SURVEILLANCE & MONITORING

Overview of the provision of prevention and testing for HIV and sexually transmitted infections for sex workers in the European Union and European Economic Area

September 2026

Key messages

- Sex workers in the European Union/European Economic Area (EU/EEA) experience a high burden of HIV and sexually transmitted infections (STIs), which underscores the need for enhanced policies and programmes.
- Available data suggest that coverage of prevention programmes tailored to sex workers remains limited, although reporting is sparse and varies across countries. While many countries provide free condoms and lubricants to sex workers, there are still potential improvements to be made in the uptake of testing.
- There are difficulties in reaching sex workers with pre-exposure prophylaxis (PrEP) for HIV prevention. Even countries that prioritise them for eligibility highlight critical service delivery gaps.
- Most EU/EEA countries report laws and policies that criminalise or penalise certain aspects of sex work, including activities related to organising, managing, selling or purchasing sexual services. Scientific evidence suggests that such punitive enforcement practices may impede access to HIV and STI prevention testing and treatment by contributing to stigma, fear of sanctions and reduced engagement with health services.
- Meaningful involvement of sex workers in service design and delivery, and measures to address stigma and legal barriers is crucial to improve HIV and STI prevention, testing and treatment uptake and outcomes in this key population.
- Strengthened monitoring systems are needed for countries and stakeholders to have the necessary data to inform and effectively tailor programmes and interventions.

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Introduction

Sex work is defined as the consensual exchange of sexual services between adults for money, goods, or other forms of compensation [1-4][1]. Sex workers are a heterogeneous population group, encompassing people of different genders (including cisgender men and women, trans and gender-diverse people), sexual orientations, and migration statuses, and are involved in different working arrangements.

Sex workers are a key population affected by HIV and sexually transmitted infections (STIs) across Europe [5]. HIV prevalence is relatively low among sex workers living without additional risk factors in the EU/EEA compared to other key population groups, ranging from 1.1% to 8.5% in a published review [6]. Nevertheless, HIV prevalence is generally higher among sex workers than in the general population and is particularly elevated among sex workers who also belong to other key population groups (e.g. those who inject drugs, transgender sex workers, undocumented migrants and sex workers who are men who have sex with other men). Evidence from European studies indicates that individuals belonging to multiple key populations groups experience higher HIV prevalence than those with a single vulnerability, although data remain limited for some populations, particularly transgender sex workers [7].

An effective public health response to HIV and STIs depends on high-quality data on the affected populations. The life conditions and characteristics of many key populations and the social, legal and structural factors that may affect their visibility and participation in data collection can make it challenging to obtain accurate estimates of disease burden and behavioural indicators. Many surveillance systems collect information on whether a case is a sex worker, or information on probable route of transmission (transmission category sex work) [8-11]. However, prevalence and or incidence rates are hard to calculate as underlying population sizes of different key populations are often unknown due to their hidden nature. In addition, members of key populations may face barriers in accessing testing, resulting in delayed diagnoses and an underestimation of the true burden of disease.

HIV, STIs and viral hepatitis share common modes of transmission, particularly sexual (and in the case of HIV and hepatitis B and C infections, via injecting drug use) and there is overlap across several key population groups including sex workers, gay, bisexual and other men who have sex with men (gbMSM), transgender people, people who inject drugs (PWID), migrants and people in prisons and other closed settings [12].

Across the EU/EEA, the increased vulnerability to HIV, STIs and other infectious diseases among sex workers is related to multiple intersecting social, socio-economic and structural factors, including but not limited to working conditions and limited ability to negotiate condom use. These challenges are compounded by high rates of experienced violence, stigma, discrimination, and legal barriers that further restrict access to health and social protections [3,13-15]. These intersecting risk factors contribute to the marginalisation of sex workers, in particular trans and gender-diverse sex workers, who may face overlapping discrimination and exclusion in formal employment markets [16,17]. Further, these contributing factors are particularly pronounced for sex workers who are also undocumented migrants [18].

Sex workers' rights organisations have argued that the decriminalisation of sex work is central to protecting sex workers' rights, including labour rights and the right to self-determination [19,20]. Scientific evidence from systematic reviews suggests punitive legal environments around sex work may be associated with poorer health outcomes and service access [14,15,21,22]. Furthermore, findings from the ECDC and European AIDS Clinical Society (EACS) survey on stigma in healthcare settings found that 6% of healthcare providers preferred not to provide care or services to sex workers, primarily due to a lack of population-specific training and the belief that sex workers engage in immoral behaviour [23].

This document provides an overview of the provision of prevention and testing for HIV and STI among sex workers in EU/EEA countries.

[1] The term 'sex work' seeks to emphasise agency and recognise the provision of sexual services as a form of labour, but this framing can be seen as ignoring exploitation, harm and the structural constraints people engaged in it can experience. In this document, we use 'sex worker' to refer to adults engaged in the consensual exchange of sexual services, but in using it we do not suggest that all involvement in the exchange of sexual services is freely chosen, equally safe or experienced as work. Human trafficking and forced sexual exploitation are distinct from consensual adult sex work and require specific prevention, protection and criminal justice responses. Although trafficking is outside the analytical scope of this report, this exclusion should not be understood as minimising the health and protection needs of people exposed to coercion, trafficking or exploitation. In light of this complexity, we acknowledge that the terminology used in this report may not capture the diversity of people's circumstances or how they might describe themselves. Resources we consulted on this subject include: https://www.unaids.org/sites/default/files/media_asset/05-hiv-human-rights-factsheet-sex-work_en.pdf https://www.unaids.org/sites/default/files/media_asset/2024-terminology-guidelines_en.pdf and https://www.ohchr.org/sites/default/files/2024-03/2024-march-sex-work-guide-un-report-short.pdf

Methods

ECDC has coordinated the monitoring of national responses to HIV under the Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia since 2008 [24], and EU/EEA countries' responses to the epidemics of hepatitis B and C since 2016 [25]. In 2023, ECDC expanded monitoring activities[2] to other disease areas, which included the development of a new system to collect data on national responses to ending the epidemics of STIs [26].

