Confronting the harm:

Documenting the prostitution experiences and impacts on health and wellbeing of women accessing the Health Service Executive Women's Health Service

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SERP

Contents

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1 Current members (2021): Emeritus Associate Professor Ursula Barry, UCD, Dr Paul D'Alton, UCD, Salome Mbugwa, AkiDwA, Dr Sarah Morton, UCD, Dr Denise O'Brien, UCD, Emeritus Professor Philip O'Connell, UCD and Dr Nusha Yonkova, Irish Human Rights and Equality Commission.

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Ruth, Linda and Monica

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About the authors

Ruth Breslin has over twenty years of research experience in both NGO and academic settings. She has an MSc in Social Research Methods (Social Policy) from the London School of Economics and Political Science. The focus of Ruth's work has been efforts to tackle and prevent violence against women and girls, and she has developed particular expertise in research and policy development on the interrelated issues of prostitution and trafficking for the purpose of sexual exploitation. Ruth is regularly called upon to input into the development of evidence-based policy, legislation and practice in this regard. Ruth was the Research Manager for Eaves on the first ever national study on women exiting prostitution in the UK – *Exiting Prostitution: A Study in Female Desistance* (2014). Ruth also designed, led and co-authored the study *Capital Exploits: A Study of Prostitution and Trafficking in London* (2013), commissioned by the Mayor of London as part of his strategy to end violence against women and girls in the city. More recently in Ireland, in her role with the specialist frontline support service Ruhama, Ruth designed and undertook research to gather professional views on how to reach out to vulnerable women and girls involved in Ireland's sex trade – *The REACH Project: Practitioner Insights* (2014). Ruth is now a core member of the research team at SERP – the Sexual Exploitation Research Programme at University College Dublin. She is the author of SERP's study on the impacts of the Covid-19 pandemic on Ireland's sex trade – *Exploitation 'As Usual'* (2020), and co-author (with Dr Monica O'Connor) of SERP's comprehensive study on the commercial sex trade in Ireland with regard to the application of current prostitution legislation – *Shifting the Burden of Criminality: An Analysis of the Irish Sex Trade in the Context of Prostitution Law Reform* (2020).

Linda Latham is the Manager and Clinical Nurse of the HSE Women's Health Service (WHS) and Anti-Human Trafficking Team (AHTT). Linda trained in Munich in 1990, specialised in Critical Care Nursing in the UK, and worked in both Accident & Emergency and Intensive Care medicine in Germany, Australia, the UK and Ireland. Her particular interest in working with marginalised groups became evident when she had the privilege of working with Aboriginal communities in Alice Springs and the Australian Outback. In Ireland, Linda's work has centred on care for addicted persons and sexual health for gay men and for women involved in prostitution and sex trafficking. She is the architect of the holistic model of service that WHS now provides. This model has moved away from the constraints of harm minimisation to adopt a more progressive and forward-thinking ethos in responding to the real needs of women in prostitution. In 2000 Linda completed a Fine Art/History of Art degree in Cambridge and in 2007 a Master's degree in Women's Studies, which formed the basis of her theoretical analysis of sexual exploitation within the commercial sex trade. In 2008 Linda developed the HSE's National Care Plan and model of care for victims of trafficking for sexual exploitation, which was later expanded to include labour exploitation, sham marriage and forced begging. Linda is also a HSE trainer on Domestic, Sexual and Gender-Based Violence. She is currently completing an MSc in Healthcare Leadership and Management at the Irish Management Institute (University College Cork).

Dr Monica O'Connor has worked on gender-based violence for over thirty years, as a practitioner, policy analyst and researcher. She has acted as a principal researcher on key projects that have investigated the nature and impacts of male violence. She is the author and co-author of numerous publications on violence against women, including a major study of the sex trade in Ireland (Kelleher Associates, O'Connor, and Pillinger, 2009). In 2010 she received a three-year Government of Ireland Scholarship from the Irish Research Council to undertake doctoral research examining the issues of choice, consent, agency and harm in the lives of prostituted and trafficked women in Ireland. Dr O'Connor has worked closely with non-governmental and statutory services in developing ethical guidelines surrounding the participation of service users in research. She has conducted

over fifty in-depth interviews and numerous focus groups with women who have been subjected to domestic and sexual violence and with women affected by prostitution and trafficking. She is currently a senior researcher at the Sexual Exploitation Research Programme (SERP), University College Dublin and a Research Fellow at the WiSE Centre for Economic Justice, Glasgow Caledonian University. In 2019 Dr O'Connor published her first book on the global commercial sex trade: *The Sex Economy* (Agenda Publishing).

About SERP

The Sexual Exploitation Research Programme (SERP) was established in 2017 under Associate Professor Ursula Barry (now Emeritus) in the School of Social Policy, Social Work and Social Justice at University College Dublin. SERP is part of UCD's Geary Institute for Public Policy, which is a centre for policy-relevant, theoretically informed, empirically grounded research. SERP is chaired by Dr Marie Keenan, Associate Professor in UCD's School of Social Policy, Social Work and Social Justice.

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SERP conducts independent feminist research on all forms of commercial sexual exploitation that creates useful knowledge for law and policy makers, practitioners, survivors, supporters and activists. SERP aims to strengthen the evidence base on current and emerging issues of sexual exploitation in Ireland, and beyond. SERP's work is designed to enhance understanding of the commercial sex trade, its impact on women and girls who are sexually exploited, on communities and on society at large. In addition to strong links with international partners and allies, SERP also works collaboratively with support services for victims and survivors of prostitution and sex trafficking on the ground, seeking to bridge the gap between academia and frontline practice in generating new knowledge, insights and solutions on these issues.

Preface

This study on the prostitution experiences and impacts on health and wellbeing of women accessing the HSE's Women's Health Service (WHS) was undertaken by SERP between the Spring of 2018 and January 2020. The bulk of data collection within the service itself was undertaken from April to August 2019, focusing on a sample of women who accessed WHS for the first time between the start of 2015 and the end of 2018.

A final draft of the study's report was submitted to funders in the HSE's National Social Inclusion Office for their approval at the end of January 2020. The global Covid-19 pandemic arrived on Ireland's shores shortly thereafter. Ireland's health service came under enormous pressure almost immediately and the HSE understandably placed SERP's report on hiatus. WHS had no choice but to close its Clinical service, although staff continued to actively advise and support women by phone.

During 2020, SERP completed its large scale, multi-method study on the Irish sex trade in the context of recent prostitution law reform,[2] which was already in progress as the pandemic raged. At the same time, we also took the opportunity to investigate the impact that Covid-19 was having on the trade.[3] It was clear that the pandemic had dire consequences for women in prostitution, including those who access WHS – women's poverty, vulnerabilities and the levels of danger and isolation they face within the trade were heightened even further by this global crisis. WHS reported that, as a result of the pandemic, women were under greater financial pressures than ever before and feeling even more trapped than ever within prostitution. Disclosures of violence perpetrated by partners, buyers and pimps increased. Buyers also increased their demands for risky practices, and without direct access to testing and contraception, harm to sexual health was a serious issue for many of the women who would usually access WHS. Women were supported remotely by the service with issues relating to crisis pregnancy and termination, emergency contraception, sexual health problems and the emergency treatment of infections. As a result of these heightened risks and experiences of significant harm, many women's mental health also suffered, with increased reports of stress, depression and feelings of extreme isolation, as well as an increase in drug use in some cases.[4]

WHS's Clinical service recommenced its in-person services in the Spring of 2021. Following approval from the National Social Inclusion Office, SERP is now in a position to publish this long-awaited study on the health impacts of prostitution. Despite the different times periods and contexts in which our recent research studies have been undertaken, we have attempted as far as possible to reflect or reference any relevant findings in this report.

We release this study into a world seismically changed by the global Covid-19 pandemic, in which the poverty, vulnerabilities, harms and exploitation experienced by marginalised people around the world have been further heightened and exacerbated by the crisis, and women in prostitution are certainly no exception in this regard.

2 O'Connor, M., and Breslin, R., 2020. *Shifting the Burden of Criminality: An Analysis of the Irish Sex Trade in the Context of Prostitution Law Reform.* Dublin: SERP.

3 Breslin, R., 2020. *Exploitation 'as usual': Emerging Evidence on the Impact of Covid-19 on Ireland's Sex Trade.* Dublin: SERP.

4 *ibid.*

Introduction and research aims

Women in prostitution in Ireland experience particular health inequalities and barriers to accessing appropriate healthcare.[5] This study was commissioned by the National Social Inclusion Office of the Health Service Executive (HSE) in 2018, in recognition of the need to strengthen the evidence base on the health impacts of prostitution and the supports that women require, given the dearth of research in this area. The overall aim of the study is to provide empirical data on the impact of prostitution on women's physical, sexual, reproductive and mental health. The research has been devised to support the HSE Women's Health Service in documenting the presenting issues of their service users.

Specifically, this study is designed to:

- Provide a profile of women in prostitution presenting to the Women's Health Service (WHS)
- Investigate the factors and circumstances which draw women into prostitution in the first instance
- Explore women's experiences within the Irish sex trade
- Document the impact of prostitution on women's physical, sexual, reproductive and mental health and wellbeing
- Document the risks and violence women have experienced within the Irish sex-trade
- Explore women's intentions to exit prostitution and the challenges they face in doing so
- Contribute to the body of academic evidence in an under-researched area in Ireland, which can also directly inform policy and practice, as well as pointing the way for future research.

This study is a collaborative effort between the HSE WHS and the Sexual Exploitation Research Programme (SERP) at University College Dublin.

A note on language

Throughout this report the authors use the broad, inclusive terms 'women in the sex trade' or 'women in/involved in prostitution'. The term 'prostitute' is not used; whilst it is the term used in Irish law, it has very negative connotations for women. Nor is the term 'sex worker' used, as only a small minority of women in the Irish sex trade self-identify as such. None of the women accessing WHS who were interviewed for this study use the terms 'sex work' or 'sex worker' to describe their involvement in prostitution. Furthermore, 'sex work' and 'sex worker', in attempting to frame prostitution as a form of regular work, are regarded by survivors of the sex trade as exclusive and deeply problematic terms that serve to obscure and obviate the profound harms of sexual exploitation that they have endured.

5 Walsh, K., 2019. *Women's Health in Ireland: Evidence Base for the Development of the Women's Health Action Plan*. Dublin: National Women's Council of Ireland, Department of Health, Health Service Executive.

The focus of this study is women and girls, who represent the vast majority of those in prostitution, both in Ireland[6] and globally. Throughout the report this includes transgender people in prostitution who self-identify as women.

6 Less than one percent of profiles on Ireland's largest online prostitution advertising platform are advertised as 'male' (see O'Connor, M., and Breslin, R., 2020, *op cit*).

The HSE Women's Health Service

Background and services provided

The HSE Women's Health Project, as it was originally called, was first established in 1991 in Dublin as the only specialised service in Ireland responding to the health needs of women in prostitution. The original aim of WHP was to prevent the spread of HIV and promote safer sex and safer drug use. It has evolved over the decades, in response to the evolution of the Irish sex trade itself, from a service that worked almost exclusively with Irish women in street-based prostitution to one that now works primarily with migrant women located in brothels and other indoor prostitution locations. Today, WHS provides wide-ranging healthcare, support and advocacy to women involved in prostitution across Ireland.

WHS provides a free sexual health service including full sexual health testing, smear tests, treatment, contraception and onward referrals, as required, to women currently involved in prostitution, including transwomen. The Clinical service is provided by a doctor and nursing staff who specialise in the promotion and care of sexual and reproductive health. Several clinics are run each week on a drop-in basis. Running alongside the Clinical service, WHS also provides a non-clinical 'Outreach' service. The Outreach service is delivered by support workers providing advice and advocacy, who can assist with a broad range of issues women in prostitution may be experiencing, including safety concerns, concerns regarding their sexual or mental health, substance misuse, housing problems, financial problems/debt, legal or criminal justice issues, immigration concerns, violence and any other challenges women may be facing. The Outreach team also assists women who are seeking to exit prostitution and provides support, advice and referrals accordingly. Women receive assistance during clinic hours, but separate opportunities are also available to receive more in-depth support. Recently, the more intensive support being provided by WHS has evolved into Outreach staff offering a dedicated casework service for some women.

WHS works alongside the Anti-Human Trafficking Team. The AHTT grew from the need to identify and address the needs of women who were being trafficked into the Irish sex trade. The team later took on responsibility for the care of victims of labour trafficking, sham marriage and forced criminality also. Potential victims are referred to the AHTT by An Garda Síochána.[7] They are allocated a caseworker and an individual care plan is designed to address, insofar as possible, the many complex needs and issues that may have arisen as a result of their experiences of exploitation. Supports provided by the AHTT include access to safe accommodation, access to healthcare, support with family separation issues, liaison with Gardaí regarding their investigations, finances and access to legal aid, social welfare, education and development and other forms of assistance.

Given their role in providing specialist support to vulnerable persons who have experienced violence and exploitation, and migrant women in particular, the work of both WHS and AHTT is grounded in and shaped by a number of relevant national policies and strategies, including the HSE's own *Intercultural Health Strategy*,[8] the *Second National Action Plan to Prevent and*

7 The Irish national police service.

8 HSE, 2018. *Second National Intercultural Health Strategy 2018-2023*. Dublin: HSE.

Combat Human Trafficking in Ireland,[9] the *Second National Strategy on Domestic, Sexual and Gender-based Violence*[10] and its related *Action Plan*.[11]

WHS and AHTT share the same management and staff and cross-referral occurs between the two teams, depending on women's needs. All aspects of the service take a holistic healthcare management approach and provide a non-judgemental environment where women can attend to their health but also their wider support needs. Another vital aspect of the service is that it is free at the point of access regardless of one's immigration status – undocumented persons can attend the service without fear of consequences. With staff operating across both WHS and AHTT teams, this allows them to share knowledge and expertise as well as enhancing their professional understanding of exploitation within the Irish sex trade, whatever form that may take. Due to the time and resources constraints associated with this study, it was not possible at this time to document the specific health impacts of being trafficked for sexual exploitation, as experienced by those who access AHTT, but this is certainly an area which merits further investigation.[12]

Developing support for women seeking to exit prostitution

WHS began as a service designed to minimise the immediate health harms of prostitution. However, over the years the service recognised the limitations of this model, which prevented a holistic approach to women's needs and did not address any of the reasons that many women had become trapped in prostitution in the first instance. Some of the limitations and flaws associated with an approach to supporting women in prostitution that is based solely on harm minimisation have been documented in recent Irish research.[13] WHS staff began to recognise the futility of merely trying to 'keep women safe' within an inherently unsafe trade, without offering any other alternatives. Focusing only on issues such as crisis, sexual health, and immediate respite (the realm of harm reduction), was seen to represent a very narrow understanding of women's health and wellbeing, one that fails to address more complex, long-term issues such as harms to women's mental health and personal relationships. Thus, while harm minimisation is still considered an essential offering of the service, the impacts of WHS's interventions have been greatly enhanced by moving beyond the limitations of harm minimisation to also provide women who wish to leave prostitution with the supports to do so. Addressing exiting is performed sensitively and professionally over a phased period of time and gives each woman who engages with this aspect of the service the opportunity to review her options and life plans without pressure. Onward referrals to specialist services that can further support exiting are also made, as necessary.

9 Department of Justice and Equality, 2016. *The Second National Action Plan to Prevent and Combat Human Trafficking in Ireland.* Dublin: Anti Human Trafficking Unit, Department of Justice and Equality.

10 Cosc – The National Office for the Prevention of Domestic, Sexual and Gender-based Violence, 2016. *The Second National Strategy on Domestic, Sexual and Gender-based Violence 2016-2021*. Dublin: Cosc.

11 Cosc – The National Office for the Prevention of Domestic, Sexual and Gender-based Violence, 2016. *Action Plan: Second National Strategy on Domestic, Sexual and Gender-based Violence 2016-2021*. Dublin: Cosc.

12 However, this study does include the experiences of women who initially accessed WHS but were subsequently referred to AHTT because WHS staff identified indicators of trafficking in their cases.

13 Breslin, R., 2020, *op cit*.

Specific supports on offer

To fully understand the data collected from WHS's Outreach service during the course of this study, it is necessary to also understand the extensive breadth of the service's work, which reflects the breadth of the needs of the women who access the service and the many adversities they face. Advice, support and advocacy is offered to women in relation to the following:

- Sexual health promotion, contraception and safer sex advice
- The provision of free sexual health supplies, including condoms, lubricant (lube), dental dams, gloves etc.
- Needle exchange
- Advice on staying safe in the sex trade in general
- Facilitation of interpreters
- The provision of printed safety and health advice and information materials in a wide variety of languages for women to take away with them
- Practical and emotional support
- A Garda liaison service which readily facilitates contact between women and the Gardaí if they wish to discuss any concerns, make a complaint or report an incident
- Support and referrals following physical or sexual assault
- Support and referrals for women struggling with mental health problems or substance misuse
- Counselling referrals
- Support for crisis pregnancies and termination of pregnancy
- Accompaniment to legal/solicitor/immigration appointments and meetings with the Gardaí
- Court accompaniment and support
- Referral and linking in with specialist services, such as free and/or migrant-friendly GP services, trans-friendly health services and GPs
- Referral and linking in with specialist NGOs providing support in relation to issues such as domestic or sexual violence, exiting prostitution, immigration advice, migrant rights, transgender advocacy
- Liaison with Community Welfare Officers and other State bodies
- Exiting supports, including exploring women's options and providing information, assistance and onward referral to a variety of opportunities for women such as English language classes, education and training, career planning and entrepreneurship
- Joint working with AHTT colleagues, for example on cases where trafficking is suspected or indicated.

Clearly, the range of supports provided is extensive and it is worth stating that in addition to all of the face-to-face interactions WHS staff have with women, in some cases a great deal of further support is also provided to and on behalf of women by telephone and email. It is also worth noting that for many women in this study's sample, WHS is the only health service they are accessing in Ireland (see 4.11).

Research methods

This study takes a mixed methodological approach, employing both quantitative and qualitative research methods. These include:

- Analysis of a sample of 144[14] unique service user records of women who accessed WHS between 2015 and 2018 to develop a profile of service users, and gather data on their entry into and experiences within prostitution, and their health and other support needs
- Analysis of the medical files of 50 of the wider sample of 144 women[15] to ascertain the main physical, sexual and reproductive health issues women present to WHS with, and the treatment/interventions they receive as a result
- Semi-structured interviews with WHS staff, which focus on the needs of women accessing WHS, the perceived psychological, sexual and physical impacts of prostitution on the health and wellbeing of the service users, and how the service responds
- One-to-one in-depth interviews with women accessing WHS, which explore their entry into prostitution, their experiences in the Irish sex trade, any impacts this may have had on their health and wellbeing and their support needs as a result.

The study achieved full ethical approval from University College Dublin's Human Research Ethics Committee and adhered to the highest ethical standards in conducting research with vulnerable groups (see Appendix A for further details).

2015-2018 is the 'sampling period' from which women's records were selected. Data collection itself took place from April to August 2019 and data were collected from the service user records on women's attendances right up to the end of August 2019. This means that regardless of the year in which a woman first accessed WHS (2015/2016/2017/2018), data were collected from the records about her attendances up until the end of the summer of 2019.

The service user records contain an initial assessment that is typically completed as much as possible during a woman's first visit to WHS, although often further details are added to this at subsequent visits. The service user records also contain all notes made by Outreach staff about each woman's attendance at WHS, whether she accessed Outreach support, what was discussed, the types of support provided and any staff observations or concerns about each woman.

The quantitative data presented in the report that follows are based on an analysis of the full sample of 144 anonymised service user records, unless otherwise stated. In Section 4 on the physical, sexual and reproductive health impacts of prostitution, the bulk of the analysis is based on the 50 medical files that were sampled from within the wider sample. On topics such as mental health and wellbeing, exiting prostitution and women's plans for the future, much of the quantitative data are based on an analysis of the service user records of women who attended WHS more than once between the start of 2015 and the end of the data collection period (100 women in total), as there was typically insufficient information available on these topics in the records of women who attended the service only once.

14 This sample of 144 women represents 54.3% of all women who accessed WHS for the first time between January 2015 and December 2018. For more information on the sampling techniques used see Appendix A.

15 Women who had attended the WHS's Outreach service five or more times according to their Outreach notes were chosen to be part of the 'medical sample' on the basis that they were likely to have engaged with the Clinical service a similar number of times – see Appendix A for further details.

The qualitative data and analysis that follows are derived from three key sources – the service user records, staff interviews and interviews with women accessing WHS. Qualitative data drawn from Outreach staff notes on each woman's attendances are presented in anonymised summary form throughout the report,[16] with specific case examples used to illustrate key themes that emerged from the wider body of data. These include direct citations from WHS staff, in single quotation marks, and from the women who access WHS, in double quotation marks. The analysis of data from interviews with WHS Outreach staff, Clinical staff and administrative staff is incorporated throughout the main text of the report. The insights of the Service Manager as a co-author of this report are also reflected throughout. All verbatim quotes included in the report are the words of women accessing the service as spoken by them in interview. Reference is also made to Irish and international literature on the nature of prostitution and its impacts that reflect the findings of this study.

All of the women in the main sample of 144 were currently involved in prostitution at the point at which they first accessed WHS, with just two exceptions.[17] The limitations of the data are set out in Appendix A, but one key limitation to be borne in mind throughout any reading of this report is that this sample cannot claim to be representative of all women in the Irish sex trade. Rather, it is representative of those women who are in a position to be able to access WHS. It has previously been acknowledged that women in prostitution in Ireland are not a homogenous group and how they interact with health services may differ depending on their context, including for example whether they are a victim of trafficking.[18] It became clear during the course of this research, and was further verified by WHS staff and the women themselves, that the profile of those accessing WHS tends be older on average than women in the trade as a whole, and (with some exceptions) they typically possess the freedom of control over their own movements to at least be in a position to actively seek out and access the support of WHS. This sample, therefore, does *not* include those women in the Irish sex trade who are prevented from accessing any forms of support or assistance, including healthcare, by a pimp or other third party.[19]

Appendix A contains further, more detailed information on how the study was established, sampling techniques, the nature of the data collected, data analysis, limitations of the data and ethical considerations.

16 Women are identified in this context only by their unique research number (i.e., W1, W2 etc.) and their nationality, where this itself does not risk identifying them.

17 W67 and W105, both of whom had been involved in prostitution up until very recently prior to their first engagement with WHS but were not involved at their first visit – in one case because she appeared to have been trafficked but had escaped and in the other because she had been attacked and was too frightened to see buyers at that time.

18 Walsh, K., 2019, *op cit.*

19 Walsh, K., *ibid.*

Findings

The findings of this study are structured and presented as follows. Section 1 describes the profile of the women who access WHS. Section 2 explores their point of first entry into prostitution and the circumstances that led them there. Section 3 outlines women's experiences of being in prostitution in Ireland, with a focus on the risks and harms that they face. Section 4 considers in detail the impacts of prostitution on women's health, and on sexual, reproductive and mental health in particular. Finally, Section 5 describes the ways in which women can find themselves trapped within the sex trade and ultimately their desires and plans to exit prostitution.

1. Profile of women accessing WHS

Section 1 outlines the profile of the sample of women who accessed WHS for the first time between the start of 2015 and the end of 2018, providing a sense of their origins, backgrounds and life circumstances.

1.1 Nationality

The globalised nature of the European sex trade has been in evidence in Ireland from the early 2000s onwards. Research in 2009 revealed that between 87% and 97% of women in prostitution in Ireland are migrants, with women of 51 different nationalities advertised online.[20] The current sample, which is derived from a single support service only, comprises 26 different nationalities, and also demonstrates that women in the Irish sex trade originate from across the globe – almost 94% of the sample are migrant women (see Table 1). The origins of women in this sample broadly reflect the profile of those advertised for prostitution in Ireland, as established by the latest research on the Irish sex trade in 2020,[21] in particular the preponderance of Latin American and Eastern European women therein. At the same time, it is also important to note that access to WHS is strongly peer-led. Almost three quarters of the whole sample (73%) stated that they were referred to WHS by a friend or peer; with women typically referring those of the same nationality. In many cases, women were directly accompanied to WHS for the first time by a friend or peer.

In the wider context, the European sex trade tends to be characterised by patterns of migration from the global South to the global North, and increasingly within Europe, from the Eastern and Central European countries to the wealthier Western European States.[22] These patterns are also reflected amongst those who access WHS.

20 Kelleher Associates, O'Connor, M., and Pillinger, J., 2009. *Globalisation, Sex Trafficking and Prostitution: The Experiences of Migrant Women in Ireland.* Dublin: Immigrant Council of Ireland.

21 O'Connor, M., and Breslin, R., 2020, *op cit.*

22 Eurostat, 2015. *Statistical Working Papers: Trafficking in Human Beings, (2015 Edition).* Luxembourg: Eurostat.

Table 1: **Nationalities of the women accessing WHS**

Nationality	Number of women	% of women*
Brazilian	54	37.5%
Romanian	46	31.9%
Irish	9	6.3%
Hungarian	5	3.5%
Bolivian	3	2.0%
Portuguese	3	2.0%
British	2	1.4%
Bulgarian	2	1.4%
Chinese	2	1.4%
Dominican	2	1.4%
Angolan	1	0.7%
Argentinian	1	0.7%
Belgian	1	0.7%
Colombian	1	0.7%
Dutch	1	0.7%
Ecuadorian	1	0.7%
French	1	0.7%
Italian	1	0.7%
Panamanian	1	0.7%
Puerto Rican	1	0.7%
Serbian	1	0.7%
South African	1	0.7%
Spanish	1	0.7%
Venezuelan	1	0.7%
Zimbabwean	1	0.7%
Other	1	0.7%
Total number of women	**144**	
Total number of nationalities	**26**	

* All percentages are subject to rounding throughout.

