SPECIAL REPORT

Thematic report: Sex workers

Monitoring implementation of the Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia: 2014 progress report

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Monitoring implementation of the Dublin Declaration on partnership to fight HIV/AIDS in Europe and Central Asia: 2014 progress report

This report of the European Centre for Disease Prevention and Control (ECDC) was coordinated by Teymur Noori, with technical support provided by Andrew J. Amato-Gauci, Anastasia Pharris, César Velasco Muñoz, Lara Tavoschi, Otilia Mårdh, Gianfranco Spiteri, Caroline Daamen, Pierluigi Lopalco, Denis Coulombier and Piotr Kramarz.

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* 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

ART	Antiretroviral therapy
ECDC	European Centre for Disease Prevention and Control
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
EMIS	The European MSM Internet Survey
EU/EEA	European Union/European Economic Area
GARPR	Global AIDS Response Progress Reporting
HCV	Hepatitis C virus
HIV	Human immunodeficiency virus
MSM	Men who have sex with men
NGO	Non-governmental organisation
NSP	Needle and syringe programmes
OST	Opioid substitution therapy
PMTCT	Prevention of mother-to-child transmission
PWID	People who inject drugs
STI	Sexually transmitted infection
WHO	World Health Organization

HIV and sex workers

This report is based on data provided by countries reporting on the Dublin Declaration[1] and summarises key issues related to HIV and sex workers in Europe and Central Asia. It also identifies priority actions to improve the HIV response for this population.

Note on data sources

This report uses the latest data reported by countries, in 2014 or 2012, for three Global Aids Response Progress Reporting (GARPR) indicators – HIV prevalence[2], HIV testing[3] and condom use[4] – and through a Dublin Declaration questionnaire[5]. The 2014 Dublin Declaration questionnaire included, for the first time, questions about the scale at which interventions are delivered for key populations, the extent of stigma and discrimination they experience and their involvement in policy and implementation; it is important to note that these questions are open to interpretation by respondents. The questionnaire and GARPR data tables are available on the ECDC website.

HIV and sex workers: the situation

Availability of recent or comprehensive data on HIV and sex workers is limited

Few countries have accurate population size estimates and most available data are from surveys that are based on variable sample sizes and use different methods. This means that there are little nationally representative data on HIV prevalence, HIV testing, condom use or treatment coverage, and that data cannot be compared over time or across countries. In addition, there are little data on new HIV diagnoses or late diagnosis in sex workers, and since most countries report data for female sex workers, there is a lack of data on male, transgender, or other subgroups of sex workers who may be at increased risk of HIV.

Overall, HIV prevalence in female sex workers is relatively low in the region, but it is very high in a number of countries

Recently reported data[6] on HIV prevalence among sex workers are available from 14 EU/EEA countries[7] and 15 non-EU/EEA countries[8] (see Figure 1). In EU/EEA countries, reported prevalence ranges from 0% in Ireland[9] to 22.2% in Latvia[10]. In non-EU/EEA countries, reported prevalence ranges from 0% in Albania, Bosnia and Herzegovina and the former Yugoslav Republic of Macedonia, to 11.6% in Moldova. Reported prevalence in the region is above 1% in 20 countries and above 5% in six countries – Latvia (22.2%), Moldova (11.6%), Ukraine (7.3%), Estonia (6.2%), Belarus (5.8%), and Portugal (5.7%).

[1] WHO Regional Office for Europe. Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia. [Internet]. 2004 [cited 1 June 2015]. Available from: http://www.euro.who.int/en/health-topics/communicable-diseases/hivaids/policy/guiding-policy-documents-and-frameworks-for-whoeuropes-work-on-hiv/dublin-declaration-on-partnership-to-fighthivaids-in-europe-and-central-asia

[2] Percentage of sex workers who are living with HIV

[3] Percentage of sex workers who received a HIV test in the past 12 months and know their results

[4] Percentage of sex workers reporting the use of a condom with their most recent client

[5] European Centre for Disease Prevention and Control. Monitoring of the Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia – Questionnaire. Stockholm: ECDC; 2009. Available from: http://ecdc.europa.eu/en/healthtopics/documents/1009_questionnaire_to_monitor_dublin_declaration.pdf

[6] Data reported in 2014 or 2012.

