

SEX

Practical *guidelines* for delivering health services to

WORKERS

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Colophon

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Excerpt from the Sex Workers in Europe Manifesto

“.....Health and well being

No-one, least of all sex workers, denies there are health risks attached to sex work, however, it is a myth that we are ‘dirty’ or ‘unclean’. In reality we are more knowledgeable about our sexual health and practice safe sex more than the general populace and we act as sexual health educators for our clients.

We call for our role within society as a valuable resource for sexual well being and health promotion to be recognised.

Stigma remains a barrier to health care for sex workers. Prejudice and discrimination occur within healthcare settings where sex workers experience degrading and humiliating treatment from some health care workers.

We demand that all health care workers treat us with respect and dignity and that our complaints of discriminatory treatment are taken seriously.

In furtherance of the health and well-being of all sex workers we demand our governments provide:

- *access to health services for all migrant sex workers*
- *access to needle exchange and drug treatment options for dependent drug users*
- *access to treatment options for all people living with HIV, without which many may die unnecessarily*
- *access to transitional treatment options for transgender persons....”*

The manifesto was elaborated and endorsed by 120 sex workers from 26 countries at the European Conference on Sex Work, Human Rights, Labour and Migration 15 - 17 October 2005, Brussels, Belgium (Europe, 2005). For more information: <http://www.sexworkeurope.org>

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Introduction

These guidelines are based on a former edition of the European Network for HIV-STD Prevention in Prostitution (EUROPAP), which published a first edition in July 2003. This update contains major changes, extensive amendments and additional chapters, which are based on the expertise of various experts in the field and the current knowledge in regard to the technical and medical issues, mentioned in this booklet.

The guidelines are meant for health and social workers who have had formal training in health issues, or developed practical experience through their work, and who deliver or intent to deliver health care and health promotion services to sex workers. Saying so, the guidelines focus on experienced and less-experienced colleagues in the field.

Some of you might have quite a 'career' in the field, others might just have started and need a genuine manual on how to set up a well-functioning service. In this case, we advise you to consult additional literature and to contact colleagues within and outside your country and to learn how they succeeded in setting up a well-tailored service. There is lots of experience through all over Europe and it would be a pity to reinvent the wheel again and again. Consultation, cooperation and networking should therefore be an essential part of your practical work.

These guidelines do not intent to be universal. We realise that the local situation is often very difficult and far from ideal. Your project might face financial problems, your colleagues might be inexperienced at the beginning or feel uncomfortable while working with sex workers. Moralistic attitudes might play a role and political or legal issues might influence your work. There are numerous factors, which can influence your work and interfere with your ambition to set up a service, which meets the needs of sex workers. Therefore, you should use these guidelines as support and inspiration and not as a universal standard.

The guidelines apply equally to male, female and transgender sex workers, who have specific and common characteristics. However, some parts of the text will only refer to female, and other to male or transgender sex workers. They describe the topics in situations where a personal and confidential contact between the health worker and the sex worker

exists. Many conditions can be less favourable, and make an individualised approach difficult. However, one should not decide too easily that communication is not possible or that 'specific groups cannot be reached'. To make services tailored and appropriate it is necessary to let sex workers actively participate in the service.

Good communication is based on a holistic approach of sexual health, acceptance and respect towards sex workers and the active involvement and consultation of sex workers within the agencies.

A health care worker should have an open mind for everything that belongs to social life and health. The guidelines are as practical as possible, and do not imply any moral standpoint regarding sex work at all. The condemnation of sex work hinders the full access to care on many occasions and does not contribute to our idea of social inclusion.

These Guidelines have been compiled by:

Justin Gaffney (SohoBoyz, London, UK), Petr Velcevsy (Charles University, Prague, Czech Republic), Jo Phoenix (Durham University, UK) and Katrin Schiffer (Correlation Network, Netherlands). Furthermore, a various number of experts has been consulted to recommend and to comment on the first draft of this booklet.

A recent UK publication from 2006, 'Sexually Transmitted Infections: UK National Screening and Testing Guidelines (Ross J, 2006)', was adapted and drawn from to inform the STI section of the guidelines. Where possible, published literature and an evidence base was used to support the recommendations.

Acknowledgements

These guidelines have been compiled with the support and active input of a number of persons.

First of all thanks to the members of the expert group on sex work, who contributed to the first concept of this update. Our special thanks go to Mr. Justin Gaffney (SohoBoyz London, UK), who took most of the responsibility and contributed extensively and thoroughly to the completion of this booklet. Thanks as well to Mr. Petr Velcevsky (Charles University, Czech Republic) who was responsible for parts of the updates. We also would like to thank Ms. Jo Phoenix (Durham University, UK), who contributed with her comprehensive article on legislation.

