Effectiveness of Culturally Appropriate Initiative on Drug-Related Harm Reduction for Sex Workers on the Thai/Malaysian Border

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Background and Objective: *Drug use can harm to sex workers. Abstinence intervention, however, may not be appropriate since drug use fosters their career performance. The objective was to develop the culturally appropriate model for sex workers participation on drug demand reduction at the Thailand/Malaysian border.*
Material and Method: *This study was a pre-post quasi-experimental design. Tripartite participation was used to develop the model aiming to reduce harm regarding drug use. The study carried out during June 2010-May 2011. Data were collected from 150 key informant interviews, 56 focus group discussions, 22 participant observations in various situations, and numerous related materials. Descriptive statistics, survival analysis and 95% confidence interval were utilized for quantitative data. Qualitative data were analyzed by content analysis.*
Results: *Drug related harm reduction was evaluated at two-week time along implementation period of 12 months. 89.5% of all sessions introduced could decrease drug related harm. Of all sex workers participated in the study, intended to treat analysis showed 86.9% success rate (95% CI; 77.1, 96.7). Of these, 32.6% became abstinence, 39.1% reduced most of drug related harm. 13.0% reduced partial drug related harm either less frequency, less quantity, less concentration, decrease types of drugs/switch to safe drugs or safer method of administration. 2.2% was infancy stage, which needed further support.*
Conclusion: *Key success of the model was tripartite participation. With active leaders and strong support, sex workers were continually motivated to reduce harm regarding drug use.*

Keywords: *Sex workers, Drug related harm reduction, Culturally appropriate initiative, Thailand*

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Drug abuse has been a problem for Thailand since 1360[1]. Drug policy in Thailand is one of general prohibition in a criminal justice framework. Although the government has regulated drug use through the Narcotics Control Act 1976, abstinence and prohibition of most substance use (with exception of substances such as alcohol, and nicotine), has characterized drug policies[2]. The Narcotics Control Act 1976 mandates abstinence-based drug policies, which established the goal of a drug-free and provided requirement to reduce drug abuse and its consequences. These policies state that all non-medical drug use are illegal, there are fines and imprisonment for substance abuse, and help is only extended to those who have a desire to abstain from all use[2]. Although prohibition has been the dominant drug policies, the number of registered drug users increased significantly, over 14 times between 2004 and 2014[3]. As is other countries in the region, Amphetamine type stimulant (ATS) is predominant factor of the major epidemic[4].

In general, people begin taking drugs for a variety of reasons: to produce intense feelings of pleasure; to relief suffering from social anxiety, stress-related disorders, and depression; to treat illness, and physical attractiveness; to improve their performance; and to be curious with or without peer pressure. Sexual intercourse has been found to be related to substances use, particularly among sex workers[5-8]. Sex workers use drugs to support the entering and maintaining of their career to serve their clients both domestic and international[9-14]. Cross border clients is an accelerated factor to the drastic growth of both sexual industry and drug use[15,16]. The situation is explicitly along the

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border of Thailand with neighboring countries (Laos PDR, Myanmar, Cambodia, and Malaysia).

It is proven that drug use among sex workers affect HIV epidemiology[17-19]. For the purpose of promoting health for the population, policies were formulated to control both drugs use and HIV. According to drug use, abstinence may not be a practical approach for all substance users. Research on substance abuse treatment suggested that some users do not abstain[20,21]. Abstinence orientation views individuals who are not complete abstinence as resistant[22]. They do not have an interest in abstinence is at least in part related to the concept of enabling, which posits that friends often allow or facilitate substance use[23]. In the enabling concept, any intervention or program that stops short of requiring abstinence is not likely to be effective and may facilitate or enable substance use. Harm reduction is recognized as a conceptual framework that provides for individuals willing to be engaged in services, but not immediately seeking abstinence. Based on a public health model of social problems, harm reduction seeks to eliminate the negative consequences of phenomena for the members of a society without necessarily eliminating the phenomena[24]. Practitioners have been using this perspective to develop interventions that reduce drug-related harm. Harm reduction regarding drug use is discussed on five assumptions:

1) The reality acceptance that drugs use is part of human life, so that leads to a focus on reducing drug-related harm rather than reducing drug use.

