Institutional Strengthening and Support for HIV Prevention Activities

TAMPEP

European Network for HIV/STI Prevention and Health Promotion among Migrant Sex Workers

NATIONAL REPORT ON HIV AND SEX WORK

B U L G A R I A

This report was drawn from information provided by the organisation
HESED / Health and Social Development Foundation, Sofia

This report is part of a series of reports produced by TAMPEP as part of the above project.
The series of reports include the following:

European Overview of HIV and Sex Work mapping
Bulgaria National Report on HIV and Sex Work
Czech Republic National Report on HIV and Sex Work
Germany National Report on HIV and Sex Work
Lithuania National Report on HIV and Sex Work
Poland National Report on HIV and Sex Work
Romania National Report on HIV and Sex Work
Ukraine National Report on HIV and Sex Work
Gap Analysis of Service Provision to Sex Workers in Europe
Skills/Training Audit and Good practice Tools

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1 COUNTRY PROFILE

	2005[1]
Population, total (millions)	7.7
Population growth (annual %)	-0.3
Life expectancy at birth, female (years)	71.0
Life expectancy at birth, male (years)	68.9
GNI/Gross National Income per capita, 2005	US$ 3,450.00[2]
Inflation, consumer prices (annual %)	5.0
Unemployment, total (% of total labour force)	13.7
Internet users (per 1,000 people)	283

Demography and Economy[3]

Bulgaria is a lower middle-income country in the Europe and Central Asia region, according to the classification of economies by region and income, FY 2005 made by the World Bank. The economy has made impressive progress in recent years by maintaining long-term stability and sustained growth. Improved macro economic policies and deep structural reforms have led average growth levels to reach 5% in the period 2000-04.

The total population of Bulgaria was 7.8 million in 2004 compared with 8.1 million in 2000. Population growth in the country was -0.6 in the year 2004, versus -1.8 in the year 2000.

In 2003 life expectancy in Bulgaria was calculated at 72.1. The infant mortality rate per one thousand live births in the same year was 12.3. Mortality rates under the age of 5 per one thousand children were 15.8 in the year 2000.

The Gross National Income/GNI of the country as per the Atlas method was US$21.3 billion in the year 2004. The GNI per capita was US$2,740 in the same year.

The Gross Domestic Product/GDP in the year 2004 was US$24.1 billion. The annual percentage growth rate of GDP in that year was 5.6.

The average annual growth rate of GDP for the period 2004-08 is estimated at 5.5%. The average annual growth rate of GDP per capita in the year 2004 was 6.1%.

Demography - According to the 2001 census, Bulgaria's population is mainly ethnic Bulgarian (83.9%), with two sizeable minorities, Turks (9.4%) and Roma (4.7%). Of the remaining 2.0%, 0.9% are distributed among some forty smaller minorities, the most numerous being Russians, Armenians, Vlachs, Jews, Crimean Tatars and Karakachans. 1.1% of the total population did not declare their ethnicity.

Roma represent almost 5% of the population but constitute the majority among street-based sex workers. Possible explanations could be:

- The census is only carried out on households and many of the houses of Roma people are illegal. For example, there are around 100 people living at one address in one Sofia neighbourhood and only 4 of them were registered in this survey.

[1] World Development Indicators (2006), www.worldbank.org
[2] www.siteresources.worldbank.org / Atlas method
[3] Infobase online, www.economywatch.com

- Due to stigma, many people don't identify themselves as Roma, even though they have all the characteristics and traditions of that group. The majority "declare" themselves as Turkish and many as Bulgarians.

According to the Open Society Institute, a more realistic estimate of the Roma population would be 500,000–700,000, or 8.67% of the population. Other NGOs estimate that their number could reach one million[4].

Bulgarian is the only official language of the country and is the mother tongue of 84.8% of the population; it is a member of the Slavic languages. Other languages such as Turkish and Romany are spoken corresponding closely to ethnic breakdown.

Most Bulgarians (82.6%) are, at least nominally, members of the Bulgarian Orthodox Church, the national Eastern Orthodox church. Other religious denominations include Islam (12.2%), various Protestant denominations (0.7%), and Roman Catholicism (0.5%), with other denominations, atheists and undeclared numbering approximately 4.1%.

Bulgaria has had the slowest population growth of any country in the world since 1950, with the exception of Saint Kitts and Nevis (due to their high emigration rate). In fact, population growth has been negative since the early 1990s, due to economic collapse and high emigration rate. Bulgaria is currently suffering a heavy demographic crisis. In 1988 the population of Bulgaria was 8,859 million people, and the 2001 census shows a population of 7,950 million.

Situation of Women

Two main cultural tendencies strongly affect the situation of women in Bulgaria: patriarchal social norms and emancipation from the communist regime. In the last 60 years women have been working alongside men, mainly because of the socialist norm of equal rights and obligations for men and women, but also often due to the economic fact that a family could not be sustained by one salary alone. Patriarchal norms, however, still influence the social positions and relationships of men and women. It is one of the main causes of relatively high rates of violence against women.

Social parameters

The unemployment rate in Bulgaria is 9%, of which 57.2% are women. Permanent unemployment is again higher among women: 63.5% of all the unemployed are women. Barriers for women could be:

- subjective: non-beneficial position due to "wrong" professional orientation; loss of professional status due to permanent unemployment; limited labour mobility; family and psychological barriers; low self-esteem in job search
- objective: gender-based stereotypes and prejudices; insufficient flexibility of the labour market, leading to atypical labour for women; direct, indirect or hidden discrimination against women in the recruitment process; lack of gender neutral criteria and company policies for hiring women; insufficient information for women, especially in rural areas, regarding their rights and specific mechanisms for job search[5]

The women in the most disadvantaged social position are again Roma women. Many of them drop out from school due to very early marriages.

[4] Monitoring Education for Roma, A Statistical Baseline for Central and Eastern Europe, Open Society Institute, 2006

[5] Gender Dimensions of Labour Market, Kirova, Alla; Stoyanova, Kapka; Employment and Social Security Economic Thought (3/2005)

Women in politics

In the current Parliament only 21% are women. It is rare for female candidates of all political parties to total more than 30%.

