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SPECIAL REPORT

HIV and sex workers

Monitoring implementation of the Dublin Declaration on partnership to fight HIV/AIDS in Europe and Central Asia: 2022 progress report

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This report was commissioned by the European Centre for Disease Prevention and Control (ECDC), coordinated by Teymur Noori, and produced by Annabelle Howard (National AIDS Trust) and Katherine Turpie (National AIDS Trust).

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[1] This designation is without prejudice to positions on status, and is in line with UNSC 1244 and the ICJ Opinion on the Kosovo Declaration of Independence.

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Abbreviations

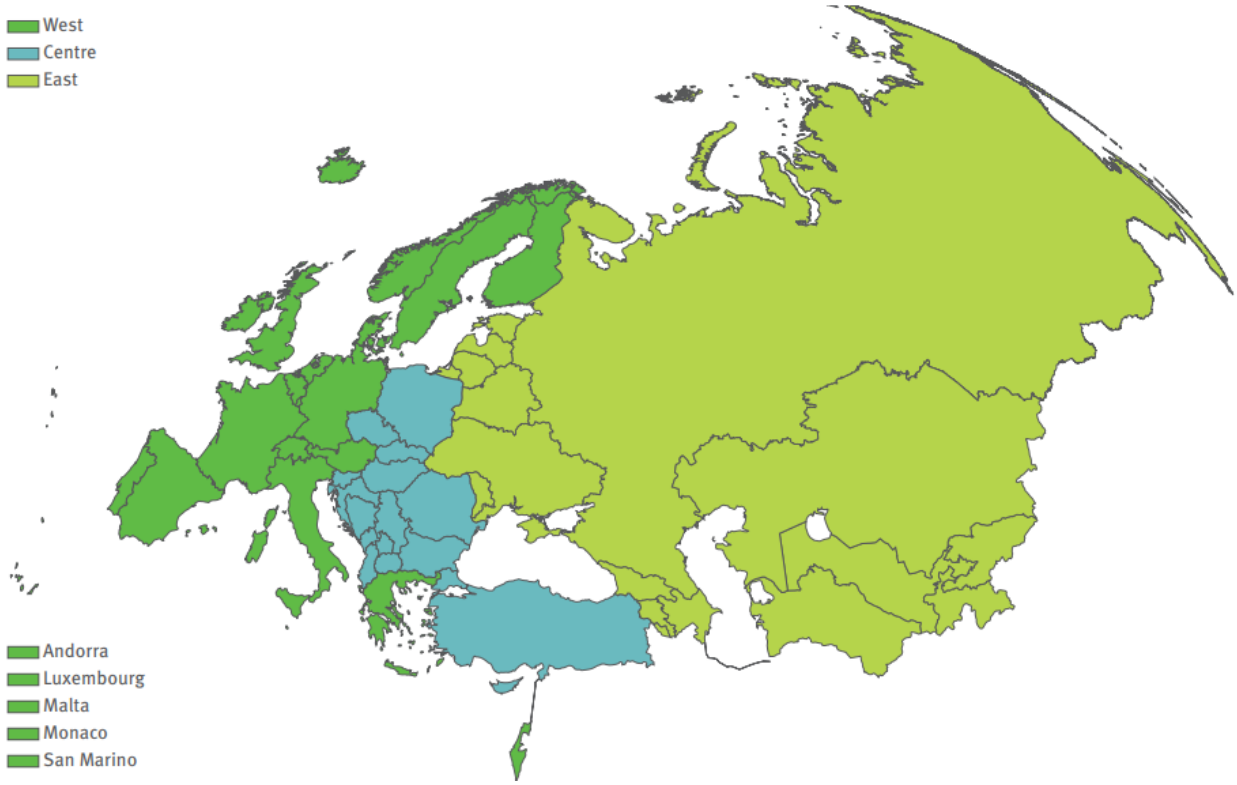
EU/EEA	European Union/European Economic Area
PrEP	Pre-exposure prophylaxis
STI	Sexually transmitted infections
WHO	World Health Organization

Introduction

Sex workers are a key population affected by HIV across Europe. Their vulnerability becoming infected with HIV is increased because of the generally criminalised and stigmatised nature of sex work, which can result in a marginalised existence for sex workers and consequent difficulties negotiating safer sex. Sex workers may also include members of other at-risk populations, including men who have sex with men, people who inject drugs, migrants, or transgender people.

This report presents the available data for describing the current situation regarding HIV prevalence among sex workers, and the efforts being made across Europe and Central Asia towards HIV prevention among this population. Given the limited data available, this report largely considers individual countries or the region as a whole. However, where feasible, findings are presented by European Union/European Economic Area (EU/EEA) membership and/or by World Health Organization (WHO) sub-regions (West, Centre, and East) which broadly group areas of Europe and Central Asia by geography and epidemic type, as depicted in Figure 1.

Figure 1. Geographical/epidemiological division of the WHO European Region



The countries covered by the report are grouped as follows:

West, 24 countries: Andorra, Austria, Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Israel, Italy, Luxembourg, Liechtenstein, Malta, Monaco, the Netherlands, Norway, Portugal, San Marino, Spain, Sweden, Switzerland, the United Kingdom.

Centre, 16 countries: Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Cyprus, Czechia, Hungary, Kosovo, Montenegro, North Macedonia, Poland, Romania, Serbia, Slovakia, Slovenia, Türkiye.