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Amsterdam, March 2008

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Legislation

Sex work is legally ambiguous in virtually every country in Europe. For the most part, selling sex is legal, but many of the activities associated with selling sex are either illegal or subject to license or civil regulation. There is no country in Europe that has decriminalised sex work (i.e. removed all criminal laws and special regulations pertaining to sex work). Individual State governments use a combination of social policy, criminal law and civil law to intervene in sex work. In practice, this means that in all but one Europe country it is legal to exchange sex (or sexual services) for money but different governments use a combination of social policy, law and civic regulations to control how, where, when and in what ways sex can be exchanged for money as well as who can do it.

Across Europe, there are two main models of regulation (criminalisation and legalisation). What distinguishes each model is the emphasis given on using the criminal law to achieve the main objective of regulation. Thus, governments can use a combination of formal legislation and social policies to abolish sex work (known commonly as an abolitionism), to reduce the dangers and harms of working in sex work (known as a 'harm reduction' approach) or increase the employment and human rights of sex workers (known as a rights-based approach). In this way, many countries may share the same basic framework of legislation but the actual approaches to sex work can be fundamentally dissimilar.

Criminalisation

What a country decides to legislate against is intimately bound up with the official consensus of what 'the problem' is. In this way most European countries do use criminal justice mechanisms to regulate or at least intervene in sex work – albeit for very different reasons. In 1999, Swedish feminist campaigns were successful in achieving an official definition of sex work as being a problem of sexual violence against women and a re-orientation of the aim of policy to abolitionism. As a result, Swedish law now criminalises men purchasing sex rather than how or where women sell it. Sweden is the only European country in which the exchange of sex for money is illegal. Whilst there is some debate about the extent to which the criminalisation of the purchasing of sex has achieved an overall reduction in sex work, given that Swedish levels of sex work have been historically low, criminalising the purchasing of sex has produced anomalous results. Many Swedish social workers have reported that some of the women who had been selling sex from the streets have now been forced to move into illegal brothels or to work alone from indoor locations. Such a move leaves these women more isolated than before, and arguably exposes them to greater risks of violence from clients (as a result of being more isolated) and exploitation. For those women who have continued to sell sex from the streets, there are also reports that such work has become substantially more risky. Some women report that because there are fewer clients prepared to go to street working women, many women are getting more desperate for money and thus are willing to accept greater sums offered for unprotected sex or will go with clients before they have had a chance to fully assess them as potentially dangerous clients.

Most other European countries operate a form of partial criminalisation in which the criminal law is used to manage, control, repress, prohibit the public visibility of sex work or to protect sex workers from the exploitation of others. For instance, in England and Wales criminal justice sanctions are brought to bear on the 'public nuisance' of sex work i.e. the visibility of sex workers. Similarly, France criminalises soliciting as does Ireland, Scotland and Finland. This 'partial' criminalisation is therefore a model of intervention in which the criminal law is used to manage, control, repress, prohibit what different constituencies perceived are the 'problematic' and 'harmful' aspects of sex work. So, the laws regarding brothels vary greatly: the UK outlaws brothels (defined as two or more sex workers working from the same premises) whereas many other countries do not. But, one of the unintended consequences of partially criminalising aspects of sex work is that whatever

the specific statute, the interpretation and application of the criminal law tends to function in ways that over-police sex workers and under-polices the crimes committed against them. Take, for example, the provision in the Sexual Offences Act 1956 against 'living off the earnings of sex work' i.e. pimping and 'exercising control over a prostitute' i.e. brothel-keeping. In 2003, 30 convictions and 4 cautions were secured for living off earnings of sex work or exercising control over a prostitute. The same year saw 2,627 convictions and 902 cautions for soliciting or loitering in a public place for the purposes of sex work (Source: Office for Criminal Justice Reform, Home Office).

