

HIV/AIDS and Health Related Needs Among Commercial Sex Workers in Michigan

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Executive Summary December 2004

This study was conducted to fill a gap in existing knowledge in the State of Michigan on the needs of a population known to be at high risk for HIV/AIDS: commercial sex workers (CSWs). The study involved 59 structured interviews with people who self-reported exchanging sex for money, drugs, or other goods on a regular basis. Participants included CSWs from five communities around Michigan: Benton Harbor, Detroit, Flint, Grand Rapids, and Ypsilanti. Quota and network sampling methodology were used to access participants on streets, around drug access points, and in drug treatment centers.

The primary goals of this needs assessment were to determine CSWs:

- Primary health concerns and access to general health services
- Sexual behavior patterns and HIV risk reduction strategies with non-paid primary and secondary partners
- Sexual behavior patterns and HIV risk reduction strategies with clients including communication and negotiation
- Drug use patterns
- HIV and Hepatitis testing patterns
- Initiators and motivators of commercial sex work and descriptive information on this work
- HIV/AIDS-related information seeking behaviors and preferences

Selected Findings

- The participants mentioned a variety of health concerns, the primary of which were getting or having sexually transmitted diseases (STDs) and HIV/AIDS, asthma, and high blood pressure. Importantly, HIV or AIDS was the most frequently mentioned concern by participants. A number of participants mentioned that dying or getting killed on the streets as their primary health concern.
- Most participants indicated that they do not or only infrequently use HIV risk reduction strategies with primary or secondary non-paying sex partners. Of those who reported using a risk reduction strategy, all reported using male condoms.
- About 25 percent of participants reported having used injected drugs in the year prior to the interview. Of those, 12 had used injected drugs (heroin only) within the week prior to the interview. Alcohol and crack were the drugs most frequently used by respondents. The range of number of times participants used

crack within the week prior to the interview was fairly wide with some indicating they used only once, while others saying they used all day, every day. One CSW estimated she had smoked crack about 240 times in the week prior to the interview.

- Ninety-eight percent of respondents reported that they have been tested for HIV at some time in their lives. When asked their reason for testing the last time they tested, participants indicated that they “just wanted to know” or “wanted peace of mind”. Other reasons cited frequently by participants included that they habitually test, were pregnant or incarcerated at the time they were tested.
- For many participants, commercial sex work was initiated and continued because of drug dependency. It was common for participants to indicate that they had considered stopping commercial sex work or quit working for a while but had to continue or resume work because of drugs, they needed money or didn’t feel like they had the skills to do other jobs.
- The majority of the participants indicated consistent condom use with clients for both oral and vaginal sex. When asked if they do anything to protect themselves from HIV when having sex with clients 66 percent said they “always” use condoms, 30 percent said “sometimes” and only 4 percent said they “never” use condoms.
- Participants indicated a variety of other HIV risk reduction strategies with clients including keeping clean through rinsing, washing, or occasionally bleaching their body parts after sex with clients. Visual inspection of clients for signs of disease was also a common strategy reported by participants.
- Twenty-nine percent of the participants indicated that they don’t talk to anyone about HIV or AIDS. Likewise, about 50 percent indicated they had never specifically sought HIV information from an agency, such as a local health department or community-based organization.
- Of those who reported that they have talked with someone about HIV, most reported talking with their private doctor, family member, significant other, or customers. The organizations that participants mentioned most often going to for HIV-related information were local health departments or clinics, Planned Parenthood, or other local community-based organizations.

Selected Recommendations

Recommendation 1: Implement prevention interventions to enhance perception of risk and encourage adoption of risk reduction strategies with sex partners who are not clients.

These findings indicate that interventions targeting CSWs should be less focused on raising awareness about HIV/AIDS or impacting the extent to which CSWs view HIV as a risk factor and more concerned with improving skills and self-efficacy levels for negotiation of condom use with sex partners who are not clients.

Moreover, interventions should persuade CSWs that condom use, as well as other risk reduction strategies, such as discussion of HIV status, is important to with sex partners who are not clients, including “primary” partners. Given that many respondents indicated multiple “primary” relationships of relatively short duration, such interventions should address behavioral risk reduction in the context of intimacy, trust, and relationships.

Recommendation 2: Implement interventions designed to build skills to negotiate risk reduction strategies with clients, including condom use.

For participants who reported consistently using condoms with partners, the topic was brought up by the CSW before the client and CSW agreed to have sex. The topic of condom use was apparently almost always initiated by the CSW (often along with the stipulation that she does not have particular types of sex) and was treated as non-negotiable. Women reported they were most likely to be able to do this when they were not desperate for drugs. Interventions should support CSWs skills to negotiate and use condoms with clients, even when they are drug sick.

Recommendation 3: Efforts to target CSWs with HIV prevention services should be coordinated with providers of substance abuse prevention/treatment as well as social and support services, such as jobs training.

These interviews revealed that the CSWs in this sample have drug use habits that often caused them to initiate commercial sex work, make it difficult to stop this work, and at times leads them to place themselves at risk for HIV. Moreover, many CSWs feel inadequate for employment other than commercial sex work. HIV prevention efforts should be considered in the context of these psychosocial factors that lead to HIV risk behaviors. Thus, prevention interventions should seek to persuade CSWs to seek drug treatment and facilitate their access to such services. Prevention services for CSWs should also be linked with programs to encourage education and skills building relative to alternative forms of employment. Similarly, substance abuse and social service programs that serve CSWs should incorporate appropriate HIV prevention efforts into programming targeted to CSWs. HIV prevention efforts targeted to this population should incorporate esteem building.

Recommendation 4: Existing HIV-prevention programs should extend their efforts to engage CSWs.

A large number of the respondents indicated they are not talking to anyone about HIV prevention. Although a majority of respondents indicated consistent condom use with clients, nearly one-third of respondents reported inconsistent condom use. A very small

percentage of respondents indicated condom use or other risk reduction strategies with sex partners who were not clients. Further, a disturbing number of CSWs indicated they had been tested for HIV without receiving risk reduction counseling. Thus, targeting of CSWs in HIV prevention activities is both appropriate and important. Risk reduction counseling along with testing for HIV and screening for sexually transmitted infections should be a cornerstone of this approach.