The EU Enlargement

Bulgaria, officially the Republic of Bulgaria, is a country in South Eastern Europe. It is bordered by the Black Sea to the east, Greece and Turkey to the south, Serbia and the Republic of Macedonia to the west, and Romania to the north, mostly along the Danube.

Bulgaria joined NATO on March 29, 2004 and the European Union on January 1, 2007. The country has been a member of the United Nations since 1955, and is a founding member of the *Organisation for Security and Co-operation in Europe*.

Migration

According to official data published by the *National Statistical Institute*[6], emigrants in the period 1992-2001 numbered 177,000. The *Agency for Bulgarians Abroad* however quotes 800,000 Bulgarians who have left the country since the Reform in 1989.

The main form of migration is labour migration and the majority of emigrants are men. Women are less likely to risk immigrating to another country without the support of relatives or specialised networks.

Female Labour Migration

According to large-scale research[7], 20% of the Bulgarian population is considering emigrating. 40% of these are women and the majority of them favour short-term migration, unlike men, who are oriented towards long-term migration. Women's preferred destination countries are the USA, Germany, Spain, Greece, and Canada.

Women's main reasons for potential migration are low income (88%), unclear prospects for development in the country (49%), criminality and corruption (38%).

When they reach Western Europe, the majority of Bulgarian women find jobs in house-keeping, agriculture and restaurants. Sex work is not mentioned in this report but the majority of the women work illegally, without health or social insurance, working long hours and for lower payment than nationals, and experiencing high dependence on employers and strong discrimination on the basis of gender, age and nationality[8].

[6] Internal and External Migration of the Population of the R Bulgaria, National Statistical Institute, 2001
[7] Internal and External Migration of the Population of the R Bulgaria, National Statistical Institute, 2001
[8] "Gender Dimensions of the New Migration Tendencies in Bulgaria: Recommendations", National Statistical Institute, May, 2005

2 PROSTITUTION MAPPING

Overview of sex industry[9]

Country	Major Group	Nationalities	Work Places
Bulgaria	90% Bulgarians	Migrants from Russia, Ukraine, and Moldova	55% indoor; street: mainly Roma and Turkish minority
Czech Republic	65% Czechs	Migrants mainly from Slovakia and Bulgaria	70% indoor, 10% highways and border area
Germany	60% migrants	55% CEE, 20% Asia, 15% Latin America, 10% Africa. A total of 38 different nationalities	80% indoor
Lithuania	85% Lithuanians	Migrants from Russia and Ukraine	70% indoor
Poland	70% Polish	Migrants from Ukraine, Russia, Belarus, Bulgaria, Moldova, Romania	70% indoor, 30% outdoor
Romania	95% Romanians	Migrants from Moldova and Turkish Roma	55% street, 15% highways and border area
Ukraine	90% Ukrainians	Moldova and Russia	80% street

Structure

The majority of sex workers are Bulgarian, very much involved in a flow of migration within and beyond the country. Working and living conditions of sex workers vary, depending on their ethnic background, social situation, rural/urban living area and sector of the sex industry.

Sex industry sectors

OUTDOOR

Street- and highway/road-based sex work – These are the lowest strata, with sex workers usually having the lowest levels of education and healthcare-seeking behaviour, and experiencing the highest levels of violence from clients and others, which could be related to criminal structures having the greatest control. Outdoor-based sex work could at the same time be the choice of those who want to work independently but without any protection either. Some sex workers, usually the most experienced, risk working without "protection" in the hope that they will earn more. They prefer working in the daytime in the safest possible areas and sometimes pay a "guard" or work more closely with the police.

Most male and transgender sex workers work on the streets. Women and men of Bulgarian nationality comprise the majority among those working on the streets, of whom 70% are of Roma origin. Among them, about 4.5% use heroin, but this seems to be losing popularity among sex workers.

Motels and parking areas - This simultaneously involves both outdoor and indoor sex work. Because of the geographical location of Bulgaria, there are several international highways and truck drivers are the main customers. Most of the truck drivers are Turkish and the sex workers are either of the Turkish minority or learn some Turkish.

[9] TAMPEP VII, 2006

INDOOR

Hotel-based sex work - Contacts are made depending on the region. Sometimes it is done through another sex worker who's been using HESED services, or through the manager. It should be noted that hotel-based sex work is covered mainly in tourist areas.

Apartment ("clubs", "offices", "brothels") sex work – This is the most diverse sector of the sex industry: some of the places are very luxurious; others are more dubious and are strongly controlled by criminals. These places are preferred by injecting drug users and migrants, mainly because they are hidden.

Those working indoors are mainly Bulgarians, and rarely women from countries in the former USSR. Roma make up less than 20% of those working indoors.

Regarding drug use: the figure of 4.5% of sex workers injecting drugs includes both indoor and outdoor sex workers. It was observed however that some of the "offices" (apartments) are quite tolerant towards injecting drug users. Data concerning cocaine have not yet been processed. According to outreach teams, many of the women working indoors snort cocaine with their customers (100% in some places) and cases of Hepatitis C have been detected among non-injecting sex workers. This was one of the reasons for including sterile straws in the materials distributed during outreach.

- Bars, striptease clubs - Usually striptease and dances with additional sexual services.
- Escort prostitution - Escort sex workers are not reached by the outreach teams.
- Resort prostitution – A recent phenomenon emerging with the fast development of the tourist industry.

Those working on the streets are in the most disadvantaged situation, meaning a high level of criminality, threat of violence, very bad working conditions, and very limited access to services. The majority of them are from the Roma and Turkish minority groups.

Sex workers working indoors have, in general, more freedom: they live and work in relatively good conditions, and have better health knowledge and awareness, as well as free access to social and medical services. In most cases, they belong to the Bulgarian ethnic group.

