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# **What I Knew was What I Learnt on the Street! Irish Drug Using Sex Workers Accounts of How They Contracted HIV and Hepatitis C**

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Additional information is available at the end of the chapter

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## **1. Introduction**

This paper draws from a larger piece of research conducted by the authors [1] for the National Advisory Committee on Drugs (NACD) whose remit is to provide advice to the Irish government on problematic drug use in Irish society. Under Action 98 of the Irish National Drug Strategy [2] the NACD was required to carry out research on drug misuse amongst groups who were considered 'at risk'. Prostitutes were identified as one such group. Because of the negative connotations and stigma associated with the word 'prostitute' the research team used the term 'sex-worker', the term favored by the World Health Organisation [3-6] and the United Nations [6].

The objectives of this paper are:

- To briefly review research on the links between HIV and sex work, internationally
- To describe the prevalence of HIV among sex workers in Ireland
- To explore the Irish policy response to HIV prevention in relation to this population
- To explore the risk environment of drug using sex workers in Dublin

The aim of this paper is to understand the myriad ways in which HIV was contracted and managed by drug-using sex workers.

## **2. Literature review**

The relationship between HIV and sex work is well documented. In 2009 the UNAIDS Advisory Group[7] was established to provide guidance and advice on issues to do with HIV and sex work, while at the same time emphasizing the human rights of female, male,

and transgender sex workers and the importance of universal access to HIV prevention, treatment, care and support.

The overall growth of the HIV global AIDS epidemic seems to have stabilized. There has been a steady decline in the number of new HIV infections since the late 1990s; and due to antiretroviral therapy fewer AIDS-related deaths have occurred. The UNAIDS vision is zero new HIV infections, zero discrimination and zero AIDS-related deaths. That said, new HIV infections are still high and worldwide there has been an increase in the number of people living with HIV. The population under discussion in this paper remain at particularly high risk [7].

The UNAIDS report (2010) states that there are three high risk behaviours associated with the spread of HIV are injecting drug use, practising unprotected paid sex, and men having sex with men [7]. There are also risks in discordant heterosexual relationships where one partner is HIV positive and risks transmitting the virus to the other partner in a long term relationship. It emphasizes the importance of couples testing for HIV. Becoming sexually active at a young age is also a risk factor; the report states that young people still lack the information and the necessary tools to practice HIV risk-reduction strategies. There is a lack of provision of harm reduction materials such as condoms and lubrication, and sterile needles. It argues that in order to protect women and girls from HIV they need to be protected against gender-based violence.

The UNAIDS Advisory Group Report [7] noted that sex workers often face widespread and interconnected human rights violations which impede both their effective participation in HIV responses and their right to access HIV and other health and social services. It stated that societal stigma and discrimination against sex workers results in repressive laws, policies and practices, and the economic disempowerment of sex workers. The Report warns countries against the persecution of sex workers and the conflation of trafficking with sex work.

### **3. Irish government policy response to HIV**

In Ireland, in response to the HIV epidemic in the 1980s the then Eastern Health Board [1] (now the Eastern Region Health Service Executive) established two specialised drugs intervention clinics (one for female sex workers and one for gay men and male sex workers) in the capital city, Dublin. These clinics provide free HIV screening and other harm reduction services such as needle exchanges and methadone maintenance for intra-venous drug users. In 1987 the Dublin Aids Alliance (DAA), a voluntary non-governmental organisation with charitable status, was set up to improve conditions for people living with or affected by HIV and AIDS. DAA is; provides front line services, such as counselling, outreach and condom distribution. It is the representative for the eastern region of Ireland on the Department of Health and Children's National AIDS Strategy Committee (NASC) and its Education and Prevention Subcommittee. NASC was established in 1991 and published its first Strategic Report in 1992. It took a multi-disciplinary approach involving

statutory and non-statutory sectors and people living with HIV and AIDs. In 2000 it published an AIDS Strategy 2000 [8] which promoted prevention, treatment and care. In 2008 NASC [9] published a 4-year plan for HIV and AIDS Education and Prevention in Ireland with the aim of reducing infection through education, awareness raising and prevention measures. The action suggests that best practice measures targeting sex workers and those buying sex should be integrated into sexual health campaigns. It recommends that there should be appropriate and innovative approaches to HIV screening and treatment including mobile services and new technology. In 2010 a mobile health clinic entitled Safetynet Network for Homeless Health Services was established in Dublin targeting homeless people and sex workers [10]. It provides primary health care and harm reduction services.

