POLICY AND PROGRAMMING IMPLICATIONS

Women drug users who sell sex, and female sex workers who use drugs, require access to comprehensive services that address both their drug use and sex work related vulnerabilities. There is little documentation about effective services that can address this complex of needs in low resource settings. However, the following are some simple steps programs working in low resource settings can take to increase the effectiveness with which they address these complex vulnerabilities:

Outreach workers in harm reduction projects should be prepared to offer sex work related services:
Harm reduction projects will be able to more effectively address sex work related vulnerabilities if they include female outreach workers who are aware of the overlap between drug use and sex work and can provide support, counselling, and services related to sex work.

Outreach workers in sex work projects should be prepared to offer harm reduction services:
Many sex worker projects do not effectively address the issue of drug use and may therefore not be prepared to offer harm reduction services. Providing training in harm reduction to outreach workers in sex work projects will allow these workers to provide simple harm reduction services-such as needle and syringe exchange-in conjunction with their outreach to the sex worker community.

Drop-in Centres for sex workers can also provide discrete harm reduction services, for example, in the context of counselling.

Drop-in Centres for drug users can also provide discrete sex worker services, for example, in the context of one-on-one counselling, and by ensuring that a female counsellor is available who is trained in both harm reduction and sex worker interventions.

Offer referral services to trusted providers:
Both sex worker and harm reduction services can provide referral services to one another.

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HIV-related Vulnerabilities and the Intersection of Sex work and Drug Use

09

BACKGROUND

There is significant overlap between female drug user and sex worker communities, but sex worker interventions often do not offer drug-related services, and harm reduction services tend not to provide support for sex workers. This makes it difficult for women who use drugs and sell sex to access all the services they require. This Information Brief provides key information on the overlap between drug use and sex work and offers simple steps that service providers in low-resource settings can take to improve delivery of the complex services required by women drug users who sell sex and by female sex workers who use drugs.

WHAT ARE THE ISSUES?

Significant overlap between female drug use and sex work:
Reports suggest that about half of female IDUs in Asia are sex workers.[1] Women drug users may be selling sex to support themselves, their children, and/or their partner. A 2001 study of women drug users in Manipur found that 80 percent of the respondents reported having sex with non-regular partners and two-thirds reported having had sex in exchange for money or drugs.[2] A more recent study of female drug users in Manipur found that more than half of all respondents reported that they had engaged in sex work for money to purchase drugs (56 percent), some had exchanged sex more directly for drugs (11 percent) or gifts (5 percent).[3] A study of women I/DU in Morocco found that 95 percent did sex work (n=52), primarily for money to buy drugs and to support their children.[4]

Some overlap between female sex work and drug use:
Studies in Asia have found that some FSWs may also be using drugs. In some parts of Vietnam, studies have found that 50 percent of female IDU are engaged in sex work-both drug using women who sell sex and sex workers who use drugs.[5] In China, a study of female sex workers in Guangxi found that 80 percent used drugs.[6] One study in Manipur, found that 19 percent of female sex workers (and 11 percent of the clients) self-reported injecting drugs in the previous year.[7]

Higher HIV prevalence in FSW/IDU:
Research has found that sex workers who inject drugs tend to have significantly higher HIV infection rates than those who do not. A study in Manipur found that HIV infection rates among FIDU/FSWs were 9.4 times higher than among non-IDU FSWs.[8]

Women drug users who sell sex: Vulnerabilities

Women drug users who exchange sex for drugs may not identify themselves as sex workers, and it may therefore be difficult to provide them with services related to their sex work. One study in the US found that up to 70 percent of women injectors who exchanged sex for drugs did not self-identify as sex workers.[9]

Female drug users may be forced into sex:
Studies in South Asia have found that many women drug users report being forced by their boyfriends or husbands to sell sex in order to supply their male partners with money for drugs.[10] A recent study in Manipur found that 10 percent of respondents reported being forced into sex either by a boyfriend or another partner.[11] Women drug users who are in this situation may have particular difficulties accessing drug treatment-such as detoxification or rehabilitation services-because husbands may depend on their wife's income from sex work for their drug money, and may therefore not want their wife to enter treatment-and stop sex work.

Poor condom use reported among IDU/FSWs:
A study of female IDU in Manipur found that only 21 percent reported regular condom use with boyfriend or partner, and less than 10 percent reported regular condom use in sex work.[12] Women IDU/FSWs may be at

[1] Reported in Resource Module for Trainers, Centre for Harm Reduction, Burnet Institute 2006. p. 168
[2] Panda et al,. 2001. Interface between drug use and sex work in Manipur. National Medical Journal of India 14:209-211
[3] Archana Oinam. 2008. Exploring the Links Between Drug Use and Sexual Vulnerability Among Young Female Injecting Drug Users in Manipur, Population Council, Delhi.
[4] Katya Burns. 2007. Women Injecting Drug Users in Morocco: A study of women's vulnerability to HIV, GTZ Rabat, unpublished.
[5] Reid G and Costigan G. 2002. Revisiting the 'Hidden Epidemic,' A Situation Assessment in the context of HIV/AIDS. Melbourne. Centre for Harm Reduction, the Burnet Institute
[6] Reported in Resource Module for Trainers, Centre for Harm Reduction, Burnet Institute 2006. p. 166
[7] NACO 2001. National Baseline High-Risk and Bridge Population Behavioural Surveillance Survey-2001, Part I FSWs and Their Clients. New Delhi, India: www.nacoonline.org/publication/41.pdf
[8] Agarwal et al. 1999. "The prevalence of HIV in female sex workers in Manipur, India," Journal of Communicable Diseases 31, pp. 23-28
[9] Rothenburg R, Long D, Sterk C, Pach A, Poitterat J et al 2000. "The Atlantic Urban Networks Study: a blueprint for endemic transmission," AIDS 14:2191-2200.
[10] Kumar and Sharma 2008 "Women and Substance Use in India and Bangladesh," Substance Use & Misuse, 43, 1062-1077
[11] Archana Oinam. 2008.
[12] Archana Oinam. 2008.