- Distribution of sex workers across sectors (according to expert estimations): 43% street, 30% clubs and striptease bars, 10% apartments, 10% massage parlours, 5% escorting, 2% others.
- Gender: 90% female, 5% male, 5% transgender.
- Number of sex workers: according to data from the *Global Fund Programme* implemented in Bulgaria, about 1,000 sex workers were reached by health services between 2003 and 2006. Many of these, however, have quit the industry or left the country. According to both official and expert estimations, there are about 5,000 to 8,000 sex workers per month in the country.
- Level of migrant sex workers: 10% migrants, 90% Bulgarians.
- Origin of migrant sex workers: 85% Eastern Europe, 15% Balkan countries.
- Main countries of origin: Russia, Ukraine and Moldova.
- About 80% of the prostitution scene is controlled by criminal structures.

Female sex workers

The majority - 90% - of national sex workers work for pimps or partners. They keep about 50% of their earnings for themselves. Only 10% work independently but this number is slowly growing. More experienced sex workers are more likely to work independently, have better clients, deal with the police, and be more assertive in making their own choices.

However, there is still reluctance to spread this "self-confidence" among younger colleagues, due also to competition. Still, one of the experienced women is currently planning to found an organisation for the support of sex workers, with the support of HESED.

Among migrants the situation varies a little: only about 80% work for others, which include pimps and partners. They also keep about 50% of their earnings for themselves. About 20% work independently.

There is a medium level of condom use among sex workers; however, this is rising. Data from the *Second Generation Sentinel Surveillance Survey* 2004 and 2005 show condom use at 95%. Of course, some social desirability should be kept in mind. We don't know yet how much of this data relates to partners and how much to clients. With partners and sometimes with regular clients, the situation is different: condom use is accepted only when there is an infidelity, proven STI or another reason for loss of trust. These contacts are seen as intimate sex life as opposed to work and it is very difficult to introduce condom use here. Partners' resistance to condoms is also very strong. Most probably, this is the main reason for infections and the high number of abortions.

Although there are no specific surveys, violence is perpetrated by controllers, clients, partners, and police. Police violence however has been significantly reduced in recent years, following a series of reforms at the Ministry of Interior, implemented according to EU requirements.

The level of drug use among sex workers is medium, with a noticeable increase in hard drugs in recent years.

Transgender and male sex workers

There is a growing number of transgender and male sex workers, mostly from the Roma ethnic group. Some men in the Roma neighbourhood have casual or regular sexual contacts, most often anal sex. The cultural norm for the average Roma man is that he should be sexually experienced, while the average woman should be a virgin. It has been found that 59% of men from the Roma ethnic group have had sex with another man[10]. According to a pilot survey project this number could be as high as 70%. It seems that taboos against homosexuality are not so strong in the Roma group, and it could often constitute a first sexual experience.

It is likely that the majority of transgender sex workers are transvestites. Transsexuals form a very low percentage.

Transgender and male sex workers work without pimps. They move freely between outdoor and indoor places, do not pay bribes to the criminal structures or police, and are very much united and supportive to each other.

There are four major differences between these groups and female sex workers: 1) They often work in violent or hidden environments, due to the stigma attached to male prostitution, 2) many of them are very mobile, travelling mainly to Germany, Belgium and other Western European countries, 3) a minority of underage Roma boys enter prostitution, and 4) they are often the focus of child protection institutions and organisations.

Roma males and transgender people are often involved in heroin use and therefore they are in an even more vulnerable situation. If heroin is not present, they mainly use alcohol before

[10] High Levels of sexual HIV/STD risk behavior among Roma (Gypsy) men in Bulgaria: patterns and predicators of risk in a representative community sample. Elena Kabakchieva MD, Yuri A. Amirkhanian PhD, Jeffery A. Kelly PhD, Timothy L. McAuliffe PhD, and Sylvia Vassileva MA, International Journal of STD & AIDS 2002, 13: 184-191

going to work. Several of them are HIV-positive and require the special attention of outreach workers and other health professionals.

There are no real estimates of male prostitution. 8% of those in contact with HESED are transgender.

Ethnic minorities

There are two main ethnic minorities in Bulgaria: Roma and Turkish.

Data from the last census in 2001: Turkish population - 746,664; Roma population - 370,908.

Quantitative evaluations of the existing conditions and needs are mainly based on analysis and forecasts, outlined in the "*Background survey on urbanisation and housing in Roma neighbourhoods*" from 2003, funded by PHARE 2002 "*Preparation for economic and social cohesion*", included in the UNDP reports. The survey is a selected sample of the data for 88 predominantly urban settlements (large and small towns) out of 161 municipalities that according to the 2001 census have a population of more than 10,000. The programme is based on the assumption that these 88 settlements include the main part of the target Roma population, which is 412,500, or 85,900 households.

The Roma ethnic minority is especially vulnerable towards HIV/STIs and other reproductive health problems. It is itself split into many tribes, but the two big subgroups are the Bulgarian Roma (who follow the Christian faith) and Turkish Roma (who follow the Muslim faith). It should be noted that a large percentage of the Roma community identify themselves only as Turkish, but their living and working conditions are different from those of the non-Roma Turkish people. Roma often have low levels of education and low healthcare-seeking behaviour. They have experience in obtaining social allowances. Health, however, is only now starting to grow in importance.

In the Central/Eastern European context, about five times more Roma than the majority of the population live below national poverty lines. Roma unemployment rates are 70 to 90%, and Roma who are employed typically do menial work. Only 10% of Bulgarian Roma complete their primary education compared to 72% of the majority population, and about 80% are illiterate. Health indicators among Roma in Central/Eastern Europe have significantly deteriorated during the past decade, and infectious diseases such as tuberculosis and hepatitis are widespread. Roma receive lower-quality healthcare due to discrimination and their poor financial status. Roma life expectancy is approximately 10 years less than Bulgaria's majority population[11].

The Turkish Roma subgroup is more likely than other Roma to be involved in trafficking in human beings. They have lower levels of education and are less adapted to the health and social systems. They do not pay health insurance and often are not registered at an address, which are the prerequisites for being included in these systems.