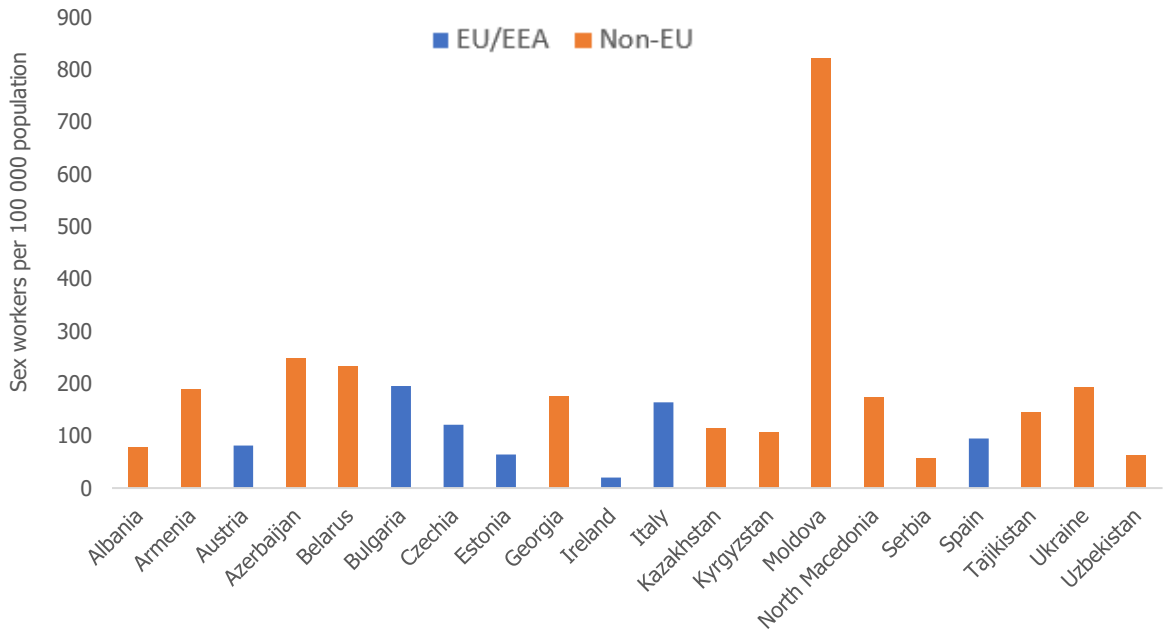
East, 15 countries: Armenia, Azerbaijan, Belarus, Estonia, Georgia, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Moldova, Russia, Tajikistan, Turkmenistan, Ukraine, Uzbekistan.

Sex worker population size

Data on the estimated size of at-risk populations were not collected in 2021 or 2022. Consequently, data collected between 2018 and 2020 provide us with the most up-to-date estimates of the size of the sex worker population across the European and Central Asian region. The rate of sex workers per 100 000 population reported varies dramatically across the region, ranging from 20 per 100 000 population in Ireland to 820 per 100 000 population in Moldova. Moldova stands as an outlier with over three times as many reported sex workers per 100 000 population as Azerbaijan, the country with the next highest rate (Figure 2).

Only 36% (20/55) of the reporting countries provided an estimate of their sex worker population between 2018 and 2020. Eleven of the 15 countries in the East sub-region provided estimates, but only four countries in the West sub-region and five in the Centre sub-region did the same. Seven countries reporting were from the EU/EEA.

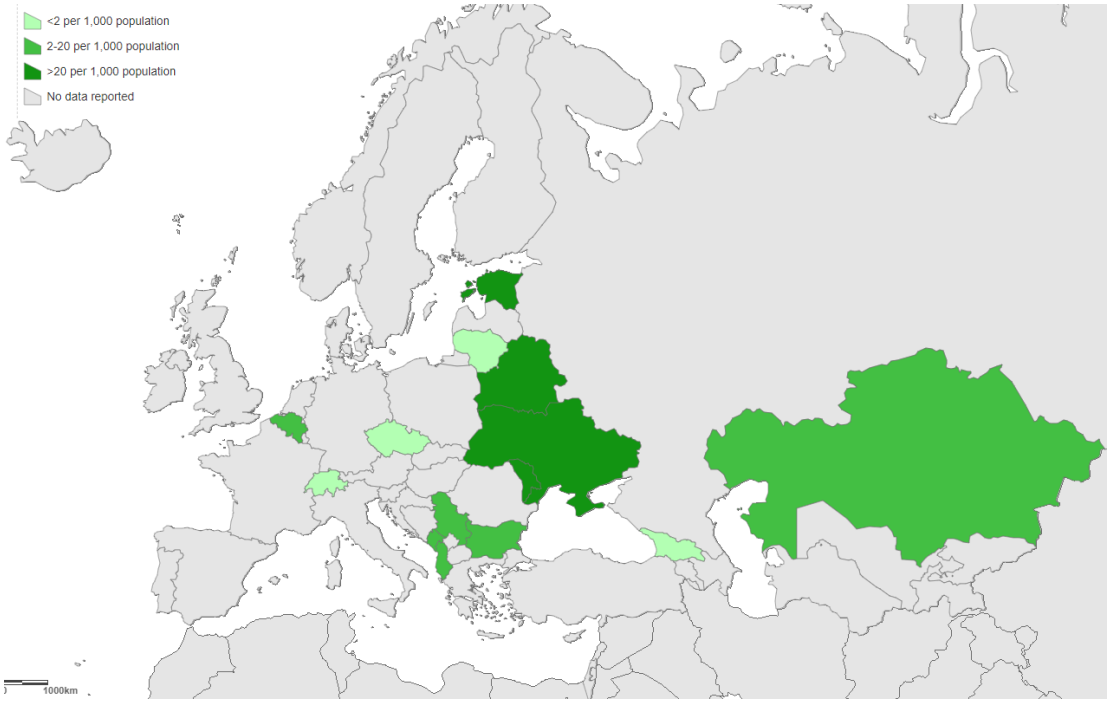
Figure 2. Sex workers population size estimated by different countries across Europe and Central Asia, by EU/EEA or non-EU country, 2018-2020 (n=20)



HIV prevalence among sex workers

Reported HIV prevalence among sex worker populations varied significantly across the sub-region, from 0.3% in Bulgaria to 13% in Estonia (Figure 3). Prevalence rates were reported by 25% (14/55) of countries across the region, with ten of these countries (71%) reporting a relatively high prevalence (>2 per 1 000) rate among sex workers. There are more data available in the East sub-region than in either the West, where only Belgium and Switzerland provided data, and the Centre, where only five countries provided data. Data provided by some countries must also be interpreted with caution, as the reported number of sex workers living with HIV is extremely low – for example, Albania, Georgia, Montenegro and Serbia all reported less than five sex workers living with HIV.

