## GENERAL CONCLUSIONS AND RECOMMENDATIONS

*Rudolf P. Mak*

An initial series of conclusions and recommendations concern laws, regulations and their enforcement. Secondly, HIV-prevention and health and social services are discussed.

# The law and prostitution

**Laws and policies that obstruct prostitutes' use of health and social services and restrict their control over their own working conditions should be reviewed and repealed.**

Undoubtedly the everyday life of a prostitute, including the way she or he works, their personal safety, earnings, and contact with the police, is influenced by the laws on prostitution and the way they are applied. In most European countries prostitution itself is not illegal; however, the practice of prostitution is effectively rendered illegal through restrictions on organising, advertising and living off the proceeds of prostitution.

The exact wording of the law varies between countries in Europe and there are often disputes over exactly what is legal and what is not. In addition, the way in which the laws are enforced varies widely across Europe, within countries and over time. In general, however, those who are responsible for HIV prevention in prostitution have found that many of the laws on prostitution are a barrier to the practice of safer sex. The following are examples of how this may work in practice; further details can be found in the country reports.

## Mandatory testing and mandatory registration

**Laws demanding mandatory testing and mandatory registration create barriers to health care for sex workers.**

Greece had the most strict regulations regarding registered prostitutes, with mandatory medical screening twice a week. As a result, most sex workers avoided registration, which made them liable for prosecution. All health care facilities and HIV prevention activities for prostitutes were limited to those who are registered. This is ineffective in public health terms: in Athens approximately 400 women are registered, while an estimated 5,000 more prostitutes are not registered. At present, due to the work of the local co-ordinators of EUROPAP, regulations are being reconsidered and less strictly enforced. Health services and prevention activities will also be targeted at non-registered prostitutes.

In Germany, approximately 50,000 sex workers are registered and are regularly seen by the health services, as required by the laws to combat venereal diseases. However, according to recent estimates a further 150,000 people work in prostitution. Registered prostitutes often complain about the impersonal attitude and approach of health care workers, which undermines confidence and, with it, good medical care. Experience in the fight against other sexually transmitted diseases has already illustrated the limits of compulsory health screening. Mandatory testing for sexually transmitted diseases produces a two tier system of registered and non-registered prostitutes with the latter having limited access to health care.

HIV seropositive sex workers

**Laws excluding people who are infected with HIV from working as prostitutes may be counter-productive in HIV prevention work.**

Legal measures have been introduced to try and prevent HIV-positive people from working in prostitution. In the same way as mandatory testing,, these measures can also create problems by encouraging prostitutes to hide from the authorities if they think they may be infected. Access to health care will thus be hindered, since HIV-positive prostitutes are liable to prosecution if they disclose their work; instead, they go underground. In contrast to legal restraints, HIV prevention projects advocate an open and trusting approach in which prostitutes can openly discuss the issues.

Many prostitutes who are HIV infected will continue to need to work; prevention projects can help to ensure that they work safely, i.e. practice safer sex, if they are able to discuss openly the options available to the sex worker, including alternatives to prostitution, which may be preferable for health reasons. However, if HIV-positive prostitutes do continue to work, there is only a small risk of transmission of HIV to a client providing a condom is used. This highlights the importance of education work with clients so that they too take responsibility for risk reduction.

## Soliciting

**Laws and regulations relating to soliciting should not promote unsafe working conditions for prostitutes.**

In most European countries soliciting (publicly attracting the clients' attention) is not allowed. The enforcement of the laws against soliciting, however, varies, not only between countries, but also within countries and over time. In many cases, this may lead to unsafe working conditions, as illustrated by the example of Ireland. In this country, soliciting of both client and prostitute is an offence, and since 1993 the police may also force a person suspected of loitering in a street to leave. This has had the effect of reducing negotiation time with the client. As one woman says: "before you only had to look out for the clients, now you are looking out for the Gardai (Irish police) as well".

