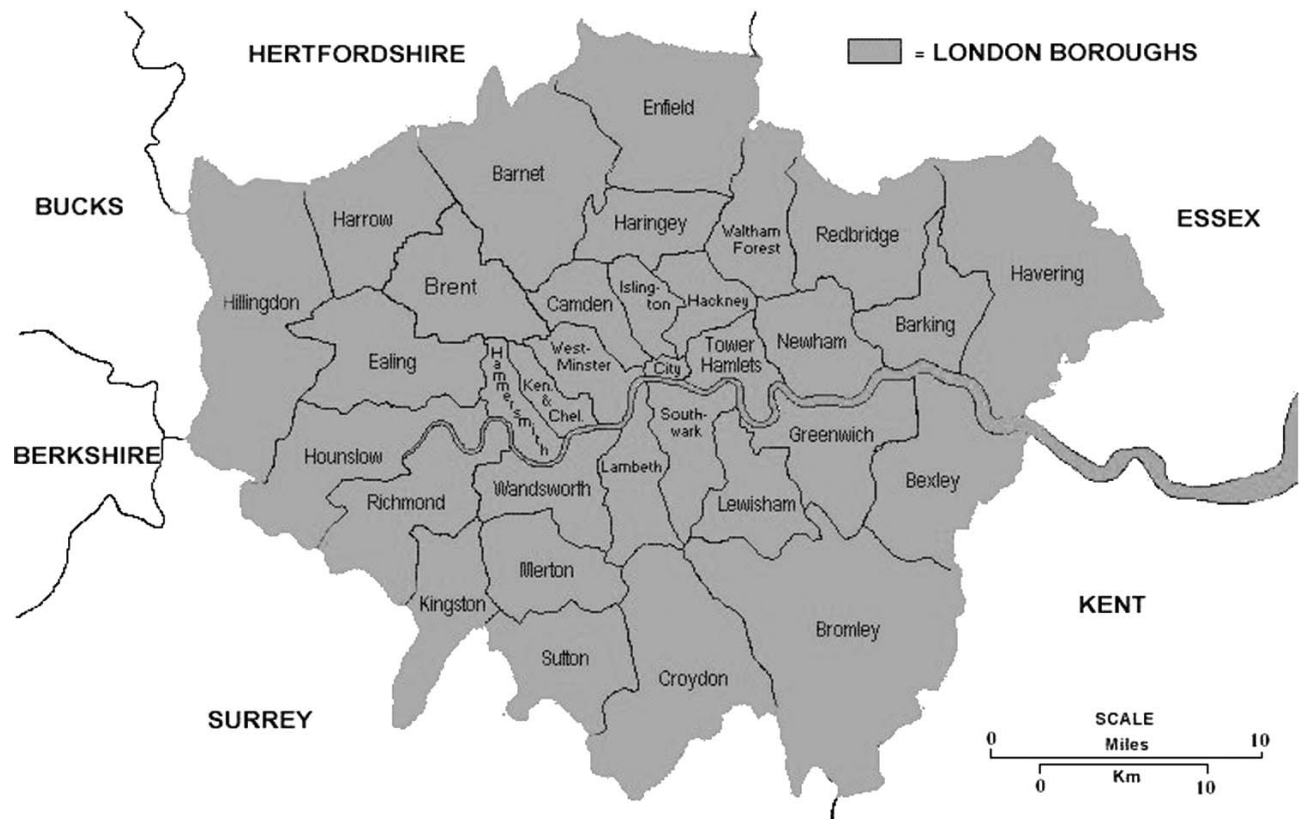
- The service should have links to a range of different service providers and advice agencies including:
 - Other (non-drug related) health
 - Asylum and refugee support
 - Immigration law
 - Mental health
 - Housing
 - Exiting sex work
 - Finance/debt advice
 - Young people and children's services.
- Staff need to be aware of which agencies will accept service users without recourse to public funds.

Other

- As the first point of contact with migrant sex workers and trafficked women is often sexual health service providers, appropriate training of staff working in these services and others, such as mental health services and NGOs, needs to be in place to ensure that the drug and alcohol needs of women and appropriate referral routes are being identified.

Appendices

Appendix A: Map of London boroughs



Source: Brent Council ²³⁰

²³⁰ Available at: <http://www.brent.gov.uk/www.nsf/0/243a9cb5fefb81e580256a560055e414?OpenDocument>

Appendix B: List of organisations contacted

Interviews Conducted

Academic

1. Child and Women Abuse Studies Unit, London Metropolitan University
2. Institute for Applied Social and Health Research, University of Paisley.
3. London School of Hygiene and Tropical Medicine

BME community groups

4. Praxis

Children and young people's services

5. NSPCC Sexual Exploitation Service (Street Matters/Bfree)
6. Project DOST
7. Barnardos Young Women's Project

Domestic violence

8. Greater London Domestic Violence Project
9. Hackney Asian Women's Aid
10. NCH Barika Project
11. Southall Black Sisters
12. Victim Support Tower Hamlets
13. Women Against Rape
14. Women and Girls Network