1.2 Age, ethnicity and gender

The average age of women in the sample when they first accessed WHS was 29, with a wide variation within this – women accessed the service for the first time from as young as 18 and as old as 56. The age profile of those accessing WHS would appear to be rather older than those in the Irish sex trade as a whole – previous estimates put the average age at 25, but again with wide variation within this.[23] This older age profile is partly explained by the large proportion of Brazilian women in the sample, who tend to be older than their European counterparts when they first arrive in Ireland and first become involved in prostitution (see 2.1 below) – their average age when they first access WHS is 30, whereas Romanian women (the second largest nationality represented in the sample) are 24 on average at first access.

Ethnicity was seldom recorded by WHS staff at the time of this study, and sexuality was not recorded consistently, so no solid data are available on these demographics for this sample.[24]

Nine people in the sample are transgender (6.3%), quite closely reflecting the numbers advertised.[25] All self-identify as women and wished to access the specialist service provided by WHS. All are Brazilian, with one exception. This finding also reflects recent UK research which suggests that transgender people may be over-represented in the sex trade.[26]

1.3 Immigration status

Women's status in Ireland was typically recorded during their first visit to WHS. Table 2 shows that while many in the sample have citizenship of a European Union country, or an EU passport obtained on the basis that a parent or grandparent had European origins, many others – 36.8% of the whole sample[27] – are third country nationals with an insecure or absent immigration status.

'Undocumented' in this context means without immigration permission to be in Ireland. This includes women who became undocumented whilst in the State, usually because a short-term visa, such as a holiday or student visa, expired. Those undocumented or on a holiday visa are Latin American or Asian, whilst the two asylum seeking women are African.

23 Kelleher Associates *et al*, 2009, *op cit*.

24 Work is currently ongoing within WHS to address these recording gaps, in line with the HSE's current *Intercultural Health Strategy*.

25 O'Connor and Breslin, 2020, *op cit*, found in their snapshot of prostitution advertising that 5.8% of profiles were advertised on the main prostitution advertising website as 'Transexual' (*sic*) or 'TS' (p. 36).

26 Hester, M., Mulvihill, N., Matolcsi, A., Lanau Sanchez, A., and Walker, S.J., 2019. *The Nature and Prevalence of Prostitution and Sex Work in England and Wales Today*. England: University of Bristol.

27 Excluding those whose status is unknown/not recorded by the service, then almost 40% of the sample have an insecure immigration status.

Table 2: **Immigration status at first visit**

Status in Ireland	Number of women	% of women
EU citizen	62	43.0%
Student visa	40	27.8%
Irish citizen	10[28]	6.9%
EU passport	9	6.3%
Undocumented	5	3.5%
Holiday visa	4	2.8%
Asylum seeker	2	1.4%
Stamp 2	1	0.7%
Stamp 4	1	0.7%
Other	1	0.7%
Not recorded	9	6.3%

Many of these women described to Outreach staff the burden of having insecure status in Ireland. Some described the dread they were experiencing as their visa expiration date approached, fearing that a renewal of their visa would not be approved, or that they would be unable to afford the associated renewal fees.

For some women, their precarious immigration status was one of the key reasons they entered prostitution in the first instance, typically coupled with a lack of money to live day-to-day (see 2.2 below for more on this). A number of women explained to Outreach staff that they entered the sex trade initially to finance the costs of their visa renewal in Ireland or to pay for the travel expenses and legal fees associated with securing a passport from another European Union country through the ties of relatives. Others described plans to leave the sex trade if they could find ways and means to extend or regularise their status in order to become eligible to undertake formal employment.

For some women in the sample their status changed over time, for example a number of women saw their student visa expire during the period they were accessing WHS and as a result they became undocumented. It was apparent that being undocumented caused considerable stress and anxiety for women in this situation, with some even fearing deportation.

These two women's experiences, as documented in their Outreach notes, clearly illustrate the precarity of the lives of many migrant women in the Irish sex trade.

28 This includes the nine Irish-born women in the sample plus one Central European woman who had secured Irish citizenship.

WHS

She has been in Ireland for two years on a student visa, which is just about to expire. She entered prostitution because of financial difficulties and is doing long hours. She has had a number of difficulties with her English language college – the first closed down after she had paid them large fees (which she lost), the second expelled her because she could not attend classes in the mornings after long nights of seeing buyers, and there was no option for her to do afternoon classes. She has been given one month to sort out her situation because GNIB[29] will not renew her visa as a result of her expulsion from college. [Three months later] She is currently pregnant and undocumented; her visa recently expired. She has a Brazilian partner, but the relationship has not been going well – she is unsure if he will be supportive of the pregnancy. She is very concerned about how she will financially support her baby and how having a baby in Ireland will affect her status. She is also very worried that she will be forced to return to Brazil as she fears her baby could be exposed to the zika virus there. W43, Brazilian

She has no money as she is currently undocumented and says she is "too nervous" to see buyers. Instead, she borrowed money from a 'friend' for food and rent. She disclosed that she feels under a lot of pressure, stressed about what has happened to her, [she was robbed and physically assaulted in the brothel where she stays] and the lack of control in her life in relation to her irregular immigration status. Because she is so worried about her lack of status a 'friend' offered to help her by organising a lawyer to sort out a visa for her, and she was told that this could be done for €8,000. She constantly fears deportation and says she feels like she is "going crazy" – she says she could not take the blow of being deported. She tells Outreach staff: "If I have to go home, how can I settle in? You can't come back when you go back." W105, Chinese

29 The Garda National Immigration Bureau (Irish immigration police).

1.4 Length of time in Ireland

Table 3 shows that many of the women in the sample were relatively new to Ireland when they first accessed WHS.

Table 3: **Length of time in Ireland at first visit**

Length of time in Ireland at first visit	Number of women	% of women
Less than one week	3	2.0%
1-4 weeks	15	10.4%
1-6 months	38	26.4%
7-12 months	11	7.6%
13-18 months	4	2.8%
19-24 months	2	1.4%
2-4 years	19	13.2%
5 years +	7	4.9%
N/A	8	5.5%
Not recorded[30]	37	25.7%

Excluding those recorded as N/A (eight Irish women[31]) and those whose length of time in Ireland is unknown (37 women), 56.6% of the sample had been in the country six months or less, and 67.7% 12 months or less. Many women in the sample became involved in prostitution in Ireland very quickly after their arrival in the State – see 3.2 below, which explores these circumstances further.

1.5 Location and living arrangements

At their initial assessment, staff ask for each woman's postcode or the general area where she is based – women are not required to provide a specific address to the service. The areas where women first said they were based are set out in Table 4 below, but it is worth bearing in mind that a significant number of women changed their locations on a regular basis whilst accessing WHS – a likely indicator of the high levels of mobility documented within the Irish sex trade.[32] Indeed, in part due to this transience, many of the women accessing WHS use the service's own address as a location to receive medical and other official correspondence.

30 This question is not asked by staff as part of women's initial assessment, which explains the number of 'Not recorded' here, but it was asked sufficiently often in the course of documenting women's case histories to warrant analysis.

31 One Irish-born woman is excluded here because she had recently been living abroad and only returned to live in Ireland a year ago at the time of recording.

32 Kelleher Associates *et al.*, 2009, *op cit*; Walsh, K., 2019, *op cit.*

Table 4: **Area of residence at first visit**

Area of residence	Number of women	% of women
Dublin	2	1.4%
Dublin 1	18	12.5%
Dublin 2	14	9.7%
Dublin 3	5	3.5%
Dublin 4	14	9.7%
Dublin 6	6	4.2%
Dublin 7	8	5.5%
Dublin 8	10	6.9%
Dublin 9	7	4.9%
Dublin 16	1	0.7%
Dublin 17	1	0.7%
Dublin 18	7	4.9%
Dublin 24	4	2.8%
County Dublin	2	1.4%
Carlow	1	0.7%
Galway	2	1.4%
Laois	1	0.7%
Limerick	1	0.7%
Meath	1	0.7%
Wicklow	1	0.7%
NFA	26	18.0%
RIA[33]	2	1.4%
Not recorded	10	6.9%

Given its Dublin location, it is not surprising that WHS is overwhelmingly accessed by women based in the city, although small numbers do access the service from outside the county too. Women's initial locations across Dublin are likely to be related to a number of factors, including where communities from their own countries of origin tend to be based, and also where the sex trade itself is concentrated. This is reflected on Escort Ireland, the main website advertising 'escort services' across the island of Ireland,[34] which indicates that prostitution in the capital city is most concentrated in Dublin 1, followed by Dublin 2, 9, 18, 8, 7 and 4, which are also the postcodes where the majority of the Dublin-based women in this sample (78 out of 99 women) are located.

This is not to say that all of these women are living in premises operating as brothels, although 29 women at their initial assessment with WHS reported that they are seeing buyers in the place

33 RIA is the Irish State's Reception and Integration Agency, which provides accommodation for applicants for international protection and suspected victims of human trafficking (also known as 'Direct Provision').

34 Escort Ireland is the largest online prostitution advertising platform in Ireland and also operates in Northern Ireland (Kelleher Associates *et al*, 2009, *op cit*.; O'Connor, M., and Breslin, R., 2020, *op cit*.).

where they also live, usually an apartment (see 3.1). The largest single 'area of residence' in the sample is in fact 'NFA' meaning of 'no fixed abode' (18% of the sample). These women do not have any fixed address or area of residency in Ireland – the majority are highly transient – they constantly move back and forth between Ireland and their country of origin or other (usually Western European) countries where they are also in prostitution (see 3.3 and 3.4 below). Women in the sample also 'tour'[35] a great deal within Ireland, particularly if they are subject to immigration restrictions, moving locations or being moved by prostitution organisers constantly. Some of the migrant women attending WHS have spent years in prostitution in Ireland without ever having a fixed address or place that they have stayed for any longer than a few weeks. Others report that they have come to Ireland to spend a very short period in the sex trade (usually just weeks or a few months) and plan to return home to their country of origin very soon, often subsequently repeating this journey over and over. In almost all of these cases, the women have no stable accommodation in Ireland and are therefore living and sleeping wherever they see buyers. These striking levels of mobility have previously been identified right across the Irish sex trade,[36] and also echo the findings of previous investigations into the inner working of the trade,[37] which highlighted the significant role played by prostitution organisers and profiteers in this regard.

Finally, a number of women also expressed the challenges they face finding and keeping accommodation they can afford, particularly in the context of the Irish housing and homelessness crisis. In some cases, women are being charged exorbitant rents – up to €700 per apartment room per week – well above the market rate, by landlords and prostitution organisers who know the premises is being used for prostitution. Similar rates have also been documented in recent Irish research.[38] A few women in the sample were under significant pressure to try to earn enough money in prostitution to pay two sets of rent – one for the apartment they live in and one for the apartment where they see buyers. Two of the Irish women in the sample reported being homeless and having to rely on homeless services and short-term hostel accommodation.

1.6 Phone numbers

WHS records women's mobile telephone numbers so that they can contact them with test results, support information and service updates. A salient finding in this regard is the number of times women change their mobile numbers during the period in which they are accessing the service. 144 women in the sample had 190 different phone numbers recorded for them, with 42 women changing the phone number WHS held on record for them once, twice or even three times. In some cases, this was because, as women grew to trust the service, they provided their personal number in place of the number they use in prostitution that had previously been recorded by the service. In other instances, women reported losing their phone, it being stolen, or seized by Gardaí. But these reasons may not explain all of the multiple number changes made by some women in the sample, which again points to the levels of transience in their lives. Recent research on the

35 'Touring' and being 'on tour' are sex trade terms for women who move, or are moved by prostitution organisers, from location to location, either within a country or across borders, for the purpose of prostitution.

36 O'Connor, M., and Breslin, R., 2020, *op cit.*

37 A year-long intensive investigation of the Escort Ireland website for the RTE (Irish national broadcaster) documentary *Primetime: Profiting from Prostitution* (2012), uncovered high levels of organisation and management behind the movement of women across Ireland for the purpose of prostitution. During the investigative period, 438 women on average were moving or being moved between brothels throughout the country every week. The findings from this investigation were presented in evidence to the Irish Government's Joint Committee on Justice, Defence and Equality's *Review of Legislation on Prostitution* – see: https://www.oireachtas.ie/ga/debates/debate/joint_committee_on_justice_defence_and_equality/2013-02-06/2/ (Last retrieved 21/04/21)

38 O'Connor, M., and Breslin, R., 2020, *op cit.*

Irish sex trade found instances of women having to change their mobile phone numbers because they are being stalked or harassed by sex buyers.[39] The use of multiple phones and phone numbers has also been found to reflect high levels of organisation within the Irish sex trade.[40]

1.7 Language ability

The service records that for 25 women in the sample an interpreter was used during their initial assessment. However, this is not a true measure of how many women actually *needed* an interpreter. Given that WHS clinics are provided on a drop-in basis where the mother tongue and English language abilities of new service users cannot be anticipated in advance, arranging interpretation 'on the spot' in a busy clinic environment is not always possible. In these situations, a simplified, partial assessment is usually undertaken, making use of whatever English the woman has and sometimes with the help of a friend who has accompanied her, or apps such as Google Translate. However, staff observed that it is far from ideal to rely solely on 'friends' for interpretation as sometimes those who accompany women to WHS are in fact prostitution recruiters/organisers. An independent professional interpreter is therefore used for subsequent attendances wherever possible.

In a small number of cases, women refuse the use of an interpreter, even when it is offered. It is not clear why this is the case; it may be that they fear that their confidentiality will be breached somehow or that they do not wish to fully engage with the service. A number of the women who refuse an interpreter or other translation options will accept health supplies and printed information in their own language from WHS, but do not seem to want to get into a more detailed discussion about their circumstances. Outreach staff note that these women can be difficult to engage with and therefore properly support because of the persistent language barrier. Some also present as being 'under pressure' and in 'an extreme hurry', which raises staff concerns that they may be subject to direct control by a third party.

In interview, Romana described how her lack of English increased her vulnerability in the sex trade, particularly because she struggled to be able to 'vet' buyers in advance.

> *I just received the calls [from buyers] and say, 'Alright, okay, come.'…But for me was easy [for] anyone to come to me, because I didn't – when I was arrived, no English.*
>
> - ROMANA[41]

Many of the women who seek support to learn English are referred by WHS to Ruhama or other community-based providers of free or low-cost English classes. It is also worth noting amongst the sample that many women's English skills improved over time and their need for interpretation when accessing the service diminished in turn.

39 O'Connor, M., and Breslin, R., 2020, *op cit.*

40 During investigations for the *Profiting from Prostitution* documentary (see footnote 37), it was found that in excess of 7,300 mobile phone numbers were being used on one website advertising prostitution and that 5,168 of these phone numbers were linked. In some cases, they had multiple users at different times and were used in multiple advertising profiles of women on the site. Source: https://www.oireachtas.ie/ga/debates/debate/joint_committee_on_justice_defence_and_equality/2013-02-06/2/ (Last retrieved 21/04/21)

41 All interviewee names are pseudonyms.

1.8 Children, motherhood and other caring responsibilities

WHS's initial assessment includes a question about whether women have children, but this is often not recorded by the Outreach service – this was the case for over half the sample.[42] Nevertheless, 26 women (18% of the sample) told Outreach staff at first assessment or later that they have children, and the majority are lone parents. Most of the children were aged ten and under at the time of recording. Many women reported entering prostitution in order to financially support their children or other loved ones, including siblings, sick and/or aging parents and other relatives (see 2.2). Three migrant women in the sample were financially supporting their mothers' cancer treatment through prostitution.

It was clear throughout this study, that the pressure of these obligations to support their immediate and often extended families financially weighed heavily on women's shoulders. This pressure, and a strong sense of their 'family obligations', were also significant factors in women both entering and remaining in prostitution in Ireland – women found that once their family began to rely on the money they were sending to them, they found it very difficult to reduce or cut off this financial support (see 5.2 for further details).

Amongst those women with children, the children's location was recorded in 16 of the 26 cases – in 11 cases the woman's children were at home with her family in her country of origin – usually in the care of her mother or another female relative. Women from Eastern Europe reported leaving their children at home in their country of origin in the care of their mothers or sisters for regular periods of three to four weeks while they 'toured' in the Irish sex trade, before returning home again. Women from Latin America were similarly relying on female relatives to care for their children, but this often meant that they did not see them in person for many months or even years at a time. Two women's children were with their child's father – in one case in Ireland and another in her home country. Three women (all Irish citizens) have their children living with them in Ireland.

Women with children outside Ireland disclosed problems related to their separation from them, including, in some cases, disputes with the children's fathers over care and custody arrangements. A number of women expressed their desire to be reunited with their children by bringing them to live with them in Ireland.

The case of this woman from Brazil who sought support from WHS, illustrates how her intention to support her children and improve their lives led to her being trafficked into the Irish sex trade, and ultimately to fear for their safety whilst she remained separated from them.

WHS

She spoke little English, so a translator was used. She said a friend from her hometown advised her to come over to Ireland as she could make money while learning English. She has three children at home in Brazil and was struggling to support them financially, so she sold her car and some of her belongings to fund the trip in the hopes that she could make

42 However, the number of pregnancies and the number of 'live births' a woman has had are recorded by the Clinical service. It is possible that some women may be uncomfortable with questions about children and reluctant to disclose to the service that they have children, given their involvement in prostitution.

good money in Ireland for her family. Her friend agreed to lodge €3,000 in her bank account, which she could use as proof that she could support herself in Ireland initially. She entered Ireland with her passport and proof of her college place. On arrival she was asked to go to Galway. There her friend explained 'escorting' was the only work available. She had expected cleaning and babysitting work until her English improved. Her friend never told her that she herself was in prostitution and that she would be expected to do the same. She did not feel she had any option but to comply as she was told she owed them money. She was then moved from location to location across Ireland for prostitution.

As the trafficker is from her hometown and considered a 'friend' she was very reluctant to give any information about what happened to her as she fears her children may be targeted. The 'friend' has threatened that if she gives any information about her to authorities she will be "in trouble". In the long-term she would like to remain in Ireland and have her youngest child brought here. She has no plans to return to prostitution again. She wishes to be granted status to remain in Ireland, and secure family reunification. Despite her fears, she subsequently gave permission for her case to be referred to the GNPSB.[43] [Several months later] She was formally identified as a victim of trafficking and sought further advice about family reunification – she wants to bring her daughter to Ireland to live with her as she continues to have concerns about her safety. W99, Brazilian

There appears to have been little opportunity in the Clinical or Outreach settings for women to discuss in any great depth the impact that separation from their children and other loved ones whilst in prostitution in Ireland had on them, although it is clear that this was certainly a struggle for some, as highlighted by Natalia and Luciana below. This is an issue that requires further investigation.

[Natalia's children do not live with her Ireland anymore, but she visits them as often as she can.] I stay like two months here, sometimes more than two months, and not to go to see them. Like yeah, they miss me and that's the very tough part, you know. When I'm cooking for the – the youngest is 16 and he always say, 'Thank you, thank you'…And that break my heart, you know, because I'd like to do that every day.

- NATALIA

43 The Garda National Protective Services Bureau, whose remit includes sexual offences, online child exploitation, child protection, domestic violence, human trafficking, and organised prostitution.

> *[Luciana first came to Ireland to be in prostitution for six months so that she could make money to support her children but found that she could not be separated from them for that long]. They were like 3 and 5 and 15... So I could only stay here for five months. I couldn't handle any longer. So, I went back to Brazil…because I've never been without them before. [Interviewer: Would you speak to them on skype or…?] I couldn't because my ex-husband made my life very difficult. Every time I called them – I wanted to talk to them at least every day, but every day I called them and he answered the phone and he said, 'No, they're busy, they don't want to talk to you.' And I could hear they screaming, like, 'Mum, mum, mum!' But he made my life very, very difficult on that time. [Luciana later brought her children to live with her in Ireland and returned to the sex trade.]*
>
> - LUCIANA

Finally, a number of women in the sample became pregnant whilst in prostitution in Ireland, and a proportion of these went on to have children during the course of accessing WHS – this is explored in further detail in 4.4.

1.9 Experiences of male violence

Aside from the numerous acts of violence and harassment women experience within the context of prostitution (Section 3), a number of women also disclosed violence they had experienced in other aspects of their lives – most typically at the hands of a current or former male partner. Domestic violence has been noted elsewhere as a common occurrence in both the childhood and adults lives of women who have been sexually exploited.[44] It is important to note here that women were not screened for experiences of this nature by WHS; rather staff recorded those incidents that women themselves chose to disclose in the course of accessing the service. Irish and migrant women reported currently being in relationships characterised by domestic violence, including coercive control and rape by an intimate partner. In a number of cases, the perpetrator used migrant women's insecure immigration status as a means to control them and ensure their compliance with his wishes. Women described perpetrators also making threats to harm their family members, and one woman was being subjected to domestic violence whilst pregnant. Another young woman reported that she was a victim of 'revenge porn' – her ex-boyfriend had posted explicit images and videos of her online. Most of these women did not know where to turn for support in these circumstances and relied on WHS to refer them to the appropriate services.

44 O'Connor, M., and Breslin, R., 2020, *op cit.*

In a number of cases, it was the breakdown of controlling, violent relationships, exacerbated by poverty, that led women into prostitution in the first instance, as Natalia explains:

> *No, in Brazil I never worked like that [in prostitution]. Actually, was married and kids. But was abusive marriage. He was alcoholic and the very abuse…It's like that. You know, beating, do bad, then come home, 'sorry' and all…Never gave nothing for the kids…Like I was very poor. I didn't have education. Like my family's really from the country. I didn't have enough food and no clothes, no dentist, all that things…he won't give me the custody for the kids…it's the way like to keep me, to hold me…Abusive husband with three kids. What you going to do, like?*
>
> - NATALIA

1.10 Discussion

The profile of those in prostitution who access WHS paints a picture of a group of women facing a series of significant adversities in their lives. Many are new to Ireland, constantly on the move, without stable accommodation, have poor English language skills and are facing the very real burden of insecure immigration status. There is much evidence to suggest that these women are in difficult and precarious situations in their lives, both before and during their involvement in prostitution in the State. Pressure to pay rent, support family and regularise their status is exacerbated for some by separation from loved ones or experiences of domestic and sexual violence in their personal lives. It seems clear that experiencing such adversities not only led many women in the sample into prostitution in the first instance, but also left them vulnerable to further exploitation and harm once involved, as the Sections that follow explore.

2. Entry into prostitution

Section 2 explores the point at which women enter prostitution and the reasons and circumstances that led them there; from poverty, severe financial pressures and obligations, to direct coercion and experiences of being pimped and trafficked.

2.1 Age of entry

At their initial assessment women are asked what age they were when they first entered prostitution. There was a very wide range within the sample – with the youngest age of entry being 16 and the oldest 56. However, excluding those where no age of entry was recorded, most women (just over half the sample – 51.3%) reported that they had first entered prostitution between the ages of 16 and 24.

Table 5: **Age of first entry to prostitution**

Age range in years	Number of women	% of women
16-19	22	15.3%
20-24	38	26.4%
25-29	23	16.0%
30-34	19	13.2%
35-39	11	7.6%
40-44	2	1.4%
45-49	0	-
50-54	1	0.7%
55-59	1	0.7%
Not recorded[45]	27	18.7%

Across the sample the mean age of entry to prostitution was 26 and the median 24. However, age of entry differed quite markedly according to nationality, for example Brazilian women tended to be older than Romanian women at age of first entry (age 28 on average for Brazilian women versus age 21 on average for Romanian women). Thirty-seven percent of Brazilian women in the sample who had their age of entry recorded reported entering prostitution aged 30 or over, whereas only 5% of Romanian women entered this late. Indeed, almost one third of Romanian women in the sample entered prostitution as teenagers (aged between 17 and 19).

45 The nature of the service that WHS provides, and the profile of the women who access it, can create challenges and limit opportunities for documenting women's case histories in full as part of their initial assessment, or indeed subsequently. The busy and often high-pressured drop-in environment of the service, the fact that women often attend in crisis or with immediate health needs that must be met, that women may speak little to no English, are 'in a rush' or reluctant to share much information about themselves, all go some way to explaining the sometimes-high instances of unrecorded data in the sample, particularly in terms of variables relating to women's past histories of prostitution.

The Brazilian women in the sample who first entered in their thirties and beyond had a number of commonalities – many were newly arrived in Ireland, here for only a matter of months, yet entered the sex trade quite soon after their arrival – and in most cases this was their first experience of prostitution. Many of these women had children or wider family to support at home in Brazil.

Of all of the Romanian women who reported entering prostitution as teenagers, most were still very young – under 23 – by the time they first accessed WHS. This group also had a number of commonalities – again, most had been in Ireland for a very short time and entered prostitution in Ireland very quickly after their arrival, sometimes within a matter of days. They had no or very low levels of English, were highly mobile, travelling every few weeks back and forth between Ireland and Romania, and in some cases other Western European countries where they were involved in prostitution also. As a result, many were NFA in Ireland, sleeping in whatever brothel they were based. Some of these young women were also experiencing issues with contraception and crisis pregnancies resulting in terminations. The vulnerabilities and range of adversities faced by young Romanian women in prostitution in Ireland are well illustrated by this case:

WHS

She is 18 and has been in Ireland for one month. She entered prostitution six months ago, starting when she was aged 17. She has no English, so a translator was required. [Later that same month] She returned to the clinic for her STI test results and again a translator was used. She says she is travelling around Ireland for prostitution. She was given the contraceptive pill on her last visit, but she is not taking it – she says she does not want to…[One month later] She attended because she was concerned that her friend, who also attends WHS, had tested positive for STIs. She does 'duos'[46] with this friend and so was afraid she had also contracted an infection. She reports that she took contraception for two to three days only and has not been feeling well since.

[Three months later] She still has very little English, so a translator was used. She has declined several offers of a referral to English language classes. She says that she wants to get different contraception from the last one and that in the meantime she had travelled home to Romania for a termination. She told WHS that she was upset about the termination but felt that she had made the right decision. She was feeling pain and discomfort, so she requested STI testing.

[Two months later] She attended the clinic saying that she was feeling unwell and 'not herself' – she asked to see the doctor as she was worried about bleeding that had lasted for two weeks so far. The doctor gave her a pregnancy test, which was positive – she was two to three weeks pregnant.