Figure 3. Reported HIV prevalence among sex workers across Europe and Central Asia*, 2022 (n=14)



Continuum of HIV care

The continuum of HIV care is a conceptual framework that provides a snapshot of critical stages in reaching viral suppression among a population living with HIV. It has become one of the central metrics through which the public health response to HIV is evaluated at the local, national and international level. The consensus definitions for each of the four stages are provided below:

Table 1. Consensus definitions for monitoring the continuum of HIV care, as part of Dublin Declaration monitoring

Stage 1: Total estimated number of people living with HIV in the country The total estimated number should be based on an empirical modelling approach, using the ECDC HIV Modelling Tool [4], the UNAIDS Spectrum model or any other empirical estimate. The estimate should include diagnosed and undiagnosed people.
Stage 2: Number/percentage of above (estimated number of people living with HIV in the country) ever having been diagnosed The number should include all new HIV or AIDS diagnoses. It should also include those people who are in care and those who have not been linked to care.
Stage 3: Number/percentage of above (estimated number of people living with HIV in the country, ever having been diagnosed) who are currently on antiretroviral treatment The number should include all people currently on ART, regardless of treatment regimen or treatment interruptions/discontinuation.
Stage 4: Number/percentage of above (estimated number of people living with HIV in the country, ever having been diagnosed or having initiated antiretroviral treatment) who had a viral load of ≤200 copies/mL at last visit (virally suppressed) The number should include all those who have ever initiated ART, regardless of regimen or treatment interruptions/discontinuation.

In 2014, the Joint United Nations Programme on HIV/AIDS (UNAIDS) established the 90-90-90 targets, which set benchmarks for each stage to be reached by 2020. Stage 1 is the estimate of all people living with HIV, whether diagnosed or undiagnosed and is necessary in order to establish a country's performance in relation to the following stages. In 2021 these targets were increased to 95-95-95 to be achieved by 2030. Stages 2-4 can be further explained as follows:

- 95% of all people living with HIV would be diagnosed (stage 2);
- 95% of those diagnosed would be receiving treatment (stage 3);
- 95% of those receiving treatment would be virally supressed (stage 4).

This translates to 86% viral suppression among all people living with HIV. The previous 90-90-90 targets translated to a target of 73% viral suppression among all people living with HIV.

As well as knowing the performance in relation to targets for the overall population, it is important that countries can disaggregate their continuum of care data by key population so that; outcomes can be measured for groups that are disproportionately affected by HIV, disparities between key populations can be identified, and responses can be targeted to meet specific needs.

The data for the continuum of care amongst sex workers in Europe and Central Asia are so limited that it is difficult to draw any significant conclusions. Only eight[ii] countries provided data (Figure 4), and just four countries – Kazakhstan, Kyrgyzstan, Luxembourg and Ukraine – were able to report data for all four stages of the continuum.

Figure 4. Number of countries reporting data for different stages of the HIV continuum of care for sex workers, Europe and Central Asia, 2022

Among the four countries in Europe and Central Asia reporting data for all four stages of the continuum for sex workers, 82% of sex workers living with HIV were diagnosed (4 607 diagnosed/5 585 living with HIV), 91% of those diagnosed were on treatment (4 192 on treatment/4 607 diagnosed) and 79% of sex workers on treatment were virally suppressed (3 331 virally suppressed/4 192 on treatment). By region, these figures were 89%, 100% and 81% in the West (only Luxembourg reported for all four stages) and 82%, 91% and 79% in the East. No data were reported from the Centre subregion (Figure 5).

In the five countries reporting data for stages 1 and 2 of the continuum for sex workers, 86% (6 095) of the estimated 7 073 sex workers living with HIV had been diagnosed. One country met the first 95% target for stage 2 of the continuum for sex workers and one country was within 10% of the target. The remaining three countries were more than 10% away from the target.

