MOBILE SEXWORKERS AND STI/HIV RISKS

By

N. Timoshkina, A. Lombardo, L. McDonald

INTRODUCTION

Women in the sex trade are commonly perceived to be at a higher risk for sexually transmitted infections (STI) and have been historically blamed for the spread of diseases. Public concerns and indignation against sex trade workers have increased dramatically in the past two decades in light of the HIV/AIDS epidemic. Activists for sexworkers’ rights have long argued that, in the industrialized countries, the majority of female sexworkers practice safe sex and are not a high risk group for STIs/HIV (e.g., McKeganey & Barnard, 1996; Morgan-Thomas, Brussa, Munk, & Jirešová, 2006). However, as will be discussed further in the text, reliable statistical data supporting this argument is limited and rather dated. Furthermore, situations vary in many parts of the developing world where STI/HIV prevalence among commercial sexworkers is significantly higher than among the general population (UNAIDS, 2004). Risks of contracting STIs/HIV are also higher for transgender/transsexual and male sexworkers (UNAIDS, 2004; UNAIDS & WHO, 2005) who may have sex with both men and women, thus representing a risk for both homosexual and heterosexual STI/HIV transmission (UNAIDS, 2002). Sexworkers who inject drugs are especially vulnerable to STI/HIV risks (UNAIDS, 2004; UNAIDS & WHO, 2005). In fact, the overlap between the commercial sex trade and intravenous (IV) drug use is considered by many experts to be the primary driving force behind the spread of the HIV epidemic (UNAIDS, 2004; UNAIDS & WHO, 2005).
Active internal (mostly from rural to urban areas) and transnational migration of both sexworkers and their clients exacerbate the problems identified above. A number of studies found that long distance truck-drivers, seasonal agricultural workers, migrants working in the mines, and other temporary migrants who frequently used services of sexworkers had higher prevalence of STIs/HIV (Population Information Program, 1996; UNAIDS & WHO, 2004, 2005). In recent years, many countries around the world also have seen a dramatic increase in the number of foreign women entering the sex trade. Each year, thousands of females, who travel from poorer to richer countries in search of a better life and adequate sources of income for themselves and their families, end up in the sex industry. Many women are trafficked into the sex trade by criminal structures though the use of violence, abuse of authority, debt bondage, and deception; others enter the trade voluntarily, but are often unaware of the harsh working and social conditions that await them in the host countries, or the degree of control that would be exercised over them (Wijers & Lap-Chew, 1997).

The presence of migrant women in the sex trade has altered all aspects of the industry, and posed a serious challenge to immigration and law enforcement systems of the host nations. The fact that thousands of women and children are trafficked from and within regions with rapidly growing HIV/AIDS epidemics (e.g., Sub-Saharan Africa and Eastern Europe) is a matter of serious international concern, especially considering that mobile sexworkers often function as “bridge population groups” linking high and low STI/HIV prevalence groups (Hamers & Downs, 2003) that pose potentially explosive health risks.

Migrant sexworkers remain largely outside of the legal, medical and social services structures. Undocumented status, poor language skills, absence of support networks, limited understanding of foreign laws and regulations, and subjection to xenophobia result in the
extreme marginalization of migrants, putting them at a greater risk of abuse and exploitation. In addition, migrant sexworkers are more likely to be affected by the negative social dynamics of the sex trade, marked by discrimination on the basis of race, nationality, class, age, and specific place in the industry’s hierarchy (Morgan-Thomas et al., 2006). All this makes migrants working in the sex industry particularly vulnerable to STI/HIV (Matteelli & El-Hamad, 1996; Morgan-Thomas et al., 2006; UNAIDS, 2005).

This chapter addresses mobile sexwork and the STI/HIV risks associated with it. The extent of trafficking and mobile sexwork are discussed from a global perspective sexworkers and data on STI/HIV prevalence rates among sexworkers worldwide are highlighted in order to provide the context for STI/HIV and sexworkers. The chapter continues on to mobile sex work and STI/HIV risks in particular, concluding with a discussion on responses to STI/HIV among sexworkers that have been undertaken thus far, and what other responses are required.