INTRODUCTION

This study was conducted to understand the needs of a population known to be at high risk for HIV/AIDS transmission and acquisition in the State of Michigan: commercial sex workers (CSWs). The study involved structured interviews with people who self-reported exchanging sex for money, drugs, or other goods on a regular basis. Participants included CSWs from five communities around Michigan: Benton Harbor, Detroit, Flint, Grand Rapids, and Ypsilanti.

The primary goals of this needs assessment were to determine CSWs:

- Primary health concerns and access to general health services
- Sexual behavior patterns and HIV risk reduction strategies with non-paid primary and secondary partners
- Sexual behavior patterns and HIV risk reduction strategies with clients including communication and negotiation
- Drug use patterns
- HIV and Hepatitis testing patterns
- Initiators and motivators of commercial sex work and descriptive information on this work
- Information seeking behaviors and preferences around HIV

This report describes the study methodology, the findings, and recommendations for HIV prevention interventions.

METHOD

Sampling

The study involved structured interviews with people who self-reported exchanging sex for money, drugs, or other goods on a regular basis. Participants included CSWs from five communities around Michigan: Benton Harbor, Detroit, Flint, Grand Rapids, and Ypsilanti. Quota and network sampling methodology were used to access participants on streets, around drug access points, in needle exchange programs, and in drug treatment centers. The quotas were set based on estimates of the size of the general population in each of the cities with the largest number of interviews coming from the city of Detroit. The goal of the sampling strategy was to reach both male and female CSWs from the middle and bottom range of the profession (e.g. not those working in escort services or private clubs), with varied racial backgrounds. It was assumed that the number of male CSWs in the sample would be low given difficulty accessing this population. Indeed, the final sample contained only one male CSW; despite anecdotal evidence that suggests an existing population of male CSWs around the State.

Procedure

Interviews were conducted over a nine-month period from September 2003 to April 2004. The interview protocol is included in Appendix A. The interview tool was piloted prior to the actual data collection with four CSWs in Detroit to assess question flow, wording of items, participants willingness and ability to answer the questions, and to allow the interviewers to practice the interview protocol. The protocol was modified slightly following the pilot interviews, but because these changes were not substantial, the data from the pilot is included in the final analyses.

After administering informed consent and requesting consent for tape recording the interviews, interviewers completed a structured interview protocol with questions designed to address the primary goals of the study. Following the interviews, all interview participants received \$20 cash compensation for their participation. The interviews were audio taped and transcribed. The transcriptions were use to create a data set of quantitative data. Thus, the data collection yielded both quantitative and qualitative data. The qualitative data were reviewed for emergent themes by the research team. The quantitative data were analyzed using the Statistical Package for the Social Sciences (SPSS).

Participants

The initial sample consisted of 63 total interview participants. Of these participants, four were eliminated from the sample because they reported never having exchanged sex for drugs or money. The four participants from the interview pilot were included in the final sample. The final sample consisted of 59 participants. Most of the sample included participants currently working as CSWs ($n = 46$), however, 13 of the participants reported not currently working but having worked within the last two years were none the less included in the sample. The breakdown of number of interviews per city is presented in Table 1 below.

Table 1. City in which interviews were conducted

		Location of Interview			
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Detroit	27	45.8	45.8	45.8
	Grand Rapids	11	18.6	18.6	64.4
	Flint	8	13.6	13.6	78.0
	Ypsilanti	5	8.5	8.5	86.4
	Benton Harbor	8	13.6	13.6	100.0
	Total	59	100.0	100.0	

Interview participants were asked to self-identify their sex and race/ethnicity. Participants, all but one of whom were female, were primarily black or African American (75%), followed by White (18%), Mixed race (5%), and American Indian (1%). The

average age was 33.21(SD= 8.79) with a range from 17 to 50 years of age. The highest level of education completed by respondents is reported in Table 2 below.

Table 2. Respondent's educational level

Highest level of education completed by respondent.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Middle School	25	42.4	44.6	44.6
	High School	23	39.0	41.1	85.7
	Some College	5	8.5	8.9	94.6
	2 Year Associates Degree	2	3.4	3.6	98.2
	4 Year Bachelors Degree	1	1.7	1.8	100.0
	Total	56	94.9	100.0	
Missing	System	3	5.1		
Total		59	100.0		

FINDINGS

Key findings obtained from these interviews are presented below. When interview participants were quoted directly, available demographic information was included to contextualize their comments and their participant ID number occurs after the quote. For quantitative data, M = Mean, SD =Standard Deviation, and n= number of participants. In the frequency tables, the “Valid Percentage” column provides the most accurate picture of the data.

Primary Health Concerns and Access to General Health Services

Interview participants were asked to describe their biggest worries or problems. Interviewers probed to inquire about health-related worries and problems in particular. Table 3 illustrates responses to this question. HIV/AIDS received the most frequent mention (22%). Getting a sexually transmitted disease and getting killed or dying on the streets were each mentioned by an equal proportion of respondents (13.6%). Among those interviewed who mentioned dying or getting killed on the streets as their primary health concern, many indicated having been attacked themselves, or of hearing of cases of other CSWs being attacked or killed by clients. For example, when asked what her biggest health concerns are, one 30 year old black female CSW said, “Getting in a car that you know might be the car that I will never get out of and something might happen to me”(#38). Participants from Benton Harbor were more likely to mention this as a concern than participants from other cities; several of them cited incidents that they had heard about of women being killed on the streets in the city as the reason for this fear.

Other concerns brought up by participants are shown in Table 3 below. Five participants mentioned that their drug use was a major health concern even though most

participants indicated either recent use of or addiction to a variety of substances. Despite being prompted, most respondents mentioned only one or two health concerns and a number indicated they do not have any health concerns.

Table 3. Health concerns brought up by respondents when asked, “What is your greatest health concern or worry?”