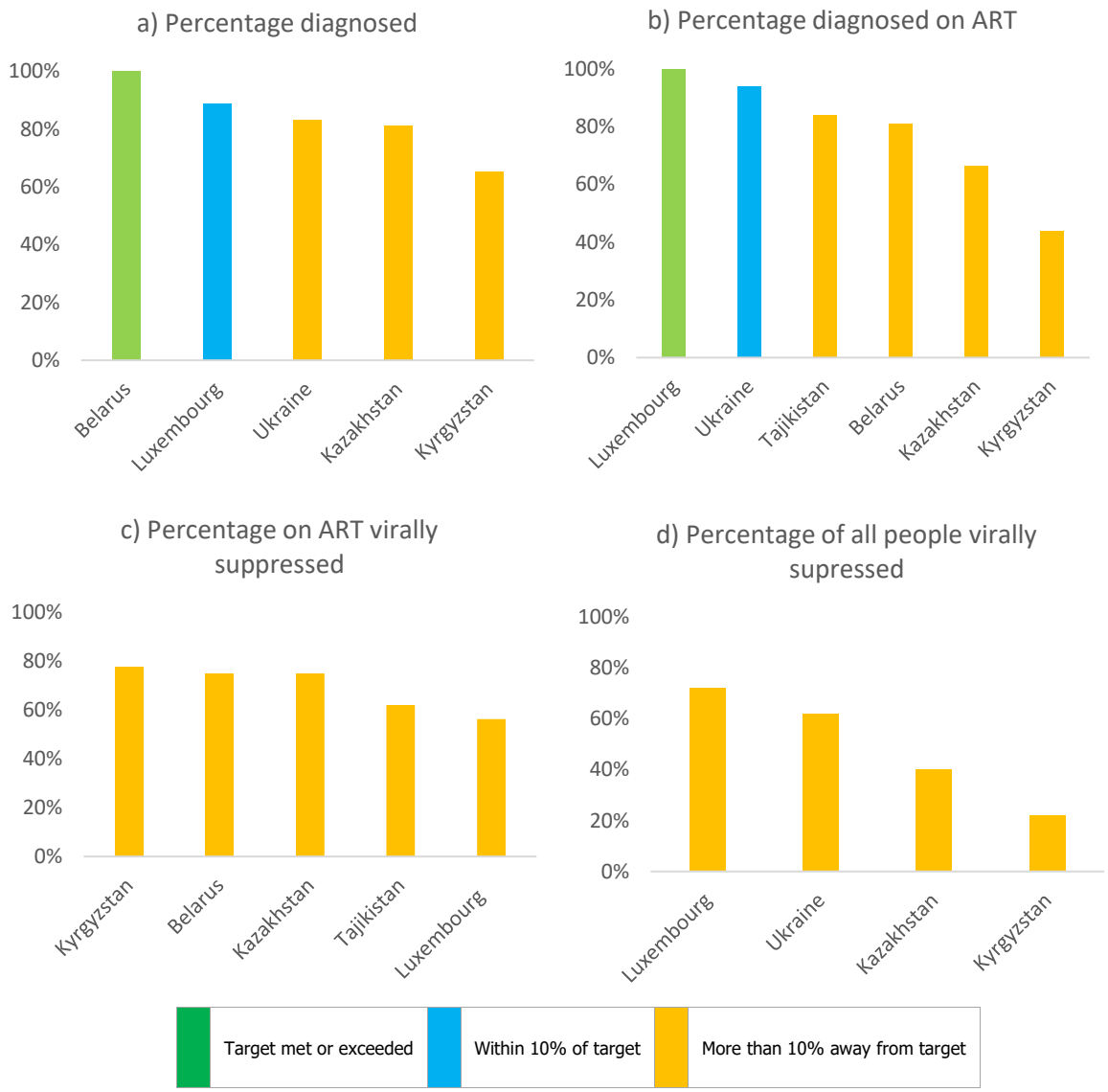
In the six countries reporting data for stages 2 and 3 of the continuum for sex workers, 88% (5 534) of the 6 258 sex workers diagnosed with HIV were on treatment. One country met or exceeded the 95% target for stage 3 of the continuum for sex workers and one country was within 10% of the target. The remaining four countries were more than 10% away from meeting the target.

In the five countries reporting data for stages 3 and 4 of the continuum for sex workers, 79% (3 416) of the 4 329 sex workers on treatment were virally suppressed. None of the countries met the 95% target for stage 3 of the continuum for sex workers. All five countries were more than 10% away from meeting the target.

Among the four countries reporting data for all four stages of the continuum for sex workers, 60% (3 331) of the estimated 5 585 sex workers living with HIV were virally suppressed. No countries met the substantive target of 86% of all PLHIV being virally suppressed for the sex worker population.

[ii] Belarus, Kazakhstan, Kyrgyzstan, Luxembourg, Malta, Moldova, Tajikistan, Ukraine

Figure 5. Progress towards the global 95-95-95 targets and the 86% substantive target for viral suppression among sex workers living with HIV in Europe and Central Asia, reported in 2022



The information in this figure reflects the latest available data reported by countries in 2022.

Stigma and discrimination

Just five countries – Albania, Moldova, Montenegro, Serbia and Ukraine – provided data on the proportion of sex workers who reported avoiding seeking healthcare over the 12 months prior to being surveyed. This ranged from 2% of sex workers in Serbia to 24% in Montenegro. Countries reported varied reasons for this, including fear or concern that someone may learn of their occupation leading to violence, police harassment or arrest. No countries in the EU/EEA reported data on stigma and discrimination among sex workers.

Due to some countries reporting very small populations of sex workers living with HIV, and the low number of countries who provided responses to questions regarding avoidance of HIV testing and treatment, it is not possible to confidently interpret the proportion of these individuals avoiding HIV testing and/or treatment. Without more data it is not possible to estimate the true impact of stigma on healthcare access among sex workers across the whole region. The lack of available data is a concern given the importance of reliable information and access to healthcare for this key population. It is vital that efforts to tackle stigma for this key population consider how stigmatising sex work interacts with HIV-related stigma.