Data collection for the first ever STI monitoring round took place among EU/EEA countries between October and December 2024, followed by HIV monitoring data collection between February and April in 2025. Questionnaires were sent to nominated ECDC national focal points. Validation exercises were performed with responding countries for both data collection rounds and corrections were made where necessary.

Both the HIV and STI questionnaires contained specific questions related to the respective epidemics among sex workers, in addition to questions about current national prevention interventions, policies, and barriers to public health services. If a country did not provide data or information for indicators in the 2025 HIV monitoring data collection, data or information from the last available reporting year were used. In addition, this report also includes two indicators from the 2026 HIV data collection on the legal environment for sex work introduced in the 2026 Dublin data collection regarding laws used in practice to criminalise or penalise sex workers based on real or perceived occupation, even when not explicitly criminalised.

Data from published systematic reviews are also used [6] as well as forthcoming data from the European-Men-who-have-sex-with-men internet survey (EMIS) [27].

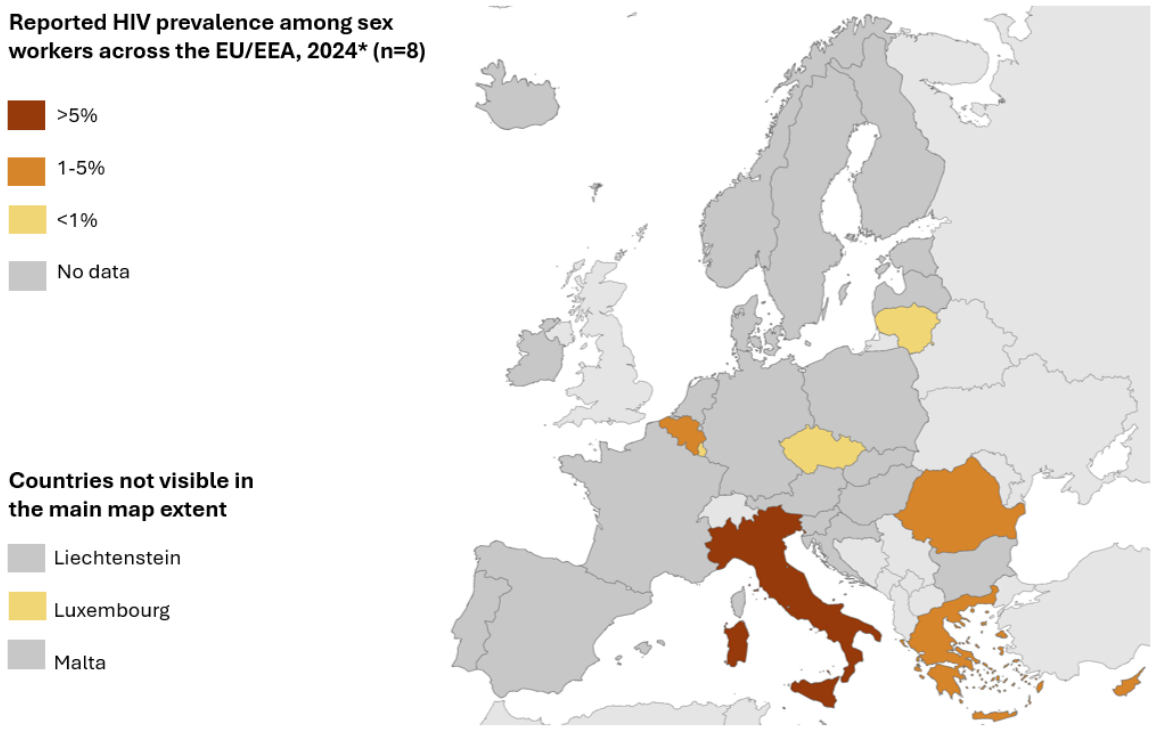
Estimated prevalence of HIV and STIs among sex workers in the EU/EEA

Within the ECDC HIV monitoring questionnaire, countries were asked to provide size estimates for key populations. Population size estimates for the number of sex workers were provided by Austria (5 443; approximately 592 per 1 000 000 population), Estonia (440; 321 per 1 000 000 population), Finland (7 000; 1 242 per 1 000 000 population) and Italy (97 000; 1 646 per 1 000 000 population).

HIV prevalence among sex worker populations varied significantly between the eight reporting countries (Figure 1). Three countries (Czechia, Lithuania, and Luxembourg) reported 1% or less; four countries (Belgium, Cyprus, Greece, and Romania) reported between 3-4.5%; and one country reported 21.6% (Italy).

[2] Under framework service contract 'Monitoring progress towards the Sustainable Development Goals as they pertain to HIV, viral Hepatitis, STIs and TB in the EU/EEA and neighbouring countries'.

Figure 1. Reported HIV prevalence among sex workers, EU/EEA, 2024* (n=8)



* *2024 or most recent year with available data: 2023 (Italy, Luxembourg).*

According to an ECDC systematic review, the prevalence of STIs among sex workers in Europe is high. In female sex workers, pooled prevalence was estimated to be 5.5% for chlamydia (n=3 878, studies from Belgium, Portugal, the Netherlands and Switzerland), 2.2% for gonorrhoea (n= 3 878, studies from Belgium, Portugal, the Netherlands and Switzerland), 9% for trichomoniasis (n=786, studies from Belgium and Switzerland), and 1.8% for syphilis (n=3345, studies from Italy, Portugal, the Netherlands and Switzerland). Among cisgender men sex workers and transwomen sex workers, prevalence estimates were found to be particularly high, with pooled prevalences estimated to be 6.0% for chlamydia (n=272, studies from Portugal, the Netherlands and Spain), 6.4% for gonorrhoea (n=258, studies from Portugal, the Netherlands and Spain), and 22.1% for syphilis (n=125, studies from Portugal and the Netherlands) [6].

