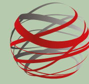
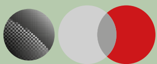


When sex work and drug use overlap

Considerations for advocacy and practice

NOVEMBER 2013

Melissa Hope Ditmore



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When sex work and drug use overlap: Considerations for advocacy and practice

Melissa Hope Ditmore | November 2013
© Harm Reduction International
ISBN 978-0-9927609-0-8

Designed by Anne Heasell
Copy-edited by Kathryn Perry

Published by
Harm Reduction International
Unit 2D12, Southbank Technopark
90 London Road
London, SE1 6LN
United Kingdom
info@ihra.net | **www.ihra.net**

Harm Reduction International is an international non-governmental organisation that works to reduce drug-related harms by promoting evidence-based public health policy and practices, and human rights-based approaches to drug policy through an integrated programme of research, analysis, advocacy and civil society strengthening. Our vision is a world in which individuals and communities benefit from drug laws, policies and practices that promote health, dignity and human rights.

The Global State of Harm Reduction is Harm Reduction International's flagship programme of work to monitor global situations and responses to drug related health harms. Resources produced within this programme inform evidence-based advocacy for increasing the commitment to scaled-up, quality harm reduction responses around the world.

Acknowledgements

This report was authored by Melissa Hope Ditmore, an independent researcher with over ten years' experience working with sex workers and people who use drugs in Africa, Asia, Europe and North America. She has written numerous books, reports, papers and articles about sex workers' and people who use drugs' health, human rights and harm reduction.

Pye Jakobsson and the staff of Harm Reduction International, Catherine Cook, Claudia Stoicescu, Damon Barrett, Rick Lines and Annie Kuch offered valuable feedback for this report.

The report was peer reviewed by Nicolette Burrows, Joanna Busza, Alison Crocket, Carina Edlund, Kitten Infinite, Emma Jolley, Sian Long, Rene Ross, Caty Simon, Gerry Stimson, Pascal Tanguay, and Annette Verster.

Table 1, containing a menu of service adaptations and additions, was reviewed during a side meeting at the International Harm Reduction Conference in Vilnius in June 2013 by Cyndee Clay, Stephanie Derozier, Carina Edlund, Pye Jakobsson, Annie Madden, Susan Masanja, Ruth Morgan Thomas, Anita Schoepp, Lludmyla Shulga, Marinette Sjöholm, and Maria Sundin.

Many others gave important input and suggested valuable resources during the development of this report, including Dan Allman, Ienes Angela, Joanna Berton Martinez, David Bloom, Borce Bozinov, Melissa Broudo, Rosie Campbell, Melinda Chateauvert, Iveta Chovancová, Jenn Clamen, Allan Clear, La Coalition, Brendan Conner, Anna Louise Crago, Matt Curtis, Nabarun Dasgupta, Susan Dewey, Beth Drevlow, Sam Friedman, Christian Grov, HIPS, Nik Krempasky, Jack Levinson, Jay Levy, Maggie McNeill, Laura McTighe, Peninah Mwangi, Katharine Owen, PROS Network, Red Umbrella Project, Marlise Richter, Pascale Robitaille, Hindowa Saidu, Greg Scott, SHARP, Stepping Stone, L. Synn Stern, Shelly Stoops, Maria Sundin, Rachel Thomas, Marija Tosheva, Bill Weinberg, Tisha Wheeler, Johannah Westmacott, and Rachel Wotton.

This report was made possible through a grant from the Open Society Foundations.

The report is dedicated to the memory of Dave Purchase, who started one of the early needle and syringe programmes and the first public syringe exchange programme in the United States in Tacoma, Washington, in 1988. He also organised the first North American Syringe Exchange Convention (NASEC) in 1990. He was an indefatigable fighter for the rights of people who use drugs, including the rights of people who use drugs and sell sex.

Abbreviations

ATS	amphetamine-type stimulants
HBV	hepatitis B
HCV	hepatitis C
NSP	needle and syringe programme
OST	opioid substitution therapy
STI	sexually transmitted infection
TB	tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNODC	United Nations Office on Drugs and Crime

Throughout the report, colour-coded boxes are used to highlight the following:

Key information

Programme examples

Table of services

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Foreword from Pye Jakobsson

It is a constant battle.

Living with stigma and discrimination is a bit like living in a war zone. You feel constantly under attack, on edge, prepared to run and hide whenever needed. Ready to protect your rights at any sign of attempts to disqualify your voice. Always vigilant, ready to keep the people you love out of harm's, and stigma's, way. The only external protection you have is the safety of your community, and in its midst you can sometimes risk taking a minute to relax and exhale.

It is a constant balancing act.

When you belong to two marginalised communities, both used to avoiding the stigma of others, you might find yourself alone rather than embraced by both. So you compromise, negotiate and make silent promises. If I am allowed to feel safe within your community I will hide the other part of who I am. I will not, even with a whisper, let my secret come out, as that would make me responsible for stigmatising you further. And you might reject me to protect yourself.

It is a constant challenge.

Trying to make the world slightly better means always holding ourselves accountable. Because stigma is the strangest thing, as it often makes us fight against stereotypes so hard that we exclude people in the process. One layer of stigma is easier to tackle than two. So some of us are left out, alone, until we are forced to choose where we belong. Am I a sex worker who uses drugs, or a drug user who sells sex? I'm both, sometimes neither, as it is fluid and ever changing.

It is a constant act of solidarity.

My two communities are slowly becoming allies. It takes time, like watching two shy people becoming friends. For some it makes no sense. For others it's confusing. For me it's real and responsible. But it needs to happen on all levels, including service provision. Until a migrant trans person who sells sex and uses drugs can be included as one person, rather than being seen through four layers of stigma that might result in being targeted by four services, it's simply not good enough.

It is a constant responsibility.

Community involvement is key, as without that we are back to being target groups, fragmented pieces of reality, without anyone really knowing what is real and what is just a result of denial of agency and inclusion. Not recognising diversity means that some of us will never fully benefit from adequate healthcare and other services that are part of our human rights. Not recognising someone like me as a person, but rather as an overlap between two stigmatised communities, is in reality making me totally invisible. And we must be able to do better than that.

This report is an important step towards doing better, taking responsibility and recognising diversity. Because in reality no one fits in the boxes designed for "target groups", life is more complicated than that. And reality is key, as it is people's lives we are talking about.

Pye Jakobsson

Board member of the Global Network of Sex Work Projects and member of the International Network of People who use Drugs

About this report

In 2011, Harm Reduction International received support from the Open Society Foundations to bring attention to the intersection between sex work and drug use, and to explore the implications for harm reduction. This report represents an important component of that work.

The report examines the multiple and varied contexts within which drug use (including use of alcohol and non-psychoactive substances, including some hormones and image- and performance-enhancing drugs) and sex work overlap. It provides a snapshot of available evidence on the factors that contribute to vulnerability among people who sell sex and use drugs. Drawing on experience from the harm reduction and sex work communities, the report explores implications for practice, highlighting existing programmes that reach people who sell sex and use drugs around the world, and offering practical suggestions on how programmes can better serve this overlapping population. While this broad and complex area cannot be explored in depth within a document of this length, the report aims to draw attention to this often neglected area, and inform policy and programmatic discussions.

It is primarily intended to be useful for people who use drugs and sell sex, and those who work with them, in order to inform advocacy and programming. It may also be useful to civil society organisations, government and multilateral agencies with an involvement in programming and policy making on drugs, sex work and health.

Key terms and their uses in this report
The term **"drug use"** refers to the use of psychoactive substances administered in various ways, including injecting and non-injecting routes such as snorting and smoking. In this report, the term also encompasses alcohol, hormones and image- and performance-enhancing drugs, which have been identified as important when examining risks faced by people who sell sex and use drugs.

"Sex work" refers to female, male and transgender people voluntarily receiving money or goods in exchange for sexual services. It is a non-judgemental term that highlights labour and income generation, and recognises the role of consent and agency exercised in a decision to enter the sex industry.[1] In this report the term refers specifically to people over 18 years of age (see pages 18-19 for a discussion on young people, drug use and the selling of sex).