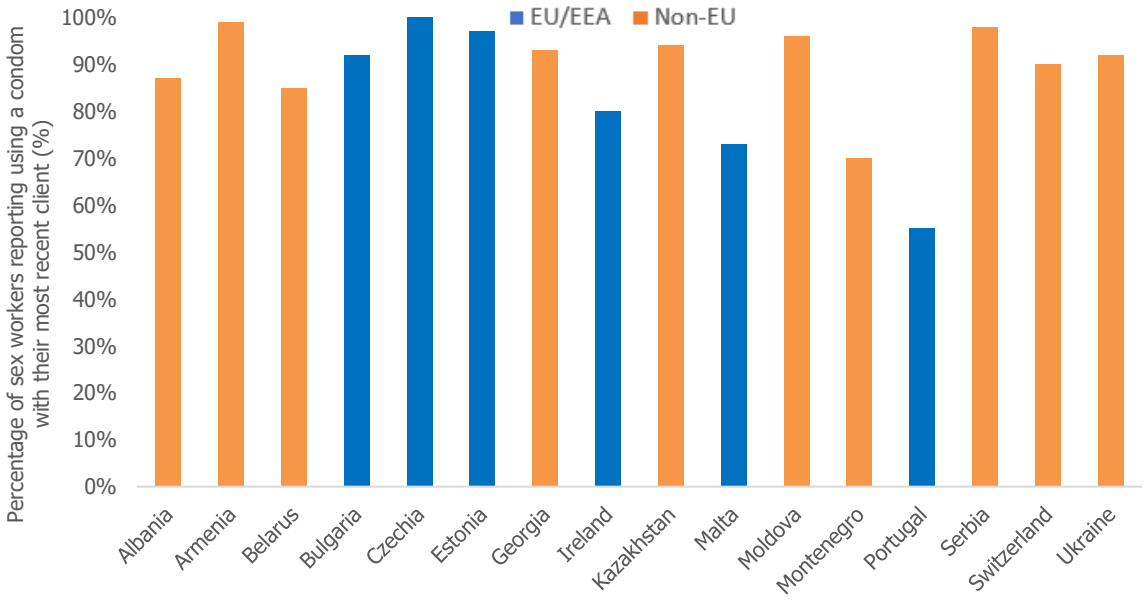
Sex workers and HIV: the response

Primary prevention

Condom provision

Condoms have long formed a core component of HIV primary prevention. Condom promotion and distribution programmes aim to ensure that individuals have access to condoms when needed. Sixteen countries provided data on the proportion of sex workers who reported using a condom with their most recent client, which ranged from 55% to 100% (Figure 6). Six of these countries are in the EU/EEA and ten are not.

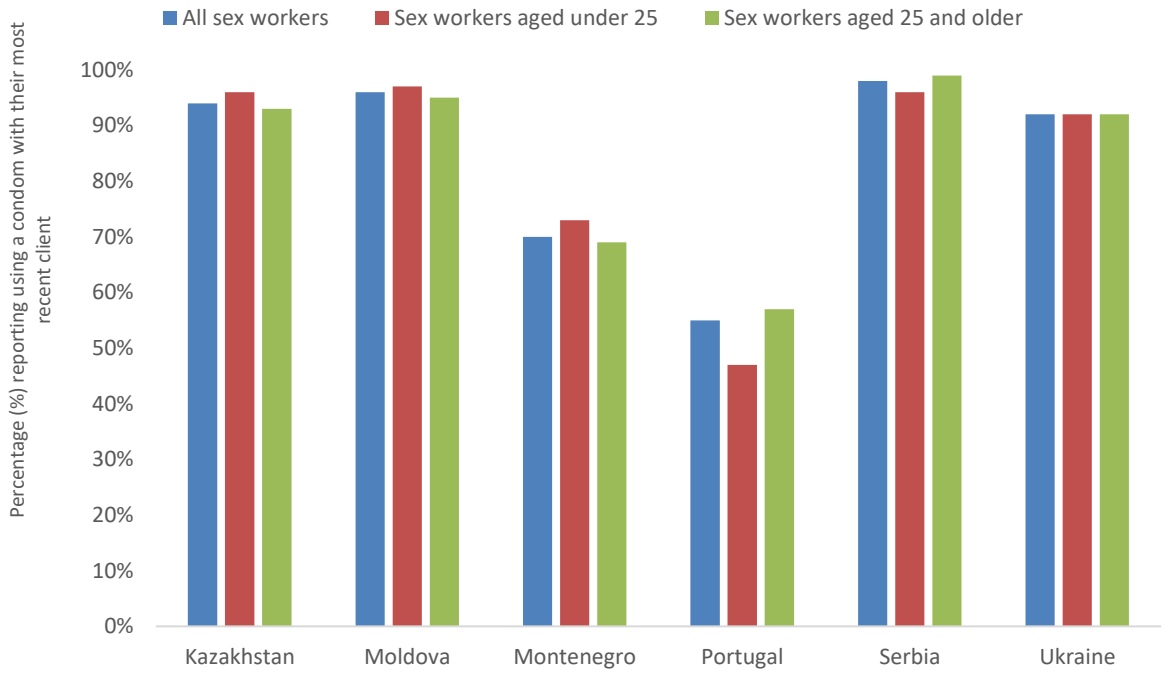
Figure 6. Data on proportion of sex workers reporting using a condom with their most recent client in Europe and Central Asia, by EU/EEA or non-EU (n=16), 2022



All 16 countries were able to provide data for female sex workers, but just three could provide data for male sex workers and only two for transgender sex workers. Six countries provided data for condom use among sex workers broken down by age (Figure 7). It is important that disaggregated data (by gender, key population, age etc.) are collected so that intervention programmes can be targeted accordingly, and sub-groups of the wider sex worker population are not ignored. Portugal was the only EU/EEA country that provided this level of detail about condom use among sex workers. The data showed that overall condom use with their most recent client was low at 55%, and sex workers aged 25 and over were more likely to use a condom than those aged under 25, with use at 57% and 47% for the two groups, respectively.

Apart from Portugal, however, data on condom use were so sparsely provided across the region that it is not possible to infer accurate patterns of condom use within the sex worker population.