		First Mentioned Health Concern			
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Nothing/None	6	10.2	10.2	10.2
	Getting an STD	8	13.6	13.6	23.7
	AIDS	13	22.0	22.0	45.8
	Cancer (Breast)	2	3.4	3.4	49.2
	Hepatitis C	2	3.4	3.4	52.5
	Asthma/Bronchial Illness	5	8.5	8.5	61.0
	Has HIV	2	3.4	3.4	64.4
	High Blood Pressure	2	3.4	3.4	67.8
	Getting Killed on the Street/Dying	8	13.6	13.6	81.4
	Housing	1	1.7	1.7	83.1
	Diabetic	2	3.4	3.4	86.4
	Drug Use	5	8.5	8.5	94.9
	Pregnant	1	1.7	1.7	96.6
	Current Herpes Infection	1	1.7	1.7	98.3
	Non-Specific OBGYN	1	1.7	1.7	100.0
	Total	59	100.0	100.0	

Participants reported accessing health care services primarily through hospital emergency services (28%) or in health departments or community health clinics (25%). A number of participants indicated that they saw private doctors (17%) or went to hospitals (non-emergency services, 15%). Frequently, participants indicated receiving health services primarily from one agency or organization rather than several. Some interview participants reported not accessing any health services. When participants were asked to describe why they go to particular places for their health, two general reasons predominated: because the service was free or because it was convenient. Participants rarely mentioned quality of services as a criterion for accessing particular services.

Sexual Behavior and HIV Risk Reduction Strategies with Non-paid Primary and Secondary Partners

Participants were asked about their sexual behaviors and HIV risk reduction strategies with non-paying primary or main partners and secondary partners.

Primary Partners

About 66% of the participants reported that they currently have a primary partner; all female participants indicated that this partner was a male. The participants were asked to self-define and identify their primary partner as opposed to secondary partners or clients. The primary partner was generally a person the participant considered a “boyfriend”, “husband”, or someone they had been living with. The length and nature of the relationships described by participants varied extensively from participant to participant. Some reported long term relationships of up to 30 years and others very short (e.g. 5 days), but intense relationships.

Participants indicated that they do not (62%) or infrequently (10%) use HIV risk reduction strategies with primary partners. Of those who reported some risk reduction strategy, all reported using male condoms. Many participants said that they had never used condoms with their primary partner; a fact that participants indicated distinguished these partners from clients. As one 40 year-old-woman from Detroit said: “Oh with him I don’t. I don’t have no protection with him at all. When I solicit the streets, that’s when I bring up the protection on everybody. Anybody that don’t want to wear one then I don’t date them.” (#5) Other women reported that in the initial stages of the relationship they used condoms and once the relationship became “established” (independent of length of the relationship) the participant stopped condom use.

When participants were asked to provide a rationale for why they do or do not use condoms with primary partners, some cited evidence that they believed indicated they did not need to use condoms with their partner; for example having knowledge of their HIV status by having seen their test results, having discussed their STD or HIV status with the partner; because of the belief that because they always used condoms with clients, there was no need to use them with their main partner or other reasons. One 40 year-old White participant from Grand Rapids said: “I don’t have to [use condoms] because we’re so clean. We both been tested and we’re clean. Well I would rather not use condoms....I’m afraid it’s going to get caught up in my coochie.” (#33)

Others indicated that they simply trusted their main partner or they believed their partner was different in some way from other men; as one 19-year old black female from Flint said, “Because that’s my man” (#44) when asked why she didn’t use condoms with him. There was a sense among some participants that they themselves were introducing HIV risk into the relationship (through their work) and they were less likely to mention possible risk behaviors on the part of their partners.

One black, 38 year-old CSW from Detroit, who reported on her sexual experience with her primary partner three days after meeting him said this when asked why she chose not to use condoms with him:

I don’t know, just the way he carry himself. It’s not a lot of girls running in and out of the house or ringing his doorbell or his phone is not ringing off the hook. I didn’t use, but normally I do. As a matter of fact all the time I do use condoms. It’s just...he wasn’t the average just being out different with a whole lot of different women. He was like well “I don’t need to use” I said

well you know I use them, but I just felt uneasy about not using them. We talked a while before we did it without a condom. I just had a feeling that it was okay (#25).

Sixty percent of participants who indicated that they had a primary partner reported that they had never talked with their partner about HIV; a fact that is important given the low rate of condom use with primary partners. Some, however, had discussed their status or their partner's status with their primary partner. As one 30 year old participant from Detroit indicated, "As far as I know he is without HIV and I'm without HIV. The reason why I know this is I just had a check up and he had to go to the hospital you know and our blood test was okay." (#9)

For respondents with primary partners, it also appears that having sex with a primary partner is experienced very differently than is sex with other partners, particularly clients. Many respondents were unable to articulate the ways in which sex with primary partners and clients differed. Among those who could, however, many indicated that their feelings for their partner made the experience different or that they were able to experience things with primary partners (such as orgasms) that they did not experience with other partners or paying clients. As one woman from Flint said "Well it's different because I have sex with him because I enjoy it and because I want to. I sleep with these motherf---ers because it's some string attached." (44)

Secondary Partners

Eighty-five percent of respondents reported they had no secondary, non-paying partners. For those who did report secondary partners ($n = 9$), these partners were often times people ("friends") who had at one time been regular customers who no longer pay for sex. Most participants reported having only one or two secondary partners, however, one 20 year-old black CSW from Grand Rapids indicated that she had a large number of partners outside of her primary relationship with her fiancé. "I know, but I have so much sex you know I've been with like sixteen guys in the past ten months. It's time for me to get really serious. These guys are going to have to pay." (#27) She subsequently indicated that she believed that this behavior, which usually involved unprotected sex, was due in part to her low self-esteem. The balance of participants indicated that they never or occasionally ($n = 6$) used condoms or other forms of protection with secondary partners.

Drug Use Patterns

Interview participants were asked about patterns of drug use for both injected and non-injected drugs. About 25% ($n = 14$) of participants reported having used injected drugs in the year prior to the interview. Of those, 12 had used injected drugs within the week prior to the interview. Eleven of the participants reported having used injected drugs within hours of the interview (M hours = 2.50; $SD = 2.11$) ranging from a half hour to seven hours prior to the interview.