"Harm reduction" refers to policies, programmes and practices that aim to reduce the harms associated with the use of drugs for people unable or unwilling to stop. The defining features are the focus on the prevention of harm, rather than the prevention of drug use itself, and the focus on people who continue to use drugs.[2]

Although the term **"harm reduction"** is also used in relation to sex work, there is a lack of consensus within the sex worker community on applying a harm reduction approach to sex work. Some advocates promoting a labour model (in which sex work is included under labour law and occupational health and safety) argue that applying a harm reduction framework to sex work issues implies that there are inherent harms involved in sex work. Harm reduction approaches can be compatible with a labour approach to sex work and may be useful in various contexts, including those where sex work is not currently considered to be labour, and where drug use and sex work overlap. A key article promoting this combined approach, published in the Lancet in 2005, described possible "harms" within sex work, including disease, violence, discrimination,

debt, criminalisation and exploitation.[3] Harm reduction strategies recommended to address them included education, empowerment, prevention and care for HIV and sexually transmitted infections (STIs), occupational health and safety, decriminalisation of sex workers, and a rights-based approach prioritising the self-determination of sex workers.[4] Importantly, this paper also recognised that workplace strategies within a labour model may not be feasible in many informal settings where sex work occurs; for example, on the street and when unanticipated opportunities for sex work arise. Similarly, it stated that where sex work is criminalised or regulated without prioritising the health and safety of sex workers, workplace strategies may not be applicable or may be challenging to implement.[5] It is in these informal settings and punitive legal and policy environments that vulnerability to harm, including drug-related harm, is increased for sex workers.[6]

Shared history: sex workers and the early days of harm reduction

Sex workers and people who inject drugs were identified as high-risk groups for HIV transmission in the first decade of the epidemic.[7] Sex workers were among the pioneers of needle exchanges in the Netherlands and Australia, and they played a role in the development of the Mersey Model of harm reduction in the UK.[8]

The Mersey Model incorporated a high level of drug user involvement, and led to the opening of a needle exchange in late 1986.[9] Outreach and anti-violence programming for sex workers in Merseyside also began in the same year. Recognising that sex workers were among those vulnerable to drug-related harms, the Mersey Model adapted to address the needs of sex workers. Sex workers were invited to 'a public meeting for the women to come and discuss and become involved in AIDS prevention. No one turned up!'[10] This experience revealed that mere invitations were inadequate to reach sex workers, and that as with other marginalised populations, tailored outreach efforts were necessary. Therefore, in 1987 an outreach service was set up to work with sex workers and learn from them what kinds of interventions would lead to the reduction of high-risk activities.[11] This project identified heroin use and the emergence of crack use among sex workers in Liverpool.[12]

At the first International Harm Reduction Conference in Liverpool in 1990, information on teaching safer sex and safer injecting to street-based sex workers was presented.[13] A training tool on this issue, entitled Tricks of the Trade, was developed at the request of the conference organisers and published in 1991.[14] This booklet was perhaps the earliest effort to reach people who use drugs and sell sex with practical information aimed at reducing their vulnerability to harms. It included information not only about safer injecting and drug use, but also tips on how to sell sex safely, how to get out of a stranglehold with a violent person, and ways to mask opioid withdrawal symptoms, together with other information useful to sex workers and agencies that serve them, including, but not limited to, those who use drugs.

Key messages

There is evidence to suggest that some people who sell sex and use drugs (including alcohol, hormones and image- and performance-enhancing drugs) face increased risk of health harms, including HIV and viral hepatitis. However, the overlap between sex work and drug use is often overlooked within HIV and harm reduction policy and programmatic responses.

In much of the world, HIV and harm reduction services for sex workers and people who use drugs fall far below necessary coverage levels. Where they exist, programmes are rarely tailored towards people who both use drugs and sell sex. Barriers to accessing services are particularly pronounced for this population, not least due to the stigma surrounding both drug use and sex work, and the prevailing legal and policy environments in most countries that criminalise aspects of both.

People who sell sex and use drugs are at increased risk of experiencing violence, both from the state and others within the community. Efforts to prevent and protect from violence, as well as those that empower to gain redress for violent incidents, are particularly important components of a HIV and harm reduction response for this population.

Innovative programme examples working with people who sell sex and use drugs should be shared to better inform programming efforts. In addition, there are useful programming principles and approaches that can be drawn on to inform the development or adaptation of programmes to better serve this population. These include, perhaps most crucially, collaboration with existing organisations for sex workers and people who use drugs, and tailoring programmes to the community they are trying to reach.

Investment from national governments and international donors falls far short of what is necessary to meet global HIV prevention targets for these key populations. Governments and donors that fail to invest strategically in HIV and harm reduction responses for sex workers and people who use drugs, including the overlapping population, must be held to account. This is particularly important given the implications of the current economic climate and donor shifts away from investing in middle-income countries. Key population networks and wider civil society working on sex work and harm reduction are crucial for the success of this work, and must be invested in.

Punitive laws and policies relating to drugs and sex work have been recognised as counter to HIV and harm reduction responses and human rights principles. Criminalising sex workers and people who use drugs causes harm. The impact of legal and policy reform on HIV epidemics among key populations must be documented and evaluated, and used to inform the development of similar approaches in other countries.

1. Where sex work and drug use overlap

1.1 Sex work and drug use: an overview of risk and response

People use drugs and sell sex in all regions of the world.[15] Researchers have estimated that female sex workers represent between 0.1% and 7.4% of the general population in different regions.[16] According to the United Nations Office on Drugs and Crime (UNODC), around 230 million people (5% of the global adult population) used an illicit drug in 2010.[17] Estimates of those who use drugs "problematically" (often defined as injecting drug use or long-duration/regular use of opioids, cocaine and/or amphetamines) were much lower, being only 0.6% of the population.[18] The latest peer-reviewed estimates indicate that approximately 16 million people inject drugs around the world.[19,a]

The health risks and vulnerabilities of sex workers, people who use drugs (particularly those who inject), transgender women (among whom sex work is highly reported) and prison populations (often including overrepresentation of sex workers and people who use drugs) are well documented.[20] Both sex workers and people who inject drugs are considered key populations for the HIV response. Currently, 158 countries have reported injecting drug use, and 120 of these have reported HIV epidemics among people who inject drugs.[21] A review in 2008 found HIV prevalence rates among people who inject drugs of over 40% in nine countries and between 20–40% in five countries. It estimated that globally about 3 million (range 0.8–6.6 million) people who inject drugs were living with HIV.[22] Similarly, a recent review estimated the global HIV prevalence among female sex workers to be 12%, and concluded that female sex workers are 13.5 times more likely to be living with HIV than are other women.[23] In sub-Saharan Africa, it was estimated that up to 37% of female sex workers are living with HIV.[24] Sex workers and people who inject drugs are also at increased risk of viral hepatitis.[25] Hepatitis C (HCV) prevalence rates and HIV/HCV co-infection rates are particularly high among people who inject drugs.[26] People living with HIV who use drugs are far more likely to contract tuberculosis (TB) and to be co-infected with hepatitis B (HBV) or HCV than those who do not use drugs.[27]

Despite this, the extent to which these populations are prioritised within national plans and associated budgets remains limited. While global spend on the HIV response has reached unprecedented levels, the extent to which funds are directed towards programmes reaching people who use drugs and sex workers remains far below estimated need.[28] Evidence-based HIV prevention, treatment and care remains difficult to access for many sex workers and people who inject drugs, particularly in low- and middle-income countries.[29] In 2012, needle and syringe programmes (NSPs) were available to varying degrees in 86 countries,[30] and opioid substitution therapy (OST) was provided to some in 77 countries.[31] Only a small number of countries have implemented high coverage harm reduction interventions and averted or reduced HIV epidemics among people who inject drugs.[32] The extent to which harm reduction responses are tailored towards those drug users identified as at increased risk of harms, or to have particularly poor access to harm reduction services, is very limited. Lack of

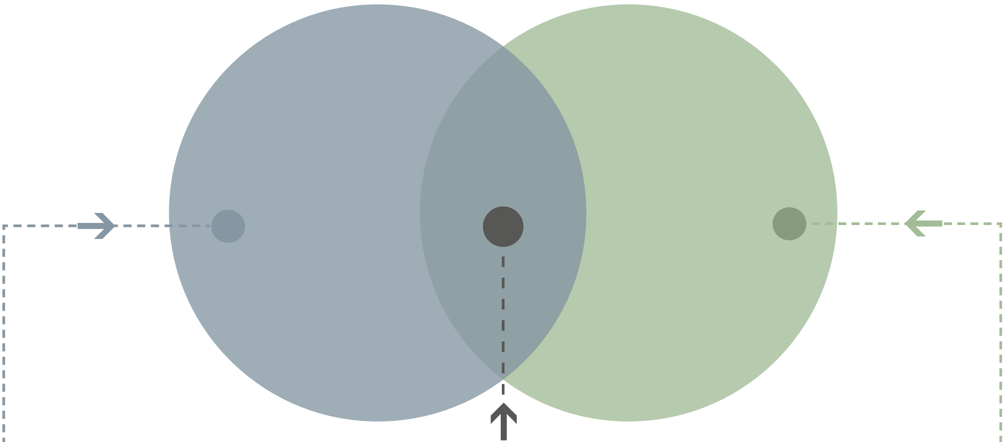
[a] In 2013, UNODC released a new global estimate of the number of people who inject drugs worldwide published in the World Drug Report. This report does not refer to this figure because HRI and other civil society organisations have questioned the transparency and independence of the data gathering process and the extent to which the dataset was peer-reviewed.

access and the absence of specialised services particularly affect those using amphetamine-type stimulants (ATS),[33] women who inject drugs,[34] young people who inject drugs,[35] men who have sex with men,[36] and sex workers.

