Public Health Policy and Practice with Male Sex Workers

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When male sex workers (MSWs) appear on the public’s radar, it often is in the form of an exposé of a public servant or a person with name recognition having hired a male sex worker. On the darker side, there have been numerous stories of men killed, often violently, by male sex workers or those the media labels as such. These sad stories typically involve an older man murdered by a young man he met online through a listserv or sex work website. Less focus is given to murdered sex workers, and it is a given that physical assaults perpetrated by a client on the MSW are greatly underreported. The public often reserves its sympathy for those forced into sex work through trafficking or other forms of coercion, but this compassion is primarily for women and children of both sexes, while adult males pressed into sex work receive much less attention.

Public exposés typically produce a great deal of comedy at the expense of the revealed transgressor. For example, late in the summer of the 2012 U.S. election season, the satirical website The Onion posted a story on the “Onion News Network” that focused on Tampa Bay-area male prostitutes gearing up for a flood of business during the Republican National Convention. Jokes about methamphetamine and unsafe sexual practices often serve as punch lines, indicating that the unhealthy aspects of male sex work are part of the public discourse. This reflects the fact that comedy often comes from uneasy truths.

In December 2012, the World Health Organization (WHO, 2012) published a report focused on reducing HIV and sexually transmitted infections (STIs) among sex workers in low- and middle-income countries. It’s a safe assumption that these recommendations might address sexual health services, safer sex, and substance abuse. Part of the public discussion moving forward must also involve improving or maintaining good health among MSWs, as this group is disproportionately at risk for HIV infection and such efforts thus are in the best interests of both the public and the sex workers. In the United States, any use of government money to fund services related to sexuality has become a political battle zone; programs for sex workers provide good ammunition for those who oppose such efforts on moral grounds. In fact, the U.S. has had a decade-long antiproduction requirement attached to receiving funding from the President’s Emergency Plan for AIDS Relief (Ditmore & Allman, 2013). Anyone receiving these funds is explicitly
FIGURE 8.1
Front and back of a safe-sex pamphlet for male sex workers in Amsterdam, issued by the European Network Male Prostitution (ENMP).

Source: © ENMP/AMOC-DHV
forbidden to “encourage, condone or promote prostitution.” This policy, known as the pledge, has resulted in the termination of programs, a phasing-out of services for sex workers, and the refusal by some to comply in order to receive U.S. funds (Ditmore & Allman, 2013).

Programs have been developed and implemented for male sex workers in Europe, Asia, and Africa. The European Union, funded by a multiyear grant from the European Network Male Prostitution (2002) to foster communication among those providing services for MSWs, published reports that included recommendations for public health policy and practice, social service programs, and other resources. The official recommendations echo those made in numerous other publications (Gaffney 2007; Parsons, Koken, & Bimbi, 2007; Smith & Seal, 2007; Williams, Bowen, Timpson, Ross, & Atkinson, 2006). More recently, the World Health Organization made its official recommendations, as mentioned above.

The WHO (2012) report calls above all for the decriminalization of sex work in order to improve the physical and emotional well-being of sex workers. Both legal and moral judgments have a long history of interfering with the implementation of and adherence to the best practices within the fields of public health and community health. Unfortunately, local politics, policies, and laws often intercede with moralistic arguments that prevent local public health professionals from designing and implementing programs for sex workers and their clients. More insidiously, antigay sentiments foster direct and indirect resistance to creating programs for MSWs and their clients, even though similar programs for female sex workers and their clients are already in place. Furthermore, as noted by Scott (2003), sex workers and their needs are viewed differently in accordance with their venue or mode of client solicitation (e.g., on the street, via Internet websites, and through real or virtual escort services). Street-based sex workers are viewed as deviants who are breaking the law and spreading disease, and thus are a problem for the criminal justice system due to community concerns about quality of life—that of local residents, not of the sex workers. Whereas indoor sex workers are more likely to be seen as victims of circumstance, financial or otherwise, and thus not viewed as criminals, they are nonetheless viewed as a public health problem.
Such stereotypes can hinder any effort to reach MSWs and improve their well-being. Homelessness, substance abuse, mental health needs (see chapter 9) are all problems sex workers experience, regardless of their “level.” Given the prevalence of HIV infection among populations of men who have sex with men in many areas of the world, MSWs clearly warrant competent, nonjudgmental services. Further public health programming should capitalize on male sex workers as a vector of sexual health education (Parsons et al., 2004) within the larger communities of gay and bisexual men who have sex with men.