Among those respondents who indicated injecting drugs, heroin was the drug used by all of them. The number of times participants reported having used heroin in the week prior to the interview ranged from 21-49 ($M = 23.75$; $SD = 12.16$). None of the respondents who used heroin reported injecting cocaine, amphetamines, or speedballs. Few respondents who reported injecting heroin reported using any other drug or alcohol. Six respondents indicated they always used clean or new needles, four respondents indicated they sometimes used clean or new needles, and one indicated she never used new/clean needles.

With the exception of CSWs who were interviewed in drug treatment centers, nearly all of the respondents who did not report injecting drug use reported using some form of alcohol or drugs within a week of the interview. Alcohol received the most frequent mention ($n=27$) with some interview participants indicating that they drank alcohol all day, everyday ($n=4$) and others reporting only occasional used (range 1-15 times in the week prior to the interview).

Crack was used by 39% ($n=23$) of the respondents in the week prior to the interview. The range of times used was fairly broad with some participants indicating they used only once, and others saying they used all day, every day; one woman estimated she had smoked crack about 240 times in the week prior to the interview ($M = 27.07$; $SD = 48.66$). Some women reported they use no other drugs, including alcohol. For example, one 42 year-old black woman from Benton Harbor said: "I don't do nothing but smoke crack. I don't even smoke cigarettes. I've been smoking crack for twenty years...as many times as I can do it" (#53). Other drugs used by respondents included marijuana ($n=15$), painkillers ($n=6$), methamphetamine ($n=1$), and non-injected cocaine ($n=1$).

HIV and Hepatitis Testing Patterns

HIV Testing

Ninety-eight percent of respondents reported that they have been tested for HIV at some time in their lives. Of those who had been tested, most reported that test result was negative (91%). Two participants indicated they were HIV positive and three said that they did not learn the results of the test. When asked when they last tested for HIV, responses ranged from within the last month to approximately 7 years ago (average months since last test = 9.8; $SD = 14.76$); with participants reporting testing an average of 3 times ($SD = 3.58$) in the last year.

When asked their reason for testing the last time they tested for HIV, 39% of participants indicated that they "just wanted to know" or "wanted peace of mind". Other reasons cited frequently by participants included that they habitually test (18%), were pregnant (12%) or incarcerated (7%). Less often participants indicated they tested because of a particularly risky experience, because they were coming out of a drug treatment program, they were paid to test, or they were feeling sick and suspected they might be HIV positive as motivations for HIV testing. Most indicated that their last HIV test was voluntary. When asked if they had changed anything, such as drug use, sexual

behaviors, use of HIV prevention strategies, after receiving their test reported that nothing had changed.

One important finding is that a large percentage (42%) of respondents indicated they had not received any type of risk assessment/risk reduction counseling in association with HIV testing. For most of the interview participants, HIV testing had been voluntary, but was offered in the context of other health services such as treatment for sexually transmitted diseases, prenatal care, or entering jail. Thus, HIV testing was not a primary reason for seeking health services.

Hepatitis Testing

Interview participants were asked if they had ever been tested for hepatitis A, B, or C. The results are presented in the tables below. Most participants reported testing negative for all forms of hepatitis. Of those who tested positive for hepatitis C (n=4), all reported receiving treatment.

Table 4. Frequency table of participants reporting testing for Hepatitis A

Tested for Hepatitis A?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Tested	21	35.6	37.5	37.5
	Positive	1	1.7	1.8	39.3
	Negative	27	45.8	48.2	87.5
	Don't know if tested or not	7	11.9	12.5	100.0
Total		56	94.9	100.0	
Missing	System	3	5.1		
Total		59	100.0		

Table 5. Frequency table of participants reporting testing for Hepatitis B

Tested for Hepatitis B?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Tested	16	27.1	28.6	28.6
	Negative	32	54.2	57.1	85.7
	Don't know if tested or not	8	13.6	14.3	100.0
Total		56	94.9	100.0	
Missing	System	3	5.1		
Total		59	100.0		

Table 6. Frequency table of participants reporting testing for Hepatitis C

Tested for Hepatitis C?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Tested	21	35.6	37.5	37.5
	Positive	4	6.8	7.1	44.6
	Negative	23	39.0	41.1	85.7
	Don't know if tested or not	8	13.6	14.3	100.0
	Total	56	94.9	100.0	
Missing	System	3	5.1		
Total		59	100.0		

Initiators and Motivators of Commercial Sex Work and Descriptive information of the Work

Initiators and Motivators of Sex Work

For many participants, commercial sex work was initiated and continued because of a drug habit. For example, when one 50 year-old black woman from Flint was asked to describe why she exchanged sex for drugs or money she said: “Well for my drugs because I’m on drugs. I’m on drugs so I receive money. I prostitute for money” (#36). Other reasons for initiating sex work included having a family member, friend or significant other who helped them start, meeting a man who enticed them with money, and experiencing financial problems including losing a job or being without shelter. One 22 year-old White woman from Grand Rapids elaborated on how she started working as a CSW:

I was seventeen, I didn’t know nothing about working the streets and I met this dude and one day he was like I want you to go get me some money. I was like what are you talking about and he was like I want you to stand on the corner and do a sexual favor with this guy for money and I tried to get away from the guy and he would find me and beat me up (#31).

When one 40 year-old40-year old black woman from Benton Harbor was asked about how she got started and why she continued sex work she said:

[I was] put out and that was the only means. The only way I could survive, so I been doing it ever since. I raised my four children from doing this and every thing else. I continue doing sex work to help take care of my habit first of all because I do have a disease. Being addicted to crack is a sickness. Secondly, I have to eat. Ain't nobody going to take care of me. The soup kitchen has to serve you one meal a day, that's not enough (#52).

It was common for participants to indicate that they had considered stopping commercial sex work or quit working for a while but had to continue or resume work

because they needed drugs, needed money or didn't feel like they had the skills to do other jobs.

Compensation for Services

Generally participants preferred to receive money for their services as opposed to drugs or other goods. Across participants there was a belief that getting the money allowed them more freedom to purchase things that they need other than drugs and that exchanging sex for drugs (rather than money) was beneath them. When asked about how much they typically charged per sex act, responses ranged from \$5 to another who said \$800. Most charged between \$20 and \$50 depending on a variety of factors including type of sex (oral sex was generally cheaper than vaginal or anal), the race of the client (white men pay more than black men), and on some occasions, whether or not condoms were used (not using condoms was more expensive than using condoms).