If a woman is charged with an offence she may incur heavy fines which force her to work extra hours to earn money to pay the fine. The role of intermediaries becomes more important, providing protection and paying bail. The same applies to England and Wales, where a law against kerb-crawling by prospective clients has reduced the time prostitutes have to assess clients and negotiate safer sex. In Belgium, many women avoid breaching the law by working officially as "waitresses" in bars. This creates difficult conditions for the women.

In some countries, such as Germany and The Netherlands, soliciting is allowed in specific areas. The location of these areas reflects pressure from residents and politicians and may take no account of the safety of sex workers themselves. In some countries, the possession of condoms is used as evidence of soliciting. It is clear that these laws form a serious barrier to creating conditions conducive to safe sex.

## Living on prostitutes' earnings or procuring

**Laws that forbid living on prostitutes' earnings may lead to unsafe working conditions.**

Another common feature in European law concerning prostitution is the notion of procuration, with "living off prostitutes' earnings" being an offence. There are examples where use of this law has made it more difficult for prostitutes to work safely. In Paris this law was used to close down apartments and hotels in the traditional prostitution district around rue St. Denis. Sex workers were forced to move to the outskirts of town where they were more isolated and where working conditions were more dangerous.

These laws also reinforce the social isolation of prostitutes, making it difficult for them to live with an adult who may be charged with procuration and living off the earnings of a prostitute.

The relationship between a prostitute and a brothel owner is necessarily criminalised by these laws, denying prostitutes any workers' rights as both prostitute and employer have to deny their business relationship. In Germany, for example, this means that some sex workers have no right of access to social and medical services.

## Consequences of local regulations

**Local regulations concerning prostitution should not have negative consequences for safe sex conditions.**

Local regulations can have a major effect on how prostitutes work, and also how HIV prevention projects work with prostitutes. For example, they may be used to move prostitutes from one area to another, making it more difficult for outreach workers to maintain contact with sex workers. In Paris the media reported a high prevalence of HIV among prostitutes working in the Bois de Boulogne; this was followed by a local regulation prohibiting cars from stopping along certain roads in order to prevent clients picking up prostitutes. An HIV prevention project worked from a bus in this area, but they too were subject to these regulations and prevented from parking, and less able to promote safer sex or distribute condoms. In Germany, most cities have zones where prostitution is prohibited, and areas of tolerance, where prostitution is found in super brothels and eros centres. Only certain sex workers are tolerated, and those who do not fit in, such as migrant workers or drug users, are expelled to isolated areas, where working conditions are more dangerous and access to health services and prevention projects may be more difficult.

## Harm reduction programmes for injecting drug users

**Harm reduction programmes for injecting drug users should not be hampered by the enforcement of repressive laws.**

Many injecting drug users, male and female, work as a sex workers to fund their drug habit. The need to earn money for drugs can often override the desire to practice safe sex. Many clients are aware of this and will attempt to purchase sex for less money, sometimes without a condom, leading to risks for the prostitute and client. Programmes to reduce the risk of HIV need to provide clean injecting equipment and also drug treatment, including the use of methadone as a substitute, with the aim of breaking the vicious circle of sex work for drugs. Some countries have legal obstacles to this kind of programme, which makes the work of HIV prevention projects more difficult.

## Illegal prostitutes

**Any law preventing access to health care and prevention programmes should be repealed.**

All European countries have strict immigration regulations for non-Europeans. Many people, however, enter these countries illegally. With no work permit and facing the constant risk of arrest and expulsion, many can only survive as sex workers, often in the worst conditions. Projects for sex workers should be able to contact these people, and to ensure their access to health care, without any interference by the police.

# Health and social services for prostitutes

## HIV prevalence

**There is a low prevalence of HIV in female prostitutes who do not inject drugs.**

Given that HIV may be sexually transmitted, the assumption was made that prostitutes were at greater risk of contracting HIV because of their multiple sexual partners. It was also assumed that prostitutes could be instrumental in spreading HIV to their clients and thus play a major role in transmitting the virus into the heterosexual population. In most European countries this view is still widely held. However, research in a variety of countries has shown that prostitute women in Europe who do not inject drugs do not have a high prevalence of HIV, and most prostitutes report high levels of condom use with their clients. Other research has shown that injecting drug users, women from endemic areas and male prostitutes have a higher HIV prevalence.