THE EXTENT OF TRAFFICKING AND MOBILE SEX WORK

There are many configurations, views and definitions of trafficking. Some experts believe that only those forced into the sex trade under false pretences should be viewed as trafficked; others perceive coercion as irrelevant and place emphasis on the issue of sexual exploitation, thus considering all sexworkers to be trafficked to one extent or another (Andrees & van der Linden, 2005). On the other side of the debate are sexworkers’ rights activists who argue that the term “trafficking” should be scrapped altogether because it carries negative connotation and portrays migrant sexworkers as passive objects of exploitation rather than active subjects who control their own destiny and have a human right to work in the sex industry (Doezema, 1999). The issue is further complicated by the fact that sexworkers’ personal circumstances change and evolve over time. For example, at the initial stage of their involvement in the sex trade, some
workers experience forceful trafficking, but later manage to escape their exploitative situations and remain in the trade on their own terms (Andrees & van der Linden, 2005). There are also disagreements among experts on whether the term “trafficked” should be used to refer only to those sexworkers who are transported across national borders, or should be applied to both international and internal migrants. In this context, the term “mobile sexworkers” seems to be most appropriate as it encompasses both international and internal migration, and both forceful and voluntary involvement in the trade. Due to the lack of consensus on the issue; however, the terms “trafficked”, “migrant” and “mobile” sexworkers are often used in the literature interchangeably.

The United Nations (2000) estimates that as many as five to seven million people are being trafficked annually worldwide. Women and girls comprise about 80% of the trafficking victims; up to 50% of these females are minors, and 70% are believed to be trafficked into the sex industry (USDOS, 2004, 2005). Western Europe, North America, and Australia are among the main destination regions for trafficked women and children for the purposes of the sex trade.

Conservative calculations placed the number of trafficked children in 2000 at approximately 1.2 million (IPEC, 2002). About 1.8 million children were in forced prostitution and pornography worldwide, especially in Latin America, the Caribbean, the Asian-Pacific region, and in developed economies (IPEC, 2002; UNICEF, 2005). It has been suggested that the number of children in prostitution could be as high as 10 million (Willis & Levy, 2002).

In most states of the European Union (EU), the number of migrant sexworkers, representing at least 50 different nationalities, is already much greater than that of the local ones (Morgan-Thomas et al., 2006). In Spain, for example, 82% of all sexworkers are migrants: 54% of them come from Africa, 33% from Latin America, 9% from Central Europe, and the rest
mainly from Asia (TAMPEP, 2004). In addition, foreign nationals represent half of female
transsexual and 27% of male sexworkers in the country (Rodriguez-Arenas, 2002). In the
Netherlands, migrants, who come primarily from Eastern Europe, account for 80% of those
working in all types of the sex industry (TAMPEP, 2004). In Germany, migrants comprise about
60% of sexworkers (Morgan-Thomas et al., 2006). In France, in 2002, an estimated 57% of
sexworkers were migrants: 43% of them were from Africa, 42% from Central and Eastern
Europe, 14% from Latin America, and 1% from Asia (TAMPEP, 2004). In Italy, the majority of
female sexworkers are trafficked from Africa (with almost 60% of all migrant sexworkers being
from Nigeria) and Eastern Europe (TAMPEP, 2004). In Greece, in 1999, out of estimated 10,000
non-registered sexworkers, 6,000 were believed to be migrants (EUROPAP, 2000).

Distribution of nationalities and patterns of mobility in the European sex trade are
becoming increasingly complex, largely due to the expansion of the E.U. and frequent changes in
immigration regulations and visa regimes. Until three years ago, for instance, Albanian
sexworkers could be found almost exclusively in Italy and Greece, while today there are fewer of
them in Italy and more in Belgium, France and Germany (Morgan-Thomas et al., 2006). Almost
half of the 100 migrant sexworkers (mainly from Eastern Europe and Latin America)
interviewed in Frankfurt, Germany, and Antwerp, Belgium, reported that they had worked in as
many as 13 different countries, both within and outside the EU (van der Helm, 2002).

From 14,500 to 17,500 persons, primarily women and children, are trafficked into the
U.S. annually (USDOS, 2005). Most come from Southeast Asia, Latin America and the former
Eastern Bloc countries, and end up in the commercial sex trade (O’Neill-Richard, 1999). At least
600 foreign women and girls are trafficked into the Canadian sex trade each year, and up to
2,200 migrants are smuggled to the U.S. to toil in brothels, sweatshops, etc., yet these numbers
may be only a fraction of the actual total (Canadian Press, 2004). Thailand, Cambodia, the Philippines, Russia and other Eastern European nations, Korea, and Malaysia serve as the principal source regions for trafficking in persons to Canada (Royal Canadian Mounted Police, 2004). Within the country, hundreds of Aboriginal women are trafficked from reserves to large urban centers, such as Vancouver.