The European Men-Who-Have-Sex-With-Men Internet Survey (EMIS), comprises survey responses among 50 330 participants [27]. Based on survey data from 2024, 2.3% of respondents had sold sex three or more times in the last 12 months. The highest proportion (4.3%) was among people below 25 years old. Respondents who sold sex were more likely to have been tested for STIs in the past 12 months, including anal swabbing, and to have received counselling about HIV PrEP at a health service. Conversely, they were less likely to have been offered hepatitis vaccination, and among those living with HIV, viral suppression was less common. Men who exchanged sexual services for compensation were more likely to be in need of prevention services, as they to a higher extent reported lack of information, confidence and control in relation to condom use, concerns about their drug use, lack of knowledge about testing and where to get tested, as well as higher rates of condomless sex due to lack of condoms.

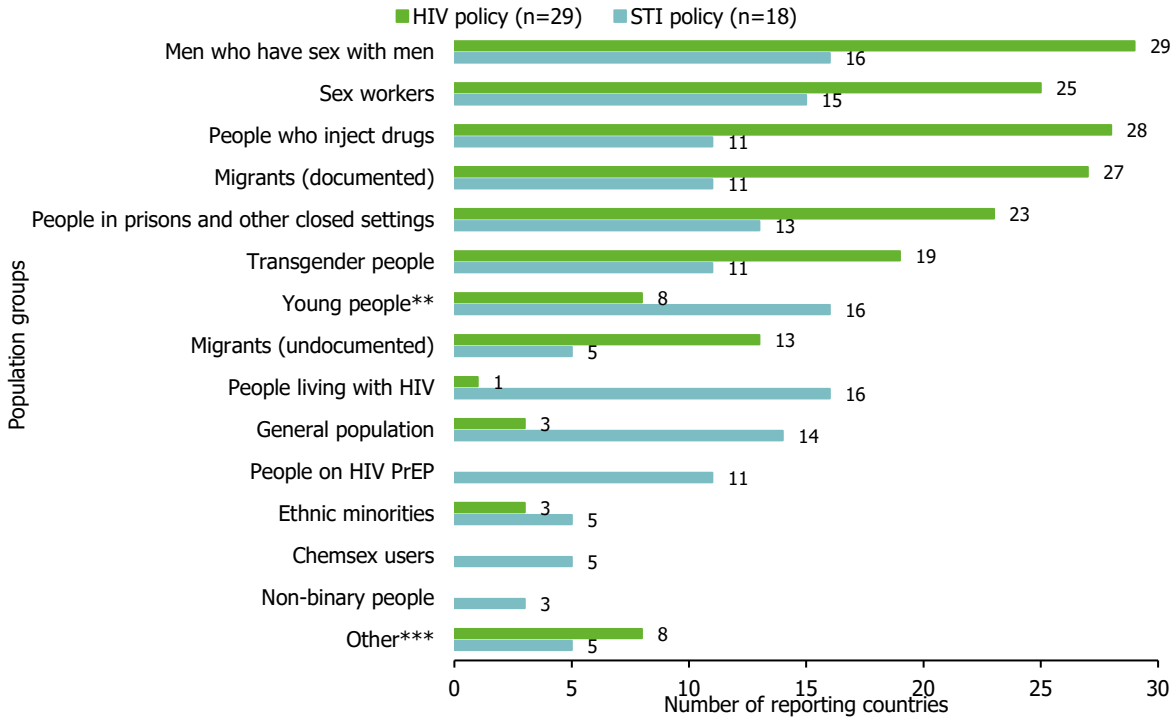
Enabling environment for prevention

An enabling environment in the context of HIV and STI prevention and control refers to the social, structural, and service conditions that remove barriers and support equitable access to integrated prevention, testing, and care, thereby improving early diagnosis, strengthening the overall effectiveness of prevention efforts, and supporting favourable treatment outcomes. Inclusion of key population groups, such as sex workers, is a key component in the development of policies related to their health in order to help to inform evidence-based, tailored and person-centred strategies.

Sex worker participation in development of policies

Of the 30 EU/EEA countries, fewer than half (14 countries[3]) had former and/or current sex workers participate in developing national policies, guidelines and strategies related to their health. However, almost all countries reported specific mention or focus on sex workers within existing national strategies, plans or policies for the prevention and control of HIV (86%; 25/29 countries[4]) and STIs (83%; 15/18 countries[5]) (Figure 2).

Figure 2. Inclusion of population groups within national strategies, plans or policies for the prevention and control of HIV and STIs, EU/EEA, 2024* (HIV n=29, STIs n=18)



** 2024 or most recent year with available data: 2023 (Austria).*
*** The definition of 'young people' was only specified in the STI monitoring questionnaire. Countries who specifically noted young people may use different definitions.*
**** Other responses for STIs included: blood donors, people living with a chronic illness, pregnant women, homeless people. Other responses for HIV included: women, pregnant women, homeless people.*

Legal environment

Laws and policies that criminalise or penalise key population groups may restrict access to health services and contribute to persistent public health inequalities.

Testing for STIs was mandatory in 12 countries for certain specific population groups (excluding blood donors)[6]. Among these, STI testing was mandatory for sex workers in Austria and Greece.

The majority of EU/EEA countries (21 of 30) reported having laws criminalising the profiting from organising and/or managing sexual services. Criminalisation of ancillary activities was identified in 14 countries for selling sexual services[7] and in nine countries for buying sexual services[8] (Table 1).

Six EU/EEA countries enforce varying levels of sex work legalisation or decriminalisation, but two (Germany and the Netherlands) specified administrative regulations related to sex work that may result in criminal liability.