Legalisation

The legalisation of sex work is a model of intervention in which the primary means of regulating sex work is through civil regulation and not criminal justice. At its most extreme, legalisation implies a model of regulation in which any or all criminal justice sanctions regarding the sale and purchase of sex are removed and replaced by non-criminal regulations regarding the legal status of the contract between the seller and purchaser of sex and the conditions in which it is permissible to sell sex. The legalisation of sex work often confers important contractual rights to individuals in sex work and provides a means through which the working conditions of those in the sex industry can be monitored and improved. For example, since 2001 sex work in Germany has been recognised as a legal profession. In Germany, the contract between sex workers and clients can be legally enforced through the civil courts and the conditions in which women work fall under other employment health and safety directives (as well as specific occupation related health and safety provision). That said, the legal recognition of sex work in Germany does not mean that sex work has the same status as other occupations. Employment centres do not advertise jobs in sex work. Individuals in receipt of state benefits are not penalised if they do not take a job in sex work. Sex work is taxed at a higher rate and local municipalities retain the right to 'zone' areas of the city wherein sex work is not permitted. In Munich, street work is not permitted throughout most of the city whereas in Berlin it is allowed almost anywhere. In contrast, other cities such as Hamburg permit street sex work in particular areas at particular times. Many countries that legalise sex work can also require sex workers to register with a licensing authority, the local authority or local courts. This may also involve mandatory systems of registration and compulsory health checks for sex workers – such as in Austria, Greece, the Czech Republic and Turkey. Other proscriptions

may also be stipulated in the civil regulations, such as in Switzerland where sex workers must be Swiss nationals or in Austria and the Netherlands, even though the age of sexual consent is lower, individuals must be 18 years old to engage in sex work (either to purchase or sell).

In relation to legalisation, it is important to remember that just because a country legally recognises sex work (and often taxes it), it does not necessarily follow that the contract of the exchange of sex for money is recognised. In other words, whilst sex workers may be entitled to some employment rights, social security benefits and so on, their ability to enforce the contract and ensure that they can claim their rights is often curtailed.

Decriminalisation

It is often claimed that the decriminalisation of sex work amounts to its legalisation. This is not the case. Decriminalisation is the removal of both the battery of criminal justice laws prohibiting sex work or sex work-related activities as well as any sex work-related civil regulations discussed above. This does not mean that the sale of sex and sex work is not subject to law or policy, but rather that it is not subject to special provision, criminal or otherwise. The contract between workers and clients would not constitute a special contract and the regulation of sex workers employment would be no different from other industries. The assumption runs that decriminalisation would remove the stigma of sex work as well as remove sex work from discussions of morality or legality. In so doing, it is also assumed that sex work would take its place as any other profession and be regulated like any other form of employment i.e. by employment legislation and health and safety provisions. At present, there are no countries that have a system of regulation based on decriminalisation.

Further reading:

Ericksson, J. (2005) 'The Swedish Model: Arguments and Consequences' presented to Prostitution in Europa – Nationale Gesetze und europapolitische Perspektiven, Feministisches Institut der Heinrich-Böll-Stiftung, Berlin, 16 March

Jacobsson, P. (2006) 'The Swedish Model' paper presented to The Ins and Outs of Sex Work and the Law: Exploring the Legal Frameworks in Different Countries Conference, City University of Hong Kong, Hong Kong, 22 October

Mitrovic, E. (2004) Working in the Sex Industry: Report on the Findings of a Field Research, ver.di: Berlin

Outshoorn, J. (ed.) (2004) The Politics of Prostitution: Women's Movements, Democratic States and the Globalisation of Sex Commerce, Cambridge University Press: Cambridge

Scarlet Alliance (1999) Unjust and Counter-Productive: The Failure of Government to Protect Sex Workers from Discrimination, www.scarletalliance.org.au



Sex work in context

Before starting sex work specific health services, and also during the work, knowledge of the field is a necessary element in good service provision. Knowledge of the field cannot be acquired in a very short period, it takes time to get to know the different types of sex work in your area, to get acquainted with the major actors in the field, not only the sex workers, but anyone involved from pimps to police. In this phase of orientation you should involve sex worker representatives, members of other health teams, and you should read reports, articles and evaluations of other projects. More detailed methods of assessment are described in the Manual Hustling For Health (EUROPAP/TAMPEP, 1998).

Different issues

The variation in sex workers may reflect the variation in the general population in the area. However, specific issues have to be taken into account. Different nationalities and, linked to it, different cultures and languages, have an important influence on the development of trust between health workers and sex workers. Well established local sex workers are an important group, who should be actively involved in setting up and developing services and interventions. Migrant sex workers often form networks, and once some individuals in this network had some positive experiences with you, access to others will become easier. Be patient, it is better to have a low profile attitude, and take your time to develop relationships.

Migrant sex workers

Migrant sex workers often form the biggest subgroup within the sex worker community. Due to language problems, cultural differences, the status of undocumented migrants and other factors, which endorse social exclusion, service providers face various problems in providing appropriate services.