Figure 7. Data on proportion of sex workers reporting using a condom with their most recent client, disaggregated by age, Europe and Central Asia (n=6), 2022



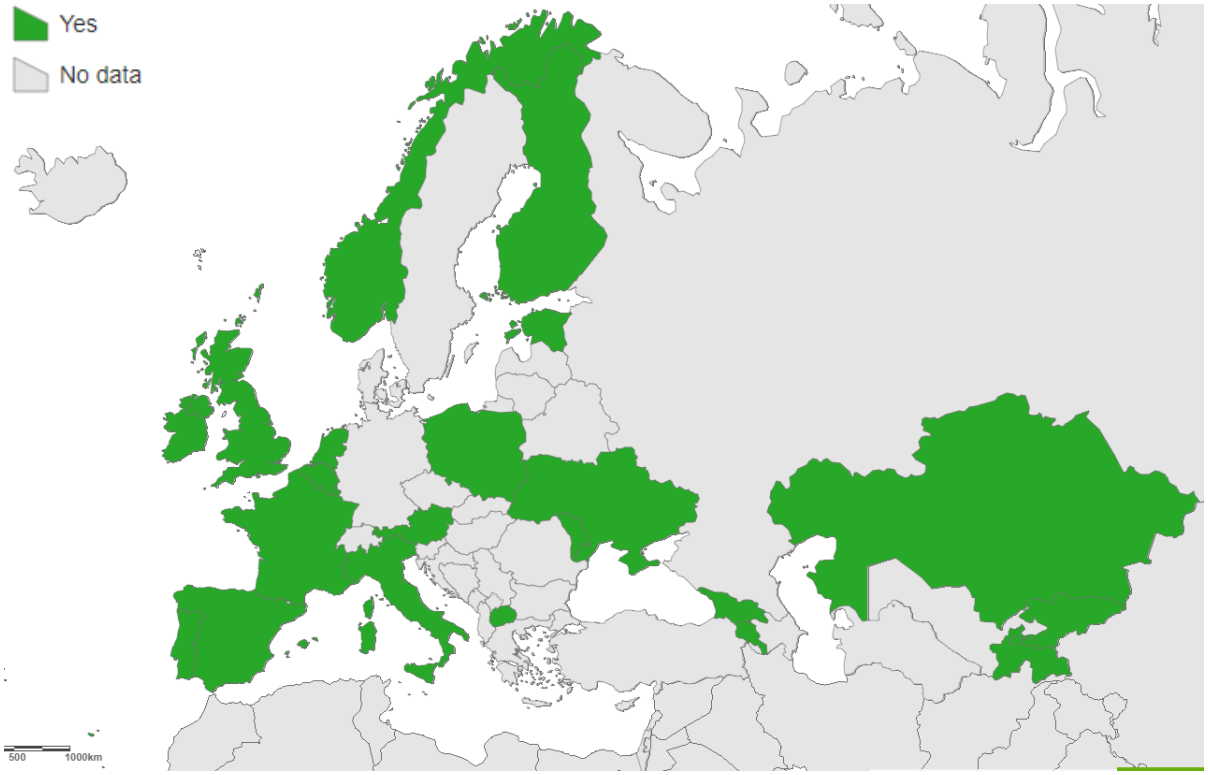
Pre-exposure prophylaxis

Pre-exposure prophylaxis (PrEP) has been hailed as a game-changer in HIV prevention as there is clear evidence that it is extremely effective at preventing the acquisition of HIV when used properly. It is a particularly useful prevention strategy for those who struggle to use condoms consistently for a range of reasons, including issues related to power dynamics, stigma, and negotiation, which may be especially relevant for sex workers.

In the 2022 survey, 36 countries reported that PrEP guidelines had been developed in their country and these guidelines were being implemented in 30 countries. Reasons countries gave for not having implemented existing guidelines included concerns about adherence and drug resistance, cost of drugs and service delivery as well as the possibility that increased awareness of PrEP would lead to lower condom use and increased HIV transmission. Twenty-three countries reported that sex workers were eligible for PrEP under their national guidelines (Figure 8). Of these 23 countries, 11 reported that PrEP was available for free through their public healthcare services (Finland, France, Georgia, Ireland, Kyrgyzstan, North Macedonia, Norway, Portugal, Spain, Ukraine and the United Kingdom). A further six countries (Austria, Belgium, Estonia, Italy, the Netherlands and Poland) reported that PrEP is available through public health services, but at a cost to the individual.

Limited data are available on PrEP usage among sex workers. Just six countries were able to provide disaggregated data on numbers of sex workers receiving PrEP at least once over the reporting period – Kyrgyzstan (7), Moldova (39), Portugal (40), Spain (27), Tajikistan (0) and Ukraine (144). While people in countries with poor availability of PrEP may purchase it online, this option may be less available to sex workers who are more likely to be economically marginalised. As more countries move towards formal implementation of access to PrEP and, ideally, the removal of cost as a barrier to uptake, sex workers should be included in universal access.

Figure 8. Countries reporting that PrEP is available for sex workers as per national guidelines, 2022