The limited data available on coverage of HIV prevention for sex workers suggest that while it may be higher than service coverage for people who inject drugs, it remains poor in many countries. Of 58 countries reporting to the Joint United Nations Programme on HIV/AIDS (UNAIDS), just under half were not yet reaching 50% service coverage among sex workers, and nine of these countries reported coverage of less than 25%. Many of the countries with low coverage also lacked legal protection for sex workers.[37]

Prisoners are also at increased risk of HIV and other infections.[38] This is important for the overlapping population who sell sex and use drugs because sex work and drug use are criminalised in most countries. The sale of sex[39] and the use of drugs are reported in prison settings around the world,[40] contributing to HIV transmission in prisons.[41] Yet despite the presence of sexual activity[42] and drug use, including injecting,[43] safer sex measures and harm reduction services are rarely available in prison settings.[44] For example, NSPs operated in prison settings in only 10 countries, and OST was available in prison settings in only 41 countries in 2012.[45]

1.2 In context: a closer look at the overlap between sex work and drug use



Some people who sell sex also use drugs. For many, drug use is independent from sex work, but for some it is intrinsically linked. Some are motivated to sell sex in order to generate money to buy drugs, which is most frequently associated with drug dependence.** Some people also trade sex for drugs, which has been associated with higher-risk behaviours like unprotected sex and unsafe injecting.*** Some consider sex work their occupation and not simply a means to generate money to buy drugs. These populations overlap, and people move between them as they stop and start using drugs or selling sexual services.

People use many different kinds of drugs (including alcohol) for various reasons, and they administer them in different ways. Some have a psychoactive affect and some have a physiological affect that may impact on appearance or physical ability. For many people, drug use is an enjoyable experience, and for the majority it produces no significant harms. Others, however, are affected by drug-related harms. These may be health-related harms, such as blood-borne viruses, sexually transmitted infections, tuberculosis and overdose, or social harms such as violence, stigma and discrimination, and social exclusion.

People who sell sex offer sexual services in exchange for something of value. For many people selling sex there is a strong economic impetus, and sex work has often simply proved more financially rewarding than other available options.* Sex work occurs in a variety of settings and contexts. These include formally organised environments like brothels and massage parlours, via escort agencies, from home (their own or their client's), and through more public spaces such as bars, restaurants, hotels, the street, markets or vehicles. Each location carries with it its own prospective harms and difficulties. Like drug use, sex work is not inherently harmful, but conditions in which sex work is practised contribute to risks such as the transmission of infections, violence and arrest.

* Weitzer R (1991) Prostitutes' rights in the United States, Sociological Quarterly 32(1):23–41.
** Cusick L (2006) Widening the harm reduction agenda: from drug use to sex work, International Journal of Drug Policy 17:3–11.
*** Cusick L (2006).

There are multiple contexts within which sex work and drug use overlap. Within public health research and policy, problematic (often injecting) drug use and sex work as a means of generating income to pay for drugs has been focused on the most.[46] In such a context, sex workers are viewed as a subset of people whose drug use has become problematic,[b] and who could benefit from harm reduction services.[47] However, drug use (including alcohol, hormones, and image- and performance-enhancing drugs) by sex workers, including in some sex work venues, is less well documented and less well understood. Therefore understanding of the related harms and ways to reduce them are also often underdeveloped and undocumented.[48]

Drug use is sometimes a central part of the interaction between sex worker and client. Some clients invite sex workers they hire to share their drugs. Some specifically seek sex workers who provide a "party" service, which involves the client and sex worker using drugs together.[49] Some sex workers experience pressure to use drugs with clients,[50] while others view the encouragement or acceptance of drug use at work as an advantage that contributes to a comfortable working environment.[51]

Clients' drug use can also affect sex workers. For example, some studies have found an association between drug use by clients of female sex workers and unprotected sex.[52] The use of drugs, including alcohol, can contribute to difficulty with sexual functioning.[53] For example, drugs can increase the time it takes for a male client to ejaculate, thereby lengthening the time spent providing a physical sexual service[54] and increasing the potential risk of torn membranes vulnerable to infection.[55] Sometimes sex workers are engaged by clients primarily to procure drugs for them rather than to provide a sexual service.[56]

The following section summarises research and anecdotal information on the overlap between sex work and drug use, exploring the various types of drugs used, routes of administration and associated harms.

Sex work and injecting drug use

Female sex workers who inject drugs experience an elevated burden of HIV and other negative health outcomes compared to sex workers who do not inject drugs.[57] Researchers investigating HIV prevalence among female sex workers have raised particular concerns about epidemics in Eastern Europe and Central Asia, where there is evidence of a significant overlap between sex work and injecting drug use.[58] A recent European review concluded that vulnerability to HIV among female sex workers was linked primarily to unsafe injecting.[59] A study in Manipur, India, found that HIV infection rates among female sex workers who inject drugs were 9.4 times higher than among female sex workers who did not inject.[60] Similarly, researchers found higher HIV prevalence rates among female sex workers who inject drugs in Ciudad Juarez and Tijuana, Mexico, when compared with other people who inject drugs.[61] Studies have also found increased rates of unsafe injecting, sex with more HIV-positive partners, lower condom use, and increased risk of syphilis and HCV among people who sell sex and inject drugs when compared with those who just sell sex or just use drugs.[62]

Injecting drug use (including injecting of hormones) has also been one of several factors associated with positive HIV status among transgender women sex workers in some studies.[63] HIV prevalence among transgender

[b] Problematic drug use is defined by the EMCDDA as injecting drug use or long-duration/regular use of opioids, cocaine and/or amphetamines.

women sex workers has been found to be far higher than that among other sex workers.[64] Factors associated with positive HIV status in transgender women include unprotected sex with primary male partners, injecting drug use, social stigma, and belonging to a minority ethnic group.[65]

Other contributory factors to increased HIV risk may be particularly likely to affect people who sell sex and inject drugs. These include stigma, discrimination and marginalisation experienced within peer groups (particularly from those who do not sell sex or do not inject drugs),[66] healthcare settings[67] and/or the wider community, as well as experiences of sexual and/or physical violence[68] and time spent in prison or other closed settings.[69]

While some may inject heroin, cocaine or ATS, others may inject hormones (for example, transgender sex workers),[70] cosmetic fillers, silicone, implants, steroids[71] and drugs to prolong erections. For transgender women, many of whom sell sex and use drugs recreationally or as part of their transition from male to female, there may be additional risks.[72] These are associated with receiving cosmetic procedures involving injecting, particularly when administered by informal, unregulated practitioners,[73] some of whom may use counterfeit or non-injectable grade substances that can harden, form lumps or migrate within the body, or cause infection.[74]

Sex work and non-injecting drug use

Smoking, inhaling or snorting drugs can also pose health risks. Sharing straws and improvised straws used for snorting drugs can transmit HBV and HCV. Smoking drugs such as crack cocaine and crystal methamphetamine through pipes can lead to the development of burns and sores around the mouth. These can facilitate the transmission of HCV when pipes are shared, and can increase vulnerability to oral infection, including STIs. In addition, some non-injecting drug use is associated with increased risky behaviour, such as unprotected sex. HIV prevalence rates similar to those among people who inject drugs have been found in parts of the Caribbean among crack cocaine smokers who sell sex.[75]

Sex work and amphetamine-type stimulants

Anecdotal reports indicate that ATS are used by sex workers for many different reasons, including to suppress appetite and avoid weight gain,[76] to remain alert and awake during long shifts,[77] to increase sociability with clients and to boost confidence.[78]

ATS are stimulants produced in pill, powder, crystalline and liquid forms that can be swallowed, snorted, smoked, injected or inserted anally.[79] People injecting ATS may be more likely to engage in risky injecting practices, such as re-using needles and hurried injecting, than those injecting other drugs.[80]

ATS use can increase the likelihood of STI and HIV transmission during sex by drying mucous membranes, decreasing sensitivity and delaying orgasm, thereby increasing the risk of torn membranes vulnerable to infection.[81] Sexual risk-taking behaviour has been associated with use of ATS.[82] It has been associated with hypersexuality and unprotected anal sex among men,[83] and with STIs and urinary tract infections among female sex workers.[84]

Sex work and alcohol use

Alcohol use is common in many sex work venues, including nightclubs, hostess bars, strip clubs and karaoke bars. Alcohol is also consumed and sometimes sold in brothels and other sex work venues. In situations where alcohol sales financially benefit sex

workers and proprietors, there is pressure for sex workers to buy their own drinks and encourage clients to buy them too. In places where commission from drinks bought for sex workers is a significant source of income, sex workers who do not meet their quotas sometimes find the cost of drinks below quota deducted from their salary. This system promotes the consumption of alcohol by sex workers while working.[85] In addition, when sex workers accompany clients to events where there is excessive drinking, such as at business dinners, they may be expected to drink as well.