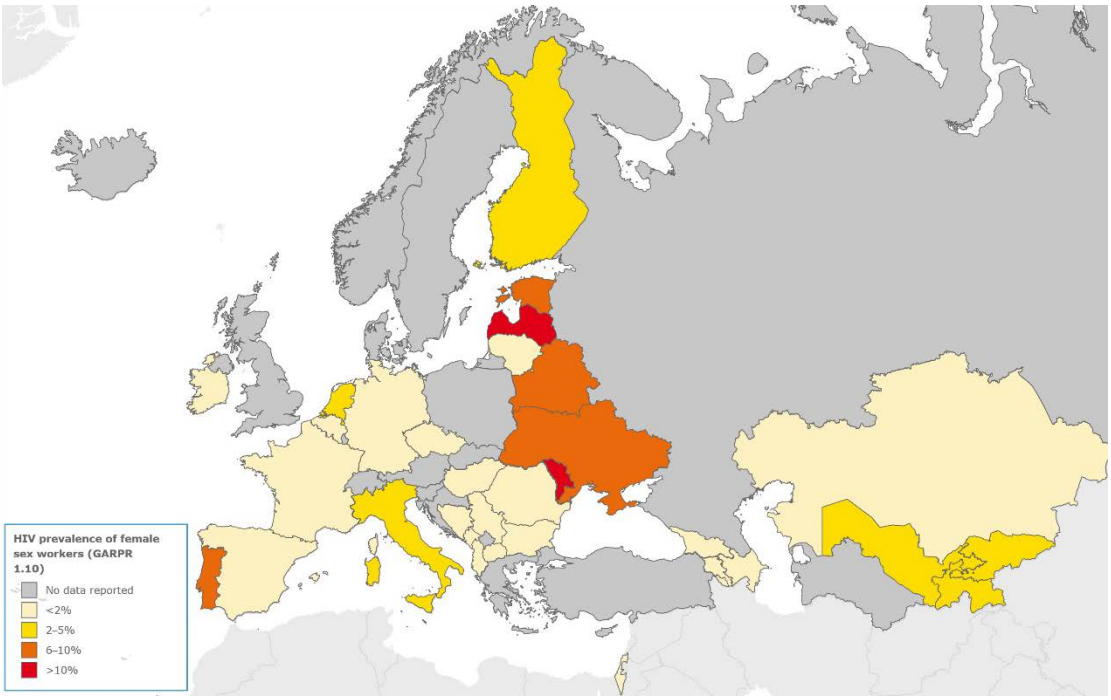
[7] No data reported by Austria, Croatia, Cyprus, Denmark, Greece, Iceland, Italy, Luxembourg, Malta, Norway, Poland, Slovakia, Slovenia, Sweden and the UK.

[8] No data reported by Andorra, Israel, Kosovo, Monaco, Russian Federation, San Marino, Switzerland, Turkey and Turkmenistan.

[9] Of a sample of 49 sex workers.

[10] Of a small sample of street sex workers.