Vulnerability and Self-Determination

The three main vulnerability factors for national sex workers are:

- Criminal control over prostitution in Bulgaria, which is directly related to the difficult economic situation and violence.
- Stigma and discrimination against sex workers from the general population and in particular from professionals (police officers, medical doctors, etc.) working directly with

[11] Ibid

them. They show resistance to helping sex workers, and many sex workers are afraid of stigmatisation if they reveal their occupation.

- Low health culture of sex workers, meaning the level of knowledge of one's body and its processes; attitudes towards seeking healthcare; compliance with treatment; health-preserving behaviour; lack of myths regarding sexual and reproductive health. In general, those who work outdoors know the least about their bodies and about the health services, and are less willing to access health services.

The four main vulnerability factors for migrant sex workers are:

- Criminal control over prostitution in Bulgaria, which is directly related to the difficult economic situation and violence.
- Lack of knowledge of migration laws and conditions in the destination countries.
- Insufficient education of members of the Roma community renders young people extremely vulnerable to poverty, social exclusion and health problems.
- Unstable social and family environment of migrants, including migrant sex workers.

Impact of recent legislation

In 2004 the Penal Code regarding drug use was changed. It criminalises the carriage or possession of one measure of any drug. One of the consequences of this legislation was that drug-using sex workers were driven underground, which increased their vulnerability and risk of all sorts of violence.

The specialised law against trafficking in human beings was revised in 2005. There was no change regarding migrant sex workers.

Routes into and out of sex work

Into sex work

Different routes into sex work depend on social and ethnic background.

Due to the social exclusion and marginalisation of the Roma ethnic community within Bulgarian society a disproportionate number of Roma are involved in the lowest strata of the sex industry. Female sex workers from the Roma community very often are the sole source of income for the whole family. Roma sex workers work in outdoor or lowest-strata indoor sectors in Bulgaria. The Roma community has its own networks for illegal migration, mainly to Western Europe, and in many cases these are also connected with trafficking networks. Within some Roma communities, child sexual exploitation and abuse occurs through the recruitment and grooming primarily of young girls for the purposes of prostitution, following which they are often 'sold'.

In addition, young girls and boys in care and juvenile detention centres are often targeted for the purposes of child sexual exploitation, as they have little or no family support and are extremely vulnerable, particularly upon leaving the institution. Females entering sex work in this way are usually very much dependent on their "bosses" or partners, while the situation of males is different. Males who started working for a pimp very soon become independent and work for themselves.

Women from rural areas often have very limited educational and professional opportunities and are often "open" to offers from people organising sex work. Sometimes these offers begin as love stories and other times they originate in word of mouth from other women who have become sex workers.

Women from the cities are often well educated. They may need to earn money for studies or children, or just choose sex work as a profession. They work mainly independently, and

exclusively indoor, often escorting or advertising on the internet. At the highest level of the sex industry are the "companions", who work at model agencies.

Out of sex work

Working mainly in environments where sex workers are active in the sex industry, HESED does not have very detailed information on the process of exiting the sex industry. What we most often see are people who stop working for a period and, in times of financial need, go back and start working again. Our information regarding leaving the sex industry is received mainly from the colleagues of women who have chosen to quit.

Whether, how and with what consequences sex workers will leave the sex industry depends on the working and living conditions they have experienced. Male and transgender sex workers usually have the freedom to leave at any time they want, but they may have the problem of lacking other qualifications.

Women working for pimps (outdoor and in some of the indoor places) and in the frames of a larger criminal network face the biggest barriers to exiting. In most cases, when they belong to the Roma minority and are being "raised" to be a sex worker, they financially support several other people (often whole families). Women recruited through these networks, both from the minorities or the majority, usually have a "debt" to pay to their bosses and don't have the right to leave until they have "bought themselves out", which rarely happens. If they attempt to leave these circumstances, threats and violence will be used. These measures are especially applied to younger and more attractive women.

An organisation formed by policewomen and former sex workers encourages sex workers to leave the industry, and offers assistance for their problems with organised crime. It provides police support when they decide to testify, but the organisation is a personal project rather than an official programme.

According to experts at HESED, however, approximately 50% of sex workers have the freedom to leave the sex industry, but often choose not to, either because they have made the choice to remain in the profession or because they don't have other opportunities for better employment.

Mobility

Factors affecting mobility could change significantly following the EU accession of Bulgaria, and the estimations presented below show trends prior to the EU accession.

Approximately 80% of Bulgarian sex workers, the majority in the country, have also worked abroad at some point, on average for a period of three months. The main destination countries are the EU countries, especially Norway, Germany, the Netherlands and France, but also Greece and Italy.

A very small group of transient sex workers is comprised exclusively of women from the former Soviet countries.

The number of sex workers returning to Bulgaria after working in Western Europe is growing and a great number do not plan to go back. Bulgaria is experiencing relatively fast economic growth and there are more job opportunities than there were 5-7 years ago. Tourism is the most developed industry. Survival still remains a concern for some people, but their numbers are not so big. Sex workers themselves say that now they can earn about the same by just travelling for a month or two to Western Europe and not staying there permanently.

However, there is also a tendency among newcomers to the sex industry to plan travel to other EU countries after January 2007. Romanians and Bulgarians were already allowed to stay in EU countries for three months without a visa before 2007.

Regarding internal migration, about 20% have already worked in another town in Bulgaria, in bigger cities, in border towns and in tourist resorts at the Black Sea.

The main reasons for mobility are:
- Poor economic situation of the region or town of origin
- Repressive law enforcement or being forced to work
- Well developed networks for both voluntary migration and trafficking within and outside the country

3 SERVICES

Access to Health Care Services

For the general population

Currently there is a network of 13 VCT[12] centres throughout the country, mainly in the district centres. Two more centres are planned for 2007. The network was created with the support of the WHO and results were boosted by the *Global Fund Programme.* Services at the centres are free of charge and anonymous. The VCT centres are situated within the newly reformed Public Health Services and the specialists are hired by the Services themselves. There have been large campaigns promoting HIV testing among the general population, and results are encouraging.

HIV treatment is free of charge and confidential**,** but only accessible to health insured persons. The total number of people registered as HIV-positive in Bulgaria is 677. Everyone who meets treatment requirements and expresses desire to get treatment receives it. The annual amount spent per person is approximately US$12,000, which is supported by the state budget. There are four centres for HIV treatment in the country, and three NGOs offering self-help groups and psychological support to patients who are already in treatment.

