# Institutional Strengthening and Support for HIV Prevention Activities

### **TAMPEP**

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

## Gap Analysis of Service Provision to Sex Workers in Europe



This report is part of a series of reports produced by TAMPEP, that includes the following:

- 1 European Overview of HIV and Sex Work
  - Bulgaria National Report on HIV and Sex Work
  - Czech Republic National Report on HIV and Sex Work
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- 3 Skills, Training and Good Practice Tools

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Gap Analysis on Service Provision

### Introduction

AMPEP (European Network for HIV/STI Prevention and Health Promotion among Migrant Sex Workers) was founded in 1993 in response to the needs of migrant sex workers in Europe. It operates a community development and participation model that is rooted within the human rights framework, and seeks to lay a foundation for equitable access to support and services for sex workers. TAMPEP is an international networking and intervention project focused on assessing the situation and needs of female and transgender (migrant) sex workers in Europe and on developing appropriate responses to reduce sex workers' vulnerability to HIV and sexually transmitted infections.

An understanding of the current reality of sex workers ability to access both health care and social services and gaps in service provision in Europe are critical to strengthening HIV prevention among sex workers in Europe. The TAMPEP service mapping provided both quantitative and qualitative data gathered by network members in 2005 and 2006 and has enabled TAMPEP to gain a broad understanding of sex workers access to public health and social care in 25 European countries; to identify trends and tendencies in relation to sex workers' ability to access health care and social services within Europe; and to identify structural barriers to service provision.

It is important to recognise that while each country has different health and social care policies and different approaches to the issues of health, sex work and to migrants in their territory, TAMPEP's goal was to identify gaps in service provision for sex workers that impact on HIV prevention, counselling, testing and treatment, and thereby restrict sex workers' right to the highest attainable standard of physical and mental health.

The health care and social services which were our focal point were clearly those most relevant to HIV and sex workers, i.e. sexual health care and general health care services. Those are most likely to be required by the specific needs and/or are most likely to respond to the unambiguous working and living circumstances of sex workers.

The first part of this report presents abstracts of the circumstances of the services in 7 selected countries (Bulgaria, Czech Republic, Germany, Lithuania Poland, Romania and Ukraine), focusing on key issues of service provision in those countries and on the entities which offer these services. Complete descriptions of service provision and of the needs of the sex workers are available in the 7 comprehensive National Reports. Whereas, in the present document the objective was to underline the most relevant aspects of the provision of the services, highlight their efficient features and consequently identify the gaps of the provisions. The 7 country reports are completed by a presentation of good practices from other states (Denmark and France). Such a selection serves the purpose of exemplifying the systems and their gaps.

The purpose of this report is to objectively present what areas of service provision for sex workers are not covered, i.e. what are the gaps, within the coverage, which is already being offered in various countries. The service providers differ in the scope of their activity, or in the statutory purpose, at time focusing more on health issues, other times specifically on STIs/HIV, other times being concerned particularly with the situation of sex workers.

The final part of the report presents the **European Gap Analysis** across the selected countries. Based on our European Services Mapping we were able to draw conclusions of what constitutes structural barriers to effective HIV/health services provision. This section of the Report lists TAMPEP's recommendations in response to the identified gaps.

### Methodology of service mapping

In order to clarify, what aspects of services were of interest to us for this analysis, we present the below lists of **Public Heath Care/PHC** and **Public Social Care/PSC**. We can also mention that, in practical terms, health care services are primarily performed by the public sector and social services by NGOs, yet the situation varies from country to country and is not a rule by any means. Every country, or in fact every region of a country, which has delegated competencies in the field of health care and social services, might provide a certain service through the public sector only, along with the NGOs, or completely leave it up to the NGOs.

In the provision of **Public Health Care** TAMPEP mapping focused on services falling within the following areas:

- Access to HIV prevention information, counselling, testing and treatment
- Access to sexually transmitted infection information, testing and treatment
- Access to condoms, lubricants, etc and safer sex information and advice
- Access to drug harm reduction information, needle exchange and drug treatment and rehabilitation
- Access to reproductive health information and treatment
- Access to mental health treatment
- Access to general medical treatment
- Access to dental treatment

In the provision of **Public Social Care** TAMPEP mapping focused on whether migrant sex workers were able to access services falling within the following areas:

- Legal information and advice
- Psychological counselling
- Emergency accommodation / shelter
- Support for victims of trafficking
- Support for those wishing to return to their mother country
- Language courses
- Other training courses

Furthermore we addressed the issue of differentiation in service coverage between migrant and national sex workers, or between those in situation of full legality and those which were undocumented or uninsured. For this purpose we focused on the following aspects:

- Which services are free of charge to migrant sex workers?
- Do social care services work with cultural mediators and/or interpreters?
- Is there an effective referral network to social care services for migrant sex workers?
- What are the critical areas of social care that migrant sex workers cannot access?
- What are the main barriers to migrant sex workers accessing social care services?

In addition, of great interests and importance was to find out the form in which the above services were being provided. We refer here to criteria such as voluntarily, anonymously and free of charge. Among the services which are voluntary, anonymous and free of charge, TAMPEP strived to assess if there is a differentiation between national sex workers and non-insured national sex workers, and non-documented or non-insured migrant sex workers. Aspects of specific health related obligations for sex workers was also analyzed, and for this purpose we tried to asses whether there are compulsory health tests for sex workers. If yes, are they free of charge for all sex workers or is there differentiation between different groups.

As the sex industry is a business where the number of foreigners and the number of nationalities is very high, TAMPEP was aiming to find about how this multicultural feature was being addressed by the service providers. For this purpose we needed to know whether public health care services and NGOs work with cultural mediators and/or interpreters. Moreover, what sort of cooperation exists among services providers. That is the reason why we addressed the issue of referral network to public health care services for migrant sex workers and the level of effectiveness this had.

The fundamental purpose of analyzing the services offered was in fact to establish the missing elements of the offer. For this reason TAMPEP indented to detect what are the critical areas of health care that national and migrant sex workers cannot access and what are the main barriers in accessing HCS.

In order to arrive at our goal of attaining a complete and detailed picture of the European service provision relevant to the sex workers, TAMPEP applied a specific methodology. Our service mapping consisted of carrying out specially designed questionnaires in 25 TAMPEP countries<sup>1</sup>. The study was multilevel, concentrating on regional, country, and internal-country-regional analysis. After having gathered all data, we were able to perform, again in a multilevel, a comparison between the different geographic areas, drawing our conclusions on the observed similarities and disparities. In total we compiled information based on data provided to us by over 1000 respondents, with a disparity of minimum 5 and maximum 52 respondents per country.

National Coordinators were assigned the tasks of: translating the questionnaire and identifying a minimum of 10 key service providers who would be able to provide the required data, sending out and following up on non-returned questionnaires, reviewing the completed ones including clarifying contradictions with informants, and finally, analysing and completing a final mapping report.

#### National Service Mapping Results

#### **BULGARIA**

Sex workers in Bulgaria are mainly nationals, who travel throughout the country and most often are not insured. HIV/AIDS/STI prevention services are being offered in 9 regions in Bulgaria and have low threshold for sex workers.

Identical services are provided to national and migrant sex workers: VCT (Voluntary Counselling and Treatment) for HIV/AIDS and STIs, medical check ups, distribution of

<sup>&</sup>lt;sup>1</sup> See Annex for a copy of the Questionnaire employed.

condoms, lubricants, sterile injecting materials (syringes and needles), and specific educational and health materials. These services are voluntary, anonymous and free of charge.

General health care is however available only to people who are insured.

Both national and migrant sex workers can meet outreach workers in nine regions in Bulgaria. They offer them health consultations, safe sex and safe injecting materials, referral and support, and also adapted educational and health materials. The outreach workers visit all working areas at least once a week. This is a relevant improvement for Bulgaria, i.e. that so many sex workers are being reached by whatever kind of free and anonymous services.

Eleven MMUs (Mobile Medical Units) function under the auspices of the Ministry of Health, their maintenance is delegated to local NGOs and the medical staff is provided by the local STI clinic. This allows the MMUs to function as bridge over the gap between the sex workers and the STI clinics and other public health and social services.

In the frame of the GFATM<sup>2</sup> 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. Their hidden situation prevents many from accessing sterile injecting equipment and often it is not perceived as a priority. More than 60% of them have Hepatitis C. Opportunities for treatments are also limited. Free treatment is delivered by psychiatric clinics and by the *National Centre for Addictions*, and they have significantly high threshold.

#### **Public Health Care**

Apart from the HIV/STI prevention services, sex workers have access only to private health care. In Sofia there are also several places where sex workers can receive contraception for free. With regards to other health care services however, a basic (again not sufficient) package is available for insured sex workers but not for the non-insured ones.

All prevention efforts targeting sex workers are however funded exclusively by external donors. The GFATM 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 (Antiretroviral therapy).

#### **Public Social Services and NGOs**

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.

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.

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<sup>&</sup>lt;sup>2</sup> GFATM/*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

#### CZECH REPUBLIC

The Czech Republic offers selected health care services and tests free of charge (HIV, syphilis, gonorrhoea). Other examinations are paid by the patients. A model program has been started to support victims of trafficking.

Main factors of vulnerability for <u>national</u> sex workers are: not enough information about their rights, low incomes, unemployment, and the "whore" stigma. <u>Migrant</u> sex workers face difficulties because of the situation in their country of origin (low income, dependent family), their weak legal status, their lack of knowledge about their rights, and because of the general bad working conditions.

#### **Public Health Care**

For <u>national</u> sex workers services are voluntary and free of charge. Some brothel owners demand regular health checking, but for majority it is a voluntary decision. It is necessary to have a health insurance. Without one, only emergency treatments are free of charge. HIV testing is anonymous but it is limited, due to the weak financial situation of the Czech Ministry of Health Care. HIV routine testing is only for pregnant women (for the protection of the child). For the rest of the population HIV testing is voluntary, and has to have the patient's agreement.

For <u>migrant</u> sex workers services are voluntary, anonymous and free of charge, but as above, they have to be health insured, otherwise they have to pay for every medical service.

Free of charge is only a basic set of tests which includes HIV, syphilis and gonorrhoea. If a sex worker has a proper health insurance, others tests can be provided free of charge but not anonymously.

Access to drug users centres is available for the general population as well as for sex workers and foreigners. Those centres offer exchange needle programs, food, clothes, etc. Treatment is only available for Czech citizens or for permanent residents with a valid health insurance.

#### **Public Social Services and NGOs**

Few sex workers projects integrate intervention services with prevention measures, commodities. The services offered for <u>nationals and migrant sex workers</u>: distribution of condoms and lubricants, health services, exchange program for IDU, social assistance, and counselling, plus outreach is being carried out. There is support for victims of trafficking through a special governmental program. Only the NGO *La Strada*, for victims of trafficking, works with professional translators. There is also a program for children of sex workers.

Public Social and Medical Care Services are in principle available but sex workers do not feel comfortable to make use of it because most of them are reluctant to talk about their job. NGOs are therefore the ones to provide health services, outreach work, social and legal counselling, shelter, computer training, etc.

<u>Services for drug users</u>: needle exchange, drop-in centres, substitution treatment, treatment and rehabilitation centres, self-help groups, support groups for parents and families of drug users.

<u>Services for male sex workers</u>: in Prague there is a NGO called *Chance*, which offers HIV saliva testing, social services, and a centre for street children.

<u>Services for HIV+/AIDS patients</u>: the *Light House*, which offers accommodation, psychological support, etc.

<u>La Strada</u> offers for trafficked persons: free and anonymous accommodation (for women only), free food and clothing, free social assistance and consultations, limited financial support, facilitation of legal assistance, health care, facilitation of psychological and psychotherapeutic support, assistance of social work: accompanying to other institutions and organizations, assistance to return to country of origin and facilitation of assistance in that country.

#### **GERMANY**

Since 2001, all public health services offer voluntary, anonymous and free of charge HIV/STI testing and (some) treatments for sex workers. There are about 40 *Public Health Care Services* in Germany specialised to attend sex workers, including migrant sex workers. ART treatment has to be paid for if the person is not health insured.