Figure 1. Reported HIV prevalence among sex workers, 2011–2013



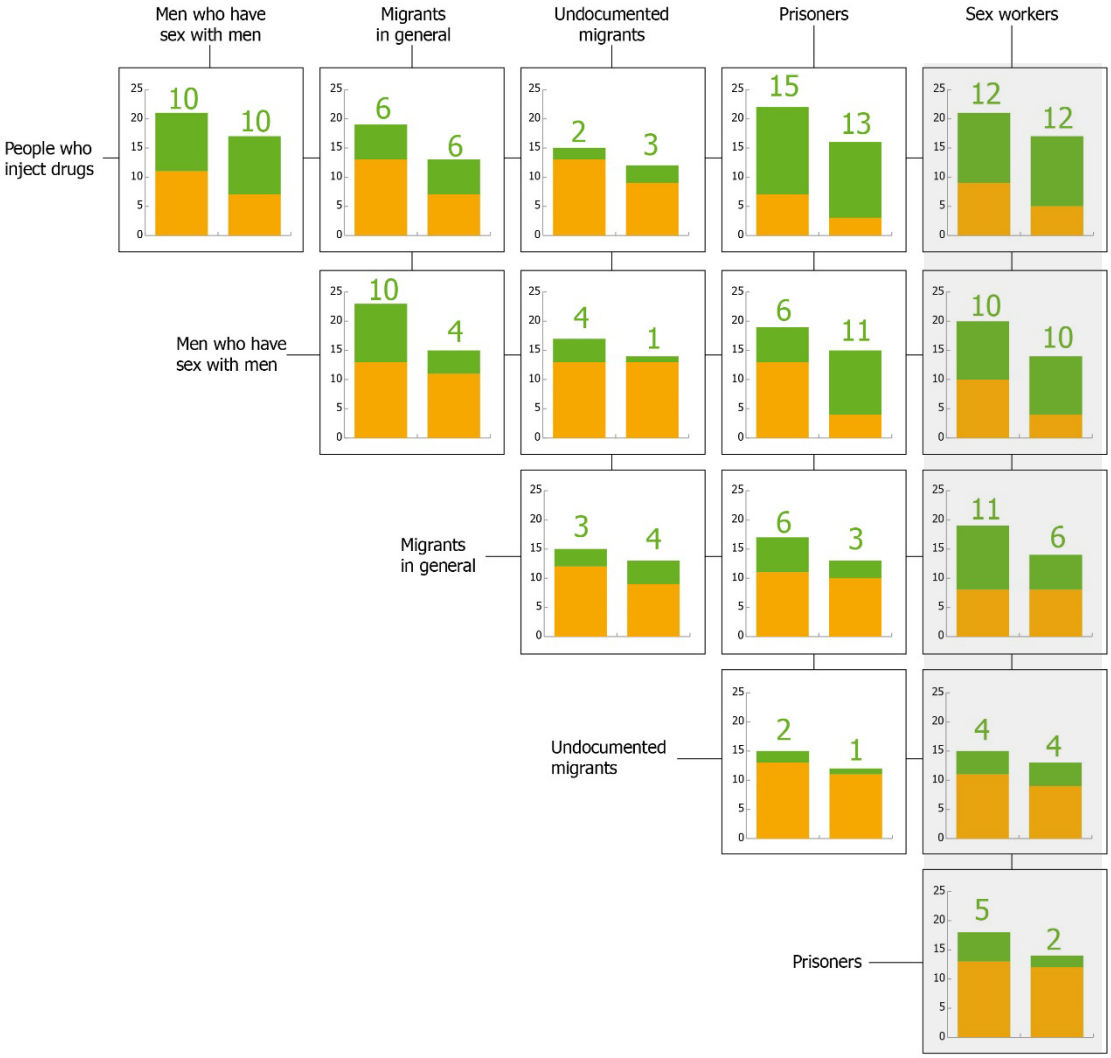
HIV prevalence appears to be higher among male sex workers and sex workers who inject drugs

Data reported in 2012 showed high rates of HIV prevalence among male sex workers, for example, 16.9% in Spain, 13.5% in Portugal and 9.1% in Belgium. The survey in Portugal in 2012 found that HIV prevalence was over 10% in both male and transgender sex workers and 47.6% in sex workers who inject drugs. In 2014, Spain reported a higher HIV prevalence in males than in female sex workers and that transgender sex workers are at higher risk. Given the recognised overlap between sex work and injecting drug use (see below), injecting drug use may be a factor in the high HIV prevalence rates reported among female sex workers in the Baltic States and Ukraine.

There are overlapping risks between sex work and other risk behaviours

Figure 2 shows the number of countries reporting that there is evidence of overlapping risk (see also Box 1) between sex work and other risk behaviours. Specific subgroups of sex workers identified by country respondents as being at increased HIV risk included transgender sex workers in France and Spain, male sex workers in Germany and Spain, migrants from high prevalence countries in Luxembourg and undocumented migrants in France.