46 When buyers pay for sexual access to two women at the same time.

> *Because of her symptoms, the clinic arranged to send her straight to Holles Street.[47] But she refused the taxi that was organised for her; she said she wanted to go home first and would go to the hospital later that night. When Outreach staff contacted her to find out how she was doing her phone was disconnected. W61, Romanian*

Recent research on the Irish sex trade documented a number of cases of women who were children at the time of entry into the sex trade.[48] Of the five women in this sample who entered prostitution under the age of 18, two are Irish, one of whom disclosed that she was groomed into street prostitution at aged 16, two are Romanian and one is Brazilian. Three of the five were in prostitution in Ireland whilst under 18, although none of these presented to WHS until they were 18 or older.

2.2 Reasons for entry – the need for money

Across the sample, the majority of women report entering prostitution because they needed money – to escape poverty, to survive day-to-day, to support loved ones, to pay off debts, to avoid economic crises in their home countries, to secure their immigration status (as described in 1.3), to pay rent, to fund their education or support future plans – such as setting up their own business. A smaller, qualitative study which also drew its sample from WHS found similar reasons and motivations for women's entry.[49]

As previously highlighted in 1.8 above, many women cited their main reason for entering prostitution as the need to support their children (especially as lone parents) and/or wider family financially, either in Ireland or their country of origin. Many women described to WHS staff the significant pressures they were under as a result, and the strong sense of obligation they felt to their families in this regard. A number of migrant women were financing healthcare for their sick parents. One Irish woman stated that she started in prostitution to pay for her child's Communion. The extent to which family members are financially dependent on women in the Irish sex trade has also been documented in recent research.[50]

Many women from Latin America described to Outreach staff how their initial plans to come to Ireland on a student visa, learn English and support themselves with a part-time job proved untenable – they struggled to secure jobs in line with their visa restrictions,[51] especially when they had so little English, and thus found the high costs of living in Ireland impossible to manage with no work or merely a part-time wage. They realised that they could not afford to pay for food, rent, bills, language school fees *and* support their families at home and therefore felt that they had no other option in these circumstances but to turn to prostitution. They were often aware that other migrant women in similar situations had done and the same, and sometimes sought or

47 Ireland's National Maternity Hospital.

48 O'Connor, M., and Breslin, R., 2020, *op cit.*

49 Sweeney, L., and FitzGerald, S., 2017. 'A Case for a Health Promotion Framework: The Psychosocial Experiences of Female, Migrant Sex Workers in Ireland.' *International Journal of Migration, Health and Social Care*, 13:4 (pp. 419-431).

50 Breslin, R., 2020, *op cit.*

51 Student visas limit the recipient to 'casual employment' up to a maximum of 20 hours per week in term time (40 hours per week outside of term).

received advice from them on how to begin. It was very apparent that a serious lack of money, the language barrier, their insecure immigration status and the restrictions of their visa combined as significant forces to drive these migrant women into the Irish sex trade. Indeed, some migrant women in the sample explicitly stated that they entered prostitution to finance their language school fees and/or their visa renewal or EU passport application, in addition to their other financial obligations.

Still others were attempting to finance their way *out* of the sex trade by trying to earn and save a significant lump sum to realise future plans such as higher education, a training course or setting up their own business in their country of origin. The sample included a number of migrant women with professional qualifications from their home country in law, journalism, business, languages and the arts – which had to be abandoned due to an economic crisis leading to unemployment or the lack of a living wage, or which carried no weight in Ireland or could not be used due to a lack of English.

In interview, several women also described how they entered prostitution for a range of financial reasons, but most especially to support themselves and their family members.

> *And my father is a complicate for me. He's like a big child…He's into the gambling, addict to alcohol. Big problem…I have to help. But for luck my brother is there, and he lives close to my father, and I send the money to my brother to buy everything my father needed. Because if I send the money [directly to her father], he don't buy anything and he spend to gamble and drink…I don't want to support these kinds of things. I worked hard for to have a better life.*
>
> - OLIVIA

> *[In Brazil] I studied for to be a lawyer, always work a lot and suffer a lot because there the economy's not so good…[She first went to Germany where she was evicted by the owner of the massage parlour where she lived and worked]. So after he put me out and I need to start to have sex [for money] because I don't have place for work [or to live]…That's the reason I started, you know. Because I don't want to. Really, I don't want to. It's much better men don't touch you and don't do nothing…Of course I can choose. I can choose like working someplace like a store. But I help my family in Brazil. I send money. My father-in-law have cancer. So, I need to support my family. And many people depend about me. How I can leave this [prostitution]?*
>
> - ELENA

Most interviewees described how they had originally planned to stay in the sex trade for a short time only. Some also described how they believed that they could earn enough money through prostitution in Ireland to fulfil their life goals.

I started to do this 19 years [old, in Brazil]. I start because I need to go out of my house because my mother fight with me, she don't want to stay with me…my father is die. I never see my dad. I'm from very poor place… in my country is more bad, you know, situation. Money, everything. Yeah, I help too much my family before. So, I come from Brazil. My family's poor people…I come here because here people say, 'You're going to have wings and oh, yes, money, enough for you buy house!' I wanted this in my country because I don't have. You understand? So, I had dreams. Okay, I go there [Ireland], I wins money, I keep money, I go back…Always I want to buy house. I want to make business. I want to do something.

- IRIS

…and there [I] was like a bit lost in Brazil, as I got divorced. And I had so many…bills to pay there, as I had a small restaurant, things like that. A business, yes, with my ex-husband. So, we got divorced, I got the bills! So, I was lost, I was very confused, and I came to Ireland trying to make some money…I had a dream to bring my kids to Ireland…So I thought like if I could bring them to Ireland, they could have choice in the future…I tried working like normally in a normal place. [A fast-food chain] was my first job here – like nine years ago. I tried doing like babysitting, cleaning, but I couldn't pay the bills. Then unfortunately I had to come back to this job [prostitution].

- LUCIANA

[When asked how she first started in prostitution] As first is the poverty... I was very poor…And I worked very hard. Always two jobs. Always two jobs in Brazil, but was work as a waitress, I work as secretary, I work as a cleaner, I work like doing laundry…So then between that I went to [another country in Western Europe]. I worked then [in prostitution] – the idea was to work only for four or five months, go back to Brazil…make the house nice, because it was only one studio with three kids…let's say like one bed. Have the very narrow kitchen and narrow living room and no bedroom…The four of you was in the double bed, like. So, I said, 'No, I'm going to make the house – I'm building the house up, I get furniture, you know, kickstart', you know…I wanted to start to build my life. I have the goals, like helping the kids to finish their education, to get a good job…I try to look after myself well because I really want to finish that thing, that mission.

- NATALIA

In all of these cases the women had remained in prostitution for longer than they first envisaged (in some cases for many years longer) and were unable to achieve the financial independence that they had hoped for. This is explored further in Section 5.

2.3 Reasons for entry – coercion, pimping and trafficking

Aside from the serious financial pressures that drove women into prostitution, as explored above, there were also numerous women who described to WHS staff being actively drawn into prostitution by another person or persons – through grooming, deception, coercion and debt bondage – indeed many circumstances that amounted to pimping and trafficking. This is to be expected given that trafficked persons do not exist in a vacuum – there is ample evidence from across Europe that the destination for the vast majority of women and girls who have been trafficked across national borders is the domestic sex trade in each State.[52] On this basis it is unsurprising that trafficked women are amongst those who access WHS.[53] Some of their experiences are explored in greater depth here.

In 15 cases from the sample that presented to the service, WHS staff were concerned that the woman was currently or had previously been a victim of pimping and/or trafficking. In some cases, women were not willing to disclose any further details about their circumstances, and/or they disengaged from the service, and so these concerns could not be followed up in any great detail. However, in other cases women were able to disclose what had happened to them and receive further support as a result.

A number of women described being coerced into the sex trade at some point in the past but had managed to extricate themselves from this situation, while others appeared to still be subject to control by a third party. Women disclosed being forced by prostitution organisers and those running brothels to provide certain sex acts to buyers against their will, such as sex without a condom. Others recounted having to hand much of the money they made from buyers over to a pimp or organiser. WHS staff documented their own suspicions regarding control in the cases of several women who always attended the clinic accompanied by an older man or woman who sat and waited for them in the reception area or outside the building throughout their attendance. They also expressed concerns about women who stated they were operating 'independently' in the sex trade, but had so little English it seemed very unlikely they would be able to arrange their own advertising and 'bookings' with buyers alone.

It was clear from the data that deception and false promises were very common tactics used by pimps and traffickers, who promised women the opportunity to earn money legitimately, but their intention was always sexual exploitation. This woman described how she was duped into the Irish sex trade and the extent to which her involvement in it was highly organised. She was subsequently able to break free from the control of the trafficker. However, despite much support and encouragement from WHS staff, several years later she remained extremely fearful of the repercussions if she were to make an official report about her experiences.

52 Walby, S., Apitzsch, B., Armstrong, J., Balderston, S., Follis, K., Francis, B., Kelly, L., May-Chahal, C., Rashid, A., Shire, K., Towers, J. and Tunte, M., 2016. *Study on the Gender Dimension of Trafficking in Human Beings – Final Report.* Luxemburg: European Commission.

53 It must be noted that this is *in addition to* the many victims of trafficking for the purpose of sexual exploitation supported by the AHTT (the HSE's Anti-Human Trafficking Team) each year.

WHS

She arrived in Ireland nearly five years ago – her travel and other costs were paid for by a third party and she did not initially know that she would have to be in prostitution. She disclosed that a 'friend' paid for her ticket, gave her cash to carry so she seemed like a tourist when she arrived and booked hotel accommodation for her in Dublin. This known 'friend' told her he would help her to get work and she would also be able to study.

He met her at the airport, took back the cash he had given to her and brought her to his apartment. He told her she owed him €18,000 for flights, accommodation, photo fees, website fees and other incidentals. He also charged her for college fees when she did not actually ever attend. He had arranged for a photographer to be at the apartment to take photos for the website where she would be advertised almost immediately. While the photo shoot was taking place, he arranged for her first buyer to come, and she had to have sex with him. Then she had to hand over the money to the organiser.

For the first month he arranged all of her 'bookings' for her as she spoke hardly any English. After that first month she travelled around the country with him; during which time she had to negotiate how much money she got to keep after seeing each buyer. It took over six months in prostitution to repay the 'friend' what he claimed she owed. During this time, he also brought another young woman to Ireland from Brazil under similar circumstances.

She said she remains very concerned about her own safety and the safety of her family in Brazil if she were to talk to the authorities about these experiences. She disclosed that her family members have been threatened via text, so she feels she cannot make any statements about trafficking to the Gardaí at this time. Staff noted that she is: 'Very anxious, tearful and nervous re her safety.' W117, Brazilian

A number of women in the sample attending WHS were formally assessed by the HSE's Anti-Human Trafficking Team (AHTT). These women had either been identified as potential victims of trafficking and referred to both WHS and the AHTT by Gardaí or, in the course of recounting their histories whilst accessing the service, WHS staff became concerned that there were indicators of trafficking in their cases. Women in these circumstances were considering reporting what had happened to them to the Gardaí, but also faced a number of fears in doing so, as this case illustrates.

WHS

She grew up in an orphanage in Romania. She went to school in Romania but left early because she saw no prospects. At her first attendance at WHS she said she was 21 years old, but staff noted that she looks younger and was quite nervous – she was very animated and giggling a lot and 'seemed immature in her speech and language.' She says that she earned money online in Romania doing 'web chats'. She says a 'pimp' (her word) arranged for her to travel to Ireland but did not tell her she would be in prostitution – she thought she could do 'web chats' and 'lounge work' where men would simply pay for her company.

The pimp arranged her travel around Ireland for prostitution in hotels, houses and apartments. He also arranged all of the 'bookings' with buyers. She says that she worked for him for three months but was hardly ever paid; he kept most of her money. She reports that at the end of every week she typically owed the pimp €1,200 for rent and other expenses. She was moved from place to place during those three months – she mentioned Cavan, Dublin 2, Dublin 6, Dublin 7, Dublin 24 and Sandyford. The locations changed all the time as did the other young women in prostitution with her, who were all from Romania also. She says that the pimp had many 'pimp friends' around the country.

The pimp eventually paid her €3,000. She thinks she must be owed a lot more money, but she says she does not care. She then managed to get away from him – she says she changed her identity and told the pimp she is now in [another Western European country]. She has siblings in Romania that she says she needs to support financially, so she is now in prostitution 'independently' and is advertising online. She was initially certain that she did not want to speak to the Gardaí about what has happened to her.

She subsequently disclosed that she was beaten up by four men who were targeting her to go out of 'business'. She thinks they may have been sent by her former pimp, or that she may have been targeted to encourage her to move on from the area by competitors. She then agreed to talk to Gardaí about her experiences and was referred to the Garda Human Trafficking Investigation and Coordination Unit (HTICU). She was due to make a statement with support, but then withdrew. She was afraid of violent retaliation from the pimp and his associates if they discovered that she had spoken to Gardaí about them. She told WHS staff that she did not want to be known as someone who "told stories" on people and stated that she can look after herself. Outreach staff noted at this point that she 'still seems very young and vulnerable.' W91, Romanian

Amongst interviewees, most described themselves as being 'independent' in the Irish sex trade, although some had not started out like this – having to pay 'fees' and 'debts' to third parties when they first arrived and became involved in prostitution in Ireland.

> *I make agree with this woman if she give me money for school [fees], paying fly [flight], later I need to give [the money back to her]…she spend [on me] three thousand [euro]…I working later and paying her. So that's my story. No easy. People lie. I come here, I stay in places I don't want to stay. Is a little hard, I remember, when I come here [cries]…When I come here, I thinking people going to kill me or do something. You want a good life, you want everything, but you no want to make any problem when you come here. This woman she lies. She jokes [in] my face too many times. Sometimes she let me go out [but] every day I am working…and she takes half [the money]…she put her number. People [buyers] call her, because she speak English, I don't speak.*
>
> - IRIS

> *One day to another I got sick, I had to close my shop, my business, and the money disappear! And somebody come and talk about this job here in Ireland…I talk with my best friend and [she] asked me 'Are you sure you want?' I'm not sure. I have no English…also the girl who introduced me on this [prostitution in Ireland] she pretend to be nice and kind, blah, blah, blah. But when I came here, she say, 'Okay, you must give me half of your income.'…And I give my extension credit card to she can book hotel or whatever, buy ticket, plane ticket and she asked me for half of my money. I say, 'No. No way.'…And I have to pay her.*
>
> - OLIVIA

Interviewees also provided examples of other women they had encountered in the trade who were being pimped – either by individual 'boyfriends' or as part of a wider, more organised network.

I used to travel. When I was travelling, I would always see girls…There are loads of them. But it's not organised like an agency, they're mostly their boyfriends. And that's a lack of education, because you can't arrest them. It's very hard. They [the young women] willingly give them [their boyfriends] the money [they earn from prostitution]…She doesn't know what to do with herself. She's afraid to live on her own. She needs someone there. She needs to say, 'Oh, I have a boyfriend.' 'Yeah, she's with me, we're together.' She needs that. You can't fault them. I've seen loads of them…Oh, yeah, 'our family'. Yeah, [except] he's dressed in Armani and you're dressed from Penney's.

- NICOLETA

I hear some people in that situation come to Ireland [from] another country which – how I say this? [Have] 'biggie bill guy', because a lot to pay [to him].

- ROMANA

This is the problem in Ireland, because there is a lot drug. 24 hour. Who can work 24 hour? No, they must to take drugs. And maybe they are under – they work for pimp…And some of those girls have childs and they took them [the women's] passport. I try to help one years ago, and her pimp say, 'Don't call her. Don't give her your phone number. I will cut you, bitch!'…I think the problem is the cheaper girls doing everything. They provide everything for fifty euro…they want money. They don't care about anything. Money, money, money, money. Because they must pay the pimp. Whoever is the 'boss'.

- OLIVIA

So, this guy [that Elena met in a brothel in Cork] he take the girls who arrived here and the girls who don't know nothing and they use the girls for make money…[He] take fifty percent. He bring Brazilian girls. And [these] Brazilian girls are so naïve when arrived here. Don't speak English, don't know nothing. The girls are so scared, you know. And I think, 'Jesus, this shouldn't happen, you know. And need to stop this guy, you know.'…Because he makes a lot of money about another girls. This is crazy, no? But this is pimp!

- ELENA

And then she [a young woman from the Czech Republic that Luciana met in a brothel] tried to explain to me everything. And I started crying. I felt so sorry for that girl, the things she told me that he made her do [the man who was controlling her was a bouncer at a well-known Dublin nightclub]…The way they work, you know. They tell the girls they have job here; it's going to work like this or like that, whatever. As soon as they get in Ireland, they take the documents, the passport, and the girls work for them. Travel. They only give them the passport back at the airport when they're leaving…these girls they charge like sixty euro and [it's] thirty euros for them, thirty euros for the guy. And some of the guys they actually, they force them to have sex with them, you know. Like that's terrible, terrible.

- LUCIANA

They do the best they can [WHS staff]. It's very hard to talk to the girls. Most of them just walk in, see the doctor, want some free condoms and that's it. And that's the ones who are still kind of alone [who are able to access WHS]. The ones with boyfriends [who are their pimps] you'll never see them here [in WHS]. You can't reach them. [Interviewer: You don't think they even come in here?] No, no. The boyfriend will be like: 'You make money. Go to Boots, buy some condoms. What you're going there for?' [Interviewer: So, you think there are probably women out there who don't use this service?] Oh, plenty, plenty. Loads.

- NICOLETA

2.4 Discussion

Whilst there is wide variation in age of entry to prostitution across the sample, which appears to be somewhat related to nationality, it remains that case that the sex trade values youth, with most women becoming involved before they reach their mid-twenties, and some whilst still minors. There is much to suggest that these very young women are a particularly vulnerable group within the sample.

It is of particular concern here to note the early age of entry into prostitution of Romanian girls and young women in the sample, with strong indications that they are being controlled and their involvement organised by third parties. This reflects international research which demonstrates that young women and girls whose lives are marked by structural discriminations based on gender, economic deprivation, race and ethnicity, combined with personal and family vulnerabilities,

are proactively targeted, recruited and coerced into the sex trade.[54] One thing that unites the sample is their immediate and often desperate need for money. The vast majority of the women in the sample are grappling with issues such as poverty, debt, and the urgent need to support themselves, but also very often their children and other loved ones. This is not about funding lavish lifestyles but simply about making ends meet while trying to provide for their families. Some are also trying to finance their way out of prostitution – attempting to gather enough money together to fund education or their own businesses. The insecure immigration status of so many of the migrant women in the Irish sex trade is also a significant, compelling factor in their entry into and often ongoing entrapment within prostitution. What becomes clear from the analysis are the ways in which poverty, personal adversity and circumscribed life circumstances combine as driving forces for entry into prostitution.

These findings are mirrored in international literature – a recent, comprehensive study of the UK sex trade notes for example: 'Our sense from the data that we have collected and from reviewing existing research is that a substantial proportion of individuals (mainly women and trans women) are selling sex to get by financially, given different constraints in their lives around caring responsibilities, physical and mental health, lack of access to social security benefits and support services, workplace discrimination, or other reasons…This moves beyond individual 'choosing' or 'not choosing' [prostitution] and recognises the structural economic and social context in which choices are narrowed: or in the case of those coerced in to selling sex, choices removed.'[55]

There are women in the WHS sample who were very clearly forced into prostitution by a third party or parties, who are clearly benefitting as a result, and this finding is closely mirrored by recent Irish research.[56] Their stories of coercion and trafficking are all permeated by fear and isolation – pimps and traffickers have no need to physically confine women when they can successfully control them through threats of harm made against them, their children and other loved ones, or by deceiving and then entrapping them in the sex trade in a country where they do not speak the language, have no other means to earn money, no safe place to live, no real friends or support networks and no one to ask for help, even if they had the language skills to do so. It is evident that being pimped and trafficked into the Irish sex trade alters the course of these women's lives permanently.

54 See for example: Clarke, R.J., Clarke, E.A., Roe-Sepowitz, D. and Fey, R., 2012. 'Age at Entry into Prostitution: Relationship to Drug Use, Race, Suicide, Education Level, Childhood Abuse, and Family Experiences.' *Journal of Human Behavior in the Social Environment*, 22:3, (pp. 270-289); Raphael, J., 2012. 'Meeting Gendered Demand: Domestic Sex Trafficking in Chicago.' In Coy, M, (Ed.) *Prostitution Harm and Gender Inequality: Theory, Research and Policy* (pp. 53-69). England: Ashgate Publishing Ltd; Roe-Sepowitz, D., 2012. 'Juvenile Entry into Prostitution: The Role of Emotional Abuse.' *Violence Against Women*, 18:5, (pp. 562-579).

55 Hester *et al,* 2019, *op cit.* (p. 4).

56 O'Connor, M., and Breslin, R., 2020, *op cit.*

3. Experiences of prostitution

Section 3 explores what life is like for women in the Irish sex trade and beyond, including their experiences with sex buyers, prostitution organisers and profiteers. It explores the risks and harms that women face in the trade and begins to consider the impacts their involvement in prostitution may have on their wellbeing and other aspects of their lives.

3.1 Location

At their initial assessment women were asked where they were in prostitution. The vast majority of the sample were involved in indoor prostitution,[57] in a variety of locations, reflecting what is already known about the nature of the Irish sex trade.[58] In fact, just one woman in the entire sample said she was involved in street prostitution at the time of first assessment – she met with buyers on the streets and in their cars. Table 6 shows the different locations where women reported they were involved.

Table 6: **Prostitution locations**

Location	Number of women	% of women*
Indoors/'Parlours'	100	69.4%
Callouts/Outcalls	52	36.1%
Own residence	29	20.1%
Hotels	15	10.4%
Buyers' homes	3	2.0%
Street	1	0.7%
Not recorded	26	18.0%

* All percentages are subject to rounding and total more than 100% here because most women were involved in prostitution in multiple locations.

'Indoors' and 'Parlours' are the categories that WHS have used for many years to record locations at initial assessment – essentially this means any premises being used as a brothel – in the Irish context this is most typically apartments. These numbers total more than the overall sample size as most women were in prostitution in more than one location – for example brothels were often combined with outcalls. Callouts or outcalls refer to women travelling to meet buyers in a location of the buyer's choosing, which often includes hotel rooms or sometimes his own home.

57 Sometimes known as 'off-street' prostitution.

58 Kelleher Associates *et al*, 2009, *op cit*; Sweeney, L., and FitzGerald, S., 2017, *op cit*; O'Connor, M., and Breslin, R., 2020, *op cit*.

These figures give a broad overview of prostitution locations amongst the women accessing WHS, but should be treated with caution for a number of reasons – for some women in the sample the type of location where they were based changed regularly; some of the above categories overlap – for example women may do outcalls to hotels and so may have been included under both categories in the table above; and whilst a sizeable number of women said they were based in their 'own residence', it was unclear in many cases whether this referred to women's permanent base or a short term rental that was not the woman's home per se, but rather the place where she slept and also saw buyers before moving to another location.

3.2 Length of time in prostitution in Ireland

As previously discussed in 1.4, most of the women in the sample had been in Ireland less than 12 months when they first accessed WHS. Table 7 shows how long women reported they had been *in prostitution* in Ireland when they first attended WHS.

Table 7: **Length of time in prostitution in Ireland at first visit**

Length of time in prostitution in Ireland at first visit	Number of women	% of women
Less than one week	4	2.8%
1-4 weeks	16	11.1%
1-6 months	50	34.7%
7-12 months	8	5.5%
13-18 months	4	2.8%
2-4 years	15	10.4%
5 years +	5	3.5%
Not recorded[59]	42	29.2%

Excluding those whose length of time was not recorded by the service, 68.6% of the sample had been in prostitution in Ireland for just six months or less. In general, women who had been involved for two years or more tended to be Eastern European or Irish, whereas those involved for shorter periods were more likely to be Latin American – in part because most of these women only have short-term permissions to be in the State.

However, it was striking, regardless of nationality, how quickly some women entered prostitution upon their arrival into Ireland – often within a matter of weeks or even days – this was particularly the case amongst young women from Romania. Some had been in prostitution previously in their own country or in other Western European countries, while for others, the Irish sex trade was their first experience of prostitution.

59 This question is not asked by staff as part of women's initial assessment, which explains the number of 'Not recorded' here, but it was asked sufficiently often in the course of documenting women's case histories to warrant analysis.

3.3 Mobility

As first explored in 1.5, many of the migrant women in the sample are very transient – travelling ('touring') back and forth between Ireland and their country of origin and/or other countries where they are also in prostitution, or alternatively, particularly if they are subject to immigration restrictions, they 'tour' around Ireland instead. A few of the Irish and EU citizens in the sample also 'tour' around both Ireland and Northern Ireland. Some women mentioned that they had regular contacts or 'agencies' that they used to rent apartments for the purpose of prostitution, which were well established across the country (see 3.7 for further details).

Women in this sample travel, or their travel is arranged for them by a third party, primarily in response to market demands, but for other reasons too – including to ensure discretion – for example if they do not wish family members to find out they are involved in prostitution. Women were typically expected to cover their own national and international travel costs, having to see even more buyers in order to do so. Some women mentioned the challenges they face in travelling so regularly and being unable to put down roots or more fully engage with support. Some seemed disoriented – not even knowing the names of the places they would be travelling to or any information about them. Women also found that 'touring' acted as a significant barrier to their successful engagement in their education – from English language classes to college courses. Indeed, there are growing concerns identified in the international literature for the welfare of increasing numbers of women within the European sex trade who are highly transient, moving or being moved by prostitution organisers swiftly across different jurisdictions for the purpose of prostitution and who are therefore very disconnected from support services.[60] Recent research on both the Irish and UK sex trades similarly notes hidden and transient subgroups within these trades who have limited to no contact with service providers and are extremely isolated and often vulnerable and lonely.[61]

Elena described how she travels for the purpose of prostitution:

> *I don't have wish for buy nothing, because I always travel and I can't see more leisure [time] here…So, I don't have wish for going in a store and buy clothes for me because I don't wear. I don't have house [Elena is NFA in Ireland]. Always I'm travelling. Moving, moving, because, you know, you can't sit down, you know. [Dublin, Cork], Galway, Northern Ireland. And here also it's difficult when you go to – like I have been for open the bank account. Everything is difficult because you need to provide the address and where your money comes from, you know.*
>
> - ELENA

Both WHS Outreach and Clinical staff noted that some of the women who access the service can be very difficult to keep in contact with between visits because they are constantly on the move. Indeed, the service's records show that a significant amount of time is spent by staff trying to make contact with women to inform them of important matters such as test results, tests that are due to be taken, or to update them on other matters such as the progress of a court case. Some

60 See for example: Walby, S., *et al,* 2016, *op cit*.
61 O'Connor, M., and Breslin, R., 2020, *op cit*; Hester *et al,* 2019, *op cit*.

women can be uncontactable by the service for months or even years, only to unexpectedly reappear in person at the clinic. Similarly, some women are regular 'no shows' at medical and other appointments that WHS have arranged on women's behalf or referred them for, despite repeated reminders. Staff observe that the pressure for women in the sex trade to acquiesce to the demands of buyers, to 'go where the money is' and be earning from prostitution at all times, in many cases even when they are unwell, creates barriers to their engagement with support, sometimes even in the case of urgent medical matters.