#### **Public Health Care**

The "Law for the Protection of Infections Diseases" effective on January 2001, abolished obligatory STI and HIV testing for sex workers. Since that date, STI tests and treatment, and HIV testing, are voluntary, anonymous, and free of charge for both German and migrant sex workers. Undocumented migrant sex workers, unlike German sex workers who have in many cases private insurance, now gained access to public health care treatment and counselling.

The non-existence of health insurance implies: difficulties accessing in-patient treatment, psychotherapy, drug and alcohol rehabilitation as well as cancer, accident, dental and general medical care. Non-insured sex workers must pay for all these services out-of-pocket. Thus, undocumented migrants have a difficult time accessing HIV treatment and care, maternity and neonatal care.

#### Migrant sex workers main barriers to access PHC

- Lack of language competence from the side of the sex workers
- Lack of language competence from the side of the HCS staff
- Lack of information regarding sources of assistance and the German health care system
- Lack of health insurance and illegal status
- Isolation and mistrust of state officers. Fear of discovery and involuntary repatriation.
- Fear of being controlled
- Cultural barriers. Fear of exclusion.
- Fear of being discriminated against as a sex worker. Insecurity and shyness.
- Dependence on third persons

#### **Public Social Services and NGOs**

Institutions listed the following areas of social care as particularly inaccessible: right to basic assistance without documentation, qualification courses, legal and psychological counselling as well as financial sources.

#### Migrant sex workers main barriers to access NGO

- Mistrust of public institutions as a result of unfamiliarity with the social system in Germany.
- Confuse NGOs with state offices
- Undocumented status and fear of the consequences, insecurity
- High rate of mobility
- Poor language competence on the side of the sex workers
- Dependence on pimps, brothel owners.

- Poor intercultural and language competence on the part of the organizations' co-workers
- Lack of awareness of the counselling centres regarding the situation and the needs of migrant sex workers
- Moral inhibitions (fear and shame)
- Experiences of discrimination and stigmatisation

#### LITHUANIA

All services have to be paid for, with the exception of those at the *Lithuanian AIDS-Centre* (a GO). There are insufficient services for sex workers, who are very much discriminated.

Outreach work for sex workers is done only in Vilnius. The *Lithuanian AIDS Centre* does outreach work around bus and railway stations, on streets and bars. Sex workers can also visit the *Centre*. The NGO created by the *Lithuanian AIDS-Centre* called the *Association of HIV Affected Women (Demetra)* also carries out outreach work in Vilnius streets, bars, saunas, hotels, massage parlours, clubs, and at three railway and bus stations. *Demetra* also makes contact with sex workers in their day centre.

#### **Public Health Care**

National sex workers with social insurance have access to all medical services in polyclinics and maternity centres. In case they are not socially insured, they can access private medical institutions and get contraception, gynaecological care, and mental health, dental and ophthalmic care which are paid services. HIV related care, needle exchange, STI care are available free of charge only at the *Lithuanian AIDS Centre*.

The following services are available voluntary, anonymous and free of charge for non-insured and/or non-documented migrant sex workers, at the *Lithuanian AIDS Centre*: HIV prevention and health promotion information and advice, condoms and safe sex supplies, drug harm reduction information and advice, needle exchange, STI testing and treatment, HIV counselling and testing, and gynaecological care. However, the *Lithuanian AIDS Centre* is unable to provide free HIV/AIDS treatment due to strict state regulations and shortage of resources.

Drug treatment and rehabilitations is also not accessible to migrants for free. There are only two organisations offering free of charge treatment for non-insured drug users.

Abortions are charged in all of cases – both for national and migrant sex workers (except of cases of medical indications and health threat).

Sex work is illegal in Lithuania, therefore health tests are not compulsory.

All medical services in the public health institutions are not anonymous.

#### **Public Social Services and NGOs**

They are accessible to migrant sex workers and to victims of human trafficking. However, a sex worker has to admit being trafficked and that she abstains from selling sexual services in the future in order to benefit of the services available.

There is a lack of NGO services specialised in projects for sex workers. However there is a great development of organisations dealing with anti-trafficking issues. Up to 20 organisations provide services to trafficking victims.

Support to women victims of human trafficking is available in Vilnius, Kaunas, Klaipeda, and Alytus. However, it should be noted that services of these organisation differ a lot and none of

them are oriented towards prevention of trafficking. Some provide information to the victims and their relatives, others help the women to integrate into society and assure psychological rehabilitation. Medical and social support, including shelter, is only available in Vilnius and Klaipeda. The *Lithuanian AIDS Centre* is able to assure professional medical consultations, testing and treatment, as well as psychological and social support.

#### **POLAND**

Free of charge HIV screening is available only in bigger cities in the whole country.

Main vulnerability factors among <u>national</u> sex workers are: poverty, the risk of an HIV/STI infection and unemployment. In addition to this, <u>migrant</u> sex workers also face constant fear of involuntary repatriation because of their weak legal status, exploitation by others (due to their vulnerable situation) and language barriers.

#### **Public Health Care**

For those with health insurance there is quite a good healthcare system in Poland, but none of it is specifically directed at sex workers. There are only a few services directed at sex workers and all of them are NGOs.

Services for nationals and for migrant sex workers are voluntary, anonymous and free of charge. They offer condoms, lubricants, health information materials, and social and legal counselling for both groups.

Non-documented persons must pay for treatment.

There has been a priority change in relation to funds for HIV/AIDS and STI prevention in sex work from the side of the Ministry of Health (via *National AIDS Centre*), as sex work is not seen as a priority issue.

#### Social services by NGOs

There are only few NGOs supporting sex workers, including migrant sex workers. Currently known, apart from TADA, exist *Parasol* (harm reduction organization also working with sex workers) in Krakow, and *La Strada* (national anti-trafficking organization) in Warsaw. TADA is an umbrella organization with branches in different cities. As since a few years ago the financing has been delegated to local governments, the capacity of TADA's branches depends on the resources and priorities of these authorities. TADA's branches financial sustainability is not guaranteed. Services available by TADA: condoms, lubricants, leaflets, social counselling. The offer will be extended soon by the provision of legal counselling.

La Strada Poland provides a wide range of assistance and support services for victims of trafficking.

- *Emergency Assistance*: hotline, recovery of documents, shelter/housing, psychosocial counselling, organisation of release from place of exploitation, medical aid, crisis intervention, basic needs (food, clothes, and toiletry), security arrangements, travel arrangements, search for missing persons.
- Long Term Assistance: legal counselling, security escort, accompaniment during testifying/in court, organisation of guardian for minors, emotional support, psychological and social counselling, psychotherapy, negotiations with family, visits in prisons and

hospitals, job training, job search, education, long term monitoring of cases, monitoring trials.<sup>3</sup>

Training programmes for young women concentrating on job skills and how to find a job, in cooperation with other agencies. This includes an internship with different employers.<sup>4</sup>

Among La Strada's activities are their cross-border activities: a prevention project in Slovakia, specifically focusing on women from Romany communities, jointly developed by La Strada Czech Republic, La Strada Poland and the Alliance of Women in Slovakia. By working together, La Strada Czech Republic and Poland transferred their expertise in providing assistance to trafficked persons, prevention and lobbying to their Slovak counterparts.

TAMPEP network members cooperate with *La Strada* network at the national and cross-border level.

#### **ROMANIA**

The only prevention and care services targeted to sex workers is assured by ARAS (*Romanian Association against AIDS*) a national NGO. Involvement of the NGOs is limited or almost inexistent due to the high level of stigmatisation of sex work in the country and due to the fact that selling sex is a criminal act in Romania, which makes intervention difficult. The association with sex work for NGOs could be negative.

HIV/AIDS treatment is not anonymous. Furthermore, some services are not free of charge for non-insured persons. Only Emergency services are free of charge. It is important to note that the public health system in the country is very weak and underfinanced and even for the general population it cannot support the needs. Additionally, corruption is a frequent phenomenon making the access to public health care very low.

The main vulnerabilities factors for <u>national</u> sex workers are: situation of forced labour and/or dependency on controller or third person, their legal status (because sex work is considered illegal) and their lack of access to medical and social services. Moreover: a rising number of sex workers using injecting heroin, the increasing number of sex workers on the streets, and of Roma sex workers. Roma sex workers are usually very young, and also use injecting drugs. They are highly vulnerable due to their ethnic origin and discrimination against them. ARAS has developed a number of activities in their favour but unfortunately remains the only service that provides assistance to sex workers in the country.

#### **Health Care by NGO**

ARAS offers the following services for national and migrant sex workers on a voluntary, anonymous and free of charge basis: HIV/AIDS/STIs prevention, testing, health promotion information and counselling, risk assessment counselling, risk reduction counselling, information materials, condoms, lubricants, primary medical care, HVA+HVB vaccination, referrals, social assistance, hygienic products, psychological support, drug harm reduction information and advice, needles exchange, distilled water, alcohol swabs, heparin gel, HIV/HVB/HVC counselling, rapid tests and accompanying to clinics and to other service.

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<sup>&</sup>lt;sup>3</sup> Appendix 1 *Services provided by La Strada members* in: "La Strada, European Network Against Trafficking in Women, Facts & Practices" at: <a href="http://www.lastradainternational.org/documents/Facts\_Practices.pdf">http://www.lastradainternational.org/documents/Facts\_Practices.pdf</a>

<sup>&</sup>lt;sup>4</sup> La Strada, European Network Against Trafficking in Women, Facts & Practices" at: http://www.lastradainternational.org/documents/Facts\_Practices.pdf

Services include outreach done by mobile units. Several attempts have also been made to reintegrate victims of trafficking into the society.

Through the *Global Found* the prevention activities of ARAS have good geographical coverage on country level. In the last 2 years the program for sex workers was developed in 10 counties all over Romania and soon it will also be started in another city, Brasov.

The barriers to an efficient service provisions: low governmental involvement constitutes an additional gap is the (practically) inexistent sexual health services for sex workers. Even the base reproductive health services are not available. The level of violence and police harassments (including taking sex workers for testing) and corruption is very high. There is an improvement in the coverage on country level (only ARAS carries out outreach programme) but since the support comes from an external founder, there is an uncertainty about the sustainability of the current and future improvement.

#### **UKRAINE**

Ukraine's medical system provides free of charge medical services for everyone. Each city is divided by district and each district has its own hospital and outpatients' clinic where people can visit a gynaecologist or sexual health specialist for testing or treatment. But in recent years, due to economic crisis in the country, state medical institutions have become very poor and are unable to provide visitors with indispensable items, tests, syringes etc. Patients who are obliged to stay in hospital for surgery have to bring surgical gloves, syringes, disinfecting substances, cotton, bandages and so on, and must buy their own medicines, because hospital budgets are too low to provide it.

Having recognised the HIV epidemic as a national threat, the Ukrainian Parliament and the Government identified a strategic response to AIDS as one of the top priorities of state policy in the sphere of health care and social development; the National AIDS Programme was written for 2004-2008. In accordance with current legislation, the Ministry of Health of Ukraine is responsible for the management and coordination of national HIV/AIDS activities, in collaboration with other central and local governments, as well as private enterprises, institutions, organisations and communities.

#### **Public Health Care**

In every regional city of Ukraine there is an AIDS Centre providing people with HIV prevention tools, HIV testing, treatment for opportunistic infections and, since recent years, ART for some groups of HIV-positive people. Ukraine is made up of 25 regions and since 2004 there are AIDS Centres in each of them. Some centres are well-staffed with 35-40 members; others are smaller. This is why levels and availability of services in AIDS vary by region. Usually visitors can undergo HIV testing in AIDS Centres, but sometimes tests are not available. In recent years private clinics and medical centres have appeared in Ukraine. In contrast with the state ones, they aim to provide patients with all possible kinds of testing, but all the services are rather expensive and not everyone is able to become a private patient.

Sex workers, like all citizens of Ukraine, can use PHC, but usually they do it only in critical situations where there is no other alternative. In state clinics they do not tell doctors that they work in the sex industry - often they are afraid or ashamed to ask questions and to truthfully describe their health complaints. The exception is when NGOs dealing with sex workers

develop an agreement with hospitals or physicians to set aside time to provide certain medical services.