Figure 2. Number of countries reporting evidence of overlapping risk between sex workers and other key populations (with data on sex workers highlighted)



Legend:

Y axis: number of reporting countries
Left bar: EU countries
Right bar: non-EU countries
Green: Number of countries reporting evidence of overlapping risk
Orange: Number of countries reporting no evidence of overlapping risk

Note: Data on sex workers shown with grey overlay

Box 1. Evidence of overlapping risk

In Bulgaria, the Centre for Sexual Health has many clients with several risk factors for HIV – the most common are PWID who work as sex workers and MSM who provide paid sexual services.

A study in Estonia showed that 15% of female sex workers in Tallinn have injected drugs; 92% (12 of 13) HIV-positive sex workers in Tallinn had injected drugs at some point.

In Hungary, drug use among sex workers is significantly higher than in the general population aged 18–34.

A survey in Latvia found that, in the last 30 days, 33% of sex workers used heroin, 8% used heroin and amphetamines, and 44% used methamphetamine and amphetamines.

Spain reported an overlap between female sex workers and migrants.

Data for 2012 from the NGO *Odyseus*, which runs a needle and syringe programme in the capital city of Slovakia, shows a clear overlap between PWID and street-based sex workers.

Sex workers face general and HIV-related stigma and discrimination

Government respondents stated that sex workers experience moderate or significant general stigma and discrimination in 29 of the 43 countries that reported, and moderate or significant HIV-related stigma and discrimination in 23 of the 40 countries that reported. General stigma and discrimination is significant in six EU/EEA countries (Hungary, Ireland, Italy, Lithuania, Norway and Poland) and three non-EU/EEA countries (Bosnia and Herzegovina, Moldova and Montenegro). HIV-related stigma and discrimination is significant in two EU/EEA (Greece and Iceland) and three non-EU/EEA countries (Albania, Moldova and Montenegro). Bulgaria commented that sex workers face discrimination from the general population and that sex workers who inject drugs or are HIV positive also face discrimination from other sex workers.

HIV and sex workers: the response

The scale of HIV prevention programmes for sex workers is inadequate in one in every three EU/EEA countries

One third of governments (10 of 30)[11] and more than two thirds of civil society respondents (15 of 22) in EU/EEA countries report that HIV prevention programmes are not being delivered at the scale required to meet the needs of most sex workers. Among non-EU/EEA countries, HIV prevention programmes are not being delivered at scale in Moldova and Ukraine, both of which have high rates of HIV prevalence in sex workers. Across the region, governments are less likely to report that HIV prevention programmes are delivered at scale for sex workers than for other key populations such as MSM, PWID and prisoners.

Rates of condom use by female sex workers for commercial sex are high. Recently reported data[12] on condom use by female sex workers are available from ten EU/EEA countries[13] and 16 non-EU/EEA countries[14] (see Figure 3). In nine of the ten EU/EEA countries, reported rates of condom use are 85% or higher; the exception is Greece, which reported a condom use rate of 4.7%. In the 16 non-EU/EEA countries, reported rates of condom use range from 53% in Azerbaijan to 96.7% in Ukraine. Of the others, only Albania (76.7%), Switzerland (58.2%) and Tajikistan (75%) reported condom use rates below 80%[15]. It should be noted that the GARPR indicator for condom use has limitations. It asks about condom use with the most recent client and so provides no information about more useful measures, which some countries do monitor, such as consistent condom use, condom use for different types of sex or with non-commercial sexual partners.

[11] EU/EEA countries where governments report that HIV prevention is not delivered at scale for sex workers: Croatia, Cyprus, Estonia, Iceland, Italy, Malta, Poland, Slovenia, Sweden, UK.