Drugs and alcohol

15. Addaction Gateway Day Programme
16. Addaction Tower Hamlets Community Drug Team
17. Angel Drug Service
18. City Drug Action Team
19. City & Hackney Specialist Addictions Unit
20. Drug and Alcohol Service for London (DASL)
21. Adolescents Specialist Addictions Treatment Service (ASATS)
22. HIV Vulnerable Adults Team
23. LBTH Drug Action Team
24. LBTH Specialist Addictions Unit
25. Lifeline London Young People's Substance Misuse Service

26. Odyssey Trust/ City Roads

27. RAPt

28. Regional Public Health, Drugs and Alcohol

29. Ashiana

Health services

30. Health E1

31. Project: London (Medecins du Monde UK)

Housing/homeless services

32. Look Ahead Aldgate Hostel, Dock Street
33. New Horizon Youth Centre
34. Providence Row Charity
35. St.Mungo's Rough Sleepers Team
36. Whitechapel Mission

Legal advice

37. Asylum Aid

38. International Organisation for Migration (AVRIM)

Local government

39. Greater London Authority (GLA)
40. Safe Exit Tower Hamlets
41. Waste Collection, Corporation of London

Mental health services

42. East London & City Mental Health Trust - Community Mental Health Teams

Police

43. Brick Lane (Tower Hamlets) Police
44. City (Bishopsgate) Police
45. City (Snow Hill) Police
46. City of London's Crime and Disorder Reduction Partnership
47. CO14 Clubs and Vice
48. Economic Crime Unit, City Police
49. Operation Maxim
50. Tower Hamlets Sapphire Unit

Sexual health

51. Ambrose King Centre, The Royal London Hospital
52. Central London Action on Street Health (CLASH)
53. Door of Hope
54. Naz Project
55. Open Doors
56. Sexual Health On Call (SHOC)
57. The Praed Street Project
58. U-Turn Project
59. women @ the well centre
60. Women and Young People's Sexual Health Service, The Sylvia Pankhurst Centre

Social services

61. Tower Hamlets Social Services - Adult Protection
62. Unspecified NHS Agencies (3 Interviews)

Women's groups

63. English Collective of Prostitutes

Organisations contacted and responded with no relevant information

BME community groups

1. Al-Hasaniya Moroccan Women's Centre
2. Asian Women's Advisory Service
3. Bangladesh Youth Movement
4. Community of Refugees from Vietnam, East London
5. Community Organisations Forum
6. Diaspora
7. East London Asian Family Counselling
8. East London Chinese Community Centre
9. East London Somali Youth and Welfare Centre
10. Ethnic Alcohol Counselling in Hounslow
11. Ethnic Community Service
12. Latin American Women's Rights Service
13. Lithuanian Church
14. Polish Church of our Lady Mother of the Church

15. Shobujshathi
16. Somali Advisory Bureau
17. Somali Health Advocacy Project
18. Somali Mental Health Project
19. St Peter's Community and Advice Centre
20. St.Hilda's East Community Centre
21. Strengthening Families Coram Project
22. The Factory Youth Project and Community Centre
23. Uganda AIDS Action Fund (UAAF)
24. Ukrainian Orthodox Church
25. Unleash
26. Zacchaeus 2000 Trust

Children and young people's services

27. AFRUCA
28. Barnardos Families in Temporary Accommodation Project
29. Corporation of London's Children, Families and asylum seeker services
30. LBTH Social Services Team EAST (children's assessment teams)
31. LBTH Social Services Team WEST (children's assessment teams)
32. Rapid Response Team (TH Youth Service)
33. Step Forward
34. TH Social Services Team WEST (Leaving Care team)
35. Youth Information Advice Connexions Service

Domestic violence

36. LBTH Domestic Violence Team
37. Newham Asian Women's Project (NAWP)
38. Tower Hamlets Forced Marriage Steering Group

Drugs and alcohol

39. Addaction Harm Reduction Team
40. CAFADS
41. City & Hackney alcohol counselling services
42. Healthy Options Team

43. NAFAS
44. One North East London
45. Westminster Drug Project

Health services

46. A&E Department Homerton University Hospital
47. A&E Department Newham General Hospital
48. A&E Department Royal London Hospital
49. Island Medical Centre
50. Leopold Street Clinic
51. London East Aids Network
52. Medical Foundation
53. Medicentres (UK) Ltd.
54. Newby Place Health Centre
55. Spitalfields Health Centre
56. Steel's Lane Health Centre
57. The Mission Practice
58. Wellington Way Clinic
59. Women's Health and Family Services, The Brady Centre