#### 4. Prevalence of HIV in Ireland

Figures published by the Health Protection Surveillance Centre [11] on newly diagnosed HIV infections in Ireland in 2011 showed that there were 152 new HIV diagnoses in the first six months of 2011 (less than the 166 cases reported in Q1&2 2010 and the 164 in Q3&4 2010). This brought the cumulative total number of HIV infections reported in Ireland to more than 6,120. The HPSC notes that, as regards new cases:

- The highest proportion (39.5%) was among men who have sex with men.
- Heterosexual contact accounted for 27.6%.
- Females accounted for 25.0%.
- People in the 15-24 year old age band comprised 9.2%.
- Intravenous drug users accounted for 7.9%.
- Of these newly identified cases, 9.2% were diagnosed with an AIDS defining illness at the time of their HIV diagnosis, and 41.4% were asymptomatic.
- Of the heterosexual cases, 35.7% were individuals originating from countries with generalised epidemics, and a further 19% were individuals with a partner originating from a country with a generalised epidemic, or with a partner known to be HIV positive or a partner who is an injecting drug user.

#### 5. Risk environment

The 'risk environment' is a simple model or explanatory framework developed by Tim Rhodes [12] to examine the multiple environmental factors that produce health and other types of risk. There are four types of environmental influences: physical, social, economic and policy in the context of three levels of environmental influence – micro, meso and macro. The risk environment is made up of the risk factors that are external to the individual; these risks can mediate the individual's capacity to reduce the risk of harm. For example, if a country provides free needle exchange programs or opiate substitution programs they help the individual user to reduce the harms associated with intravenous opiate use.

Although harm reduction is most commonly applied to reducing harms related to drug use (especially intravenous drug use), harm reduction principles are increasingly being applied to sex work. The harms associated with sex work include the vulnerabilities that may lead to sex work, the harms that are introduced by engaging in sex work such as stigma [13], criminalisation, and the mutually reinforcing harms such as problem drug use and in particular injecting drug use [14]. The nature and extent of harms associated with sex work varies with the type of sex market they work in e.g. brothels, massage parlours, escorts, street work, however, the harms are greatest in street-based sex markets [15] and where sex workers' pre-existing vulnerabilities can be exploited [16].

There are a number of layers in the risk environment in Ireland. In terms of sex work, there is the legal environment which criminalizes sex workers if they work in brothels or if they solicit sex on the streets[17]. Due to policing, risks are increased because sex workers cannot take time to negotiate with clients and assess the safety aspect of the transaction. To decrease their visibility on the street, there is the added risk of sex workers working in badly lit and remote areas where they are more likely to be victims of violent clients. Due to the societal disapproval of sex work, there is the risk of stigma[13] or public disclosure. The use of crack cocaine has been shown to be associated with street sex working in Dublin [18].

In response to the heroin epidemic in the 1980s in Dublin drug treatment clinics and harm reduction services (methadone maintenance, needle exchange programs etc.) were established [19] within a risk environment where illicit drug use is criminalized[17]. Despite the criminality associated with drug use, reported levels of cocaine use in Ireland are above the European average [20] and Ireland also reports the highest estimate of opioid use in the European Union [20]. The Irish Health Service Executive [21] reports that there are 9,264 people in methadone maintenance treatment, whilst it is estimated that there are another 10,000 heroin users who are not in treatment [22]. In the past heroin use was concentrated in Dublin however now it is spreading all over Ireland. Disadvantaged communities are hardest hit.

A tragic consequence of illicit drug use is early death. In Ireland in 2009 (the latest figures available) there were 357 deaths due to illicit drug use. Cocaine was implicated in 52 of these, heroin was implicated in 108 and methadone in 66 [23]. Poly substance (heroin and methadone) use was implicated in 117 deaths. The majority of those who died were aged between 25 and 44 years; the median age was 38 years. Delays in service provision are clearly a factor: drug users seeking treatment have to wait an average of three to 18 months for opioid substitute treatment depending on the area of Ireland they live in [20].

Although there are adequate health services available for sex workers in Dublin, sex workers are stigmatized [13] on many levels (due to injecting drug use, HIV or HCV infections, and sex working) and may hide their work from health personnel. There is also a high incidence of HCV (70%) among injecting drug users in Ireland [13]. Whilst it is not possible to ascertain the prevalence of HIV among drug using sex workers in Ireland and it is certainly unjust to consider them as vectors of disease, one fifth of the sex workers in our study [13] self-reported as being HIV positive.

## 6. Methods

The focus of this research was to gain an understanding of drug-using sex workers' lived experience of risk, in order to understand how the local risk environment (i.e. the physical, social, economic and policy environment) produces risks in their daily life and work contexts, and how drug-using sex workers implement strategies to manage and reduce the risk of harm. A qualitative methodology was chosen as being the most appropriate to answer the research question. Ethical permission for the study was sought and granted from the Drug Treatment Centre Board in Dublin and also from the Prison services.

## 7. Sample

A purposive sample (4 men and 31 women:  $n=35$ ) of drug-using sex workers was selected. They were located for the research by key service providers and by an agency which offers specialist support to drug using sex workers. In order for sex workers to be eligible for inclusion in the study they had to self identify as a problematic drug user as defined by the Irish National Drug Strategy – i.e. their drug use caused them social, psychological, physical or legal difficulties, and they were involved in sex work or had recently given up sex work after a prolonged period of sex working.