In these ways, pressure to use alcohol is the most prevalent of all pressures to use a psychoactive substance while doing sex work. As Kitten Infinite, a US-based sex worker, explained,

"*Some sex workers who want to avoid drug and alcohol use find legal drinking establishments to be the most unsafe places to work in terms of drug and alcohol temptation and drunk violence and/or harassment because it's not only normalized but expected.*"[86]

People who sell (or simply have) sex while intoxicated may be more vulnerable to STIs and HIV for reasons related to difficulty using condoms.[87] A review of existing literature found evidence that alcohol use by female sex workers and their clients can present problems for safer sexual and social interactions, but this area remains under studied.[88] Overuse of alcohol, marked in part by it affecting ability to function in everyday activities and also as self-reported by sex workers, has been documented in settings with both male[89] and female sex workers, who described the need for alcohol-related services as a high priority for them.[90] In South Africa, skills training to reduce risk, including avoiding drinking to the extent that judgment is impaired, has been associated with condom use among female sex workers.[91]

Sex work, hormones and image- and performance-enhancing drugs

Some sex workers seek to change their appearance using cosmetic implants and fillers, hormones (particularly transgender sex workers) or steroids (particularly male sex workers). The injection of prostaglandin (also called alprostadil or Caverject) to maintain erections while selling or buying sexual services is also reported.[93] While mitigating the risks associated with unsafe injecting is typical work of harm reduction programmes, they are less likely to be familiar with the particular risks of injecting these kinds of substances, and most will not be tailored to the people who use these substances.[94]

Cosmetic procedures and iatrogenic infection (transmission of infection as a result of a medical procedure) may also be possible routes of HIV transmission among sex workers in some places.[95] This may be of particular importance among transgender people who inject implants and hormones, and are at exceptionally high risk of HIV.[96] Other risks associated with injecting silicone and hormones include necrosis, allergic reactions, fibroses and varicose veins.[97] Cosmetics that can be injected also pose risks. For example, researchers and harm reduction service providers have raised concerns about the risks faced by people injecting self-tanning materials Melanotan I and II (the latter also associated with induced and prolonged erection).[98]

Coping with intoxication at work

The Bar Hostess Empowerment and Support Programme (BHESP) in Kenya supports sex workers who meet their clients in bars. In this context, alcohol, drugs and sex work are deeply intertwined, and sex workers take care of each other while at work. If one of them is intoxicated, her friends may decide to take her home, or watch over her as she dozes off at the table. Her peers typically take her property, usually a mobile phone and cash, to prevent her from being robbed.

Peninah Mwangi, the director of BHESP, said, "*If a sex worker is going out with a customer while high on beer or drugs, she is reminded by her peers not to forget her condoms no matter what, and that for safety purposes, one should not board a client's car, especially a new client.*"[92] Additionally, sex workers are encouraged to ask their clients to pay for lodgings that are close by, usually behind the bars.

Strategies that sex workers use to be less intoxicated include drinking water or tonic water. Many alternate drinking alcohol with non-alcoholic drinks.

Most-at-risk and most overlooked: young people engaged in selling sex and using drugs

An in-depth discussion on the particular vulnerabilities faced by young people who use drugs and sell sex is not possible within this report. However, it is important to recognise that people under the age of 18 who are selling sex and using drugs are likely to be particularly vulnerable to harms for several reasons, not least their age-related developmental, social, economic and environmental vulnerabilities. They are likely to be considered among the most at risk or vulnerable within any population. Vulnerability is exacerbated by age limits and fears that services that address youth who sell sex or use drugs may be prosecuted or closed, denying services to the very people who need them most. Individuals and programmes have justifiable fears about legal repercussions if they offer services to youth. These legal repercussions create further obstacles to access to services for young people, who may be experimenting with sexual activity and using drugs without guidance or materials to prevent infection, abscesses, injury, violence, and other possible harm.

A lack of age-disaggregated data limits our understanding of the size of this population and the nature of the particular harms they face, but existing literature is indication enough that action is needed.[99] A recent assessment of injecting drug use among under-18s globally[100] revealed significant numbers in some countries. For example, one study estimated there to be 50,000 children and young people (13–19 years old) injecting drugs in Ukraine, and another estimated that 20% of people who inject drugs in Nepal are under 18 years old. Data on age of initiation into injecting also provide indications that this is a significant issue in many countries.

Similarly, there is a lack of age-disaggregated data on sex work, perhaps partly due to the legal distinction made within the Convention on the Rights of the Child and in many, but not all, countries on the sale of sex, deemed exploitation when among people younger than 18 years of age. The blanket application of this legal distinction can be unhelpful, as factors such as levels of maturity and ability to make informed decisions must also be taken into consideration when assessing individuals under the age of 18.[101] However, it should be noted that the likelihood of coercion and exploitation being a factor becomes much more likely for people under the age of 18. Among people who sell sex, there is evidence that youth is correlated with both positive HIV status and experiences of violence.[102]

Young people who inject drugs are also at higher risk as they are more likely to rely on other, older people to access drugs and injecting equipment. Early onset of injecting and being a new injector has been associated with increased risks of HIV and HCV transmission.[103] Specific groups of young people, such as those who are street-involved, living in poverty, or have experienced trauma such as childhood physical and/or sexual abuse, are likely to be particularly vulnerable. Overall, young people are less informed about risks and their rights.[104]

Barriers to accessing existing services are increased for young people, ranging from a lack of appropriate, tailored interventions through to parental consent requirements and legal age restrictions attached to provision of particular services (for example, NSPs, OST or reproductive health commodities and services).[105] Fear that accessing a service could lead to arrest, police harassment and/or being taken into custody in a juvenile facility or another institutional setting that may be difficult or impossible to leave is an additional barrier.

There is a need for a distinct approach to effectively prevent, reduce and respond to harms for young people using drugs and selling sex. In many countries, effective responses will include legal and policy reform. For example, the legal age of consent for autonomous access to HIV and sexual and reproductive health services must be in line with or lower than the legal age of sexual consent. Equally, legal age restrictions that impede access to harm reduction services for young people who use drugs must be removed.[106] However, the absence of data and a supportive legal environment should not hinder the development of necessary international and national policy guidance to inform ethical and effective programming in this area. There is a need to incorporate services for people under the age of 18 in core packages for people who use drugs and sex workers, and to assess the appropriateness and accessibility of existing services as well as additional services that could be offered in order to adequately reduce minors' vulnerability to harms. Civil society organisations are developing useful tools in this regard; for example, a tool to prepare harm reduction service providers for work with children and young people,[107] and a tool for service providers to make ethical decisions about their actions in relation to children of key populations.[108]

Working with young people who use drugs and sell sex in Sierra Leone

GOAL in Sierra Leone works with vulnerable young people, including those who sell sex and use drugs, offering a safe haven, nutrition and informal education. The organisation provides services to 7,374 young people between the ages of 8 and 24. In 2011, a survey of GOAL's clients found that 92% were not in school and 19%, mostly female, had children of their own.[109] Only 53% of clients had regular shelter, and many of them sold sex in order to get immediate income. More than three times as many young people living on the street reported drinking alcohol (60% of the sample), compared to those living with their families. Three-quarters of the sample also reported using at least one kind of drug, including marijuana, diazepam, cocaine, heroin, available anti-psychotic medications, petrol and lighter fluid.

GOAL now works with a new organisation, FDID started by people who formerly used drugs. FDID, who introduced naloxone to Sierra Leone in October 2013, has brought to the partnership their extensive knowledge of local "hideouts" where people, including young people, use drugs. FDID and GOAL have now worked together to identify over 100 hideouts in Freetown, where they conduct outreach and refer people to GOAL for services. The strong relationships between FDID and the people who run the hideouts and sell drugs there has made them better able than any other organisation to access the hideouts and engage people who use drugs, who may be suspicious that outsiders will jeopardise their security.

This joint work demonstrates not only that young people require services, but also the benefits of partnerships with people from target populations, especially when they are organised. Working together, FDID and GOAL are now bringing overdose prevention and reversal services to young people, many of whom sell sex and/or use drugs.

1.3 Violence, sex work and drug use

The combined stigmatisation and criminalisation of sex work and drug possession increases the incidence of violence against sex workers who use drugs.[110] A substantial proportion of sex workers and people who use drugs experience violence. This may be physical, sexual and psychological violence, and may be perpetrated by state agents such as law enforcement officers, staff within closed settings such as compulsory drug detention centres, clients, family, intimate partners and other community members. A recent study in Sierra Leone, for example, found that over 95% of people who sell sex, people who inject drugs, and men who have sex with men had experienced violence in the previous year.[111] A study in Bangladesh found that 94% of female workers had experienced violence from clients, police, gatekeepers, intimate partners or neighbours.[112] In Ukraine, it was found that over 50% of women who inject drugs reported psychological violence from their partners, with 49% reporting physical violence.[113] RedLACTrans (a regional transgender network working within Latin America and the Caribbean) has documented the particularly heightened levels of violence experienced by transgender people, in many cases resulting in murder.[114]

Female sex workers are at increased risk of sexual violence and other forms of victimisation,[115] including murder.[116] People who sell sex while intoxicated are more likely to experience violence than those who are not intoxicated,[117] particularly in street-based and low-status settings.[118] Sex workers' ability to be street savvy may be compromised when they have used psychoactive drugs, including alcohol, making them more vulnerable. The association between using drugs while selling sex and client drug use with violence must be further explored.

