6. Health and safety for mobile populations and drug users

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6.1 Migration, mobility and health

Providing primary health care to migrant communities requires particular skills and planning. Ideas about health, sex and reproduction vary between cultures, making the task of providing health care and education more complex. The circumstances of migrant sex workers can make health promotion even more difficult. Many live and work in conditions which are not conducive to good health and which limit access to health care. Migrant sex workers may:

- be reluctant to visit services for fear of arrest and deportation or be prevented from doing so by others (bosses and minders)
- find health care is not available or is too expensive
- face language and cultural barriers
- not know what is needed or available
- rely on poor advice and inappropriate medication.

A number of projects throughout the world have developed responses to the needs of migrant sex workers, some with remarkable success.

Types of mobility

There are many reasons why sex workers and clients move their location. As with all types of sex work, project planners must ensure that they understand the real nature of migration in their area and do not stereotype migrants.

Sex workers move temporarily or permanently in their own countries as well as across national borders. Migration from rural to urban areas is common, particularly in countries which are undergoing rapid industrialisation. Sex workers also travel within their own countries to avoid arrest, deal with personal problems, make more money, or simply to experience different places. Frequently, they travel to places where there are large numbers of potential clients such as military camps, mining towns and roadside truckstops. Sex workers also travel as part of larger population movements, such as to festivals or special events, or away from war zones or famines.

Mobility sometimes involves a new language or dialect and significant cultural change. This can happen even when sex workers travel in their own country from a rural to an urban area or to another culture in a large country such as India.

Sex workers

Women and men travel from developing countries to richer countries, either specifically to work in the sex industry or in circumstances which lead them to sex work. Much attention has recently focused on the extent to which migration to richer countries is connected with organised crime, coercion and slavery-like conditions such as bonded labour (see Chapter 2). Regardless of how people arrive in a destination country, conditions should ensure their access to health care and information.
Travel to richer countries usually involves major changes of language and culture and fear of arrest and deportation. Sex workers from developing countries often work in places where conditions are below the accepted standard in the destination country. Sex workers may be more vulnerable to client demand for unprotected sex because they have no right to refuse clients, are in debt or do not know about sexual health. Sometimes migrant sex workers provide services to clients who are also immigrants and who themselves may not have access to information about sexual health, perhaps because they do not speak the local language.

**Clients**

Clients are also mobile, especially as international travel becomes cheaper. Sex tourism has developed as men, and less frequently women, travel to find cheaper or better commercial sex than in their own country. It has become a focus of international attention, especially with increasing awareness of HIV and the exploitation of children.

Despite the publicity about sex tourism there are other significant patterns of client mobility which should be considered when planning a project. Sexual services are purchased in the course of business and tourist travel both between and within countries. There are also large numbers of truck drivers, miners, military personnel, and agricultural workers who routinely purchase sexual services away from home.

**Health promotion and care**

**Clients**

In many cases, men from Western countries who pay for sex in poorer countries have already been exposed to health education campaigns at home. Reinforcing these messages can be an important strategy for projects in developing countries. Messages can be distributed through leaflets and local guidebooks, in tourist agencies, hotels and bars. Western men seem to discuss sex with outsiders more openly when they travel so projects may consider recruiting hotel staff, guides, taxi drivers and others to reinforce safe sex messages, in written or spoken form, and to tell clients where to purchase condoms as well as sexual services.

Several projects encourage men to demand safe sex as well as seeking to address sex workers' powerlessness. Strategies include teaching sex workers about clients' language and culture.

A number of projects target men along truck routes. Both prevention and STD care can be provided in truckstops where paid sex with men and/or women is available.

**Sex workers**

More is known about female sex workers from developing countries living in Western countries than about male sex workers in similar situations, or about migrant sex workers in developing countries. Even so, some agencies and projects successfully overcome barriers to provide services to migrant sex workers. Hopefully, the lessons learnt from these experiences can be appropriately adapted and transferred to other situations.
Some of these lessons are:

**Access to health care**
There may be important practical and psychological reasons why migrant sex workers are less likely to use clinics, drop-in centres and other services or allow access to outreach workers. These barriers can be identified and reassessed during the project.

Because migrant workers may fear deportation or other persecution, health care should be anonymous or confidential, and be seen to be so. Clinics should keep note-taking to a minimum and give assurances that information is not collected.

Gaining trust is vital. When migrant sex workers use a clinic where they are not required to identify themselves and do not suffer persecution, they can be encouraged to tell others.

If free health care is not available anonymously or confidentially there are strong arguments for policy changes which projects can put to relevant authorities (see Chapter 2). In the meantime, sympathetic doctors and health workers may be able to offer help at reasonable cost.

**Cultural barriers**
These can be partly overcome by providing "cultural interpreters" who can explain how things work and assist sex workers to establish themselves in a new country, for example by securing accommodation, banking facilities and health services.

It is not only immigrants who should learn to deal with a different culture. Cultural interpreters can provide information for health and project staff and translators about the religion, culture and language of the immigrant workers who attend their service. Staff can familiarise themselves with a few key words of another language.