Quite a number of projects and agencies managed to provide successful health and social services to migrant sex workers. The European Network TAMPEP developed a specific methodology, including the active involvement of peers and cultural mediators, which can be implemented by agencies that provide services for sex workers. Tampep and the various agencies, which are united in the network can also advise you in setting up services for migrant sex workers (TAMPEP, 2008).

Trafficked sex workers

Sex workers in one-way or another forced into sex work must be treated with great sensitivity. You should be able to provide support for those who wish to change their situation and be familiar with the possibilities of getting someone out without risk. If you know that the only result of your action will be that the trafficked person is thrown out of the country, and that the trafficker has little chance to get a conviction, you should think twice before taking action. Again, try to build a relationship with the sex workers, and let them decide what steps to take. Besides, a first focus on health prevention and health issues might make it easier to establish a trustful relationship.

Young and underage sex workers

Young sex workers and those whose have recently started may need specific attention. They are less knowledgeable and have less experience with health issues. They may never have had sexual health screening, and their awareness of the risks may be low. They are a very important group to pay attention to, and need to be contacted and provided with health education materials as soon as possible. When sex workers are underage, you need to adhere to local protocols dealing with child protection. Nevertheless, be aware that especially underage sex workers need to rely on a non-moralistic approach and a trustful and confidential relationship with the service provider. You should develop information on services in your country or abroad who have managed to set up effective programmes for young and underage sex workers.

Drug using sex workers

Drug using sex workers also need special attention and specific services. When someone is addicted to drugs, and is in sex work, there is a risk that the working standard of safer sex, and setting ones own limits, may be jeopardized. Safer sex might not be one of the biggest priorities for the drug using sex worker. Knowledge of the most prevalent drugs, and techniques for using safely, is important, as is establishing links with drug support projects in your area. Services, which have been set up specifically for drug using sex workers might differ a lot from the services in other sex workers organisations. Most organisations will focus on drug issues (e.g. harm reduction), whilst sex work aspects will be addressed only in the second place.

The European Network Correlation has a number of partners, which work successfully for years in this field. If you need assistance and support in this particular field you should approach the network and/or individual partners for specific support.¹

Male sex workers

Male sex workers mainly sell sex to other men. Some may work together with female sex workers in clubs selling sex to men and women, or giving sex shows with a female colleague.

Services for male sex workers need to be specific and have to make sure that they meet the needs of this particular target group. The situation and the problems of male sex workers are different, compared to female sex workers. Therefore, it is advised, that at least one person in the team is specializing on this particular group. Services should also be aware that the group of male sex workers is diverse. Men, who sell sex to men do not automatically identify as gay. Issues as sexual identity and the often negative attitude towards homosexuality are important issues and should be considered during group- or individual interventions, health education and prevention projects.

In the past few years a new development has been recognised: many male sex workers changed their working environment and started to solicit their clients and customers through Internet. This makes it harder for organisations to deliver services to sex workers.

1

www.correlation-net.org

Nevertheless, many organisations managed to build up specific Internet based services. The European Network Male Prostitution (ENMP)² managed to summarise a number of these best practices in a Manual (Schiffer, 2002, October). A large number of the partners in this former network are currently united in the Correlation Network.

Transgender sex workers

Transgender sex workers might form a majority in some specific areas of a city, and have particular problems and healthcare needs, which need to be addressed carefully. The European network TAMPEP and the project PASTT³ have developed experience in working with this group and can advise you in setting up services in this particular area.

Specific needs of porn industry

Safer sex porn films are rarely produced by the porn industry, since they do not sell. This may pose specific problems for porn actors. Your safer sex advice will simply not be followed. Discuss openly how safety in these conditions can be optimised. If your project decides to offer services to this sector, you have to work out a strict set of guidelines on screening, confidentiality and valid certification together with the actors and the producers.

Other stakeholders

There is a large group of other stakeholders in the field, with whom you might be confronted when undertaking work: brothel owners, partners, boy or girl friends, pimps and clients. All of them will have their own specific role and relationship with the sex worker. Be aware of the large variation in the private lives and arrangements of different sex workers. Avoid oversimplification, assuming that all partners of sex workers are pimps or lover-boys. Many women would feel insulted when their lover would automatically be considered as a pimp. Sometimes, however, a sex worker may live in an exploitative relationship, where violence and control for financial gain by the partner are obvious for you, but not for the sex worker. Be very sensitive to this issue, it is not useful to express your own anger to the sex worker or to push too hard – at all times remain non-judgemental.