Respondents in Grand Rapids were more likely than those contacted in other cities to report being “managed”, i.e. another person, usually a male, who managed their money and protected them. CSWs contacted in Grand Rapids were also somewhat younger and more likely to use crack than respondents in other cities. Among respondents who were not currently being “managed”, several reported having at one time had a manager, or “pimp”, but preferred to control the money that they earned.

Across the data it appears that some CSWs are better business people than others – some charged 10 times what others charged for the same services, in the same city. A look at the data reveals that the amount charged by participants per date was uncorrelated with age, times reported using heroin, crack, or alcohol, but was correlated at $r=35$ ($p=.01$, $n=54$) for education level. Indicating the more educated a CSW, the more she charged for her services.

Location of Work

Respondents were asked about where they most frequently go to meet or solicit clients. As can be seen from Table 7 below, CSWs reported meeting clients on streets while walking. Others had regular customers who called them or came directly to the respondent's home or shelter for services.

Table 7. Primary location in which participants reported meeting clients/dates

Where do you meet dates?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Street	37	62.7	71.2	71.2
	My House	3	5.1	5.8	76.9
	Friends House	1	1.7	1.9	78.8
	Resturant	1	1.7	1.9	80.8
	Library	1	1.7	1.9	82.7
	Dates Call Me	4	6.8	7.7	90.4
	Store	1	1.7	1.9	92.3
	BusStop	2	3.4	3.8	96.2
	Escourt Service	1	1.7	1.9	98.1
	Truck Stops	1	1.7	1.9	100.0
	Total	52	88.1	100.0	
Missing	System	7	11.9		
Total		59	100.0		

While a majority of respondents were contacted “on the streets”, it is important to note that there appears to be a hierarchy among CSWs interviewed as part of this research, with “hoes who work the streets”, on the lowest rung of the hierarchy. Several respondents reported that they had started as relatively high priced “escorts” or exotic dancers and progressed, downward, to the “streets”. Drug use was often articulated as primary reason for this downward progression.

Encounters With Police and Violent Incidents

Respondents were asked if they ever had encounters with the police. Interestingly, many immediately thought the interviewer was asking them about “dates” with police. A number of respondents reported having been arrested a number of times in the past, but few reported harassment by police. A number of respondents reported having been solicited by police officers. Several respondents, particularly from Flint, reported having been solicited by officers on duty and in uniform, sometimes to avoid getting arrested or ticketed. The following exchange between an interviewer and one 30 year-old black woman respondent (#37) illustrates this point.

Interviewer: Have you ever had any encounters either as dates or as problems with the police?

Respondent: Of course.

Interviewer: Which one, have you ever had dates with the police?

Respondent: Two of them.

Interviewer: And what happened there?

Respondent: Nothing.

Interviewer: They were just customers?

Respondent: They came over to see me, we had sex, they give me money and go back to work.

Interviewer: In uniform?

Respondent: Yes.

One respondent from Detroit recounted her experience being solicited by a police officer: “Well first let me tell you about this one guy. [The officer said] I’m the police. You better give me some head. I’m going to take you to jail. Man here take me to jail. The next thing I know he give me money” (#P1).

A small but significant number of respondents reported violent incidents with clients or potential clients. Some of these incidents were quite severe. One respondent reported that she had her throat cut and had then been thrown from a moving vehicle by a client. Many respondents also recounted to interviewers, stories of other women who had been killed while working. Several women suggested that they had learned through the years the “type” of people to avoid in order to reduce their chances of getting assaulted. One woman suggested, for example, that she avoided young men because they are more prone to violence than older men. A small number reported sexual abuse from family members; commonly these occurred during the respondents’ youth.

Sexual Behavior Patterns and HIV Risk Reduction Strategies with Clients Including Communication and Negotiation

Sexual Behavior Patterns

Respondents were asked to report the number of “tricks” or “dates” in a typical week or day. There was a wide range in the number of dates reported by respondents. The number of dates or tricks ranged from 1-140 per week. The respondent who indicated 140 dates each week was an outlier in the distribution. Two respondents reported the next highest number of dates, 70 per week. With the outlier removed from the analysis, respondents reported about 19 dates each week ($SD = 17.78$).

Respondents indicated that a majority of their clients are male, as illustrated in Table 8.

Table 8. Biological sex of clients

Biological Sex of Clients					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Men Only	42	71.2	76.4	76.4
	Both men and women, mostly men	12	20.3	21.8	98.2
	Both men and women, mostly women	1	1.7	1.8	100.0
	Total	55	93.2	100.0	
Missing	System	4	6.8		
Total		59	100.0		

When asked about the type of sex in which they engage with clients, oral and vaginal sex received the most mention. When asked how many times in the last week the participant had had sex with a client, oral sex was most common ($M = 9.01$ times, $SD = 16.03$; Range: 0-100 times) and appeared to be most preferred by respondents, followed by vaginal (M times = 4.98; $SD = 8.91$ Range 0=50 times). Few respondents reported engaging in anal sex. The average and standard deviation for anal sex were below 1.0 with a range of 0-3 times.

HIV Risk Reduction Strategies

The majority of the respondents indicated consistent condom use with clients for both oral and vaginal sex. When asked if they do anything to protect themselves from HIV when having sex with clients, 66% of respondents said they “always” use a condom, 30% said “sometimes” and only 4% said that they “never” used condoms. For example, one 40 year-old black woman was asked if there was ever a time she did not use condoms with clients she said “No, because if they can’t use the condoms or allow me to use it to protect themselves, then I know they don’t give a f--k about me so apparently they must be sick already you know” (#52). Importantly, for those who reported always using condoms with partners, the topic was brought up by the CSW prior to going with a client (e.g., before getting into their car), prior to agreeing to the transaction (e.g., before the client and CSW agreed to have sex), was almost always initiated by the CSW, and was non-negotiable.