## 8. Research instruments

Two research instruments were utilised to register these sex workers' accounts. A topic guide was designed for use in in-depth face-to-face interviews, and a short survey was used to gather biographic and demographic information and to record current drug use frequency and any associated criminal activity over the previous 90 days. The interviews were conducted in a number of different venues: some in rooms provided by an agency, some in cars, some in prison and some in cafés. In keeping with NACD policy all participants were recompensed for their time with a voucher for a local chain store.

In order to comply with ethical guidelines, prior to conducting the interview, the research was explained to the participant, who signed a consent form and was assured that they could withdraw from the study at any time and that all information was confidential and anonymous. Their permission to audio record the interview was also sought; all agreed to be recorded.

The interviews lasted 45 minutes to an hour and the data quality was good. Generally speaking, the sex workers were very open and viewed the interview as a way of helping out, or doing the researcher a favor. Ethical guidelines were complied with in relation to storage of the data on a password protected computer; all personal identifiers were removed from the data. The data were anonymized, each sex worker was given a pseudo-name (in alphabetical order). Hard copies of the data were stored in a locked filing cabinet. Data was only used for the purpose of the research.



## 9. Data analysis

The researchers fully immersed themselves in the data by listening repeatedly to the recordings. All interviews were fully transcribed. Emerging themes and trends were identified in the data as were comparative data. Inductive analysis of the qualitative data was facilitated by the use of QSR NVivo software, and quantitative data were analysed using the statistical package for the social sciences (SPSS). In the following accounts, I denotes 'Interviewer' and R denotes 'Respondent'.

## 10. Findings

The women and men interviewed were white indigenous Irish people; the vast majority were from Dublin, and all, but one, were living in Dublin at the time of interview. In addition many respondents reported other vulnerabilities such as being homeless, two had spent many years in residential care systems, four were in prison at the time of the interview either serving a sentence or on remand; four women had recently been released from prison and were living in transitional accommodation (specifically for women released from prison). Nine were living in emergency accommodation, most in city centre hostels and nine were living in the private rented sector. Four were living in the parental home or were staying with friends. In many cases, their marginality was compounded by the loss of their children, many were parents (24 women and one man) but the majority had put their children into care which substantially added to their distress and to their drug use. A brief outline of participants' reported drug use sets the context for reading their accounts of managing risk in their daily lives and work.

## 11. Illicit drug use and treatment experience

Research participants [were asked about their use of a range of substances in the 90 days prior to interview. Although 88 per cent of participants were on prescribed methadone, 65 per cent also reported recent heroin use, 29 per cent reported cocaine use, and 15 per cent reported crack cocaine use. Participants who were actively involved in sex work at the time of interview were more likely to report the use of all substances [1].

All 35 participants had a history of injecting drug use: 53 per cent reported injecting in the 90 days preceding interview, and seven were high frequency injectors (they reported daily injecting in the preceding 90 days, with five of them injecting more than four times per day in that period). Four of these high frequency injectors were injecting cocaine daily [1].

Participants reported a high level of contact with healthcare services: 64.7 per cent reported having had a health check in the 90 days prior to interview. Almost all also reported having been tested for HIV (figures for reported infection have been given above). Over three-quarters of the study participants (78.1 per cent) had had a positive HCV diagnosis; 26.7 per

cent said that they had received information about the virus, 36.7 per cent reported having received an onward referral; however, only 13.3 per cent (n=4) reported having ever received treatment for HCV. Less than half the sample (43.8 per cent) reported having received the hepatitis B vaccine, and 17.2 per cent had received it in the last three months; 19.4 per cent had received confirmation that the vaccine had worked. Only one of the study participants reported receiving the combination interferon and ribavirin HCV treatment and three of the women were receiving HIV triple therapy treatment; all three commenced treatment while in prison [1].

## 12. Risk and risk management in participants' accounts

While all participants reported using needle exchanges to access sterile injecting equipment, most admitted to engaging in unsafe injecting practices in the past. Because they had commenced illicit drug use at a young age, many were unaware of the attendant risks of contracting HIV/HCV at the time and in any case were unable to access sterile injecting equipment, because there were limited harm reduction interventions in Dublin at the time.

Some spoke about recent occasions where they put themselves at risk by sharing injecting equipment or accidentally using another's equipment, for example, Eileen explained:

*R: I have shared works and that's how I got the hepatitis. And then one day last year I was with a girl and she has the HIV. We were actually out one night and we got cocaine off somebody. And I actually brought her home back to the hostel. And we went to IV cocaine, and she was after putting her needle, her works into me and she only realised, or so she said, she only realised that she put the wrong needle in, that it was hers. And it was after being used already because she had HIV. So my head was wrecked, for the whole three months I had to wait for the antibodies and all to come back.*

Despite having access to sterile needles, Úna explained how she unwittingly used a friend's equipment because she was in the throes of withdrawal. This account highlights the struggle to maintain safe practices in a very risky, unsafe environment with an irresponsible drug using friend who was HIV positive. This detailed narrative has been tabulated to facilitate reading. Úna's account is presented in the left hand column where it is broken into numbered blocks to highlight the main topic focus in each. In the right hand column the author's accompanying analysis and interpretation is presented.