Nationals and uninsured migrants have access to contraception and abortion. Maternity and gynaecological care is only available to those with health insurance.

For sex workers

Apart from the HIV/STI prevention services, sex workers have access only to private health care. In spite of being nationals, they are very rarely health-insured and as they don't declare themselves as socially disadvantaged, they don't receive state insurance. It is important to note that sex workers' life and work experience have more bearing on whether they have health insurance than their sector of the sex industry. Therefore, young sex workers from ethnic minorities and/or rural places are more likely to be deprived of health care. This allows many myths and self-treatment methods to be widespread.

[12] *Voluntary Counselling and Testing Centres*, which are established throughout the world, according to UNAIDS and WHO guidelines. The policies of UNAIDS and WHO were reformed at the end of 2006, but VCT services have been the norm for HIV testing for decades. For more information: http://www.unaids.org/en/Policies/Testing/HIVtesting_UNAIDS_policies.asp

There has been a big change in the last two years in health services offered to sex workers: the *National Programme for Prevention and Control of HIV/AIDS*, funded by the *Global Fund to Fight AIDS, TB and Malaria*, has a specific component aimed at HIV prevention for sex workers. By doing this, the Bulgarian Ministry of Health recognised sex workers as being an important group to receive specialised care and services.

Thanks to increased efforts by the national network, the number of sex workers contacted throughout the country has risen to about 8,000 in various settings: tourist resorts, motels, parking areas, apartments, border areas, disadvantaged minority neighbourhoods, small towns and villages. According to estimations of experts and the Ministry of Interior, 5,000 – 7,000 sex workers are offering services per month in the country. Mobility and turnover in the group is very high and the coverage of services is approximately 45%. The services offered during outreach work and in the six mobile medical units include health counselling, distribution of safer sex and safer injecting materials; peer education training; HIV/STIs/Hepatitis B and C testing; treatment of STIs; sexual health check-ups.

Prevention

All prevention efforts, however, are funded exclusively by external donors. The GFATM[13] programme will come to an end in 2008, which will seriously threaten services nationwide. The Ministry of Health cannot cover more than diagnostics and ART treatment, and to date, municipalities express vague concern regarding support for prevention activities. For a low-prevalence country with economic difficulties, HIV is not a high priority on their agenda.

Most probably, after 2008 the scope of prevention efforts among sex workers will decrease significantly. The national HIV prevention team and local NGOs are lobbying municipalities to include prevention programmes among sex workers in their action plans and budgets. No municipality has yet shown any readiness to support the activities among sex workers (unlike some isolated ones which show concern for drug users). Knowledge in the country on how EU funds can be used is still vague and scarce and the capacity to apply is limited. Most external donors are leaving the country. The EU HIV policy is still a young one and strategies for work with vulnerable groups are not well developed. The voluntary sector is facing huge problems with funding and capacity building. The national government is not very likely to support more than HIV diagnostics and treatment.

Most likely, individual NGOs and networks of NGOs will seek external donors in order to retain some of the services, especially when the country is about to face HIV-concentrated epidemics.

Treatment

With regards to ART treatment, sex workers living with HIV in theory have the same rights as all other patients. Theory is not the same as practice however. Most of them inject drugs and 90% of the identified ones live in Sofia. None of the sex workers identified as HIV-positive have begun treatment or even had their initial medical tests. One was only identified at an advanced stage and eventually passed away. Reasons are of course complex, but the majority of them are related to fear of stigma and discrimination (by relatives, partners, and colleagues), serious psychological barriers, lack of trust on the part of sex workers towards institutions, unrealistic expectations on behalf of treatment centres, and lack of or insufficient social support networks.

[13] *Global Fund to Fight AIDS, Tuberculosis and Malaria*. This fund was created at the G8 summit in 2003 and is currently the biggest donor in the HIV field.
www.theglobalfund.org

Treatment centres often do not provide ART to these people because they are overloaded and they don't know whether these patients will comply with the treatment as they are often homeless, drug users, "glue" users, etc.

Although the Roma population is quite a vulnerable one, there are still very few cases of HIV infection. This is explained because there are still very few infected people in the entire country, but living conditions are in place to indicate that it is a ticking time bomb.

After being diagnosed HIV-positive in the Mobile Medical Units, all of our service users have gone through a very difficult period. In spite of concentrated efforts of outreach workers to spend more time with them, outreach visits were not a suitable venue for this, especially because they wanted to keep their status secret from their colleagues. During the period of dealing psychologically with the result, they had no place or service to access support. Organisations for people living with HIV have limited resources and work mainly with those who are already in treatment.

For drug users

Bulgaria is still facing serious drug problems with a very weak and insufficient system of care. Numbers of drug users are not increasing with the same speed as in the mid-nineties, but the pace is still very high (2,000-3,000 new heroin users per year) and the age of first use is falling. A significant number of new drug users belong to the Roma community.

In the frame of the same GFATM funded programme, prevention efforts with drug users are prioritised and 10 organisations offer harm reduction services. NGOs working with drug users conduct outreach work, use mobile medical units and run drop-in centres. They experience serious difficulties, however, in reaching their clients, mainly because of the unfavourable change in Bulgarian law, enforced in 2005, which criminalises drug possession. This change has sent many drug users to prison and significantly changed their drug-using behaviour. It also led to higher numbers of injecting drug users with HIV throughout the whole country and primarily in the biggest Roma neighbourhoods. Their hidden situation however prevents many from accessing sterile injecting equipment and often it is not perceived as a priority. More than 60% of them have Hepatitis C.

The law change forced a lot more drug users underground and concern over the condition of their equipment became less and less of a priority to them. Usually one person injects everyone in the group, and the others have little control over the process. These "shooting galleries" exist behind closed doors, and outreach workers have great difficulties getting in. Contacts with drug users are mainly made through a "gatekeeper", which impedes efforts to help them change their behaviour: a hard enough thing to do with heroin users in the first place.