In many places there is little or no recourse when sex workers try to report violence committed against them.[119] People who use drugs experience a similar disregard when they try to report violence.[120] Obstacles to reporting violence and the lack of investigation of violence against both sex workers and people who use drugs further increases their vulnerability to violence. Perpetrators believe there will be no consequences since they know that violence against sex workers and people who use drugs is unlikely to be punished. This is particularly true of violence perpetrated by armed uniformed state agents, who are often the source of violence experienced by sex workers[121] and people who use drugs.[122] For example, street-based female sex workers who use drugs in Russia and Ukraine have reported being picked up by police, taken to private residences or bathhouses and subjected to sexual violence, including beatings and humiliation, over the course of several days.[123] Sex workers around the world cite police as the people most likely to violate their rights. People who use drugs also have difficult experiences with police. Sex workers in New York City, including those who use drugs, have described great difficulty reporting violence to police.[124] Sex workers in India have described similar difficulties, alongside successes when they work collaboratively to improve police interactions and responses to sex work.[125]

Violence experienced by people who use drugs and sex workers increases vulnerability to HIV. Studies from Ukraine have found links between arrest and experience of police violence to a greater likelihood of living with HIV among people who inject drugs.[126] A recent study among female sex workers in three Russian cities found that those who injected drugs and those who reported experiencing client-perpetrated physical and sexual violence

were significantly more likely to be living with HIV.[127] Sexual violence can involve exposure to HIV and other infections.[128] However, links between violence and HIV are not always so visible. Experiences of violence can also lead to stigmatisation and victim blaming, as well as lowered self-esteem, resulting in diminished self-care, including HIV prevention.

Aggressive policing and arrest, or having to pay protection money, can also increase the potential HIV risk for sex workers who use drugs by necessitating longer working hours and encouraging riskier sex to make up for lost income.[129] Arrest can be a result of self-defence against violence.[130] In order to avoid being identified as a sex worker and subjected to police violence, sex workers may choose not to carry condoms. Furthermore, people who are threatened by violence may prioritise avoiding violence before avoiding HIV.[131]

People who use drugs and sell sex may also experience violence from their partners. In this context, intimate partner violence refers to non-commercial, non-paying sex partners of people who sell sex. Intimate partner violence against female sex workers in India has been found to be as significant as violence from paying partners regarding vulnerability to HIV.[132] Research also indicates that women who inject drugs experience intimate partner violence more commonly than women among the general population.[133] Where shelters for victims of domestic violence exist, many have policies excluding people who inject drugs,[134] and in some cases sex workers[135] (particularly those on sex offender registries)[136] and transgender people.[137] This protection gap forces women to remain in violent relationships or face potential homelessness. For these reasons, efforts to prevent and protect from violence, as well as those that empower seeking redress for violence, are crucial components of an HIV and harm reduction response for this population.

Anti-violence programming for sex workers includes compiling and distributing “bad date” or “ugly mugs” lists, and self-defence training; strategising responses to violence, including media and awareness campaigns; and information sharing (see page 23). Although this kind of programming may appear unfamiliar at first, the methods will be easily recognised; that is, peers equipping peers with information on keeping safe.

Anti-violence interventions: "bad date" and "ugly mugs" lists in New York City

Traditional harm reduction programmes and organisations of people who use drugs may include a peer-to-peer information-sharing practice that aims to increase safety. "Bad date" and "ugly mugs" lists share a similar principle. Ugly mugs are people who assault sex workers – and sex workers have been sharing descriptions of people to avoid for many years. A bad date list is a community response aimed at promoting safety for those involved in sex work. For example, one woman in New York contacted agencies and escorts on behalf of sex workers to compile a list of people who had assaulted them. Her bad date list eventually contained information on more than a thousand individuals.

The PROS Network (Providers and Resources Offering Services to sex workers) is a coalition of sex workers, organisers, direct service providers, advocates and media-makers in New York City. Service providers involved in the PROS Network take reports of violent incidents against sex workers, including information regarding location, what the assailant looked like and wore, car license plate numbers, and details about what happened. The information is then circulated to all network members, who go on to share it with their clients via street- and site-based handouts, as well as email. In this way, information that can help others avoid these assailants is circulated to sex workers over a wider catchment area than any single organisation serves, ensuring that information about dangerous individuals gets to as many people as possible. Additionally, the information functions as a way of monitoring violent incidents, enabling the network to track perpetrators of violence and how they are operating.

Successful anti-violence interventions with police

Sex workers who are intoxicated have been documented to be highly vulnerable to violence, contributing to exposure to HIV.[138] Interventions to reduce and address violence have included working at the individual and community level to share information about violent assailants, and at the structural level to advocate with police to change how law enforcement addresses violence in sex work, and to advocate for law reform.

The Armistead Sex Work Support Project in Liverpool, UK, has successfully advocated and worked with police to introduce a number of initiatives to encourage reporting of crimes by sex workers to police, and to improve police responses to these crimes. This has culminated in police sex work liaison officers being appointed to build relationships with sex workers and Armistead in order to encourage reporting of violent incidents. These officers have no enforcement role in policing sex work, instead focusing on the safety of sex workers, encouraging reporting, and monitoring progress in investigations. The ugly mugs third-party reporting scheme coordinated by Armistead has been enhanced and linked to police intelligence systems. An analyst then processes reports made by sex workers to aid identification and investigation of offenders.

Scheduled reviews of investigations into violent incidents against sex workers, including sex workers who use drugs, have been instituted at regular intervals. Armistead takes reports from sex workers about violent incidents, and then police from the specialist rape and sexual offences team (Unity team) and hate crime unit (with expertise in enhanced victim care and offering quality policing to minority community groups) start an investigation. This means that the investigation is taken very seriously. Armistead, through the role of the specialist independent sexual violence advisor, works closely with the Unity team to support the victim immediately after the assault, during investigations and at court, including any particular support needs for sex workers who use drugs and alcohol.

These investigations have now shown positive results. The rate of rape convictions for people who have assaulted sex workers is higher than other rape convictions in the UK.[139]

Mediation with police in Kenya

A groundbreaking programme in Kenya has sponsored long-term mediation between sex workers and police, leading to a reduction in police violence, greater ability of sex workers to report violent incidents, and better relations overall between law enforcement and sex workers.[140] In many countries where police activity impedes the delivery of services for people who use drugs, police engagement is a core aspect of harm reduction programmes.

1.4 Legal and policy environments

Social stigma against people who use drugs and sell sex is reflected in laws criminalising sex workers, the clients of sex workers, and people who use drugs. The legal regime in which a person uses drugs and trades sex may be the strongest determinant of their vulnerability to infections. No country has yet decriminalised both drug use and sex work, so people who use drugs and sell sex are affected by some kind of criminal status everywhere in the world. This includes laws against drug use and possession; laws against sex work, including criminalisation of clients; and laws against homosexuality.[141] The legislative environment also affects social inclusion for sex workers who use drugs; for example, through limiting access to education, employment, custody of children and housing. In short, the criminalisation of people who sell sex and use drugs has the potential to affect every aspect of their lives.

The criminalisation of sex workers and people who use drugs also limits their options within and outside of sex work and drug use. Arrests related to drug possession or sex work, or being added to a registry of drug users or sex offenders,[c] are barriers to employment. This may encourage some people to sell sex. Similarly, long gaps between employment in mainstream professions due to sex work being a primary occupation, or being incarcerated, are significant barriers to re-entering the mainstream workforce. For some communities with particularly heightened barriers to employment, including transgender people, migrants who lack documentation or work permits, and people with severe mental health problems, the sex industry may be considered one of few options available to them.[142]

Laws against drug use not only affect users directly but can also impede the delivery of and access to NSPs and OST.[143] Laws against sex work have been expanded in many places not only to include the criminalisation of sex workers and managers of sex industry establishments, but also clients and people in ancillary positions, such as taxi drivers in New York City[144] and motorbike taxi drivers in Cambodia.[145] Laws against homosexual activity are frequently used against transgender and male sex workers; for example, in India.[146] Although little is documented about lesbians and transgender men who use drugs and sell sex, they have been targeted by laws against homosexual activity too.[147] Some lesbians who use drugs also sell sex (including to male clients), particularly in places where lesbians are highly stigmatised and discriminated against in other income-generating activities.[148]

Convictions for drug use and sex trade-related offences, depending on location and legal regime, are associated with jails, prisons and compulsory drug detention and rehabilitation centres.[149] Where sex workers are included in registries of sex offenders[150] or "antisocial behaviour orders",[151] access to housing, employment, child custody and even a person's freedom of movement are restricted. Criminalisation of drug-related and sex trade-related activity can and does inflate prison populations. The implications of these legal frameworks apply to those convicted for both drug use and sex work-related offences, and have public health implications for all.