Housing/homeless services

60. Centrepoint
61. Children's Society - Refugee and homeless team
62. Corporation of London Allocations Manager
63. Corporation of London, Homeless Team
63. Corporation of London, Housing Department
65. Kipper Project
66. LBTH Homelessness Service
67. LBTH Housing Advice Service
68. Providence Row Housing Association
69. Tower Hamlets Link Worker Scheme

Immigration

70. Colnbrook Immigration Removal Centre
71. Enforcement Policy Unit (EPU), Immigration and Nationality Directorate, Home Office

72. Gatwick Intelligence Unit
73. Oakington Immigration Reception Centre
74. Tinsley House Immigration Removal Centre
75. Yarl's Wood Immigration Removal Centre

Legal advice

76. Ferguson Centre/ Citizens Advice Bureau
77. Joint Council for the Welfare of Immigrants
78. Kalayaan
79. Mare Street (East End) Citizens Advice Bureau
80. Oxford House
81. Refugee Legal Centre
82. Refugee Women's Legal Group
83. Refugee Women's Resource Project (RWRP)
84. Rights of Women
85. TV Edwards Solicitors

Local borough licensing teams

86. LBTH Licensing Department

Mental health

87. Beside
88. Dockland's Outreach Project
89. ELCMHT's Blood Borne Virus Team
90. Maudsley Hospital
91. Mind in Tower Hamlets
92. SANE

Police

93. Association of Chief Police Officers
94. Child Protection Unit, Met Police
95. Crown Prosecution Service
96. District Crown Prosecutor, East Central London Prosecution Service
97. Victims and Confidence Unit, Office for Criminal Justice Reform

Sexual health

98. Barts Sexual Health Centre
99. GUM Clinic, Homerton Hospital
100. GUM Clinic, Royal London Hospital
101. Mainliners
102. Margaret Pyke Centre
103. Marie Stopes Central Office
104. Options
105. The Haven
106. The Space KC

Women's groups

107. New Start Women's Group
108. Powerhouse
109. Women in Prison
110. Women's Link
111. Women's Relief

No response received**BME community groups**

1. African Community Welfare Association (ACWA)
2. African Women's Welfare Association
3. Antill Road Centre
4. Bangladesh Welfare Association - Tower Hamlets
5. Chinese Church in London (Finsbury Park Congregation)
6. Community Links
7. Congolese Community Council
8. ELBWO
9. Eritrean Community in the UK
10. Gujarat Welfare Association
11. Hackney Muslim Women's Council
12. Horn of Africa Community Group
13. Island Advice Centre
14. Jagonari Women's Educational Resource Centre

15. Kingsway International Christian Centre Hackney
16. Kongolese Centre for Information and Advice
17. Limehouse Project (Lifra Hall)
18. London Chinese Lutheran Church
19. London Churches Group for Social Action
20. Manor Gardens Health Advocacy Interpreting & Training Programme
21. Marylebone Bangladesh Society
22. Newham Bengali Community Trust
23. Nile Centre
24. Polish Church
25. Refugee Women's Association (RWA)
26. Renewal Refugee and Migrant Project
27. Polish Lutheran Church
28. Romanian Orthodox Church
29. Russian Orthodox Cathedral in London
30. Social Action for Health
31. Somali Advice and Resource Centre
32. Somali Banadir Welfare Association of UK
33. The Involvement Consortium
34. Tower Hamlets African Caribbean Health
35. Tower Hamlets Community Church

Children and young people's services

36. Safe Space

Domestic violence

37. Hackney Domestic Violence and Hate Crime Team
38. Nia Project
39. Tower Hamlets Asian Women's Aid
40. Tower Hamlets Women's Aid Community Project
41. Victim Support - Hackney and City of London
42. Victim Support - Newham

Drugs and alcohol

43. Project Liban

Health services

44. A&E Department, St.Anne's Hospital
45. A&E Department, St.Mary's NHS Trust
46. A&E Department, St.Thomas Hospital
47. A&E Department, University College Hospital
48. Bethnal Green Health Centre
49. Community and Salaried Dental Services
50. Medical Justice Network
51. Whitechapel Walk-In Centre

Housing/homeless services

52. Alone in London
53. City of London Homeless Person's Unit
54. Hackney Road Project, Providence Row Housing Association
55. Nacro - Tower Hamlets Accommodation Project
56. Refugee Housing Association
57. Shelter London Advice Service
58. The Poppy Project

Immigration

59. Immigration Advisory Service - Central London

Legal advice

60. Bow Citizens Advice Bureau
61. Bow County Court Citizens Advice Bureau
62. City of London Citizens Advice Bureau
63. Dalston (East End) Citizens Advice Bureau
64. East Central London Prosecution Service, North East Sector, CPS London
65. Hackney Community Law Centre
66. Larkwood Centre/ Citizens Advice Bureau
67. Legal Advice Centre
68. Leytonstone Citizens Advice Bureau
69. Noden & Company
70. Release
71. Sutovic & Hartigan