Many respondents talked about doing visual inspections of potential client’s genitalia in order to determine whether or not the person was disease free and a number mentioned cleaning themselves after sex (with a range of things from wet wipes to bleach) as a means of staying disease free. As one woman said “I look them over. Check the penis and everything to see if sores and everything are there....yeah for dripping, yeah” (#40). One black CSW from Detroit said she was careful to keep herself clean to avoid HIV and other STDs:

I wash good, douche good. Oh yeah definitely....hardly ever do anything in a car. It’s very rare for me; you have to take me to a hotel. I’m not getting busted. So if you can’t deal with that then I don’t know what to tell you. If I do a blow job in the car, because I have I make sure I got tissue on me or toilet paper or something to where I can at least wipe up and I carry those, those wet nap things from Kentucky Fried Chicken. I got about a hundred of them (#5).

HIV-Related Information Seeking Behaviors and Preferences

Respondents were asked about which people they talk with about HIV and organizations they have gone to for HIV-related information. They were also asked about the sources they trust most for information.

Twenty-nine percent of the respondents indicated that they don’t talk to anyone about HIV or AIDS. Likewise, 53% indicated they had never gone to an organization

specifically to obtain information about HIV/AIDS. Of those who reported that they have talked with someone about HIV, most reported talking with their private doctor, family member, significant other, or customers. The organizations that respondents mentioned most often going to for HIV-related information were local health departments or clinics, Planned Parenthood, or other local community-based organizations.

When asked about the sources they trust most for information about HIV/AIDS, respondents most frequently indicated private doctors or the health department (see Table 9 below). Respondents were also asked to talk about why they trust particular sources of information. Most often people indicated they trusted particular sources of information because they seem to have information or know more about HIV/AIDS.

Table 9. Trusted sources of HIV-related information

		Who do you trust most for information about HIV?			
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No One	5	8.5	9.1	9.1
	Counselors	2	3.4	3.6	12.7
	People with HIV	3	5.1	5.5	18.2
	Private Doctor	15	25.4	27.3	45.5
	NEP	4	6.8	7.3	52.7
	Health Department	10	16.9	18.2	70.9
	Family or Friends	4	6.8	7.3	78.2
	Myself	5	8.5	9.1	87.3
	Cherry Center	1	1.7	1.8	89.1
	Planned Parenthood	1	1.7	1.8	90.9
	Hamilton Clinic	3	5.1	5.5	96.4
	Pamphlets other readings	1	1.7	1.8	98.2
	Anyone	1	1.7	1.8	100.0
	Total	55	93.2	100.0	
	Missing	System	4	6.8	
Total		59	100.0		

One woman from Detroit said this about the health department,

Because I believe that they studied it more and their information would be most accurately represented to me than someone off the street. Because I know there's more to it than you know if you use behind someone you're going to catch HIV. I know there's a lot more to it than that and a lot of people out here don't know that and I have heard people speak that work at the health department and they give a lot of good information (#5).

One 41 year-old black woman from Ypsilanti said this when asked who she trusted and why: "I cannot remember the name of the place she works for, but it's a governmental

office that provides information on HIV and AIDS. Because they have the most up to date information, based on statistics. I used to get clinical information” (#48).

DISCUSSION AND RECOMMENDATIONS FOR INTERVENTIONS

The following section addresses conclusions suggested by these data and recommendations for prevention interventions. These recommendations are not presented in order of priority.

Recommendation 1: Implement prevention interventions to enhance perception of risk and encourage adoption of risk reduction strategies with sex partners who are not clients.

Overall, respondents appeared to possess relatively high levels of knowledge about HIV/AIDS, including transmission modes and preventive strategies. Many reported engaging in risk reducing strategies with clients. Few, however, report engaging in risk reducing strategies, such as using condoms, with sex partners they consider to be “primary” partners.

Respondents also appear to consider individuals with whom they have had relatively short (e.g. three days) and emotionally intense relationships as “primary” partners. While these women very clearly understand risks for HIV and prevention strategies and have the skills to enact appropriate risk reducing measures (that is, they know how to use condoms), they decline or are unable to do so with individuals they consider to be primary partners. They simultaneously were unable to clearly articulate logical reasons why primary partners presented lower or no risk for HIV, instead offering explanations such as “I just trust him”, or “He looks clean”. This suggests that competing needs and priorities such as needs for intimacy and security, self-esteem, or notions about love and relationships may be factors mediating self-perceptions of HIV risk.

These findings suggest that interventions targeting CSWs should be less focused on raising awareness about HIV/AIDS or impacting the extent to which CSWs view HIV as a risk factor, in general. Instead, HIV prevention interventions should address enhancing CSWs perception of HIV-related risk in the context of relationships with “primary” partners, and other sex partners who are not clients. Such interventions should also seek to build the skills and self-efficacy necessary to negotiate condom use or other risk reducing strategies with sex partners who are not clients.

Recommendation 2: Implement interventions designed to build skills to negotiate risk reduction strategies with clients, including condom use.

While a majority of respondents reported fairly consistent condom use with clients, nearly one third of respondents did not report consistent condom use with clients. This suggests that it is important to target CSWs with HIV prevention strategies which increase the skills needed to successfully negotiate risk reduction practices, particularly condom use, with clients. Among those respondents who reported consistent condom

use with clients, a specific set of strategies for addressing condoms emerged from these data. Specifically, for those who reported always using condoms with partners, the topic was brought up by the CSW prior going with a client (e.g. before getting into their car or walking away from the point of meeting) and prior to agreeing to the transaction (e.g. before the client and CSW agreed to have sex). Further, the topic of condoms was almost always initiated by the CSW (often along with the stipulation that she does not have particular types of sex – generally anal, but sometimes vaginal) and was treated as non-negotiable. As this general strategy appears to make risk reduction feasible for a majority of CSWs, this suggests that peer-based approaches to HIV prevention education/skills-enhancement are preferable.

Generally, respondents reported they were most likely to be able to successfully negotiate use of condoms or other risk reducing strategies, such as oral sex instead of vaginal, when they were not drug sick. A significant proportion of respondents indicated use of alcohol and other drugs, including crack and heroin on a regular basis. Together, these findings strongly suggest that facilitating entry into substance abuse treatment programs is an essential HIV prevention strategy for CSWs. Simultaneously, however, CSW would benefit from interventions which assist them in adopting risk reducing strategies even when drug sick.