Policies on drugs and sex work affect public health when they enable law enforcement harassment of projects offering services through outreach to sex workers and people who use drugs.[152] Anecdotal reports from

[c] In some countries, arrest for sex work can result in being added to a sex offender register.

projects include threats of arrest of outreach workers, interference with bad date list distribution for sex workers, and interference with the distribution of safer sex and safer drug use materials. Reports have also included undercover officers posing as sex workers in sting operations accepting materials from harm reduction and outreach projects.[153] Multiple projects have described threats of arrest effectively eliminating some harm reduction services (for example, the distribution of kits for safer drug use), and there are numerous examples of harm reduction organisations refusing to undertake anti-violence programming with sex workers who use drugs.

Criminalisation disproportionately affects people of low socio-economic status and people who do not conform to expected social norms. People who are racially or ethnically different from the dominant group, migrants, transgender people and other marginalised groups are typically over-represented within prisons and detention centres.[154] Being involved with the criminal justice system has not typically been a gateway to services for sex workers and drug users where sex work and drug use is criminalised.[155] Police involvement in people's lives is not usually helpful to people perceived as potential criminals and therefore stigmatised by society, institutions and, frequently, the criminal justice system itself.[156] Although laws and policies criminalising or imposing restrictions on drug use and sex work have little bearing on each other, for people who use drugs and sell sex, the impact of criminalisation and punitive policies is potentially doubled.

The criminalisation of drug use has fuelled the spread of HIV and other infections among people who use drugs, their families and intimate partners.[157] The "war on drugs" law enforcement approach includes high penalties for illicit drug use, including prison terms.[158] Under current drug laws in some countries, possession of very small amounts of illicit drugs is considered evidence of drug trafficking or distribution. This means that people who use drugs can receive heavy prison sentences,[159] even in countries where drug use is decriminalised within the law; for example, in Indonesia.[160] Harm reduction service providers are also sometimes subjected to arrest and police harassment,[161] interfering with their service delivery, particularly direct outreach and distribution of sterile injecting equipment and condoms.

Registries of people who use drugs present difficulties in searching for employment and housing, and for anyone who wants to avoid the stigma and discrimination faced by many people who use drugs.[162] For some, the barrier to employment that it presents may make sex work one of the few economically viable options. In some places, people are kept on registries indefinitely, impeding access to other services, and facilitating police and state interference in their lives, including where registration is nominally voluntary. Registries impede access to harm reduction services because they lead to far-reaching consequences (for example, child protection services can be alerted to people being on registries, affecting child custody),[163] even for people who have ceased to use drugs. In this context, people avoid accessing services.[164]

How legal reform can improve the situation for sex workers who use drugs: New Zealand Prostitutes' Collective

The New Zealand Prostitutes' Collective (NZPC) is a peer-led and autonomous sex worker organisation that has been operating since 1988. NZPC is contracted and funded by the ministry of health to provide a range of services within five community bases around the country, two of which include NSPs managed and staffed by people who use, or have used, drugs. In 2011, these two community bases had 8,777 contacts with sex workers, 3.2% of them also being people who inject drugs.

Sex work was decriminalised in New Zealand in 2003. The law now protects the human rights of sex workers, promotes their welfare and occupational health and safety, and is conducive to public health. Occupational safety and health guidelines developed by sex workers, and endorsed by the department of labour, address relevant harm reduction issues in the sex industry, such as managing concurrent drug use and sex work in brothels, being aware of violence prevention, and vulnerabilities while using drugs.[165]

Prior to decriminalisation, people who used drugs or had drug convictions were vulnerable to being excluded from massage parlours (the main sex work venues) by discriminatory police action. Street-based sex workers were also frequently arrested. The decriminalisation of sex work has now created opportunities to provide stable work environments for sex workers. Furthermore, street-based sex workers can carry condoms, as well as safer injecting equipment, knowing these will not be seized in an attempt to establish evidence of illegal sex work.

Decriminalisation and legalisation of aspects of sex work and drug use or possession can include regulation with varying levels of restrictions and requirements; for example, ongoing protections for children and young people. Some restrictions and requirements may not have harm reduction principles at their core, and some may even run counter to them; for example, imposing mandatory health checks or obstacles to NSP delivery. Legalisation of sex work has numerous restrictions, usually about protecting clients of sex workers from STIs, rather than ensuring working environments comply with occupational safety and health standards. Regulations may mandate condom use, and determine hours, locations and what can occur on the premises, such as whether sex and alcohol are available on the same premises.

Legal reform is a long-term process, and implementing laws to emphasise the rights of people who use drugs and trade sex may meet resistance. Portugal has decriminalised most drug use and possession of small amounts for personal use, and seen positive results in lower rates of HIV and criminal activity.[166] New Zealand has decriminalised sex work, offering workers' rights to sex workers,[167] and seen positive results, such as the ability of people who use drugs to work in sex work venues, and the ability to carry condoms without fear of them being used as evidence against them (see page 27). Senegal has decriminalised sex work, and implemented a registry of sex workers associated with healthcare services for sex workers and their families. This system is credited with contributing to the decline of HIV prevalence, even while many sex workers choose not to register or are under 21 years old.[168] These legal situations are the result of long activist efforts promoting reforms. However, decriminalisation and other legal reform will not remove potential harms or barriers for all. In New Zealand, for example, migrants still have difficulties working in the recognised sex industry.

1.5 Barriers to accessing services

Few existing HIV and harm reduction programmes are tailored to people who use drugs and sell sex. Where services are available, whether community based or within a more formal healthcare setting, there are barriers to access that may be accentuated for, or particular to, people who use drugs and sell sex. Some of these are highlighted below.

Specific exclusions from services

Some providers require people to give up selling sex and using drugs before they can access a service, preventing uptake or forcing people to lie in order to use services.[169] Access to drug treatment programmes is often limited, and most require people to stop using drugs while receiving OST.[170] Some projects exclude people who continue to use drugs and others exclude those who sell sex.[171] Access to domestic violence shelters, where interventions could be offered, is limited for people who use drugs and sell sex.[172] In several countries, people who inject drugs remain excluded from accessing antiretroviral treatment, contrary to international guidance.[173]

Lack of appropriateness/gaps in existing services

Few programmes are tailored to meet the needs of sex workers who use drugs, particularly those injecting cosmetics and hormones. Services aimed at the general population, or even at people who use drugs or sex workers, may not be appropriate for people who sell sex and use drugs. This could be evident, for example, in poor awareness among service staff of drug use, sex work and issues faced by this population, inconvenient opening times or a lack of anonymity.

Age restrictions and youth-specific barriers

Barriers to accessing existing services are increased for young people, including a lack of appropriate, tailored interventions; parental consent and legal age restrictions attached to provision of particular services (for example, NSP, OST and reproductive health commodities and services);[174] and fear that accessing a service could lead to arrest, police harassment and being taken into custody in a juvenile facility or another institutional setting that may be difficult or impossible to leave. Other barriers include a lack of youth-friendly harm reduction services and expertise and training on working with young people among harm reduction service providers. In addition, youth participation in the design of policies and programmes remains rare.[175]

Police activity

Punitive and aggressive policing compromises the safety of people who use drugs and sell sex, increases their vulnerability to harm, and impedes access to and delivery of HIV prevention and harm reduction services.[176] (See section 1.4 for more detail.)

Stigma and discrimination within healthcare settings

Within healthcare settings, people who use drugs experience discrimination in various ways, including hostility and reluctance or refusal to prescribe antiretroviral and other treatments, despite the evidence of treatment success and international best practice guidance.[177] There are many reports of pharmacists overcharging or refusing to sell injecting equipment to people they suspect will use them to inject drugs.[178] Sex workers also report that they frequently experience stigmatisation and discrimination from healthcare providers, including higher fees, longer waiting times, being denied treatment,

hostility and violations of privacy,[179] resulting in them avoiding and delaying seeking treatment.[180] Transgender people also report experiencing stigma and discrimination in healthcare settings.[181] Because they cannot access comprehensive, transgender-friendly healthcare services, they are discouraged from health-seeking behaviour, and resort to, for example, the use of black market hormones.[182]

Lack of integration

In addition to sex work and harm reduction services often operating separately from each other, services targeted at particular diseases are also often isolated. Different service providers offer services addressing HIV, TB and viral hepatitis, all prevalent among people who sell sex and use drugs.[183] In particular, delivery of antiretroviral treatment is rarely available on site from services for people who inject drugs.[184]

Overcoming exclusion with dedicated services for transgender people in Indonesia

Srikandi Sejati is a programme for transgender women in Jakarta, Indonesia. Their drop-in centre is in a large compound, where voluntary counselling and testing for HIV is offered. Outreach workers also go to places where transgender people congregate, including places where sex is sold on the street. Because transgender people may not be able to go to their families, as old and ill people in Indonesia are expected to do, Srikandi Sejati has a hospice for terminally ill people, many with HIV. Transgender people, many of whom sell sex, have the highest rates of condom use in Indonesia (30%) compared to other key populations in the fight against HIV.[185] While there is still much to be done, Srikandi Sejati is well positioned to work among transgender people because of their unprecedented acceptance by this population and because they have created a safe space in the drop-in centre and hospice.