Most sex workers still do not have adequate access to services, as there are too few NGO running projects, hardly any user-friendly government services, and many projects seem to reach only a minority of sex workers in their cities.

Services for the diagnosis, treatment and counselling of STIs are provided by a specialised network of Dermatology-Venereology Clinics located in every regional city. Usually such clinics have patient and outpatient departments and, like the overall system of state medical care in Ukraine, they have a very low budget for diagnostics and treatment. Confidential information has been known to leak from institutions.

#### **Health Care by NGOs**

Many of the achievements in providing sex workers with medical services are due to the activities of the Ukrainian NGOs working in different regions of the country. In spite of sex workers' inclusion as a high-risk group in the 2004-2008 National AIDS Programme, the state healthcare system alone can not cover all the needs and government services still not always offer user-friendly quality. In 2006, 15 non-governmental organizations in 14 cities provide health services for female sex workers, mainly with street- and highway-based workers, reaching only around 35% of the target group in their cities, which constitutes a very low coverage.

Therefore, in spite of the improvement of the geographical coverage of the prevention and care activities most sex workers do not have sufficient access to adequate services. The NGOs running prevention projects have no or very limited resources and a gap in the governmental services.

Despite the improvement in the HIV prevention and care for high risk population enabled by the GFATM, NGO's presence in the territory and the outreach activities are not supported by a guarantee and continuity of resources. Majority of activities are based on small grants by external donors and on project base. Interruptions in providing access to medical services sometimes lasting for months - have a negative influence on the health and behaviour of sex workers as well as on the continuation of the programme.

<u>Services available to drug users</u>: rehabilitation, needle exchange, legal assistance, methadone, social assistance, assistance in setting up businesses for those who successfully underwent detoxification, and counselling before and after HIV testing. Medical workers visit drug users and provide testing on outreach.

Services for victims of trafficking: International Organization for Migration (IOM) Office in Ukraine and *La Strada* Ukraine offer the following services: broad range of assistance for trafficked persons, "Hotline" for emergency telephone assistance, research on violence against women, expertise on legislation and advisory capacity concerning women's status in Ukraine, educational programmes for youth on women's rights, prevention of trafficking in women, and other kinds of violence and exploitation, cooperation with mass media and distribution of information about the issues, publishing and distributing materials, bulletins and leaflets, cooperation with governmental and non-governmental organizations in Ukraine and abroad with the goal of preventing trafficking in women and providing assistance for trafficked persons, cooperation with law enforcement bodies and lawyers in the field of improving Ukrainian legislation concerning trafficking in human beings, and trafficked persons' protection.

#### Overview of key indicators

	Population (in millions)	Income per capita (in US\$)	Estimated Number of Sex Workers	Migration estimates
Bulgaria	7.7	3.450	7.000 (-0.1% pop.)	3.5 million emigrants
Czech Republic	10.2	10.710	10.000 (-0.1% pop)	No data provided
Germany	82.5	34.580	(400.000) (-0.5% pop)	(10% of population are immigrants, 20% have migration background)
Lithuania	3.4	7.050	3.000 (-0.1% pop.)	300.000 emigrants
Poland	38.2	7.110	8.000 (+ 0.2% pop.)	2 million emigrants in the UK alone
Romania	21.6	3.830	No data provided	2004: 13.000 <sup>5</sup> (62% women/ 8.000)
Ukraine	47.1	1.520	50.000 (+ 0.1%)	1 million emigrants

#### National GAPS & RECOMMENDATIONS

#### RECOMMENDATIONS

### Bulgaria

#### Lack of appropriate and targeted support and services for Roma ethnic minority.

Although the Roma account for at least 10% of the Bulgarian population approximately 70% of street based sex workers are Roma.

Increasing number of male and transgender sex workers in Bulgaria, most are Romas.

Drug use and dependency is increasing within the Roma communities.

Low health culture within Roma communities; they are disproportionately affected by Tuberculosis, Hepatitis and HIV.

The majority of Roma are not health-insured and have no registered address which restricts access to both health and social care.

- Develop appropriate and comprehensive support and services with and for the Roma communities.
- Develop strategies for reaching and engaging with Roma sex workers, including training peer educators and cultural mediators.
- Provide training to sex work projects and other service providers in relation to working with male and transgender sex workers.
- Ensure appropriate access to health care, including developing medical outreach services to provide testing, counselling and treatment within the Roma communities.

#### Lack of access to drug harm reduction services, including drug treatment and rehabilitation programmes.

The criminalisation of the possession of illicit drugs in 2004 resulted in drug users, particularly drug using sex workers, being driven underground making it more difficult for both sex work projects and drug harm reduction projects to conduct outreach services. There has been a significant increase in deaths due to drug overdoses since 2004.

There are only 5 drug treatment programmes offering substitute prescribing of Methadone

- Develop appropriate and comprehensive drug harm reduction services, including drug treatment and rehabilitation.
- Develop strategies for reaching and engaging with drug users, including training peer educators
- Extend substitute prescribing beyond methadone and provide social support as essential component of drug treatment programmes.

Gap Analysis on Service Provision

<sup>&</sup>lt;sup>5</sup> Governmental Statistics Office figures

across Bulgaria, only one of which is lowthreshold and free of charge. The programmes are based on medical model of drug treatment rather than a holistic approach to drug dependency.

#### Stigma and discrimination

Professionals in many public services continue to treat sex workers in a judgemental and discriminatory manner.

Many sex workers lack trust in service providers, and have a lack of accurate information about services and their rights.

- Develop anti-discrimination training programme (in collaboration with sex work projects) for the sensitisation of professionals working with sex workers.
- Develop and disseminate promotional and educational materials about services available and sex workers rights to access services and be treated with respect.

### Lack of comprehensive geographic, temporal and sex work setting coverage

HIV prevention services are limited in cross border areas where there has been an increase in commercial sex.

HIV prevention services are limited in seasonal tourist areas where there has been an increase in commercial sex.

No targetted HIV prevention for clients of sex workers.

- Develop regular mapping and assessment of sex work settings across the country; review configuration of existing service delivery and develop new services as appropriate to respond to the needs of sex workers and changing geographic, seasonal or sex work setting trends.
- Develop cooperation and partnership working with sex work projects and other service providers from bordering countries especially Romania, Turkey and Greece
- Develop and promote peer education training and activities as a means of reaching highly mobile sex workers
- Develop and promote appropriate educational campaigns for clients in relation to safer sex, HIV prevention and attitudes to sex workers, including promoting peer education among clients.

#### Lack of accessibility of HIV treatment

Although numbers of sex workers living with HIV are currently very low, primarily among injecting drug users, those who have been diagnosed are not accessing appropriate HIV treatment and health care. The reasons given for not accessing treatment are lack of confidence in health care providers, stigma, discrimination, and inadequate social support.

HIV prevalence is currently low, however, should HIV prevalence rapidly increase then lack of accessible HIV prevention, treatment and health care will present a significant threat to public health.

- Ensure accessible HIV prevention/drug harm reduction services for injecting drug users.
- Develop training for health care providers working with drug users and sex workers living with HIV.

Lack of programmes to prevent and protect vulnerable children and young people from sexual abuse, including through prostitution.

Lack of communication and partnership working with agencies working with excluded young people.

- Develop early intervention/prevention programmes for vulnerable children and young people, particularly those in residential care and within the Roma community
- Develop and implement appropriate child protection protocols, which ensure the best interest of the child is priority
- Ensure young people who continue to be involved in prostitution have access to information, support and services that may enable them to protect

themselves from HIV, STIs and unwanted pregnancies.

### Czech Republic

### Lack of comprehensive geographic, temporal and sex work setting coverage

HIV prevention services are limited in border areas where there has been a significant increase in commercial sex. There is high mobility from, around and towards these border areas among both migrant and national sex workers

Lack of regular and consistent HIV prevention outreach services to newly emerging 'hidden' indoor and outdoor sex work settings.

Lack of effective strategies for responding to sex work settings becoming more mobile and 'hidden' as a result of law enforcement initiatives

No targeted HIV prevention for clients of sex workers.

Lack of planning to respond to increased mobility and migration flow when Czech Republic becomes member of the Schengen Zone in January 2009.

#### Develop regular national mapping and assessment of sex work settings across the country; review configuration of existing service delivery and develop new services as appropriate to respond to the needs of sex workers and changing geographic and sex work setting trends. Particular attention will be required when Czech Republic join Schengen Zone in 2009.

- Develop cooperation and partnership working with sex work projects and other service providers from bordering countries especially Germany and Austria.
- Develop and promote peer education training and activities as a means of reaching highly mobile and 'hidden' sex workers
- Develop and promote appropriate educational campaigns for clients in relation to safer sex, HIV prevention and attitudes to sex workers, including promoting peer education among clients.

## Lack of use of translators and cultural mediators when working with migrant sex worker

Only *La Strada*, an NGO providing support for victims of trafficking, works with professional translators.

With approximately 40% of sex workers being estimated to be migrants there is a need to ensure that services are able to communicate effectively, particularly when providing support around client violence or abusive controllers.

- Ensure sex work projects and other service providers can communicate with migrant sex worker.
- Ensure professional translators and cultural mediators are selected and trained appropriately for working with sex workers

### Lack of appropriate and targeted support and services for Roma ethnic minority.

Approximately 50% of street based sex workers are Roma.

Develop strategies for reaching and engaging with Roma sex workers, including undertaking a needs assessment, training peer educators and cultural mediators.

## Lack of access to drug harm reduction services, including drug treatment and rehabilitation programmes.

Approximately 30% of sex workers reported illicit drug use, primarily psycho-stimulants. Levels of drug dependency or problematic drug use were not reported.

- Develop cooperation and partnership working between sex work projects and drug harm reduction services.
- Develop comprehensive drug harm reduction services that are appropriate for psycho-stimulant non-injecting as well as injecting drug users engaging in sex work.
- Develop strategies for reaching and engaging with drug users, including training peer educators.

Lack of knowledge among sex workers about existence of and access to services, particularly free of charge health care services

- Develop promotional materials for services for sex workers that can be distributed in sex work settings.
- Increase outreach services to both indoor and outdoor settings
- Encourage gatekeepers to disseminate information about services to sex workers
- Develop and promote peer education training and

activities as a means of reaching highly mobile and 'hidden' sex workers.

### Germany

#### Lack of understanding of needs of migrant sex workers within public health and social care services

With approximately 60% of sex workers being estimated to be migrants (may of who are undocumented, isolated and highly mobile) it is essential that public health and social services staff across Germany have an understanding of the needs of migrants.

- Provide training to public services staff regarding background, values and habits of the different migrant groups.
- Public health and social care services should train and employ cultural mediators and use professional translators on a regular basis when working with migrants.

## Lack of services and comprehensive geographic coverage in the border and cross border area.

HIV prevention services are limited in border and cross border areas where there has been a significant increase in commercial sex and where sex workers are highly mobile.

- Ensure that appropriate services are developed in cross border areas where commercial sex occurs.
- Develop cooperation and partnership working with sex work projects and other service providers from bordering countries, particularly Poland, Czech Republic and Austria.
- Develop and promote peer education training and activities as a means of reaching highly mobile sex workers.

### Lack of knowledge among clients about HIV prevention and safer sex

The increased demand for unprotected sex by clients highlights a lack of knowledge about HIV prevention, safer sex and respect for sex workers.

 Further develop and sustain the educational campaigns targeting clients of sex workers, regarding safer sex practices and attitudes towards sex workers.

## Lack of access to HIV treatment and health care for non health-insured and undocumented sex workers living with HIV.

HIV counselling and testing is provided by public health care services for all – free of charge and on a voluntary and anonymous basis. However, a non-health-insured/undocumented person who receives a positive diagnosis for HIV infection is not entitled to free of charge HIV treatment and health care.

- Public health services should recognise HIV as a sexually transmitted infection and should provide free of charge treatment for non-health insured/undocumented persons as they do for other STIs.
- Ensure access to ART for all people living with HIV.

### Lack of comprehensive social support and services for adult sex workers

Reduction in funding to NGOs who have historically provided social support and services to both migrant and national sex workers.