[3] Reported in 2025: Bulgaria, Czechia, Estonia, Finland, France, Germany, Greece, Ireland, Italy, Lithuania, the Netherlands, Portugal, Slovenia. Reported in 2023: Norway.
[4] Austria, Belgium, Bulgaria, Croatia, Czechia, Estonia, Finland, France, Germany, Greece, Ireland, Italy, Latvia, Liechtenstein, Lithuania, Luxembourg, Malta, the Netherlands, Norway, Poland, Portugal, Romania, Slovenia, Spain, Sweden.
[5] Bulgaria, Croatia, France, Germany, Hungary, Ireland, Italy, Lichtenstein, Lithuania, Luxembourg, Malta, the Netherlands, Portugal, Spain, Sweden.
[6] Austria, Bulgaria, Croatia, Cyprus, Czechia, Estonia, Greece, Hungary, Lithuania, Luxembourg, Portugal, and Romania.
[7] Ancillary activities associated with selling sexual services include sex work-related advertising and soliciting (offering sexual services), sex workers congregating in one place, sex workers living with each other, and sex workers working too close to a school or place of worship.
[8] Ancillary activities associated with buying sexual services include soliciting (looking for sexual services) and curb-crawling.

Table 1. Legal context of sex work in the EU/EEA: number of countries reporting laws criminalising certain aspects of sex work at national or sub-national levels in EU/EEA countries, 2025* (n=30)

Legal situation	Number of countries	Countries
Profiting from organising and/or managing sexual services is criminalised	21	Bulgaria, Cyprus, Czechia, Denmark, Estonia, Finland, France, Iceland, Ireland, Italy, Liechtenstein, Lithuania, Luxembourg, Malta, Norway, Poland, Portugal, Romania, Slovenia, Spain, Sweden
Ancillary activities associated with selling sexual services are criminalised	14	Bulgaria, Croatia, Cyprus, Estonia, Finland, France, Iceland, Ireland, Italy, Liechtenstein, Luxembourg, Malta, Poland, Sweden
Ancillary activities associated with buying sexual services is criminalised	9	Croatia, Cyprus, France, Iceland, Ireland, Lithuania, Malta, Norway, Sweden
Selling sexual services is criminalised	7	Croatia, Cyprus, France, Liechtenstein, Lithuania, Malta, Slovakia
Other punitive regulation of sex work	2	Iceland, Malta
Sex work is not subject to punitive regulations and is not criminalised	6	Austria, Belgium, Germany**, Greece, Hungary, the Netherlands**
Do not know	1	Latvia

** This policy indicator was included in the 2026 Dublin Declaration HIV monitoring data collection.*
*** While sex work is legal in Germany and the Netherlands, administrative regulations can result in criminal liability. Specific sex work legislation in Germany includes designated prostitution-free zones. In the Netherlands, the unlicenced operation of a sex work business establishment is a criminal offence, and therefore subject to criminalisation of related activities involving the selling, organising and/or managing of sexual services.*

Laws and enforcement practices that penalise sex workers on the basis of real or perceived occupation, even where sex work is not explicitly criminalised, can exacerbate stigma, violence, and fear of prosecution, discouraging engagement with health services and undermining effective and equitable HIV and STI prevention and care.

Among EU/EEA countries that provided information on other laws used in practice to criminalise or penalise sex workers based on real or perceived occupation, even when not explicitly criminalised, five countries reported various laws being applied in this manner (Table 2).

Table 2. Countries reporting application of non-sex-work laws to penalise sex workers based on real or perceived occupation in EU/EEA countries, 2025* (n=30)

Laws used in practice to criminalise or penalise sex workers based on real or perceived occupation, even when not explicitly criminalised	Number of countries	Countries
No such laws are used in this way	21	Austria, Belgium, Croatia, Czechia, Denmark, Estonia, France, Germany, Iceland, Ireland, Italy, Lithuania, the Netherlands, Norway, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden
Anti-prostitution or sex work laws	4	Greece, Liechtenstein, Luxembourg, Malta
Public morality or public decency laws	3	Finland, Greece, Malta
Vagrancy or public nuisance laws	1	Finland
Do not know	4	Bulgaria, Cyprus, Hungary, Latvia

** As of 2025. This indicator was introduced in the 2026 Dublin Declaration HIV monitoring data collection.*

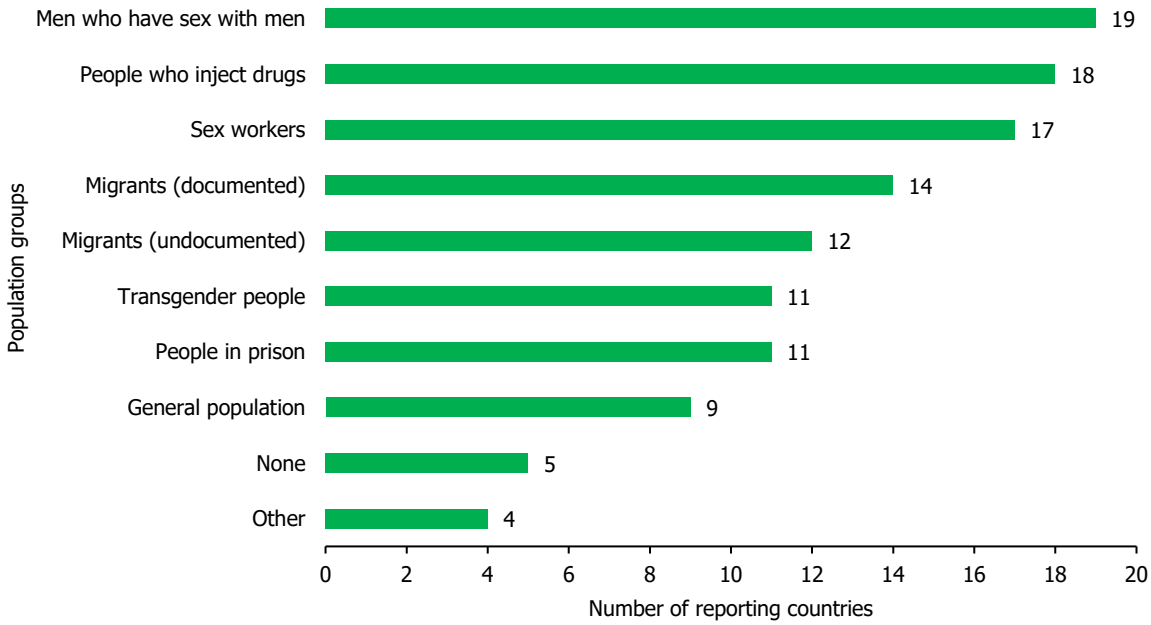
Condom provision and safe sex counselling

Condoms have long formed a core component of STI and HIV primary prevention. Condom promotion and distribution programmes aim to ensure that individuals have access to condoms when needed.