2) Abstinence from substances is clearly effective at reducing substance-related harm, but it is only one of many possible objectives of services to drug users.

3) Drug use inherently causes harm; however, many of the most harmful consequences of substance use (HIV/AIDS, hepatitis C, overdoses etc.) can be eliminated without complete abstinence.

4) Services to drug users must be relevant and user friendly in helping people minimize their drugs-related harm.

5) Drug use must be understood from a broad perspective and not solely as an individual act; accepting this idea moves intervention from coercion and criminal justice solutions to a public health or social work perspective[25-28].

Harm reduction has been the basis of substance abuse policies and practices in several countries[29]. In Thailand, harm reduction has been the underpinning of drug policy and practice since 2009[30]. A recent development is the rapid adoption of harm reduction among HIV/AIDS service providers in response to the association between HIV/AIDS risk and injection drug use. In this context, HIV/AIDS prevention took priority over preventing substance use. Applied to drug use, however, harm reduction principles aim to reduce individual, community and societal harms including harms to health, social and economic functioning[31]. Hence, this study introduced culturally appropriate model on drug related harm reduction for sex workers in Thai Malaysian border.

Material and Method

This study was a pre-post quasi-experimental design. The entire research process took a total of 12 months to complete (June 2010-May 2011). This research project was approved by the Human Research Ethical Committee Khon Kaen University based on the principle of Declaration of Helsinki, and ICH GCP standards (#HE531186).

Area of study

Songkhla Province, in southern Thailand, was selected as the area of study. It was one of the four provinces along the Thai Malaysian border. The Sadao District was the biggest border crossing to Malaysia. Communities close to the crossing border were selected as study sites. The communities were officially settled in 1988. Since then, tourist related industry have been prosperously for the Malaysian. Most of the people who lived in the communities were not registered. The ratio of unregistered people was 1:11[32]. Unregistered temporary migrant workers were estimated at 3,500 workers a day. Of these, 70% work in entertainment settings. This figure served about 5,000 tourists during weekends and 6,000 tourists during the long weekends[33].

Population

The target population consisted of local people who were closely related to drug use, clients, sex workers, government officers and NGO who work on drug related problems. Purposive sampling was done to select samples for key informants (150) from the target population based on experience, the ability to provide relevant information and willingness to cooperate in the implementation of the study. Of these, 60 individuals were female sex workers and 90 were not. Among 60 female sex workers, 46 agreed to participate in the drug-related harm reduction program. The rest participated as key informants and volunteers.

Intervention

Intervention refers to the comprehensive culturally appropriate model on drug related harm reduction set up in Samnukkham sub-districts of Songkhla Province. Intervention was designed utilizing the concept of the existing government services, local knowledge and sex workers participation. Stakeholders from government, private sector, leaders, and volunteers were actively involved in designing and implementing the model. It is based on three crucial premises. First, individual risk and the environment in which they are embedded are unified with each mutually defining and supporting the other. Second, the risk communication is not a 'one shot' deal, but requires an interactive strategy where information feeds back into the intervention to support the program's activities. Third, risk communication requires an integrated participatory communication process, integrated along the lines of a combined top-down-bottom-up approach as well as the integration of media and interpersonal communication programs.

The development objective of the initiative is to increase participation in culturally appropriate initiatives among sex workers to reduce drug-related harm by their own actions and by the effective utilization of government and/or private sector services.

The immediate objectives in the initiative development are:

1) Strengthen the capabilities of related partners in planning and operation strategy building, training, and evaluation on culturally appropriate initiative on drug related harm reduction for sex workers.

2) Improve the quality and diversity of drug-related materials and information.

3) Increase participation of sex workers in the drug-related harm reduction implementation.