Lack of funding for social support services which promote sex workers' personal development and empowerment and assist sex workers wishing to move on within or from sex work.

Lack of training within public support services to enable staff to respond appropriately to the complex and diverse needs of sex workers. In addition, undocumented migrant sex workers do not have access to public social services, unless for the purpose of voluntary repatriation or as a recognised victim of trafficking.

- Ensure social support and services are accessible to all engaged in selling sexual services – regardless of where they are from and how they became involved.
- Community based NGOs should continue to be funded and supported as the most effective means of meeting the needs of sex workers.
- Ensure lifelong learning and employability programmes are accessible to sex workers.
   Provide realistic opportunities for alternative employment for those wishing to move on from sex work.

#### Lithuania

### Lack of comprehensive geographic and sex work setting coverage

HIV prevention services are limited to Vilnius and Klaipeda.

Lack of effective strategies for responding to sex work settings becoming more mobile and 'hidden' as a result of the criminalisation of clients.

No targeted HIV prevention for clients of sex workers. The criminalisation of clients should not prevent HIV prevention education campaigns targeting clients in the same way that the criminalisation of sex workers does not prevent HIV prevention education and services being provided.

- Develop regular national mapping and assessment of sex work settings across the country; review configuration of existing service delivery and develop new services as appropriate to respond to the needs of sex workers and changing geographic and sex work setting trends.
- Develop and promote peer education training and activities as a means of reaching highly mobile and 'hidden' sex workers
- Develop and promote appropriate educational campaigns for clients in relation to safer sex, HIV prevention and attitudes to sex workers, including promoting peer education among clients.

## Extremely limited access to appropriate health and social care services for sex workers.

Only one health care service provides voluntary, anonymous and free of charge medical care which can therefore be accessed by non-health-insured (migrant) sex workers.

There are only four organisations funded to provide HIV prevention support and services for sex workers, while there are 18 organisations funded to provide support victims of trafficking.

Lack of communication and partnership working among organisations providing support and services to sex workers, resulting in a possible double counting of sex workers due to high mobility.

- Improve national access HIV and STI counselling, testing and treatment services for sex workers.
- Extend support and services for sex workers beyond current focus on sexual health and drug use.
- Ensure health and social support and services are accessible to all engaged in selling sexual services – regardless of where they are from and how they became involved.
- Develop cooperation and partnership working between sex work projects and other service providers and establish a national network

### Lack of knowledge among sex workers about existence of and access to services

- Develop promotional materials for services for sex workers that can be distributed in sex work settings.
- Increase outreach services to both indoor and outdoor settings
- Encourage gatekeepers to disseminate information about services to sex workers
- Develop and promote peer education training and activities as a means of reaching highly mobile and 'hidden' sex workers.

## Lack of access to drug harm reduction services, including drug treatment and rehabilitation programmes.

Approximately 60% of outdoor based sex workers are drug dependent, the majority inject illicit drugs.

- Ensure drug harm reduction services, including drug treatment and rehabilitation are accessible to sex workers.
- Develop cooperation and partnership working between sex work projects and drug harm reduction services.

Develop strategies for reaching and engaging with drug users, including training peer educators.

### Lack of personal safety and crime reporting initiatives for sex workers

Sex workers face an administrative fine for

 Policy makers should address as a matter of urgency the barrier to sex workers having equal protection of the law and develop protocols for enabling sex workers to report crimes of violence engaging in sex work which is a significant barrier to sex workers reporting crimes against them and having equal protection from the law as is there right.

The anti-trafficking/combating men purchasing sexual services educational material developed does not address the issue of the unacceptability of crimes of violence, such as abduction, assault, attempted murder, rape, sexual assault against sex workers.

- and abuse to law enforcement officers without any penalty.
- Policy makers should ensure that gender based violence strategies include tackling the disproportionate levels of violence experienced by sex workers.
- Develop training and protocols for implementing personal safety and crime reporting initiatives for sex workers.

### Limited access to social and legal services for migrant sex workers

Services are only accessible for migrant sex workers if they admit to and are recognised as having been victims of trafficking and if they agree to abstain from working in the sex industry in the future.

 Ensure health and social support and services are accessible to all engaged in selling sexual services – regardless of where they are from and how they became involved.

#### **Poland**

Lack of programmes to prevent and protect vulnerable children and young people from sexual abuse, including through prostitution.

Increasing numbers of under 18 year olds have been reported as involved in prostitution.

Lack of communication and partnership working with agencies working with vulnerable and excluded young people.

- Develop early intervention/prevention programmes for vulnerable children and young people, particularly those in residential care and within the Roma community
- Develop and implement appropriate child protection protocols, which ensure the best interest of the child is priority
- Ensure young people who continue to be involved in prostitution have access to information, support and services that may enable them to protect themselves from HIV, STIs and unwanted pregnancies.

#### Stigma and discrimination

Professionals in many public services continue to treat sex workers in a judgemental and discriminatory manner. Sex work continues to be referred to as a social pathology by many policy makers and service providers.

Many sex workers lack trust in service providers, and have a lack of accurate information about services and their rights.

- Develop anti-discrimination training programme (in collaboration with sex work projects) for the sensitisation of professionals working with sex workers.
- Develop and disseminate promotional and educational materials about services available and sex workers rights to access services and be treated with respect.

## Lack of access to drug harm reduction services, including drug treatment and rehabilitation programmes.

Drug use is reported as common, however, psycho-stimulant drug use is increasing while opiate based (injecting) drug use is declining.

- Develop appropriate and comprehensive drug harm reduction services, including drug treatment and rehabilitation that are appropriate for psychostimulant non-injecting as well as injecting drug users engaging in sex work.
- Develop strategies for reaching and engaging with drug users, including training peer educators.
- Develop communication and partnership working between sex work projects and drug harm reduction services

Lack of use of translators and cultural mediators when working with migrant sex workers

Only La Strada, an NGO providing support for

 Ensure HIV prevention services are accessible to migrant sex workers and that sex work projects and other service providers can communicate with migrant sex workers. victims of trafficking, works with professional translators.

With approximately 30% of sex workers being estimated to be migrants there is a need to ensure that services are able to communicate effectively, particularly when providing support around client violence or abusive controllers.

 Ensure professional translators and cultural mediators are selected and trained appropriately for working with sex workers

### Lack of comprehensive geographic and sex work setting coverage

HIV prevention services are limited in cross border areas where there has been an increase in commercial sex.

HIV prevention services are limited in small towns and rural areas where there has been an increase in commercial sex.

No targetted HIV prevention for clients of sex workers.

- Develop regular mapping and assessment of sex work settings across the country; review configuration of existing service delivery and develop new services as appropriate to respond to the needs of sex workers and changing geographic or sex work setting trends.
- Develop cooperation and partnership working with sex work projects and other service providers from bordering countries especially Germany, the Czech Republic, Slovakia and Ucraine.
- Develop and promote peer education training and activities as a means of reaching highly mobile sex workers
- Develop and promote appropriate educational campaigns for clients in relation to safer sex, HIV prevention and attitudes to sex workers, including promoting peer education among clients.

#### Romania

#### Stigma and discrimination

Professionals in many public services continue to treat sex workers in a judgemental and discriminatory manner.

Many sex workers lack trust in service providers, and have a lack of accurate information about services and their rights.

The criminalisation of sex work inhibits sex workers access to public health and social care services and perpetuates social exclusion

- Develop anti-discrimination training programme (in collaboration with sex work projects) for the sensitisation of policy makers and professionals working with sex workers.
- Develop and disseminate promotional and educational materials about services available and sex workers rights to access services and be treated with respect.

## Lack of access to drug harm reduction services, including drug treatment and rehabilitation programmes.

It is estimated that there are 24,000 injecting drug users in Bucharest alone, representing 1% of the city's population. Injecting drug use is prevalent among sex workers.

- Further develop and ensure drug harm reduction services, including drug treatment and rehabilitation are accessible to sex workers.
- Extend substitute prescribing and ensure access to range of substitutes beyond methadone and provide social support as essential component of drug treatment programmes.
- Develop cooperation and partnership working between sex work projects and drug harm reduction services.
- Develop strategies for reaching and engaging with drug users, including training peer educators.

### Lack of appropriate and targeted support and services for Roma ethnic minority.

Romas are disproportionately represented among sex workers.

Drug use and dependency is increasing within the Roma communities.

- Develop appropriate and comprehensive support and services with and for the Roma communities.
- Develop strategies for reaching and engaging with Roma sex workers, including training peer educators and cultural mediators.
- Ensure appropriate access to health care,

Low health culture within Roma communities with limited access to both health and social care.

including developing medical outreach services to provide testing, counselling and treatment within the Roma communities.

### Lack of personal safety and crime reporting initiatives for sex workers

The criminalisation of sex work and corruption among law enforcement officers are significant barriers to sex workers reporting crimes against them and having equal protection from the law as is there right.

- Policy makers should address as a matter of urgency the barriers to sex workers having equal protection of the law, including corruption within law enforcement agencies, and develop protocols to enable sex workers to report crimes of violence and abuse.
- Develop anti-discrimination training programmes for law enforcement officers.
- Policy makers should ensure that gender based violence strategies include tackling the disproportionate levels of violence experienced by sex workers.
- Develop training and protocols for implementing personal safety and crime reporting initiatives for sex workers.

#### Lack of programmes to prevent and protect vulnerable children and young people from sexual abuse, including through prostitution.

25% of sex workers reported that they were less than 19 years old, 60% of them reported selling sex services before they were 18 years old.

Romas are disproportionately represented among children and young people involved in prostitution.

Lack of communication and partnership working with agencies working with excluded young people.

- Develop early intervention/prevention programmes for vulnerable children and young people, particularly those in residential care and within the Roma community
- Develop and implement appropriate child protection protocols, which ensure the best interest of the child is priority
- Ensure young people who continue to be involved in prostitution have access to information, support and services that may enable them to protect themselves from HIV, STIs and unwanted pregnancies.

### Lack of comprehensive geographic and sex work setting coverage

HIV prevention services are limited in cross border areas where there has been an increase in commercial sex.

ARAS is the only organisation providing HIV prevention service to sex workers, although it has satellite services outside of the capital it is limited to major cities

In addition ARAS does not undertake outreach services to indoor sex work settings.

No targeted HIV prevention for clients of sex workers.

- Develop regular mapping and assessment of sex work settings across the country; review configuration of existing service delivery and develop new services as appropriate to respond to the needs of sex workers and changing geographic or sex work setting trends.
- Develop cooperation and partnership working between ARAS and other service providers from bordering countries especially Bulgaria, Hungary and Ukraine.
- Develop and promote peer education training and activities as a means of reaching highly mobile and 'hidden' sex workers
- Develop training and protocol for negotiating with gatekeepers, including controllers, of sex work settings.
- Develop and promote appropriate HIV prevention education messages for gatekeepers and encourage them to disseminate information to sex workers
- Develop and promote appropriate educational campaigns for clients in relation to safer sex, HIV prevention and attitudes to sex workers, including promoting peer education among clients.

### Lack of comprehensive health and social support and services for adult sex workers

ARAS is the only organisation in Romania providing support and services to sex workers. Public health and social care services are not accessible to sex workers.

No support available for sex workers wishing to move on from sex work, only two organisations funded to provide support to victims of trafficking.

- Further develop and extend health and social care services to sex workers.
- Ensure health and social care support and services are accessible to all engaged in selling sexual services – regardless of where they are from and how they became involved.
- Provide realistic opportunities for further education and alternative employment for those wishing to move on from sex work.

#### Ukraine

## Lack of access to drug harm reduction services, including drug treatment and rehabilitation programmes.

It is estimated that there are 400,000 injecting drug users in the Ukraine, the 43 harm reduction programmes currently reach less than 25%. It is estimated that more than 20,000 sex workers inject drugs, however, there is a significant variation in levels of injecting drug use among sex workers across Ukraine. HIV prevalence among injecting sex workers has ranged between 25% and 80%.