Approximately 1,000 women are trafficked annually into prostitution in Australia (Australian Centre for the Study of Sexual Assault, 2005). These women originate mainly from Thailand, as well as China, Indonesia, Malaysia, Vietnam, Columbia, and the former Soviet Union; many women holding Thai passports are believed to have been previously trafficked to Thailand from Myanmar (Australian Centre for the Study of Sexual Assault, 2005).

Active migration of sexworkers – both forced and voluntary – also occurs within the developing world. In Asia, for example, thousands of female and male Nepalese sexworkers go to work in India (Simkhada, 2002); large numbers of women from Cambodia, Laos, Myanmar and Vietnam work in brothels in Thailand, while sexworkers from Thailand and the Philippines work in Japan and Singapore (Population Information Program, 1996). China has become a destination country for trafficking in women and girls from Burma, North Korea, Vietnam, and Russia (USDOS, 2005). A similar situation exists in Africa. For instance, many women from Côte d'Ivoire work in prostitution in Ghana (Population Information Program, 1996), while both female and male sexworkers from Ghana, as well as Burkina Faso, Mali, Liberia and Nigeria are involved in the trade in Côte d'Ivoire (Family Health International, 2005; Ghys, P.D., Diallo, M.O., Ettiegne-Traore, V., Kale, K., Tawil, O., Crael, M., Traore, M., Mah-bi, G., De Cock, K.M., Wiktor, S.Z., Laga, M., & Greenberg, A.E., 2002), while sexworkers from Lesotho routinely cross the border to South Africa (Robinson & Rusinow, 2002). In Cotonou, capital of
Benin, approximately 40% of commercial sexworkers are migrants from the surrounding countries of Nigeria, Togo, Ghana, and the Ivory Coast (African AIDS Awareness Campaign, 2005). Extremely high mobility of sexworkers has been recorded also within Latin America, particularly among Central American countries (Belize, Guatemala, El Salvador, Honduras, Nicaragua, Costa Rica, and Panama) and Mexico (Dreser, Caballero, Leyva, & Bronfman, 2002).

Since 1989, there has been a noticeable shift in the sources of supply to the global sex industry. With the collapse of the Socialist regimes and wars in the Balkans that produced substantial numbers of migrants and refugees, countries of the former Eastern Bloc became the primary sender states, supplementing and replacing previously significant sources of women from Asia and Latin America (Caldwell, Galster, & Steinzor, 1997; IOM, 1998). It has been suggested that two-thirds of the estimated number of women and children annually trafficked for prostitution worldwide come from Eastern and Central Europe (Hughes, 2000; McClelland, 2001). According to the U.S. government sources, every year over 100,000 women are trafficked from the former Soviet Union, with an additional 75,000 from Eastern Europe (Miko, 2000). Some experts argue that the former Soviet republics – Moldova, Ukraine, and Russia in particular – have replaced Thailand and the Philippines as the epicenter of the global business in trafficking women (Baker, 2002; IOM 2001; Miko, 2000).

**STI/HIV Prevalence Among Sexworkers** There are no routine statistical data on health status of commercial sex trade workers. This could be explained by the clandestine nature of the sex trade that makes this population highly marginalized and hard to reach, especially when it comes to migrant sexworkers, most of whom work in the host countries illegally. Studies on STI/HIV prevalence among sexworkers are scant and usually based on small, non-representative samples in select cities. The numbers of infected sexworkers vary greatly, not only from country to
country but from city to city, and the available studies generally do not differentiate between local and migrant sexworkers. Some highlights of STI/HIV prevalence rates among sexworkers around the world are noted below (a more comprehensive review of these data is beyond the scope of this chapter).

**Africa**

In Africa, the lowest HIV prevalence among commercial sexworkers was recorded in the capital of Madagascar – 0.1% in 2001 (UNAIDS & WHO, 2004), and was also low among sexworkers in Morocco (2.3 % in 2003) and Sudan (4.4%) (Sudan National AIDS Control Program, 2004).

In Mauritius, HIV infection levels among female sexworkers were estimated at 3-7% (UNAIDS, 2005). In Algeria, these levels ranged from 1.7% in the northern city of Oran to 9% in Tamanrasset, in the south, where they rose sharply from 2% in 2000 (UNAIDS & WHO, 2005).

Infection levels of 21% were recorded in 2002 among female sexworkers in the capital of Burkina Faso, Ouagadougou, which was a steep decline from 59% in 1994 (Kintin et al, 2004 cited in UNAIDS & WHO, 2005). In 2000, HIV prevalence stood at 21.0% in the capital of Mali and at 25.5% in the capital of Kenya (UNAIDS, 2004).