In the above account Úna describes how she always accessed sterile needles (1), and would always put an identifier on them (6), dispose of them carefully (14) and would not inject in a public space (15). She expresses her horror (9) and disappointment at discovering that she had used another's works and had thus contracted HIV (13). This narrative also emphasizes other risks such as homelessness (4), sex working (3) to fund a cocaine habit (13) and the dangers of social drug (3) use with a treacherous drug buddy who did not alert her to his HIV positive status. She received her HIV diagnosis in prison (12), given her marginalized position she may never had had a blood test for in a treatment service.



Una's account	Analysis
1. I used to go up to [Drugs Treatment Service] and get them [sterile needles]. I always did yea, but then	Commitment to safe drug use
2. I ended up meeting a fella [boy]. He was only a friend ... like, he wasn't a boyfriend or that. He was more like a drug buddy. We used to just go off and get drugs together and	Drug buddy enabling and sharing in use
a. he'd give me a lift up to [...] Street every night and he would wait in the car for me and I'd go off, do whatever and come back and he would give me a lift back up to get the drugs. But I was buying drugs for the two of us. He would go up to the park and have a turn-on and then we'd go back out and make more money and that's the way it was going then, every day. And	Enabled to do sex work to fund shared drug use
3. I was living on the streets, and we were sleeping in the car, like he was letting me sleep in the car. It was a robbed car but he was sleeping in it as well.	Buddy enabling shared marginalisation, sleeping in a stolen car
4. So I didn't know that he had HIV. He had it for 14 years, but he never told me and	Risky relationship
5. we ended up going up to the Park one night to have a turn-on [inject drugs] and I used to burn the end of me works so I'd know that was MY works.	Concern for safe injecting by putting identifier on own syringe
6. And I was dying sick that day and we were just basically rushing to get the drugs into us like, 'cause I was dying sick.	Hunger and hurry and impaired judgement due to being in the throes of withdrawal
7. And he ended up anyway taking my works and giving me his works. And I didn't know. I didn't cop it until I had my turn-on and then until he was having his turn-on and I copped that the works that he had was my works and I looked and I had his works and	Using the other's contaminated syringe
8. I nearly died. I went mad over it like and a few days later his ex-girlfriend called me, and she was saying to me "I hope you're not using after him, 'cause did he not tell you that he has HIV?". And I said, "No". She said "He has it for the last 14 years". She said, "Don't use after him".	Awful horror at discovering that her drug buddy was HIV positive
9. I was getting real agitated because I knew that I was after using his works. I didn't use his works knowing that it was his works. I didn't know that it was his works. Like, he gave me I thought it was my works,	Reemphasizes that she would not knowingly use another's works
10. and he thought – well, I don't know if he knew that he was using my works and I think he did know that I was using his works but he didn't open his fuckin' mouth	Treacherous, reckless buddy
11. I came in here [prison] then and I found out then a few weeks later that I was HIV positive.	HIV diagnosis done in prison

Úna's account	Analysis
12. I knew that I was after catching it from him. I was after being stopped [cocaine] for a while and I was after getting back on the coke then and he was the only one then I was hanging around with and that I was going and getting drugs with. He was the only one that I knew I was after using after because	Links between cocaine use and sex working
13. I was always careful about my needles and all. And I'd always clean up after myself and I'd wrap them up well and I'd throw them out, you know like. I'd never leave them around or	Pride in strict hygiene practices
14. I'd never, like, up in X Apartment Block they'd all sit round the stairs and you'd come up, they'd have their trousers down banging [injecting] their groins and all.	Rejects reckless practices of those who inject in public spaces such as the stairs in apartment blocks
15. I'd never do anything like that.	Asserts own carefulness

**Table 1.**

Yolanda has also contracted HIV and Hep C from sharing needles.

*R: I don't know, I just think I shared with other people.*

*I: Do you think that you might have accidentally used other peoples?*

*R: I don't know. I knew some of the times.*

Carol talked about her lack of knowledge and ignorance of how blood borne viral infections were transmitted

*I: But at that time, because you were very young did you know anything about needles?*

*R: I knew nothing about nothing. What I knew was what I learnt on the street. That's where I learned how to inject from someone else showing me. I knew nothing at the time. I didn't know anything really about hepatitis till I went in for clinics to get off methadone, to get clean completely and that was seven years ago. Other than that I knew nothing about nothing. I knew nothing. Nobody tells you anything. You have Hep C and that's the end of it. There's no one telling you what hepatitis is, or anything like and to get to the doctor, now you ring the doctor and you have to wait three months to see the doctor. When you go into the doctor you're only in there and you could have a list of questions and they only want you in and out real quick because of the way it runs; so many behind you. It's ridiculous.*

*I: So thinking back to that period, would you have shared needles?*

*R: Yes. But I was very fussy, a fussy junkie, people say, but I was. I'd only share with X [my sister] and Y [my child's father] father at the time. Anybody else, no I wouldn't. I was fussy. Even with the prostitution when I had had enough. The last time I had a right cry was when I came home and I was on my knees crying. I never had to score drugs for a few days. I was actually asked to work three or four days non-stop at that time. I was more crying, you know that kind of way. I said I'll never do this again. I'd rather go sick. I'd never try prostitution again.*

Having a baby was a turning point in Yseult's life in that she decided to discontinue the use of illicit substances and stopped engaging in sex work.