- Develop cooperation and partnership working between sex work projects and drug harm reduction services, particularly in areas where injecting drug use is prevalent among SEX WORKER.
- Further develop, extend geographic coverage and ensure drug harm reduction services, including drug treatment and rehabilitation are accessible to sex workers.
- Extend substitute prescribing, ensuring appropriate levels of prescribing and access to range of substitutes beyond methadone and provide social support as essential component of drug treatment programmes.
- Develop strategies for reaching and engaging with drug users, including training peer educators.

### Lack of comprehensive health and social support and services for adult sex workers

It is estimated that only 1 in 3 sex workers are in contact with HIV prevention support services

Public health care services are constrained by economic problems which require patients to bring surgical gloves, syringes, disinfecting substances, cotton, bandages etc and to pay for medicines.

Few sex workers choose to access public health care services unless it is a critical situation and they have no other alternative.

- Develop and extend public and NGO health and social care services for sex workers, including the development and implementation of training programmes for professionals in both public services and NGOs (social workers, outreach workers, medical doctors, nurses, psychologists, etc).
- Ensure sex workers are involved in the design, development, implementation and evaluation of services.
- Ensure health and social care support and services are accessible to all engaged in selling sexual services – regardless of where they are from and how they became involved.
- Provide realistic opportunities for further education and alternative employment for those wishing to move on from sex work.

### Lack of comprehensive geographic and sex work setting coverage

HIV prevention services are limited to major cities

Lack of effective strategies to identify and respond to mobile and 'hidden' sex work settings.

Lack of regular and consistent HIV prevention outreach services to indoor based sex work settings.

- Develop regular mapping and assessment of sex work settings across the country; review configuration of existing service delivery and develop new services as appropriate to respond to the needs of sex workers and changing geographic or sex work setting trends.
- Utilise knowledge and experience of other sex work projects that have developed strategies for reaching out and engaging with sex workers in diverse sex work settings, both in Ukraine and

No targeted HIV prevention for clients of sex workers.

internationally.

- Develop cooperation and partnership working between sex work projects and other service providers. Further develop the national network of sex work projects and other service providers working with sex workers.
- Develop and promote peer education training and activities as a means of reaching highly mobile and 'hidden' sex workers
- Develop training and protocol for negotiating with gatekeepers, including controllers, of sex work settings.
- Develop and promote appropriate HIV prevention education messages for gatekeepers and encourage them to disseminate information to sex workers
- Develop and promote appropriate educational campaigns for clients in relation to safer sex, HIV prevention and attitudes to sex workers, including promoting peer education among clients.

Lack of programmes to prevent and protect vulnerable children and young people from sexual abuse, including through prostitution.

- Develop early intervention/prevention programmes for vulnerable children and young people, particularly those in residential care and in rural area
- Develop and implement appropriate child protection protocols, which ensure the best interest of the child is priority
- Ensure young people who continue to be involved in prostitution have access to information, support and services that may enable them to protect themselves from HIV, STIs and unwanted pregnancies.

### Lack of accessibility to appropriate HIV and STI treatment

Lack of accessible HIV and STI prevention, counselling, testing and appropriate treatment presents a significant threat to public health.

It is estimated that only 41% of patients with an STI were properly diagnosed and appropriately treated

There is limited availability of ART for people living with HIV, it is estimated that only 13% of people living with HIV receive ART. The generic ART available is reported as having extreme side effects.

- Develop training for health care providers working with drug users and sex workers living with HIV.
- Ensure accessible HIV prevention/drug harm reduction services for injecting drug users and sex workers

#### Stigma and discrimination

Professionals in many public services continue to treat sex workers in a judgemental and discriminatory manner.

Many sex workers lack trust in service providers, and have a lack of accurate information about services and their rights.

- Develop anti-discrimination training programme (in collaboration with sex work projects) for the sensitisation of policy makers and professionals working with sex workers.
- Develop and disseminate promotional and educational materials about services available and sex workers rights to access services and be treated with respect.

#### **Alternative Models**

In addition to the 7 countries identified by the UNFPA (Bulgaria, Czech Republic, Germany, Lithuania, Poland, Romania and Ukraine) two further national reports (Denmark and France) are provided as examples of service provision required to meet the complex and diverse needs of sex workers. Denmark provides an example of a comprehensive social care system for sex workers (NB although only for documented migrant and national sex workers and recognised victims of trafficking). While France provides an example of the most comprehensive range of HIV prevention, counselling, testing and treatment services for undocumented migrants of any country in Europe.

#### **DENMARK**

Denmark is an example of a comprehensive and coordinated action plan for sex workers based on GOs, with high level of governmental support, yet only intended for "persons in prostitution" with legal residence status. This action plan is a good example of governmental involvement however contains low participation of sex workers' organisations and NGOs dealing with migrants.

#### **Competence Centre on Prostitution**

The establishment of a nationwide Competence Centre for Prostitution in Denmark had a significant impact on sex workers situation in Denmark is.

The staff is composed of 12 persons (8 are social workers doing outreach work). The Danish Government has granted 45 million Danish Crowns (about 6 million Euros) to this overall effort to help and support men and women in prostitution. The target group of the action plan is "persons in prostitution" with residence permit in Denmark.

#### **Main characteristics**

- Nationwide social outreach work starting from teams placed in the three biggest cities
- Building bridges between the social and health care system and the people working in prostitution in Denmark
- Strengthening job alternative programs for prostitutes
- Awareness rising and capacity building among social workers at the municipality level
- Support when a prostitute needs to get in contact with the authorities by providing an assessor
- Counselling on safe sex conduct, and on economical, legal, social and personal matters
- Psychological counselling
- An anonymous telephone, and internet counselling for prostitutes and costumers
- Capacity building among employees at residential homes for young persons to be aware of and to avoid that the young persons get involved in prostitution
- The Competence Centre in Odense has been in contact with approximately 200 clinics.

#### Results of the action plan

■ The action plan has resulted in outreach work in massage parlours in Denmark's main cities (Århus, Ålborg, Odense, Herning and Randers), where the majority of sex work activities takes place. In most of the massage parlours, social workers were welcomed and they distributed leaflets on safe sex conduct, condoms, visit cards etc. In September 2006 the outreach work included Copenhagen and the rest of Zealand.

- Counselling on safe sex conduct, and on economical, legal, social and personal matters have started and some women in prostitution have got psychological counselling and are connected to rehabilitation programs.
- The anonymous telephone counselling for costumers have been busy since it opened.
- Capacity building among social workers at the municipality level have been organised in the second largest city in Denmark (Århus).

The project, however does outreach only in the indoor prostitution area and offers counselling only for those speaking Danish - although migrants represent about 50% of the sex workers population. The gap in contacting and reaching migrant sex workers is still there. Also the access to social supportive measures is limited to the legal residents in the country. On the other hand, everyone (Danish and non-Danish) has the right to be tested anonymously for HIV/STI<sup>6</sup>.

**Public Health Care** - It is difficult to make a summary on the Danish public health care services because it varies from city to city. In Århus there is no formal agreement with the hospital to provide terminations for migrant sex workers. In Copenhagen, the *Nest Stop Trafficking Centre* pays the abortion for victims of trafficking at the Bispebjerg hospital.

**Public Social Care** - They are primarily targeting presumed victims of trafficking. This is a comprehensive system but not for non-documented sex workers and where the job alternative programme (in reality an exit programme) is strongly incorporated.

#### **FRANCE**

France is the only country in Europe with access to ART for undocumented migrants. Legalization of their situation and a residence permit are possible if they suffer from severe pathologies included HIV/AIDS under condition that their origin country can't provide the treatment. Another very significant aspect is the non-differentiation between migrant and national sex workers in their access to the public sexual health services. Although, this egalitarian treatment is also deteriorating as of a few years ago, and currently migrants' access to services is more restrictive (for details see below). Favourably, all of the cares are voluntary and anonymous.

Moreover, the activity of NGOs is very well developed. Their geographical and service coverage is very wide-reaching allowing to say that France's infrastructure for providing services is a model for other countries. Notwithstanding this preparedness to offer the services, there are some obstacles. For example, the interior security law (*Loi pour la sécurité intérieure*<sup>7</sup>) called the Sarkozy law, which deals with public order in fact punishes street prostitution has pushed sex workers' activity away from visible areas, i.e. away from the city streets, towards forests or inside apartments. The greatest hindrance this has created is the difficulty in reaching prostitutes who are more frequently changing work location, lack a stable address and, who are in more covert locations. Moreover, the new public order law has worsened the access to services of migrant sex workers more than of the nationals.

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<sup>&</sup>lt;sup>6</sup> The Clinic of Venereal Diseases at the Bispebjerg Hospital in Copenhagen offers testing of HIV/STI, examinations and counselling. In Århus the Clinic of Venereal Diseases offers examinations and treatment without referral from GP's. In Vejle County there is a local agreement with GP's to test anonymously for HIV/STI. There might be other local agreements.

Journal officiel de la République française 19 mars 2003, Loi n°2003-239 du 18 mars 2003

#### **Public Health Care**

The French public health care system is founded on a very comprehensive approach, e.g. it intends to offer coverage to undocumented migrants. Undocumented migrants can get AME (*L'Aide Médicale d'Etat*, medical help from the state) which allows them to have access to health care freely as AME gives rights to a reimbursement of 100% of the cares, medical regulations and hospital fixed price. Yet, as of 2003 some restriction were introduced and the condition for receiving AME is now being able to prove (in a written form) that the person has been in France for more than 3 months. This new regulation is difficult to satisfy for migrant sex workers as it is often complicated or impossible to provide proof of being in the country for the required period. As a result of this, some 30% of all migrants are excluded from AME.

For those who cannot get the AME, mainly sex workers from CEE countries and Africa, there is a possibility of free access to gynaecological care, HIV and STI testing and treatment, contraception, and basic mental health care. Others non-insured can go to the hospital for other services but have to pay. They can get free care only in cases of high emergency. These life-threatening situations refer to the risk of spreading transmissible disease to (HIV, tuberculoses, STIs), cares for minors and certain maternity examinations.

In 2004 the PASS (permanence d'accès aux soins de santé hospitalière) was crated which aims at facilitating the access to hospital cares for people in a precarious situation and without insurance. Advantageously it also incorporates referral with the institutional or NGO's networks of cares and social help.

#### **NGOs**

As the situation of the migrant sex workers very much depends on their legal situation, those who are non-documented have very few contacts with the public social services. The **health** care for non-insured people rely very much on NGOs (mainly *Médecins du Monde*), who provide free care. However it is mostly basic care and these NGOs struggle with a shortage of staff and financial means.

Due to the Sarkozy law, services such as HIV prevention and health promotion information and advice, condoms and safe sex supplies, drug harm reduction information and advice can only be performed by outreach programmes able to contact directly the migrant sex workers in their new location.

In terms of **social care services** migrants also access them mainly in the NGO's. The main problem is that those sex workers can not have access to trainings and to the labour market, neither the inclusion projects of the NGO's. The housing situation is problematic as well, the non-documented migrant sex workers have to live in either really expensive or very precarious hotels, as housing and social services are available only to national and legal migrants.

On the positive side, NGOs and/or community based sex worker's organisations (santé communautaire, which offer broad social services, majority are financed by DASS a governmental institution, part of Ministry oh Health) are present in all big cities in France and there is a abundance of organisations that offer services specific for sex workers, ranging from outreach, psychological care, shelters, STI prevention, to health care.

### European Gap Analysis

ffective HIV and sex work programming requires comprehensive service provision which responds to the diverse health and social care needs of sex workers; is both psychologically and physically accessible to both indoor and street based sex workers; includes low-threshold harm reduction services in relation to both sex work and drug use; and operates within accepted good practice guidelines and protocols. In addition, successful HIV prevention requires reaching the majority of sex workers within each country; therefore it is essential to ensure both geographic and temporal coverage of all sex work settings operating within the country. This analysis provides an overview of the current situation in Europe, however, it is imperative that each country undertakes a thorough mapping of sex work in urban, rural and border areas, identifies the various sex work settings and times of operation, assesses the effectiveness of current service provision and establishes gaps in current HIV prevention support and services for sex workers. Access to both health and social care services as well as strengthening the capacity of multi-sectorial services are imperative for reducing vulnerabilities of sex workers.

Both the 'service' and 'sex work and migration' mappings undertaken by TAMPEP identified a number of key gaps which are common across Europe. While each gap presents a threat to effective HIV and sex work programming, it also provides an opportunity for services' development.