If they did not face structural barriers (e.g., the pledge) and ideological and moral biases (e.g., sex work is always bad), public health officials and community workers could develop effective services for MSWs and their clients. In many cases, both the client and the sex worker have the same needs: general sexual health, prevention of STI and HIV transmission, prevention of and treatment for substance abuse, and protection from violence. These concerns clearly have been recognized worldwide as public health issues, regardless of the cultural and social contexts of male sex work within localities, regions, and nations.

Background

There is a dearth of research into general or occupational health issues among MSWs; what is publicly disseminated typically focuses on sexual practices and drug use as they relate to HIV transmission (Bimbi, 2007; Browne & Minichiello, 1996; Minichiello, Scott, & Callander, 2013). Much of what is known about male sex workers in general and specifically about their unique health issues comes from researchers and health professionals who reach out to men on the street (Koken, Bimbi, Parsons, & Halkitis, 2004), most often within the context of HIV-related research (Bimbi, 2007; Minichiello et al., 2013; Scott, 2003).

The social stratification of sex work also dictates different needs among different types of sex workers. Men working the streets are more likely to be severely economically disadvantaged (e.g., homeless), struggle with drug abuse or addiction, not be gay identified, and may be more part of the overall “street scene” (Bimbi, 2007), whereas higher-end “escorts” are more likely to be gay identified and may have more interaction with the gay community in bars/clubs and social spaces in
FIGURE 8.2
predominately gay neighborhoods. Therefore, in the absence of direct evidence, anecdotal evidence from the larger subculture (e.g., homeless youth, the gay male community) may be needed to inform any direct or indirect public health efforts.

Nevertheless, quite early in the HIV epidemic, sex workers of both genders came to be viewed as a threat to public health. In his book, *The Origins of AIDS*, Jacques Pepin (2011) provides an excellent description of the social (e.g., 1:10 ratio of women to men in early European colonial towns in West Africa that promoted prostitution and polyandry) and economic (e.g., no “female” jobs) dynamics that inadvertently helped spread HIV through heterosexual sex work and sex trading. As HIV in the developed world was first identified among men having sex with men, the leap was made that male sex workers were spreading HIV without any direct evidence.

The first wave of research reported the prevalence of HIV among samples of MSWs (Bimbi, 2007; Minichiello et al., 2013) as a means to demonstrate the “threat” these men posed to the health and welfare of the larger public. Specifically, MSWs were argued to be “a vector for transmission of HIV infection into the heterosexual world” (Morse, Simon, Osofsky, Balson, & Gaumer, 1991). However, when reporting the prevalence of HIV among samples of MSWs, the authors did not include (perhaps the data were not available) the corresponding prevalence among men who have sex with men (MSM) in the same geographic area (e.g., “20% of our MSW sample reported being HIV positive which is similar to the prevalence rate of all MSM in our area”). Therefore, absent a comparison, MSWs are portrayed as spreading HIV due the presence of HIV positive men in a research sample.

The “Typhoid Harry” stigma (Koken et al., 2004) labels sex workers as vindictive and uncaring about the risk of spreading infection to their clients; what is forgotten is that when unprotected sex does occur, it is typically in response to client pressure or coercion (Jamel, 2011), not the sex worker’s willful intent or cavalier attitude about unprotected sex (Bimbi & Parsons, 2005; Parsons, Koken, & Bimbi, 2004). There seems to be wide consensus among male (and female) sex workers in most wealthy nations that condom use is part of the job (Browne & Minichiello, 1997; Parsons et al., 2004). Some researchers have found
that this has had the unintended effect of MSWs eschewing condoms when having sex for their own pleasure (Allman & Myers, 1999; Weber et al., 2001), as condoms become associated with work. It also could be that the observed high number of sex work partners may be related to increased rates of “safe sex burnout” (Bimbi, 2007). In comparison, sex workers in developing nations and poor sex workers overall report lower rates of condom use with clients (Pisani, 2008). Sex workers, regardless of venue, often must deal with clients offering more money for sex without condoms. There also are structural constraints on MSWs using condoms. As with female sex workers, male sex workers, out of fear of being arrested for “providing evidence of prostitution,” may not carry condoms (Allman & Myers, 1999; Morse, Simon, & Burchfiel, 1999). There has been some organized pushback against this law enforcement practice from sex worker advocates and sex worker organizations. In New York State, for example, there have been repeated (failed) attempts to pass legislation that bans police from this practice, most recently in 2012 (Kloppot, 2012). This is a clear contradiction between state-funded public health programs that distribute free condoms and the criminal justice system (Human Rights Watch, 2012).