72. Tower Hamlets Law Centre
73. Walthamstow Citizens Advice Bureau
74. Whitechapel (East End) Citizens Advice Bureau

Local agencies

75. Corporation of London's licensing team

Mental health

76. Chinese Mental Health Association
77. City and Hackney Mind.
78. Early Psychosis Service

Police

79. Bethnal Green (main station) Metropolitan Police
80. Isle of Dogs Metropolitan Police
81. Limehouse Metropolitan Police
82. Poplar Metropolitan Police
83. Tower Hamlets Community Safety Unit

Sexual health

84. GUM Clinic St.Bartholomew's Hospital
85. GUM Clinic, Homerton Hospital
86. St Anne's Hospital, Ugly Mugs.

Social services

87. Corporation of London's social services (adults)

Women's services

88. Account 3 Women's Consultancy Services
89. Black Women's Rape Action Project
90. Positively Women
91. UK Network of Sex Work Projects

Appendix C: Case studies

Case study: Amely

Amely is 47 and comes from an EU Eastern European state. She arrived in London in December 2005. Amely worked as a sex worker in London up until three weeks before she was interviewed for this study. She would usually see four clients a day and charge them £30 each time. Many of her clients were regular and they would meet at the same place.

At the time of the interview, Amely had been on methadone for three weeks. Amely has a history of substance use. She started taking marijuana, then cocaine (aged 20), crack at age 25 and heroin at age 30. Shortly after Amely started using heroin, she became homeless. She also drank alcohol when taking drugs. Amely had previously been through five drug-treatment programmes. When Amely was sex working she would go without food for days, sometimes up to a week because she had 'no time to eat' and 'no money to eat': 'every money that you got was for heroin and coke'.

The use of drugs has had negative effects on Amely's health. Her Parkinson's diagnosis has been linked to taking cocaine/crack. She has also been diagnosed with Bi-polar disorder and Crohn's disease. At the time of the interview Amely was also being tested for STIs (unspecified) and HIV.

When Amely was a sex worker, she would use contraception approximately 50% of the time. Amely experienced incidences of violence when she was a sex worker and reported having been raped several times before arriving in the UK. Amely is currently homeless, but she is staying in shelters provided by churches in the area, which is where she also gets her clothes and meals. Amely expressed a motivation to remain drug-free and to seek employment in the UK.

Source: Interview with service user of local agency

Case study: Anna

Anna is 32 years old and comes from Albania. She has been in the UK since 2000. Anna previously worked as a sex worker in Italy and as a housewife in Albania. At the time of the interview, she was working in Greenwich and had previously worked in Brighton, Leyton and Tottenham. In Greenwich Anna is working in a flat with two other women, one Albanian and one British.

Anna has worked in this flat for four years and her shift is usually from 11 am - 9 pm. On average she sees 10-15 men a shift. Most of her clients are British men.

Anna is working as a sex worker to earn money to send to her family back home, mainly for her brother's education.

Anna's health situation is described as 'good' with no

reported health problems before she arrived in the UK. Anna is registered with a GP who she has seen for blood pressure treatment. Anna is waiting for a decision from the Home Office on her asylum claim and is therefore only able to register temporarily with a GP. Anna reports 'always' using condoms. She travels from Greenwich to access services at CLASH. Anna reported 'sometimes' feeling depressed but does not attribute this to her job.

Anna does not identify as having any substance use problems and drinks alcohol 'once a month'.

Source: Interview with CLASH service user

Case study: Jessie

Jessie is 22 years old and is from Albania. She arrived in the UK three years ago and is currently working in Mayfair. She works in a flat on her own and her hours are from 1:30 pm to 12 am. She usually sees 7-8 clients a day. She said she feels safe in her work place.

Jessie's reasons for going into the sex industry are to earn money and to travel. Jessie expressed a great desire to exit and to get a 'normal' job.

Jessie said she had good health and that her health had not changed since arriving in the UK. Jessie has a GP, but has never needed to go there for a consultation. Jessie reports 'always' using a condom. She used to take the contraceptive pill but the hormones made her ill and she lost a lot of weight. She said she does feel depressed because of her work sometimes and said that it's not exactly a 'dream job'.

Jessie is accessing services at CLASH and a West London GUM clinic. Jessie mentioned how she had had a bad experience at the GUM clinic when the nurse had asked her what she did for a living and Jessie replied 'working woman'. The nurse reacted badly and did not want to treat her. This was some time ago but Jessie is still attending the GUM clinic.

Source: Interview with CLASH service user

Case study: Lina

Lina is a 30-year old sex worker from Russia. She arrived in the UK in 2004 and works for an agency in 'central' London, on outcalls to (mainly) upmarket hotels. Prior to coming to London, Lina worked as a travel agent in her hometown.

Lina identifies her motivation for sex working as a means of supporting her parents and her young son in Russia. Lina works a 'couple of hours' a day and sees one or two clients a day. She has been sex working for

about a year, before that she was living off her savings. She came to London to study English, is on a student visa and would like to find a different job but says finding part-time work in London has become more difficult since the accession to the European Union of the eight CEE countries.