Seventeen EU/EEA countries had a policy of providing condoms and lubricants for free to sex workers (Figure 3). In five countries, there was no existing policy related to free condom and lubricant provision for any specific population group[9]. Four countries[10] specified that condoms and lubricants were only distributed for free in certain settings (such as youth STI testing clinics) or on special occasions (such as LGBTQ+ Pride events).

[9] Hungary, Liechtenstein, Malta, the Netherlands, Romania.
[10] France, Germany, Poland, Sweden.

Figure 3. Number of countries with a policy to provide free condoms and lubricant to certain population groups, EU/EEA, 2024 (n=30)



Coverage of prevention programming among sex workers

Effective counselling on condom use and safer sex provides individuals with accurate information on HIV and STI transmission, encourages safer sexual practices, develops skills in using prevention effectively, reduces stigma and provides emotional support and connection of individuals to additional resources, including testing services.

Coverage data of prevention programming among sex workers were very limited. Between two and five countries could provide available programme[11] and/or behavioural surveillance survey data[12] on the provision of prevention services and programme delivery (see Box 1).

Box 1. Coverage of prevention programming among sex workers in the EU/EEA

Proportion of sex workers reached with HIV prevention interventions designed for sex workers
Only three countries had sufficient programme coverage data to calculate the proportion of sex workers reached with HIV prevention interventions designed for sex workers. Austria reported that 100% (1 456/1 456) of sex workers were reached in the public sector, Estonia reported 51% (224/440) of sex workers were reached, and Greece reported 43% (249/579) of sex workers were reached in a key population-led organisation.

Estimated number of condoms and lubricant distributed to sex workers
Five countries (Austria, Bulgaria, Estonia, Greece, Latvia) provided estimates on the number of condoms and lubricant distributed to sex workers, ranging from 1 284 condoms in Latvia to 137 700 in Greece.

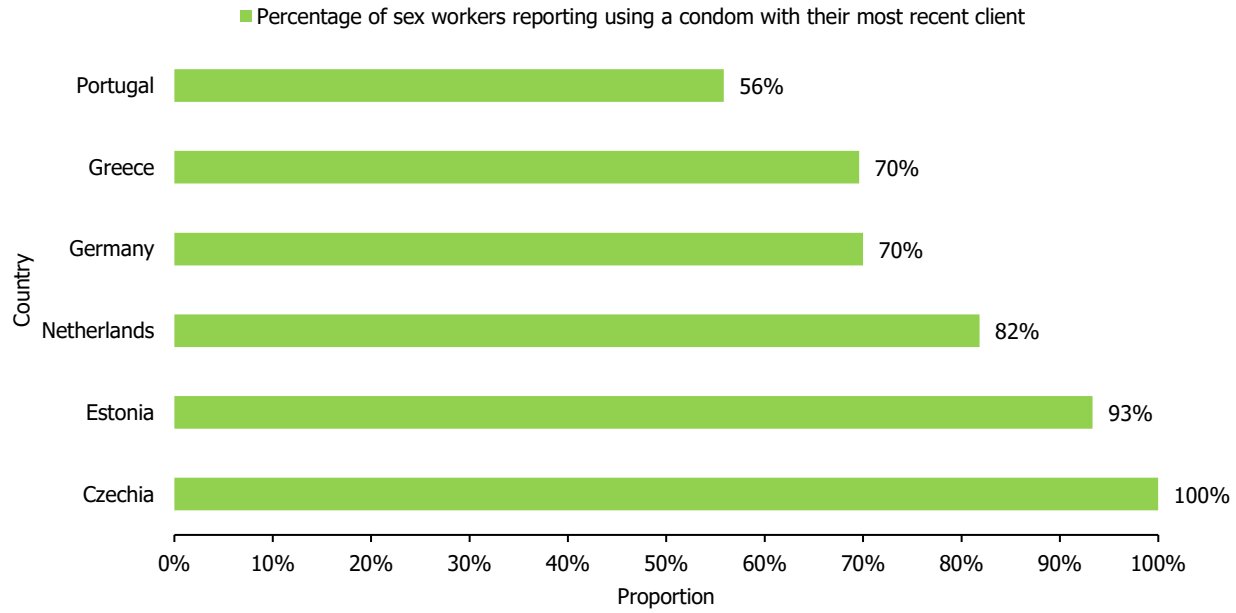
Total number of service provision sites dedicated to sex workers
Among nine countries[13] with available information on the number of service provision sites dedicated to sex workers, the highest number of sites were reported in Latvia (27 sites) and Bulgaria (22 sites) while the remaining countries reported less than 10 sites.

Condom use among sex workers

Six countries[14] reported information from behavioural surveillance and special surveys on condom use among sex workers (Figure 4), with the proportion of all sex workers reporting using a condom with their most recent client ranging from 56% (Portugal) to 100% (Czechia) (median: 76%).

[11] Programme data were reported for various indicators by Austria, Estonia , Greece.
[12] Behavioural surveillance survey data were reported for various indicators by Germany, Portugal, Slovenia.
[13] Austria Bulgaria, Czechia, Estonia, Finland, Latvia, Romania, Slovenia, Sweden.
[14] Czechia, Estonia, Germany, Greece, the Netherlands, Portugal.