The risk behavior that does occur with clients may result from negative attitudes toward condoms and a lack of knowledge about HIV transmission (Minichiello et al., 2000), as well as a perceived (lack of) susceptibility to HIV (Simon, Morse, Balson, Osofsky, & Gaumer, 1993). A perceived lack of control in interactions with clients may also lead to unprotected sex (Joffe & Dockrell, 1995; Morse et al., 1999; Simon et al., 1993). As gay and bisexual men who desire men themselves, MSWs may be tempted to engage in unprotected sex with clients they find attractive, which is known as “heaven trade” (Browne & Minichiello, 1995; DeGraaf, Vanwesenbeeck, Van Zessen, Straver, & Visser, 1994; Joffe & Dockrell, 1995; Simon et al., 1993; Smith & Seal, 2008). Repeat clients and clients who become familiar with a male sex worker may also build a sense of trust (Davies & Feldman, 1997) or a longing for intimacy (“the single blues”; Joffe & Dockrell, 1995; Smith & Seal, 2007), which may lead to sexual risk-taking.

Aside from burnout or other psychological factors, behavioral and situational factors such as injection drug use have been shown to be related to MSWs having unprotected sex with casual partners.
(Bower, 1990; Williams et al., 2003). Several studies have suggested that MSWs may be more at risk for contracting or transmitting HIV through needle sharing than unsafe sex (Elifson, Boles, & Sweat, 1993; Estep Waldorf, & Marotta, 1992; Waldorf & Murphy, 1990; Waldorf, Murphy, Lauderback, Reinarman, & Marotta, 1990). Nevertheless, it has been reported repeatedly that, in samples of gay men in developed countries, drugs popular with the gay scene, particularly nitrate inhalants (“poppers”) and stimulant drugs or those with similar effects (crack, methamphetamine; Mimiaga, Reisner, Tinsley, Mayer, & Safren, 2009), are strongly associated with having unprotected sex. Therefore, drug use “on the job” may lead to having unprotected sex with clients. Many clients (and this also applies to those hiring female sex workers) often want to “party” with the sex worker and arrive at arranged meetings already drunk or high on drugs. Some gay MSWs who are involved with the party scene may view “free” drugs provided by the client as a bonus.

On the other hand, MSWs who are uncomfortable about their work may use drugs or alcohol to numb their feelings while with clients (Bimbi, Parsons, Halkitis, & Kelleher, 2001; Mimiaga et al., 2009). Straight-identified men in particular may use drugs to deal with the threat to their identity that results from engaging in same-sex behaviors (Bimbi, 2007). Men both gay and straight who are dependent on alcohol or drugs may exchange sex for drugs, or engage in sex work only to pay for drugs (McCabe et al., 2011; Mimiaga et al., 2009). Regardless of motivation or etiology, substance misuse among male sex workers is clearly a phenomenon that needs more attention and program development. (See chapter 9 for a further discussion on substance use among MSWs.)

While identifying risk factors clearly is important in public health, factors that promote protection and condom use should not be overlooked. As advertising for sex has mostly moved online, away from restrictions imposed on print classified ads, sex workers are free to be as sexually explicit or expressive as they want, although they may purposely avoid “quid pro quo” statements about the exchange of sex for money. It is quite common to see the phrase “payment is for my time only” in such ads. Many male sex workers directly promote safety on their Internet profiles by including statements such as “safe sex only” and state their own HIV status or employ euphemisms such as
“healthy” or “disease free.” Some may not state anything about health status or protective practices, and there are far fewer who explicitly advertise for barebacking (sex without condoms).

Some argue that the online milieu for sex work is conducive to more open and honest sexual negotiation (Minichiello et al., 2013; Parsons et al., 2004). MSWs themselves have also reported feeling responsible for initiating condom use and practicing universal precautions (Minichiello, Mariño, & Browne, 2001; Parsons et al., 2004). For many, condoms have become part of their “work equipment” (Bimbi, 2007; Parsons et al., 2004; Smith & Seal, 2008). In fact, there may be no negotiation at all, as the sex worker may introduce the condom as part of foreplay, avoid penetrative anal sex, trick the client by putting on a condom orally, or simply end the session and walk out.