The ability to practice safer sex in prostitution is influenced by a range of factors, such as demand by clients for unprotected sex, urgent need for money, alcohol abuse, homelessness, ignorance, lack of resources, younger age, etc. It is not possible to separate high and low risk sex workers and people may move between the two risk groups. Projects that promote safer sex in prostitution will be of benefit to sex workers and those they have sex with, and therefore barriers to health care and health promotion for prostitutes, the clients and other sex partners, should be minimized.

## General health care services

**General health services in Europe do not fully meet the needs of sex workers.**

The organisation of health care varies considerably across Europe. Some countries provide a national health service, with free access for all citizens (UK, Denmark, Portugal, Ireland, Spain), some have a private medical system (Belgium) and others provide a mixture of the two (The Netherlands, Greece, France). The organisation and funding of sexually transmitted disease services is similarly varied: in the UK, Denmark, Ireland, Spain, and in the main cities of The Netherlands and France, there are dedicated genito-urinary medicine clinics. In countries such as Portugal and Belgium most sexually transmitted diseases are treated by private general practitioners, gynaecologists, dermatologists and urologists. In Germany and Greece public health officers are responsible for enforcing laws to combat venereal diseases, and for organising sexually transmitted disease services for registered prostitutes.

We have identified two main obstacles to health care for sex workers.

1. Some prostitutes do not qualify for health services. This applies in some countries where sex workers are not entitled to social security as their work is not recognised. In Germany and Belgium the health care system is only available to employees or self-employed workers who pay taxes which make them eligible for social security; prostitutes generally lack this official status. In Denmark and Spain this applies only to Social Welfare, not health care. People with no residence permits are similarly excluded. 2. The health system is not appropriate for sex workers. This is a complaint common to all the country reports. Staff in clinics and hospitals are often reported as having a negative attitude towards prostitutes and prostitution. As a result sex workers may avoid health services, or, if they do attend, do not disclose their work to the health staff. Health care workers are often ignorant about prostitution and the specific problems prostitutes may face. Many prostitutes would prefer to have treatment anonymously, i.e. without having to provide official documentation, because they fear that their doctor will inform other state agencies about their prostitution. Many men and women working as a prostitutes have had bad experiences with "official" institutions, and therefore distrust "official" health and social services. Further constraints include unsuitable opening hours; for example, clinics may be shut during the hours that prostitutes would like to use them. Health promotion in general, and sexually transmitted disease and AIDS prevention in particular, are often not emphasized in existing health care services, where the emphasis is more on cure.

## Specific health services

Existing health services do not fully meet the needs of all sex workers in any European country, and therefore consideration should be given to the development and provision of specific services. In the light of this discussion of existing health care, it is clear that to optimise access to health care special attention should be paid to the provision of health care and health promotion for prostitutes. In most countries in Europe this need has already been identified. One of the objectives of EUROPAP was to learn from the services that have emerged all over Europe. The country reports include detailed descriptions of major projects. Based on these reports, and discussions with all the local co-ordinators, a number of important requirements for successful services have been identified:

### Implementation:

*Pilot phase for new projects*: the start of a new project in an area where no projects existed before remains a difficult task. It is important to select appropriate project staff, provide training, secure funding, assess, network with existing services and establish the trust of the prostitutes. Preliminary research should be undertaken, in close collaboration with the sex workers of the area, to determine the best way to organise the project before, for example, attempting to rent premises or a mobile van, or employing several staff.

*Continuity of funding*: when we review the conditions for a good project it becomes evident that short term funding is a severe constraint. Almost all the local co-ordinators reached the same conclusion. Clearly, security of employment of staff, ability to plan in the medium and long term, and continuity are important in the provision of a high quality service. In addition, prostitutes are often a dynamic and mobile population, making continued interventions essential. HIV prevention for prostitutes is a continuous activity. To build a good project takes several years. To break it, a few months.