*I: And what about blood test for HIV or Hepatitis C?*

*R: Yes I have Hepatitis C. And the last blood test I had was after I had him. But I haven't turned on [injected] or used or anything like that since then, so I don't think I have HIV and I didn't go for any other blood tests. But when he was born I was HIV negative and Hep C positive.*

*I: When was that last test?*

*R: Well he is two now, so it was about two years ago. I don't go into all the risks that I would have taken when I was using.*

Florence felt that using cocaine was the factor which precipitated her throwing caution to the wind and asked her friend to inject her with equipment that turned out to be contaminated.

*R: ... the time I got the hepatitis C, 'cause when I was on the coke, I, it's like, with gear you have a conscience, but with coke you don't and this young fella, now, I wasn't going out with him, we were just friends, but I couldn't get meself, so I needed him to get me, and that's how, I got hepatitis from him. I knew he had hepatitis and I still used, we just threw the works on the table and whichever ...*

Mary was unsure as to whether or not she was HIV positive, one doctor had said she was and another had said she wasn't.

*R: ... when he told me, I nearly collapsed, because at the time I wasn't sleeping around. When I was working I wore condoms. I never shared a needle in my life. I was always scrupulous clean, spotless like. If I had a turn on, I'd have everything ready down to tissue, water, and you know the way if you're injecting with a few friends, and they say do you want me to clean that out, I say oh Jesus, no. I don't know whether I'm sick or not. What do you mean, sick or not? I say I don't know if I have the virus or not I'd say. I'd have a tissue, I'd have a bag. I'd have a tissue in the bag for squirting the watery blood into. I don't know if I have or not. I'm not in denial.... they just told me that they were sorry, because I was after giving 3 signatures for Hepatitis A, B and C. And then it came back with like a print, except it was writ in pen, but photocopied and HIV. But I didn't sign for any HIVs to be done. They told me, "Sorry you haven't any hepatitis (s) but it's very unusual for you to be HIV" because when I went to the hospital they told me they couldn't detect any virus in my body. So that's why I was to get it re-checked because I am still convinced that I haven't got it. And that's why I don't like answering questions about because I'm not sure if I have it or not. One place told me I had it and the other place told me I hadn't. And that's why I went up to James's Hospital*

Angels contracted HIV as a result of being raped.

*R: I still got HIV from the time I was raped down there. You know like. Every time like I came in here and they asked me: 'Did I have hepatitis C test? And they asked me, "Did I want a HIV test? I don't need a HIV test! The only person I used after was me partner". Other than that I never had unsafe sex apart from three times, I was raped. And it comes back and they told me that I had HIV, I couldn't believe it. I asked for another test just to make sure. And then I accused my partner, they wanted to know what I had done. But I asked him for his results, his results came back negative. So the only other person I could lead it to was that ... creep...*

Twelve of the research participants lived in city centre hostels, refuges or emergency accommodation and had experienced homelessness in the past. Due to the lack of a private space, they used semi-public or public environments to administer their injections which increased their risks of unhygienic injecting practices. For example:

*R: ... sometimes I have to take them [drugs] in the toilets of – [drug service]. You're not meant to, you're not allowed to, but people do it, you know what I mean, but I'd use, most of the time I'd use in public toilets. I'd do it on my own ... most of the people that I know are on the streets and you're not going to be going with a group of people somewhere to have a turn on. So you go into the discretion of a toilet where no one sees what you are doing. (Laura)*

*... With me like, I'd have to go to a restaurant toilet or sometimes and do it [inject], or like if I was in a car and drive somewhere to the Park or somewhere and do it, but I wouldn't dare do it on a stairs or just anywhere. (Úna)*

### 13. Condom use

All the men and women interviewed were aware of the risk of contracting and transmitting a range of sexually transmitted infections, including HIV and HCV infection if they did not use condoms. The vast majority reported always using condoms while working. However, most said that although they did not have sex with a customer without a condom, they were aware that other sex workers did. For example, Iseult said:

*R: ... like you'd get a fella that would come up to you: 'Will you have sex without a condom?' and I'd say, 'No way!' and next of all, say a girl that was standing down there, a couple of yards away, she would jump into the car, but I know what he is after asking, and I do be thinking: 'Jesus Christ, she is going to bring that home' and he is bringing that [HIV] home, and then he is going to come back out here next week. And the next stupid girl that gets in the car with him is going to.*

Among the few who reported having unprotected sex with a paying customer, the enticement was always the prospect of getting more money.