Lina describes her general physical health as 'ok', she has however started smoking since arriving in the UK, which she attributes to the emotional stress of her job. Lina suffers from depression as a result of her work, she self identifies as having 'a lot of emotional problems', feels 'lost', as though she has no-one to talk to and says she 'can trust nobody'. Most of her friends in London are also sex workers; Lina is reluctant to talk to her friends about her problems as she 'doesn't want to burden my friends when they are already unhappy'. Lina's parents and family in Russia are unaware of what she does for a living.

Lina usually feels safe when working but says she is always on her guard against possible violence. She referred to a flat in East London (South Woodford) where an Estonian friend of hers works and which was recently robbed at gunpoint. Lina says she feels 'lucky' in comparison with that friend who Lina says is addicted to cocaine to the point where she 'can't get out of bed without a line, she can't work, can't do anything'.

Lina is not registered with a GP. Since arriving in the UK she has attended an NHS walk-in clinic on one occasion with severe back pain. That clinic advised her to present to A&E where she was diagnosed with a kidney infection and prescribed antibiotics. Other than a long waiting time Lina identified no problems in accessing either of those services.

Lina reports that she 'always' uses a condom, has used a coil in the past and is about to start taking the contraceptive pill.

Lina usually drinks a glass of wine a day, in the evening, to 'help lift my spirits'. In addition, two to three times a week she will drink larger quantities of wine before working, at times when she feels particularly low or when she doesn't feel as though she 'could do it sober'. Lina says getting drunk makes her feel better in the short term but then often feels even more down afterwards. In Russia she would 'hardly drink', maybe once a week when out with friends.

Lina does not use drugs but says that 'most girls' who work for the same agency 'take drugs or alcohol of some kind'. She says the agency charges high rates so the women make 'plenty of money but they're so unhappy, how can anyone be happy doing this job?'

During the course of the interview Lina also referred to a young woman she knows of, an 18-year old Latvian

working in a flat in the Seven Sisters area of London who Lina believes has been 'sold by her parents'.

Source: Interview with CLASH service user

Case study: Megan

Megan is aged 21 from Lithuania and has been a sex worker in London since arriving in the UK two years ago. Her elder sister (by three years) is also a sex worker in London. Megan works on outcalls, mainly to hotels, across London through an agency which advertises through the Internet. Megan used to work in Soho flats but prefers her current working conditions. Megan is essentially 'on-call' 24 hours a day but can choose when she works and usually sees two or three clients a day.

Megan describes her current state of health as 'not good'. She suffers from chronic cystitis (ongoing for 18 months) which antibiotics and other natural remedies have not been able to treat successfully. She is registered with a GP but doesn't feel as though she can disclose what she does for a living as she believes that would affect the treatment she would receive. She also believes that non-UK nationals get a different (worse) standard of service from health providers. Megan attends a private clinic for laser treatment for her cystitis (for which she pays £30 a session) which she says helps her symptoms.

Megan is aware of other sex working women who suffer from 'bad pain' but are scared to go to any clinic/doctor as they are afraid they might be told they can no longer work.

Megan has not experienced any incidences of violence while working but says she generally does not feel safe. Megan's condom use 'depends on the customer' and she does not use a condom for oral sex.

Megan does not drink alcohol as she 'doesn't like the taste'. For a four-month period at the end of 2005/beginning of 2006 Megan was a daily user of cocaine, which was supplied (and paid for) by a male Turkish friend. At the time of the interview Megan had not used cocaine for two months. She stopped using as she 'didn't like how it made [her] feel'. When on cocaine Megan had problems sleeping, lost her appetite and was concerned that she was losing weight. She was able to stop using without any reported difficulties.

Source: Interview with CLASH service user

Case study: Nicole

Nicole is a 22-year old from Romania who arrived in the UK in 2004. She works in a flat in southwest London, mainly alone but sometimes with another woman. She typically works a ten-hour shift and sees on average six clients a day. Nicole estimates that she has worked in approximately 20 different flats across

London in the two years that she has been a sex worker. Before coming to the UK Nicole worked on farms and gardens around her home village.

Nicole is 'generally happy' with her working conditions, she is working in London to 'make a lot of money' and eventually plans on returning to Romania. Nicole describes her general health as 'good' and has not noticed any significant changes in her health since arriving in the UK and starting sex working.

Since living and working in the UK Nicole has regularly attended CLASH's sexual health clinic; she has undergone a cervical coloscopy at a West London GUM clinic and a termination at a private clinic. She tested positive for chlamydia 10 months ago which she attributed to a client removing a condom without her knowledge. Nicole is not registered with a GP and prefers to use walk-in centres for non sexual-related health problems.