Figure 4. Proportion of sex workers who reported using a condom with their most recent client, EU/EEA, 2024 (n=6)

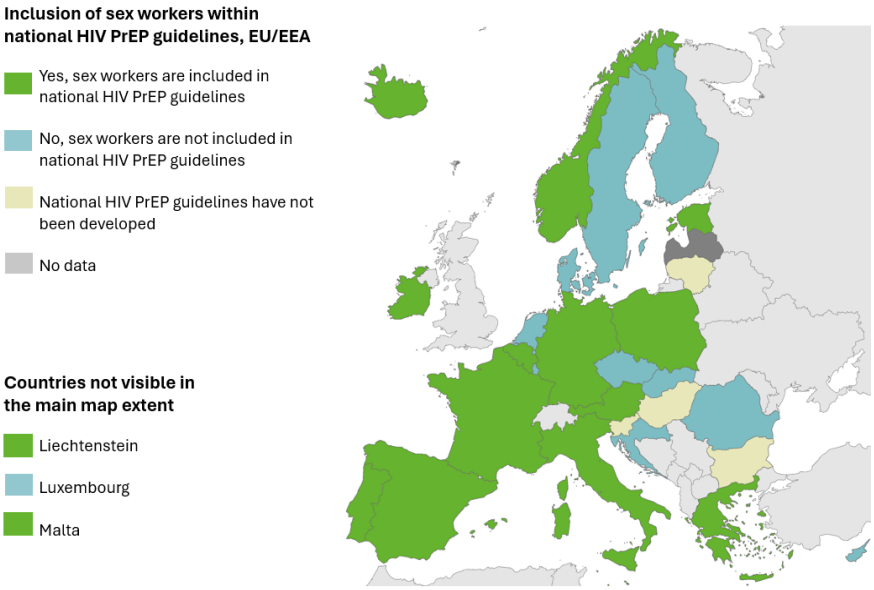


HIV pre-exposure prophylaxis among sex workers

Pre-exposure prophylaxis (PrEP) is an antiretroviral medication taken by people who are HIV-negative in order to reduce their risk of acquiring HIV. As a highly effective HIV prevention tool, PrEP accessibility and uptake is an important element in the HIV response, and critical for progress towards ending the AIDS epidemic [28-30]. 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.

Among the 25 EU/EEA countries with national PrEP guidelines developed, 15[15] included sex workers as eligible for PrEP (Figure 5). However, almost half of these same countries[16] also reported difficulties in reaching sex workers.

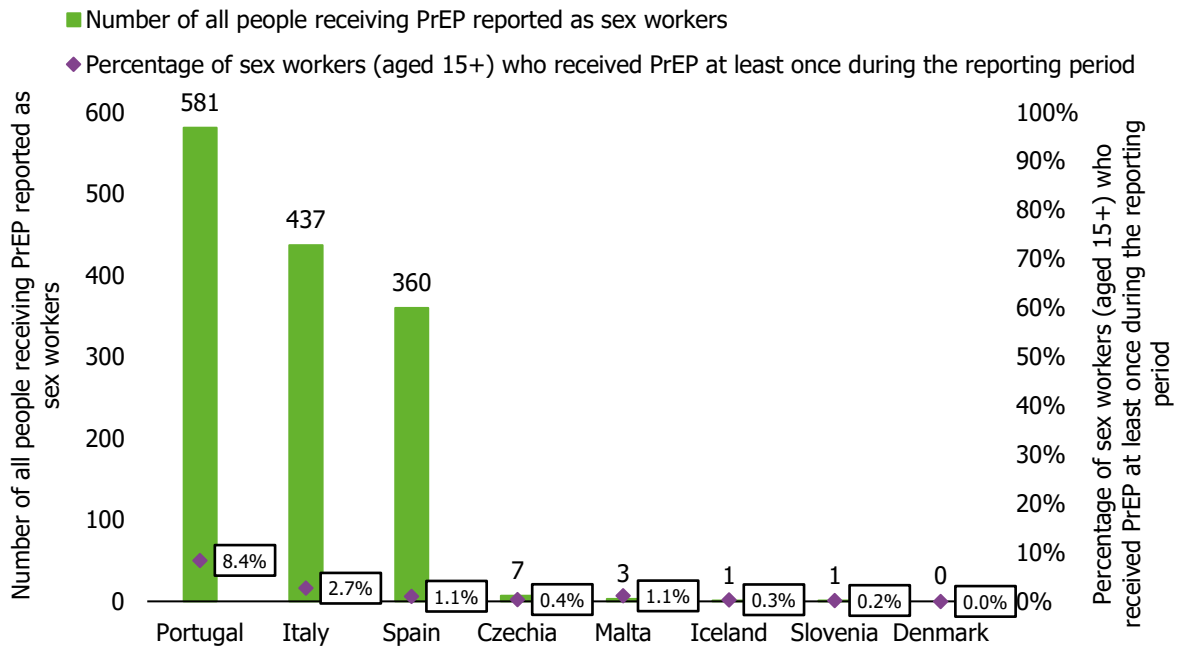
Figure 5. Inclusion of sex workers within national HIV PrEP guidelines, EU/EEA, 2024 (n=29)



[15] Austria, Belgium, Estonia, France, Germany, Greece, Iceland, Ireland, Italy, Liechtenstein, Malta, Norway, Poland, Portugal, and Spain.
[16] Six countries that include sex workers in national HIV PrEP guidelines that also reported difficulties in reaching sex workers: Germany, Iceland, Italy, Malta, Norway, and Poland.

In the eight EU/EEA countries[17] able to provide data, both the number of people receiving PrEP who were reported as sex workers and estimated PrEP usage among sex workers varied substantially. Portugal reported the highest number of people receiving PrEP who were reported as sex workers (581) and the highest percentage of sex workers receiving PrEP during the reporting period (8.4%). In the remaining countries, fewer than 10 people receiving PrEP were reported as sex workers, with estimated PrEP usage among sex workers ranging from 0.0% to 1.1%. (Figure 6).