In other areas, HIV prevalence among sexworkers is significantly higher. Prevalence in the range of 30-40% has been reported among sexworkers in Senegal (UNAIDS, 2004; Gomes do Espirito Santo & Etheredge, 2005), Guinea (UNAIDS, 2004), Angola and Niger (UNAIDS & WHO, 2004). Approximately half of the commercial sexworkers in South Africa are believed to be HIV-positive (UNAIDS, 2004). The prevalence rate is 60.5% for HIV in Porto-Novo, the capital city of Benin (UNAIDS, 2004); the 1999 data on female sexworkers in the city of Cotonou also showed prevalence rates of 40.6% for HIV, 20.5% for gonorrhea, 5.1% for Chlamydia, and 1.5% for syphilis (Alary et al., 2002).
The highest HIV prevalence on the African continent was found among sexworkers in Sierra Leone (71%) and urban sexworkers in Ethiopia (74%) (UNAIDS, 2004). In Ghana as well, surveys in 1999 found HIV prevalence rates of 74.2% among street-based and 27.2% among home-based sexworkers in Tema and Accra; a very high rate of 83% was reported among sexworkers in Kumasi (UN-OCHA Integrated Regional Information Networks, 2005).

**Asia**

Arguably the most comprehensive data on STI/HIV prevalence among sexworkers come from Asia. In the capital of Laos, HIV prevalence among sexworkers was recorded as low as 1.1% in 2001 (UNAIDS, 2004). In China, in the capital city of Beijing, prevalence was also extremely low – 0.2% in 2000 (UNAIDS, 2004). Yet, prevalence is higher in male sexworkers: according to a recent survey, 5% of male sexworkers in the southern city of Shenzhen were HIV-positive (UNAIDS & WHO, 2005). A study on female sexworkers conducted in Guangzhou in 1998-1999 also found high STI prevalence: 32% for Chlamydia, 14% for syphilis, 12.5% for trichomoniasis, and 8% gonorrhea (van den Hoek et al., 2001).

In Bangladesh, HIV prevalence in urban female sexworkers has stayed between 0.2% and 1.5%, and prevalence of other STIs has declined to under 10% in 2002 (Ministry of Health and Family Welfare Bangladesh, 2004). In the capital city of Dhaka, however, HIV prevalence among sexworkers was 20% in 2004 (UNAIDS, 2004). In addition, as of 2001, about 43% of female sexworkers and 18.2% of male sexworkers in Central Bangladesh had syphilis (The World Bank Group, 2003).

In the Malaysian capital of Kuala Lumpur, HIV prevalence of 10% was recorded among sexworkers (an increase from 6.3% in 1996) (UNAIDS & WHO, 2004). In Thailand, the first country to implement the 100% Condom Use Prevention Program, HIV prevalence among
brothel-based sexworkers has declined from 43% in 1997 to just over 10% in 2003 (UNAIDS, 2004; UNAIDS & WHO, 2005), while in the capital it was as low as 2.6% in 2002 (UNAIDS, 2004). HIV prevalence of 16% was found in sexworkers in Vietnam, although levels of infection in the cities of Hai Phong, Ho Chi Minh City, Hanoi and Can Tho were higher (Ministry of Health Viet Nam, 2005). In Cambodia, HIV prevalence among brothel-based sexworkers dropped from 43% in 1998 to 21% in 2003 (Saphonn et al., 2005 cited in UNAIDS, 2005; National Center for HIV/AIDS, Dermatology and STIs, 2004).

In Indonesia, HIV infection levels among female sexworkers vary widely – from 0% in the capital of Jakarta to 8–24% in other parts of the country (UNAIDS, 2004). HIV prevalence among transgender sexworkers (waria) in Jakarta rose and was nearly 22% in 2002 (UNAIDS, 2004); among male sexworkers, it was approximately 4% (Pisani et al., 2004; Riono & Jazant, 2004). Studies conducted in 2003 also found that an average 42% of sexworkers in seven cities were infected with gonorrhoea and/or Chlamydia (Monitoring the AIDS Pandemic Network, 2004).

