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Editorial

Projects for sex workers in Europe

The control of sexually transmitted diseases (STD) in prostitution is considered to be an effective public health intervention, especially in high prevalence areas.¹ Although the prevalence of STD and HIV in European prostitutes or sex workers is considerably lower than in the developing countries, factors such as migration and intravenous drug use create a very dynamic situation where the characteristics of the sex worker populations in Europe may change over a short time.

Control of STD in sex work is a complex matter, and is not only influenced by the organisation of health services, but also by the way sex work itself is organised in society, by the law and its enforcement.

Safe sex should be the norm in a sex worker-client contact, but as long as this objective is not achieved, public health interventions are needed. Control of STD in sex work may be the responsibility of non-specific general health services, or it may include targeted interventions for sex workers.

In their excellent review in this issue of the journal (p 161) Sophie Day and Helen Ward describe three main models of targeted public health intervention for sex workers: a first strategy working through mandatory screening and registration of sex workers; a second strategy providing accessible and appropriate services wanted by sex workers themselves; and a third strategy giving sex workers a central role in health promotion.

As coordinator of the EUROPAP/TAMPEP programme (European Intervention Projects AIDS Prevention for Prostitutes/Transnational AIDS/STD Prevention among Migrant Prostitutes in Europe, co-financed by the European Union in its DG V "Europe against AIDS" programme) I would like to discuss if these models are actually put in practice in Europe, and what lessons could be learned. This is the objective of EUROPAP/TAMPEP, combining all 15 EU member states. In each of these, a "local coordinator" is responsible for the creation of a national network of existing specific services targeted to prostitutes. In this way, a maximum amount of first hand information can be gathered in collaboration with those who work in STD/HIV prevention for prostitutes on a daily basis.

The first model, with registration and mandatory screening and treatment, can still be found in Greece and Germany. Today, 400 registered and 50 non-registered sex workers are seen at the STD clinic in Athens,² the only clinic providing services to sex workers. However, health promotion and health care hardly reach the other estimated 5000 non-registered sex workers, who are illegal and subject to arrest by police.

In Germany³ registration in most federal "lands" is the responsibility of health services under the law to combat

venereal disease. About 50 000 people are registered, but the actual number of people in prostitution is estimated to be much higher. Registered sex workers often complain about the impersonal attitude and approach of healthcare workers, which undermine confidence and, with it, good medical care. The motivation of clients to use condoms may be lowered in contact with "officially controlled" prostitutes.

The second strategy, attempting to promote access to sex workers, by providing appropriate services that they want, is more widely spread in Europe. These services are mostly linked to non-governmental organisations, and are only recently established. The Netherlands has the longest tradition, and some projects have been sustained successfully for more than 10 years, often in good relation with governmental services.⁴

The third strategy in its pure form is rare, and most services of this kind are embedded in projects applying the second strategy. In France,⁵ some projects have a strict rule of composing a team of 50% (ex-) prostitutes and 50% non-prostitutes. Further prostitute self help organisations providing health promotion services are found in the UK,⁶ Italy,⁷ and Germany.³

In some countries, however, targeted interventions for sex workers have no strategy for health promotion at all. In Sweden⁸ governmental social services for sex workers have the objective of encouraging sex workers to enter "rehabilitation" programmes and to give up prostitution. The promotion of condom use and other prevention activities are not included in their task, although these services do outreach work and are in contact with many sex workers. Projects like these can be found in other countries as well, often linked to churches or other religious institutions.

In many areas in almost all countries in Europe, we find no targeted services and sex workers need to rely on existing health and social services. Staff in these services are often reported to have a negative attitude towards sex workers. Healthcare workers may be ignorant about prostitution and the specific problems prostitutes face. As a result, sex workers avoid discussing their professional risks, and the conditions to talk about prevention are unfavourable. In a study in Belgium almost 50% of the sex workers indicated that they did not disclose their prostitution to their own doctor or gynaecologist. In the same study, it was found that only 0.9% of the group (n = 349) was vaccinated against hepatitis B in the existing health system.⁹

Where existing services are not appropriate, which is virtually the case all over Europe, there is a place for targeted services. Designing one model that would fit all European countries does not seem feasible. The organisa-

tion of health services, public opinion, the budget for public health in general, a country's policy and its laws, and the socioeconomic situation are all important background factors that have to be taken into account when setting up targeted services for sex workers.