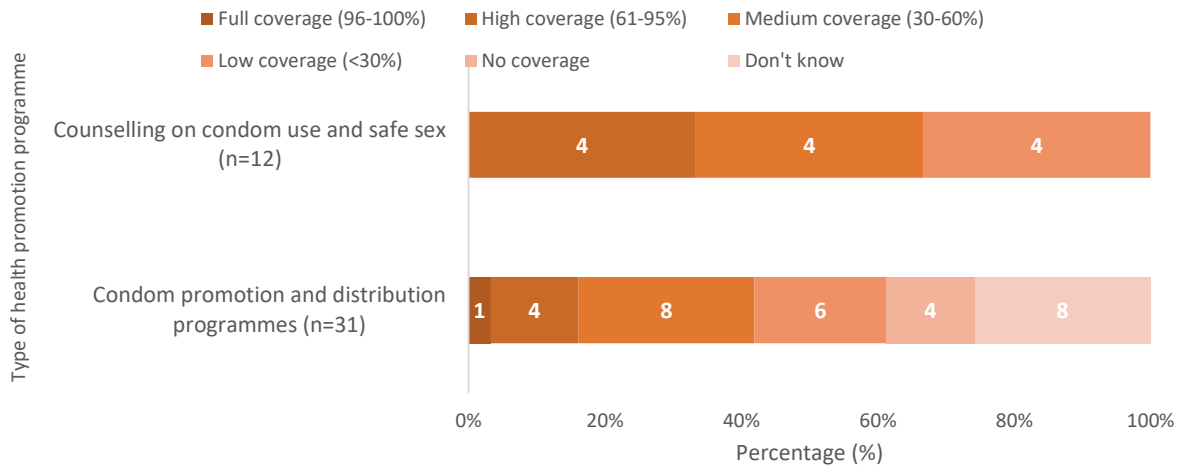


Health promotion programmes

Health promotion programmes seek to reduce HIV acquisition by addressing poor knowledge of transmission risk and behaviour that puts people more at risk. Effective interventions can be information-based or behavioural, such as supporting adherence or increasing the use of condoms or clean needles among sex workers who are also people who inject drugs.

The impact of health promotion programmes among sex workers was measured through the reported coverage of condom and lubricant programmes, as well as counselling on condom use and safe sex (Figure 9). Forty-three countries (nearly 80% of reporting countries) did not provide a response regarding counselling, and no country reported full coverage for this type of programme, indicating that more awareness in this space may be necessary to increase implementation and coverage, so that sex workers understand the importance of condom use and safe sex in preventing the transmission of HIV. Nineteen countries reported some level of coverage for condom promotion and distribution programmes, with four reporting high coverage, and one country, France, reporting full coverage for these types of programmes.

Figure 9. Estimated coverage of health promotion and behaviour change programmes for sex workers across Europe and Central Asia, 2022

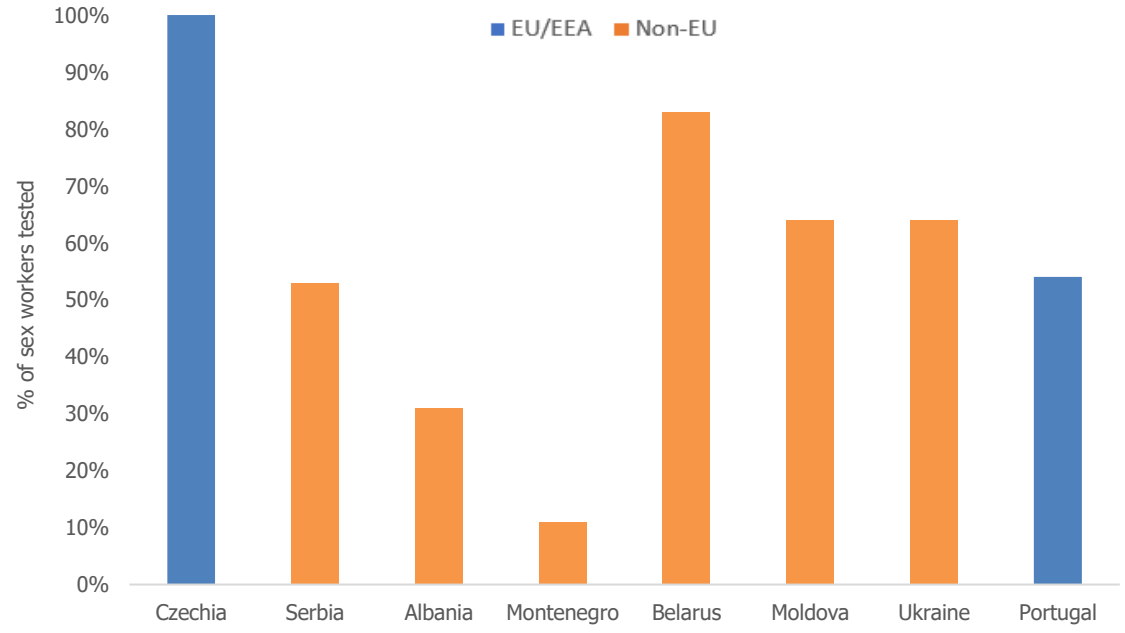


Secondary prevention

HIV testing

High levels of provision and uptake of testing, combined with prompt treatment, are crucial for reducing overall HIV incidence. In 2022, eight countries reported having new data on HIV testing rates for sex workers. Just two of these countries, Czechia and Portugal, are from the EU/EEA (Figure 10). Reported testing rates range from 11% in Montenegro to 100% in Czechia, with both Montenegro and Albania reporting a rate lower than 50%.

Figure 10. Data on HIV test uptake among sex workers, Europe and Central Asia (n=8) 2022



Treatment guidelines

Ensuring prompt access to treatment after an HIV diagnosis can result in a normal life span as well as reducing the risk of onward transmission, as those on treatment with an undetectable viral load are unable to pass on HIV. In 2022, 40 countries across Europe and Central Asia reported that they had guidance advising initiation of treatment regardless of CD4 count, in accordance with WHO and EACS clinical guidelines.