### Staff and skills

*Involvement of sex workers*: projects for sex workers should work with the participation and involvement of sex workers. Projects should provide sex workers with training in health promotion (peer education) and related activities. It may take time to build a team of prostitutes and non-prostitutes, but a combination of their skills is important in developing appropriate services for sex workers.

*Skills of staff*: projects should organise adequate staff training, particularly by sex workers. Staff should be informed of occupational risks and problems in sex work. They should understand the working and living conditions of prostitutes, and be aware of potential difficulties with managers and brothel owners.

*Attitude of staff*: anyone working in a project should have a non-judgemental attitude to sex work. If prostitutes want to leave prostitution they will indicate that and ask for appropriate support. In general, however, prostitutes will come with a specific problem which should be dealt with appropriately, without the prostitute receiving a lecture on why s/he should leave prostitution.

*Adequate payment of all staff, including peer educators*: providing services and health promotion is a professional activity, and should be adequately paid and recognised.

**Material/strategies**

*Location*: prostitute projects should be conveniently located for prostitutes. In some cities this may involve a mobile unit, such as a bus or van (e.g. Paris, Madrid).

*Outreach*: project staff should be able to go to the prostitutes themselves. This may be done on foot from appropriately located premises, others may have a mobile team, which visits bars and clubs up to 40 kilometres from the project's base (e.g. Ghent), and some may operate with street workers (e.g. Brussels).

*Solid infrastructure*: : whether based in a drop-in centre or a mobile bus, projects should supply high quality materials reflecting their aim of providing quality services.

*Appropriate health education materials*: sex work has its own characteristics and dynamics. Risk reduction strategies are also specific, and health education material needs to reflect them. For example, the Dutch STD Foundation has developed a safe sex brochure for sex workers which has been translated into English and French for use in Belgium. A comic strip about safe sex, from the same organisation, exists in Spanish, English, French, and Greek.

*HIV prevention in a broad perspective*: projects are often set up to work specifically on the prevention of HIV. However, issues around HIV are not always the priority for a prostitute, and other problems may be more pressing. Where a service focuses on HIV prevention alone, they may have difficulty establishing credibility, and their HIV prevention work will not reach the target group. HIV prevention should, therefore, be placed in a wider context, taking into account other needs of sex workers.

**Target population**

*Extension to remote areas*: projects should attempt to reach prostitutes in more remote areas. As indicated before, a country's policy towards prostitution may result in the movement of prostitutes out of town. Outreach work should not be limited to inner cities.

*Attention to all forms of sex work*: sometimes a project is directed only at a selected population of prostitutes, e.g. drug using street workers. In most areas, however, other forms exist, each with its specific needs and characteristics. Examples include occasional prostitutes, transsexuals, and transvestites. In many countries the lack of initiatives with male prostitutes was noted. Projects should attempt to identify these different groups and develop appropriate work for all groups.

*Attention to all sex workers*: it is clear that contact with migrant prostitutes requires knowledge of their language and culture. People with appropriate language and knowledge will be important in establishing contact and trust with different groups of prostitutes.

*Attention to other people involved in prostitution*: prostitution is a social phenomenon involving prostitutes, clients, managers, police and other state functionaries. Interventions should not focus solely on the sex workers themselves. For example, health promotion may be facilitated by work with the managers of clubs and brothels, or through work with clients. Police will often be present in prostitution areas. Projects should create a neutral position in relation to all these interested parties. Balancing the interests of all players in and around the sphere of prostitution demands a very sensitive and careful approach.

**External collaborations**

*Anonymity and confidentiality*: as long as the taboo in society on sex work remains, and repressive laws apply to sex workers, services should offer confidentiality for those who wish it. In some first line outreach projects, anonymity may even be preferable, e.g. when dealing with illegal residents.

*Free of charge*: contrary to common belief, many prostitutes are often in financial difficulty. If they require health care, lack of money should not hinder access. Some sex workers in some countries may prefer to pay for services. A project should be flexible and make arrangements in close consultation with the prostitutes themselves.