*R: But I never ended up catching anything else 'cause I used to say, if they wanted to do it without a johnnie [condom], I used to put up the price. But they'd have to be sorta clean, or if there was someone who sorta that has a bird [girl friend] or something. ... I even let some young fellas use without a condom, but I used to put the price up, sure, they used to think it was worth it ... (Carmel)*

Zoë said she had sex once without a condom with a customer (for €200), but bitterly regretted it afterwards: 'It was the worst thing I ever done because I had to get tests after that.'

Although sex workers may use condoms with their customers, there is also the danger that they will not use condoms in intimate relations with their partners. Pauline reported that her partner would not use condoms thus increasing the risk of transmission of HIV.

*R: My partner hasn't got HIV, only Hepatitis.*

*I: And so do you use condoms when you are having sex with him?*

*R: No to be honest and he said, 'No, he won't!'*

Some participants reported being overpowered by a customer and being raped, and said that this was the only time they had sex without a condom. Angela said, 'I never had unsafe sex apart from three times when I was raped.' Similarly, Molly said, 'I always used my condoms, except for the times that I was either beaten up or whatever.'

#### 14. Men who have paid sex with men

Four men -- Alan, Barry, Colm and Darragh (three were gay and one was heterosexual) -- were interviewed in this study. All were illicit drug users and were either having paid sex with other men, or had discontinued to do so. Men who have sex with men are at risk of contracting HIV (as are those who start having sexual relations in their adolescent (15 years) [24].

Despite embodying all these risk factors, Alan had not contracted any blood borne viral infections. He was working as an escort, and had been homeless since the age of 15. He started smoking cannabis at the age of 12, progressed to ecstasy and then used heroin as a 'come down'. At the time of the interview he was injecting heroin. His choice of drugs was: 'If money was no object, heroin and LSD or cocaine mixed in with heroin and LSD. That would be definitely the choice of drugs'. He was fully cognisant of the dangers of injecting drug use: 'I'd be very, very worried about contracting certain diseases such as hepatitis virus and HIV virus'. Consequently he always uses the needle exchange for sterile needles and ensured to dispose of his needles in a responsible way:

*R: Yes, definitely go to [X needle exchange] and get clean needles. We have "puncture bins". We call them "sin bins". I always carry one of them around with me to make sure that, you know I'd hate the idea of any syringe being left around or the thought of a child pricking themselves on a syringe, you know that kind way. I'd always have a sin bin with me as I call them.*

He describes how he started injecting drugs and sex working.

*I: In terms of the start of that – when do you appear to have started?*



R: I'd say about 15, 16. I couldn't get any money off the Government whatsoever. ... I was homeless. I couldn't get any cash. No cash whatsoever. I was unprepared to go out to one of those fucking boys' homes and be locked up; you know that kind of way. It wasn't an option for me at the time. And plus I was dealing with my sexual orientation as well on top of it which is not an easy task. And to deal with your sexual orientation and actually go out to [a boy's home], it ain't a good idea. You'll end up hurting yourself more or hurting someone else. So, I'd rather hurt myself than someone else, you know that kind of way. So, I would have been about say fifteen, sixteen. ... At that time, that is when I started using heroin intravenously. That's when I started really using heroin intravenously.

I: Do you think in terms of starting that it was more to do with just the fact that you were homeless and had nowhere to live.

R: Well, it was everything. First of all, no stable accommodation, no cash, hungry, low self-image in yourself, you know, all these things contribute to the fact and I just went absolutely insane like. I wasn't the only one. There were a good few of us around, you know.

At the time of the interview, Barry was no longer engaged in sex working and was carving out a new life for himself, he was living independently and was no longer using drugs or alcohol; he was making substantial efforts to live a healthy life with a HIV diagnosis. He commenced alcohol and illicit drug use at the age of 12.

R: I found myself being abused from the age, the very early age of seven up to 14. I started getting into alcohol, drug taking, so I found with the alcohol, the drug taking that it was much easier to go out and sell myself, cos I was already after being abused and had no value on meself. ... Other male prostitutes, would have introduced me to, there was a group of 12 of us, now, there is only 3 of us left alive out of the group, there was 2 actually murdered there, in the field of prostitution, a lot of them died, HIV related and myself, I was diagnosed as HIV in 1990, and that still wasn't me turning point, I was still addicted, I was still in prostitution, and still addicted at that time.

I: But would you think it is separate between, you weren't doing the prostitution in terms of the money for the drinking or the tablets? Were the two connected?

R: No, I was doing prostitution for the money, 'cause I was going off, literally going off where anything that would pay me, and in male prostitution, which is also on the female side, of when you are addicted, it is a whole different story, when you are on the game. Punters and clients are working on your vulnerability, say I am with a punter one night and he is giving me €50, he will see me the next night, and say he'll know I am that desperate, he will offer me a tenner (€10).