Young transgender people in Jakarta are now benefitting from a dedicated and peer-lead service, Sanggar Suara Remaja (SWARA) or Association for Youth Voices. SWARA was started by a board of directors and is now run by young people themselves, with guidance from the board. SWARA has produced monthly bulletins featuring articles on gender. It also runs a beauty salon as part of an income-generating programme – a crucial intervention for transgender people, many of whom sell sex because they have few employment options due to stigma and discrimination. SWARA also hosts beauty pageants that are community events offering opportunities for fun and education together. The most exciting project may be Transchool, which offers skills-building courses on self-acceptance, leadership, human rights and advocacy. In the context of the high level of stigma faced by transgender people in the increasingly religious context in Indonesia, self-acceptance is a prerequisite for caring about their health. For this reason, SWARA and its board promote sensitisation and mainstreaming sexual and gender identity among this community and stakeholders.

2. Considerations for advocacy and practice:
how to improve programmatic responses for people who sell sex and use drugs

The coverage of existing services for sex workers and people who use drugs is too low in much of the world. These services must be scaled up urgently in order to have an impact on epidemics among sex workers and people who inject drugs.

International guidance for programmes with sex workers and people who use drugs

Guidance from the World Health Organization (WHO), UNAIDS and UNODC on HIV prevention, treatment and care for people who inject drugs recommends nine core interventions, prioritising NSP and OST among them.[186] International civil society has argued for a broadening of this list to include interventions such as advocacy and legal support,[187] which have now also been recognised by international agencies as critical to the effectiveness of HIV responses for key populations.[188] Drug consumption rooms[d] and naloxone distribution are also important interventions to address drug-related deaths and harms, including among sex workers who inject drugs.[189] These services should be made accessible and available to all people who use drugs, including sex workers.

International guidance from the United Nations and the Global Network of Sex Work Projects for HIV prevention programming with sex workers recommends anti-violence programming and empowerment, in addition to the full spectrum of HIV-related services. It also explicitly includes NSP as an intervention for those who inject drugs.[190] The increased risk of HBV for sex workers and people who inject drugs has prompted WHO to recommend vaccination for both these populations.[191] However, beyond the inclusion of harm reduction services within HIV prevention programmes for sex workers, there is little international guidance available on the implementation of services for people who sell sex and use drugs

[d] Drug consumption facilities typically provide a place where people use drugs in a safe and supportive environment, without fear of arrest and with safer sex, safer injecting and other safer drug use paraphernalia made easily available.

2.1 Developing a menu of services for people who sell sex and use drugs

The following guiding principles and interventions draw on examples of existing programmes reaching people who use drugs and sex workers to provide a menu of options for programmes seeking to better tailor their services towards those who sell sex and use drugs. It should be noted that some of these options depend on some services already being in existence, and unfortunately in many settings services are unavailable.

Where services are available, efforts should be made to **collaborate with existing organisations for sex workers and people who use drugs.** Sharing resources and co-hosting activities with organisations and groups offering services to sex workers and people who use drugs is one way to create partnerships that will add value to both. Such cooperation should ensure that the services offered are appropriate, and help to make connections with local people who both sell sex and use drugs.

In addition, services should ensure that they are **tailored to the community they are trying to reach.** Community members are best placed to consult with their peers on their drug use and sex work, to identify needs, and to implement and evaluate interventions. Information gathered from the community on the kinds of commodities preferred, the common problems faced, and the best times and locations for service delivery, can be used to shape the service. For example, any equipment and advice provided must be tailored to safer injecting of the particular substances being injected. Even the most seasoned harm reduction staff, including those who inject drugs, may not be familiar with the injection of substances such as hormones and silicone.

Adding new programming to existing services may lead to changes in dynamics at service provider offices. Harm reduction practitioners can find that offering interventions specifically for sex workers draws in new service users. It may also lead to current service users, and sometimes service providers, disclosing experiences of sex work. Healthcare providers will require **training on how to work with populations that are new to them,** and to confront their own biases. Members of the overlapping community of sex workers and people who use drugs should be hired to facilitate sensitisation for service providers. Some service users may not support or welcome members of other key populations; for example, transgender sex workers may be stigmatised by others, and people who do not use drugs may stigmatise people who do. Therefore, education among people who access the service is beneficial, both in the form of addressing the use of stigmatising language and staff modelling non-discriminating behaviour themselves. This is most effectively and quickly accomplished by **hiring members of the populations being served.**[192] In some cases, hiring from among key populations requires increased training, but this cost will be offset by the connections they bring to the target community. These connections will be greater when community members among the staff reach positions above peer educator and outreach worker, and have more input into programme design and implementation.

Service providers should **not restrict access to their service and should make efforts to remove barriers to service access** for those members of the community less able or inclined to seek support. Services may need to adapt in order to make it more feasible for some people to access them. For example, there are various

steps that some harm reduction programmes have taken in order to ensure access for women who use drugs.[193] Services that may see young people should prepare for this by training staff on the particular vulnerabilities that young people face in their community, and the laws and policies that affect them, such as legal age restrictions. Services should work to develop or improve relevant organisational policies, such as those relating to child protection, so that service providers have clarity on what they can offer young people. Engaging young people in service design and delivery is also key to developing youth-focused services. For example, where fear of being taken into custody by social services is a barrier to accessing services,[194] engaging a skilled and articulate peer advocate can be useful to supporting young people in dealing with child protection agencies. (See pages 18-19 for more detail on young people who use drugs and sell sex.)

Stigma and discrimination towards people who use drugs, sex workers and transgender people within healthcare settings is well documented.[195] Those populations who have experienced stigma and discrimination may be more likely to delay seeking medical care until a situation becomes urgent. Ensuring that services offer a friendly and positive experience to those they seek to reach is crucial. Harm reduction and sex worker services often use an **empowerment approach to health promotion,** which does not simply seek to reduce harms and vulnerability but also to improve participants' lives. For example, rather than stressing fear of infections, the information and materials provided might describe how to maximise the efficacy of drugs used, or the income or profits in sexual transactions, and how to minimise time spent with less desirable clients or healthcare providers.

Services reaching those most affected by punitive laws and policies, violence, stigma and discrimination can be well placed to advocate for legal, policy and social change, and to support service users to engage in advocacy. Service providers may wish to **create a safe space for the development of a network or collective,** and to support service users to advocate for their rights.

Table 1: A menu of services for people who sell sex and use drugs

The following table contains a menu of options for programmes seeking to improve and expand services in order to better reach people who both use drugs and sell sex. It contains core interventions recommended within international guidance for people who inject drugs and sex workers (see page 31), as well as other practical options for service providers to consider. As resources available in different settings vary widely, the services are sorted into three groups based on an approximate magnitude of cost, time and effort required for implementation, ranging from those that require no or little additional expenditure to those that require establishing a new stand-alone service.

Table 1: a menu of services for people who sell sex and use drugs	
Adjustments and small additions to existing interventions Added commodities distributed, additional staff training, and designation of special activities for people who sell sex and use drugs of any gender:	> Addition of sex work-specific items to basic harm reduction kits. Safer sex kits include the full range of male and female condoms in a variety of sizes (from extra small to extra large), water-based lubricant, information about perpetrators of violence against sex workers, and information about local sex worker groups and occupational health and safety for sex workers. Kits could include items specific to women, such as feminine hygiene products (including sponges, tampons, and sanitary towels) and underwear, if the sex worker population is primarily female. > Addition of drug-related harm reduction items to basic sex work kits. This could include safer injecting and safer smoking kits,[e] and information about safer drug use and the harm reduction services that are available in the local area. Information should be tailored to local circumstances and clients' needs, and may involve providing these materials either to all clients or on request. Additional items to be added to basic sex work kits should be determined by the type of drug use and related harms identified within client groups; for example, more personal lubricant may be required by people who use drugs that lead to dehydration, such as amphetamines. It is important for programmes to know what is permitted and what requires licensing in their area. > Outreach in sex work venues, such as brothels and apartments, through managers and peer educators. > Outreach to people who use drugs through peer educators in places where drugs are sold or used. > Staff training by sex workers to sensitise them on sex work issues; for example, to provide counselling for people who have experienced violence. > Staff training by people who use drugs to sensitise them on drug use issues; for example, to provide drug counselling.

[e] Safer injecting kits often contain sterile needles/syringes, citric acid, cooker, water ampoules and chewing gum. Safer smoking kits for crack often contain a choreboy, spark plug caps, pipe stems, alcohol swabs, condoms, chewing gum, lip balm and educational information. Safer smoking kits for ATS often contain a straw with a scoop end, pipestem, condoms, water-based personal lubricant, foil, plasters, a small sponge, water ampoules and alcohol swabs.