greater risk of sexual transmission as the length of time they have been using drugs increases: Women who use drugs and are also sex workers have reported riskier sexual practices as the length of time during which they use drugs increases: Women who have been using drugs and selling sex for longer periods of time report they are less likely to use a condom with clients. Women drug users report that when they begin sex work they tend to have considerable control over condom use with clients. As drug use progresses, a woman (I)DU/FSW tends to experience three phenomena: Her dose requirements increase, she therefore requires increased income, and her fee per client tends to decrease (and the number of clients per day therefore increases). As a result, over the course of a woman's drug use, she tends to become increasingly susceptible to demands for unprotected sex with her clients-when a client demands sex without a condom or offers more money for unprotected sex, she is more likely to agree. Thus, women who have been using drugs and selling sex for extended periods of time tend to report more clients and less condom use.[13]

IDU/FSWs may have particularly risking injection behaviours:
Research has found that women IDU who trade sex for money or drugs are more likely to share injecting equipment than FIDU who do not do sex work.[14]

Female sex workers who use drugs: Vulnerabilities

Some brothel owners or pimps may introduce women to drug use.

Female sex workers who use drugs may experience stigma about their drug use from non-drug-using FSWs:
Sex workers report a hierarchical divide between sex workers who use drugs and those who do not. Injecting drugs may be highly stigmatised in sex worker communities and in brothels; injecting drugs may be discouraged or forbidden. Perceptions in brothels and among clients that FSWs who inject drugs are at high risk of HIV and other STIs can have a detrimental effect on brothel business, and this can lead to FSWs who inject drugs being rejected from their places of work. This leads FSWs who inject drugs to hide their drug use as much as possible. Additionally, FSWs who are known to be injecting drugs tend to be able to charge less money per client, and they are thus very motivated to hide their drug use from clients and from the FSW community. This makes it difficult for them to access harm reduction and other drug related services.

FSWs who use drugs tend to have poor attendance at harm reduction services:
FSW/IDUs tend to attend sex worker interventions, but not attend IDU-related services such as harm reduction interventions; sex worker interventions often do not offer drug-related services. This makes it difficult for women who use drugs and sell sex to access all the services they require.

Male IDU interaction with FSW and the impact on IDU/FSW and FSW/IDU HIV vulnerability

Male IDU interaction with FSWs and unsafe sexual practices fuel HIV vulnerability among FSWs and may especially impact HIV vulnerability in IDU/FSWs-because they tend to have less power to negotiating condom use than non-IDU FSWs. A study in Bangladesh found that fewer that 1 in 10 male IDU consistently used a condom when having sex with a FSW. Some IDU/FSWs have reported that male clients who are IDU are more likely to insist on not using a condom because prolonged drug-use compromises the male clients' ability to maintain an erection-a situation that is further exacerbated by using a condom. IDU/FSWs also report that male IDU clients, even if they do agree to use a condom, tend to take longer to achieve orgasm and are prone to become frustrated and remove the condom part way through the sexual act.[16]

Male IDUs who have sex with FSWs tend to have especially high HIV-infection rates:
A study in Northern Thailand found higher HIV infection rates among male IDU who reported having sex with FSWs (35 percent HIV-positive) compared to those who had not (23 percent HIV-positive).[17] High HIV infection rates among male IDU who have sex with FSWs put FSWs at heightened risk of HIV infection-and this may especially be the case for IDU/FSWs because they have less power to negotiate condom use.

EVIDENCE: GOOD PRACTICES

Ideally, harm reduction and sex worker interventions should be closely linked, either through a referral service or by offering on-site services: harm reduction services at sex worker project sites and sex worker services at harm reduction sites. In practice, there is little documented evidence of services that comprehensively address the needs of IDU/FSWs and FSW/IDUs in low resource settings.

In Canada, a "street nurse" program Associated with Vancouver Coastal Health and a project called Sheway provides drug-related HIV services via outreach. Street nurses effectively access IDU/FSWs and FSW/IDUs-although the project's target group is much broader-providing both drug-related and sex work-related services.[18] Services are provided in the outreach setting, and via referral to Sheway-a one-stop shop that provides the range of services for women drug users.[19]

At one project in New Zealand, a "Prostitutes Collective," run for and by sex workers, operates full needle and syringe services at numerous drop in centres around the country. The collectives works as an integral part of national NSP and sexual health networks.[20]

In Manipur, the Social Awareness Service Organisation (SASO) in Imphal, built a Drop-in-Centre specifically for women in 2006. Many of the DIC's clients are women drug users who also sell sex.[21]

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[21]Breaking New Ground, Setting New Signposts: A Community-Based Care and Support Model for Injecting Drug Users Living with HIV. The SASO-Alliance Experience. Alliance in India. December 2007.