In Myanmar, HIV prevalence among sexworkers has remained steady around 25% since 1997; in 2004, 27% of sexworkers (one in four) were found to be HIV-positive (UNAIDS & WHO, 2005). In the capital of Nepal, HIV prevalence among sexworkers ranged from 17.0% to 36% in 2002, while in other urban areas it could be as high as 36% (UNAIDS, 2004; UNAIDS & WHO, 2005). In Pakistan’s main trading city of Karachi, 36% of male sexworkers were found to be infected with syphilis (Ministry of Health Pakistan, Department for International Development, & Family Health International, 2005); HIV prevalence, however, was 0% (Baqi et al., 1999).
In various parts of India, HIV prevalence rates among sex trade workers vary considerably. For example, in Kolkata’s Sonagachi red-light district (in West Bengal), HIV prevalence among commercial sexworkers was under 4% in 2004 (UNAIDS & WHO, 2005). In Mumbai, however, HIV infection rates among female sexworkers are extraordinarily high – from 52% to 70% (AVERT, 2005; National AIDS Control Organization, 2004).

Oceania

Statistics on STI/HIV prevalence among sexworkers in Oceania are scant. Commercial sex trade workers in Australia reportedly have the lowest rate of HIV/AIDS amongst sexworkers in the world, and virtually all cases of HIV infection are attributed to IV drug use. To date, no cases of HIV transmission from sexworkers to clients have been recorded in the country (Scarlet Alliance, 2005). A 1991-1998 study in Sydney found an HIV prevalence rate of 6.5% among 94 male sexworkers, a rate higher than that of female sexworkers (0.4%), but lower than homosexual men who were not sexworkers (23.9%) (Estcourt et al., 2000). In the capital of Papua New Guinea, HIV prevalence among sexworkers was estimated at 16.0% in 2000 (UNAIDS, 2004), while studies in East Timor in 2003 found that one quarter of commercial sexworkers in Dili had gonorrhoea and/or Chlamydia, and 60% were infected with HSV2 (UNAIDS & WHO, 2005).

Western Europe

There are very few recent statistics on STI/HIV prevalence among sexworkers in Western Europe as most data come from studies conducted between the 1980s and early 1990s. The available estimates suggest that HIV prevalence among female sexworkers in the region is low, yet the rates are generally higher among male, drug-injecting, and transgendered/transsexual sexworkers.
One survey of 896 female sexworkers in nine European nations found average HIV prevalence of 5.3%-31.8% for IV drug users and 1.5% for non-drug users (European Working Group on HIV Infection in Female Prostitutes, 1993). In Greece, in the mid to late 1990s, an HIV prevalence of as low as 0.4% was recorded among registered sexworkers and 0.22% among non-registered workers (EUROPAP, n.d.). In Vienna, Austria, only 0.8% of sexworkers were HIV positive in 1986, and all of the infected workers were either IV drug users or had drug-injecting sexual partners (Kopp & Dangl-Erlach, 1986 cited in Hawk, 1998).

Estimates from the Netherlands vary; a small study of 32 non-drug using female sexworkers in Amsterdam, found no cases of HIV; in contrast, 24% of a group of 25 transsexual/transvestite sexworkers were HIV-positive (Gras et al., 1997 cited in Hawk, 1998). A larger study carried out in Rotterdam in 2002-2003 found that 7% of sexworkers and almost 12% of those working the streets were HIV-positive (UNAIDS & WHO, 2004). In the U.K., HIV prevalence was very low even among drug-injecting sexworkers. Studies on IDU sexworkers in Glasgow, for instance, found prevalence of no more than 2.5% (Green & Goldberg, 1993; McKeganey et al., 1992). Among London-based male sexworkers, however, HIV prevalence was around 25% (Tomlinson, Hillman, Harris, & Taylor-Robinson, 1991).

Estimates on HIV infection in female sexworkers in Belgium range from 0.3% to 1.16%, and from 17.4% to 38.5% for male sexworkers (EUROPAP, 2000). A recent study in Antwerp, Belgium, found an HIV prevalence rate of 10.8% among 120 male sexworkers (Leuridan, Wouters, Stalpaert, & Van Damme, 2005). In Spain, estimates on HIV prevalence among female sexworkers vary between 1.2-12.6% for non-drug users and between 18.6-45% for IDUs (EUROPAP, 2000). A study of 418 male sexworkers from 19 Spanish cities, conducted between
2000 and 2002, found HIV prevalence rates of 12.2%; 67% of these male sexworkers were of foreign origin (Belza, 2005).

**Eastern Europe**

Data on STI/HIV prevalence rates among sexworkers in Eastern European countries is largely unavailable. In the past several years, however, countries of the former Soviet Union have seen a dramatic increase in the number of people living with HIV, with the commercial sex trade and drug injection being the driving forces behind the spread of the epidemic.

Low rates of HIV prevalence have been reported among sexworkers in Lithuania (0.5%) (UNAIDS, 2004), and in Poland and the Czech Republic (under 1%) (EuroHIV, 2003). Studies on street-based sexworkers in Moldova found an HIV prevalence of 5% (WHO Regional Office for Europe, 2004).