Recommendations

It does appear that gay-identified MSWs are at high risk for HIV infection, due to factors related to their same-sex attractions and involvement with gay subcultures (e.g., the party scene), as well as through recreational drug use, regardless of sexual identity or orientation. Although there are clear public health needs among MSWs and their clients, evidence-based recommendations for practice and policy are sorely lacking. Fortunately, sex worker advocates have filled in those gaps, and there is enough consensus in the evidence to inform broader polices for program and service development that could be implemented within existing indigenous governance systems. Before implementation, however, structural barriers must be addressed. The WHO (2012) official recommendations to improve the health and well-being of sex workers (regardless of gender) include the following as the foundation for programs and services:

1. All countries should work to decriminalize sex work and eliminate the unjust application of non-criminal laws and regulations against sex workers.
2. Governments should establish anti-discrimination and other rights-respecting laws to protect against discrimination and violence, and other rights violations sex workers face, in order to
FIGURE 8.3
Front cover of a pamphlet issued by the European Network Male Prostitution, which is aimed at service providers in Switzerland to promote sexual health programs for male sex workers.

Source: © ENMP/Swiss AIDS Federation
realize their human rights and reduce their vulnerability to HIV infection and the impact of AIDS. Anti-discrimination laws and regulations should guarantee sex workers’ right to social, health, and financial services.

3. Health services should be made available, accessible, and acceptable to sex workers, based on the principles of avoiding stigma, non-discrimination, and the right to good health.

4. Violence against sex workers puts them at risk for HIV and must be addressed in partnership with sex workers and the organizations they lead.

The WHO also explicitly recommends the following interventions to enhance community empowerment among sex workers:

- Voluntary HIV testing and counseling for sex workers
- Anti-retroviral therapy for HIV-positive sex workers
- Correct and consistent condom use among sex workers and their clients
- Strategies to reduce harm to sex workers who inject drugs
- Including sex workers in catch-up hepatitis immunization strategies for sex workers who didn't receive these immunizations in infancy

Obviously, any interventions should deal competently with gay culture(s) and sex work culture(s) by building partnerships with local gay and sex work communities, specifically with businesses that cater to these populations, and with nongovernmental organizations and health-care providers. Cultural competency and community partnerships are essential to successful implementation.

Implementation

If the above recommendations answer what to do and for whom, putting those recommendations into practice asks where, when, and how. When implementing programs and attempting to draw MSWs in, we must
FIGURE 8.4
Pages from a pamphlet aimed at Swiss service providers to promote sexual health programs for male sex workers.
Source: © ENMP/Swiss AIDS Federation
address who the target is and what we are trying to accomplish. This will require developing different service levels or program content based on the differing needs of sex workers (e.g., housing, counseling), with the specific goal of improving health and wellness. No one program can be all things to all types of sex workers, so providers must be knowledgeable about other services to which they can refer them when necessary. To cast the widest net and reach as many sex workers as possible, outreach efforts should tailored for broad audiences, such as all men who have sex with men (the population approach), and for targeted audiences, such as men who sell and buy sex (the community approach).

Such approaches are reflected in two frameworks utilized in public and community health efforts. The Institute of Medicine (Mrazek & Haggerty, 1994) has defined levels of intervention for the implementation of public health programs: universal interventions target an entire population or community; selective interventions narrow the focus to those who may be at risk; and indicated interventions are aimed at those with demonstrated risk. Clearly these levels address the “who” and thus leave the “what,” as in what are the goals of the interventions.

Another framework (Commission on Chronic Illness, 1957) for goal-setting in public health prevention is more focused on the “what,” which is as follows: primary prevention includes activities and efforts aimed at preventing health problems before they develop (onset); secondary prevention focuses on early detection of problems through screenings (e.g., STI testing), followed by appropriate follow-up, which may include harm-reduction strategies to reduce the likelihood of long-term poor health outcomes; and tertiary preventions involve the treatment of health problems and promote improved quality of life for those with health problems.