The ultimate goal is to develop a culturally appropriate model on comprehensive drug-related harm reduction with all related partners and appropriate materials for sex workers in the improvement of their own life.

The design elements are originally planned and outlined to provide an understanding of the background of the project. Multiple partners is a key design element. It is the use of the Tripartite Model[34]; services providers, active leaders/sex workers, and scholars/research team. Another key element is the role and function of volunteers.

The model consisted of;

1) Pre-research stage (1 month). The research team developed drug-related materials and information A) materials for sex workers self-regulation, B) materials for peers, and C) materials for services providers. In addition, the workers-providers network had been developed to facilitate drug-related harm reduction.

2) Harm reduction stage (12 months). Sex workers were encouraged to evaluate their own drug use behavior and assess their own needs for drug-related harm reduction. There were three alternatives on drug-related harm reduction on this study; self-regulation, peers consultation, and service-provider assistance. Sex workers were encouraged to make their own decision among the three alternatives. Either choice, sex workers would get a booklet of instructions, which emphasized easy to understand concepts with clear accompanying images.

3) Assessment stage (12 months). Sex workers were visited at home at two-week intervals. Sex workers were allowed to withdraw or to switch their prior choice.

Eight research assistants were employed who went to each establishment everyday for the entire year to collect information and to impart knowledge. Further information about drug-related harm reduction, sex workers could obtain from health care providers.

Outcome of interest

The evaluation of the drug-related harm reduction model could be measured by an outcome indicator. The indicator was the behavioral change in terms of drug-related harm reduction. It could be less frequency, less quantity, less concentration, minimal types of drugs, safer drugs, safer method of administration, or even abstinence.

Data gathering

Quantitative and qualitative data were obtained. Qualitative data involved 150 in-depth interviews, 56 focus group discussions and 22 participant observations. Each focus group discussion took approximately 2.40 hours to complete and each in-depth interview and interview took 45 minutes-1 hour, each. Quantitative data involved drug use reports from 46 drug users.

Data analysis

Data double entry was utilized to construct the research database. Data exploration was done to correct the out of range, outliers, and missing values problems. Percentage, midpoint and its dispersion, and survival analysis and 95% confidence interval were utilized for quantitative data. Qualitative data were

analyzed by content analysis, which involved transcribing the data, encoding the transcribed data and comparing the encoded data before extracting conclusion.

Results

Baseline

Of 60 sex workers in this study, 63.3% were professional, 10.0% were optional, and 26.7% were opportunistic and match makers[35]. 16.7% were from neighboring countries (Myanmar, Laos PDR, Cambodia, China), 38.3% were local people and from nearby provinces, and the rest were from the other parts of Thailand. The average age was 24.8 years old (SD 5.39), ranging from 15 to 40 years old. 88.3% was normal sexual identity while 11.7% was bisexual orientation. 36.7% was single, 21.7% was separated/divorce/widow, while 39.9% was married and 1.7% was living with their partner. One third finished their elementary education or lower. 73.6% entered to this career between 1-6 years with an average of 5 years (SD 3.52), ranging from 1 to 15 years. Of these, 8.3% selected clients on their own.

Regarding drug use experience, an average duration was 4.5 years (SD 2.95), ranging from 1 to 12 years. With respect to the different groups of substances, ATS was predominantly used among sex workers. 51.7% of sex workers preferred ecstasy to other drugs while 40.0% used methamphetamine pills and 35.0% used crystal methamphetamine. The rest were cannabis, *Mitragynaspeciosa kroth* (Kratom), and psychoactive substances. Three quarters was poly drug users who combined these drugs to improve their career performance. Functional drug use also includes legal substances (alcohol, smoking, caffeine etc.) vitamins, herbs and contraceptive pills.

Model implementation

During June 2010, a brochure was developed and tested (Fig. 1). Implementation was organized into three stages, namely:

1) The improvement of the staff enabling them to motivate sex workers to participate in the project.

2) The development of an effective system, tripartite model, appropriate for drug related harm reduction specifically in the context of sex services.