Nicole reports using 'extra strong' condoms 'for everything' and is very critical of women who offer unprotected services. She maintains that women need educating about the health risks of (particularly) unprotected oral sex but also admits that some women are aware of the risks but choose to ignore them as a means of saving money more quickly. Nicole is also vociferous about the need to educate the clients on similar health risks and reports an increase in recent months of men requesting unprotected oral sex.

Nicole reports 'occasional' cocaine use (when socialising) but states that she prefers to save her money for her future life in Romania.

Source: Interview with CLASH service user

Case 1

Case 1 is a 22 year old Eastern European (non-EU) woman who was trafficked to the UK but managed to exit the trafficking situation and subsequently returned to her country of origin. Case 1 then returned voluntarily to work in saunas and flats. She regularly attends the clinic for sexual health check ups and looks after her health. Case 1 does not take drugs, but occasionally binge drinks at weekends when going out with her friends. She is having problems in her relationship with her regular boyfriend, feels quite depressed and is having trouble sleeping.

Case 2

Case 2 is a 25 year old Thai woman who was initially trafficked to the UK but has now paid off her contract and is working voluntarily to send money to her family back home. Case 2 misses her family, feels sad and expresses frustration with her job, stating that it 'makes

you mad'. She also says that she does not trust others easily. She copes with these difficulties through prayer and the support of her friends.

Case 3

Case 3 is a 34 year old Turkish woman who works on the streets, uses crack and occasionally smokes heroin. She has ongoing medical and gynaecological problems and uses sexual health services intermittently when in crisis. Case 3 engages sporadically with drug and alcohol services but conflicts with staff often lead to relationship breakdown and her leaving the service.

Source: Psychology Services at the Ambrose King Centre.

Note: Cases 1-3 are amalgamated where all identifying characteristics have been changed.

Case 4

Case 4 is in her mid twenties. She was trafficked to the UK in 2000 after being promised a job by friends from her home country. She ended up working in a nightclub (striptease club/ massage parlour) in London owned by family friends. A month after she arrived in the UK, she started taking drugs (cocaine and cannabis) and drinking alcohol. These were provided by the owners of the club, although according to Case 4 she was not forced to take them. She is a Muslim and had not previously used drugs or alcohol. When she escaped her trafficking situation, she stopped drinking and using drugs. However, Case 4 had developed severe and enduring mental health problems and, following referral to an NHS agency, was assessed as suffering from Post Traumatic Stress Disorder. Her PTSD symptoms included reliving her attacks, hypervigilance, compromised cognition, paranoia and self harm. She was sleeping badly and not eating well. Her treatment included taking an SSRI anti-depressant and seeing a psychiatrist every three months or more often if necessary. Since arriving in the UK, Case 4 has also undergone two terminations.

Source: NHS agency

Case 5

Case 5 is in her early twenties. She was trafficked to the UK by a friend from her home country. Case 5 was made to work as a lap-dancer and sex worker. Case 5 was denied food by her traffickers and instead received supplies of drugs (cocaine and cannabis) and alcohol. She suffered loss of weight. When out of the trafficking situation, Case 5 was referred by her solicitor to an NHS agency for assessment but was not found to suffer from PTSD or as being clinically depressed. Staff did say that

she did present as low in mood and that Case 5 had said she had regular nightmares about her trafficking situation, on a weekly basis. Case 5 stopped using drugs when out of her trafficking situation.

Source: NHS agency

Case 6

Case 6 is 23 years old and is from Thailand. Case 6 paid £10,000 to come to the UK. Her documents were taken away by the people who organised her journey, with the promise they would be returned to her when she had paid back the money. Having arrived in London, Case 6 decided to work as a sex worker in order to pay back the debt. Case 6 worked independently and saw up to ten clients a day. Case 6 has tested positive for HIV and is currently pregnant. She is receiving ante-natal care of which part of her treatment is to avoid transmission of the virus from mother to baby. Case 6 did not get her documents back upon re-paying the money she owed, something which has complicated her immigration status in the UK and which eventually will mean that she will not be able to get recourse to public funds whereas her child will.

Source: Ante-natal care clinic

Case 7

Case 7 was 16 when she arrived in the UK from Uganda in 2003. For the first four months, Case 7 was held captive here. Details of her captivity are vague and not fully known. Case 7 was under the care of the asylum team of social services in East London. On her way to the UK, she had been raped in transit. She was pregnant as a result of the rape and social services organised the termination for her. She had at this point not been tested for HIV or STIs. When she was referred to Project DOST, Case 7 expressed concerns about this and, with the support of a project worker, she attended a clinic for comprehensive sexual health testing. Case 7 tested HIV positive. Case 7 stayed in semi-independent housing in London, but when Case 7 turned 18 she was detained. Before returning home Case 7 asked Project DOST to collect all her personal belongings from the place at which she had been living. When collecting her things, Project DOST found photos of Case 7 with white middle aged men and the photos were from different cities across the UK. Project DOST believes this points in the direction of Case 7 having been sexually exploited during her stay in the UK, although Case 7 denied this.