Figure 6. Number of people receiving PrEP reported as sex workers and percentage of sex workers who received PrEP at least once during the reporting period, EU/EEA, 2024* (n=8)



* *Countries with data older than 2024 include Portugal (2022) and Malta (2023).*

Of note, when compared to other HIV key populations (men who have sex with men, people who inject drugs, migrants and transgender people) in EU/EEA countries, sex workers had the lowest percentage of PrEP uptake [31].

HIV and STI testing

Accessible, stigma-free HIV testing and prompt treatment are important for reducing overall HIV incidence. Integrating routine, quality-assured testing across diverse service settings, particularly for key populations at higher risk for acquiring STIs, further strengthens early detection and timely linkage to care.

Inclusion of sex workers in national testing policies, strategies or other recommendations

With regards to HIV testing, of 27 EU/EEA countries with national policies, strategies or other recommendations on HIV testing, 19 countries cover content specifically on sex workers (see Annex). In terms of STI testing, out of 18 countries with national policies, strategies or other recommendations on STI testing, only seven countries cover content specifically on sex workers (see Annex).

Countries reported on the settings where STI testing was available. Of the 29 countries reporting, the majority (23 countries) reported STI testing was available within non-governmental organisation/community settings [24]. NGOs play an important role in providing low threshold and tailored testing service delivery to key populations such as sex workers. Community-led and/or based STI service delivery can often be the primary means of contact with key populations as they can overcome barriers related to stigma, discrimination, mobility, and legal concerns.

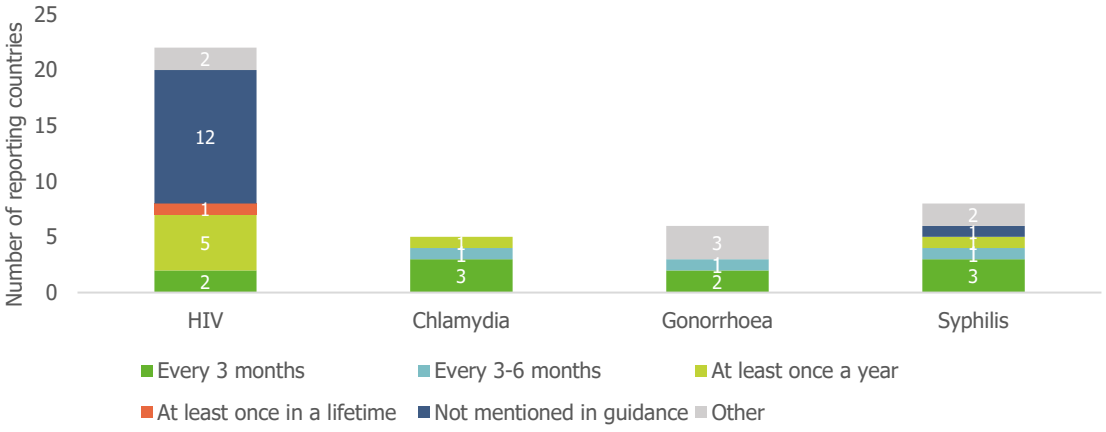
[17] Czechia, Denmark, Iceland, Italy, Malta, Portugal, Slovenia, and Spain.

National recommendations for regular HIV and STI testing among sex workers

Twenty-two countries provided data on guideline recommendations of frequency of regular HIV testing for sex workers (Figure 7). In 12 countries, national guidelines do not specify how often sex workers should be tested for HIV. Among the countries that do provide recommendations, five of the reporting countries (Estonia, Greece, Portugal, Romania and Spain) recommend testing at least once a year, two countries recommend testing every three months. One country recommends testing at least once in a lifetime, while two countries reported an alternative testing frequency (that did not fit the predefined response categories), although no further information was provided.

With regards to frequency of regular asymptomatic STI testing among sex workers, data are less available. Routine asymptomatic STI screening recommendations for sex workers were uncommon with eight countries (out of 29) reporting such recommendations. Most countries reported that STI testing is performed following exposure, symptoms, or individual risk assessment. Recommendations for routine asymptomatic testing of gonorrhoea among sex workers varied considerably across countries from every 15 days in Greece, every six weeks in Austria and every six months or after a case notification in the Netherlands. Overall, the findings indicate substantial variation in national recommendations, with routine asymptomatic STI screening recommended in only a minority of countries.

Figure 7. Number of countries with specific recommendations for the frequency of regular HIV (n=22) and asymptomatic STI testing (n=29), by infection, among sex workers in the EU/EEA 2024*



** 2024 or most recent year with available information on HIV testing recommendations: 2023 (Croatia, Cyprus, Luxembourg, Norway, Poland).*

Among the countries that carry out routine asymptomatic STI testing, the most frequently cited anatomical site for asymptomatic testing of chlamydia and gonorrhoea among sex workers was urogenital (four countries), followed by rectal and pharyngeal sites (two countries). Two countries (Germany and Greece) stated that all three anatomical sites are tested. Countries reporting 'other' anatomical site testing locations specified that this was dependent on individual sex practices and anatomy.

Testing coverage among sex workers

While no country reported information on STI testing coverage among sex workers, eight countries reported information on HIV testing coverage with the proportion of all sex workers who know their HIV status (positive or negative) ranging from 60% to 100% (median: 85%). As reported data sources for HIV testing coverage were primarily programme data with varying sample sizes, it is not possible to generalise these findings for the EU/EEA.

Treatment coverage among sex workers

Ensuring prompt access to HIV treatment following diagnosis is essential for enabling sex workers to achieve a normal life span and for reducing onward transmission, as people who maintain an undetectable viral load cannot pass on HIV. At the same time, guaranteeing accessible, high-quality testing and treatment for STIs is a critical component of comprehensive healthcare for sex workers.