*Building links with existing services*: prostitute projects will vary in the extent of services they can provide themselves. Some will offer clinical services, drug treatment, social support and counselling. Others will be more restricted to, for example, distributing condoms and providing advice and support. In general, it will not be possible for project staff to meet all the needs of the prostitutes, therefore it is important that good links are made with other available services in the area. Parallel services should in general be avoided, and only organised if existing services are clearly insufficient to meet the needs of sex workers. For example, in some cities it is more appropriate to co-operate with existing services for injecting drug users (needle exchange, drug replacement), especially where the prostitute population contains many non-drug users. Collaboration with existing sexually transmitted disease services may be successful, as in Portugal, although even this project hopes to provide some medical services on-site in the prostitutes' drop-in centre.

*Building links with other specific prostitute services*: most prostitute areas have their own characteristics, and the organisational model of a service may not be generally applicable to

other areas. Nevertheless, there are many common experiences between different projects, and close collaboration between projects would be useful. Joint forces may also be needed to convince public authorities of the importance of good access to care for prostitutes.

## The size and characteristics of the population of sex workers

**It is difficult to estimate the number of women and men working in prostitution in Europe.**

Estimating the number of women and men working in prostitution remains a difficult problem all over Europe. The illegal or semi-legal character of prostitution makes sex workers reluctant to identify themselves, particularly to the authorities. Yet many people are interested in knowing the numbers: public health officials, police, prostitute organisations, the general public, researchers, the media etc. In the country reports estimates were made using different sources, mostly police records, research findings and prostitute organisations. A closer look at the figures in the country reports shows the enormous variation in these estimates.

Would it not be in the interest of all parties involved to have an as accurate as possible estimation of how many people are earning money as sex workers? As long as the illegal status of sex workers remains in many countries, the answer might well be "no". Anonymity and invisibility help to protect the sex worker against repressive measures by those who are responsible for enforcing the law. Specifying numbers is not enough to describe prostitution in a country - how and where prostitutes work, the conditions and organisation of prostitution are of equal importance.

## Evaluation

The word evaluation creates a lot of misunderstanding. On the one hand you find a purely scientific approach, with a strong emphasis on methodological issues. In this approach one may want to have a pre-intervention and post-intervention evaluation and a control group designed to evaluate the impact of a prevention project in terms of any specific health (or other) outcome. Such an approach is difficult for the following reasons:
- field workers, working with prostitutes, have many problems with this approach. Prostitutes are an ever changing, dynamic, mobile and hard to reach group, with characteristics that vary considerably from place to place. Many prostitutes do not like to be interviewed with long standardized questionnaires or don't like to be treated as the subject of research;
- it is difficult to find a representative sample in this often criminalised and stigmatised group;
- good evaluation takes up a lot of resources, and projects are often poorly funded.

On the other hand how do we evaluate the efficacy, effectiveness and efficiency of AIDS-prevention projects for prostitutes. If we think the projects are necessary, how can we support this claim? If we start a new project, what did we learn from the previous ones ?

EUROPAP is now bringing together experiences from 12 countries. We are trying to find a consensus for the description of good models of practice, by combining information from the local co-ordinators. The local co-ordinators have different backgrounds, and include prostitutes, social workers, nurses and medical doctors. The information from the different projects in each country was obtained using a common set of "indicators", which give an idea of the "process" and the "outcome" of a project. An extensive list of indicators was developed, and applied to the projects as far as possible. This resulted in different sets of indicators for

different countries. It was not considered feasible to apply exactly the same set of indicators to each project. However, it was considered useful to produce a list of possible indicators applicable in most places. This list is a base for future work as well.

The list of indicators should form a framework for the description and evaluation of projects: check list of items to be assessed before and during a project. It can be used to make a description of, or to set up, a project. >P> Some indicators are useful as a tool for measuring the project's performance and progression. These are most useful for statistical analysis, e.g. in annual reports. Others are more descriptive, although the evolution of these indicators over time is interesting because it gives an insight in the history of a project.