#### **KEY GAPS**

### Lack of geographic and sex work settings coverage: HIV prevention services focussed in major cities and/or public sex work settings

- **Barrier** lack of resources, however, also lack of national mapping of sex work and assessment of local sex work settings
- **Recommendation** national mapping should be undertaken on a regular basis, preferably annually as sex work and sex work settings are fluid and mobile. Services for sex workers should operate at times and in locations where they will be accessible
- Example Bulgaria has good national coverage (tourist resorts, parking areas, motels, apartments, border areas, small towns, villages) achieved through national plan and external funding. In Romania MMUs cover majority of the sex work settings also. Additionally, these outreach programmes are combined with the presence of multidisciplinary staff: general practitioner, psychologist, health educator, social worker. Moreover regular mapping assessment of the locations changes is carried out.

### Lack of communication and partnership between service providers to ensure comprehensive support and services for adult sex workers

■ **Barriers** – The fundamental barriers in the lack of broad cooperation and referral practices are the different philosophies of the service providers. There are very many

organizations which directly or indirectly treat with sex workers issues, and/or with HIV/STIs in the sex workers community. Further on, there are many centres for victims of trafficking and/or which specialise in anti-trafficking activities (especially among the new EU member countries). NGOs (and other service providers) sometimes limit the scope of their collaboration only to their statutory objectives on grounds of ideals which created these NGOs. Sometimes the limitations are due to the goal of their funding organizations. A lot of service providers working alone are incapable of rendering realistic social support and empowering of the community of sex workers.

- **Recommendation** When seeking to offer proper HIV/AIDS prevention/care and treatment it is vital to work above and beyond ideological differences. Both the service providers as their sponsors should seek common ground rather than differences when establishing cooperation. Funding institutions should endorse referral and networking and therefore provide necessary resources to enable such practices. Empowering should be a key issue in reducing the vulnerabilities specific to the populations at risk. An open and non-judgemental partnership of cooperation and referral, focused on the common goal is essential for ensuring comprehensive support and services for adult sex workers.
- Example TAMPEP's European and International Network is a cross border cooperating programme base on partnership of many different NGOs, CBOs and some GOs; in Germany, Netherlands, UK, France, Italy there is a good developed system of GOs (mainly Health Care Services) and NGOs networks.

### Lack of comprehensive and targeted support and services for ethnic minorities and lack of access to health care services

■ **Barriers** – In some countries of CEE the majority of the street sex worker are from an ethnical minority, for example Romas. The Roma community is an ethnic group which experiences particular social exclusion and discrimination in many countries in Europe. They are the biggest group among the minority communities in the sex industry in CEE countries; a group which is very mobile and difficult to reach, a group with specific cultural values and norms. Roma sex workers are victims of a double discrimination. Additionally, most often they live in poor conditions, an underprivileged social and economic setting, are at great risk of HIV/STI, there is a large amount of sex workers, among who many are minors and use drugs.

There are other overrepresented ethnical groups in prostitution facing lack of targeted support and services. For example, in the Baltic states sex workers of Russian ethnicity (and nationality in some cases) are in possession of an 'aliens' passport and also experience obstacles in equal access to health care on grounds of being a foreigner.

- **Recommendation** There is a need to provide adequate, effective and specifically targeted services, prevention campaigns regarding HIV and STI, counselling and treatment.
- Example Some specific projects targeted to health education and reproductive health issues are carried in Hungary, Romenia and in Bulgaria in the Roma community. Experience with peer education and involvement of young leaders of the community brings positive results. Knowledge of specific cultural values and norms coming from the representatives of the specific ethnic minority community is used in the development of information campaigns targeted to these groups in The Netherlands, Italy, Germany and others.

### Lack of access for undocumented/uninsured (migrant) sex workers to health care services

■ Barriers - Being undocumented for most means not having the possibility to obtain insurance under the public social security scheme which the state offers to its citizens and to foreign residents with a regulated residence situation. Undocumented migrant sex workers are therefore excluded from the basic public health care system. For many a private insurance is the only alternative, yet it is expensive, and when this is not affordable it creates another barrier leading for many to factual lack of access to any services. In many cases it is not in the migrant sex worker's gesture to change their legal and therefore public insurance situation. Immigration, residence or work permit policies which apply to a migrant are determined by his/her nationality, and there are very limited possibilities of either changing one's nationality or finding exceptions to the general rule, in order to gain better social security coverage.

Another possible scenario takes place when the migrant sex worker has a regulated residency situation yet as sex work is not recognised/illegal as a profession, in that particular country, the sex worker does not have the possibility to contribute to social security and therefore benefit from the services, as he/she is constrained to work black. The same circumstances apply to national sex workers' difficulties in access to services, as where sex work is not a recognised occupation both migrant and national are pushed to clandestinity and the black economy. The reasons for being excluded from the national insurance for national sex workers may also be the lack of fixed registered residence due to frequent changes of address or also the fact of being outside the social system.

A third circumstance is when sex worker is a recognised profession, but the migrant sex worker might lack work permit and therefore, as in the case above, may not participate in the social security coverage as he/she works black.

In almost all countries, sex workers who are already in a situation of much vulnerability have an additional handicap: of being left without access to public health care based on the fact of being either not insured or not documented.

- Recommendation Governments in their policies must address these exclusion scenarios
  and the health risk issues derived from having in their territory groups which are in fact
  not covered.
- Example in majority of countries non insured people have only access to private health care, this means also that only the insured have access to public HIV treatment. NGO combine HIV prevention activities with provision of basic care services and/or mediate with state institution for

### Lack of comprehensive and targeted HIV prevention campaigns for clients of sex workers

- Barriers There are very few programmes which are targeted at safe sex behaviour of clients and few campaigns targeted at the clients in the different possible sex work settings. The mobility of clients of sex workers (which derives from either sex tourism or their profession e.g. truck drivers) is not taken into consideration enough and there are no campaigns which address different patterns of mobility. Clients, their knowledge, approach and behaviour are key factors and cannot be ignored in the holistic intervention.
- **Recommendation** Intervention and prevention activities should consider the involvement of these key actors. Addressing clients and their mobility is crucial in health

prevention and HIV risk reduction. Targeted campaigns information for clients should be based on the different prostitution settings, considering different cultural values, taking advantage of specific concentrations of potential clients (sport events, conventions, tourist resorts, etc.).

■ Example – In Germany and Italy there are specific campaigns aiming to change clients' sexual behaviour and to challenge their attitudes towards sex workers. Such activities are critical to increase sex workers ability to successfully negotiate safer sex with clients.

#### Lack of communication and partnership between sex work projects and drug harm reduction services, including lack of access to drug treatment and rehabilitation services

- Barriers Drug use and drug dependency among sex workers is various and bound to the different setting, environment and community. There is insufficient knowledge among service provider about the patterns of drug use in sex work setting. Lack of comprehensive interventions and services targeted to the specific level of HIV risks, needs and behaviour. Outreach programmes in the setting of the injected drug user provide syringe exchange but are not able to provide treatment (substitutes).
- Recommendation There is a necessity to integrate HIV/STI prevention and drug treatment options within the outreach programmes carried out for sex workers. Plus, there is a need for diversity in the harm reduction activities according to the types of drugs consumed and according to the diverse health risks they carry (injecting drugs, pills, cocaine, etc.). Moreover a diversification is desirable in terms of approach to the setting of the drug use, the drug users' behaviour as well as the specific community it takes place in e.g. tailored approach for drug consumption in Roma community.
  - Using this specific example of Roma community we must say that the level of risk of HIV transmission is higher there than in other settings. Integrated community approach and knowledge are needed for this particular community. For example, for the prevention and care it is important to consider an approach to the entire community not just the individual person in the sex work setting. Holistic approach would require considering the high level of injected drug use, poor living conditions, poor access to health care, risky sexual behaviour, close contact to dealers and to controllers in these settings, the behaviour of clients and the capacity and/or possibility of sex worker to negotiate safe sex practice, etc.
- Example The majority of sex workers projects cooperate with harm reduction networks in order to assess the levels and patters of drug use to better address their specific vulnerability and supporting services. In Romania, ARAS involves members of the Roma community in the prevention activities and also contacts the controllers and drug dealers in the environment of sex workers.

### Lack of comprehensive and integrated personal safety and crime reporting schemes for sex workers

■ Barriers - Violence against sex workers is not included in gender based violence strategies. sex workers experience violence at disproportional levels; in some countries 80% of sex workers state having been treated violently by their clients. In some countries law enforcement officers are amongst those who commit crimes of violence against sex worker. In some countries the illegality of engaging in sex work means sex workers will be fined if they report a crime of violence or exploitation relating to sex work.

Comprehensive personal safety and crime reporting initiatives are only developed by some sex work projects.

- Recommendation Violence against sex workers needs to be included in gender based violence strategies, protocols need to be developed with policymakers and law enforcement agencies (appropriate to the realities and possibilities in each country), law enforcement officers need to be trained and corruption among law enforcement officers needs to be addressed by establishing a police liaison and complaints procedure. Violence experienced by sex workers must be observed as a relevant factor of health risk and of vulnerabilities. What is also needed are measures against the different levels of violence effecting the susceptible population.
- Example Information and advice about how to reduce the risk of violence from clients and support in violence reduction options and in some case self defence training is now provided by sex work projects. In some programmes sex workers are involved in developing tips for staying safe. One of the best examples is the one developed by SCOT-PEP and set up by sex workers in Edinburgh with a comprehensive range of initiatives as described in more detail in the *Skills*, *Training and Good Practices Report*.

### Lack of comprehensive and targeted support and services for young people sexually exploited through prostitution<sup>8</sup>

- **Barriers** risk to safety and in some cases the lives of young people and outreach workers who are seen by controllers to be a threat.
- **Recommendation** need to establish close working relationships between sex work projects and agencies working with vulnerable young people and to establish child protection protocols. Need to ensure young people who continue to engage in prostitution have access to information and prophylactics to protect themselves.
- Example There are various local initiatives targeted to young people exploited through prostitution, e.g. in the UK the *Barnardos SECOS Project*, in the Netherlands *The Pretty Woman* Project for young girls victims of 'loverboy', in the Netherlands and in Italy the municipality is in charge (i.e. becoming legal guardians) of minor who are victim of trafficking where the family is not able to take the children back in the mother country. The characteristic of these initiatives are that they are targeted to the specific needs of young people exploited in prostitution, are low threshold and with referral system from Social Services, Police, education, community services and other outreach programmes.

### In CE European countries HIV prevention services are externally funded and the majority of that funding (GFATM<sup>9</sup>) is due to end in 2008

■ Barriers – Service providers and especially NGOs are funded in a variety of ways. Some are financed by local and national entities and others by external donors. In recent years the improvement of a specific component aimed at HIV prevention for sex workers in the *National Programme for Prevention and Control of HIV/AIDS*, was possible through the funding of the *Global Fund to Fight AIDS*, *TB and Malaria*. After 2008 there are no financial coverage for the continuation, particularly the prevention part carried out by

Gap Analysis on Service Provision

<sup>&</sup>lt;sup>8</sup> Young people in this situation are predominantly national sex workers rather than migrant sex workers

<sup>&</sup>lt;sup>9</sup> 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

NGOs. Another barrier is that national policy of some countries to delegate the financing to the local authorities, which are not prepared to take on the responsibility. The consequence is that the majority of NGO's are short term project bases. Funding for NGOs is crucial, without it they are paralysed. But it is not just receiving funds which is an issue - their sustainability is an equally vital subject. Without sustainable funding NGOs risk interrupting their highly needed interventions. This is particularly a problem for NGOs which work on short term project base or those (from CEE countries) which receive funds from external donors for timely limited actions (annual, biannual, etc.). This constitutes a barrier for continuity of their projects and for the maintenance of contact with sex workers.

• **Recommendation** – Governments need to be sensitised to the necessity of providing funding which is national and sustainable. Focus needs to be placed on the prevention activities for vulnerable populations in order to secure a comprehensive public health system. This is because sometimes governments tend to have a preference for funding medical activities rather than prevention or sometimes finance on specific project base rather than in a permanent manner. Local and national funding on prevention, care and support are mutually reinforcing elements and must be guaranteed and continuous for a comprehensive approach.