3.4 Experiences of prostitution in other countries

Women were not asked about where outside Ireland they had been in prostitution as a standard initial assessment question (hence the large number of 'not recorded' cases in Table 8 below), but nevertheless this information was recorded fairly regularly as part of taking women's background history. The data reveal that of the 81 women who provided this information, 54.3% had been involved in prostitution in Ireland only, whilst the rest had been in prostitution in more than one country, and indeed many still were whilst they were accessing WHS, given the frequency of 'touring' within the sample.

Table 8: **Countries where women attending WHS reported being in prostitution**

Number of countries	Number of women
One country	
Ireland only	44
Two countries	
Ireland and Australia	1
Ireland and Brazil	5
Ireland and Colombia	1
Ireland and Germany	3
Ireland and Hungary	2
Ireland and Italy	3
Ireland and the Netherlands	1
Ireland and Northern Ireland	1
Ireland and Portugal	1
Ireland and Romania	1
Ireland and Spain	2
Ireland and the UK	6
Ireland and the USA	1
Three countries	
Ireland, Italy, the UK	1
Four countries	
Ireland, Brazil, Britain, Northern Ireland	1

Ireland, Denmark, Northern Ireland, Scotland	1
Ireland, Romania, Spain, the UK	1
Six countries	
Ireland, Germany, Italy, Netherlands, Spain, the UAE	1
Multiple countries (number unspecified)	
Europe	4
Not recorded	63

The multiple countries in which some women had been involved in prostitution reflects the global nature of the sex trade and also highlights once again the levels of mobility within the sample.

3.5 Buyers' demands and their impacts on women

Very little information is recorded by WHS about the buyers women see and the sex acts they request or demand in the context of prostitution, although recent research on the Irish sex trade does shed some more light on this.[62] Information on buyers tends only to be recorded by WHS when women disclose specific incidents of intimidation, harassment, violence, or rape perpetrated against them by buyers – see 3.6 below for further analysis of this.

WHS Clinical staff noted that they often operate around a 'black box' of the sex acts involved in prostitution – they acknowledge some reluctance on their own behalf to ask women about the nature and frequency of sexual acts with multiple buyers in the context of prostitution. There are a number of reasons suggested for this reticence. Some are practical – a short consultation with the doctor or nurse, or meeting with Outreach staff in the context of a busy drop-in service, is rarely the place to get into detailed conversations with women regarding the experience of men buying sexual access to their bodies. Also, clinicians noted that their focus in treating STIs is to get to the root source of the infection and address it, and so they tend not to ask many questions about the experience or circumstances surrounding the sex act/s involved.

But Clinical staff also acknowledged that their reticence stems from the fear of 'opening a can of worms' by enquiring about issues women may find distressing to discuss – especially when in that moment they remain reliant on prostitution and are likely to be leaving the service that afternoon or evening to go straight to a 'booking' with a buyer. Staff note that many women cope with prostitution by presenting to the service as upbeat and putting a 'brave face' on their situation, as well as creating boundaries for themselves regarding what they do or do not disclose to support services. Given this, staff are reluctant to erode such coping mechanisms or try to break through such boundaries in women who are involved in prostitution right in that moment, for fear of leaving them feeling very vulnerable and exposed.

Having said this, in interview women were surprisingly open to discussing sex acts in the context of prostitution and required no prompting to do so. Women outlined the profile of the buyers they see – usually Irish, typically fathers who are married or in a long-term relationship, and usually older (forties and beyond) – this is mainly because the women interviewed actively avoided seeing younger men who often proved to be 'trouble' for them.

62 O'Connor, M., and Breslin, R., 2020, *op cit.*

Some women described the need to emulate sexual desire for buyers that they did not feel:

> *…it's like sometimes you are not in the mood, sometimes you're not well – like I'm not well today – and yes, and they think you are horny all the time. Like you are doing that because of horn, it's not because of money… Sometimes [I'm] not well, they text you, 'Are you horny?' I say, 'Oh, yeah, I'm very horny!' [laughs]… Like you won't say, 'No, I'm not.' You have to say you are.*
>
> - NATALIA

> *And the guys think, 'Ah, she have pleasure.' Of course not. Stupid, you know…The guys think, 'Ah, no, I come here for give to you pleasure'. And I think, 'Jesus, no, disgusting!'*
>
> - ELENA

Interviewees also outlined demands by buyers they could not agree to, or that disgusted or concerned them:

> *Here is like the guy sometimes – most time – treat you very bad here [in Ireland]…And the guys can write what they want…have guys make [blackmail] me, like, 'oh, if you don't do oral without condom, I put bad things for about you' [i.e., give her a negative review on the Escort Ireland website[63]].*
>
> - ELENA

> *For example, yesterday I got a phone call for a couple of hour appointment…He called me and say, 'I looking forward to our appointment'. [She replied] 'Did you read my [advertising] profile?' [He replied] 'Yes, but I'm looking for something I didn't read in your profile' [a sex act without a condom]. If you didn't read it in my profile, it's because I don't provide…for me it's not only about the money. It's about me, about myself. I don't want spend my life in the doctor's. Or to destroy my life.*
>
> - OLIVIA

63 This website provides a forum for sex buyers to rate and 'review' the women they have purchased sexual access to, including rating them out of five stars on measures including 'accuracy of photos', 'location', 'value for money', 'appearance', 'satisfaction' and 'overall experience', as well as sharing details in their reviews of women's demeanour, the specific sex acts they provided, whether they would recommend them to other buyers etc. (for a further analysis of buyer reviews see O'Connor, M., and Breslin, R., 2020, *ibid*).

With Irish [buyers]…just lack of manners and common sense. Just demanding, demanding. And [demanding] cheap fucks. That's the main problem.

- NICOLETA

Okay, sometimes they want to do things you don't want to do…I hate that people like want a schoolgirl. When they call and they said, 'Ah, can I pretend I am your son?' Oh my god, I have kids! Like dress like a schoolgirl, things like that, you know? I don't know, maybe I don't call it paedophile, but if something goes against me I can't, you know.

- NATALIA

And the bad thing I listen here, in Ireland…was like [a buyer who phoned her and said] 'Ah, I know you are Brazilian because I am looking your profile, and I want have sex with you, but I want you have sex with my dog.' And I say, 'What?' Disgusting, no? Because after I start to cry because it's the animal. And you know what, I don't know what this man do with the animal…So, this was really disgusting because one person who do this with animal, who do this with a child, do this with kids, do this with old people, you know – it's sick persons, sick people. And I was so scared, you know. This here in Ireland…and another thing I think is so strange for me is when a guy…[asks] you can put on a college, school [uniform]? A schoolgirl - Jesus! I said 'No', you know. Jesus, I can't, because now this is paedophilia.

- ELENA

Elena went on to describe a further range of demands she had received from buyers that she felt uncomfortable with, such as being asked to anally penetrate, hit, urinate and defecate on them. She believes that women in prostitution are a particular target for such demands:

Because, you know, some men thinks crazy. Crazy!...I think don't say to the wife, don't say to the girlfriend they want to do really this, and they have shy or embarrassed for say the woman. His woman. And don't have in his house, so he goes [to women in prostitution] for do this kind of thing.

- ELENA

Olivia related what happened when she refused to see a buyer:

> *And I worry about one more thing. And it's very important, because for me it was a shock, complete shock, here in Ireland. I won't cry. Long time ago…I was in Galway…And I got photograph for – somebody sent me a baby with dick in front of the baby…Somebody said, 'If you don't want to see me, I will fuck her.'…I showed the picture and all of those men I showed the picture…Nobody want to still involve with these…Just I talk with a friend of mine and everybody is here like, 'Don't thinking, don't see, don't say.'…'Like it's better done now…leave it'…I say, 'It's no – it's no like that. It's a baby'…This is the most weird things I have in this job.*
>
> - OLIVIA

Elena also described how she handles buyers who make demands she is not willing to meet, or who threaten her:

> *But I know my rights here also. Before I come [to Ireland] I try it, because I studied in Brazil [she researched the laws on prostitution in Ireland] and I didn't want to have the same situation like I had in Germany [where she was attacked by a buyer who then called the police on her]. So, I know everything, and I know like if the client go for looking for one escort, he have the fault also. So, men, guys, come and they said to me 'Ah, I pay less, or I want my money back because you don't did this and this and this and this. And I call the police for you.' I say, 'Really? So, with me not, because I know my rights. I will call the police for you!'*
>
> - ELENA

Women also discussed in interview how they think men buying sexual access to their bodies has affected their feelings about sex.

> *And now, like after a while time, I'm working for this [prostitution] you don't have more wish for have [sex] I can tell you. I've wished for be find love, but I don't have this for have sex, because you see so men thinks like disgusting…Not like tired about have sex, because it's nice if you love someone. But tired about you [being] like scared. Who is this guy, you know? What he likes?*
>
> - ELENA

> *I have to say most men [buyers] is married. Like most of them is married. Like I know they don't want trouble…Okay, so I won't get love. I won't get trouble. Like give me the money, do the sex, that's it. But it's not about the job, it's about – how I'm going to say that? It's like if I look for someone it's for the company, for to have nice company. It's for to go for holidays, not sex anymore.*
>
> - NATALIA

Here Luciana describes why and how she is slowly but surely trying to exit from prostitution by reducing the sexual access men have to her body:

> *So, I offered 'full service' [penetrative sex], as they say, for a few years. But I was like really, really, let's say, sick, I don't know, in my head. That thing [the sex acts involved in 'full service'] like made me feel really sad. I didn't like what I was doing…[she started to access counselling]…So, after four years offering full service, I decided to not offer full service anymore. I was ready to try massage because I couldn't handle anybody touching my body…it was horrible…So, I decided to do only massage even knowing I couldn't get the same money…I didn't want anybody touching my body because of money, even when they paid me. I didn't want that anymore…They [buyers] lie down there and I give them massage. I know at the end they have to turn around and I give them a hand job, whatever, you know – but anyway they don't touch me. You know, they don't go to my privacy, my intimacy…actually they keep trying to break the rules, yes, yes, and cross the line. But I always say 'No'…and then after, when I came back [from a short trip to] Brazil, I told myself, I said, 'Oh, no, I don't think I need therapy anymore; I can handle this now,' as I'm not, you know, I'm not exposing my intimacy anymore.*
>
> - LUCIANA

Women also outlined in interview how they think prostitution has affected their feelings about relationships with men more broadly, and in particular their ability to trust.

> *It [prostitution] still wrecked my head because I, you know, I lost the trust in men. Now I find myself very hard to believe in a man because I know my clients, I know their lives, I know they love their wives, their lives, their kids, their families, and they still want something else, you know. And now I just feel, oh my god, when I get out of this I don't know if I'm able to find someone, fall in love, and trust that person.*
>
> - LUCIANA

> *I already want to have family – I have the dream for have kids, you know, like everybody and other girls, other womans…And this make me feel sad, you know. When I meet someone and the guy ask me 'Oh, what do you do?' this is true and this hurts me, because what can I do, you know? [she feels she cannot be honest and tell him she is in prostitution].*
>
> - ELENA

> *I have to look after them [her children]. I have to – so I'm not thinking about getting boyfriend or something like that…I just work for my kids. I used to help my family, but no pimps, no boyfriends. Because of that job you don't have like a real relationship, you know. Sometimes you get crush on guy but no relationship, and I don't pay a drink for nobody! No, no, there's no way. I have about two very gorgeous guys. One was in Spain. Gorgeous. And 'Oh, you are very nice.' I say, 'That fella is so gorgeous, I'm sure [I] was to get fell in love with him and [he] start pimping me.' I said, 'No way!' No, no, I get scared…Once a guy said to me, 'You must be crazy. I'm never going to marry with an escort with three kids.' It's like that. And I know with my situation I get more difficult, you know. And it's not something I'm looking, hunting for, you know. If someday I find a brave man – !*
>
> - NATALIA

Romana was attacked and violently assaulted on two separate occasions by buyers who had contacted her via the Escort Ireland website. Here she describes the impact these incidents have had on her sense of trust:

> *[After the first attack I was] really scared, really unhappy. I had paranoid. A lot of problems. A lot of problems…I mean, I not trust the men anymore. I take a break [from prostitution], like a month. And then I back again. But like after a month I was attacked again, with knife…you can't get happiness from that money [prostitution]. Always you'll be sad, will be paranoid.*
>
> - ROMANA

The interviewees appear to be expressing very similar sentiments to those identified in a US study of 119 women in prostitution, which found that 'performing' sex in the context of prostitution was a negative and/or traumatic experience 90% of the time, with women feeling a range of negative emotions including sadness, worthlessness, anger, anxiety, and shame.[64] These findings cast

64 Kramer, L.A., 2003. 'Emotional Experiences of Performing Prostitution.' *Journal of Trauma Practice,* 2: 3/4), (pp. 187-197).

further light on the validity of framing the sexual acts within prostitution as consensual, rather than unwanted, undesired acts which women must acquiesce to, as has been discussed in a range of Irish and international literature.[65]

3.6 Experiences of risk and violence in the sex trade

Evidence of serious violence perpetrated against women in prostitution is well-documented[66] and women in prostitution are known to be at far higher risk of violence and murder compared to the general population,[67] with the highest homicide victimisation rate of any set of women ever studied.[68] Aside from the ongoing harms, particularly to their sexual and mental health, experienced by women as a result of their involvement in prostitution (as documented in Section 4), women across the sample also disclosed specific incidents of violence they had suffered in the sex trade.

During this study's data collection period,[69] women in the sample reported 47 incidents of criminality and violence to WHS. Several of these incidents had happened to someone else known to the woman recounting it, and sometimes the same incident was reported numerous times by more than one woman. Therefore, to avoid overcounting, the analysis focused on incidents of criminality, threats of harm or violence and actual violence reported to the service directly by the women against whom they were perpetrated. These acts all occurred in relation to their involvement in prostitution. Perpetrators included buyers, pimps, traffickers and other criminals. Twenty-two women reported 33 such incidents to WHS, all of which occurred between 2014[70] and the end of the data collection period in 2019. Of these 33 incidents, the majority were categorised as serious – involving fear of violence, actual physical and sexual violence, or direct coercion into prostitution, including trafficking.[71]

All of these women, with one exception, had attended WHS more than once. This means that more than one fifth (21%) of the sample who attended the service on more than one occasion disclosed experiencing incidents of criminality, threats of harm or violence and actual violence, all of which occurred in the context of prostitution, and the vast majority of which were severe. A fuller analysis of these experiences has been documented by the authors in recent research on the Irish sex trade.[72]

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65 Moran, R., 2013. *Paid For: My Journey Through Prostitution*. Dublin: Gill & Macmillan; O'Connor, M., 2017. 'Choice, Agency, Consent and Coercion: Complex Issues in the Lives of Prostituted and Trafficked Women.' *Women's Studies International Forum,* 62, (pp. 8-16); Bacik, I., 2021. '#MeToo, Consent and Prostitution – The Irish Law Reform Experience.' *Women's Studies International Forum,* 86; MacKinnon, C.A., 2016. 'Rape Redefined.' *Harvard Law & Policy Review*. Vol. 10 (pp. 431-477); Farley, M., 2018. '#MeToo Must Include Prostitution.' *Dignity: A Journal on Sexual Exploitation and Violence*, 3 (1).

66 See for example: Farley, M., Cotton, A., Lynne, J., Zumbeck, S., Spiwak, F., Reyes, M., Alvarez, D., and Sezgin, U., 2003. 'Prostitution and Trafficking in Nine Countries: An Update on Violence and Posttraumatic Stress Disorder.' *Journal of Trauma Practice*, 2: 3/4, (pp.33-74); Farley, M., Banks, M., Ackerman, R., and Golding, J., 2018. 'Screening for Traumatic Brain Injury in Prostituted Women.' *Dignity: A Journal on Sexual Exploitation and Violence*. 3: 2, Article 5; Hester *et al,* 2019, *op cit*; O'Connor, M., and Breslin, R., 2020, *op cit*.

67 See for example: Farley, M., 2004. 'Bad for the Body, Bad for the Heart: Prostitution Harms Women Even if Legalized or Decriminalized.' *Violence Against Women, Special Issue, 10* (pp. 1087-1126).

68 United Nations Office on Drugs and Crime (UNODC), 2018. *Global Study on Homicide – Gender-related Killing of Women and Girls.* Vienna: UNODC.

69 2015-2018 is the sampling period from which women's records were selected, but data collection took place during 2019, until August of that year, so data were collected on women's attendances right up to that point.

70 One woman who first accessed the service in 2018 reported being trafficked to Ireland in 2014.

71 O'Connor and Breslin, 2020, *op cit*.

72 *ibid*.

Women across the sample recounted a series of frightening incidents of harassment, threats, aggression, intimidation and physical and sexual violence perpetrated by buyers, some of which were prolonged in nature. Similarly, in interview, women also described a broad range of very frightening and often violent incidents they had experienced at the hands of buyers. It is worth noting that these women were taking calls from buyers themselves directly and therefore had more control over who they saw and had the opportunity to try to 'vet' them than women subjected to organised prostitution, yet sexual violence and physical violence, including assaults with weapons, was still part of their experience.

Luciana recounted the behaviour of a buyer that really frightened her and led to further harassment:

> *As soon as he got in [to the apartment], he asked me to turn [my] back to the wall and he kept touching my back…he said 'Oh, I love your back, I love your back.' But he kept saying that. Then I got scared, [it was] really weird. He asked me to lie down on bed and he was just giving my back massage. I never see that guy in my life! How could I let someone do that? Imagine if he had the intention to kill me? I couldn't defend myself…So I got very scared…half an hour passed. He wanted to stay there…and it was really hard to put him out. [Afterwards] He kept calling me, calling me… like every day, every day, every day trying to make another appointment. I said 'No, no'. I don't know his intentions, you know.*
>
> - LUCIANA

Elena described two incidents of being physically assaulted by buyers when they decided she did not meet their demands:

> *So, one time one guy comes and he could not cumming. I did everything! And he wanted the money back. And I say, 'Sweetie, you had sex with me, I'm not give your money back.' And he was hitting me and I put him out. I don't know how I could put him out [but she managed to]. And then closed the door and he stay outside [banging on the door and shouting] 'I want my money! I want my money!'*
>
> *…I had one guy, he was with me in Galway, and very tall, very strong, and he comes and he uses [drugs]. He start to feel bad inside my room and I say, 'Do you want water? Do you want something?' And I gave to him water, everything, and I say, 'My god, oh my god, this guy can die here!'… So, I was so scared. I am putting his [him] out and I said, 'Sweetie, now all your time finish.' And then he said to me, 'Ah, but I didn't do nothing. I want my money back.' And then he start to fight with me and he start to come for hit me. And I am luck because I have one guy with me in the house. He helped me [get the buyer out].*
>
> - ELENA

Olivia explained the need to protect herself after a traumatic experience with a buyer:

> *I say between the escorts – we share. We share if someone is dangerous… It was scary in the beginning to met that person [new buyers]…For security reason I can call my friend and they come close to my house, help me…I have spray pepper in my house…[Before that] I had a problem with my telephonist [a woman she paid initially to take her calls as she had very limited English to begin with] because she answer any call, [any] blocked number…she only wanted money…and I have very bad experience with [a] man. Dirty, stole my money, and horrible time…I was afraid about this…But at the end I learn the lesson and I felt to build myself [up]. I'm here, I'm alive, yay!*
>
> - OLIVIA

Natalia and Romana described severe and terrifying instances of sexual and physical violence perpetrated against them by buyers:

> *…because I work alone, I'm by myself…They [the buyers] are the king, right? If they try to do something without a condom or something I really don't like, I give the money back. Even like if they stay already twenty minutes. Have one…guy. Because sometimes I'm joking, you know, I flirting. So, he called me and said, 'What you do?' I said to him, 'I do everything. I can iron, clean.' Like, you know, I just made a joke, but he understood like I can do everything [sex acts] and [he] supposed without condom. He paid an hour. He stay forty minutes really raping me because there was blood on the condom. Tried hard with anal. But because he could not feel nothing, and he was done with me, he stay forty minutes and I give his money back and ask him to leave. And I prefer that way. So then when they leave the door I text and I say, 'Please don't call me again,' and I block the number.*
>
> - NATALIA

> *I start to work and go to school, but I think when I was around five or six months [in Ireland], I was attacked here in Dublin…when I was working in Dublin 1, City Centre…I take a break [from prostitution], like a month. And then I back again. But like after a month I was attacked again with knife again…Another attack, from Irish guy. I went to the Guards, because the neighbours, two neighbours, two Irishwomans, called the Gardas in. [Interviewer: Okay, and what did this man want? Was he robbing you? Like what was in his head?] No rob. Just he attacked me, brutal, with knife. No robbing, nothing…And my life has changed, everything, after this attack...My psychology, all my life.*
>
> - ROMANA

Violence perpetrated against women in prostitution by members of crime gangs was also prevalent in the sample, with gang members often employing similar modus operandi. Women disclosed assaults by more than one assailant, typically accompanied by robbery. In these cases, multiple men entered the premises where women were based and stole any cash and other valuables they could find, including women's phones and laptops and sometimes their identification documents. In all cases physical violence was used by the perpetrators, who often also carried weapons.[73] These methods are often used by pimps to frighten women controlled by rival gangs away from their perceived 'patch'. Recent research explored the links between these violent incidents and highlighted how women in prostitution suffer the consequences of being used as 'soft targets' in the 'turf wars' played out between rival crime gangs involved in pimping and the organisation of the sex trade in Ireland.[74] Natalia describes just one such incident:

> *Then I heard about the men…in Smithfield. So, the girl starts working there and show up three or four guys and beat her up. She had to go to hospital. Then I heard just because it was like [their] main area they didn't want girls working there.*
>
> - NATALIA

The use of violence and, in particular, threats of violence by traffickers and pimps are also well documented throughout the sample (see 1.8, 2.3 and recent research[75]) as a means of drawing women into the sex trade and controlling them within it. Credible threats to harm women's children and other loved ones are especially common in this context. Debt bondage was also used in some cases as a means of control. Women who have been pimped and trafficked into the Irish sex trade have little to no say over their movements around the country, the type or number of buyers they have to see or the sex acts they are forced to perform. They typically receive little to none of the money paid by buyers to their controllers and/or may even have to pay them over-inflated sums for rent, advertising and other 'expenses'. The threat of violence is usually constant throughout.

73 *ibid.*
74 *ibid.*
75 *ibid.*

3.7 Profiteering and its impacts

In addition to those cases of pimping and trafficking documented throughout this study, there was also ample evidence from across the sample of the involvement of third parties, operating in an organised fashion, who were profiting from the prostitution of women and the exploitation of many of the women's dire need for money. As previously highlighted, there are a variety of features of the Irish sex trade that indicate different levels of organised involvement, including women's mobility and the speed with which they entered prostitution in Ireland, despite often having very poor English language skills and a lack of other resources. Nicoleta describes the approach of just one crime gang involved in the Irish sex trade:

> *I've seen it before. It was a wave of women that were doing anything for fifty [euro]. Same photographer. You can see it on the website if you know what to look…Same photographer, same location, everything. A gang that were all working for fifty euros per half an hour, and they were moving – Galway, Cork – twenty of them. You can see that it's a 'big fish' moving [them]…Yeah and they're young, they're new, they have no reason not to make money…And I was like, 'Where am I going next week?' I was like, 'Can anybody tell me where are they next week?'…Because you don't want to be there [because] your price is double, so…*
>
> - NICOLETA

A number of women described to WHS staff how they relied on specific 'contacts' in the sex trade to facilitate their involvement. Some women specifically stated that they were doing 'agency work' – in most cases this meant paying a prostitution 'agency' to arrange accommodation, 'bookings' and often advertising for women, in exchange for a cut of what they earned. These agencies facilitate 'touring' as they can arrange premises for women to stay overnight and see buyers at fairly short notice in locations right across the country.

Nicoleta describes how a prostitution 'agency' works:

> *They [an agency] will have to give you something. They will have to give you accommodation, make your pictures, organise your clients, and then I can say, 'Sorry, how much work you're giving me? Because you're getting a percentage'…An agency needs to be big enough to have a clientele, because if I'll go working for an agency I want to know how busy am I, because I'm going to pay you thirty, forty percent. You need to give me accommodation, make me pictures, everything, but you've got to make sure I'm busy.*
>
> - NICOLETA

Other prostitution organisers were also in evidence in the sample – for example those that arranged and sometimes paid for women's travel in and out of Ireland for the purpose of prostitution. Natalia and Nicoleta describe how organisers based in Ireland typically guard their 'territory' in the sex trade, and in some cases attempt extortion:

> *But to work there like an area [names a specific area in Dublin], that's the Romanian area. You need to ask permission! New girls used to go to [a well-known hotel in the area]. They will just get a phone call – 'That's my area, get out.'*
>
> - NICOLETA

> *That fella was calling. Call few girls…and ask for money. But [he] ask for two thousand [euro] for letting me to work in the area. Call a few girls [and said the same]. So, he called me. I said, 'Okay, but I'm going to give you three thousand…Can come up and collect.' I was by [my] own, you know, but I want to scare [him], [make him think] 'when I get there going to be five guys waiting for me'.*
>
> - NATALIA

Research on the sex trade in Northern Ireland revealed that significant numbers of those involved in prostitution in that jurisdiction have to pay fees or relinquish some of their earnings to a third party – in the majority of cases this share was below 50% of their earnings – arguably a very sizeable proportion in most instances.[76] The same study also highlighted the 'high additional costs' of being in prostitution, particularly among those who are 'touring', including the costs of travel, hotel rooms, short-term apartment rentals, advertising and 'agency' fees. Recent research on the sex trade in the Republic of Ireland found that women in this jurisdiction are paying exorbitant rents – sometimes up to €700 per week – to organisers or landlords who know that their premises is being used for prostitution.[77] Additionally, women may be paying €160 or more per week to advertise on Escort Ireland, with options to generate more clicks such as double ads, 'top' ads and flashing 'available now' icons, costing even more.[78] It would appear that such costs put women in the trade, and especially those who are 'touring', under significant pressure to see as many buyers as they can in order to cover all of these costs and still have enough money left over to live on and, in many cases, to support loved ones also.