For HIV, the data for the continuum of HIV care among sex workers in EU/EEA countries are so limited that it is difficult to draw any significant conclusions. Five countries (Bulgaria, Estonia, Germany, Luxembourg, and Malta) provided continuum of care data for all sex workers living with HIV[18].

[18] Data older than 2024: 2023 (Bulgaria, Estonia, Malta); 2022 (Luxembourg).

Within the STI monitoring questionnaire, only one country (Malta) reported on treatment coverage among sex workers. From clinic-based data, Malta reported 100% coverage for gonorrhoea treatment among five sex workers. Given the small numerator and clinic-based data source this estimate should be interpreted with caution and not be understood as national treatment coverage.

Limitations

The definition of the sex worker population may differ between EU/EEA countries, which can impact their response(s) within ECDC's HIV and STI monitoring systems. Furthermore, national legal frameworks regarding sex work are presented as reported by countries, sometimes based on expert opinion, and may not reflect the actual implementation at regional and/or local levels, where punitive measures may still be enforced despite a more permissive legal framework.

The low number of countries reporting available numerical data on coverage indicators (e.g. the proportion of condom use, tested and treated) hindered the ability to draw conclusions about coverage. Furthermore, the numerical data provided by countries often varied in size, data source and timeframe and so could not be used to make any country comparisons. As a result, the interpretation of findings on coverage indicators should be approached with caution as this may not reflect actual condom use behaviour or access to HIV and STI testing and treatment for sex workers in the EU/EEA.

Conclusions

The available evidence indicates a substantial burden of HIV and STIs among sex workers across the EU/EEA, and ECDC monitoring data suggest that there are opportunities to strengthen the policy and programmatic response to prevent these infections among sex workers.

Although sex workers are commonly recognised in national HIV and STI policies, their involvement in policy development, the availability of tailored services, and the monitoring of service coverage remain limited in many countries. This may reduce the effectiveness of prevention and control efforts and hinder progress towards equitable access to prevention, testing and care. Limited engagement of sex workers in the design and delivery of policies and programmes may also reduce the extent to which prevention, vaccination, testing and treatment services are responsive to their needs.

The lack of population estimates and robust HIV and STI testing and treatment coverage data makes it difficult to draw firm conclusions about service delivery and uptake within or between EU/EEA countries. While more than half of countries are providing condoms and lubricants for free for sex workers, the limited monitoring data available on coverage of HIV testing and the absence of STI testing coverage data among sex workers in the EU/EEA indicate there are still potential improvements to be made.

Half of the EU/EEA countries that prioritise sex workers as eligible for HIV PrEP also note difficulties in reaching sex workers with PrEP. Given that this prevention strategy is particularly relevant for those who struggle to use condoms consistently for a range of reasons, this indicates a key service delivery gap.

Legal and enforcement environments form part of the structural context in which HIV and STI programmes operate. The existence of punitive laws and policies in EU/EEA countries that criminalise various elements of sex work may create barriers to service access. Public health responses should therefore prioritise accessible and confidential services while recognising and responding to the distinct needs of people exposed to coercion, exploitation or trafficking.

Priority areas for action

The gaps identified between available evidence on policy and programme implementation limit countries' ability to monitor progress and optimise HIV and STI prevention and control efforts for sex workers. Priority areas for action include:

- **Strengthening the availability and accessibility of HIV and STI prevention, testing and care services for sex workers**, including ensuring that services are tailored to population needs and informed by the meaningful involvement of sex workers in their design and delivery.
- **Addressing barriers to the uptake of prevention and control** services by integrating sex workers into programmes for populations with overlapping vulnerabilities, including people who inject drugs, migrant populations, people experiencing homeless and men who have sex with men. This should include equitable access to HIV testing, PrEP, and actions to reduce stigma and discrimination related to HIV and sex work in healthcare settings and the wider social environment.
- **Improving the availability, quality and use of surveillance and monitoring data on sex workers**, particularly data on population size estimates, disease burden, service coverage, and uptake of prevention, testing and treatment services. Where possible, data should be disaggregated by gender and other relevant characteristics, including intersections with other key populations, to better inform targeted public health responses.

Annex

Table A1. Countries with inclusion of sex workers in national prevention and control policies, strategies or other recommendations for HIV and STIs, EU/EEA, 2024*

Country	National policy/strategy or other recommendations on HIV testing	Prioritisation of sex workers	National policy/strategy or international recommendations on STI testing	Prioritisation of sex workers
Austria	Yes	Yes	Yes	Yes
Belgium	Yes	Yes	Yes	Yes
Bulgaria	Yes	Yes	Yes	No data
Croatia	Yes*	Yes*	Under development	NA
Cyprus	Yes*	No*	Under development	NA
Czechia	Yes	Yes	Yes	No
Denmark	Yes	No	Yes	No
Estonia	Yes	Yes	Yes	No
Finland	Yes	Yes	Yes	No
France	Yes	Yes	Yes	Yes
Germany	No	NA	Yes	Yes
Greece	Yes	Yes	Under development	NA
Hungary	No*	NA	Yes	No
Iceland	Yes	No	Yes	No
Ireland	No	NA	Yes	No
Italy	Yes	Yes	Yes,	Yes
Latvia	Yes	No	No data	No data
Liechtenstein	Yes	Yes	Yes	Yes
Lithuania	Yes	Yes	Yes	No
Luxembourg	Yes	No	No	NA
Malta	Yes	Yes	Yes	Yes
Netherlands	Yes	Yes	Yes	Yes
Norway	Yes*	Yes*	Yes	No
Poland	Yes	No	Under development	NA
Portugal	Yes	Yes	Yes	No
Romania	Yes	Yes	Yes	Yes
Slovakia	Yes	No	Yes	Yes
Slovenia	Yes	No	Yes	Yes
Spain	Yes	Yes	Yes	Yes
Sweden	Yes	Yes	Yes	Yes

** 2024 or most recent year with available data: 2023 (Croatia, Cyprus, Hungary, Norway).*
NA: not applicable; No data: missing response.

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