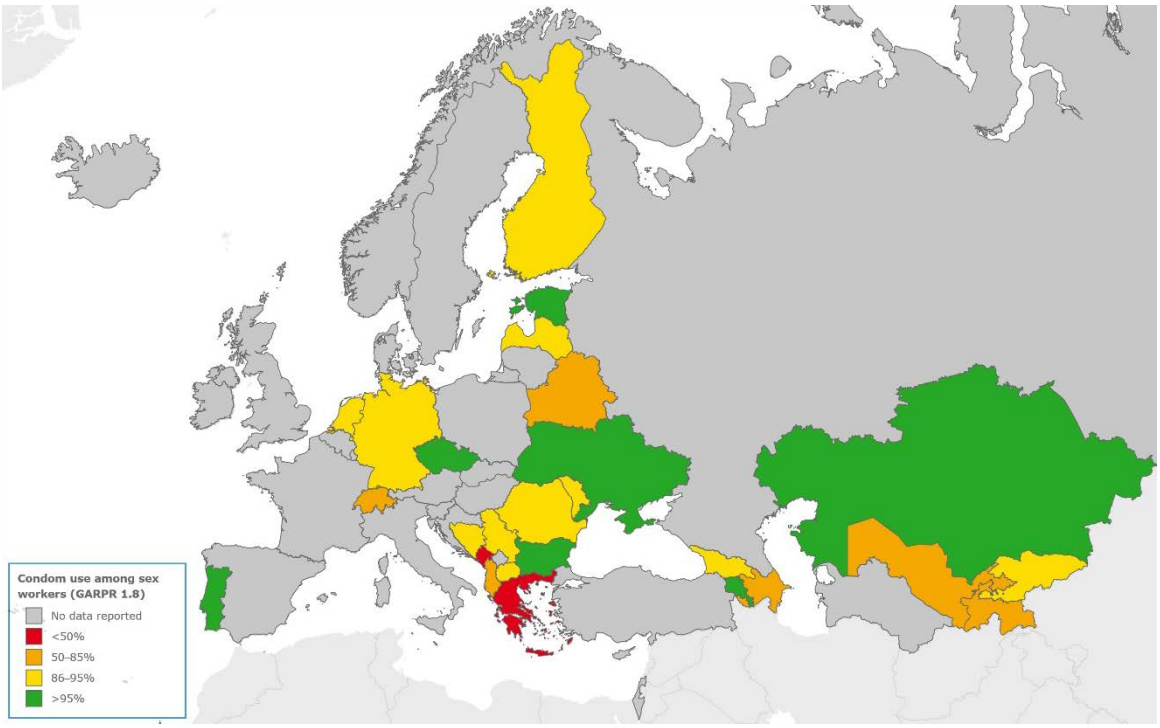
[12] Data reported in 2014 or 2012.

[13] No data reported by Austria, Belgium, Croatia, Cyprus, Czech Republic, Denmark, France, Hungary, Iceland, Ireland, Italy, Lithuania, Luxembourg, Malta, Norway, Poland, Slovenia, Slovakia, Spain, Sweden and the UK.

[14] No data reported by Andorra, Israel, Kosovo, Monaco, San Marino, Russian Federation, Turkey and Turkmenistan.

[15] Reported rates of condom use in the other 11 countries are: Armenia 90%, Belarus 81.8%, Bosnia and Herzegovina 87.7%, FYRM 88.9%, Georgia 91.1%, Kazakhstan 95.5%, Kyrgyzstan 90.6%, Moldova 87.5%, Montenegro 77.5%, Serbia 91.2%, Uzbekistan 80.7%.

Figure 3. Reported rates of condom use among sex workers, 2011–2013[16]



Rates of HIV testing in sex workers vary, but are low in some countries

Recently reported data[17] on HIV testing among sex workers are available from 14 EU/EEA countries[18] and 15 non-EU/EEA countries[19] (see Figure 4). In the EU/EEA, testing rates range from 36.8% in Romania to 100% in Ireland[20]. In the other 12 countries, rates of testing were 50% or above. In non-EU/EEA countries, testing rates range from 11.1% in Montenegro to 89.1% in Kazakhstan. Of the other countries, only three reported rates above 50%; ten reported rates below 50%. It is important to note the limitations of the GARPR indicator, which asks about testing within the previous 12 months, as there will be a proportion of sex workers who know their HIV status and have no need to repeat a test.