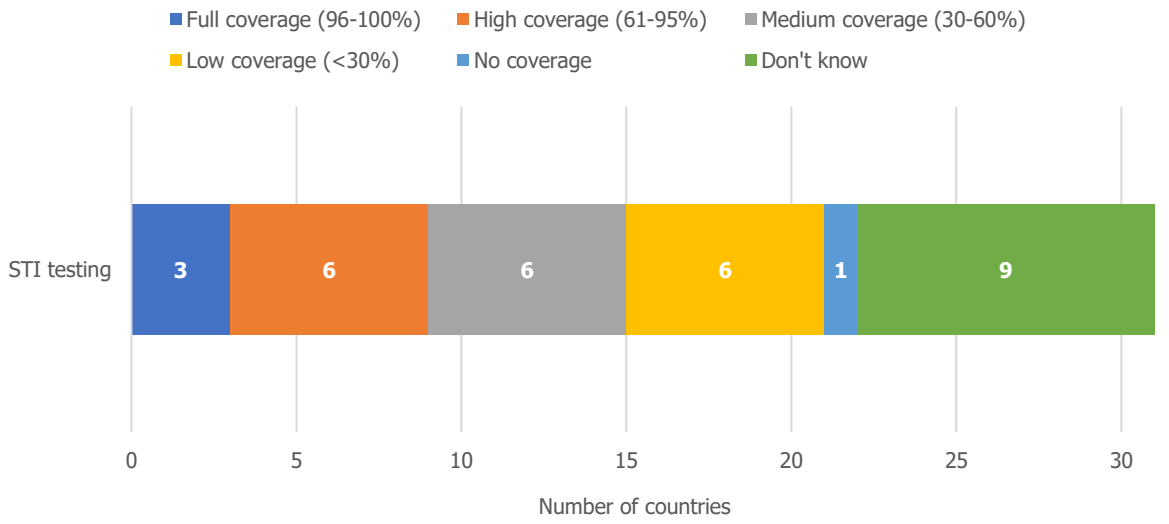
Thirteen countries did not provide a response regarding initiation of treatment, but two countries – Bulgaria and Uzbekistan – reported having a threshold for initiating antiretroviral therapy. Bulgaria does not recommend antiretroviral treatment until individuals have a CD4 count of 500 cell/mm^3 or less, and Uzbekistan did not specify their threshold. Bulgaria has a considerably higher prevalence of HIV infection among sex workers than other countries, at 3 per 1 000 population, and Uzbekistan was not able to provide prevalence data for this population. While treatment policy is relevant across the entire population living with HIV, it will have more impact among populations with higher prevalence – both in terms of health outcomes and treatment as prevention.

Tertiary prevention

Testing and treatment services for sexually transmitted infections in sex workers

Access to testing and treatment for sexually transmitted infections (STI) is important, not only because it comprises an element of holistic healthcare for sex workers, but also because the presence of STIs is known to increase the risk of HIV acquisition. Less than 50% of countries (21 out of 55) across the region report any level of coverage of STI testing and treatment services targeted at sex workers (Figure 11), which is considered to be insufficient given the higher risk of STIs and HIV among this population. Of these 21 countries, 18 were in the EU/EEA. Six countries across the whole region reported high coverage and three countries – Denmark, Israel and Spain – reported full coverage.

Figure 11. Estimated coverage of STI testing and treatment services for sex workers across Europe and Central Asia (n=31) 2022



Conclusions

The absence of robust data makes it difficult to draw firm conclusions about the risk of HIV acquisition in the sex worker population or their access to prevention, testing, and treatment This also makes it difficult to draw conclusions about the adequacy of the response from individual countries, or to monitor whether the situation is improving or worsening across the region. Generally, data provision is superior in the East sub-region. It is assumed that better monitoring supports targeted service provision, although it is not clear this is the case for the East sub-region where, for example, poor testing rates among sex workers are still reported. The lack of data in many countries may indicate that the needs of some sex worker sub-populations are not visible, particularly given the common risk-behaviours that exist among at-risk populations – overcoming barriers is crucial to targeting services appropriately to meet the varied needs within the sex worker population.

The limited data which are available do give cause for concern. Among countries able to report HIV prevalence data within the sex worker population, 71% identified relatively high prevalence. The very limited amount of continuum of care data that was available indicates that barriers towards achieving viral suppression among the sex worker population exist at each stage of the continuum – diagnosis, access to treatment, and viral suppression for those on treatment. Improvements in monitoring must take place to ensure that targeted interventions can be implemented effectively if the epidemic is to be tackled, at least in part, through achieving viral suppression among all sex workers living with HIV.

Consistently low coverage of targeted prevention programmes reflects a response that is not meeting the needs of the sex worker population. The failure to implement adequate HIV and STI testing programmes targeted at sex workers across the region does not support public health measures associated with prompt treatment of HIV (i.e. being unable to pass on HIV when the viral load is undetectable). Furthermore, data regarding counselling on safe sex and condom use are almost non-existent, and where they are provided, coverage is poor, meaning sex workers who are at risk are not being educated about how to prevent transmission through these channels.

The introduction of PrEP may create new possibilities for prevention that are especially important for sex workers in situations where they are unable to negotiate condom use. As sex workers are more likely to be economically marginalised, the removal of cost as a barrier to PrEP is essential. Therefore, it is vital that PrEP programmes are rolled out universally, as soon as possible.

Priority options for action

- Improvements in monitoring and data collection should be made for the sex worker population on the full range of HIV-related matters – prevalence, access to treatment, health outcomes, prevention programmes, and stigma. To allow for effective targeting of responses, data should be disaggregated by gender, including transgender status, and in intersections with other key populations.
- Data should be collected for all four stages of the continuum of care, and a targeted response to any stage that results in poor viral suppression among the sex worker population should be implemented. This means ensuring that sex workers living with HIV are diagnosed, have prompt access to treatment, and are supported in adhering to their treatment regimen.
- Relevant prevention and testing programmes should be made available to sex workers. This requires investment in targeted interventions, prioritisation of counselling, and particularly, consulting with sex workers themselves to ensure that existing or new services are accessible and meet their needs.
- Use of PrEP among sex workers should be prioritised through implementing programmes that enable access to PrEP and support its uptake.
- Barriers to the uptake of services should be addressed through challenging stigma related to both HIV and sex work among healthcare providers, as well as in the wider society, and further empowering this key population through the decriminalisation of sex work.

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