2 ENMP existed from 1997-2003; heritage is taken over by the Correlation Network

3 PASTT (Prévention, Action, Santé, Travail pour les Transgenres) pastt@noos.fr

Clients of sex workers, as well as brothel owners can also play a supportive role and inform you about new developments. They observe and will notice more easily, when something is wrong. A number of projects cooperates closely with clients of sex workers and have good experience of such work. On the other hand it is important to make sure that sex workers feel safe and don't get the impression that you share information about them with others.



The organisation of sex work and assessment of the field

The way sex work is organised in an area depends a lot on the legal framework surrounding sex work. The more repressive this framework, the more hidden the sex worker population. These forms of sex work are the hardest to reach with health services. It will also depend on local conditions and history. Before starting your health interventions, you should have a clear idea of how sex work is organised in your area, and of how you will access the different forms of sex work. It is important to remember that involvement in sex work may not always be a conscious decision on behalf of the sex worker, and in many circumstances it is necessary to consider how much power the sex worker has within their working environment.

‘Set your own limits’ is some of the best advice that can be given with regard to the context of a holistic approach to healthcare with sex workers. Try to keep this as a central message, because if a sex worker is forced to cross their own limits, their psychological and physical health may be at stake. The use of condoms, avoiding dangerous sexual techniques, the decision to go to have a sexual health check up, to accept a vaccination, to seek medical help in response to suspicious symptoms – these are all decisions that

need some power on the side of the sex worker. Occupational psychology theories from other professions clearly demonstrate that job related stress is directly proportional to the level of control/autonomy (perceived or real) the employee has to organise their own work, as opposed to the demands of the job or amount of work.

Lack of money will lessen the power of a sex worker. If the money is urgently needed, e.g. to pay debts, to feed children, to send to family back home, or to buy drugs, then it is much more difficult to decline an offer of more money for unsafe sex. Those providing services for sex workers should show respect for that, and not disapproval. Then you can discuss strategies to lower the risks, and explain that chronic or recurrent health problems may have a more long-term effect than a short-term economic crisis.

Another factor influencing power is low self esteem. Some sex workers may have had previous bad experiences and mental health problems, lowering their self-esteem. In a society with a negative attitude towards prostitution sex workers cannot get respect from society through their work, as do others. They tend to hide their job from significant others, and have to lie about it. People surrounding sex work, such as pimps and traffickers, may lower the power of sex workers by physically forcing them to cross their limits. Lack of legal status and discrimination against migrants increases their vulnerability to exploitation and may disempower them.

The following are examples of how sex work is organised in some parts of Europe and is not an exhaustive list.

Street work and other Public Sex Environments (PSEs)

Sex workers may solicit their clients on the street, and sexual services are given in a car, in a hotel, or in a park. When undertaking outreach on the street, services may want to directly approach the sex worker with offers of health assistance, but on the street there is not enough privacy to discuss all the necessary issues. In many street prostitution areas therefore some form of location has been created where you can go with the sex worker, or where the sex worker will go him/herself to access health services. Often projects make use of a mobile van or a bus, or sometimes a prefab building is mounted near the street zone. Another possibility is to rent a room nearby, which serves as the location where

health services can be given. In areas with a lot of street sex work, a small clinic or ‘drop-in centre’ may be created. Drug using sex workers are more frequently found in street work, since the level of organisation is the lowest; you do not need to rent premises, and there is no ‘employer’, as found in more organised forms.

Some sex workers prefer to work in public sex environments (PSEs) as opposed to the commercial sex working scene or other social networks. Some cruising areas offer opportunities for unsafe sexual encounters, so it may be necessary to try to change peers norms and expectations in relation to safer sex. It is also useful to hear about additional issues facing sex workers in PSEs and on the streets, such as “queer bashing” or police harassment.

Examples of PSEs include toilets in parks, lay-bys, shops, theatres, town centres and rural communities; back alleys near gay bars and clubs; paths by rivers and canals; beaches; car park and truck stops; saunas and swimming pools; trains/coach and train/coach stations; backrooms in bars and porn cinemas, and of course the street. In short, the list encompasses any location, which offers willing participants and opportunity.

Often individuals who work in PSEs or on the street are opportunistic sex workers. They may be specifically in the PSE to sell sex, likewise they may have gone there to obtain casual anonymous sex with non-paying partners, and found that a paid sexual encounter has occurred. In the same way, PSEs and the street are often used by younger gay men, and gay/bisexual men who are coming to terms with their sexuality and using such environments as places of experimentation. In so doing, such young men may be approached by older gay men who are seeking to buy sex, who may offer the younger men money or favours in exchange for sex. The young man may capitalise on this opportunity, and realise that he has the ability to sell sex, thus begin to develop sex selling skills. It is less commonly reported for this to be the same experience for girls and young women. If working in such environments, girls and young women will often have been ‘taken’ there by an older individual, such as a pimp.