Women interviewed for this study similarly emphasised how much it costs them to be active in prostitution in the Republic of Ireland, often paying over-inflated sums for necessities such as accommodation and advertising, without which they could not earn any money at all.

76 Huschke, S., Shirlow, P., Schubotz, D., Ward, E., Probst, U., and Ní Dhónaill, C., 2014. *Research into Prostitution in Northern Ireland*. Northern Ireland: Department of Justice, Northern Ireland.

77 O'Connor, M., and Breslin, R., 2020, *op cit.*

78 *ibid.*

> *When do you rent someplace, like I want to rent someplace…and the guy realised, the owner realised I do this kind of work [prostitution]. He told me that the double price.*
>
> - ELENA

> *First, that apartment, you know. I pay seventeen hundred [euro] for that apartment [where she lives and sees buyers, per month]. For the profiles [advertising] more four hundred a month. To be here and nourished and everything, down you put more like a two hundred euro a month. So… we're talking about two-and-a-half grand with everything like for to be here and sitting now, you know, and [before you even] start work. So, you make the money and the money go for the other door.*
>
> - NATALIA

> *Ah, Jesus, they [rents] tripled up…after that I got my last apartment was two grand a month. I could barely pay myself for that…now you wouldn't make three, four hundred a day and your rents and ads have got up the roof…I have more money in a normal job now than I had when I was an escort.*
>
> - NICOLETA

Natalia and Luciana both explained that at certain points they have paid double rent – that is renting an apartment where they saw buyers and a second place where they lived with their children, in their efforts to provide them with safe, stable homes.

> *They even don't know – like they look at me, they don't see escort, like small clothes, lots of make-up. They see me as mum…It's difficult like because I lie to them [not telling her children she is in prostitution]. Like, okay, because I work only the daytime I have to get two apartments… everything was like double.*
>
> - NATALIA

I wasn't able to get a normal job and pay my bills yet because I had my girls in school [when they joined her in Ireland] and I didn't want to live with so many people. I always wanted to keep my daughters very close to me. I didn't want to live like a student here, as they live, like in an apartment for eight, ten people. And I didn't find it safe for my girls. I always wanted them to be safe...We rented a house in [a Dublin suburb]…I was working [in prostitution] on the school time. So, I left them in school in the morning, came to city centre, I worked until two or half-two [in a rented apartment], took the bus, got them [from] school, and went home…I never wanted to travel ['tour']. You know, I never wanted to leave my kids.

- LUCIANA

A number of women in interview further discussed how reliant they are on advertising on the Escort Ireland website, which essentially has a monopoly in Ireland in this regard, and the exorbitant fees they pay to do so, particularly if they have to rely on the site's many features to boost clicks on their ads, which cost even more.

I could pay one go it's three hundred euro [per month to advertise on Escort Ireland]. Yes, that's for the month. But because I pay a week[ly], because I never know when I go home, it's four hundred a month. Yeah, one hundred a week.

- NATALIA

You need to have 'top ads' [where women pay extra to appear at the top of site searches], banners, everything…Yeah, because when I came in, if you were just paying a week ads, you were having enough business. Now you have to pay double ads, front page. You end up paying them a fortune. You end up paying them like a grand a month to still make some money.

- NICOLETA

And the website costs a thousand euro. A thousand euro costs the website! Yesterday or before, I fighting with the website. I'm saying…'It only makes a lot of money at the moment here only Escort Ireland. Escort Ireland – they pimp us!'

- OLIVIA

3.8 Lack of social support

As previously noted, WHS as a service was very often recommended to women by a friend and many attended clinics with a friend who was also involved in prostitution. Some women lived with friends and/or shared premises with them where they saw buyers. A number of women in the sample also mentioned being first introduced to Ireland and/or to prostitution by a friend. In most cases the boundary between this person being a friend who was 'showing them the ropes' and someone who was organising their involvement in prostitution was unclear. Some women mentioned in this instance that they were required to repay money to these 'friends' who had arranged and financed their travel and often their visa and associated costs also.

In general, most in the sample had few friends, social circles or support networks in Ireland and certainly none outside of prostitution. Indeed, quite striking within the sample was the extent to which prostitution was all-consuming – for some women prostitution was their primary experience of being in Ireland and something that took up the vast majority of their time whilst in the State. A number of women disclosed to Outreach staff feelings of loneliness, isolation and lack of support in this context.

Women in interview described similar experiences of isolation and a sense of being very much alone whilst in prostitution in Ireland.

> *And I came to Ireland because I had a friend here and she's arrived one month before…I came to Ireland for study English…And the first six months everything was new here for me…I never speak English before… And [then] my friend left…She's had enough in Ireland…And I was here alone…I feel lonely, no speaking English.*
>
> - ROMANA

> *Where am I going? Nowhere, I'm staying at home, because when the bloody phone rings [with buyers calling] you've got to be at home. It's very solitary, even when you're with other girls.*
>
> - NICOLETA

> *No friends. But I found sometimes little people will help you, you know, but no friends-friends. When I come here, I make two friends. One go Portugal, another go Thailand. So…no more here…No, I stay in my house.*
>
> - IRIS

[Natalia made sure she told one staff member in WHS her real name and explained why]. Yes, yes. I was here by myself, like. I didn't know nobody. Like came from a new country, no one, and I say if something [seriously bad] happened to me, at least they [the staff member] know who I am…I don't have friends and that [outside of prostitution] because…how I'm going to do – make a friend, you know? Because I can't talk about my life.

- NATALIA

Here Romana, Elena and Nicoleta describe how, like many migrant women in the sample, their overwhelming experience of being in Ireland is centred around prostitution:

You can't have life. Always you must stay in your house. You can't go out with friends. You can't go – because the way [as soon as] you go out the phone's ringing – 'Are you free?' I can't go now…always working. Always…This is not – this life is not from good. It's from I don't know where. Because it's not healthy way.

- ROMANA

It's not like [your] work – because I already working normal…I had normal works [a regular job before]. You go and come home and relax and finish. [But in prostitution] I stay with my phone on the whole time. The whole time, you know…I mean like this was not one normal job… It's like this work is dangerous. This works can give you illness. [In] This work can happen many things.

- ELENA

…but even during the day, if you have the kind of day when you knew, hmm, I might not be busy at all today, I would already start getting angry, knowing that I'm going to waste my day, I'm going to stay at home, the phone's not going to ring, I'm not going to be busy, and I wasn't out to do something else. I was always in between states…And when I was going out, the bloody phone start ringing. It will make you angry instantaneously. I've seen a few psychologists and they said, 'No, you need a change. Make the change. That's what you need. There's nothing we can do. I can listen to you all day long, but there's nothing you can do.'…then I said, 'No, I need a different routine'. Each time I was going out to do something the phone was ringing. Then I was sitting at home…it wouldn't ring again. And it was driving me nuts. And I was drinking more and more and more and I said, 'This is not going anywhere.'

- NICOLETA

These experiences were somewhat borne out by the fact that during interview, a number of the interviewees' phones were constantly ringing or buzzing with notifications, and the women confirmed that the callers were buyers trying to make contact with them.

3.9 Discussion

The high levels of mobility and transient nature of the sample, the lack of social supports and experiences of isolation within the trade and from the rest of society all highlight just how marginalised women in the Irish sex trade really are. It is clear for some that their precarity and rootlessness increase their isolation, making it more difficult for them to access formal or informal sources of support, especially amongst those who experience prostitution as all-consuming.

The speed of entry into prostitution in Ireland, the ways in which women are spread across different locations within the State and indeed 'tour' across Europe, all point to a system or systems of prostitution that go beyond individual endeavour; indicating varying degrees of organisation and therefore gain by third parties.

The interviews in particular reveal some of the bodily but also emotionally harmful realities of prostitution – having to emulate non-existent sexual desire for buyers, handling demands they find repellent or frightening, enduring physical and sexual contact they can no longer bear – and the cumulative negative effects these experiences have on their own sexual lives, identities, intimate relationships and ability to trust. This sense of being violated in the context of prostitution is consistent with studies where women express similar feelings of sexual intrusion, disgust and revulsion.[79] The specific impacts such experiences have on women's overall health and wellbeing is elucidated further in the next Section.

Women in the Irish sex trade also face the constant risk of violence from a variety of sources, and very often this risk becomes a reality. Violence and the threats of violence are used by criminals, pimps, traffickers and buyers alike as a means to control women or ensure that they bend to their will. It is clear that violence and the fear of violence is endemic to the trade, and this was the case across all years of data collection.[80] It is noteworthy that women never truly know what to expect from a new buyer, even when they have tried as much as possible to vet him in advance. At the same time women are very vulnerable to and often targeted by criminals associated with the trade, as appears to be the case in the series of violent robberies suffered by a number of women in the sample.

Within the trade, women are also subject to those who organise and profit from it, all benefitting in some way from women's vulnerabilities, their isolation, their need to earn money or other difficult life circumstances. The high financial costs to women associated with being in prostitution mean that they need to make a significant sum weekly before they can even cover these costs and earn something for themselves or the loved ones they are supporting. It is these conditions that often entrap women in prostitution or ensure they leave it no better off financially than when they first began (see Section 5 for a further analysis of this).

79 See for example: Coy, M., 2009. 'Invaded Spaces and Feeling Dirty: Women's Narratives of Violation in Prostitution and Sexual Violence.' In Horvath, M., and Brown, J., (eds), *Rape: Challenging Contemporary Thinking*, (pp. 184–207). Portland, Oregon: Willan Publishing; O'Connor, M., 2017, *op cit*.

80 O'Connor, M., and Breslin, R., 2020, *op cit*.

4. The health impacts of prostitution

Section 4 explores the complex and wide-ranging impacts that prostitution has on women's health and wellbeing, with particular reference to their sexual, reproductive and mental health.

4.1 Approach to the analysis of health data

To explore how involvement in prostitution impacted on women's physical, sexual and reproductive health specifically, data were collected from the medical files of 50 women who first accessed WHS during the sampling timeframe of 2015 to 2018. These women were selected from within the larger sample on the basis that they had engaged well and relatively consistently with the service – women were selected who had had five or more engagements with the WHS Outreach team at the time of data collection, and were therefore also likely to have had similar levels of contact with the Clinical team (for more information on selection, data collection and the limitations of the data in this context see Appendix A).

Data (primarily quantitative) pertaining to women's physical, sexual and reproductive health were collected from the medical files by the Service Manager. Additionally, data relating to women's mental health and wellbeing were gathered from medical files, but in fact the primary source of mental health data came from the Outreach notes, as women were far more likely to discuss issues relating to their mental health and wellbeing with the Outreach team (see 4.8 for further details and analysis).

The 50 women in the medical sample made a total of 333 visits to WHS's Clinical team between January 2015 and the end of August 2019 (the date of the most recent clinical visits in the sample noted during data collection). The average number of visits per woman during this period was 6.7, broken down as Table 9 shows.

Table 9: **Number of visits to WHS's Clinical team by women in the medical sample**

Number of clinical visits	Number of women
0 visits	1[81]
1-5 visits	24
6-10 visits	18
11-15 visits	4
16-20 visits	0
21-25 visits	3

81 This woman had multiple contacts with the WHS Outreach team and on this basis was included in the medical sample in line with the selection criteria (see Appendix A). However, whilst she received quite intensive support from Outreach regarding an ongoing legal matter, she did not access the services of the Clinical team at any time.

4.2 Overview of sexual and reproductive health issues

Table 10 displays the 28 different, broad-ranging sexual and reproductive health issues women in the medical sample presented to WHS's Clinical service with during the data collection period, and the number of women that were affected. 'Presenting issues' are defined here as those symptoms and conditions women complained of to Clinical staff, alongside those that were observed and diagnosed by Clinical staff.

Table 10: **Sexual and reproductive health – Presenting issues**

Complaint	No. of times presented	No. of women affected
Vaginal discomfort/discharge/odour	70	31
Candida (commonly known as 'thrush')	38	22
Pain when urinating (dysuria)	23	14
Bacterial Vaginosis (BV)	22	15
Abdominal/pelvic pain	19	12
Pregnancy concerns	19	13
Bleeding (vaginal)	18	13
Blisters/sores (genital)	12	6
Chlamydia	12	10
HPV (Human Papilloma Virus)	11	5
HSV (Herpes Simplex Virus – Types 1 & 2)	10	7
Anal pain/bleeding/haemorrhoids	7	5
Pain during sex (dyspareunia)	7	5
Vaginal pain/lesions	7	6
Painful/problematic periods	6	6
Breast pain/lump	5	5
Cervical erosion	4	4
Medical issues related to gender transition[82]	4	4
Gonorrhoea	3	3
Hepatitis C	3	2
Sore throat	3	3
Hepatitis B	2	1
PCOS (Polycystic Ovary Syndrome)	2	2
Syphilis	2	2

82 These issues were usually related to the need to obtain the hormones necessary for medical transition in Ireland (as often these had originally been prescribed in the person's country of origin), and the need for onward referral to specialist sources of healthcare and support. Given the small numbers in the sample, it was not possible in this study to explore specific or unique harms to health experienced by transgender people in prostitution in Ireland, but this certainly warrants further investigation.

Complaint	No. of times presented	No. of women affected
HIV (Human Immunodeficiency Virus)	1	1
Groin pain	1	1
Allergy to lubricant	1	1
Low libido	1	1

Some caution is required in interpreting these data given the potential for overlap or links between a number of these complaints – for example women regularly present to the clinic with 'vaginal discomfort' but may not complain of conditions such as candida or BV specifically (of which such discomfort is a symptom) – these conditions may subsequently be diagnosed by Clinical staff. Conversely, women may present complaining of precisely these conditions, particularly if they have experienced them before and recognise the symptoms. In other cases, women present with specific concerns about having contracted a particular STI, but subsequently test negative for same. The intention here was to record as faithfully as possible what, if anything, women complained of and were concerned about in terms of sexual and reproductive health symptoms and conditions, alongside what staff observed and noted on examination. This provides as full a picture as is possible to glean from the files of the nature and frequency of the sexual and reproductive health problems faced by women accessing WHS. In terms of frequency, it is clear from the data that women in prostitution are experiencing multiple forms of such health problems, the most common of which tend to be reoccurring, requiring repeat attendances and repeat or ongoing treatment.

Indeed, the sexual and reproductive health issues faced by women in prostitution accessing WHS are also reflected in the treatment and preventive measures undertaken by the clinic in response. Table 11 provides a list of the most common drugs, medications and vaccines prescribed and/or administered by the clinic. It should be noted here that WHS directly administers to women vaccines such as Engerix B ® (the Hepatitis B vaccine) and drugs such as the oral contraceptive pill (OCP). In other cases, it issues prescriptions for the women to fill themselves, or recommends various treatments (usually topical) that can be purchased in a pharmacy 'over the counter', without prescription. Table 11 contains the 17 most common items administered/prescribed/recommended by the clinic to women in the medical sample on at least three or more occasions.

Table 11: **Drugs/medications/vaccines most commonly administered/prescribed/recommended by WHS on three or more occasions**

Drug/medication/ Vaccine	No. of times administered/ prescribed/ recommended	No. of women	Use
Engerix B ® [83]	45	20	Hepatitis B vaccine
Canestan ® pessary	29	20	Treatment of candida
Cerazette ®	28	8	OCP

83 Requires three separate doses to be administered by injection over a period of six months.

Drug/medication/ Vaccine	No. of times administered/ prescribed/ recommended	No. of women	Use
Clindamycin	23	19	Treatment of BV
Microlite ®	18	11	OCP
Canestan ® cream	15	11	Treatment of candida
Azithromycin	13	12	Treatment of chlamydia
Twinrix ®	7	4	Hepatitis B vaccine
Levonelle ®	5	5	Emergency contraception
Imiquimod	5	1	Treatment of genital warts (HPV)
Trimethoprim ®	5	3	Treatment of UTIs (urinary tract infections)
Depo Provera ®	4	4	Contraceptive injection
Macrodantin ®	4	4	Treatment of UTIs
Diflucan ®	3	3	Oral treatment of candida
Analgesic	3	3	Pain relief
Anusol ®	3	2	Treatment of haemorrhoids and other problems of the anal area such as anal fissures
Valtrex ®	3	3	Treatment of genital herpes (HSV)

Some of the reasons why women present with these particular complaints, their frequency and impact are explored further in the subsections that follow.

4.3 Contraception use

At first contact with the doctor or nurse, women are asked what forms of contraception they are currently using to prevent pregnancy. Table 12 sets out the findings on contraception for the medical sample.[84]

Table 12: **Types of contraception used**

Type/s of contraception	No. of women
Condoms only	31
Condoms and OCP	5
Condoms and contraceptive coil	4
Not using any contraception	2
Not recorded	1

84 This does not include six transwomen and one woman who had previously had a tubal ligation (sterilisation).

Clearly, sole reliance on condoms to prevent pregnancy was very common in the medical sample. Indeed, across the sample as a whole there was some reticence detected regarding use of the oral contraceptive pill (OCP). A number of women were encouraged to take the pill by the WHS's doctor or nurse but would report at a later visit that they started it but then stopped taking it very quickly. Young women in particular tended to worry about the side effects of the pill or stated that it did not suit or 'agree' with them.

Similarly, Clinical staff observed some women's reticence about using the pill, noting that women fear it may change the physical appearance they feel they need to maintain to attract buyers (such as through weight gain and bloating), or cause irregular bleeding, which may affect the number of buyers they can see. They also noted that some women, especially younger women, have reservations about putting synthetic hormones into their bodies, whilst others simply forget to take the pill as required.

4.4 Pregnancy

Amongst the medical sample, 25 pregnancy tests were recorded to have been conducted by the clinic for 20 women; four of whom received a positive result for pregnancy. Some of these tests were conducted as standard practice – such as before administering a medication that may be contraindicated in pregnancy, but in other cases they were undertaken because the woman was concerned she may be pregnant, particularly after a 'condom accident' (see 4.5 below), which was a common occurrence in the sample.

Indeed, many women across the entire sample attended WHS reporting concerns about being pregnant, and in addition to those who were prescribed/recommended emergency contraception by the clinic, there were more women who had accessed this form of contraception directly themselves.

A number of women from across the wider sample[85] became pregnant whilst accessing WHS – for some this was positive news, but for others it represented a crisis. Clinical staff observed that this was particularly the case when women became pregnant by a buyer. A few young women experienced the anxiety of not knowing for certain whether the father of their baby was their boyfriend or a buyer.

One woman described in interview her reaction to becoming pregnant by a buyer:

> *I was in break of pills. I always take pills, contraceptives. It was in break and the condom broke, got pregnant. Went home [to Romania], take it out, not doing this…That's what happened. I was home doing my exams in university, and I just noticed my period didn't come. [I] Jumped into the next hospital…[and requested a termination urgently].*
>
> - NICOLETA

85 Four women in the medical sample tested positive for pregnancy at the clinic during the data collection period, alongside several more women in the wider sample who reported a positive pregnancy test, usually self-administered, to WHS staff.

Migrant women who are undocumented and became pregnant in prostitution feared the impact their lack of status would have on their baby, and worried about whether they could live stable, secure lives in this context.

Eight women across the entire sample disclosed to WHS that they had had one or more terminations; in most cases whilst involved in prostitution. One young African woman described being forced to have an abortion when she was 16. Some of the women mentioned travelling to their country of origin or sourcing pills for a termination from outside the State, as abortion was illegal in Ireland in most circumstances throughout the data collection timeframe.[86] A few experienced complications post-termination, such as abdominal pain, pain during sex, infections or irregular cycles, and attended the clinic with their concerns. A number of other women in the sample seriously considered having terminations, typically because of the instability of their lives, often linked to their insecure immigration status and their involvement in prostitution, but then decided to proceed with their pregnancies despite the challenges they faced.

4.5 Protection and risk

Clinical staff observed that the vast majority of those who access WHS are doing everything they possibly can to protect their health and avoid sexually transmitted infections and unwanted pregnancies, as they are all too aware of the many risks posed to their sexual and reproductive health by prostitution. The vast majority are using condoms to prevent pregnancy, but also to protect themselves from STIs. Whenever possible, they insist on buyers using condoms and are usually very knowledgeable about correct condom usage, typically trying to make sure that they put the condom on the buyer themselves, rather than relying on him to do it right. Here Elena describes some techniques she uses to try and stay safe:

> *Sometimes the guy bring the condom and then [I] don't trust. If bringing the box it's okay, but if he bring in the hand, like, you know, without the box, I don't trust. And another thing: I put the condom. And I have some positions you can see the guy. So, he can't pull out [and take off the condom]. So, you need to pay attention.*
>
> - ELENA

Nevertheless, it is worth noting how very common 'condom accidents' were across the entire sample of 144 women. This was the blanket term used by staff and women accessing WHS to describe any kind of condom failure, such as a broken, torn or burst condom, or a condom that slipped off a buyer during vaginal or anal intercourse. Some women experienced multiple condom 'accidents' during the course of the data collection period. Table 13 also includes incidents where a buyer deliberately removed a condom during intercourse without the woman's consent – a practice colloquially known as 'stealthing', which was reported by a number of women in the sample, and also identified in recent research on the Irish sex trade.[87] This is clearly not an 'accident', so the

86 This legislation was repealed following a referendum in May 2018, but abortion services did not become available in the State until January 2019.

87 O'Connor, M., and Breslin, R., 2020, *op cit.*

Table below provides data on all of the condom 'issues' experienced by women in the sample more broadly. Women were not routinely asked about these experiences, so what is captured here is just some of the incidents that women chose to disclose to Outreach and/or Clinical staff.

Table 13: **Condom issues experienced by women in the full sample**

No. of condom issues	No. of women reporting
3	4
2	4
1	20

Overall, 28 women in the full sample experienced a total of 40 condom accidents/issues, including 'stealthing'. Women described a range of incidents involving condoms that burst, were too small, rolled off, slipped off inside their bodies or that were deliberately removed by a buyer during a penetrative act. The nature and frequency with which some women experienced these issues are highlighted by these two examples.

WHS

She attended to see the doctor for emergency contraception as she says a condom came off inside her last night with a buyer. [Twelve months later] She came to see the doctor for a screen as she had a condom accident – she reports that the condom had a hole in it. She took emergency contraception herself. [Twelve months later] She came to see the doctor as she had a condom accident two days ago – she thinks she used too much lube. She got emergency contraception herself from the chemist. W27, Romanian

She reported to Clinical staff that she had had a condom accident – the condom had burst – she requested a full screen. She is also considering getting the contraceptive injection on her next visit. [Later that same month] She attended to see the doctor for the contraceptive injection and reported that she had had an incident with a buyer – he ejaculated blood into the condom he was wearing, but as it had rolled off slightly, some blood seeped out inside her. The woman was very concerned she had been infected with an STI as a result and wanted to see the doctor urgently. She said that the buyer laughed about the incident and showed no concern for her. W33 Romanian

In interview women also reported similar experiences and described how they handled them.

> *So, I think I make a test here and maybe two, three times because of this [broken/burst condoms]…So sometimes broken. This happens, yes. He no cum inside but I'm scared about this.*
>
> - IRIS

> *It did happen twice in the past yes [condom accidents]…I got very concerned. Oh my god, scared. And I came straight to the clinic to have the test…Not that the condoms broke [they slipped off]…Because you know the way if you plan to have sex with somebody without condom, without protection, you do that because you want to…but when you don't plan [that] and it happens, oh my god, that's so scary!...It's so much risky. Imagine if you get something really serious from many of these men? So, your money won't buy your health.*
>
> - LUCIANA

Interviewees also reported having to deal with specific incidents of stealthing:

> *Like I got [one] guy. I know him long time. I think maybe seven years or eight years. Then he got a mortgage now and now he starts trying to take the condom [off]. He did that few times, and I said, 'Look, you know, if you do that it's a rape, right?' Because he got a house, now he wants a wife and the thing – he didn't ask me if I'm available to marry him! But the way he takes on – 'No, I want to take the condom [off], make you pregnant, so then you go to live with me.' I caught his hand…[he said] 'Oh, no, just came off'. Come on, that doesn't come off like that! [I] explain to him, look, that's a rape if you do that. My concern is a rape.*
>
> - NATALIA

> *I knew a few that were always trying to do it [stealthing]. But I knew them and I said, 'Don't even think about it.' We used to know them – we would watch them. Because we have besides the website we have a private chat for the woman…Yeah, and we will say, 'That one, that's what he's trying to do. He's fine but keep an eye on him'.*
>
> - NICOLETA

> *I think only once it happened. The guy asked me to – he asked me to go – to go on my knees on the bed and he was behind me. But I'm not stupid! So, I put my hand down there – and he was without condom. I said, 'Ah, fuck you!' You know? Crazy, because they don't know you, you know? How can they think of having sex [without a condom] – and not because we are escorts – any woman?…I think it's most of the men they don't like condoms and they just don't think about the risks…Oh, god, they're so stupid.*
>
> - LUCIANA

Condom 'accidents' and experiences of stealthing were clearly a significant source of risk and indeed anxiety for women in the sample (see 4.8 on mental health and wellbeing for more on this), as they feared becoming pregnant or contracting an STI as a result. Some women were also very concerned about the impact of contracting STIs on their fertility in the long-term. But with specific reference to the 'accidents', Clinical staff emphasised that condoms are generally very robust and rarely fail (break/burst/slip off) if used correctly, so the research explored whether there were any other reasons that might explain the frequency of condom 'accidents' within the sample. Clinical staff suggested that some women may be reluctant or embarrassed to admit to a doctor or nurse that they did not use a condom, preferring to say instead that the condom failed somehow. Staff noted that women (or those controlling them) are typically offered more money by buyers for penetrative sexual acts without a condom, and indeed there is evidence to support this supposition. International research has demonstrated that the demand for vaginal, anal and oral sex without condoms is common amongst buyers,[88] and the same has also been found in the Irish context.[89] In interview, several women also described just such demands.