In Russia, HIV prevalence of 14% and 15% was found among sexworkers in the cities of Moscow and Ekaterinburg respectively (WHO Regional Office for Europe, 2004; EuroHIV, 2003). For drug-injecting female workers; however, the figures are believed to be considerably higher (Smolskaya et al., 2004a cited in UNAIDS & WHO, 2004). In the Ukraine, HIV prevalence among non-injecting female sexworkers in the cities of Odessa and Donetsk is estimated at 17%, while 35%-67% of drug-injecting sexworkers in cities are believed to be HIV-positive (Ukrainian AIDS Center, 2005).

In the former Soviet republics of the Caucuses and Central Asia, HIV infection rates among sexworkers also vary: 4.6% in Kazakhstan (EuroHIV, 2005; UNAIDS & WHO, 2004); 6%-11% in Azerbaijan (WHO Regional Office for Europe, 2004); 7.5% in Armenia (UNAIDS, 2004); and 10-28% in Uzbekistan (Todd et al., 2005 cited in UNIADS & WHO, 2005).

The highest STI rates among sexworkers in Eastern European region were reported in
Bulgaria: according to one study, 43% of female sexworkers had evidence of one or more STI (Tchoudomirova, Domeika, & Mardh, 1997).

**Latin America and the Caribbean**

HIV prevalence among sexworkers in Latin America and the Caribbean is generally low, although the commercial sex trade is believed to be the driving force behind the spread of the epidemic in the region (UNAIDS, 2004). HIV prevalence has been reported at only 0.3% in Mexico in 1999 (UNAIDS, 2004); 0.8% in Colombia in 2001-2003 (UNAIDS & WHO, 2005); 0.5-1% in Bolivia in 2002 (Carcamo, 2004 cited in UNAIDS & WHO, 2005); 1% in Nicaragua; and 2% in Panama (UNAIDS & WHO, 2005). In Ecuador, the 2002 prevalence was under 2% (UNAIDS & WHO, 2005), although in the capital city it was as high as 14% in 2002 (UNAIDS, 2004). In the Dominican Republic, HIV infection levels range from 3–4% among sexworkers in Santo Domingo to 12.4% in the southern province of Bani (UNAIDS, 2004; UNAIDS & WHO, 2005).

In most Central American nations, street-based sexworkers are at least twice as likely to be infected with HIV as those working in brothels and out of hotels and bars (UNAIDS & WHO, 2004). In Guatemala, for example, HIV prevalence among street sexworkers was recorded at 15%, compared to 3.6% among sexworkers in brothels; in Honduras, these levels were measured at 14% and 4% respectively (UNAIDS & WHO, 2004). HIV prevalence among street sexworkers in San Salvador and Puerto de Acajutla, El Salvador, was 16% (UNAIDS & WHO, 2005). One of the highest HIV infection levels among female sexworkers in Latin American region was found in Suriname – 21% in 2005 (UNAIDS & WHO, 2005).

In Brazil, levels of HIV infection among female sexworkers are estimated at 6.1% (Chequer, 2005 cited in UNAIDS & WHO, 2005), with higher prevalence recorded in those
working in the cities of San Paolo and Santos: overall, 7% of sexworkers there were HIV-positive, but among those living in slums and especially among illiterate women, HIV levels reached 18% and 23% respectively (Gravato, Morell, Areco, & Peres, 2004 cited in UNAIDS & WHO, 2004). Levels of HIV prevalence among transvestite sexworkers in Brazil have been reported between 60.7 – 63% (Inciardi & Surratt, 1997 and studies cited therein).

North America

In Canada, there are currently no official estimates on STI/HIV prevalence among sexworkers, but there is also no existing epidemiological evidence to show regular transmission of HIV from sexworkers to their clients (Canadian HIV/AIDS Legal Network, 2005). The situation could be more complex in Vancouver’s Downtown Eastside – an area that evidently has the highest HIV infection rate in North America, and is plagued by chronic poverty, crime and drug use (Duddy, 2004). It has been reported that female sexworkers in that area, almost 70% of whom are Aboriginal, have been disproportionately affected by the local AIDS epidemic (Duddy, 2004).