We will present the indicators more or less as elaborated during the workshops held by EUROPAP.
In the first column we present the indicator, or relevant item, in the second we give some comments or, if possible, a measuring instrument.
In most cases the analysis will concern a specific area, where a prevention project has already been established, or is in the planning phase.
A basic assumption adopted by EUROPAP is that AIDS-prevention should not be approached vertically, but in a broader perspective. It is about making proper decisions, which in turn need stem from the self understanding and self esteem of the target population. Therefore, empowerment and provision of support are always important factors.

| **A. Assessment of situation** | |
|---|---|
| 1. *Assessment of context of the project*, laws and policies, characteristics of target group and prostitution structure in the region, e.g. Do existing laws and regulations interfere with safe sex at the work place ? | Over time these factors may change, e.g. the number involved in and the different types of prostitution, and an assessment at regular intervals is therefore recommended |
| Does the region have a clear policy towards prostitution ? | Repression, regulations, limited areas, obligatory medical control |
| 2. *Assessment of needs of target group* with regard to HIV prevention in prostitution.. | Involvement of sex workers is an important condition in the assessment of the needs. |
| Assess ongoing strategies of sex workers for HIV prevention | |
| Assess how existing health and social services in the area are dealing with prostitutes | Which is the percentage of prostitutes openly discussing work related health and social problems with existing services ? |
| *Some important issues* : | |
| Attitude and skills of staff | The experience of sex workers with these services ? |
| Anonimity | Does contact with the health services risk activating repression by the authorities ? |
| Financial barriers<br>Accessibility: opening hours, outreach work | |
| Appropriate health education materials | Adapted to the real working conditions (condom breakage, lubricants) |

| | |
|---|---|
| Networking between relevant services | |
| 3. *Other health and social needs* | |
| **B. Aims and objectives** | |
| Based on the assessment of the situation a project should define its aims and objectives in the areas of HIV and STD prevention, health, social services, drug prevention and treatment, emancipation, etc... | Again, involvement of sex workers is necessary |
| **C. Putting the aims and objectives into operation** | |
| 1. what kind of services are provided ? | Medical, social, psychological, juridical, self-defence |
| 2. for whom ? | Specification of target group, types of prostitution, nationality. This can be recorded in a registration system |
| 3. how, where and when ? | Low threshold, opening hours, active outreach, free of charge, drop-in center, mobile van or bus |
| 4. which methods of intervention ? | Workshops, face to face medical and social services, vaccination, etc.. |
| 5. what material is used ? | Brochures, video, audio-cassettes, etc... |
| All these items are useful for process evaluation. | |
| **D. Features and characteristics of the organisation** | |
| EUROPAP identified a list of necessary conditions which an organisation should adhere to:<br>• Involvement of sex workers<br>• Confidentiality<br>• Skills & training and attitude of staff<br>• Continuity, time table, (long term) planning<br>• Funding<br>• Organisational aspects: number of staff, juridical structure | |
| **E. Relations of project with others involved in the sphere of prostitution** | |
| • Within the prostitution milieu<br>• Within other service providers, police, co-operation agreements, referrals (social map),<br>• Networking with similar projects<br>• Policy makers | |

| | |
|---|---|
| • Public relation, neighbourhood, press | |
| **F. Methods of evaluation, process and outcome** | |
| Does an organisation have a form of evaluation ? | Most projects use a registration form where each contact with a prostitute is anonymously recorded, with information on: age, sex, kind of prostitution, workplace, first or repeated contact, referred or not, own initiative or not etc. |
| Examples of monitoring the activity: | Registration of total number of contacts made, number of different women/men contacted, number of condoms/leaflets distributed, numbers of STD checks carried out, numbers of vaccinations done, number of women completing a self defence course etc. |
| | When registered over a period of time, the change in the proportion of women and men who have participated in the activities of the project will give more insight in the outcome of the project.<br>It may be used to set targets,<br>e.g. the project wants to raise the proportion of sex workers vaccinated for Hepatitis B from 10 % to 30 % within two years. |
| Example of evaluation at project level<br><br>1. Select representative group of respondents<br>2. Apply relevant questionnaire<br>3. Interview staff, prostitutes and peer educators<br>4. Describe context<br>5. Repeat step 2 to 4 after 3 to 6 months and specific experiences with intervention<br>6. Compare results | |