Drug-using sex workers are in the most vulnerable position, as they have to be extra careful and consequently are more hidden. They are discriminated against by other sex workers and by controllers, and often have to work for lower rates of pay, without using condoms, and in more dangerous places.

There are currently five methadone programmes in the country, out of which only one is low-threshold and free of charge and it has very limited capacity. All methadone programmes are based on treatment, not harm reduction. Compliance with methadone treatment criteria - requiring all those in treatment to remain drug-free - is difficult and leads to low retention.

Opportunities for treatment are also limited. Free treatment is delivered by psychiatric clinics and by the *National Centre for Addictions,* and they have significantly high threshold. There are several private programmes and some offer a wide range of treatment opportunities, but of course they are charged for.

No HIV-positive injecting drug users have entered into an ART treatment programme. There is an anxiety among treatment specialists with regard to these potential patients' compliance with treatment. A limited number of them are in methadone programmes; some are not willing to disclose their identity (unlike sex workers, whether using drugs or not).

Access to Social Care Services

Public social care services such as shelters and psychological and legal consultations are only available to women who are underage and/or have reported being victims of violence, in particular trafficking. The social services available to other sex workers are limited to social or financial support in raising their children.

When sex workers are not registered at the municipality level, they have no access to social services. This is also determined by their mobility throughout the country.

Services provided

The GOs mainly target sex workers through contracting out to NGOs, who implement the majority of the activities (already described). There are no plans yet regarding how this will continue once the GFATM programme comes to an end.

(Regarding harm reduction services and treatment, please see the section on services for drug users.)

The majority of VCT centres are located at the Public Health Services, which are governed by the Ministry of Health. They can be used by the general population as well as by sex workers, drug users and other uninsured people.

General healthcare is available only to people who are insured. The dermatological and sexual health clinics, which are responsible for STI testing and treatment, can be approached directly: patients do not have to be enrolled in the health system, but in such circumstances they must pay for treatment. This is affordable for most people in cases of syphilis, but more expensive in cases of other STIs.

There are no maternity allowances to women who haven't had a labour contract for at least seven months before birth. The healthcare system also treats emergencies as services and has different prices for uninsured people.

NGOs providing services to sex workers are mainly focused on HIV/STIs and some offer free treatment on the spot or referral to the dermatological and sexual health clinics. Some have negotiated lower prices for sex workers with a local gynaecologist, identified as the most common concern. In most cases treatment is related to pregnancy or complications arising from long-term STIs.

Within the frame of the GFATM-funded programme implemented by the Ministry of Health, nine organisations besides HESED have been selected, trained and supported to offer outreach services to sex workers. Six of them maintain mobile medical units, which offer free medical check-ups, and testing and treatment for HIV, Hepatitis B and C and syphilis. All local dermatological clinics have been included in the activity, offering low threshold services for sex workers.

These outreach services extend to outdoor- as well as indoor-based sex workers. The target set by the Global Fund is to reach 60% of **all** sex workers in the country, so considerable efforts were made in all sub-groups.

In nine cities the Public Health Centres carry out *Second Generation Sentinel Surveillance* and therefore offer free testing. Representatives of the Ministry of Interior have been trained

and involved in the decision-making process. In Sofia there are also several places where sex workers can access contraception for free.

The six mobile medical units (MMUs) equipped and specialised for work with sex workers are located in Sofia, Varna, Rousse, Plovdiv, Haskovo and Bourgas. All of them function under the auspices of the Ministry of Health. Their maintenance is delegated to a local NGO and medical staff are provided by the local STI clinic. This allows the MMUs to function as a bridge between sex workers, STI clinics and other public health and social services.

Health services for both insured and uninsured sex workers are voluntary, anonymous and free of charge**.** They include: VCT for HIV and STIs, medical check-ups, distribution of condoms, lubricants, sterile injecting equipment (including needles and syringes), and adapted educational and health information materials.

As there is only a very small number of migrant sex workers, services do not work with translators or cultural mediators. Migrant sex workers have great difficulty in accessing specialised medical services because the majority are outside the health insurance system and therefore they have to pay high market prices. Maternity care, out of all social and medical services, is identified as the most critical area of social services for sex workers.

Strategies for reaching sex workers

The teams of ten organisations have been able to cover a much larger geographical area and are now very well acquainted with the prostitution scene in the country. They have gained sex workers' trust and are also much better known by the health authorities. Preliminary observations of the third phase of the *Second Generation Sentinel Surveillance Survey,* carried out among 1,100 sex workers in 13 different regions, have revealed a significant decrease in the number of syphilis cases, no HIV cases, and a much better knowledge about certain "risky" practices used by sex workers, which led to the improvement of healthcare-seeking behaviour.

Sex workers are mainly reached through near-daily outreach work carried out by the different organisations. Working under Objective VI of the GFATM-funded programme, this is carried out in more than 23 towns and villages in nine regions of Bulgaria**.** In Sofia, however, there are also other organisations offering services to outdoor-based sex workers, especially those who use drugs. Thanks to these regular visits in the nine Bulgarian regions, detailed information about all relevant services has been provided to female and male sex workers.

Various strategies are used to enter indoor establishments, depending on the situation. Direct contacts are the primary method, but also contacts through SMS, referral from other brothels/bars, through an already known sex worker, through acquaintances with managers, etc. More creative (and brave) strategies are employed for settings which are more difficult to access (like parking areas, border houses) and some of the outreach workers visit posing as clients or as sex workers seeking employment.

Barriers to sex workers' access to services

The main barriers to sex workers' access to health and social services are:

- In December 2006, during the annual meeting of NGOs working with sex workers (under Objective VI: HIV prevention among sex workers of the GFATM Programme), it was concluded that, outside Sofia, at least 80% of all sex workers in each region were reached, both indoor and outdoor. Sex workers who are still not reached are either students who sell sex occasionally, escorts, or sex workers working in a very small number of bars and apartments where access was denied.

It is very difficult to estimate the size of the group in Sofia but approximately 50-60% of all indoor settings have been reached by the team of HESED. Human and financial resources are not sufficient to enable greater coverage. 95% of outdoor-based sex workers in Sofia are covered with both outreach and mobile medical services.