These two frameworks clearly raise the question of which to use and when integration may permit public health professionals, community-based organizations, and government entities to reach more persons in need. These frameworks have been integrated and adapted or revised, often in response to pedagogical critiques (Kutash, Duchnowski, & Lynn, 2006). The following proposes a similar new framework based on blending or collapsing the levels of intervention and prevention. In the Institute of Medicine’s levels of intervention, selective and indicated interventions target at-risk individuals, while the primary and secondary
levels both include the goal of harm reduction. Therefore, each of the aforementioned pairs could be collapsed to simplify the model. Table 8.1 provides a general idea of how the levels could be combined in a more manageable 2x2 matrix, based on scope (broad, targeted) and goal (prevention versus intervention). This may permit better use of limited resources and more effective outreach, with increased community participation (e.g., men getting the services they need). The following reviews the approaches, with examples and suggestions for programming.

*Universal Prevention*

Any effort to reach out to male sex workers through the wider gay community would be a type of universal prevention. In many parts of the world, there is not one “gay community” but several, based on cultural and social interests, which might further complicate broad implementation. Nevertheless, there are some places of intersection, frequently the local gay media (newspapers, party papers, local websites), many of which may feature listings or advertisements for escorts, companions, body workers, etc. Many gay media proprietors offer reduced advertising fees or waive them altogether for public health promotions. In many areas, the webmasters and owners of websites and, more recently, mobile applications for dating or “hooking up” may include links to local health departments or to websites featuring sexual health information. Some also allow direct messaging to site users, as well as banner ads for programs and services.

Many nations have various listservs, such as Craigslist in the United States, that contain message boards frequented by sex workers. Due to legal issues, most listservs for broad audiences prohibit sex work posts. Coded language is therefore the norm, such as “looking for a generous man.” These listservs clearly can be employed in universal prevention programs with regular postings. Whether in print or at online forums, ads targeting MSWs would also reach the entire readership community and thus, if the ads had a professional, nonjudgmental tone, could help reduce the stigma of sex work. Even within a community with more positive attitudes about sex work (Bimbi, 2007; Koken et al., 2004), MSWs still experience stigma, prejudice, and judgmental attitudes about prostitution.
TABLE 8.1
Levels of Intervention x Levels of Prevention

<table>
<thead>
<tr>
<th>PREVENTION</th>
<th>INTERVENTION</th>
</tr>
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<tbody>
<tr>
<td>UNIVERSAL</td>
<td></td>
</tr>
<tr>
<td>Community-wide</td>
<td>Universal Prevention</td>
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<tr>
<td></td>
<td>All men who have sex with men</td>
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<td></td>
<td>Educational</td>
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<td></td>
<td>Informational</td>
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<tr>
<td></td>
<td>Promotional: mental and sexual health screenings</td>
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<td></td>
<td>Pros/cons of sex work</td>
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<tr>
<td></td>
<td>Universal Intervention</td>
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<tr>
<td></td>
<td>All men who have sex with men</td>
</tr>
<tr>
<td></td>
<td>Advertise programs for those in most need (e.g., drug-using sex workers, those with mental health issues)</td>
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<tr>
<td>TARGETED</td>
<td></td>
</tr>
<tr>
<td>At-risk Groups</td>
<td>Selective Prevention</td>
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<tr>
<td></td>
<td>Young men who have sex with men, low-income and current MSWs</td>
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<tr>
<td></td>
<td>Educational</td>
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<tr>
<td></td>
<td>Informational</td>
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<td></td>
<td>Promotional</td>
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<tr>
<td></td>
<td>Pros/cons of sex work</td>
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<tr>
<td></td>
<td>Rational decision-making</td>
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<td></td>
<td>HIV education and testing</td>
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<td></td>
<td>Drug/alcohol abuse screening</td>
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<td></td>
<td>Mental health screening</td>
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<td></td>
<td>HIV education</td>
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<td></td>
<td>Housing programs</td>
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<td></td>
<td>Treatment</td>
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<td></td>
<td>Job training</td>
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<td></td>
<td>Other diversion programs</td>
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<tr>
<td>INDICATED</td>
<td></td>
</tr>
<tr>
<td>Intervention</td>
<td>Indicated Intervention</td>
</tr>
<tr>
<td>CURRENT MSWS</td>
<td>Drug misuse/abuse, inconsistent condom use, dysthymia or any other mental health issue, HIV care</td>
</tr>
<tr>
<td></td>
<td>Harm reduction for drugs</td>
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<tr>
<td></td>
<td>Harm reduction for safer sex</td>
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<td></td>
<td>HIV care/medication adherence</td>
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<td></td>
<td>Mental health counseling</td>
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<td></td>
<td>Exit planning</td>
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<td></td>
<td>Treatment for addiction</td>
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<td></td>
<td>HIV care/mental health counseling</td>
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<td>Job retraining</td>
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<td>Career change</td>
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<td></td>
<td>Exit</td>
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The goal of universal prevention would be to educate all men about the pros and cons of being a sex worker. This would also include the promotion of sexual health care, testing and treatment for HIV, as well as mental health screenings. Education about substance abuse is also clearly warranted. The potential risks of engaging in sex work should be included, but not framed in a judgmental or fear-based tone, as this might drive men away from participating in a program or working with a particular agency. Nevertheless, it is strongly advised that the actual content and images be developed with the input of a broad selection of sex workers from local areas and target populations. Although the above discussion concerns media advertising, the same principals apply to direct outreach in terms of messaging and staff training.