3) Model implementation in target communities and its expansion.

Although participatory approach in Thailand has been well recognized for the period of time, it has never been adopted to drug-related harm reduction. In this study, network participation in tripartite model had involved in planning, objective determination, role and function assignment implementation, evaluation and cooperation in obtaining the findings. Participation level in tripartite model had increased along the timeline shown in Fig. 2.

It should be noted that action research had been suggested to utilize in this particular comprehensive model. The model must be able to incorporate with existing systems and be benefit with minimal workload.

Outcome

Drug-related harm reduction was evaluated at two-week time along implementation period of 12 months. Of 46 sex workers, the total of 526 two-week periods were evaluated. Of these, 471 two-week periods were decreased drug-related harm (89.5%) while 38

Fig. 1 Drug related harm reduction brochure.

periods remained the same and 17 periods reverse harm. At the end of implementation, however, intention to treat analysis showed 86.9% success rate (95% CI; 77.1, 96.7). An average time to reduce drug-related harm was 29.5 weeks after receiving intervention (Table 1).

Regarding drug-related harm reduction of sex workers, 32.6% became abstinence, 39.1% reduced most of drug-related harm. 13.0% reduced partial drug-related harm either by less frequency, less quantity, less concentration, decrease in the types of drugs or a safer method of administration. 2.2% was its infancy stage and needed far more support. The rest remained the same.

Discussion

This study demonstrated the implementation of the harm reduction in Thailand. Applied to drug use, this study defined a harm reduction as the reduction of drug- related harm rather than abstinence-oriented strategies, which reduced the harm to those who continue to use drugs. Although the analysis is mostly descriptive, the results are nevertheless compatible with a positive impact of the harm reduction on drug use. The hypothesis of a positive impact of this study is supported by the decrease of drug-related harm behavior.

Limitations of the study must, however, be acknowledged. The system used to monitor drug-related harm (two-week sessions) is probably almost exhaustive. However, because the study did not apply urinalysis through outreach work, data obtained from self-reported, which could result in response bias. This should not, however, have a large impact on the results since various qualitative methods used to validate reports from these outreaches indicated stability over time.

The level of participation seemed to be an essential part of the study. Sex workers participation tended to increase drastically in three months. In contrast with service providers, the level of participation slightly increased and maximized at the end of the project. Although, arrests for illicit drugs are influenced by the laws in force and the level of activity of local law enforcement, this situation could affect

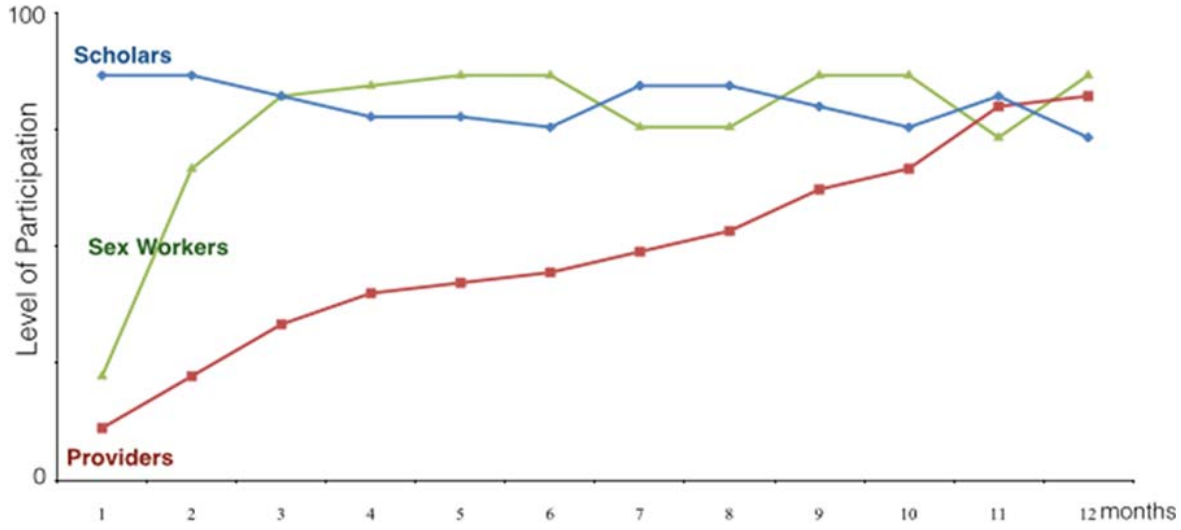

Fig. 2 Participation level in tripartite model.