Street scenes and other PSEs may have a local reputation for being places where sex is sold, which may be the initial draw of the young person.

PSE may be used by a variety of people, mostly men, although in recent years, the concept of 'dogging' has developed, that is public areas often accessed by car (lay-bys, hill top locations with views, etc.) where mostly heterosexual couples go to have sex, often in their cars, and where voyeurs (mostly other men) will approach the car and watch the intercourse through the windows (with the knowledge of the copulating couple, who enjoy providing the sex show) whilst masturbating themselves.

People use PSEs and the street sex work scene for a wide variety of reasons, and often they are considered to be sordid paces, exclusively inhabited by 'dirty old men', that give the community a bad name. This may be the opinion of health and outreach workers also. Such attitudes need to be challenged and it should be accepted that for many of the sex workers, selling sex in such environments is a positive decision, which affords them choice and opportunity. It follows that health/outreach workers must also strive to be non-judgemental when they are working in a PSE and on the street. Workers are unlikely to endear themselves to a sex worker in a PSE if they give them the impression that they are disgusting perverts, and it will be necessary to adopt a positive attitude towards PSE use when working on the street, which nevertheless addresses issues of safety from attack and police arrest, sexual violence and safer sex practice.

It may be also useful to look at the question of choice: for instance, it may be fine that some young people may actively choose to sell sex on the street or in PSEs, but not if they'd prefer to go elsewhere, and don't have the courage, money or experience to do so. There are also certain situations that should be considered when undertaking outreach to PSEs or on the street. Violent situations are best avoided at all cost, and healthcare/outreach workers should ask themselves what possible benefit they can get from attempting to talk to a sex worker who is very drunk/ or intoxicated from illegal substance misuse, who is engaged in sex (you may spy a worker having unprotected sex with a customer, but is it wise to tackle them then and there about it)?

The question of age is problematic, and will vary from country to country. Some people consider that distributing condoms to a young person below the age of consent (to engage in sex work activity if legal) is tantamount to encouraging an illegal sexual act or enticing them to sell sex. Each project/service will need to give this matter very serious consideration, and to have a clear rationale and policy about how you would manage

a younger or under age sex worker, and what the substance of your intervention will be. There is an obvious difficulty in assessing age accurately, especially if it's dark. An appropriate strategy with some young people may be to ask other sex workers to have a word with them on your behalf; they may be more than willing to do this, since there can be a strong sense of community on the streets, and in PSEs.

Many old sex workers are also keen to discourage very young people from using the location, since their presence is likely to heighten police activity. In extreme cases where it seems that a very young person is in vulnerable position you may feel morally or even contractually bound to report what is happening to a third party, such as the police or social services (in the latter instance this would especially apply if you were employed within a Governmental Organisation (GO) and required to follow child protection guidelines). This can cause all sorts of conflicts concerning your role in the PSE/ on the street, and is best resolved by having a clear policy and procedure in place, and ensure that health/outreach workers are skilled and confident in the application of such protocols.

Essentially workers are guest in the PSE or on the street, when they're actually working, and as such are in a privileged position, which should not be exploited (it can sometimes be similar to being the only sober person at a party). Possible strategies for work in a PSE and on the street, include talking to sex workers about safer sex or more general social issues (such as where they are staying), assessing the extent of violence and police harassment, distributing condoms and lubricant, written information, putting up stickers or posters, or referring them back to your project/service's drop-in or to another appropriate venue for a more in-depth discussion about HIV testing and so forth.

It should also be considered that the nature/circumstances of the sex worker using the PSE or street scene would dictate the nature of the outreach. For example, if the scene is one which revolves around drug use (such as crack cocaine), their drug use will be the predominant feature of the outreach intervention, sexual health and HIV prevention may come low in the list of immediate concerns for the sex worker. Health/outreach workers need to familiarise themselves with the local scene and ensure their approach is informed and able to meet these needs.

Even if health/outreach workers are familiar with a PSE or street scene, they will need to

observe it before they contemplate any interventions. They may need to research a number of PSEs or street areas before they choose the most appropriate one for targeting. Points to considered are: do the sex workers use it extensively? Is it easy for you to get to? How popular is it with the police? If it's a toilet or park, are there adequate entrances/exits, benches where you can sit around?

