

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

Summary Findings



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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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Tower Hamlets Partnership

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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 of London (the 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 extensive. 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, 2004; 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 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.

1 Including Dickson, 2004 and Lilley, 2005.

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

The telephone survey carried out for the current study indicates a slightly lower proportion of foreign nationals than did Dickson (2004), 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).

Overall, the most common regions identified 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%).

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.

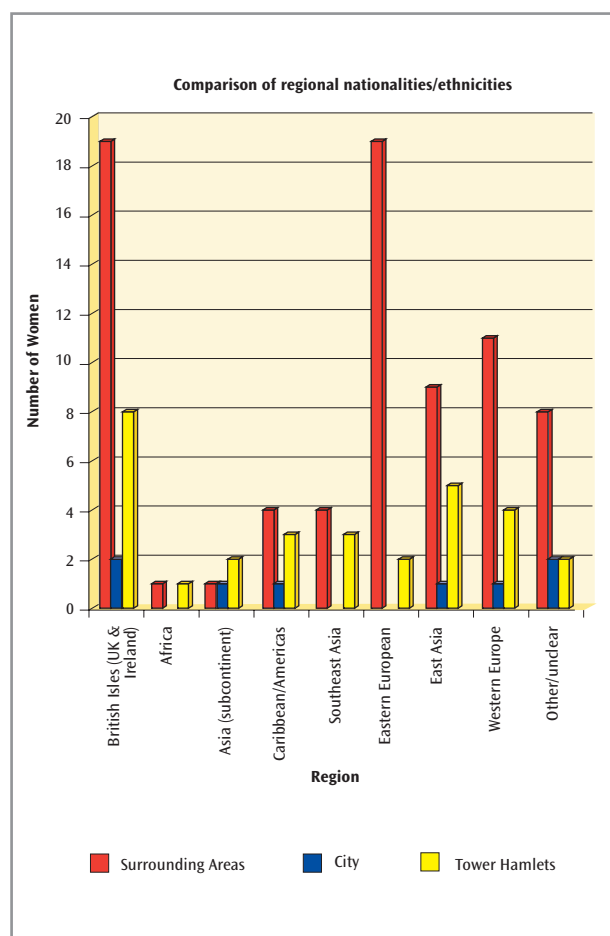
Tower Hamlets was found to have 21 off-street premises with 30 women. Eight women were from the British Isles. The other 22 women were identified as the following ethnicities/nationalities: Brazilian; Burmese; Chinese; Czech; Egyptian; half Indian/half Bengali; Hong Kong; Indian; Italian; Japanese; Oriental;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

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.



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.

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.

The most common regions identified in PunterNet reports 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.

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

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 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 introducing 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

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.

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.
- 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.

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Further information

These findings represent a summary of the report, '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'.

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