The available information on HIV prevalence among sexworkers in the United States is rather dated. One study conducted in the 1980s, tested 1,396 female sexworkers in six American cities and found HIV seroprevalence ranging from 0% to 47.5% depending on the particular city and level of IV drug use (CDC, 1987). Research on brothel-based sexworkers in Nevada showed that, as of 1993, out of 20,000 HIV tests, no woman tested positive (Albert et al., 1995). Studies on male sexworkers conducted in the late 1980s found seroprevalence from 11% to as high as 50% (Bastow, 1995; Elifson, Boles, & Sweat, 1993; Simon et al., 1994). A study of 53 transvestite sexworkers in Atlanta, Georgia, between 1990 and 1991, found highly elevated rates of HIV among the transvestite sexworkers versus nontransvestite sexworkers (68% vs. 27%, respectively) (Elifson, Boles, Posey et al., 1993).
Mobile Sexwork and STI/HIV Risks

The presence of migrants in local sex trade industries of many nations is not a temporary or static phenomenon but a rapidly growing trend. Yet, in most countries, current legal and social policies in the areas of sexwork, immigration, and STI/HIV prevention do not reflect this. Basic human rights of migrant sexworkers are routinely violated. In most parts of the world, prostitution is an illegal and highly stigmatized activity, and there exist discriminatory, often repressive policies and attitudes towards persons with HIV/AIDS. Mandatory registration and medical check-ups of sexworkers in countries where prostitution is legalized (such as Greece and southern Germany) have proven to be oppressive and counterproductive, as they drive sexworkers further underground (EUROPAP, 2000). Many countries also have strict laws against illegal migration, which put migrant sexworkers at high risk of arrest and deportation. Migrants are also subjected to xenophobia and discrimination. In the Netherlands, for instance, where prostitution is legalized and regulated, a new law was introduced in October 2000 that prohibits owners of brothels to employ women from non-EU countries and who have no permit to stay (van der Helm, 2002). As a result, migrant sexworkers are becoming increasingly dependent on international criminal structures/traffickers, which directly affects their already unenviable working conditions. Moreover, it forces sexworkers to frequently move between various cities and countries to avoid being caught, thus contributing to the potential spread of infections.

Many experts consider migrant sexworkers to be particularly vulnerable to the risks of STI/HIV transmission (EUROPAP, 2000; Matteelli & El-Hamad, 1996; Morgan-Thomas et al., 2006; UNAIDS, 2005). Even when migrant sexworkers come from the areas where STI/HIV prevalence is lower than in their host countries, they face an increased risk for infections for several reasons. First, many migrants are new to the sex trade and lack awareness of potential
health risks and safe sex practices. Second, illegal and clandestine status of most foreign
sexworkers prevents them from accessing health-care services and makes them more vulnerable
to abuse from clients who refuse to use condoms. Finally, due to their desperate economic
situation, migrants are more likely to engage in unprotected sex if clients are willing to pay more
(Matteelli & El-Hamad, 1996; Morgan-Thomas et al., 2006). Indeed, higher risks of STI/HIV in
migrant sexworkers “have been associated with the least favorable working conditions, the
highest financial needs, the lowest levels of well-being and job satisfaction and greater
experience of violence and victimization in the sex industry” (EUROPAP, 2000, p. 6).

A study by van Haastrecht and associates (1993) that tested 201 non-drug using female
sexworkers in the Netherlands found that although HIV prevalence among them was very low
(1.5%), all HIV-infected women were recent migrants from AIDS-endemic countries. In Madrid,
Spain, the 1998-2003 data on immigrant male and female sexworkers, most of who came from
Sub-Saharan Africa, the region with the most serious HIV/AIDS epidemic in the world, showed
that 5% of the workers were HIV-positive (UNAIDS & WHO, 2004). In addition, an increase in
syphilis among sexworkers in some European countries, such as Portugal, has been linked to
migration from the former Eastern Bloc where there are substantial epidemics (EUROPAP,
2001).

The fact that infected migrant sexworkers return or are deported to countries that do not
have adequate STI/HIV treatment programs only adds to the problem. In Ghana, for instance,
“many rural women who left for Côte d'Ivoire and became sexworkers brought HIV home with
them to their villages, which now have a high prevalence of HIV” (Population Information
Program, 1996, p. 11). Rates of HIV infection among Nepali sexworkers under the age of 18
working in Mumbai, India, have been recorded as high as 72% (UNAIDS, 2000), and now in
many parts of Nepal returnees from Mumbai are automatically stigmatized as AIDS carriers (Simkhada, 2002).