Even where it is possible to communicate by gesture (for example, "take a seat") it is a mark of respect and declaration of goodwill to be able to say a few words in the person's language.

Pictures and music can tell people that a service is open and friendly to people from a variety of backgrounds.

Projects should monitor how their service is used by the various ethnic or language groups. If sex workers of a particular ethnic group are not participating, or participating in a different way, such as having noticeably shorter or less frequent contact, a consultation with that community may be able to identify the reasons and develop a strategy for encouraging equal access.

Clinics can identify language needs and provide interpreters or arrange access to telephone interpretation. Sex work projects sometimes provide interpreters. Intermediaries may need to explain issues to interpreters to help prepare them to translate conversations about sex work and sexual health. Many translators have had no experience of talking about sexual health and practices, homosexuality and other stigmatised behaviours, especially in non-judgemental terms.

Printed materials in relevant languages can encourage healthy practices and behaviours. Doctors in migrants’ own countries and immigrants who have lived for some time in destination countries may be able to provide information.
Transnational AIDS/STD Prevention Among Migrant Prostitutes in Europe (TAMPEP)

TAMPEP is a project which spans four European countries: The Netherlands, Italy, Germany and Austria. It is a model of intervention, reaching a total of 23 different migrant groups of women and transgender people from East Europe, South East Asia, Africa and Latin America.

TAMPEP provides migrant sex workers with culturally appropriate HIV and STD education, resources and materials appropriate to sex work. It seeks to increase empowerment and responsibility. It educates social and medical establishments to better respond to migrant sex workers' health needs. It is a reference point for migrant sex workers and it observes the variations and dynamics of migration in the countries served by the project. It researches social, legal and working conditions of migrants. For each cultural target group there are two TAMPEP-trained professionals: a "cultural mediator" from the migrant community who acts as a bridge between members of the cultural community and the social and medical institutions; and a peer educator who receives training to pass on messages and increase responsibility and empowerment for her peers.

German language classes are provided by TAMPEP for Spanish speaking transgender sex workers. The students said that they needed to know basic German, especially phrases they needed at work. The courses cover language necessary to attract a client's attention, basic conversation when first meeting a client, negotiating sexual practices, everyday conversation and grammar.

Once a year, in Tamil Nadu in India, a festival takes place in a remote village. Transsexuals called alis come from all around India to the celebration. Of the 10,000 pilgrims who attend, 20 per cent are alis while 30 per cent are men who pay the alis for sex. The State AIDS project health team developed a rapport with some alis, observed and respected their customs and their unique language, and identified a lot of HIV and STD risk behaviour among them. They found that they had no access to treatment, education or condoms. With the help of a team of all peer educators they set up a bus at the festival site from which they provided health awareness material and condoms to alis and clients. A specialised medical team provided medical assistance.

The sex worker organisation in Berlin, Hydra, publishes its information for women in the sex industry in several languages.
6.2 Strategies for drug users

"Strategies for dealing with the reality and underlying reasons for drug use are needed and they should be formulated so as to avoid using drug use as a further excuse for oppressing and victimising sex workers."

Resolution of the European Symposium on Health and the Sex Industry, 1994

There are substantial fears that injecting drug users who are HIV positive are likely to infect clients who would not otherwise be at risk of contracting HIV. There is a widespread assumption that drug-using sex workers sell unprotected sexual services, even when they know that they have an STD or HIV, because their need to buy drugs for an addiction outweighs the responsibility to have safe sex. It can be argued, though, that everybody participating in consensual sex must be responsible for her or his own sexual health. To blame sex workers, including those addicted to drugs, for unprotected sex is to take away responsibility from clients.

Epidemiological evidence from industrialised countries suggests that sex workers who are injecting drug users are not a major source of HIV infection. This may be because there are relatively few HIV-positive drug users who have unprotected sex with clients and also because HIV is not as easily transmitted from women to men. Nevertheless, in the interests of sex workers’ health, projects for sex workers should consider if there are drug users in their target areas. If there are, they should either integrate drug services in their work or develop an appropriate approach to drug use, such as making referrals to relevant agencies and distributing needles and syringes.

Harm reduction

Harm reduction is a relatively new concept for agencies working with drug users. Previously, agencies aimed to help their clients stop taking drugs. Harm reduction aims to reduce the harm caused by drug use and misuse. It encompasses HIV and hepatitis prevention, reducing damage to veins, and promoting general health and life issues, such as dental hygiene and parenting skills. Total abstention from drugs has a place in harm reduction programmes as one of the choices available to drug users. Harm reduction methods include:

- providing clean injecting equipment and advice about how to inject and use drugs more safely
- counselling about choices and methods available
- prescribing replacement drugs such as oral methadone or codeine (and, in a few cases, injectable methadone, heroin, cocaine or other drugs of choice)
- social support including advocacy of the rights of drug users, for example to good quality health care including palliative treatment, assistance in criminal justice matters, family health etc.