He discussed the difficulties for male sex workers in terms of their own low self-esteem, their addiction issues and the difficulties of negotiating condom use with clients.

R: Condoms! And it is still a big issue today, condoms can be introduced into prostitution but most prostitutes with addiction, if they are asked not to use it, they won't use it. It's not an issue on the game, that would be like: "We're addicts", mm people like myself having no value on myself, like "Fuck it, I want to die anyway", like "I don't like this life", "I don't like myself" "I



*don't even wanna be here", you know, you just have no value like, 'cause when I was diagnosed, before I was diagnosed HIV, I was diagnosed negative, and they told me, they said "You're clean", like, it's the tip of the iceberg with you, like you are going to come back positive". Three months later, then I came back positive then.*

Colm was also sexually abused as a young boy of 12 by a twenty year old male neighbour; he started using heroin at the age of 15 and started sex working at 16 to make money to buy drugs. He had contracted HCV before the introduction of needle exchanges.

*R: I tell you, the needle exchanges have really, really been fantastic, because they have changed. I'm telling you a lot of people would be infected with HIV or Hepatitis C only for them. Whoever got that brought in may God bless them, I'm telling you, because I'm Hepatitis C, 'cause I was unlucky because I was using well before they allowed that, pass that agreement, you know.*

He was unsure of his HIV status: 'One time they told me I had it and one time they told me I hadn't got it, I don't know'. There were occasions in the past when he didn't use condoms, but now always does so.

*I: Can I ask you now about safer sex? Were there times when you didn't use condoms?*

*R: There was times when I didn't.*

*I: And do you think that was just at the beginning, years ago?*

*R: That was years ago and a couple of times I didn't and I escaped.*

*I: And what were the circumstances around that? Did the punter ask you not to?*

*R: He gives you plenty of, gives you more money if you don't. But then, then, it's not my fault like I didn't know.*

*I: You know you said you still occasionally would do people? Would they know your status or would you know their status?*

*R: No, I always bally [use a prophylaxis] up, I always use condoms, always.*

In addition to receiving opiate substitution treatment (90 mg methadone) he was also injecting a quarter gram of heroin twice a week and taking both prescribed and un-prescribed benzodiazepines.

Darragh commenced drug use at the age of 12: 'I started off smoking hash, and then taking a few tablets like Upjohns, Roache 5, and things like that and napps then, and start banging up napps'. Unlike the three other men who were gay he was heterosexual and was the father of two children. He was currently in opiate substitute treatment and was prescribed 190 milligrams of methadone, but in addition he was also buying tablets on the street: 'But I do buy tablets as well, like Roache, and Dalmaine, Zimovane and all that'. He had not contracted HIV but was HCV positive. He accessed needles in his local needle exchange and had devised a strategy for when he ran out of needles: 'If I run out, I would end up using one of the old ones that I had, or else I would try and buy a new one off someone else, like you know'.

He was currently sex working in well known places in Dublin city centre:

R: *I'd be going to the Park from about four up to till half nine, ten. After that then you head into town like and you meet people coming out of the [X Pub]. Then you go into the [X city centre] buildings, find a little spot and do what you have to do, like.*

I: *And how many times would you go to the Park?*

R: *Most nights*

I: *And how many clients would you see, how many clients would you see a night?*

R: *In a night? It all depends, sometimes I would meet one client and he would give me €500, just for being with him for half an hour. And then sometimes I would meet a client and I would only get €70 or €80 off him. That's the way it goes, like.*

I: *Would you have regular people?*

R: *Ah yea, yea I have at the moment regular people that ring me. These are all barristers, and cops, top people, you know what I mean?*

If offered more money for sex without a condom, Darragh had a pragmatic and practical reason for agreeing to do so.

I: *In terms of sexual health, do you bring condoms with you or would you bring condoms with you when you go to the Park?*

R: *Mmm, no. They would say: "Ah no, I'm not into using them condoms", this, that and all, they make up an excuse like, they are not interested.*

I: *Have you fucked anybody without a condom?*

R: *I have, yea.*

I: *And you can't charge more though for that, can you?*

R: *You can, yea, they say I'll give you x amount if you do it without the condom, you do be saying to yourself, that extra few quid will save me coming up tomorrow like, you know what I mean?*

## 15. Discussion

The three categories of high risk behaviour (sex working, injecting drug use, men having sex with men) identified by the UNAIDS *Report on the Global AIDS Epidemic 2010* associated with the transmission of HIV are also the risk behaviours which emerged from the analysis of our data. These risks are similar in low, middle-income and higher income countries. Engaging in unsafe injecting (and sexual) practices facilitates the spread of the HIV and HCV viruses [25, 26]. For the participants in this study, blood borne viral infections (HIV, HCV) were transmitted as a result of accidents (sharing works, having a friend administer the injection, unwittingly using another's works, re-using old syringes), and of ignorance of the

consequences of injecting drug use. Although some respondents were aware of the dangers of using another's injecting equipment, their judgement was impaired due to: being 'strung out' (suffering withdrawal symptoms), to administering the injection in a rushed unsterile environment, and to the distractions and confusion that can occur when injecting in the company of friends/drug buddies and allowing friends to administer the injection to them.