Source: Project DOST

Case 8

Case 8, a client of NSPCC Sexual Exploitation Service (SES), is a 15 year-old British born mixed race girl who until recently was living in a children's home in Tower Hamlets. When she was 14 she began exchanging sex for crack cocaine and other drugs in flats/ crack houses and cars in Tower Hamlets and other London boroughs.

SES became aware of Case 8's situation in 2005 and soon began advocating for her to be placed in a secure unit for her own protection. However, secure placements are seen as a last resort when all other placements have been exhausted. Case 8 was therefore placed in a drug rehabilitation centre from which she absconded. She was then placed in a local children's home on the condition that she continue to work with SES and receive treatment for her substance misuse. During this time, Case 8 lived in different children's homes in Tower Hamlets and other parts of London.

Case 8's treatment included a daily meeting with a drugs worker specialised in treating adolescents, contact with nursing staff and key work from SES. In addition, she frequently attended a sexual health clinic, where she was tested for STIs and provided with emergency contraception on more than one occasion.

Tower Hamlets social services eventually agreed to place Case 8 in a secure unit in February 2006. By this time the police had begun looking into the case as part of a wider investigation into a paedophile ring apparently targeting children's homes and vulnerable young people in London. The police have identified several Looked After young people sexually exploited by this group of adults. There is serious concern that other young people in care in Tower Hamlets and elsewhere in London are being sexually exploited by being coerced into serious drug misuse which they then have to repay in sexual services.

Because Case 8 is in the secure unit and therefore no longer at risk of exploitation, intimidation or possible retribution the police have been able to gather evidence from Case 8 in the hope of prosecuting the people running the operation.

Source: NSPCC SES

Case 9

In 2001, an Asian woman was abducted at a wedding in her country of origin and forced to go through a marriage ceremony with the abductor. Her husband used her to 'entertain' his friends by forcing her to have sex with them. In 2005, one of the husband's friends took her to the UK, also for the purposes of sexual exploitation. By this time Case 9 had had one

termination and two children, both girls. One of her daughters was brought with her into the UK; she does not know what has happened to her other daughter. Case 9 and her daughter were taken to the North of England. They stayed in a flat there where some clients were introduced to the woman.

In November 2005 Case 9 was told by the man who had brought her into the UK told her that she was going to travel to Europe. She was taken to a house full of men in the East End of London and left there. Her trafficker disappeared and she overheard the other men talking. They informed her that they had purchased her and later raped her.

Case 9's child, now about four years old, became unwell and was taken to an Accident & Emergency department. In hospital it was revealed that the child had been sexually abused by the men who were abusing the mother. The child confirmed this. Social services were alerted and they decided to take the child into care given the nature of the woman's work and her status as an illegal immigrant.

Case 9, now aged 30, was referred to a local refuge following the hearing at the High Court. She is being represented by a law firm in Tower Hamlets. At the time of writing, she was still in the temporary accommodation offered by the refuge, paid for by social services (although as an illegal immigrant the woman would normally have no recourse to public funds and in such cases social services have no obligation to assist parents whose children have been removed from their care). The refuge was seeking to refer the woman on to another organisation.

There was no involvement of drugs or alcohol in the woman's trafficking experience as far as the refuge knows.

Source: Local women's refuge

Case 10

An Eastern European woman in her mid twenties was found by CO14 during a raid on a brothel in London in late 2005. She had been in the UK illegally for two or three years working in off-street prostitution and claimed to have been trafficked. She alleged that she had been raped over a year previously in a sauna in Bethnal Green, which she had not reported before because she was afraid of the police. She was therefore referred to the Sapphire unit in Tower Hamlets. Case 10 failed to substantiate her claim or to turn up for appointments with Sapphire in order to follow up on the case. Sapphire suspected that she made the rape allegation in order to avoid being deported. Case 10 did not present as drug dependent.

Source: Sapphire, Tower Hamlets police

Case 11

In about 2003, Hackney Asian Women's Aid had contact with a trafficked woman from Asia. Case 11's precise age was not known but she is thought to have been under 40. Case 11 had been promised a job in the UK, which did not materialise, and was then prostituted in a flat in London. She managed to escape from the premises and was referred to the police, who referred her to the Hackney Asian Women's Aid for accommodation and advice on immigration, among other subjects. Case 11 is known to have been drugged as part of her sexual exploitation, although no further information was available on this.

Source: Hackney Asian Women's Aid

Case 12

In around 2003, Hackney Asian Women's Aid provided assistance to a mixed race Asian/white (probably second generation) sex worker who was trying to escape her pimp. She was housed in a Hackney Asian Women's Aid refuge. Despite the refuge's 'no drug' policy, Case 12 drank alcohol on a daily basis, often to the point of being drunk, and also used cannabis. She moved to another refuge as she was afraid that her pimp would discover her location.