[16] GARPR data reported in 2014 or 2012.

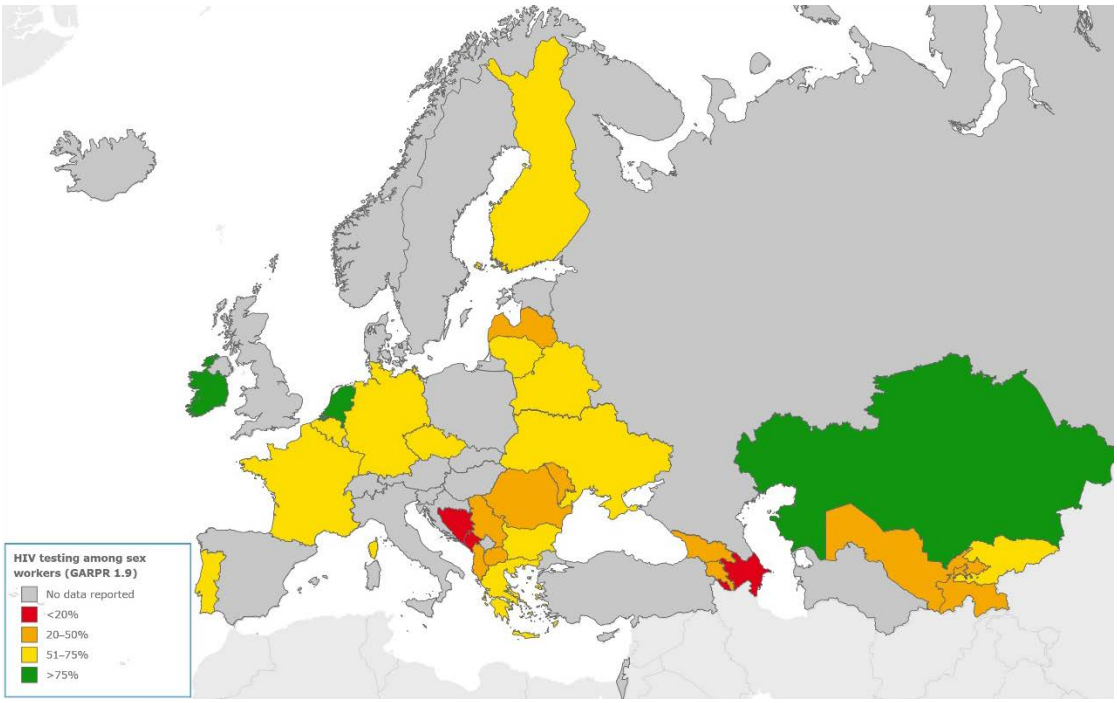
[17] Data reported in 2014 or 2012.

[18] No data reported by Austria, Croatia, Cyprus, Czech Republic, Denmark, Hungary, Iceland, Italy, Luxembourg, Malta, Norway, Poland, Slovakia, Slovenia, Spain, Sweden and the UK.

[19] No data reported by Andorra, Israel, Kosovo, Monaco, San Marino, Switzerland, Russian Federation, Turkey and Turkmenistan.

[20] Of a small sample of 49, all of whom were tested for HIV.

Figure 4. Reported rates of HIV testing among sex workers, 2011–2013[21]



Testing rates are low in some countries that report delivery of HIV testing programmes at scale

Most countries in the region report that HIV testing programmes are delivered at scale for sex workers, but one in six government (5 of 29)[22] and almost two thirds of civil society respondents (13 of 22) in EU/EEA countries report that testing coverage is inadequate.