In a systematic review and meta-analysis of interventions to prevent Hepatitis C virus infection in injecting drug users, it was found that a complex of interventions worked best to reduce the incidence. For example combining counselling with strategies such as -- enabling the injector to maintain control over the injection process by not injecting in chaotic and rushed settings; maintenance in opiate substitution treatment of  $\geq$  than 60 mg a day; and using sterile syringes obtained from a syringe exchange program [27]. In our study, most of the participants were accessing some of the elements in such a treatment complex. However, their attempts to reduce their risks were exacerbated by the fact that many were homeless and spent much time on the streets and were likely to inject in public places and spaces which lacked the necessary hygiene. Only three of the seven who reported being HIV positive were receiving anti retroviral treatment; two others were unsure of their HIV status. They are a high risk group in terms of passing on the virus to others. Other research has found that sex workers who are injecting drug users are associated with poorer engagement with Opioid Agonist Treatment and retention in treatment[28]. Other jurisdictions[24] in Europe have been successful in reducing the rates of new infections among people who inject drugs: for example in Switzerland and in the Netherlands, HIV infections have almost been eliminated (at most 5% of new infections in 2007 and 2008 respectively) amongst those who engage in 'social' drug use, involving several people using the same contaminated injecting equipment. Whereas in Ireland, the rate of new infections for intravenous drug users accounted for 7.9% of all newly diagnosed cases in 2009. And in this small study the rate of HIV infection among the 35 people interviewed was 21 per cent.

For sex workers and their clients, unprotected sex increases the risk of contracting and transmitting a range of sexually transmitted infections (STIs), including HIV [29] and HCV infection [30]. In this study, sex workers were aware of the importance of protected sex and were generally proactive in the use of condoms with clients. Offers of increased money for sex without a condom weakened their resolve. This suggests that it is clients rather than sex workers who are more prepared to take the risk of contracting HIV. The power dynamics and the inequalities in physical strength between a sex worker and a customer can rob the sex worker of the opportunity to negotiate condom use [31]. Gender violence against women and rape also led to the transmission of the HIV virus. Rape was a common experience for the sex working men and women. Enhanced policing practices could help to reduce the possibilities of sex workers being raped, and therefore of contracting HIV through rape. The latest Home Office Review of Effective Practice document and the new ACPO (Association of Chief Police Officers) Strategy & Operational Guidance for Policing Prostitution and Sexual Exploitation [32] mention's the partnership work in Merseyside of the UK Network of Sex Work Projects. It endorses taking a harm reduction approach to prostitution by introducing schemes such as the 'Ugly Mugs' scheme which can help to improve safety by allowing sex workers to report

incidents of violence, which in turn can enable information about dangerous individuals to be disseminated to other sex workers or be used to report a crime to the police for investigation.

In this study, the male interviewees, because they were men who have paid sex with other men, constitute a high risk group for transmitting blood borne viral infections, particularly if they are using used syringes, and are not practicing safe sex.

## 16. Conclusion

Despite the existence of harm reduction interventions such as opiate substitution treatment, needle exchanges for drug users who engage in sex working, this population remain a high-risk group for contracting blood borne viral infections and death. In Ireland, some injecting drug users and other young people are still taking risks as exemplified in the recent surveillance statistics[11]. The introduction of safe injecting spaces and places might enable intravenous drug users to inject in more hygienic and safer settings thereby reducing the risk of transmission. Health messages displayed in public places might inform the intravenous drug users of the harmful consequences of unhygienic injecting practices and sharing equipment and may therefore increase their awareness of the inherent risks. Marginalized, vulnerable young people such as those leaving residential care in the justice or social welfare systems need to be targeted and informed of the dangers of illicit drug use and sex work. Health messages should also target customers and potential customers of sex workers, their insistence on not wearing a condom during sexual intercourse is putting them and whoever else they are having sex with at risk.

A change in how drug use and addiction is perceived could result in a change in the risk environment in Ireland. For example, in Portugal [33], since heroin use has been decriminalised, public perceptions have changed from viewing opiate users as criminals and addicts to viewing them as sick people in need of treatment. In Switzerland and the Netherlands successful harm reduction interventions have reduced the rates of new infections among people who inject drugs

Changes to the risk environment in Ireland in terms of policy, perception and policing could lead to the creation of an enabling environment for injecting drug using sex workers so that changes in individual behaviour could be brought about by enhanced structural interventions [34]. This approach advocates all forms of social interventions (improved education, greater needle exchange coverage, enhanced condom provision) which are extra-individual – in other words interventions that change the context within which risks are produced and reproduced [12].

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