- Because police and other authorities control activities, sex workers tend to live and work in very isolated conditions.
- Mistrust towards institutions and authorities in general.
- The insufficiency or inadequacy of services.

  Services are inadequate mainly because of the high threshold (i.e. they require health insurance, payment and identification) and inconvenient opening hours for sex workers. Many of them close at 2pm or at the latest 4pm.

  HESED provides HIV testing but the strategy is not to duplicate medical services already provided by the government; rather, it is to foster trust in medical staff and then refer the sex workers to them.

  Many sex workers started regularly visiting a Centre for Sexual Health, where they could access free contraception, tests and medical check-ups. The Centre however has become very popular among the general public and long waiting hours have become a serious problem for the sex workers.

  There is a lack of a permanent centre offering specialised services, a safe place to receive medical results and psychosocial support, especially for sex workers living with HIV.
- Lack of registration in a particular living area.
- Lack of knowledge and motivation to use the existing facilities. This is caused by the high threshold of services; inconvenient working hours; long queues; sometimes discriminatory attitudes from staff; fear of compulsory treatment. Other components: not viewing health as a priority; irrational fear of visiting a doctor; lack of desire to spend time, effort and money on health issues; lack of freedom to visit a doctor.

Plans to overcome these difficulties:

- Continue the on-going efforts to increase popularity of the existing services among sex workers, to accompany them whenever necessary, and to work towards making the services themselves more user-friendly, especially for vulnerable groups.
- Introduce stronger campaigns among sex workers for entering the mainstream health system.
- Search for funding to keep and develop the specialised services, which cannot be replaced.

Services for victims of trafficking

Several organisations in the country, including *La Strada* and IOM, offer legal information and advice, psychological counselling, emergency accommodation and support for victims of trafficking, including support for those wishing to return to their home country.

If a sex worker was not trafficked and is not registered as a citizen in a particular area, she has very limited access to social services.

4 GOOD PRACTICE

Reducing vulnerability

- Each of the teams working with sex workers report significant changes in the knowledge and behaviour of their target group: they have seen an increase in the use of condoms, lubricants and other safer sex materials.
- Organised training provides tools for condom negotiation and protection from violence.
- Diagnostics and treatment of STIs decrease sex workers' vulnerability to HIV, and regular HIV tests, along with counselling, make them a lot more aware of HIV than even people outside of the so-called vulnerable groups.
- The current legislation and its enforcement seem to be favourable for sex workers and the services designed for them (apart from the drug-using ones).

Improving access to services

Regular outreach work, and in particular the work of the mobile medical units, has led to an increase in use of health services by sex workers. They are usually referred by the medical doctor at the mobile unit to her own surgery at the clinic where she works. It is much less stressful for them to visit this surgery. A short time later they are referred to other medical professionals, according to their needs and requests.

It is clear, however, that most health services (apart from STI clinics) remain difficult for sex workers to access and that there is a lack of social services accessible to them.

Moves taken to reduce vulnerability:

Vulnerability to HIV infection has been addressed by the above interventions, namely:
- distribution of safer sex supplies and safer injecting equipment
- counselling on HIV, STIs and other sexual and reproductive health issues
- training in skills for condom negotiation, physical safety and professional approach to sex work
- on-the-spot diagnostics and, where possible, treatment of STIs
- on-the-spot diagnostics of HIV, Hepatitis B and C, and syphilis
- empowerment of sex workers, whenever possible, to prevent trafficking and violence, and negotiate with clients and controllers

Moves taken to improve access to services:
- Specialised low-threshold services have been made available to sex workers.
- Referral and accompaniment to health services has been one of the priority tasks of outreach workers.
- Provision of detailed information on all existing services to sex workers and those around them.
- Positive experiences with the MMU medical staff reduce fear and the reluctance to make use of medical services.

- In 2002 HESED, as part of the Albena project[14], invited leading professionals in the field of dermatology and sexual health to develop "Practical Guidelines for HIV/STI control among Sex Workers", which is currently widely used by sexual health clinics.
- Since 2002 HESED regularly takes part in lectures at the Academy for Police Officers.

5 LEGAL FRAMEWORK

Migration

The *Asylum and Migration Law* was developed in 2002 and the last amendments were made in April 2005. This law stipulates the conditions and regulations for granting special protection to foreigners in Bulgarian territory as well as their rights and obligations. The special protection that Bulgaria grants to foreigners within this law includes asylum, refugee status, humanitarian status and temporary protection.

Foreigners seeking or granted protection in Bulgaria receive the rights and obligations according to this law and bear civil, administrative and penal responsibility according to the conditions and regulations applicable to Bulgarian citizens. Asylum is the protection that Bulgaria grants to foreigners persecuted for their beliefs or activities for protection of internationally recognised rights and freedoms.

Sex Work

Sex work in Bulgaria is neither legal nor criminal. Charges are brought against persons who organise paid sexual services. Articles 153, 155 and 156 of the 8th Section of the Penal Code address the organisers of sex industry businesses and people providing venues for sex work as criminal subjects.

Selling or buying sexual services is not illegal. An additional article from the *Law for Public Order* has been recently employed in fining sex workers for "gaining money in an immoral way".

Sex work in Bulgaria has never been included in the Penal Code, apart from pimping and offering venues for paid sexual services. Even if the abovementioned fine is incurred, it's considered an administrative offence. This article is quite vague and mainly targets (according to the statement) people like charlatans, fake money changers, etc. This is not being widely used against sex workers - there have been only isolated cases, but it is still worth drawing attention to them.

Sex work in Bulgaria is still controlled by criminal organisations. Whether a sex worker has a pimp or not, they must still pay the "owner" of the scene for soliciting there.