Source: Hackney Asian Women's Aid

Case 13

In around 2000, Hackney Asian Women's Aid assisted a 19-20 year-old Indian Sikh woman who was brought to live in the UK with her husband and mother-in-law. At first the husband and mother-in-law had treated Case 13 normally, but after about six months their behaviour changed and they began to pressurise her into having sex with strangers in a hotel. They threatened her with sending her back to India if she refused. Case 13 was from a very poor background and was scared of going back to India because of the stigma and fear of being a burden on her family. She therefore agreed to have sex with strangers a few times. She escaped from the family and came to Hackney Asian Women's Aid. The organisation was able to help her be re-housed since by then she had permanent residence in the UK. Case 13 said that her husband's family often used to drink alcohol to the point of getting drunk in the evenings and encouraged her to do the same, although she had not previously drunk alcohol.

Source: Hackney Asian Women's Aid

Case 14

In about 2003, a Brazilian woman who alleged to have been trafficked was referred to the Maze Marigold Project (a former project for young vulnerable women in prostitution based in Tower Hamlets). According to Case 14, she had been sold into bonded domestic labour in the UK by her family but was also expected to provide sexual favours as part of her work. She had eventually run away, met a series of men and had a child.

When Case 14 was referred to Maze Marigold, she was about 33 and had been in the UK for about five years. She had been working in a brothel in South London and living with a Russian pimp who was beating her regularly and threatening her life. One day he attempted to strangle her. A maid from the brothel where the woman worked let the woman stay with her for a few days but then, afraid that the pimp would discover the location, contacted a sexual health outreach service provider, who in turn referred Case 14 to Maze Marigold. At about the same time, Case 14 discovered that her pimp was planning to sell her son, who was being looked after by friends of the pimp's, to two gay men. She was allowed a last visit to the child and managed to escape with him.

Maze Marigold referred Case 14 to Eaves Housing for Women. However she did not fit Eaves' criteria and was returned to Maze Marigold with her son. Maze Marigold then attempted to find accommodation for them. This was extremely difficult because as an illegal immigrant Case 14 had no recourse to public funds. Maze Marigold had to call the duty officer at social services every evening from the police station to see if the woman and her child would get accommodation that night.

Eventually a central London social services department got in touch about the child, who was being at risk of being abducted and sold, and gave Case 14 and her son accommodation in a refuge overnight. The next day, social services took the boy into care, but arranged for Case 14 to visit him and continued to fund her place in the refuge while the case was resolved. Case 14 made a statement to the police.

The British authorities started to make arrangements to deport Case 14 and her son back to Brazil. Case 14 was afraid that her traffickers would find out and threaten her family. She stopped visiting her son and cooperating with the police. She and her son were apparently deported.

Case 14 had been given cocaine by her pimp but did not present as having a drug problem. She was sometimes depressed. When she was referred to Maze Marigold, marks were visible on her neck from attempted strangulation by the pimp. Her access to services was limited by the fact that she was an illegal immigrant

and spoke little English. She had however had sexual health check-ups via the brothel where she worked.

Source: Staff member of U-Turn Project, formerly of Maze Marigold Project

Case 15

Case 15 is a 26-year-old 'independent' sex worker from Brazil who works in a flat in Tower Hamlets and in other flats outside London. She works shifts of 10-12 hours and sees three to 10 men per shift.

She reported 'always' using condoms and has quarterly sexual health check-ups. Her last test was recent and showed she was 'clean' of STIs. She attends a hospital in Whitechapel for check-ups and condoms, and also goes to The Space in Earls Court for condoms and information on sexual health. The flat in Tower Hamlets where she works does not receive outreach visits from any sexual or other health organisations and, as far as she knows, has never been contacted by any such organisation. She felt that outreach visits would be useful.

Case 15 said that although she was quite aware of health issues and tries to be 'as safe as possible, she thinks there are 'lots' of migrant women who need information on how to deal with sex work safely. She believes many of them are engaging in risky behaviour such as unprotected sex and need to be made more aware, e.g. via leaflets on sexual health for sex workers. According to her, a lot of these girls cannot (legally) work in the UK but do it anyway and so are wary of discussing their problems or seeking treatment in case their irregular situation comes to light or for fear of being judged.

Case 15 said she suffered from depression, which she attributed to the nature of her work - she only started doing sex work in the UK and said: 'the work is not easy'. She has taken antidepressants in the past but stopped because she felt better and thought she had to 'face her problems rather than take pills'.

She reported drinking alcohol, particularly wine, to get through long days. She said that the amount she drinks depends on the number of clients she has - the more clients, the more alcohol. She regularly drinks a bottle of wine per shift. She has taken cocaine in the past with clients but she had a 'bad experience' with it and does not take drugs any more. She is aware of other migrant sex workers using drugs, e.g. marijuana, cocaine and tobacco. However, she would not describe any of them as heavy users. When they use cocaine it is usually because the client brings it.

Source: Telephone interview with migrant sex worker

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