> *Every man want to do this [sex without a condom] but if you do, you have a problem forever in your life. Because if you work in this you know these men go to many womans. If he ask for you, he going to ask another. So, [another] woman here accept, you know, accept for money.*
>
> - IRIS

88 See for example: Raymond, J., D'Cunha, J., Ruhaini Dzuhayatin, S., Hynes, P., Ramirez Rodriguez, Z. and Santos, A., 2002. *A Comparative Study of Women Trafficked in the Migration Process: Patterns, Profiles and Health Consequences of Sexual Exploitation in Five Countries.* Coalition Against Trafficking in Women (CATW); Jovanovski, N., and Tyler, M., 2018. '"Bitch, You Got What You Deserved!": Violation and Violence in Sex Buyer Reviews of Legal Brothels.' *Violence Against Women*, 24:16 (pp. 1887 –1908).

89 See for example: Kelleher Associates et al, 2009, *op cit*; Sweeney, L., and FitzGerald, S., 2017, *op cit*; O'Connor, M., and Breslin, R., 2020, *op cit*; Breslin, R., 2020, *op cit*.

> *When I had the [advertising] profile for full service they always asked for so many things, like cum in my mouth, you know…Oh, so many of them [ask for sex without a condom]. So many of them…And actually I was laughing and like playing with them…I told them, 'Oh, do you do it with your mum? Would you do that with her? So, think about.'…It's no respect at all.*
>
> - LUCIANA

> *That's the reason also I want to say about this. And this is the problem here, because the Irish guys think, when see the girls from other country, think can do everything. And the Irish guys used to ask about 'I don't want to have sex with condom'. And this is crazy because have the girlfriend or have the woman in the house. So how you can trust? I don't trust it's safe to do Irish guy. It's not about the culture but know how the guys are here…I make a joke always. Like the guys send message, text message [asking for sex without a condom], and I say, 'Do you want to have HIV? If you want, let's do that.' And then they say, 'No, thank you, thank you.' I say, 'Stupid. Don't ask me this.'*
>
> - ELENA

> *…Most of the guys who are assholes, and there are plenty of them, would go to see girls who know they have poor English, who they see that it's a receptionist answer the phone, because they knew they can push her to do whatever the fuck they want, and she won't be able to say no…Always. Always. Clients read the bloody list of things you do [in the advertising profile] and then ask you exactly for what you don't.*
>
> - NICOLETA

Finally, Clinical staff reported their increasing concerns about women having anal intercourse with buyers without condoms, in response to their demand for this, but also because women feel doing so is one way to avoid pregnancy, without necessarily realising the higher risks of sexually transmitted infections associated with condom-less anal versus vaginal sex.

4.6 Sexual and reproductive health screening and testing

One of the key offerings of the clinic is sexual health screening and other related testing, such as the provision of smear tests and pregnancy tests. Appendix C provides a brief description of the main STIs and related conditions WHS screens for, their symptoms and impacts on health and the types of screening tests undertaken. Table 14 displays the number of different types of tests the 50 women in the medical sample underwent from 2015 until the end of the data collection period.

Table 14: **Sexual and reproductive health screening and testing**

Type of screen/test	No. of screens/tests
'Full screens' (bloods & swabs)	71
Bloods-only screens	51
Swab-only screens	50
Non-standard tests[90]	27
Smear tests	37
Pregnancy tests	25

Excluding smear and pregnancy tests (see 4.4 above), the women in the medical sample underwent between them 178 'batches' of screening tests. A 'batch' is defined here as a set of STI tests women underwent on a single date. Table 15 shows the number of batches of tests undertaken by the women in the medical sample from 2015 until the end of the data collection period. This gives some sense of frequency of STI testing, but this is difficult to be precise about because some women will have received multiple screens within a single year of engaging with the service, whereas others will have been screened periodically across over four or more years of engagement.

Table 15: **Screening 'batches'**

Number of screening 'batches'	Number of women
0-2 batches	22
3-5 batches	20
6-10 batches	7
11-15 batches	0
16-20 batches	1

Women who access WHS are offered STI screening as part of their general sexual health check-ups, but many women in the overall sample attended the Clinical service specifically to request screening because they had concerns about infection, particularly following condom 'accidents' and related issues (see discussion in 4.5 above). Table 16 shows the number of women in the medical sample who tested positive for a variety of sexual health-related conditions when screened by WHS. All received treatment for these conditions from WHS or were referred externally for specialist treatment, as appropriate. It is important to note that, whilst typically linked to sexual health, not all of these conditions are STIs, and not all of them are included in routine screening by the clinic (see Appendix C for further details). Conditions defined as STIs are highlighted in the Table below.

90 Non-standard tests include those that are not routinely part of the WHS's standard screening service as outlined in Appendix C (such as rectal swabs and facial/oral/genital swabs for HSV 1 & 2) but are undertaken when Clinical staff deem necessary.

Table 16: **Positive test results for sexual health-related conditions**

Condition	No. of positive results	No. of women
Smear requiring follow-up[91]	8	7
BV	7	7
Chlamydia	6	5
Hep C	3	1
Hep A	3	3
Candida	2	2
Hep B	2	2
HSV1	2	2
HSV2	2	2
Gonorrhoea	1	1
HIV	1	1
Syphilis	1	1

It is worth explaining here some of the discrepancies between data on the sexual and reproductive health issues women initially present to WHS with, those they are treated for and those they actually test positive for. Treatment for very common complaints that tend to be quite readily detected upon physical examination, such as BV and candida, is often provided by Clinical staff without requiring the test results for same. In the case of STIs, taking chlamydia as an example, slightly more women were treated for this STI in the medical sample (Table 11) than initially presented with it (Table 10) – this is because for many women chlamydia can be asymptomatic and may only show up on screening once results have been returned, at which point treatment is then prescribed by the clinic. On the other hand, if a woman presents with suspected symptomatic chlamydia and gives a history of same – such as a current partner who has tested positive for chlamydia – or presents with abdominal or pelvic pain symptomatic of Pelvic Inflammatory Disease (a sequelae of chlamydia) – then urgent treatment may be provided, without necessarily waiting on test results.

Nevertheless, data on presenting issues, screening results, treatment of a broad variety of sexual health conditions, crisis pregnancies and the other risks to health associated with condom issues, taken in the round, provide a broad overview of the myriad, interlinked and often persistent or reoccurring sexual and reproductive health harms women face arising from their involvement in prostitution.

4.7 Rates of infection and other sexual health harms

As Table 16 above demonstrates, the *number* of positive test results for STIs and other sexual health-related conditions in the medical sample of 50 across the data collection period appears to be quite low, given the circumstances. However, it is difficult here to compare infection *rates* with

91 For the majority of women this means in the first instance a colposcopy examination to assess abnormal cell changes in the cervix. These changes are mainly caused by the HPV virus (human papilloma virus), which is a viral STI.

the general population or indeed specific population cohorts, given the small sample size of 50. A cursory comparison would seem to suggest that the rates of STI infection amongst women accessing WHS are indeed higher than the general population as a whole.[92] This undoubtedly makes sense if one considers the frequency of penetrative sexual acts with multiple buyers in the context of prostitution, and the issues women face in protecting their sexual health, including condom failures, stealthing, and buyers' demands for unsafe practices. Indeed, people involved in prostitution in Ireland have been formally recognised as a specific group within the general population 'who are at greater risk of negative sexual health outcomes.'[93]

Again, taking the example of chlamydia, Clinical staff observed that women accessing WHS, although older,[94] appear to have rates of chlamydia infection more similar to the under 25s age group – which is deemed to be a more at-risk age group in the general population.[95] Higher rates of chlamydia infection amongst women in prostitution have also been identified in UK research.[96] It should also be noted, once again, that all data related to screening presented here pertain only to those women in prostitution in Ireland who have the knowledge and freedom of movement to access WHS and its screening service in an attempt to protect their sexual health. Establishing the true extent to which all women are facing the risks of STIs as a result of their involvement in the Irish sex trade, including those who are controlled and their movements limited by a pimp or trafficker and are therefore fearful of or directly prevented from accessing services, clearly merits further investigation, ideally drawing on a larger sample.

Returning to the findings presented in Tables 10 and 11, what these reveal is that the most prevalent harms to women's sexual health in prostitution result from the *frequency* with which multiple, different, often previously unknown buyers have sexual access to their bodies. WHS does not record the number of buyers women must see, but recent research in Northern Ireland sheds some light on this, estimating that those involved in the sex trade in that jurisdiction on a 'fulltime' basis have on average 15 'transactions' with buyers per week (and typically more than this for those who 'tour'), amounting to 780 'transactions' per year with approximately 210 separate 'clients'.[97] At the upper limits, over one quarter (28%) of survey respondents in this same study see over twenty 'clients' per week, with one in ten seeing 30 or more.

If similar levels of demand are present in the Irish sex trade, it is necessary to consider the impact this has on women's bodies. This appears to be demonstrated by the issues women most commonly present to WHS with, including vaginal discomfort, abnormal discharge, abnormal odour, candida, BV and pain when urinating, which typically indicates a UTI. One or more of these most common issues were experienced by 79% of the relevant sample overall, and in most cases, they were experienced by women on multiple occasions across the data collection period. Clinical staff observed that, with the exception of UTIs, these particular issues arise when the balance of naturally occurring organisms in the vagina is disrupted. This can be related to or triggered by frequency of intercourse, especially with multiple men, but they also noted that amongst women

92 See for example: HSE Sexual Health & Crisis Pregnancy Programme, 2018. *Sexual Health in Ireland: What Do We Know?* Ireland: HSE; and The Health Protection Surveillance Centre, 2019 *Sexually Transmitted Infections (STIs) in Ireland: Trends to the End of 2018.* Ireland: HSE, by way of efforts at comparison.

93 HSE Sexual Health & Crisis Pregnancy Programme, 2018, *ibid*.

94 The mean age of the sample when they first access WHS is 29 (see 1.2).

95 Young people aged 15-24 accounted for 49% of all chlamydia cases notified in Ireland in 2018. Source: The Health Protection Surveillance Centre, 2019, *op cit*.

96 See for example: Mc Grath-Lone L, Marsh K, Hughes G, *et al*., 2014. *Sex Transm Infect*, 90 (pp.344–350).

97 Huschke *et al, op cit.* Whilst the study authors argue that only very few, if any, persons in prostitution in Northern Ireland will actually complete as many as 780 'transactions' per year for a variety of reasons, including the fact that many are not operating on a 'fulltime' basis, this finding does at least give some sense of levels of demand in this context.

accessing WHS, these kinds of conditions are created or further exacerbated by over-washing of the vaginal area (women usually wash or shower after every buyer), the use of perfume and perfumed products in the vaginal area such as douches and scented wipes, in addition to the irritations caused by repeated, frequent use of condoms and lube – as highlighted by these examples.

WHS

She wanted to see the doctor for contraception but also for advice about the repeated UTIs she keeps experiencing. She is feeling concerned about this, but also about STI infection risks. She told staff that she is rinsing and washing inside her vagina regularly after buyers, so staff advised against this, explaining that it throws off the body's natural balance. W48, Eastern European[98]

She attended to see the doctor for contraception. She received the contraceptive injection but also discussed with staff the need to still use condoms to prevent infections. She says lube makes her feel sore, so when she removes it, she uses a lot of different hygiene products – staff advised her to reduce the use of same as this may be causing her irritation. W91, Romanian

Elena and Luciana also described similar discomforts:

I have been here [to the clinic] because I have a problem – infection of pee. Because I don't drink a lot of water…it's crazy because I am very perfectionist. Yes, and if I'm working, I can't be relaxed if I don't have clients. So, I can't…make pee, but in my mind [she knows she needs to go but] I can't. Yes, I don't drink water because I don't want to [have to] go…And that ways I have problems about this.

- ELENA

98 This woman's specific nationality has been disguised to protect her identity.

> *Oh, that time, to be honest, as I offered full service, I always used protection, but…I never offered kisses to any man because I find kiss very personal, very private… [and] I never gave them oral without protection, but they gave me…And so I went to the clinic – I came to the clinic so often in the past to ask for medication because always something was going [on], you know, in that area there…because they used to lick my pussy, so I got like bacteria…it was one of the reasons I decided to not have sex, not offer sex anymore, because I said 'No, I don't want anybody putting their dongs, their mouth in my vagina anymore'. Jesus, it's horrible.*
>
> - LUCIANA

Clinical staff reported that women describe the need to 'feel clean' after a buyer – to wash away any semen and other bodily fluids, germs and odours, to get the buyer off and out of the body but also to prepare for the next buyer. This explains the constant washing and use of perfumed products. Clinical staff also observed an over-use of lube, which can be an irritant, but is heavily relied upon by women because the sex acts involved in prostitution, and indeed the buyers themselves, are unwanted and undesired (as previously highlighted in 3.5).

Finally, Clinical staff also related their concerns about the pressure some women appear to be under to continue to see buyers without a break – citing examples of women taking the OCP without a break to avoid menstruating or using coloured condoms or absorbent sponges inside the vagina in an attempt to hide menstrual blood from buyers.

What becomes clear from these findings is that it is not just STIs that harm the sexual health and wellbeing of women in prostitution, but also the seemingly high levels of discomfort, pain and anxiety they experience as a result of frequent sex with multiple buyers, and their efforts to be 'clean' and appealing to each. Clinical staff observed that the women who access WHS display remarkable strength and coping skills in enduring the impacts that prostitution has on their bodies in general, and on their sexual, reproductive and mental health in particular.

4.8 Mental health and wellbeing issues

During the data collection period, WHS did not undertake any formal screening or assessment of women's mental health. However, in the course of receiving support from both the Outreach and Clinical aspects of the service, women do disclose issues they are experiencing related to their mental health and wellbeing. It was found that this tends to happen once women have attended the service long enough to build some level of familiarity, trust and rapport with the staff. Staff themselves also record in their notes any issues they observe in this regard – such as if a woman appears very anxious or low.[99] As noted in 4.1, whilst data relating to women's mental health and wellbeing were gathered from the medical files, the primary source of mental health data came from the Outreach notes, as women were far more likely to discuss issues relating to their mental health and wellbeing with the Outreach team.

99 This is not a clinical diagnosis nor, in the case of Outreach staff, a medical view. However, in an attempt to build as holistic a picture as possible, this study sought to capture and analyse all data that relate to the overall mental health and mental wellbeing of women accessing WHS, both self-reported and observed.

The negative and often traumatic mental health consequences of prostitution have been well-documented in numerous domestic and international studies.[100] Table 17 shows the variety of mental health and wellbeing-related issues experienced by women who have attended WHS more than once (100 women in total).[101] Overall, 66% of these women presented to WHS with issues and concerns relating to their mental health and wellbeing.

Table 17: **Mental health and wellbeing-related issues experienced by women who have attended WHS more than once**

Mental health and wellbeing issues	No. of times presented	No. of women
Health worries	61	37
Anxious/upset/coping difficulties	56	33
Non-health worries	50	30
Stressed/under pressure	26	21
Nervous/fearful	24	13
Experiencing depression	10	8
Problematic drug use	7	4
Isolated/lacking social supports	6	5
Problematic alcohol use	6	3[102]

The most common concerns women presented with here were worries related to their health; primarily their sexual and reproductive health and the impact that prostitution has had on this. As part of these concerns, some women also worried about the impact on their future fertility of contracting an STI. Women often presented to the service as very upset and anxious upon testing positive for an STI following screening. A number of women reported particular anxiety about receiving the treatment they would require, especially for blood borne STIs, such as Hepatitis B, that require attendance at hospital appointments. There were a small number of vulnerable women in the sample who struggled to engage with treatment of this nature and would skip or miss their treatment appointments, often out of fear, whilst remaining very worried about their long-term health outcomes.

Women also presented with other health concerns relating to their wider physical and mental health, particularly stress, anxiety and depression. Women regularly reported feeling 'run down', stressed, experiencing migraines and/or struggling to sleep due to the combination of pressures they were facing within the sex trade, including financial struggles. A small number of women described having panic attacks linked to the stress they were under, and some asked WHS, as the only health service they were accessing in Ireland, for help in treating their depression.

100 See for example: O'Connor, M., and Breslin, R., 2020, *op cit*; Farley *et al*, 2003, *op cit;* Farley, 2004, *op cit*; Farley *et al*, 2018, *op cit*; Zimmerman et al, 2006. *Stolen Smiles: Report on the Physical and Psychological Health Consequences of Women and Adolescents Trafficked in Europe*. London: London School of Hygiene and Tropical Medicine; Lewis Herman, J., 1992. *Trauma and Recovery: From Domestic Abuse to Political Terror.* London: Pandora.

101 Insufficient data were available in the sample on mental health and wellbeing for those women who had only attended the service on a single occasion. Women were far more likely to disclose a mental health issue, and staff were also more likely to observe and record such an issue, on their second or subsequent attendance than on their very first.

102 One woman disclosed that she was using both drugs and alcohol problematically.

Additionally, women presented with difficulties coping with different aspects of their lives, again in the majority of cases related to their involvement in prostitution. Women disclosed feelings of being 'low' or overwhelmed, having poor self-esteem or struggling to be assertive and stand up for themselves. In many cases these feelings were linked to the lack of control women frequently felt they had over their lives, caught up as they so often were in the continuous cycle of needing to see buyers to make enough money to live day-to-day and to fulfil all of their other financial obligations. For many, this sense of a lack of control was exacerbated by having an insecure immigration status. Some were trying to find viable alternatives to prostitution but felt trapped when they did not succeed (see Section 5 on entrapment). WHS staff offered to help many women in the sample to access counselling support to address their mental health issues and referred women accordingly. Some found counselling very helpful, while others struggled to fully engage with this form of support and others still refused, as they did not feel ready to talk about a situation they were still enmeshed within.

Some women also reported struggling to cope following a specific traumatic incident they had experienced in prostitution, such as a violent attack or robbery, as this case demonstrates.

WHS

> *She attended to see the doctor about a possible infection but had tested negative. She told Outreach staff that she is struggling to cope with feelings following the attack [she was attacked by a buyer with a knife]. She says she is nervous and has not seen many buyers as a result – she may even think about going home for a while. [Later that same month] She says she is now really struggling to cope and finding it very difficult to sleep. She needs to register with a regular GP so she can access further support. She will also consider accessing counselling. [Ten months later] She attended for condoms only and says she is doing better – she is seeing a counsellor for help in dealing with the trauma she suffered as a result of the attack. W77, Brazilian*

In terms of wider worries and fears, women regularly reported to WHS their fear of official authorities in Ireland – particularly immigration, police and social welfare authorities. Some women, especially those with insecure immigration status, were afraid of being deported (as previously documented in Section 1 above), of getting into trouble with the police, or accessing any kind of State supports that would put them 'on the radar' of the State. Many women also described serious financial and debt-related worries and pressures (see Section 2 above for more on this). A number of women feared being 'outed' to loved ones or more generally – in some cases for their involvement in prostitution and in others for their gender identity. Somewhat related to this, a number of women in the sample also reported fearing for their own safety and/or the safety and wellbeing of loved ones. Reasons for such fears include specific threats to the safety of transwomen, particularly if they were forced to return to their country of origin, experiencing domestic violence at the hands of a current partner, and fears of violent retaliation from pimps and traffickers for speaking out against them.

Women in interview also discussed the impact of prostitution on their mental health and general sense of wellbeing.

> *…always I think about my health. Always I look after. But in this kind of life, you don't sleep enough. I start to have problems about depression… My mental health is not good now, no ways. Like in Brazil we don't have so much but we are happy people, understand? So, this [prostitution] you can make money, but it's not – it's unhappy life. So always I'm worried about what the guys can do [to] me.*
>
> - ELENA

> *I need to be very busy. That's why escorting was killing me, because it was keeping me in the house – and I was jumping off the balcony. I couldn't sit. I was up and down outside the house seven, eight times a day just to buy some tomatoes or whatever, [just] to go out. [Interviewer: So how are you feeling now since you got out (of prostitution)?] Different, yeah. I still feel anxious. I still drink. I used to see a psychologist for a while, but too many sessions and I run out of – I still feel anxious.*
>
> - NICOLETA

It is worth noting that while many women in the sample were experiencing issues with their mental health and were in need of support in this regard, only one woman in the whole sample had a diagnosed psychiatric disorder (Borderline Personality Disorder) and was under the care of a psychiatrist. Just one other woman in the sample disclosed seeking psychiatric support, in this case for severe depression.

Clinical staff noted that in the short consultation periods they have with women who access WHS's Clinical service, the focus is their sexual health, and that the length and context of the consultation does not leave much room for discussing women's mental health issues and concerns. Clinical staff explained that although they can make the relevant referrals, if necessary, a sexual health consultation is not the right setting to effectively address mental health concerns, and that enquiring too deeply about the mental health impacts of prostitution risks revealing a level of distress that they may not be in a position to respond to effectively. However, Clinical staff are very clear that women are indeed experiencing trauma and other negative mental health issues such as dissociation caused by their involvement in prostitution. They therefore highlighted the essential nature of WHS's Outreach support and its complementarity to the Clinical service. Unlike in a short sexual health consultation, the Outreach service is able to provide more time and space for women to open up about issues with their mental health and wellbeing, and the impact that prostitution has on this, and be supported accordingly.

Having said that, Outreach staff themselves acknowledged that while they do provide a great deal of support to women in relation to both mental health and substance use issues, some women require a more intensive response that is beyond WHS's remit. However, the psychological support that is available externally is typically overburdened and inadequate – women are reluctant to even access it, especially as it is unlikely to be tailored to their needs or have a proper under-

standing of their experiences of prostitution. Outreach staff therefore emphasised that the women currently accessing WHS are in urgent need of the specialist, formal support and counselling that could be provided by an in-house psychologist, and that the need and demand for this kind of support is growing.[103]

4.9 Drug and alcohol use

Both Outreach and Clinical staff ask women about their use of drugs and alcohol. Only a small number of women in the sample directly disclosed to WHS staff that they were experiencing problems with alcohol and/or drugs. However, staff observed that they have concerns about many women accessing WHS who do not reveal their dependency issues to the service. For those who do, serious issues of alcohol and drug dependency were identified. Women gave a variety of reasons for their drug and alcohol use, including in some cases that they were being offered and requested to use drugs with buyers, in particular cocaine. Some buyers offered women more money if they agreed to participate in drug-taking with them, in other instances buyers expected women to provide drugs for use during their time together.

Buyer demands aside, it was clear that women were using substances primarily for their numbing affect – to help them cope with being in prostitution. Indeed, numerous studies highlight the ways in which women use both alcohol and drugs to block out the discomfort, pain, violence and other realities of prostitution.[104] WHS staff noted women who were binge-drinking to the point of blackout, and women who attended the clinic whilst under the influence of alcohol and often in distress. One woman reported using GHB[105] and crystal meth on a regular basis, which was severely disrupting her life. These women themselves disclosed that they were worried about their levels of drug or alcohol intake and were very aware that this was affecting their overall physical and mental health. They sought help from WHS to reduce or withdraw. They were referred for support accordingly, but typically continued to struggle to stop or control their use.

The cases of these young women highlight the extent to which drug use can become bound up in their involvement in the sex trade, relied on as a coping mechanism, but causing significant risk and harm to them at the same time.

WHS

She disclosed that she is currently using alcohol and cannabis. She has also been using ecstasy pills with buyers in strip clubs. Her student visa has expired, and she has been in prostitution for two months now, but she is trying to get a job as she feels unable to continue with prostitution. She is also trying to cut down her drug usage and use cannabis and alcohol only.

103 It must be noted that support of this nature was subsequently put in place by the HSE following the completion of this study, with a psychologist joining WHS and AHTT in the Spring of 2021 on a one-year pilot basis. Funding is currently being sought to continue this service.

104 See for example: Kramer, L.A., 2003, *op cit*; Stankiewicz Murphy, L., 2010. 'Understanding the Social and Economic Contexts Surrounding Women Engaged in Street-Level Prostitution.' *Issues in Mental Health Nursing*, 31: 12 (pp. 775-784).

105 Gamma hydroxybutyrate – a 'party drug' often used in chemsex because it can produce a feeling of euphoria and enhance libido.

She said that she is feeling very confused and depressed about her use of pills with buyers and is paying privately for counselling to address this. [Ten months later] She told Clinical staff she is still trying to leave prostitution but needs the money at times. She said that she sometimes has sex with strangers for alcohol. She reported one guy who drugged her – she believes that he raped her. She is continuing to receive counselling but remains concerned about her drug and alcohol use. W63, Brazilian

She started using cocaine at the age 16. She is 24 now but she has been in street prostitution since 16 – it was noted that she may have been groomed into prostitution. She has been snorting cocaine for the last four years, but she is now attending NA[106] and is hoping to get a place on a detox programme. Clinical staff noted that she has been using more in the last two to three years but is now ten days clean. [Eleven months later] She was completely off cocaine for six months but has started to use again – this has happened on a number of occasions recently. She feels that this is in part because she has also returned to street prostitution after reducing this when she began college last year. She thinks she would like to do some counselling to give her skills to recognise the triggers for her drug use. W116, Irish

Despite the relatively low numbers of reported drug use recorded by WHS, interviewees themselves were adamant that drug use is very common across the Irish sex trade amongst the women involved, and this is reflected in recent research.[107] Interviewees also noted that drug use is common amongst buyers, who often request or expect drugs to be provided when they meet with women.