Once a PSE or particular street location has been identified, you need to become comfortable with it, and what this involves depends on the nature of the PSE/street location. That could mean visiting it at quiet times of the day to get the feel of it. It can be useful to note well-worn paths, cubbyholes, piles of cigarettes butts, which indicates, places where men sit and wait/chat, and also evidence of condom use. Clearly this all needs doing as unobtrusively as possible. Be familiar with the layout, know where the street lights and well lit areas are, map and plan escape routes, check the location of populated areas, such as pubs or cafes, and pay telephones, so you can call for help in an emergency.

Familiarisation with (public toilets, sometimes referred to as cottages) might include checking the number of cubicles, whether they have locks, the content of the graffiti, opportunities for contact between cubicles (e.g. holes), and checking out the places where men gather outside cottages (such as on nearby walls, benches or patches of grass). It may be thought safest and most appropriated to work only with men outside cottages, rather than men who are standing at a urinal, washbasin or in a cubicle. The latter options might increase the chances that your role is unclear, or that you'll get arrested.

The next step might be to visit the PSE or street location when it is in use, without making any interventions. For safety reasons, you should always work with another person, though a couple chatting but not cruising or buying sex may well excite suspicion. If for any reason you are on your own, you should be aware of the messages that you are giving out while observing. A person watching without cruising/soliciting might lead to suspicions that they are a plain-clothes policeman, voyeur or gay basher/gang member.

One way of gaining a foothold in a PSE or the street location without leading to a misunderstandings (and it can speed the work up too) is to identify a local sex worker who is well known and respected, and who is willing to introduce you and your colleague

to other sex workers so that you can explain your role and offer reassurance. The trick is to find a key sex worker who is willing to offer you time and who will also have to accept that while they are accompanying you they cannot get involved in selling sex. Obviously, an element of luck may come into this.

You may wish to visit a PSE or street location at the same time every day/week, or vary your visits. The former has the advantages of predictability for users, and you may be able to develop deeper contact; the latter has the advantages that you'll encounter a wider range of men. It may be safer to visit an outdoor location in daylight, but you may find that it is not well used. If you visit at night, stay near a lamp for greater safety. Sitting areas or the fringes of the PSE/street location itself might be more sensible locations than dark corner or undergrowth, which could lead to all sorts of misunderstanding and trouble. If working exclusively with male sex workers, some outdoor PSEs and street locations are best avoided immediately after the time when straight pubs and clubs turn out their customers, some of who may fancy a spot of anti-gay violence.

Bars

For many of the EU countries, there are established commercial scenes, bars and nightclubs, where it is known that people selling sex many go to socialise, but also to look for business. In some towns and cities throughout Europe, some of these bars or clubs may be specifically known as venues to buy sex, men may specifically go there for this purpose, and often owners/managers will be aware of (and often encourage) this. It maybe that they turn a 'blind eye' to when a sex worker slopes of to the toilet closely followed by the man who has been chatting with the former at the bar, some even provide darkrooms or private rest areas for this sexually activity.

However, they are not running a brothel, as it is very rare for the bar or club staff to be involved in actually negotiating the sexual sale, their profit margin attained purely from the sale of alcohol and liquor, which lubricates these discussions. In some venues, the owners/managers may also charge the sex worker 'rent' for the hire of a room, if provided for the sexual activity, and the sex worker may earn additional money for encouraging the client to buy additional drinks - run up their bar bill.

It may also be that sex is being sold in venues, which are more generic bars and clubs, that is those frequented by a normal mix of men using the scene, and the venue is not specifically known as a place to buy sex, that the selling of sex in these venues is often opportunistic or occasional.

One of the main reasons for targeting outreach to such venues is the large number of sex workers, which might be contacted in this way. You may be interested in assessing the needs of sex workers on the scene, as well as raising awareness of HIV/AIDS and safer sex in this setting. In addition, you may feel it important to establish a presence on the scene and use it to raise your project's profile.

As with other areas of outreach work, bar venue work requires initial observation, to establish the layout of the venue(s), or where there are a number of venues which are known to be frequented by sex workers, which are best to visit at which time. Health/outreach workers should frequent the venue(s) at different times of the day, to observe when is the peak time at which the maximum number of sex workers may be encountered. While during this observational time it is best to avoid contact, it may be useful if possible to have limited contact with popular sex workers on the scene, who can advise you on the best times to undertake outreach sessions.

Depending on how supportive managers/owners are, health workers may benefit from talking to bar staff, and gaining information from them to inform their future interventions. The aim of this intervention to be to establish contact with sex workers, discuss safer sex and HIV prevention issues, talk to them about their experiences, and increase awareness of your project/service. One of the difficulties of this type of outreach centres around making contact, even with known sex workers this may pose a difficulty, because sometimes it can be hard to establish whether the sex worker is 'working' or just socialising on the bar/club scene, especially in those more generic, mixed crowd venues.