Table 1. Time to reduce drug related harm (two-weeks sessions)

	Estimate (weeks)	Std. Error	95% confidence interval	
			Lower bound	Upper bound
Means	29.495	2.180	25.223	33.768
Median	26.000	5.511	15.199	36.801

participation in the project, particularly with sex workers. However, as the legal framework did not evolve during the study period, this study assumed that law enforcement activity remained relatively constant over time. As in Fig. 2, sex workers participation has descended twice. Actually, this was not affected by law enforcement. Rather, long weekends with much clients effected sex workers compliance to the study.

Harm reduction is a feature of sex work interventions mainly where sex workers are a subset of problematic drug users[36]. Drug use is frequently associated with sex work and negative consequences for the sex worker's health, risk of certain substances[37,38]. A number of literatures exist providing evidence of the extent of overlap between drug use and the sex-working population and the nature of relationships between various types of the sex market and drug market[39-41]. Other mutually reinforcing behaviors and attitudes include desire for money to pay for general goods and other lifestyle enhancing expenses[42]. By pointing to commitment and the ongoing nature of lifestyle expenses such as mortgage payements, school fees, and desire to escape poverty as a motivation for sex work. Thus, harm reduction cannot be constructed in isolation from an understanding of the empowerment.

Conclusion

Harm reduction is recognized as a conceptual framework that provides for individuals willing to be engaged in services, but not immediately seeking abstinence. Key success of the model was peer assessment and active mentors. With active mentors, sex workers and volunteers were continually motivated. Not only HIV/AIDS and drugs use but also other health related issues could be benefit from harm reduction approach. Harm reduction principles are synonymous with the reduction of drug-related harm, which could possibly be applied more widely.

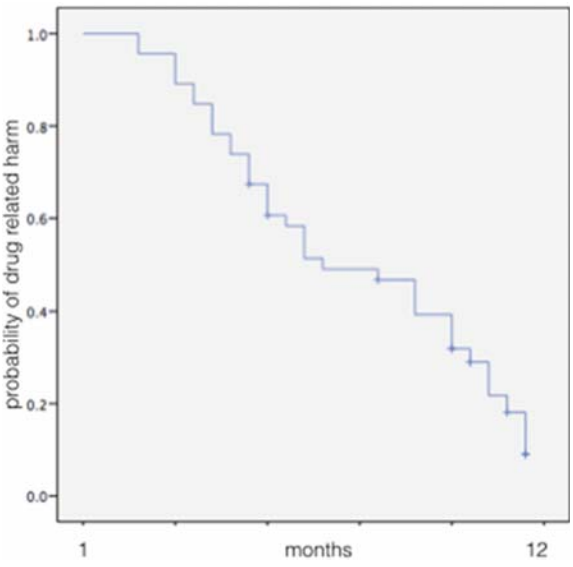

Fig. 3 Time to reduce drug related harm (two-weeks sessions).

What is already known on this topic?

Harm reduction has been used for a period of time. Most of harm reduction focus on injecting drugs users (IDU) and their risk regarding HIV/AIDS. Needle exchange programs seem to be the highlight of harm reduction. It is an alternative strategy to abstinence.

What this study adds?

Harm reduction principles could be extended beyond needle exchange. It could be less frequency, less quantity, less concentration, decrease in the types of drugs, switch to safer drugs, safer methods of administration, or even abstinence. The results of this study demonstrate harm reduction adoption to drug use, even among sex workers who want to use drugs to supplement their career performance.