The role of violence, or at least the potential for violence should be highlighted here as well. Approximately 14% of respondents reported violence or the fear of dying was an important worry for them. A number of respondents reported having survived violent attacks, themselves, or relayed stories of other CSWs having been attacked or killed while working. The threat of violence may be a very real barrier to the use of risk reduction strategies, including use of condoms. This suggests that HIV prevention interventions targeted to CSWs should support development of skills to negotiate risk-reducing behavior while simultaneously minimizing the potential for violence with clients or potential clients.

Recommendation 3: Efforts to target CSWs with HIV prevention services should be coordinated with providers of substance abuse prevention/treatment as well as social and support services, such as jobs training.

These interviews revealed that commercial sex work is inextricably tied to drug and alcohol dependency. Drug habits that caused respondents to initiate commercial sex work, make it difficult to stop this work, and at times makes them place themselves at risk for HIV (by not wearing condoms with clients). Most, respondents, however, did not see drug use as a salient health concern and many seemed unwilling to stop their current drug-related activities. This is coupled with a fairly low level of education reported by respondents (44% had completed up to middle school) making pursuit of other careers challenging. Thus, any HIV prevention efforts should be considered in the context of these factors including persuading CSWs to seek treatment and facilitating their ability to do so as well as encouraging and facilitating access to additional educational and skills building around alternative forms of employment. These interventions should be considered in tandem with esteem building activities.

Simultaneously, substance abuse and social service programs that serve CSWs should incorporate appropriate HIV prevention efforts into programming targeted to CSWs to provide additional support for adoption of risk reducing behaviors while transitioning from commercial sex work.

Recommendation 4: Existing HIV-prevention programs should extend their efforts to more effectively engage CSWs.

This research clearly illustrates that CSWs are at high risk for HIV and experience real and substantial barriers to HIV prevention. Thus, engagement of CSWs should be central to future interventions targeting at risk populations. The specific content of interventions is addressed in the above recommendations. Risk reduction counseling/skills-building along with HIV testing should be a cornerstone of this approach.

A large number of respondents also consider HIV/AIDS and other sexually transmitted diseases as a salient health concerns. Simultaneously, a majority of respondents reported that they are not talking with anyone about HIV prevention. Most CSWs interviewed for this research reported using emergency rooms, health department clinics and community health clinics as their primary sources of health care for episodic care, rather than preventative and primary care and are therefore unlikely to be presented with information and education about HIV/AIDS. Further, a substantial number of them indicated they had been tested for HIV without receiving risk reduction counseling. Not surprisingly, most CSWs also indicated that receiving their HIV test results had little substantive impact on their behaviors.

This suggests that it is critical that HIV prevention, including risk assessment/risk reduction education be integrated into clinical services in settings which serve individuals who engage in commercial sex work. Of particular emphasis should be sexually transmitted disease clinics, reproductive health/family planning clinics, and emergency and urgent care clinics. Such services could be provided either on a one-to-one basis by trained health educators, social workers, or through lower intensity interventions such as VOICES, a video-based intervention. Motivational interviewing or similar models could be adopted by clinicians to provide CSWs with ongoing access to prevention services. Where provision of behavioral/social interventions such as individual prevention counseling is not feasible on-site, risk screening should be used by clinicians to refer CSWs to prevention programs operated by community-based organizations.

The findings suggest that CSWs interface with law enforcement relatively regularly. Some respondents reported experiences “dating” police officers and other reported being repeatedly arrested. This suggests that it may be appropriate to extend HIV/AIDS education to police officers. Simultaneously, it may be helpful to educate law enforcement officials about community referral resources that could benefit CSWs in terms of HIV/AIDS prevention or other supportive services.

LIMITATIONS

The findings of this research relate to a small number of CSWs in five urban communities in Michigan. They primarily represent commercial sex workers who “work the streets” and all but one individual in the sample was female. Thus, these findings are should not be generalized to other populations of commercial sex workers including male sex workers, CSWs working at truck stops/rest stops, individuals working for escort services or others. They should also not be generalized to populations of individuals who exchange sex for drugs or money, but do so only occasionally or periodically. Future needs assessment activities could be useful in understanding the HIV prevention-related needs of these populations.

All behavioral data relied on self-reports of respondents. Interviewers reported having the sense that the CSWs who were interviewed for this research tended to over estimate the extent to which they consistently engaged in risk reduction practices, including use of condoms, particularly in the context of oral sex. Thus, the findings related to risk reduction practices should be viewed with some level of caution, and if anything probably represent an overestimate of protective behaviors.

APPENDIX A
Interview Protocol
Interview Questions-Needs Assessment CSW

Interviewer: _____ **Participant ID:** _____

Date: _____

Site (city, location of interview):

Situational Factors (safety etc.): _____

Verbally Administer Informed Consent **Yes** **No**

Thanks for agreeing to talk to me. The questions I ask you will focus on health issues and where you go for health information. I would first like to ask you a few questions about your general worries or concerns.

1. What are your biggest worries or problems?

Probe: What other problems?

Probe: What about health worries or problems?

2. Where do you go when you have problems with your health?

Probe: Do you go to a private doctor?

Probe: Do you go to any local clinics or hospitals? (Where in the hospital?)

Probe: Do you go to any community organizations (e.g. substance use organizations, non-profits)?

Probe: Why do you go to these organizations (and not go to others)?

We would like to ask you some personal questions about your sexual behaviors. We understand that these questions are sensitive, but they are important to help us bring services to people. You do not have to answer any questions that make you uncomfortable.

3. Do you currently have a person you consider a main or steady sexual partner(s) (girlfriend, boyfriend, husband, wife, etc.)?

If NO Skip to question 5.

If YES:

Probe: Tell me a little about your relationship with this person...

Probe: About how many times in the last week did you have sex with this person?

4. When you have sex with this person do you ever do anything to protect yourself from HIV and STDs?

If YES to question 4:

Probe: What kinds of things do you do?

Probe: What do are the things you believe protect you from HIV? (if haven't said)

Probe: Who usually brings up the issue of using protection (or state specifically whatever they have stated –e.g. “condoms”) -you or your partner?