There has been a strong leaning throughout 2006 towards the legalisation of prostitution. Key criminal structures were the ones defending the law project, strongly supported by the police. The law project has not been made public and most probably aims to be a control instrument rather than being based on sex workers' human rights. This will probably be voted on and put into force in 2007, when tourism is expected to grow with Bulgaria entering the EU. The

[14] Albena Project: prevention of STI and HIV/AIDS and facilitation of provision of comprehensive health and social support for sex workers in Bulgaria, SOAAIDS, HESED, 2001-2003, MATRA Programme

Ministry of Tourism has pushed for legalisation, due to expectations of greater income through (sex) tourism.

According to article 156, §1 of the Criminal Code, a penalty of 10 years imprisonment and a fine of up to 1 million BG Leva (about €514,700) is applied to those who kidnap a woman for the purposes of debauchery. This act is defined as "*Abduction with purpose of debauchery*", but is treated as a special case, in which the subject of the crime targets an additional aim – to commit the victim to a third person for the purpose of debauchery.

The new decree of the same article establishes three additional and heavier charges, which incur a penalty of imprisonment between 3 and 12 years. The underlying hypothesis of this new decree refers to cases in which the victim is under 18 years old, the victim has been committed for debauchery, and especially where the purpose of the abduction is that the victim is committed to debauchery outside the country.

According to article 31 of the Personal Income Tax Act, Part II, Chapter 7, letter (t) and (u) there is a licence tax for companions and masseurs, which implies sex work.

Trafficking in Women

In 2003 a specialised *Law on Combating Illegal Trafficking in Human Beings* was issued, with the last amendments being made in 2005. It regulates the institutionalised response to trafficking in human beings at various governmental and non-governmental levels, including shelters, social reintegration of victims, and prevention of the phenomenon.

The 9th section of the Penal Code of the Republic of Bulgaria concerns "*Trafficking in Human Beings*", punishable by up to ten years in prison and a fine of 15,000 BG Leva (around € 7,700).

Another step taken by Bulgarian legislation towards protection of the victims of trafficking is the decree for witness protection, adopted in 1997, article 97 A of the Criminal code, guaranteeing that witnesses' identities will be protected in cases where their lives, health and property are jeopardised.

Bulgaria signed the Palermo Protocol in December 2000 and ratified it in December 2001[15].

Law Enforcement

There are special units for combating trafficking in women in all police departments, including the Central Police Directorate. They report much better results than before but these are still not satisfactory with regards to convicting traffickers and combating their networks. There is still confusion amongst law enforcement agencies between prostitution and trafficking, which affects the effectiveness of measures taken against both traffickers and those who coerce women into prostitution.

Drug use

The main legal change in the last two years related to the criminalisation of the possession of drugs, with the result that drug users could no longer carry even a small quantity of drugs on their person. Consequently, all drug users were treated as dealers and many were sent to

[15] www.unodc.org/ United Nations Office on Drugs and Crime/ Protocol to Prevent, Suppress and Punish Trafficking in Persons, especially Women and Children, supplementing the United Nations Convention against Transnational Organised Crime.

prison, where they continue to inject drugs, with unsafe practices facilitating the spread of disease in this environment.

This legal change led to a drastic increase in the number of deaths, due to overdose among sex workers injecting drugs.

Additionally, drug-using sex workers became more hidden, their access to health services was hindered significantly and it became more difficult for services to reach them.

The 1999 Law on Drugs regulates the licensing of needle exchange programmes. These are currently all conducted by NGOs. Social reintegration of injecting drug users is lacking and thus a cohesive structure is needed for drug treatment, screening for HIV, and social support. Health insurance does not cover methadone; instead it is provided as part of the Drug Centre's budget[16]. There are also five private methadone programmes, which function well but are quite expensive. Methadone programmes are based on treatment, not harm reduction.

According to the *National Centre for Addictions*, the number of heroin users in Bulgaria is approximately 300,000, but the number of people using cocaine is difficult to estimate.

Currently, the number of sex workers using heroin is approximately 4.5%[17]. Cocaine use however is growing, though no precise numbers are available yet.

6 ORGANISATION

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Mission

To carry out health promotion activities and stimulate the social development of underprivileged groups and communities in Bulgaria. To carry out prevention of HIV/STIs and other diseases.

Vision

To take care of one's health is established as a core individual, community and social value. Communities in Bulgaria participate actively in civil society and have equal opportunities for social development and access to services (health, social and educational).

Aims

At an individual level

- Positive change in the knowledge and attitudes of vulnerable groups towards decreasing risky behaviour and establishment of responsible health-seeking behaviour.
- Support for the development of social skills for people from vulnerable groups so that they can take responsibility and make decisions on their lives and their health.

At a group and community level

- Development of resources for the social development of vulnerable groups and communities.
- Building up positive attitudes, beliefs and group norms regarding health-seeking behaviour.

At an environmental and policy level

[16] World Bank Working Paper, 2003
[17] Second Generation Sentinel Surveillance Survey, 2005, Prevention and Control of HIV/AIDS Programme, Ministry of Health of Bulgaria

- Establishment and enforcement of professional standards in the field of health promotion and prevention of socially significant diseases.
- Active involvement in the establishment of an environment supportive of health choices.
- Participation in the development of social policy endorsing health as a basic value and guaranteeing equal opportunities for all members of society.

Services for Sex Workers

Indoor and outdoor outreach work with sex workers

- Safer sex materials (condoms and lubricants)
- Safer sex and health consultations
- Specifically designed and adapted new information materials - strip brochures on HIV, STIs, family planning, physical safety, etc.
- Referral to other relevant services.
- Safer injecting equipment and consultations.
- Psychological support.
- Prevention of trafficking consultations.
- Training of peer educators for sex workers.
- A mobile medical unit specialising in work with sex workers, offering:
  - Free check-ups
  - Free tests for HIV/STIs and Hepatitis
  - Free treatment and medication
  - Pre- and post- test counselling
  - Free condoms, lubricants and injecting equipment
  - Specialised educational materials.

Approximately 200 female and male street-based sex workers accessed the MMU in 2004 in Sofia. In 2005 about 450 sex workers received VCT services at HESED's mobile medical unit, and 830 in 2006. The unit was funded by the GFATM Programme, and respectively 150 and 175 of the sex workers were respondents in the Second Generation Sentinel Surveillance Survey.