Table 1. HIV response in countries reporting high HIV prevalence (<5%) among female sex workers

Country	HIV prevalence	HIV testing	HIV testing delivered at scale	HIV prevention delivered at scale	Priority for prevention funding (ranking)	Condom use
Belarus	5.8%	63.4%	Yes	Yes	Yes	81.8%
Estonia	6.2%	66.7%	Yes	No	2	97.6%
Latvia	22.2%	49.6%	No	Yes	3	85.5%
Moldova	11.6%	22%	Yes	No	3	87.5%
Portugal	5.7%	55%	Yes	Yes	3	97.8%
Ukraine	7.3%	63.1%	Yes	No	3	96.7%

Laws that criminalise sex work hinder HIV prevention for sex workers

In 90% of EU/EEA countries (27/30), governments report that they do not have laws that are barriers to prevention, treatment and care for sex workers. However, in seven countries, civil society organisations report that laws are a barrier, in particular for HIV prevention. For example, in Croatia and Lithuania, because sex work is illegal, it is difficult to implement services and to reach sex workers. In Finland, laws concerning sex work are reported to be a barrier to HIV prevention. France identified the need to address the legal status of sex work. In non-EU/EEA countries, 67% of government and civil society respondents (12/18) report that there are no legal barriers. However, legal barriers to prevention and the need to revise laws or decriminalise sex work were mentioned by Albania, Belarus, Moldova, Montenegro, Serbia and Ukraine.

[21] GARPR data reported in 2014 or 2012.

[22] EU/EEA countries where government report that HIV testing is not delivered at scale for sex workers: Italy, Latvia, Malta, Slovenia, UK.

Table 2. Countries reporting that laws hinder HIV prevention for sex workers

EU/EEA countries	Government: Croatia, Finland, France,
	Civil society: Croatia, Finland, Lithuania, Spain, Sweden
Non-EU/EEA countries	Government: Albania, Belarus, Moldova, Montenegro, Serbia, Ukraine
	Civil society: Belarus, Moldova, Montenegro, Serbia

There is an apparent trend towards greater criminalisation of sex work in the EU/EEA

Some EU/EEA countries raised concerns about the implications for HIV prevention and outreach of an apparent shift towards greater criminalisation of, and a more repressive environment for, sex work. Civil society organisations highlighted an increase in the public debate about restricting sex work in Germany, negative local government attitudes towards sex workers in Spain, and the impact of the Sex Purchase Act in Sweden. In the Netherlands, anti-prostitution measures are reported to be resulting in more sex workers going underground and avoiding contact with treatment, care and support. Civil society also raised concerns about the implications for HIV prevention if countries implement the recommendation of the European Parliament to criminalise sex workers' clients.

Few countries report that sex workers have difficulty accessing treatment, care and support

In EU/EEA countries, most government (26 of 30) and civil society (17 of 21) respondents report that HIV treatment is delivered at scale for sex workers, but almost one third (9 of 30) of government and half of civil society (11 of 22) respondents report that HIV care and support is not delivered at scale. Government respondents in Estonia, Finland and Greece reported that sex workers experience difficulty in accessing treatment, care and support, due to the limited availability of services, stigma, provider attitudes and lack of awareness of rights.

Table 3. Countries reporting that HIV treatment and HIV care and support for sex workers are not delivered at scale

EU/EEA countries	HIV treatment for sex workers not delivered at scale	HIV care and support for sex workers not delivered at scale
Government	Finland, Greece, Italy, Malta	Cyprus, Estonia, Finland, France, Greece, Italy, Lithuania, Malta, Poland
Civil society	Denmark, Greece, Slovakia, Spain	Denmark, Greece, Hungary, Italy, Latvia, Norway, Portugal, Slovakia, Spain, Sweden, UK
Non-EU/EEA countries	**HIV treatment for sex workers not delivered at scale**	**HIV care and support for sex workers not delivered at scale**
Government	-	Albania, Israel, Moldova, Serbia
Civil society	Ukraine	Albania, Georgia, Moldova, Montenegro, Serbia, Tajikistan, Ukraine

Civil society organisations report that sex workers experience difficulties in accessing services in other EU/EEA countries, including the Czech Republic, Hungary, Lithuania, the Netherlands, Portugal, Spain, Slovakia and Sweden. In non-EU/EEA countries, most government and civil society respondents report that HIV treatment, care and support for sex workers is delivered at scale; no government reported that accessing treatment, care and support is difficult, but civil society organisations stated that sex workers experience problems in Montenegro and Tajikistan.