The overlap between the mobile sex trade and IV drug use is a serious driving force behind the spread of the HIV epidemic. For example, in Rome, Italy, high rates of HIV prevalence—74% (Gattari et al., 1992 cited in Inciardi & Surratt, 1997)—among South American transsexual sexworkers were significantly associated with the use of injected drugs (Spizzichino, 1993 cited in Matteelli & El-Hamad, 1996). Further, studies conducted between 1997 and 1998 found an HIV prevalence rate of 20% among 40 transvestite sexworkers in Rome, 65% of who were from South America (Spizzichino et al., 2001; Verster et al., 2001).

Conclusions
This chapter has provided an overview of the changing nature of trafficking and mobile sexwork, and how mobile sexworkers, in particular, are impacted by STIs/HIV. The intersection of increasing mobility patterns and STI/HIV prevalence rates puts mobile sexworkers in a particular perilous position with respect to their health. Prevention interventions specifically aimed at mobile sexworkers are urgently needed to protect the sexworkers themselves as well as to help stem the transmission of STIs/HIV to their contacts.

There are already some examples of successful safe sex programs for sexworkers. For instance, 100% condom use programs implemented in a number of countries – such as Thailand, Bangladesh, and parts of India (e.g., the red-light district of Sonagachi in Kolkata) – helped to significantly reduce STI/HIV prevalence among sexworkers (UNAIDS, 2004). Another highly effective STI/HIV prevention initiative is the TAMPEP/EUROPAP project in Europe that specifically targets migrant sexworkers (Morgan-Thomas et al., 2006). Yet, much more needs to be done.
In most countries, services for migrant sexworkers are virtually non-existent. Even sexworkers’ organizations, which are active in many parts of the world, have very little contact with migrants, who generally view their involvement in the industry as temporary and do not wish to associate themselves with sexworkers (Brussa, 1998; Pheterson, 1996). In addition, the relationships between local and foreign sexworkers are often quite negative, as local women tend to blame migrants for driving down prices and violating professional standards by engaging in unprotected sex (Chapkis, 1997; McDonald & Timoshkina, 2004). At the same time, it is virtually impossible for migrant sexworkers to form their own, independent organizations due to their illegal status and high mobility (Morgan-Thomas et al., 2006).

Programs are therefore urgently needed to address the unique needs of mobile sexworkers in STI/HIV prevention. Confidential, culturally sensitive, non-judgmental services should be made available to migrants regardless of their willingness to leave the sex trade and return to their home countries. Such services should include: anonymous STI/HIV testing; distribution of condoms and safe sex information materials in relevant languages; substance abuse treatment and harm-reduction programs for IV drug using workers; and general health services. Emphasis should be placed on regular and continuous outreach in all workplaces of migrant sexworkers.

Furthermore, services for migrants working in the sex trade should not be limited to health promotion. The only way to address the multitude of problems facing migrant sexworkers is to create services that are holistic. Drop-in centers and crisis lines for migrant sexworkers should be established to provide various types of counseling and referrals. Counseling should be combined with housing and legal protection services, language courses, vocational training, and educational programs. The services for migrants working in the sex trade should employ cultural mediators, cultural advocates and peer educators who possess knowledge of the migrant
sexworkers’ needs and are able to develop trusting relationships with the workers (Morgan-
Thomas et al., 2006). Migrant sexworkers should be actively involved and integrated into the
service delivery system. It is essential to promote formation of migrant sex worker peer support
and self-help groups that would allow them to build self-efficacy, and empower them to take
control over their working and living conditions. As well, it is imperative to build bridges of
understanding and cooperation between local and migrant sexworkers to eliminate xenophobic
attitudes towards migrants and their discrimination within the sex industry.
Services for migrant sexworkers should function in collaboration with government and law
enforcement officials, health-care professionals, and the general public who should be educated
about the realities of the sex trade and the situation of migrants in it to de-stigmatize sexwork
and, consequently, to increase accessibility and effectiveness of services and responses to
STI/HIV. But services alone can provide only temporary solutions. The problems surrounding
mobile sexwork call for the development of adequate policies, specifically those governing
immigration and the commercial sex trade, that will address the needs of migrant sexworkers
within the framework of human rights and social justice. Non-governmental organizations should
take a leadership role in the international migrant sexworkers’ rights and advocacy initiatives,
and should engage in comprehensive program evaluation and dissemination of best practices.
These initiatives should be informed by rigorous, methodologically sound quantitative and
qualitative research. The collection of routine statistical data on STI/HIV prevalence rates among
sexworkers worldwide is particularly important.
REFERENCES


Australian Centre for the Study of Sexual Assault. (2005). *Trafficking in women for sexual exploitation (ACSSA Briefing no. 5, June).* Melbourne: ACSSA.