Moreover, key organizations need to be involved in the creation of national financial plans, not just treated as receivers of donations. For this purpose it would be conducive to make the national financial plans transparent.

■ Example – Romania, Bulgaria are financed by the *Global Fund* during a period where they are perceived as a key interest country by the donor – when this period finishes their currently developed projects risk being interrupted until further donors are found or totally discontinued jeopardising the benefits created through the NGOs hitherto intervention activities.

#### No adequate services in response to the increased mobility of sex workers

- Barrier Majority of sex workers in Europe are migrants. The new intensified migration flows within the sex industry (both cross-border and inside the country) due to all the complex push and pull factors in the sex industry are not met by the service providers' approach and offer. Language barriers and other (cultural) difficulties inhibit the development of a mutual understanding of migrant sex workers' needs. This also restricts the rights of migrant sex workers as often it is not possible for them to self-determine their condition and treatment and they are not treated respectfully as service user but face racist, discriminating and non-accessible structures as migrants and as sex workers. Moreover, the high level of mobility of sex workers makes it difficult to maintain contact with them.
- Recommendation Regarding the Government response, this aspect of increased mobility must be considered in creation of all policies and measures. In terms of service providers cultural mediation (or interpreters) needs to be more widely implemented in public health and social care services. Adjustments should also be made in maintaining long-term contact between sex workers and service provider, e.g. if the sex worker must move, referral could be made to the organizations that could be contacted and services which could be reached in the new destination.
- Example The TAMPEP founder members in Italy, Germany, Austria, and the Netherlands work with multinational outreach workers and developed a model of multicultural outreach based on cultural mediator and peer educators. Some PHS in those

countries adopted that methodology as well, and some of them work in cooperation with the local TAMPEP staff. TAMPEP multilingual material designed for this purpose had a European distribution. Peer education is used in this context as a way of reaching mobile sex workers in their different work places in Europe.

#### Lack of representation and involvement of sex workers organizations

- **Barrier** There are practical barriers to the sex workers' involvement, such as their illegal status in some countries, discrimination, social attitude, judgemental look upon. These factors limit the empowerment of sex workers and minimise possibilities of leadership among sex workers. Good practices need to be better supported.
- Recommendation Community involvement in prevention and care efforts must recognise as priority the community development and must address the issue of intervention in specific communities. It is important to recognise the significance of empowering the community members, create leadership models, and implement peer education. Moreover, there should be direct involvement and representation of the sex workers in the development and creation of policies.
- example in italy, a national sex worker organisation reached the level of being involved in the development of policies regarding prostitution, anti-trafficking issues and being responsible for the implementation of programmes in all national territory. They take the leadership while cooperating with local authorities, law enforcement and NGOs. The local administrator is therefore setting up a realistic and comprehensive support for victims of trafficking.

In Paris, the organisation for transgender sex workers called PASTT, took the leadership what regards the protection of their human rights and the demand for better services, housing and support programmes for those with HIV/AIDS. In Europe other sex workers organizations and CBOs are in dialogue with public authorities for development of policies and parallel to this are a service provider.

### Sex workers are seen only as "victims" of prostitution in the majority of information materials available

- **Barrier** A victimising approach hinders an increased self-esteem.
- **Recommendation** In order to empower sex worker, the material aimed at them has to respect them, their choice for work in the sex industry, and be non-judgemental.
- **Example** TAMPEP information materials is produced with involvement of sex workers and as a result of a series of workshops and discussions.

### Structural Barriers to HIV Programming and Services for Sex Workers

n addition to the gaps identified in service provision a number of structural barriers to strengthening HIV services have been identified. These barriers occur at three different levels:

<u>State Level</u>, where legislation or regulation by local or national government impacts on comprehensive and effective HIV service provision;

<u>Service Provider Level</u>, where the configuration or operation of services impacts on sex workers accessing support and services; and

<u>Sex Worker Level</u>, where sex workers internal beliefs and perceptions of service providers impact on access to support and services.

#### STATE LEVEL

- 1. Certain types of services are only offered under the condition the person declares her/his will to abandon sex work or if she/he already abandoned it. In majority of countries social services are accessible to migrant sex workers only if they are recognised by the authorities as victims of human trafficking.
  - <u>Solution:</u> an effective and comprehensive system of support to reduce vulnerability to HIV is base on equal assess to support and care.
- **2.** Majority of countries, **medical and health services** are available **only** for **insured** persons and they are **not anonymous.** If not insured the person has to pay. Whereas in Greece, following a decree of 2005, public services are simply not provided to undocumented sex workers.
  - <u>Solution</u>: guaranty the access to prevention, care and treatment, as it is a universal right and a necessary measure in terms of fighting against HIV/AIDS. A better network of services providers is important to provide policy makers with examples of good practice based on the quality guidelines of the VCT protocols.
- 3. The subject of difficulties in access to public health care services is particularly serious when we analyse access to ART for non-insured people. This affects undocumented sex workers living with HIV, who are obliged to continue to work in prostitution in order to generate income which allows them to cover the therapy's costs. Migrants which are not insured lack access to free of charge treatment. Solution: universal access to ART.
- **4.** Further on, in some countries the coverage of ART has improved and is able to reach a much wider population which requires this treatment. Yet the higher coverage is due to the fact that the **generic substitutes** are used in place of branded medications. The capacity to reach a wider group of people living with HIV is weakened by the fact that people are unwilling to begin or to continue a therapy based on generic medications.

Therefore cheaper for the providers and more accessible to people with HIV generic therapies decrease the adherence to ART. They either find out from others prior to beginning or discontinue the process after experiencing themselves the multiple negative side effects of the generic drugs.

Solution: Ensuring quality treatment and care by the State.

5. In some countries **medical services** in the public health institutions are **not anonymous** and the legal status of sex workers is known (e.g. Lithuania).

Solution: to separate medical care data from legal persecution, to avoid discrimination.

6. Registration systems and compulsory health checks are unhelpful in the task of HIV/health service provision for sex workers because it gives a false picture of the volume and features of the country's sex workers' population. This impacts the statistical aspect of understanding and addressing the sex workers' true situation in a given country. There where check-ups are restricted to the registered population, registration additionally affects the factual access to these medical checks. In order to benefit from these services a sex worker must be registered, yet in order to be registered she/he must first have a regulated legal status. Moreover, compulsory health checks rather than generating a healthier environment for all involved are conducive to clients' abusive demands for unprotected sexual services, therefore steering away from basic HIV/STI prevention techniques. Mandatory health checks are also inefficient because they do not cover minority groups, and are therefore not an efficient health prevention measure.

<u>Solution</u>: To substitute a mandatory health system by an anonymous and volunteer health check system, as registration for prostitutes underlines a discriminatory and stigmatising method.

**7.** No **standardised regulations** on national level in terms of the provision of public services regarding HIV prevention and care.

<u>Solution</u>: to ensure that the national action plans priorities provide resources and clarity, local and regional characteristics should be considered while implementing them on national level.

- **8. Reduction of funding** for sex work programs, often due to the shifting of these funds to more anti-trafficking orientated and re-socialisation actions.
  - <u>Solution</u>: the creation of partnership, forums and alliances to provide effective results, in order to guarantee the continuity of access to prevention care for all sex workers.
- **9. Police's abuse of authority**: e.g. obligatory health testing happens via cooperation between the Police and representatives of Public Health Service: together they collect sex workers in their workplace and take them to the Health Care Service (Czech Republic). Another example is the collecting of syringes as a proof against drug users and/or obliging sex workers to take STIs testing and use eventual positive result of infection as evidence of being a sex worker (Ukraine, Romania).

<u>Solution</u>: Sensitisation and training for Low Enforcement: to monitor a system of negative effects regarding public order measures connected with public health misuse.

**10.** Lack of approach to sex work in terms of **occupational health** services.

<u>Solution</u>: to develop a framework regarding Occupational Health and Hygiene. This would be the managers' of indoor establishments responsibility. Parallel, develop a network of general health care professional to offer a broader medical support, not only restricted to HIV and STI.

**11.** Lack of **long-term intervention programmes** on national and lack of cross-border partnership between state agencies and NGOs.

<u>Solution</u>: Focus on reducing the vulnerability of sex workers to HIV/AIDS in a comprehensive and structural national plan with the guarantee of sustainability of long-term intervention, taking into consideration the internationalization of the sex industry and the cross-border aspect. Knowledge on push/pull factors is key element in the capacity of the service provider to enhance the HIV prevention. For this it is essential to strengthen the cooperation between GOs and NGOs in between countries.

#### SFRVICE PROVIDERS LEVEL

- **1.** Public social care services are **primarily** (Denmark) or solely (Lithuania) targeted at recognised **victims of trafficking**.
  - Solution: improve referral system between social care and medical care
- 2. In some countries there is a lack of professional training, skills and knowledge of the professionals who work with sex workers. Also a barrier is the judgemental and discriminatory manner of treating sex workers by professionals in public services.

  Solution: Training courses for professionals like the police, social workers and medical doctors should be organised nationwide, as well as low-threshold services should be better developed. These trainings should also include sensitization and the anti-discriminatory element.
- **3.** In the majority of countries there are very **few**, or sometimes just one or none at all, entities **offering services specialised** for sex workers, e.g. only *Pro-tukipiste* in Finland, one in Latvia. In contrast to some other countries as UK, Germany and the Netherlands where there is an abundance of sex work projects.

  <u>Solution:</u> Improve the coverage either through umbrella structure (model of TADA) or the capacity of the outreach activities of the already existing entities.
- **4. HIV Testing**. There is a pattern of improvement in the testing and diagnostic coverage of the sex workers, which includes anonymous, voluntary and free of charge testing. Yet there is not the same progress in the field of pre- and after- counselling, in harm reduction programmes, and in accessible in treatment for HIV/AIDS.

  <u>Solution</u>: There need to be a parallel progress in all related areas in order to achieve true advancement. In terms of STIs, we observe that there is also an improvement in the diagnostic, nevertheless there is a lack of access to free of charge treatment and care for STIs.
- **5. Differentiation** between services offered to migrants and to national sex workers: either through legal barriers, language barriers, or through discrimination.

  <u>Solution</u>: Anonymous and free of charge VCT and STIs screening and care as an integrated of the health care system and in cooperation with outreach activities.
- **6.** Poor level of openness and **intercultural capabilities** of the **service providers: no** use of cultural mediators or interpreters.
  - <u>Solution</u>: Training in cultural mediation and working with an international staff, cooperation with migrant community organizations.
- **7. Divergence** of the **services needed** and the **services offered** due to inaccurate or incomplete assessment of sex workers' needs.

<u>Solution:</u> Frequent assessment of the needs of the service users and adaptation of the offer accordingly

8. Service provider's response to the current changes. In addition to the already complex and diversified reality of the sex work, there are currently abrupt changes within the sex industry which pose for the service providers a supplementary challenge. They need to develop a capacity to adapt to these transformations. It is imperative for service providers and outreach performers to be able to identify these developments and adjust their offers according to the new needs. Continuous coverage and reaching persons in intensified indoor prostitution may serve as an example of one of the current changes, which so far has not been fully addressed. An even stronger illustration of a need to adapt to change is the situation which the new EU countries are facing. They are experiencing very intense and new migratory movements in the sex industry, as former countries of origin transform into transit and destination countries. Yet the consequences of this situation expand well beyond the new EU members, i.e. migrant sex workers from the new states migrate to all EU countries due to easier entry and stay policies, while migrant sex workers from outside the EU now treat the new EU countries as much more attractive destinations, or transit countries. There is also a lot of new forms of clandestinity and of illegality all across Europe in result to these changes and therefore new populations are beyond the reach of the outreach workers/services.