Sex workers have limited involvement in planning and implementation of HIV programmes

Twelve EU/EEA countries report that there is no involvement of sex workers in planning and implementation. Non-EU/EEA governments reported higher levels of involvement. Overall, responses from countries suggest that sex workers are less likely to be involved in policy and programmes than MSM or PWID.

Conclusions

The lack of data makes it difficult to present a clear picture of the situation concerning HIV and sex workers in Europe and Central Asia, to monitor trends and to assess whether or not the response to HIV for sex workers is adequate or effective. However, some conclusions can be drawn from reported data about the extent to which HIV is a problem among sex workers and to which national responses are commensurate with the situation.

High HIV prevalence among sex workers in some countries, in particular where there is an overlap with other HIV risk behaviours and populations, is of concern. There is also evidence that some subgroups of sex workers, including male sex workers, sex workers who inject drugs and migrant sex workers, may be at increased risk of HIV. Monitoring HIV infection among sex workers and specific subgroups of sex workers in a safe and confidential environment will continue to be important in a number of countries.

Low coverage of targeted prevention programmes in a significant proportion of EU/EEA countries and some EU/EEA countries, and the lack of information about whether these are reaching the most vulnerable sex workers, responding to the changing dynamics of the sex industry, and meeting the needs of sex workers with multiple risk factors are key issues. Sustaining financing for prevention programmes is a particular concern in countries affected by reduced funding from international donors such as the Global Fund. Low rates of HIV testing in countries that report delivery of HIV testing programmes at scale require investigation to identify whether there are geographical areas or subgroups of sex workers that are not being reached, or whether other factors, such as the legal context or stigma and discrimination, limit uptake of testing. The potentially adverse impact of greater criminalisation of sex work and of sex workers' clients on HIV prevention programmes and sex workers' access to services is also a serious concern.

Priority options for action

Strengthen prevention and testing programmes for sex workers

- Ensure HIV prevention and testing programmes for sex workers are delivered at scale in countries where coverage is low and HIV incidence and prevalence in this population is high.
- Develop more effective approaches to reach most-at-risk sex workers with prevention interventions, and to increase uptake of HIV testing in these subgroups of sex workers.
- Implement comprehensive, integrated prevention and harm reduction programmes for sex workers with multiple risk factors for HIV including sex workers who inject drugs, male sex workers, transgender sex workers and migrant sex workers.

Address barriers to provision and uptake of services for sex workers

- Reduce general and HIV-related stigma and discrimination towards sex workers, in particular in healthcare settings.
- Consider reviewing or revising laws criminalising sex work or activities related to sex work that also serve to hinder prevention and outreach work.
- Consider monitoring the legal context for sex work and the impact of this on provision and uptake of HIV services by sex workers.
- Support coordinated action by networks and projects to address barriers to provision and uptake of services.

Improve data on HIV and sex workers

- Enhance monitoring of HIV incidence and of HIV prevalence trends among sex workers, particularly in countries where prevalence in this population is high or apparently increasing.
- Collect disaggregated data for female, male and transgender sex workers.
- Collect country-specific data to identify subgroups of sex workers who are most at risk.
- Improve availability and quality of data on risk reduction behaviours, including condom use among male sex workers, sex workers who inject drugs, transgender sex workers and migrant sex workers, and condom use with non-commercial sexual partners.
- Improve availability and quality of data on HIV testing and late diagnosis among female sex workers and subgroups of sex workers who may be at increased risk of HIV.
- Enhance monitoring of the dynamics of sex work including the impact of migration, mobility and trafficking on subgroups of sex workers at increased risk.
- Improve the availability and quality of epidemiological and behavioural data, through joint funding and harmonised data collection tools.

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