- Active involvement of sex workers and people who use drugs in service provision and design, including as staff, managers and board members.
- Hours dedicated only to people who sell sex and use drugs, perhaps segregated by gender if desired.
- Support groups and specific counselling services for people who sell sex and use drugs.
- Relationships with trusted healthcare providers and specialists for client referrals to health services, including general health, sexual and reproductive health, contraceptives, emergency contraception, access to safe abortion, and access to treatment for HIV, hepatitis and STIs.
- Pregnancy-related services and training for healthcare providers targeted towards female sex workers who use drugs, including on drug use, drug treatment (including OST and assurance that OST is what provides the greatest stability for both the mother and foetus), HCV and HIV transmission, and overdose reversal during pregnancy. A skilled and articulate peer advocate who can support sex workers who use drugs may also be helpful for dealing with child protection agencies.
- Staff training on the particular vulnerabilities faced by young people in their community, and the laws and policies that affect them, such as legal age restrictions. Develop or improve relevant organisational policies, such as those relating to child protection, so that service providers have clarity on what they can offer young people. Engage young people in service design and delivery. For example, where fear of being taken into custody by social services is a barrier to accessing services,[196] engaging a skilled and articulate peer advocate can support young people in dealing with child protection agencies. Provide information on how to prevent infections, and offer commodities to prevent HIV, HCV and STIs, or link to other services that already reach young people to integrate this into their service. Skills-building training to prevent transmission of HIV, HCV and STIs, and overdose prevention and reversal could also be considered. Link with services for homeless and abused young people, including those offering shelter, job placements and education.
- Interventions and information that describe the structure of local health and social services for migrants, and are available in the relevant languages.
- Availability of intramuscular syringes that are more often used for injecting hormones, and staff training on harm reduction information for injecting hormones and cosmetic substances.
- Links between interventions and services for people who use drugs and sex workers, including discreet provision of harm reduction for sex workers who are unable to openly visit a harm reduction site, and discreet provision of sex work interventions for people who use drugs who are unable to openly visit a site for sex workers.
- Staff training on offering sex workers effective and prompt referrals to harm reduction and related interventions.

New interventions to be added to existing programmes

Hiring a new staff member, adding new interventions to an existing programme, and designating permanent space or significant equipment to sex workers and people who use drugs of any gender:

- Addition of harm reduction interventions to sex work programming. This could include NSP and safer smoking and ATS-related interventions.
- Anti-violence interventions, including documentation, information sharing, and assistance in reporting crimes against sex workers and people who use drugs to authorities.
- A specialist to work with children of sex workers and people who use drugs.
- Support groups for sex workers who are parents.
- Child-friendly spaces for parents attending services, including nutrition for children and childcare in order to permit parents to focus on services.
- Services for the non-paying partners of sex workers, including STI testing and treatment.
- Staff training to sensitise them on sex work issues; for example, counselling for people who have experienced violence.
- Staff training to sensitise them on drug use-related issues, including training to counter stigma and discrimination by staff.
- Counselling services to respond to violence against sex workers and people who use drugs, possibly including reporting to authorities and access to a lawyer to support pursuing charges.
- Sex worker- and people who use drugs-only facilities or hours, and space within centres dedicated to sex workers or people who use drugs. Hours for these services should be determined by people who use drugs and sell sex.
- On-site appointments with a healthcare provider who is sensitive to sex work and drug use issues.
- Mobile interventions for sex workers and people who use drugs who are unable to visit sites.
- Free and low-threshold sexual and reproductive healthcare, including prevention of mother-to-child transmission.
- Legal services covering all forms of stigma and discrimination related to sex work and criminalisation, including documenting human rights violations, help with housing discrimination after arrest or exposure, assistance with documents, immigration advice and services, and access to social support.
- Occupational training, job placement assistance and economic empowerment programmes, including assistance with financial services, opening bank accounts and working with revenue collection agencies
- Social support for sex workers and people who use drugs being released from prison, including overdose prevention.

New stand-alone services Creation of an entirely new intervention, centre or service site:	> Transitional housing for sex workers and people who use drugs of all genders and their families, including age-specific support for sex workers and people who use drugs who are legal minors. > Comprehensive healthcare services for sex workers who use drugs, including maternal and postnatal care.

Integrated services for sex workers at St. James Infirmary, San Francisco

The St. James Infirmary was founded in 1999 by COYOTE (Call Off Your Old Tired Ethics) and the Exotic Dancers' Alliance, in partnership with the STI control and prevention section of the San Francisco department of public health (City Clinic). The St. James Infirmary is operated by current, former and transitioning sex workers from various sectors of the adult entertainment industry. Its mission is to provide compassionate and non-judgmental healthcare and social services for all sex workers, while preventing occupational illnesses and injuries through a comprehensive continuum of services.

The St. James Infirmary serves male, female and transgender sex workers of all sexual orientations, their children and their partners. Most clients accessing their services live in San Francisco, but the clinic does serve clients from the broader Bay Area, and from other states. The broad range of health services provided include primary care, transgender hormone therapy, HIV/STI/HCV testing and counselling, STI treatment, needle and syringe exchange, hepatitis A and B immunisation, and TB screening.

To date, the St. James Infirmary has provided clinic-based health services to over 3,200 sex workers, their children and their partners, and outreach and venue-based testing services to over 20,000 sex workers in the Bay Area. Annually, they provide approximately 4,500 clinic-based services and 2,000 venue-based services.

Before coming to St. James, the majority (70%) of their clients had never discussed their sex work history in a healthcare setting. They offer a wide-range of peer-support activities, and apply a non-judgemental approach to all services so their clients feel comfortable discussing their health issues without fear of being treated poorly or receiving sub-standard healthcare.

2.2 Considerations for research and advocacy

Existing literature suggests that people who use drugs and sell sex may face a greater risk of HIV and viral hepatitis transmission, and increased vulnerability to violence compared to those who only sell sex or only use drugs. However, more research is needed to better understand the needs of this population in many countries and to inform evidence-based programming. While there is some research on female sex workers who inject or otherwise use drugs, there is less on male and transgender sex workers who inject or otherwise use drugs and their different needs. Similarly, there is some literature about women who sell sex to support their drug use, but far less about men who do so.[197]

Transgender people, who are disproportionately affected by HIV and disproportionately represented among sex workers, are another neglected population in the literature on drug use. This gap is especially significant for tailoring HIV programming to the particular needs of transgender people, many of whom inject hormones and non-psychoactive substances, and is complicated by the inclusion of transgender people among men who have sex with men in reporting. Research into drug use and selling of sex among young people, including young men who have sex with men, is very limited, particularly in low- and middle-income countries. There is a need for further research in order to be able to tailor programming to the particular needs of young people who sell sex and use drugs.

Further documentation of and research into violence experienced by people who sell sex and use drugs, whether perpetrated by state actors, clients or others, is needed to inform the development of strategies to avoid, and therefore prevent, violence for this population. It is also key to advocating for their right to health and freedom from torture or cruel, inhuman or degrading treatment or punishment. Research into workplace drug use and the use of drugs (including alcohol) during sexual transactions is also crucial to understanding the specific needs of this population. This research should be instigated, led and undertaken by sex workers who identify as drug users in a variety of country and cultural settings.

Greater commitment to reaching sex workers and people who use drugs with HIV prevention, treatment and care is urgently needed at both international and national levels. Investment from national governments and international donors falls far short of what is necessary to meet international HIV prevention targets for these key populations.[198] In calling government and donor agencies to account, it is essential that the specific situations facing people who both sell sex and use drugs are considered. International advocacy for increased funding and commitment to harm reduction and sex worker programmes could be strengthened through collaborative efforts of civil society focused on sex work and harm reduction. At a local level, the collaborative efforts of those involved in providing services or advocating for the rights of sex workers and people who use drugs are necessary to ensure that the needs of people who both sell sex and use drugs are represented. As long as sex work and drug use remain criminalised, and as long as sex workers and people who use drugs face stigma and discrimination, it will remain a significant challenge to develop and deliver effective interventions that are accessible and meet their needs. Legal and policy reform on a global scale is essential if prevention of HIV and a reduction of other harms experienced by this population are to be realised.

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This report explores the overlap between sex work and drug use, including alcohol, hormones and image-and performance-enhancing drugs. Drawing on experience from the harm reduction and sex work communities, it examines implications for advocacy and practice and offers practical suggestions on how programmes can be better tailored to people who sell sex and use drugs.

Harm Reduction International is an international non-governmental organisation that works to reduce drug-related harms by promoting evidence-based public health policy and practices, and human rights based approaches to drug policy through an integrated programme of research, analysis, advocacy and civil society strengthening. Our vision is a world in which individuals and communities benefit from drug laws, policies and practices that promote health, dignity and human rights.

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