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Potential conflicts of interest

None.

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ประสิทธิผลของมาตรการแทรกแซงที่เหมาะสมกับวัฒนธรรมของผู้ให้บริการทางเพศในการลดอันตรายจากการใช้ยาเสพติดในพื้นที่ชายแดนไทยมาเลเซีย

วรพล หนูนุ่น, มานพ คณะโต

ภูมิหลังและวัตถุประสงค์: *การใช้ยาเสพติดเป็นอันตรายต่อผู้ให้บริการทางเพศ อย่างไรก็ดีมาตรการแทรกแซงที่ต้องการให้เลิกใช้ยาเสพติดอาจไม่เหมาะสมเพราะการใช้ยาเสพติดเป็นส่วนหนุนเสริมในงานอาชีพของคนกลุ่มนี้ โดยมีวัตถุประสงค์เพื่อการพัฒนารูปแบบการที่เหมาะสมกับวัฒนธรรมของการมีส่วนร่วม จากผู้ให้บริการทางเพศในการลดความต้องการใช้ยาเสพติดบริเวณชายแดนไทย-มาเลเซีย*

วัสดุและวิธีการ: *การศึกษานี้เป็นการวิจัยกึ่งทดลองแบบวัดก่อนหลัง โดยการมีส่วนร่วมแบบไตรภาคีเพื่อพัฒนารูปแบบการลดอันตรายจากการใช้ยาเสพติด ดำเนินการในช่วงเดือนมิถุนายน พ.ศ. 2553 ถึง พฤษภาคม พ.ศ. 2554 เก็บข้อมูลโดยการสัมภาษณ์จากผู้ให้ข้อมูล 150 คน จัดสนทนากลุ่ม 56 ครั้ง การสังเกตในสถานการณ์ต่าง ๆ 22 ครั้ง รวมถึงจากเอกสารอื่น ๆ ที่เกี่ยวข้อง วิเคราะห์ข้อมูลเชิงปริมาณด้วยสถิติเชิงบรรยาย การวิเคราะห์ความอยู่รอดและช่วงเชื่อมั่นร้อยละ 95 ส่วนข้อมูลเชิงคุณภาพใช้การวิเคราะห์เนื้อหา*

ผลการศึกษา: *การประเมินอันตรายจากการใช้ยาเสพติดดำเนินการทุก ๆ 2 สัปดาห์ตลอดระยะเวลา 12 เดือน พบว่าร้อยละ 89.5 ของการประเมินอันตรายจากการใช้ยาเสพติดลดลง จากผู้ให้บริการทางเพศทั้งหมด การวิเคราะห์ intention to treat แสดงอัตราความสำเร็จของการลดอันตรายจากการใช้ยาเสพติดร้อยละ 86.9 (ช่วงเชื่อมั่นร้อยละ 95; 77.1, 96.7) ในจำนวนนี้ร้อยละ 32.6 เลิกใช้ยาเสพติด ร้อยละ 39.1 ลดอันตรายจากการใช้ยาได้เกือบทั้งหมด ร้อยละ 13.0 ลดอันตรายจากการใช้ยาได้บางส่วนในแง่ของการลดความถี่ในการเสพ การลดปริมาณที่ใช้เสพ การลดความเข้มข้นของตัวยา การลดจำนวนชนิดยาที่ใช้หรือเปลี่ยนไปใช้ยาตัวอื่นที่อันตรายน้อยกว่าหรือใช้วิธีการเสพที่มีอันตรายน้อยกว่า ร้อยละ 2.2 อยู่ในช่วงเริ่มต้นลดอันตรายซึ่งต้องการการสนับสนุนต่อไป*

สรุป: *กุญแจสำคัญของรูปแบบคือการมีส่วนร่วมแบบไตรภาคี ผู้นำที่เข้มแข็งและการสนับสนุนที่ดีจูงใจให้ผู้ให้บริการทางเพศลดอันตรายจากการใช้ยาเสพติดลงได้*