The harm reduction approach acknowledges that drug use has different meanings and roles in the lives of individual drug users, and that not all people who use drugs are addicts. Sex work and drugs have different connections for different women, men and transgender people in the sex industry. Some use drugs to support (sex) work.
while some work to afford drugs. For some, there is no particular connection — after all, people in all jobs take drugs.

For some people the capacity to provide safe sexual services is not affected by drug use, while others fit the stereotype of the desperate drug user. Sex work projects are often well placed to work with individuals, as well as having an impact on local drug taking practices in general. Remember: sex workers are often “part of the solution, not part of the problem”. Many needle exchange projects report that drug-using sex workers are effective volunteers and peer educators.

Harm reduction originates in the USA, the Netherlands and Switzerland. It was initially used in urban areas. However it has been adapted successfully to developing countries and rural areas, such as traditional tribal communities in Manipur, India, near the Burmese border; Kuala Lumpur, Malaysia; Nepal; and among indigenous Australians in remote communities.

Harm reduction is controversial. It can be seen as accepting drug use rather than fighting it. Projects which provide harm reduction services should have firm policies about their work and be ready to answer any criticisms which may arise.

Supply of safe drug-using equipment
Where sex workers inject drugs, whether for pleasure, hormones or medicines, it is important to provide needles, syringes, sterilising swabs and sterile water. This can be done on an exchange basis if the project is able to collect and appropriately dispose of used equipment. Alternatively, the project can distribute appropriate containers and instructions for sex workers to dispose of the equipment themselves. In many places, distribution of needles is forbidden or adequate supplies are not available. In these cases bleach is distributed for cleaning used injecting equipment and drug users are told about less harmful methods of taking drugs.

For more information about ways of providing aids to safe injecting contact your local health services.

Syringe disposal
Where commercial sex and drug use take place in the same area, sex workers are often blamed for syringe litter, even if other drug users are littering. Some places supply secure bins in streets where drugs are used. In some cases sex workers who have access to education about safe needle disposal have encouraged other drug users to dispose of syringes properly.

Agencies in Germany have created a “care pack” for female drug-using sex workers. The pack contains condoms, lubricant, cleaning tissues, menstruation sponge (with spermicide and information about its use), information about safe drug use and a questionnaire. In Australia, a “shower pack” has been distributed to male drug-using sex workers. It contains samples of expensive men’s cosmetics, swabs, sterile water and a tourniquet, along with condoms, lubricant and printed information.

Oral hygiene is often an important topic for drug users, particularly for those who use crack (smokable cocaine) and/or provide oral sex. One outreach worker noticed that the men he was visiting cleaned their teeth before working and that this caused their gums to bleed. They said it was to have fresh breath when working. After discussion they decided to use liquid breath freshener before work and brush their teeth after work.

making sex work safe
6.2 Strategies for drug users

**Other injecting substances**

Illegal drugs are not the only substances which are injected. Hormones, medicines, vitamins and silicone products are also injected. Appropriate equipment and instructions should be available to people injecting these products to make them as safe as possible. Similarly, projects should be prepared to provide equipment and/or advice about other piercing, tattooing or flesh-cutting practices which occur as part of work or private life.

**Non-injectable drugs**

Injectable drugs are not the only drugs which impact on sex workers' health and safe commercial sex. Research has shown that prescription drugs, alcohol and solvents used by sex workers can cause impaired judgement and loss of inhibition, leading to unsafe sex as well as vulnerability to violence. Sex workers strongly suggest that clients' consumption of alcohol is also a significant threat to safe commercial sex.

In the USA the incidence of HIV is disproportionately high among users of crack and there are indications this will happen in some Latin American and European countries too. Several explanations have been suggested: people who are already vulnerable to HIV use crack; oral damage from crack pipes facilitates oral transmission (acquisition) of HIV, hepatitis and other STDs; and/or the extreme disinhibiting character of the "crack high" and the need for more money to buy more crack quickly leads to reckless and unsafe sex. These and other reasons may combine to create this high HIV vulnerability. Whatever the case, in many places there is an urgent need to develop health promotion strategies for sex workers who use crack.

**Women's health and drug use**

Women who use drugs face specific health and welfare problems. Appropriate support is often not available, especially for women and transgender people who sell sexual services. In recent years, more effective and "user friendly" drug services for women in general, and sex workers in particular, have been developed in a number of countries.

Sex work projects can help drug agencies to become more accessible and relevant to women and sexual minorities. Female sex workers who use drugs may require a range of health and welfare services such as reproductive health services, advice about drug use and drug substitution during pregnancy and parenting support.

A German sex worker organisation, Madonna, found that sex workers quickly became disenchanted with services offered by drug agencies. They arranged for a Madonna staff member to attend drug services on designated days to contact sex workers and provide a more sensitive approach to their health and welfare needs. Similar experiences in Malaysia led to the development of a drop-in centre for drug-using sex workers, many of whom were transsexual.