…what I could realise here is like here have so much drugs here…Really. Really, really, really. So much. I don't use nothing, you know, but…most girls use because the guys – this is the bad way, here, because the guys want the girl use together…And if the girl don't use – don't make money… Here in Ireland, I never saw drugs like here…I saw drugs here I never saw in my life before…I don't know how to say which kind of drugs.

- ELENA

106 Narcotics Anonymous.

107 O'Connor, M., and Breslin, R., 2020, *op cit.*

> *Most of the young ones get hooked on cocaine. 20, 21, when they're about that age. They go, do some parties, guys throw some money, then there's cocaine. Then after that they go for the cocaine, they don't care about the money anymore.*
>
> - NICOLETA

> *I don't work sometimes because they [buyers] wants drug part. I don't do drugs part…they [buyers] go for the girls, most of the girls, like I think 70% does [drugs with buyers]. Most is cocaine, yeah. And I hear about crystal…And they call it stone. Yeah, heavy stone as well. But most it's cocaine.*
>
> - NATALIA

Luciana and Olivia described how they reacted when buyers asked them to take drugs with them:

> *So, a few of them the just came into the apartment and then as soon as they got in, they showed me drugs. They said, 'Oh, I have cocaine, do you want cocaine?' Now, I never did drugs in my life, so I wouldn't do it at work, you know, not even for money. And I asked them to get out.*
>
> - LUCIANA

> *When they [buyers] ask 'You can provide some cocaine?' [She replies] 'What do you think, I'm a dealer? Fuck off!' Even if they ask me for to share, no way. I did write in my [advertising] profile 'no drugs, no drunk people'. Because I don't like that.*
>
> - OLIVIA

Nicoleta reflected on the reasons why she and other women in prostitution may find themselves relying on substances:

> *This job it's very lonely, pushes you into drugs, alcohol a lot…All escorts are alcoholics, on some drugs. They're lonely. It gives you anxiety to start with…There's no one night you slept in peace, saying, 'Ah, no, it's going to be fine'…But if the landlords find out, you're out in the street, if the neighbours find out, they complain, you're out in the street. So, it gives you a big anxiety. All the girls I know are on either wine, either cocaine, one or the other…the ones who stay long-term – I was an alcoholic. I'm still not fully out of being an alcoholic. I don't drink as often, but still do.*
>
> - NICOLETA

4.10 Physical health issues

Given that the focus of WHS's Clinical service is specifically the sexual and reproductive health of women in prostitution, when women present with other issues relating to their more general physical health, they are usually advised to access a GP or are referred to a relevant specialist if necessary. As a result, broader physical health issues experienced by women in the medical sample of 50 were mainly documented 'in passing' by Clinical staff, often when mentioned by women in the context of receiving a sexual health check. Nevertheless, it is interesting to note the issues women were experiencing, where this was documented. The most common physical health issues that women presented to WHS with include:

- Common (non STI) infections (such as colds/coughs/chest infections/sinusitis/flu/ vomiting)
- Digestive problems (such as appetite loss/poor diet/weight gain/bowel issues)
- Tiredness, exhaustion and sleeping problems
- Migraines
- Fever
- Feeling 'run down'
- Anaemia
- Scabies.

Other issues mentioned by just one woman in the sample of 50 include: back pain; blood pressure issues; diabetes (type 1); fibromyalgia; leg pain; swollen glands; and thyroid problems.

4.11 Access to mainstream health services

At initial assessment of the whole sample of 144, just 12 women (8.3%) were recorded as being registered with a GP, primarily Irish and other EU citizens. Just three women (2%) were recorded as having a medical card.[108] It became clear, particularly given the mobility of the sample, that for many women the only healthcare service they are accessing in Ireland is WHS. As the service focuses primarily on sexual health, women are usually advised they need to access a GP for more general health concerns, although women are not turned away if they present with general health concerns that require immediate attention.

Without a medical card, and for some without any entitlement to one, the cost of attending a GP was prohibitive. In these cases, women were provided with information by WHS about various free GP and other medical services they could access around Dublin. These services tend to be run on a charitable basis and provide care to vulnerable populations, including undocumented migrants.

A small number of women reported facing large medical bills as a result of a hospital admission in Ireland that they were unable to pay. One woman noted that she was currently trying to make the money to pay a hospital bill of €1,400 through prostitution.

4.12 The need for a specialist health service for women in prostitution

Given women's lack of engagement with mainstream health services in Ireland, as documented above, the need for a specialist dedicated health service for women in prostitution is clear. In interview, women described how invaluable this service is and how thankful they are that it exists and is free for them to access, even if they are undocumented in Ireland. Without exception, the women were full of praise for the service and grateful for the care that they have received from both the Clinical and Outreach support aspects of WHS.

> *Yeah, I used to see the doctor and get the medication. But they are very helpful in any way, any way you need. Even if I wanted like some therapy, something like that, they do all they can to help me. You know, I've never found like people like that. They're very helpful…I could talk to them, yes, yeah…I think they have all we need…because if they don't have it here, they have places to bring you to, you know…that can help.*
>
> - LUCIANA

Women were particularly thankful and relieved that the service was non-judgemental about their lives, particularly in relation to their involvement in prostitution. They liked the ease with which they could access WHS's Clinical service, but also greatly welcomed the support and 'listening ear' provided by the Outreach team. Women really valued the opportunity to simply be able to talk to someone understanding about their lives, fears and health and other concerns. They noted that they shared information about themselves with WHS that they felt that could not share with other health services, especially when it came to prostitution.

108 A card issued by the HSE to residents of Ireland who are entitled to free or reduced-rate medical treatment.

> *I think that the respect that they have about this is very important because what they do for the womans is [interesting]. And the respect that they have about the womans too. Because they know that not all the girls that work [in prostitution]…is because it's choice.*
>
> - DANIELA

> *[Asked if WHS had helped her] A lot…Yes, very good. The woman, Joanne, is very nice…You know, she help you. She's not embarrassed if I talk.*
>
> - ELENA

> *…it's amazing [WHS]. The girls are so well-trained and, you know, like, 'Oh, you have lovely hair, it's so nice.' And all the stories, don't judge us, no. Just ask, you know, what we need. You're always there for us, yeah…so free to the girls…They do that and they're very nice and I think it's wonderful. It's the best thing ever because put us out of, you know, disease…Yes, and even somewhere you can go like talk. Because I can't go to my GP and talking about, you know, certain things. And it's a safe place that you go and…No judgment at all. Yeah, that's nice.*
>
> - NATALIA

Outreach staff observed that many women avoid mainstream healthcare settings, particularly if they have a precarious immigration status and/or do not feel comfortable disclosing their involvement in prostitution. Staff also noted that those women who are willing and able to pay for private health care, particularly for their sexual health, are not willing to discuss being in prostitution with the practitioner, and so the healthcare response they receive is not properly tailored to their needs. Once again this highlights the need for a specialist, dedicated service for women where their involvement in prostitution is essentially a given from the point of first access.

A small number of interviewees made recommendations for the enhancement of WHS services. Nicoleta made a recommendation regarding the need for peer support – which she felt was particularly important to address given the loneliness and social isolation that she and other women often report feeling whilst involved in prostitution (see 3.8 for more on this).

> *Then what they could do is this thing here. It's a place visited mostly by the independent ones within reason. Make a kind of thing, not a week, maybe once a month, when you can ask them to come together and talk to each other, go for a coffee…Be less lonely. Not all of them are going to get along, but you're going to have a few groups of two, three, four that are going to become friends, keep in touch. Link them in…If that will bring some of these women together, they'll have access to information quicker when something happens. That house been broken [into]. That woman's been attacked. By who? Send pictures. Even make them a WhatsApp group where they could share.*
>
> - NICOLETA

Elena felt that the availability of more psychological support provided within WHS would really benefit the service,[109] while Luciana felt that more women in prostitution need to know about WHS and where the service is located since it moved premises in 2017.

> *Here the people treat me very well, have the Brazilian girl [staff member] – but I think mental health for the womans. This is really needs everywhere, you know? Yes, like a psychologic [psychologist] …And sometimes the person needs your help – because I heard like a lot about the girls who kill herself also or take many pills because their lifestyles don't make sense after a while time. You have the money, but you don't have nothing.*
>
> - ELENA

> *I think most of the girls they don't come very often anymore because of the location, or maybe because they don't really know where the clinic is.*
>
> - LUCIANA

This was echoed by Clinical staff who emphasised the need to better and more widely promote and advertise WHS both online and in face-to-face situations. They observed that there are likely to be many more women in the Irish sex trade who are not accessing WHS, either because they do not know of its existence, or because they are reticent to engage for fear they may be judged or placed on the 'radar' of Irish authorities. The open and accessible nature of the service needs to be highlighted for all, as well as exploring with service users how WHS could be made even more welcoming and user-friendly for them.

109 As previously noted, support of this nature was subsequently put in place by the HSE following the completion of this study, with a psychologist joining WHS and AHTT in the Spring of 2021, on a one-year pilot basis.

4.13 Discussion

It seems clear from these findings that prostitution has multiple and wide-ranging impacts on women's health, and on their sexual, reproductive and mental health and wellbeing in particular. Women are dealing with persistent rounds of vaginal, genital and urinary tract issues, which primarily result from the frequency with which they have typically undesired intercourse with multiple buyers. The frequent and often persistent discomfort and pain that women experience as a direct consequence is very apparent. At the same time, women are regularly exposed in the context of prostitution to the risks of unwanted pregnancies and STIs, exacerbated for some by the occurrence of condom 'accidents' and 'stealthing' by buyers. This leads women to undergo regular rounds of STI screening and related testing, often prompted by fears for their sexual and reproductive health. Positive STI results, the need for emergency contraception and terminations are not uncommon.

Given the harms to their health that women are undoubtedly experiencing in the context of prostitution, it is hardly surprising that their mental health is also negatively impacted. Women report a wide variety of concerns and fears, often relating to their health. They also disclose stress, anxiety, depression and difficulties coping with life. Some have developed problems with alcohol and drugs, using these substances to numb or cope with the experience of prostitution.

At the core of prostitution is the buyer's purchase of sexual access to a woman's body, involving the penetration of the internal orifices of the mouth, vagina and anus. There is a strong sense arising from the data of women's feelings of bodily invasion experienced through prostitution and their need to overcome these feelings. This is demonstrated through women's over-washing to remove remnants of the buyer from her body, the use of substances to numb of block out the sense of invasion, repeated screenings to ensure she has not been infected by a buyer, and regular accessing of emergency contraception and terminations to ensure she has not been impregnated by him. The harms to physical, sexual, reproductive and mental health that result from these prostitution experiences are undeniable.

Access to mainstream health services is low, and so for many women WHS is a lifeline, that could be extended to many more through the enhanced promotion of the service.

5. Entrapment and the desire to exit

Section 5 investigates women's desires and plans to exit (leave) prostitution and how, for some, these plans are derailed when women find themselves feeling trapped within the trade.

5.1 Plans to exit

While the core work of WHS is the care of women's sexual health during their involvement in prostitution, over the years the service has developed an 'exiting ethos'. This means that staff proactively ask women about their future plans where the opportunity to do so arises, offer a supportive environment for women to give consideration to moving on from prostitution, and provide assistance and onward referral to other agencies, should they express a desire to leave. However, exploring women's desire to exit can be challenging in a busy, drop-in service with a clinical focus. Women are not routinely asked about their future plans at their initial assessment – this is a discussion that more commonly arises on subsequent visits, and possibly as women's familiarity with and trust in the service develops. Of all women in the sample who attended WHS more than once (100 women), 71% either explicitly expressed a desire to exit prostitution and/or described their future plans outside of prostitution.

Women attending WHS were not always explicit about the specific aspects of prostitution they disliked. However, women commonly disclosed to staff that their involvement in the sex trade was making them unhappy, and even if they felt they had chosen to enter, many were struggling with their feelings about this decision. A common theme across the sample was women who were very anxious to 'move on' with their lives – to leave prostitution as soon as possible, and either find employment and settle in Ireland or return to their country of origin. In this context, some women worried about how best to approach job-seeking and how they would account for the gaps in their CVs as a result of their time in the sex trade.

It is particularly interesting to note that many women in the sample who had quite recently entered prostitution were already discussing their plans to leave and the alternatives they had in mind; with some describing prostitution as 'temporary', and often with a specific planned 'end date' in sight. The significance of a woman's 'plan' – such as embarking on a training course or setting up her own business – cannot by underestimated in this context – it was these plans and goals with an endpoint in sight that clearly kept her going throughout the often-arduous experiences of prostitution.

For those women who had long considered exiting prostitution, also noteworthy are the particular 'tipping points' or 'turning points'[110] in their lives that ultimately did lead them to exit, or at least to start down that path. For the women in this sample, these include a mix of significant positive and negative life events such as starting a new relationship, becoming pregnant, having a baby, a close relative falling ill in their home country, contracting an STI or having other health-related problems caused by prostitution, or being the victim of an assault.

110 As described by Matthews, R., Easton, H., Young, L., and Bindel, J., 2014. *Exiting Prostitution: A Study in Female Desistance.* Basingstoke: Palgrave Macmillan.

Recent Irish research has highlighted the sometimes complex and often-nuanced nature of women's exiting pathways or 'journeys'.[111] Three interviewees (Iris, Nicoleta and Romana) had succeeded in exiting prostitution at the time of interview, and one (Luciana) was on her own journey to do so.

> *[Romana described what happened after she was violently attacked by a buyer for the second time] I have some friends say to me sometimes in life bad things have to happen to make the good things. And now my life changed…[in] Ireland I had support. In future day, Ireland gave me support. From here [WHS], from Garda, from the govern…a big support from Ruhama. Yes, now I'm feeling better, but the things changed. I'm not to work [in prostitution] anymore…now I'm back to my profession. I'm a hairdresser and now I'm working. And I'm really happy because I left this life. Yes, if I can say anything it's not to [get involved in prostitution]. Find another solution, to get another profession, to think about another life, not this life, because this life is – money's good, but not everything in that life [is good], escort life – make you sad, not happy…Yeah, it one hundred percent is not good for you – I have friends, a lot of friends working [in prostitution], and I also…talk with my friends. I can see my friends has problem in mental [health] or depression. I can see how dangerous it is working. Just not life – is really, really dangerous…[But] now I'm feeling I have a life. I have a routine. I have time to eat, time to rest…I have time to recover.*
>
> - ROMANA

> *[Interviewer: So how are you feeling now since you got out?] I always want a change. I'm always in between anyway. But I wouldn't want to change [having left prostitution]. I want a change to be a better job, better education. I wouldn't want a change to go back. To go up, yeah, but to go back – no.*
>
> - NICOLETA

Luciana clearly described the careful steps she was still taking in her own exiting journey:

> *…So, I only do massage now…I don't work in a website anymore. But after I started doing massage, of course I lost so many clients from the past because they didn't want massage [without full intercourse]…I keep coming back to this clinic to get condoms because I offer like blowjobs,*

111 O'Connor, M., and Breslin, R., 2020, *op cit.*

you know…And I feel okay, but I still have problems because I really, really want to find another way, you know, to keep going with my life, with my girls. I feel like I have two lives. I do. Of course, I have to lie. I can't tell my girls what I do…but now I'm going to try a few things next year. I'm going to do like some course in Brazil as I'm going for Christmas now. So, I'm going to do a course there – waxing. Yeah, I'm going to try, like. You know, I can't get out of this because I'm paying for my girls' college and everything, you know, but at least I'm going to start doing some other things…it was quite hard [when she first started to offer massage only] but I kept going, and now I can say if I want to have sex with someone it's because I want to, not because I have to, you know, not because of the money...I don't really think I need therapy by now, you know. Just I need an opportunity to change my life. That's it. So, it will help me a lot. And I'm doing it now. I'm making it work now.

- LUCIANA

5.2 Entrapment

It is widely understood that exiting prostitution is not a linear process[112] and indeed there were many examples in the sample of women who were making steps towards exiting even if they had not yet fully reached this goal. Women regularly described taking breaks from prostitution (especially when they visited their families/home countries), reducing the number of days or buyers they see, only seeing 'regulars', and in some cases, like Luciana above, reducing or limiting the types of sexual acts they provide – for example providing massage with sexual contact but avoiding full vaginal and anal intercourse. A number of women noted that even a reduction in the number of buyers, or trying to limit the sex acts they provide, improved their sense of wellbeing, even if they were unable to leave prostitution completely.

There were also numerous examples of women who explicitly stated their wish to exit and did in fact stop prostitution, only to return or be drawn in once again. Some women would regularly mention to WHS staff their imminent plans to return home (which for most also meant leaving prostitution), or to take up a new job or training opportunity, only to reappear in the clinic months or sometimes even years later. In these instances, women's future plans had not always worked out and they remained under significant pressure financially, which they felt left them with no choice but to return to the sex trade. A few felt very defeated in this context, sometimes increasing their previous drug or alcohol intake in order to cope.

Given that so many women in the sample had entered prostitution in the first instance to get money together for some pressing reason, very often related to the need to support family members, many also seemed to hope that once they had overcome this financial crisis they could exit straight away. But it appears that the process was not always as simple as that. The financial pressures

112 See for example: Matthews, *et al, op cit*; Bindel, J., Brown, L., Easton, H., Matthews, R. and Reynolds, L., 2012. *Breaking Down the Barriers: A Study of How Women Exit Prostitution*. London: London South Bank University and Eaves.

that lead so many women in the sample into prostitution in the first instance are often the same pressures that keep them there once they started. This finding is also mirrored in recent Irish research,[113] and encapsulated by these young women's experiences.

WHS

She originally became involved in prostitution in Ireland to support her family. She has two small children under three years old. This includes financially and emotionally supporting her mother, who is undergoing cancer treatment. Staff noted that she has very limited social supports in Ireland as all of her time is spent either in prostitution or caring for her children and mother. She attended the clinic on many occasions over three years having experienced several condom 'accidents' and one incident of stealthing by a buyer, as well as suffering from recurrent UTIs. She was constantly worried about contracting STIs in prostitution and was treated by WHS for gonorrhoea.

She is not an EU citizen and therefore has not been able to access any form of social welfare supports in Ireland. As her mother reached the end of her life, she disclosed that she was feeling very overwhelmed by the need to care for her and that her own health was suffering as a result. She told staff that she would really like to exit prostitution completely and get employment that sufficiently supports her family, but that she felt under a lot of pressure to remain in the sex trade so that she could provide for them. She often stopped prostitution for short periods when she was unwell or following bad experiences with buyers, but she always returned, saying there were 'many bills to be paid.' W48, Eastern European

She first attended WHS in 2016 – she had become involved in prostitution because of a series of financial difficulties and later became undocumented when her visa expired. She disclosed that she was struggling with her involvement in prostitution and wished to exit – she had moved in with her partner and wanted to stop prostitution and focus on their lives together. Staff noted that her long-term goals are to have: 'a normal life with her partner, including home and job, not prostitution-related.' Later in 2016 she experienced a crisis pregnancy but decided to have the baby. She attended the clinic in 2018 when her baby was just over one year old. Her mother was staying with her and helping her to look after the baby as she had returned to prostitution three days per week. She had no other means of financial support but nevertheless was seeking information about education options and continued to express a desire to exit. W43, Brazilian

113 O'Connor, M., and Breslin, R., 2020, *op cit.*

It is clear that many women in the sample felt trapped in prostitution – typically the pressures that initially drove them into it persisted – they, and very often their family members especially, became reliant on the money it provided and no other viable means were found to earn a similar income. In many cases, women were quite desperate to leave but at the same time felt they had no other alternatives but to stay. For a sizeable proportion of women in the sample, their plan to enter and stay in prostitution for just a few months turned into many years. Services providing support for exiting continually highlight the absence of financial resources accruing to women despite many years in the sex trade and the high levels of emotional and practical support needed to create a sustainable life after exiting.[114] Indeed, it has been suggested that the longer someone stays in prostitution, the harder it can be to leave completely.[115]

The women who were interviewed particularly emphasised the necessity of financially supporting their families in their country of origin – their sense of obligation in this regard was extremely strong – whether this was to their children, their parents, their siblings, or all combined. There was also a sense that women sometimes felt that when their adult family members thought of them they viewed them first and foremost as income generators – far away in Western Europe but expected to provide a steady stream of income for them to better their own circumstances, without necessarily considering what impact earning this money might be having on their daughters/sisters, or what life is really like for them in this part of the world.

In interview, Nicoleta discussed some of the things that had kept her in prostitution for more than five years, and why many of her friends still remain:

> *I still have at least twenty friends in, which I told them 'If you ever think about coming out, I'll help you, make you a CV, I'll tell you where to start'…because you have to make a start somewhere. [But they stay because] it's what they know. It's also the luxury. It's going to Brown Thomas, buying shit you don't need. Every year I drew a bag full of them. I still have them. They don't do you anything [any good]. [Interviewer: And were you sending money home as well?] Oh yeah, absolutely. I send it for my mum. Have to…My mum comes over. She comes shopping! [Interviewer: Do you bring her shopping?] I have to! Look, she's all I have.*
>
> - NICOLETA

114 See for example: O' Connor, M., 2018. *The Sex Economy*. UK: Agenda Publishing; Benson, S. 2017. 'Designing and Delivering an Effective Mental Health Response to Victims of Commercial Sexual Exploitation – A Specialised NGO Model of Work.' Paper delivered at the *Women's World Mental Health Conference: Rights, Resilience, Recovery*. Dublin, Ireland; Latham, L., 2007. 'Harm Reduction is Not Enough: A Feminist Review of the Health Service Executive (HSE) Women's Health Project.' Unpublished thesis for completion of the Master's Degree in Women's Studies, University College Dublin; Stephen-Smith, S. and Edwards, S., 2008. *Routes In, Routes Out: Quantifying the Gendered Experience of Trafficking to the UK*. London: Poppy Project.

115 Hester, *et al,* 2019, *op cit.*

Natalia and Elena also described how they became trapped:

That's the thing I would like the world to know, the girls [considering prostitution] to know about getting into that job is a quick money. It's not easy money. It's quick money. But it's not healthy…Very difficult to get out because [you] get stuck and it's very difficult, it's so hard to get out, you know. Okay, like, I didn't have food enough for the kids. My daughter she's very sick…and I didn't have that money for to do [her treatment], you know…because the idea was to get some money, go back to Brazil. I buy a nice apartment. But then [I] get scared if it [her plan] doesn't work…because [you] don't know [if] the money's coming in and you don't know to take a risk and to know what's going to happen and that's what make you trapped in that thing, because you scared of having no money coming in…Because I know when you need food, you need a doctor for your kids, you need a nice place to put them, you do anything…of course sometimes you get upset because I should have done something different you know…if I could go back on [in] time…Because don't want to die of starvation like. Don't have nothing, you know. But I don't know if I come back [to the start] if I should have done it all again.

Okay, did a lot of [to financially help] my parents when I could afford. I couldn't [help] my mother because she dies before I had money. But my father I helped him a lot. I help the entire family. But yes, dignity's gone, put it that way, you know. It's first thing you lose when I get that job [prostitution]…you get in and you don't know if you're going to get out…Because I want to find a nice man, then we fall in love…you want to make a life with them. But that doesn't happen, you know. It's not like a wonderful woman like with Richard Gere there for them.

- NATALIA

I go to there [Ireland] because I want to improve in my English. [But] how I work, and I go to school, you know? I could not because the clients [want to see her] during the day and in the night. So, for you pay [to live], you need to do [prostitution]. The whole time. It's like it's one circle, you know. It's crazy. Because you don't stop…I had panic attacks. So, I start to take pills about this. When I started this kind of work. And yes, this change a lot of my life because…I can't have relationship, I can't go out, I can't do nothing, you know. Like yes, I save money, I help my family, but I feel like so much pressure in me, you know. It's not life.

- ELENA

5.3 Discussion

Perhaps unsurprisingly, given all that has been documented in this study, there was nothing in the data to suggest that women felt prostitution was something that they could tolerate in the long term. What was apparent instead was that none of the women were 'getting rich quick' – there was no sense of women emerging from prostitution far wealthier than when they first started – in fact quite the reverse – they were poor when they entered prostitution and, while they may have managed to support themselves and their families along the way, they were still poor if and when they left. This is similar to the findings of Canadian research, which details the lifelong negative impacts of prostitution on women's health and found that, combined with the lack of education and skills gained during those critical years of young adulthood, women were left vulnerable to lifelong poverty which, it is suggested, debunks the perception of the lucrative monetary rewards that can be reaped in the sex trade.[116] In short, the data refute the promotion of prostitution as a route out of poverty for women that provides them with a stable income and the prospect of them bettering their lives.

The sense of entrenchment and indeed entrapment within prostitution was strong across the sample, and because of the high levels of mobility amongst the women accessing WHS it is often difficult for the service to track and capture the true outcomes for the women they have lost contact with or perhaps not seen for some time. Nevertheless, the findings point to the crucial need for WHS to be open and explicit about the exiting supports the service provides, that go far beyond merely minimising harm, to removing it from women's lives as they exit. Being alert to women talking about their desire to leave prostitution or experiencing 'tipping points' into exiting, and proactively asking women what their plans are for the future, all serve to let women know that WHS is a service that does not view prostitution as inevitable for some women in society and that there are other options and paths that can be explored.

116 De Riviere, L., 2006. 'Human Capital Methodology for Estimating the Lifelong Personal Costs of Young Women Leaving the Sex Trade.' *Feminist Economics* 12: 3, (pp. 367–402).

Conclusions and Recommendations

Conclusions

Based on this study's findings it is difficult to conclude that prostitution is *anything but* seriously detrimental to women's health and wellbeing, particularly when it comes to their sexual, reproductive and mental health. Even before their first entry into prostitution, the women in the sample were already facing lives full of adversity, including in many cases poverty, separation from family, insecure immigration status, lack of stable accommodation, poor English language skills and a history of violence in their lives. It was these difficult life circumstances that led many into prostitution in the first instance, in an attempt to overcome such adversities, although in other cases women entered by force as a result of pimping and trafficking.