The EUROPAP/TAMPEP group is elaborating guidelines that could help initiatives for setting up new services. Prior assessment of needs, and, from the very beginning, close involvement of sex workers from the area where the project will be active, are basic elements in a model that combines strategy two and three. Other key concepts are pilot phase, collaboration with existing services, attitude and skills of staff (non-judgmental, knowing the occupational risks of prostitution, and understanding the working and living conditions of sex workers), confidentiality, proper location (in the prostitution area), outreach activities (project staff should know and visit the work places), adapted health education materials (directly linked to occupational risks), and long term planning and funding.

Most existing sex work projects are financed on a short term basis, often exclusively through HIV prevention budgets, and their future is very unsure. Does this mean that they do not do a good job? Why is it so difficult to convince decision makers at national and local levels to support projects for sex workers? In a recent debate with politicians someone stated: "Do all these projects not stimulate a tolerant climate for prostitution, leading to normalisation of sex work? We do not want that, do we?" This view, which is prevalent among decision makers, partly explains the reluctance of politicians in Europe to take responsibility for health promotion among sex workers. In my view, we should not mix personal moral views with public health initiatives. Organising proper care for sex workers, intravenous drug users, or other groups does not imply any moral judgment. It does not stimulate trafficking, or child prostitution. It is more a matter of strategy. Does one believe in repression and control, as mirrored in strategy one, or does one believe in reinforcing people's abilities to make responsible choices, whatever these may be? Ward and Day state that punitive legislation is widely recognised as ineffectual. However, in many European countries it is still the basis of thinking for policy initiatives.

Another reason for the failure to support sex worker projects may lie in the difficulty in evaluating its actions. Setting up evaluation procedures comparing intervention and non-intervention groups is hardly feasible in practice. An immediate reduction in HIV incidence may be seen in high prevalence areas, but not in Europe. Other end points may be registered, such as other STD, condom use and failure rates, contact with health care, and success of hepatitis B vaccination campaigns. In EUROPAP/TAMPEP, this issue received a lot of attention and, in the guidelines for setting up projects, the importance of built in evaluation tools is stressed.

When we consider prostitution on a European scale, other factors influence the organisation of prevention of STD as well. Increased imbalance in socioeconomic con-

ditions, social inequalities, and a general climate of intolerance towards prostitution create an increased mobility of sex workers, bringing together men and women from many nationalities in one area. The central objective of the TAMPEP group¹⁰ is to work with migrant sex workers from different cultural backgrounds. Through cultural mediators and peer educators, good communication between project staff and sex workers is ensured.

At the same time initiatives to organise health promotion and proper STD care towards sex workers in eastern European countries, which lack these facilities today, seem sensible.

In conclusion, as long as general health and social services in Europe are not considered appropriate by sex workers themselves, targeted interventions in close collaboration with them are needed. These targeted services should be complementary to existing services, and help them to improve their quality of work. Many sex workers have already found their way to proper health and social services, and do not need specific interventions. Others, however, have problems in relating to existing services, and they will benefit most from targeted interventions. In the study in Belgium, significantly more women who did not reveal their profession to their doctor accepted the project's offer for free STD screening.⁹

In many European cities targeted interventions do not exist. Public health authorities should assess the needs for such services, and stimulate them where needed. A nationwide network of sex worker projects should continue to discuss how to organise a broader general health structure where each sex worker can openly discuss health hazards and social problems in relation to prostitution, without fear of rejection.

On a European level, the necessity of information exchange between the national networks is underlined by the very international character of prostitution itself.

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