Solution: New and/or additional interventions are needed to reach the (new) target groups. Intensive research has to be carried out to properly assess the changed situation (e.g. through mappings), followed by actions to improve the working and living conditions of (migrant) sex workers. This especially applies to those countries within the region that so far were not confronted with the presence of migrant sex workers. Changes refer to the legal status and possibilities of the sex workers, their work places, language and cultural background, discrimination as migrants, additional stigmatisation as migrant sex workers (also from within the original community), discrimination and hierarchical structures within the group of sex workers, increased dependency because of a weak legal status, less self-confidence/empowerment. These services should primarily focus on providing useful (legal) information, bridging language barriers and increasing the self-confidence of sex workers through their empowerment and support.

- 9. Lack of adequate coverage and/or cooperation between specific services for sex workers in cross-border areas (e.g. East-Central-West Region). No coverage of the services in the cross border area. The Central European has as one of its peculiarities the intensified presence of sex work in border areas, and consequently has specific needs of services adequate for this type of work. Sex workers work and live in their country of origin but are at the same time practically isolated. They work with clients from "the West", need language abilities to negotiate with them and often even the bar owners are from e.g. Austria or Germany and speak another language.
  - <u>Solution:</u> It is important to develop a specific kind of cross-border cooperation work to reach the sex workers who work those regions, e.g. as already developed as pilot project in borders of Germany-Poland, Austria-Slovakia and Italy-Slovenia.
- **10.** Difficulty for service providers to reach sex workers (and potential increasing vulnerabilities to HIV and STI infections) due to their dispersion and displacement provoked by local authority and law enforcement's eradicating activities of sex work from areas where degree of conflict with community escalates.
  - <u>Solution:</u> Service providers should also address the topic of **conflict mediation**, for the communities which either live directly in tolerance zones or simply where prostitution is

present and visible. As to some people the mere presence of sex workers is problematic, this often leads to clash of interests and to heated disagreements. Service providers should be able to mediate and resolve these tensions.

#### SEX WORKER LEVEL

- 1. Migrant sex workers often lack information on the scope of assistance in health care systems of the countries they reside in and which they are entitled to, or lack access to sources which could furnish this information. Service providers fail to reach all sex workers; sometimes for valid reasons: e.g. insufficiently funded, understaffed, lack of accurate and up-to-date knowledge on sex workers locations and number. Other times the obstacles in reaching sex workers could be overcome but are not, due to a lack of will and/or inefficiency.
- 2. Migrant sex workers often lack information on the scope of rights they are entitled to in the countries they reside in, or they lack access to sources which could furnish accurate information. This includes not only prostitution legislation but also immigration laws, information on working conditions/regulations, asylum or marriage. There is no adequate integrated legislation system within the region. Drafts of laws and changes do not improve the situation but spread insecurity over increasing restrictions. They fear, have no knowledge about the consequences of this situation and/or how to legalise it.
- 3. The stigma, the fear of being judged and discriminated, a feeling of insecurity.
- **4. Poor competence** of the local **language**, or the lack of knowledge of a common language to deal with the local service providers.
- **5. Dependency of 3<sup>rd</sup> persons** (pimps, brothel owner, people they are in debt with, people who impose paid protection).
- **6. Isolation**, no integration with the local society and sometimes restriction to free movement
- **7. Mistrust** of **state officials** and therefore unwillingness to contact any public administration authorities
- **8.** Fear of being discovered and of being **repatriated**, fear of being exposed as sex worker, distrust towards organisations that deal with prostitution. Where sex workers are contacted through police raids in the course of anti-trafficking interventions, the main barriers for access services include: the illegal status and the fear of being taken by the police, poor knowledge of the territory and of services available as a consequence of little information, poor autonomous capacities and free movement due to traffickers.
- **9. High rate of mobility** imposed on sex workers because of difficult circumstances (local policies, change of policies, intensified raids, escaping pimp/trafficker, etc.) creates an obstacle to establish and maintain regular contact between sex workers and service providers. It also hinders sex workers to settle into a stable living situation.
- **10.** Unwillingness to use NGO services due to lack of information and/or confusion about who is a public service provider and who is a NGO. The **preference is to avoid contact with anyone** who can potentially lead to an inconvenient or difficult situation (e.g. imposing tests or registration, penalising, discriminating, etc.). The consequence is the evasion of contact with any service provider.

### STRUCTURAL BARRIERS

### **General Comments**

Diversity in the sex worker community

iversity of vulnerabilities to HIV must be supported by prevention measures and commodities with comprehensive methods of social support and schemes against social exclusion. A tailored approach in the services is necessary in order to reach the factually differentiated sex workers community (minor, migrant, gender, ethnic). There is different level of vulnerability pertaining to different groups, which in addition to the specific level of gender violence must be taken into consideration when creating a comprehensive and broad intervention. Outreach programmes working with national sex workers report a significant percentage of young people in sex industry, some are minors. Some of the identified groups are: young people with orphanage background, young Roma girls, and young girls/boys from ethnic minority groups and/or young migrants. From the perspective of the outreach programmes the present services are not sufficient to cover, prevent or to empower the ones that need these services. Multidisciplinary intervention in required and particularly focused on the gender based violence and on the social vulnerability of young people. Comprehensive efforts are needed in policy and service development. What is essential is a global approach, which engages various actors, local communities, the states, international agencies, public and non-public service providers and sex workers themselves.

#### **Human Rights**

In the UNAIDS Policy Position Paper 'Intensifying HIV prevention' <sup>10</sup> Seven principles of Effective HIV Prevention were set out - the first of those being 'All HIV prevention efforts/programmes must have as their fundamental basis the promotion, protection and respect of human rights including gender equality.' As with all HIV programming it is essential that service provision for sex workers be done within a human rights framework.

We observe that the current limitations which sex workers face in the access to support and services is due to the lack of a comprehensive human rights approach. HIV prevention policies which overlook the human rights aspect cannot expect to be effective, to have positive repercussions within society or improve the public health situation. It is important to develop guidelines and to share experience for a comprehensive human rights based approach.

How service providers address migration, mobility and repatriation

Another specific approach is needed to address the particular **vulnerability of women in the migration process**. The identification of these vulnerabilities needs to be an inherent part of a

http://data.unaids.org/publications/irc-pub06/jc1165-intensif hiv-newstyle en.pdf Also available in Russian, Spanish and French

comprehensive system of services between mother country, transit country and destination country. Seeing that majority of the sex workers in Europe are migrants and highly mobile, (including having moved from a different continent), additionally noticing that in Europe there is more repatriation and return (voluntary and non voluntary) trend, it is essential to find methods of reaching the potential groups who want to migrate, those who are in transit and those who already migrated. Furthermore, the offer and structure of services needs to be continuous and comprehensive in order to reduce the vulnerabilities of these groups. Therefore the aspect of interruption of the services in the case of migration, transit or reparation needs to be equally addressed. TAMPEP notices a failure to evaluate and draw conclusions on the effects of **involuntary return** for migrant sex workers in a situation of dependency.

There is a great probability that involuntary repatriation will generate more abuse and retrafficking, as people usually return to the place where they were initially trafficked from. Addressing the problem of trafficking in a narrow manner (i.e. only from the destination country's perspective) is not only irresponsible and lacks international community spirit it and neglects the human right endorsement. Usually this overlooks the risks and threats such practice impose on the returned person. Comprehensive policies of destination/repatriating countries must address the inexistence of a support mechanism in most of migrant sex workers' home countries.

Linked strongly to high levels of migration among the sex workers community is the issue of how service providers cooperate, i.e. do they have similar protocol, similar knowledge on the cultural values etc. This is why an effective referral system must be part of a sustainable/continuous provision of services. International cooperation, integrated services and preparedness to work with very mobile population (with continuous and new entry) are vital in creating proper coverage of the entire population at question.

#### Civil Society Involvement

NGOs involved in sex work projects attempt to meet the needs of the specific issue which arise in the society yet often face shortcomings in the form of staff, funding, expertise, geographical coverage, public recognition, etc. It is difficult for them to involve the broader civil society, more sectors and relevant actors and stakeholders. **Cooperating with government** organizations is essential for securing the success of the NGO's objective. TAMPEP still notices insufficient cooperation between GOs and NGOs in the field of HIV/STIs, sex worker, health issues specific for sex workers, drug users, people touched by HIV/STIs. Moreover, most NGOs and GOs can not address all relevant issues alone, what is vital is a developed **referral** system among GOs and between NGOs/GOs. A good coverage and networking can only be guaranteed with a well functioning referral system which works in all directions.

In relation to the discussed above changes it is essential to develop and strengthen international cooperation, be it either through building of NGO networks, through setting up the referral system, sharing good practices and knowledge, cooperating between NGOs and other organizations. Such improvements in the international cooperation are vital in order to strengthen and develop the capacity of cross border programmes.

An integral element in building the capacity of service providers in reducing the vulnerability of sex workers to HIV/AIDS is ensuring empowerment and community participation of the sex workers on all levels.

#### Criminal Organisations/ Law Enforcement

Another trend which requires being addressed is the influence of criminal organisations and how they determine different levels of vulnerability of sex workers. Therefore a comprehensive service provision should involve law enforcement authorities and public and private sector engagement. One of the ways of fighting against the influence of criminal organisations is the protection of the abused person. Empowering the victim is essential in for effective protection by the justice system.

Involvement of law enforcement is essential in HIV programmes. On practical level they determine the effectiveness of the outreach programme in some countries.

For the provision of a framework to reduce the vulnerability for sex workers to STI, provoked by violence and unsafe environment, it would be recommendable:

- More involvement and cooperation between those involved in the national platform on HIV/AIDS and the civil society representatives, to reach synergy and the harmonisation of efforts.
- The existing model and training programme should be implemented in a broader setting.
- Examples of good practices should be shared.
- More countries should cooperate and be involved, because law enforcement is a key actor.

#### Sensitisation

Sensitisation campaigns for the general public are also required due to the fact of continuous and nearly omni-present social discrimination of sex workers. These campaigns should therefore address the issue of stigma and discrimination, but might also touch the specific subjects of health and HIV, for example, when addressing more specific audiences, such as the clients mentioned above in reference to their high mobility. Awareness-raising in the community should have the ultimate objective of empowering sex workers, but will additionally impact more peaceful cohabiting and better mutual understanding and most importantly should decrease the vulnerabilities and violence experienced by sex workers.

#### Governments' responsibility

There is the need to call attention of policy makers to the vulnerability of sex workers to HIV and STIs, to sensitise politicians with regard to ensuring an appropriate balance between prevention and treatment services and protecting sex workers (human) rights to access non-discriminatory health services, including prevention, counselling, testing and treatment, programmes. Moreover, to facilitate, encourage and support the participation of sex workers, within a community participation framework, in all levels of activities developed for them.

### Conclusions

ffectiveness of the prevention efforts is directly related to the capacity of developing and implementing a comprehensive and multi-sectorial service provision. Strategies and policies need to be based on clear principles: equitable access to support and services, addressing the specific needs with a person centred approach and simultaneously with a community development focus, addressing all key actors in the sex work setting: managers, clients, controllers, etc. Our priorities include providing quality services, with knowledge and experience based professional approach and skills.

Performing outreach is essential to build trusting relationships, but street work and other outreach must be systematic, frequent and intensive. It should not be limited to distributing condoms, lubricants and information, but include social, legal and psychological assistance as well. Moreover, it should consider an interaction with the police, the judiciary, the media, politicians and policy-makers. This way what can be attained is a broad platform and involvement of other sectors than just the health care area, with the objective to create and develop comprehensive health promotion and well-being strategies.

Social vulnerabilities of sex workers is one of the structural determinants of the risks to health and well-being and in particular to HIV and STIs. The often unsafe and violent environment of the work place and the poor living conditions of sex workers increases their vulnerability. What should be strengthened and improved is the relation between the provision of health and social services prepare to respond to the needs

In the civic area, existing sex work projects and services may function as both advocates for the rights of sex workers and sources of information. Expertise of the community based organisations and sex worker projects needs to be recognised. Depending on the needs of the country in question, such work might entail creating a national advocacy platform, collecting and disseminating evidence, providing expertise to ministries and local authorities, creating a protocol for best practice or increasing public awareness through media work and campaigns.

Most importantly, what needs to be taken into consideration is the protection of the individual human rights of sex worker, which are in frequent occasions violated. It is vital to consider the role and impact of the service provider and particularly of the Community Base Organisations and Sex Work projects in the civic area.