Once involved, women's transience, social isolation and the constant, all-consuming pressure to keep moving and keep making money appear to compound their vulnerabilities, often making it very difficult for them to effectively engage with support. It is also clear that their experiences with buyers cause both bodily and emotional harm and place them under considerable stress, whilst at the same time having a broader impact on their own personal relationships.

The data on the recurrent sexual and reproductive health problems, STIs, crisis pregnancies, condom issues, including stealthing, and risky sexual practices demanded by buyers lay bare the extensive harm of prostitution to women's physical and sexual but also emotional health. It is very apparent that the levels of physical pain and discomfort women feel arising from their involvement in prostitution are further compounded by the sexually and psychologically invasive experiences of 'performing' prostitution to satisfy buyers' requirements and expectations. It is hardly surprising that this leads to negative mental health impacts for many women in the sample, and, for some, the need to use substances to block and numb the realities they face.

In addition to the inherent health harms of prostitution experienced by the women in the sample, it is also evident that violence is endemic to the sex trade, with women suffering this at the hands of buyers, pimps, traffickers and other organised criminals. Exploitation of the women is also rife, with many third parties profiting substantially from prostitution. For virtually all women in the sample, prostitution did not provide the solutions they had hoped for when they first entered, and most were eager to exit as soon as possible. But some found themselves trapped, with children or sick relatives to support or other family obligations to fulfil.

The multiple and often complex health and other support needs of the sample, including for advocacy and psychological support, the palpable sense of isolation and of lives lived on the margins, the challenges these women face in engaging with support and particularly with mainstream services, all point to the continuing essential need for a specialist health service that is carefully tailored to the needs of women in prostitution in Ireland, has extensive expertise in this regard and really understands what is going on in these women's lives. This report ends by making a series of recommendations primarily focused on sustaining and strengthening WHS and its vital provisions into the future.

Recommendations

Based on this study's findings, the following recommendations are made to strengthen the ongoing development and delivery of the HSE's Women's Health Service in its provision of comprehensive, specialist healthcare to women in prostitution.

Specialist health service provision

- This research points to the continuing need and indeed demand for a dedicated, specialist health service for women in prostitution that provides free and accessible healthcare, with a particular focus on sexual and reproductive health, for a very marginalised and often vulnerable cohort. WHS plays an essential role in supporting women in the Irish sex trade to protect their health, in so far as this is possible in the context of prostitution.
- Given the specific harms to women's sexual and reproductive health caused by prostitution it is critical that all women in the sex trade across Ireland have access to the specialist healthcare and supports provided by the WHS team, who have developed a great deal of expertise is responding to the needs of this client group. It is therefore recommended that WHS extend its geographical reach to better serve women based outside the capital city.

Mental health supports

- The impact of prostitution on women's mental health and wellbeing is of serious concern, as this study's findings demonstrate. The recent appointment of a psychologist is a positive step in addressing previous gaps in the service's capacity to address women's mental health issues, but ideally this role should continue to be a core part of the WHS team for the foreseeable future, beyond the initial pilot phase, working closely with both Outreach and Clinical teams and taking a trauma-informed approach.
- WHS should introduce across the service some simple, standardised screening tools to assess the status of women's mental health (including substance use) when they first access the service, repeated again at later points to ensure that interventions in this regard can be tailored according to need, and any serious crises addressed before they can escalate further. Staff would also benefit from training in this approach.
- To ensure that women are being provided with a truly holistic service, which addresses all aspects of their involvement in prostitution, it is important that all staff members continue to receive support and supervision to facilitate open discussions with women who have experienced sexual exploitation about the nature of the sexual acts that buyers demand, their experiences of unwanted, undesired sex within the context of prostitution and the traumatic consequences this can have.

Exiting supports

- As the research findings indicate, the large majority of the women accessing WHS are seeking to exit prostitution and/or have future plans for a life outside of prostitution. Working alongside the critical Clinical service, the Outreach team need both time and resources to provide a holistic service which assists women to identify their varied support needs as they embark on their exiting journeys. It is recommended that the Outreach team works in close cooperation with the specialist exiting support service Ruhama as part of their comprehensive response in this regard.
- This comprehensive response also requires the continued extension of the case-working model within Outreach support, developing this further along similar lines to the support and advocacy service currently provided by the AHTT, but adapted for women currently involved in prostitution. This would further enhance the more in-depth intensive support and follow-up that Outreach staff provide outside of drop-in clinic times and would ensure that more women receive a more rounded and holistic service from WHS, according to their needs.

Identification and support of trafficked women

- Given the fact that the vast majority of women trafficked into Ireland for sexual exploitation are located in the domestic sex trade, and that there are numerous cases of women attending WHS who are subsequently identified by the service as having been trafficked, WHS should enhance its identification procedures in this regard as part of both its initial assessment and ongoing support provision.
- Women who have been trafficked into Ireland for the purpose of sexual exploitation and are receiving support from AHTT are also very likely to be experiencing harms to their sexual and reproductive health and should therefore be encouraged by AHTT staff to access WHS's Clinical service for testing and treatment, as required.

The voice of the service user

- Service enhancements are clearly only of value if they meet the needs of the service user. WHS should consider exploring ways in which to more directly engage with service users to gain a clearer understanding of the service they want to receive. Simple mechanisms such as anonymous service user feedback forms, and opportunities for women to provide verbal feedback in a structured way, could facilitate this.
- Women in interview and staff highlighted the social isolation experienced by many women in prostitution in Ireland and recommended exploring ways to establish peer-based support. This work is not without its challenges, but WHS could consider exploring a model of peer support that can be delivered in a safe and boundaried way. This could be something as simple as women meeting other women who are in similar circumstances in a relaxed environment, supported and facilitated by WHS.

Promotion of WHS

- If WHS is to ensure that it is open and welcoming to all women in prostitution who need its services, it cannot continue to rely on peer referrals alone. To reach younger women, women who are less 'independent' within the trade, and women of an even more diverse range of nationalities, the service must greatly improve the ways and means it uses to promote itself and its specialist area of expertise. This includes an accessible online presence, as well as developing materials and strategies that can be used to advertise the service directly to women in a targeted fashion. WHS should also be promoted more proactively across the wider HSE, in particular in Emergency Departments, Maternity Services, Primary Care and Local and Regional Drug and Alcohol Task Forces. All promotion must emphasise the free, non-judgemental and confidential nature of the service, which can be accessed by women in prostitution regardless of their immigration status.

Record-keeping

- It is strongly recommended that the service move from a primarily paper-based to an electronic record-keeping system. This would greatly improve WHS's ability to capture, monitor and report on its work, the demand for the service, the profile of those who access it, their healthcare and other support needs, and service outcomes, thus allowing for more streamlined and impactful service provision into the future. This must include extending WHS's routine recording practices at first assessment and beyond to include women's ethnicity and sexuality, in accordance with best practice.

Future research

- There are many health issues facing women in the Irish sex trade that time and resource constraints prevented this study from exploring in the depth they deserve. Some particularly notable areas for future research include:
  - The experiences and impacts on health and wellbeing of sexual exploitation amongst the women being supported by the Anti-Human Trafficking Team (AHTT). AHTT holds a wealth of data on the experiences and impacts of prostitution on women who have been trafficked into Ireland and further study is required to explore these cases and their outcomes in greater detail
  - A study of the long-term outcomes and impacts of prostitution on women's sexual, reproductive and mental health, drawing on a larger sample to assess the true STI rates among those accessing WHS comparable to the general population, and including an exploration of the impacts of trauma experienced by women as a result of multiple counts of unwanted, undesired sexual acts in the context of prostitution, and how they can be supported to overcome this trauma
  - Research exploring the specific experiences and health and other support needs of transgender people in the Irish sex trade in order to further understand the risks and harms they face so that health and support service responses can be tailored accordingly.

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Appendix A – Methodology

Establishing the research

This is a multifaceted study – involving a wealth of both quantitative and qualitative data from a variety of sources, exploring multiple aspects of women's health, and focused on the complex and often challenging issues of sexual exploitation. As such, great care and time were taken to establish the research within the HSE service providers at the outset – to ensure that it was robust, ethically sound, effectively embedded within the service in which it is being conducted, and that its purpose and value were clearly understood by all concerned. To this end, the following steps were undertaken:

- Time spent by the researchers within WHS and AHTT to better understand how the service operates
- Briefings and individual discussions with staff about the purpose and nature of the research
- The development of a written 'Research agreement' between the SERP research team and the Service Manager, which included a data handling protocol to ensure that all data were gathered and stored in accordance with GDPR requirements, in line with the HSE's own National Consent Policy, and that only de-identified data were used for the purposes of the research
- A successful application made to University College Dublin's Human Research Ethics Committee; thereby securing the University's full ethical approval for all aspects of the research (see Ethical considerations below).

The full sample

Quantitative and qualitative data on the profile of women accessing WHS and their entry into and experiences of prostitution were gathered from service user records held in the WHS's paper-based filing system. A new service user record is created for each woman the first time she accesses the service, and then is filed in the system in date and numerical order. Following a review of the filing system by the research team and Service Manager, the decision was made to randomly select three records per month over a four-year period of 2015-2018. This timeframe was chosen to capture the most recent experiences of women in the Irish sex trade but was also dictated by the internal time and resource constraints of the study itself. Three records per month over 48 months yielded 144 records in total, which was the most that could be examined in the time available. During 2015-2018, 265 new women accessed WHS for the first time and 265 new service records were created for them – the research team succeeded in sampling over half of these (i.e., 144, which is 54.3%).

2015-2018 is the 'sampling period' from which women's records were selected, but it is important to note that most service users access WHS on multiple occasions and many across more than one year. Data collection itself took place from April to August 2019 and data were collected from the service user records on women's attendances right up to the end of August 2019. This means that regardless of the year in which a woman first accessed WHS (2015/2016/2017/2018), data were collected from the records about her attendances up until

the end of the summer of 2019. This means that the 'data collection period' referenced in the main body of the report runs from January 2015 to August 2019.

Three records of women who accessed the service for the first time each month from January 2015 to December 2018 were randomly selected, de-identified and then assigned a unique research number by the research team (i.e., W1, W2, etc.). Women are identified by this number and their nationality only throughout the report, with the exception of a small number of women whose nationality is not provided in order to protect their identities, typically this is because only one or two women within the whole sample were of this same nationality. The data collected from each record were primarily extracted from a series of pro forma WHS uses to record data (primarily the Initial Assessment form, but also forms that capture information on drug and alcohol use, education support requested or required and a form on any concerns about trafficking that may have arisen), and from the detailed notes made by Outreach staff following each Outreach intervention. Quantitative data were captured from all these sources in Excel and qualitative data (primarily found in the Outreach notes) were recorded in Word, both in password protected files on an encrypted UCD laptop used solely for the research.

The medical sample

Alongside data capture forms and notes from Outreach interventions, each woman's service user record also contains her medical records from any contact she has had with WHS's Clinical service. Access to these medical files is restricted to Clinical personnel – and so data within these files could only be captured by the Service Manager as co-researcher and also a member of the clinic's nursing team. Due to time restrictions and other practical constraints, it was not possible to capture medical data for the full sample of 144 women. It was decided to select from within this larger sample, focusing on women who had had most engagement with the service. Women who had attended the Outreach service five or more times according to their Outreach notes were chosen to be part of the 'medical sample' on the basis that they were likely to have engaged with the Clinical service a similar number of times, and therefore there was likely to more medical data recorded about them overall than women who had accessed the service less often. Fifty women in the wider sample of 144 met the criteria for having engaged with Outreach five or more times and so they comprised the medical sample.[117] Obviously, selecting women in this purposive way does introduce bias and this is discussed under Limitations below.

The research team designed a short pro forma which was used by the Service Manager to capture de-identified data from these 50 medical files. The data in these files pertain primarily to women's sexual, reproductive and physical health and much of the content could be easily quantified. Once captured, the medical data could be matched with each woman's data from the Outreach records, according to her unique research number.

The interviews

Five interviews were undertaken with WHS Clinical and Outreach staff during the course of the study, and insights on the operation of the service were also gathered from administrative staff

117 One woman selected for the medical sample according to these criteria had multiple contacts with the WHS Outreach team and received quite intensive support from Outreach in relation to an ongoing legal matter, however, she did not access the services of the Clinical team at any time and therefore no medical data is available in her case.

throughout. Interviews were loosely structured and explored the main themes emerging from the data gathered from the service user records, including routes into and experiences of prostitution, health impacts, experiences of violence and women's hopes and plans for the future. Interviewees were also asked to contribute their views on any gaps they perceived in WHS's services and any recommendations that would make for its development. The interviews with the two doctors linked to the service focused more specifically on health impacts and outcomes.

It was agreed that a member of Outreach staff and the Service Manager would approach service users to take part in interviews with the researchers as they had already built a relationship of trust with these women. Given the study's focus on health it was decided to select women from within the medical sample (described above) to invite for interview. 31 of the 50 women in this sample had attended WHS's Clinical service five or more times. Clearly, it was not possible to interview all 31 women – the goal was six to ten interviews – so women from this group were selected on the basis that they met the ethical criteria for inclusion in the study (see Ethical considerations below), the service was able to make contact with them, and that they then agreed to participate. Staff made contact with five women from within this wider group who met the criteria, agreed to take part in the study and then attended for interview. Some women were uncontactable, and others agreed to interview but then did not attend as arranged. This convenience sampling approach was extended when three women from outside the study's original sample agreed to be interviewed – this usually happened when researchers were present in the service conducting interviews and women attending at that time were invited by Outreach staff to participate if they met the criteria and agreed. These women were then assigned a new research number.

Eight women in total were interviewed during November 2019, and despite their different routes into the study, ultimately these women broadly reflected some of the key characteristics of the wider sample in terms of nationality, age and gender identity. All were currently involved in prostitution when they first accessed WHS and for some time afterwards, but three of the women had exited by the time they were interviewed, for a variety of reasons, and one woman described herself as being in the process of leaving prostitution. Pseudonyms are used for interviewees throughout. See Appendix B for an overview of the eight interviewees.

The interviews with the women were fairly loosely structured and focused on their lives before prostitution, their entry into and experiences within it, any perceived impacts prostitution has had on their health, their plans for the future and their views on and recommendations for WHS. Each interview lasted approximately one hour and at the end women were given a gift voucher from the research team as a token of recognition and appreciation for their time, but they were not made aware that they would receive this in advance of the interview. All women were offered follow-up support from WHS staff after interview if they required it (see Ethical considerations below).

Data analysis

Analysis of all of the quantitative data gathered during the course of the study primarily generated descriptive statistics on the profile and demographics of the sample, their entry into and experiences of prostitution, health impacts, experiences of violence and intentions to exit. As described in the Research methods section in the main body of the report, quantitative data were drawn from the full sample of 144 in most instances, with the exception of data on sexual, reproductive and physical health, which were primarily drawn from the medical sample of 50 women. In some cases, analysis was undertaken using data from those women within the wider sample who attended WHS more than once (100 women), as insufficient data on issues such as mental health

and exiting were available for those women who had only attended on a single occasion. It was found that as women's familiarity with and trust in the service grew, they were far more likely to disclose a mental health issue or discuss exiting, and staff were also more likely to observe, discuss and record these issues, on women's second or subsequent visit than on their very first visit.

Staff interviews were transcribed by the research team, while women's interviews were professionally transcribed. In addition to the interviews with staff and service users, staff notes from Outreach interventions with women generated a wealth of qualitative data. Thematic analysis was the method chosen to analyse all of the qualitative data gathered during the course of this study as it is an appropriate method for identifying and analysing patterns of meaning within a data set.[118] It is a flexible method which can be applied methodically and rigorously to search for meanings and patterns within interviews. This method involves verbatim transcripts, thorough immersion in and familiarisation with the data, the generation of codes, and the identification of themes and subthemes. For brevity and also to preserve service user confidentiality, qualitative data arising from the Outreach notes are presented in summary format throughout the report, with specific case examples used to illustrate key themes that emerged from the wider body of data. In interview, women tended to speak very freely, and certain themes arose that were not apparent in the sample's Outreach or Clinical notes, such as their specific experiences with buyers and the impact that this had had on them. These were included in the thematic analysis and ultimately incorporated into the study's findings. None of the interviewees had English as a first language but were more than able to make themselves understood – to preserve the authenticity of their contributions their own speech patterns are retained and presented in their verbatim quotes throughout the report.

Ethical considerations

As previously noted, following a comprehensive application process, this study received full ethical approval from University College Dublin's Human Research Ethics Committee. All data from service user records were handled with great care and sensitivity and in accordance with the original Research agreement between WHS and the research team.

The study also carefully adhered to the World Health Organisation guidelines for research on domestic violence and trafficking,[119] which recommends that all participants in qualitative interviews are sourced via dedicated support agencies (in this case WHS); that a risk assessment prior to interview is carried out by support workers (in this case Outreach staff and/or the Service Manager conducted this assessment); and that ongoing support is put in place, should this be required during or following interview (all interviewees were given the opportunity to speak with Outreach staff or the Service Manager directly after interview or at any later time, should the need arise). In addition, the research team developed a written Distress Protocol that detailed how women's distress, should this arise during interview, would be addressed.

118 Braun, V. and Clark, V., 2013. 'Teaching Thematic Analysis: Overcoming Challenges and Developing Strategies for Effective Learning.' *The Psychologist*, 26: 2, (pp. 120-123).

119 World Health Organisation (WHO), 2001. *Putting Women First: Ethical and Safety Recommendations for Research on Domestic Violence*. Geneva: WHO; Zimmerman, C. and Watts, C., 2003. *World Health Organisation (WHO) Ethical and Safety Recommendations for Interviewing Trafficked Women.* Geneva: WHO.

Further, to ensure the highest ethical standards for interviewing women who are potentially vulnerable and that their welfare is treated as paramount, the following criteria had to be met:

- Women were assessed by WHS staff *before* they were asked to participate, and an assessment was made in relation to:
  - their physical and psychological well-being of the woman
  - their present level of safety and security
  - the length of time they have been accessing support services
  - their English language capacity.

- No woman could be approached for interview who:
  - was less than six months attending the service
  - was displaying signs of severe stress or trauma
  - was at risk in terms of safety and security
  - had a language where there was no specialised translator available.

As it transpired, translation services were not required during any of the interviews as all of the women had sufficient command of English. All women were given verbal and written information about the study and what their participation involved prior to interview. Informed consent was obtained from all interviewees, who signed consent forms and agreed for their interview to be audio recorded by the researcher. In addition to the follow-up support made available to interviewees after interview, women were also given the opportunity to receive a copy of the full transcript of their interview and request any content that they were not comfortable with to be removed.

Limitations of the study

Firstly, it is important to state that data, and especially numerical data, captured by staff in the context of delivering a busy service that is often responding to women in distress or facing crisis, are typically open to recording errors, which will then have been repeated in data collection and analysis. Where any questions arose about the accuracy of data this was checked with staff, but some errors in this context are inevitable.

Furthermore, the nature of the service that WHS provides, and the profile of the women who access it, can also create challenges and limit opportunities for documenting women's case histories in full as part of their initial assessment, or indeed subsequently. Again, the busy and often high-pressured drop-in environment of the service, the fact that women often attend in crisis or with immediate health needs that must be met, that women may speak little to no English, are 'in a rush' or reluctant to share much information about themselves, all go some way to explaining the sometimes-high instances of unrecorded data in the sample, particularly in terms of variables relating to women's past histories of prostitution.

Similarly, and for very understandable reasons, women do not always provide fully accurate data to the service – in particular they may not provide their real names and dates of birth and occasionally may not reveal their true nationality. For this reason, findings that relate to women's nationalities and ages in the sample and potentially also the age at which they first entered prostitution should be treated with some caution.

As outlined in the Methods section in the main body of the report, a key limitation of this study is that the WHS sample cannot claim to be representative of *all* women in the Irish sex trade. Rather, it is representative of those women *who are in a position to be able to access* WHS and are not prevented from doing so by a pimp or another third party. This was confirmed by WHS staff and indeed interviewees during the course of the research. Thus, it should therefore be borne in mind throughout that the WHS sample does *not* include women in the Irish sex trade whose movements are controlled by a pimp or other third party to the extent to which they are prevented from accessing any forms of support or assistance, including healthcare.

Finally, it is acknowledged that bias was introduced during sampling and interviewee selection by focusing on those who had accessed the services of WHS five or more times. These decisions were mainly led by the study's time and resource constraints and the assumption that more data are available on those who have more actively engaged with WHS. It is a positive for these women that they had the wherewithal to access and remain engaged with the service, but this also means that they may have remained in prostitution longer than others in the wider sample and that they were possibly less mobile than others in the sample and so may have some different experiences of the sex trade. Such caveats need to be borne in mind throughout any reading of this report.

Appendix B – Profile of interviewees

The Table below provides of brief overview of the profile of women interviewed during the course of this study. More information on interviewee selection is provided in Appendix A. A number of nationalities and age ranges are represented here and one of the interviewees is a transwoman. Pseudonyms are exclusively used for each woman throughout the main body of the report.

Pseudonym	Nationality	Age range	In original sample?	Currently involved/exiting/exited
Daniela	Western European[120]	30s	Yes	Currently involved
Elena	Brazilian	30s	No	Currently involved
Iris	Brazilian	30s	Yes	Exited
Luciana	Brazilian	40s	No	Exiting
Natalia	Brazilian	40s	No	Currently involved
Nicoleta	Romanian	20s	Yes	Exited
Olivia	Latin American[121]	40s	Yes	Currently involved
Romana	Brazilian	20s	Yes	Exited

120 This woman's specific nationality has been disguised to protect her identity.
121 This woman's specific nationality has been disguised to protect her identity.

Appendix C – Sexually Transmitted Infections (STIs) and other sexual health-related conditions

A standard screen provided by WHS includes pharyngeal and vaginal swabs to test for chlamydia and gonorrhoea. Evidence of candida and BV may also show up in the same tests. Also included in this standard screen are blood samples taken to test for HIV, syphilis and hepatitis A, B and C. The Table below provides a brief description of the main STIs and related conditions WHS screens for.

Condition	Brief Description
BV	Bacterial Vaginosis (BV) is the most common cause of abnormal discharge from the vagina. BV is an infection of the vagina that happens when there is a change in the normal balance of bacteria there. BV is not usually sexually transmitted but is associated with sexual activity. The chances of developing BV seem to increase with the number of sexual partners a woman has.
Candida	Candida (thrush) is a very common cause of itch and discomfort in the genital area. It is caused by an overgrowth of yeast (candida). It is not considered an STI even though some of the symptoms are similar.
Chlamydia	Chlamydia is a bacterial STI. It is one of the most common STIs. Chlamydia can infect the cervix, urethra, the uterus, fallopian tubes, ovaries, testicles, rectum, pharynx and sometimes the eyes. Women with chlamydia are often asymptomatic. If the infection is untreated, a person with chlamydia risks health problems. This is particularly true for women – if left untreated it may lead to Pelvic Inflammatory Disease (PID), which in turn can lead to infertility and permanent damage to women's reproductive organs.
Gonorrhoea	Gonorrhoea is a bacterial STI. Gonorrhoea infects the cervix, the urethra and the rectum. It can also sometimes cause eye and joint infections. Women with gonorrhoea are often asymptomatic. If it is not treated, it can cause infertility in women and infections in the testicles in men.
Hepatitis A	Hepatitis A is usually passed on through contaminated food and water, but it is also a sexually transmitted infection. Hepatitis A is caused by a virus that infects the liver. It usually causes a mild illness that clears on its own within 1 to 2 weeks, without needing any treatment.
Hepatitis B	Hepatitis B is a serious infection of the liver caused by a virus found in blood, semen, vaginal fluids and saliva. It is a major cause of serious liver disease such as cirrhosis and liver cancer. There is a safe and effective vaccine to protect against infection with Hep B (e.g., the vaccine Engerix B ®).

Hepatitis C	Hepatitis C is a viral infection that infects the liver and is a major cause of liver disease worldwide. Hepatitis C is mainly passed on through using contaminated needles and syringes or sharing other items with infected blood on them. It is also a sexually transmitted infection that can be passed on through unprotected sex, although this is less common.
HIV	HIV (Human Immunodeficiency Virus) is a virus that attacks the human immune system and weakens its ability to fight infection and disease. AIDS (Acquired Immunodeficiency Syndrome) is the final stage of HIV infection, when the immune system is severely damaged. HIV is transmitted when infected blood, semen or vaginal fluids enter the body.
HPV	See 'Smear requiring follow-up'
HSV1	Herpes Simplex Virus 1 (HSV1) or oral herpes can result in cold sores or fever blisters on or around the mouth. However, most people do not have any symptoms. Most people with oral herpes were infected during childhood or young adulthood from non-sexual contact with saliva. A swab taken from the blisters can be used to test for HSV1.
HSV2	Herpes Simplex Virus 2 (HSV2) is a viral STI and the main cause of genital herpes (although HSV1 can also be spread from the mouth to the genitals through oral sex). Symptoms of genital herpes can include painful ulcers or blisters, swollen glands in the groin, flu-like symptoms, a feeling of being unwell and pain when passing urine. A swab taken from the blisters can be used to test for HSV2.
Smear requiring follow-up	Abnormal cell changes in the cervix are mainly caused by a virus known as human papilloma virus (HPV), which is a viral STI. HPV is usually harmless and goes away by itself, but some types can lead to cervical cancer. Low grade cell changes that show up in a smear test are tested for HPV. High grade changes mean that a woman is likely to require further follow-up and examination such as a colposcopy.
Syphilis	Syphilis is a bacterial STI caused by bacteria called Treponema pallidum. Some people have no symptoms. Symptoms can vary from a painless sore (ulcer) in the genital, anal or mouth area to a rash all over the body. If syphilis is not treated it can cause problems with the heart, brain, eyes and nervous system.

Table content adapted from the following sources:

http://www.guideclinic.ie/sti-clinic/stis-and-treatments/common-stis (Last retrieved 21/04/21)
https://sexualwellbeing.ie/sexual-health/sexually-transmitted-infections/types-of-stis/ (Last retrieved 21/04/21)
https://www.cervicalcheck.ie/news/cervicalcheck-introduces-hpv-testing-in-the-cervical-screening-pathway-for-certain-women.7553.html (Last retrieved 21/04/21)
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