**Universal Intervention**

The implementation of universal interventions would be very similar to universal preventions but with the narrower goal of reaching sex workers who may be in need. Health promotion would focus on creating awareness of programs focused on problem areas, such as substance abuse, mental health, housing, etc. Such programs may be sex-worker specific or open to all gay, bisexual, and other men who have sex with men.

**Selective Prevention**

Selective prevention narrows the focus to places where sex workers are definitely present. Specifically, websites that permit escort listings and escort-specific websites are clearly targets for messages and service promotion. There also may be population subgroups, such as homeless youth and youth-centric cultural scenes, that outreach workers can target. The message and promotion are focused on prevention, such as health screenings and tips for sex worker safety.

**Indicated Intervention**

As with selective prevention, the focus narrows to places in which some sex workers present are clearly at risk. The goal is to help individuals access the help they need. This may involve direct outreach to drug-using sex workers, HIV positive sex workers, homeless sex workers, etc. Interveners
must be aware that drug use, homelessness, and HIV are not discrete problems and may be interrelated with other mental health conditions.

Conclusion

A word of caution: any program, outreach effort, or services that do not address the needs of sex workers will most likely be a resounding failure. Case in point: the Coalition Advocating Safer Hustling (CASH) was funded by the American Foundation for AIDS Research through a grant to the Gay Men’s Health Crisis in New York City during the mid-1990s. There was a clear clash between the sex workers involved with the program and agency staff concerning the governance and mission of CASH (Boles & Elifson, 1998). The sex workers were more interested in an advocacy organization with broad goals, whereas the community-based organization sponsoring CASH was mostly concerned about HIV prevention.

Furthermore, any programs that explicitly serve gay, bisexual, and other men who have sex with men must also provide services that are culturally appropriate to meet the needs of sex workers within these populations (Gaffney, 2010). Many higher-earning male (as well as female and transgender) sex workers (or “escorts”) will not access services that primarily target street-based sex workers. Therefore, it is imperative that service providers address the needs of sex workers and clients as part of serving gay and bisexual men and other men who have sex with men from various communities. This will be accomplished most easily with providers who cater to the gay community or those within urban centers, whereas service providers outside of urban centers might not be prepared or open to serving these men. Even in the absence of structural barriers, there may be some reluctance to provide competent care to sex workers, for to do so may be viewed as “promoting” or “tolerating” prostitution. This chapter seeks to prompt thoughtful implementation of programs and services that will improve the sexual health of male sex workers. Finally, local providers are strongly urged to do their homework and identify problem areas or local trends in risk-taking, such as what party drugs are currently in vogue, as knowledge of their local sex work scene.
FIGURE 8.2 and figure 8.5 are from printed and online materials distributed by HOOK Online, Inc., a U.S.-based grassroots program that supports men who are or were involved in the sex-work industry. According to its mission statement, “HOOK educates men in the sex industry, clients, and the public about sex work to reduce harm and to develop a network of service providers and nonprofit programs.” Their program is about “encouraging dialogue between men in the sex industry about choices for health and wellbeing; promoting visibility and representation of the needs and issues of men in the sex industry within public and private forums; fostering informed discussion about men in the sex industry; encouraging sex industry businesses to recognize their role as conduits in communicating with men in the sex industry by adopting harm reduction efforts as responsible business practice; [and] aiding social service providers to respond in a non-stigmatizing manner to the needs of men in the sex industry.”
FIGURE 8.5
From the website of HOOK Online, Inc., a U.S.-based grassroots program that supports men who are or were involved in the sex-work industry.
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Gaffney, J. (2010). Contemporary harm reduction & support service needs of male sex workers in the UK: The SohoBoyz male sex worker needs assessment and skills development