Probe: Have you ever talked to your main partner about your/their HIV status?

Probe: Tell me a little about that...

Probe: The last time you had sex with your main partner, did you or your partner wear a condom?

Yes No

Go to question 5.

If NO to question 4:

Probe: Why not?

Probe: Have you talked with this partner about using protection? What happened?

Probe: Have you ever talked to your main partner about your/their HIV status?

Probe: Tell me a little about that...

Go to question 5 (next question)

5. Do you have any other sexual partners (outside of a main partner)?

IF THE PARTICIPANT BRINGS UP CLIENTS HERE ASK THEM TO TALK HERE ABOUT NON-PAYING SEX PARTNERS OUTSIDE THEIR MAIN PARTNER HERE AND TELL THEM YOU WILL TALK ABOUT CLIENTS/DATES NEXT.

]

If YES to question 5:

Probe: Tell me a little about your relationship with ((this person/these people)).

Probe: Are these other sex partners:

Men only Women only Both men and women, mostly men

Both men and women, mostly women

IF NO "OTHER PARTNERS" skip to question 7.

6. When you have sex with ((this person/these people)) do you do anything to protect yourself from HIV and STDs?

If YES to question 6:

Probe: What kind of things do you do?

Probe: Have you ever talked to any of these other partners about your/their HIV status?

Probe: Tell me a little about that...

Probe: The last time you had sex with one of these other partners, did you or your partner wear a condom?

Yes No

Go to question 7.

If NO to question 6:

Probe: Why not?

Probe: Have you ever talked to any of these other partners about your/their HIV status?

Probe: Tell me a little about that...
Go to question 7 (next question).

7. Have you ever exchanged sex for drugs or money? **(IF NO SKIP TO QUESTION 13)**

Probe: Tell me more about that...

Probe: Do you usually exchange for drugs or for money? (probe this issue- why)

Probe: About how often? (times/day or week)

Probe: Where do you usually work/meet dates?

Probe: What kind (e.g. oral, anal, etc.) of sex do you usually give?

Probe: How much do you usually get for ((sex/these different types of sex))?

Probe: How much money do you think you make in a typical week?

Probe: Do you charge differently depending on whether or not protection (e.g. condoms or protection of some kind) is involved?

8. How did you start working?

Probe: How long have you worked? (years or months)

Probe: Do you have a manager/or pimp (or other person who works with, e.g. protection)?

Probe: What is his/her role in your work?

Probe: Have you ever had any encounters (either as dates or as problems) with the police? Tell me a little about that...

9. Why do you do sex work?

Probe: Are there other jobs you think you could find?

Probe: Have you ever thought about stopping?

Probe: What are the things that make it hard/difficult for you to stop?

Probe: Is there anything you think could happen that would help you stop?

10. When you are working/having sex with clients/dates, are there things you do to protect yourself from HIV?

IF YES:

Probe: What are they? Why do you use these things?

Probe: How are the times you protect yourself different from the times that you do not?

Probe: Do you ever have sex with your clients when you are drunk or high? Does that change whether or not you decide to use protection?

IF NO:

Probe: Why not?

11. How does the subject of protection come up with your clients?

Probe: Do you bring it up, or do they? Tell me a little about this....

Probe: Have you ever been verbally or physically abused when you brought up using protection? Tell me more about that....

Probe: Have any of your clients ever demanded unprotected sex? How often?
What activity?

Probe: Do you ever talk to dates/clients about their HIV status? Or about STD's?
Tell me more about that....

12. Are your clients...

- Men only Women only Both men and women, mostly men
 Both men and women, mostly women

13. If person has a steady partner/main partner:

a. How is having sex with your "steady partner" (whatever term interviewee uses) different from or similar to having sex with those who pay/tricks?

b. Does your "steady partner" (whatever term interviewee uses) know about your sex work?

14. About how many times in the **last one week (7 Days)** have you had each of the following types of sex **with clients/dates ONLY?** (if none, please fill in "0")

Oral _____ times

How many times did you use some type of protection for HIV? _____ times

What was the protection?

Anal _____ times

How many times did you use some type of protection for HIV? _____ times

What was the protection?

Vaginal _____ times

How many times did you use some type of protection for HIV? _____ times

What was the protection?

IF participant is a CSW and has sex with both men and women:

14a. Do you have sex with both men and women for money/drugs only?

I would now like to ask you some questions specifically about HIV and other STDs.

15. Is there anyone you talk to about HIV?

Probe: Who?

Probe: What have you talked about with this person?

16. Are there any organizations that you go to talk about HIV?

Probe: Which organizations?

Probe: Do you go to a private doctor?

Probe: Do you go to any local clinics or hospitals?

Probe: Do you go to any community organizations?

Probe: Why do you go to these organizations (and not go to others)?

17. Who do you trust most for information about HIV? Why?

18. Have you been tested for HIV? Yes No (If NO skip to question 22)

If YES:

18a. When were you last tested for HIV? _____ (day –if remember, month, year)

18b. The last time you were tested, why did you decide to test?

18c. Did you volunteer to get tested or was it mandatory (prison, hospital)?

18d. Did someone give you counseling before you took the test?

18e. Where did you find out about testing/test site?

18f. The last time you were tested, what was the result?

Positive Negative Didn't find out results Don't Remember

19. After this HIV test, did anything change in your life? (drug use, sex, views on risk)

Probe: Tell me a little about that...

20. How many times have you tested in the last year? _____

21. Why do you test?

Next, we would like to ask you a few questions about your substance use.

22. In the last year, have you used injected drugs?

Yes No (If NO skip to question 26)

If YES:

23. When was the last time you used? _____

If have not used in the last week skip to question 26.

If used in the LAST WEEK:

24. In the last week, which of the following have you injected: heroin, coke, amphetamines, speedballs? (check all that apply)

Heroin Alone If checked: How many times in the last week? _____

Cocaine Alone If checked: How many times in the last week? _____

Amphetamines (speed etc.) If checked: How many times in the last week? _____

Speedballs (heroin and coke) If checked: How many times in the last week? _____

None of the above in the last week