Establishing contact in a socialising context may arouse suspicion from the sex workers friends and companions, which might lead to a potential risk of exposure or breach of confidentiality. This is less likely to occur in those venues, which are known to be more working pubs and clubs, where the very presence of a sex worker signifies they are working.

Where there is a large and established bar/club scene, this may be difficult and will require a significant number of observation sessions and intelligence gathering, to establish which are the best venues, and at what is the best time to visit those venues, to maximise potential contact with people selling sex. Obviously, where there are known sex selling venues, this may be easier. It is still worth conducting some baseline observations in other more mixed generic venues from the onset, and periodically during the course of your work. Especially so, in response to reports from established sex selling contacts, of new and emerging venues used by people to sell sex.

Be clear from the onset on the purpose of doing outreach to commercial pub and club scene venues. Some workers can find this type of outreach very daunting and intimidating, especially if in an isolated or small location, where the scene is small and limited, and may be where they socialize when off duty. Sometimes this merging of personal and professional environments can cause individual workers some tension.

Health/outreach workers need to realise that in most pub and club environments interventions need to be kept brief, as the men/women are there to work, and playing attention to an outreach worker can distract them from this. If just starting to work a new venue, or meeting new contacts, workers also need to avoid the potential of either being taken as a potential non-paying sexual pursuant, or a customer. Interventions need to be targeted and provide clear messages. Health/outreach workers may also want to consider whether they will buy contacts alcoholic drinks, as a way of establishing/maintaining contact, or whether that may go against the health promotion ethos of your organisation. It must be remembered that it is difficult to undertake detail interventions or to engage in one-to-one counselling in a busy and noisy club or bar, therefore it is important to recognise that the purpose of outreach (as opposed to detached) work is to refer back to your project/service base or drop-in centre for more detailed work with clients. However, sometimes it might be necessary to do counselling at the spot, especially at the very beginning, when sex workers do not fully trust you or your service.

Some projects/services may decide that it is beneficial to approach managers/owners of known sex selling clubs, or venues where sex is thought to be sold opportunistically, and seek their support for the outreach work. This needs to be considered carefully, as they

may perceive that your outreach may either deter customers, or draw unwanted attention to the fact that sex is sold on their premises, and therefore deny you entry. Health/outreach workers may also want to consider their relationship with the men/women selling sex, which needs to be established around trust. That may be compromised if workers are seen (or perceived) by the sex workers as being 'over familiar' with the owner/manager.

Due to the nature of the commercial bar/club scene, this type of work is best undertaken in pairs. Some gay venues (especially those known to be sex selling venues) will be exclusively male only, so the outreach team will have to be all male, but in more generic scene venues, with a mixed clientele, female staff together may undertake the work. When working with people selling sex, you want to blend in and be discrete, not draw attention to yourselves or even the sex workers you may be working with.

It is important to debrief as a team at the end of a piece of bar or club scene outreach. This should ideally be undertaken away from the venue in which you have been working. Any issues or concerns from the session should be discussed, and those which cannot be resolved during the debrief, be taken to team or personal supervision. It is at this time that details of contacts met during the session should be recorded, even if only in short note form, for addition to any motoring or record system your project/service utilises at a later date, while the details are fresh in your mind.

Some bars and clubs (mostly gay), especially in Western Europe, will have a secluded area, a room or series of connected rooms, which are poorly lit, and used for sex. These are often referred to as the 'darkroom'. Darkrooms are areas where men go to engage in anonymous casual sex while using the facilities of the bar or club. This may range from voyeuristic self-masturbation while watching others, through to unprotected receptive anal intercourse (receptive UAI). Like work in PSEs or the street, outreach work in a darkroom environment can be difficult, even when targeting just gay men, focusing on young men potentially selling sex in darkrooms is even more complex.

As the name suggests, these rooms are very dimly lit, making locating even known sex worker contacts difficult. In practical terms, it may be best for the outreach team to position themselves just with the darkroom (often such areas only have one access point). This gives the advantage of being able to view men as they enter the darkroom, and it

may even be to adopt a generic outreach strategy, such as issuing condoms and lube to all men as they enter the darkroom, but try to establish a longer engagement with those young men who may potentially be selling sex.

Co-operation of the bar or club owner is much the same as for bars or clubs without darkrooms, if you can achieve their support it will assist you with the work, but if not, it may be necessary to maintain a low profile and not draw unwanted attention to your work.

In some European cities now there are an increasing number of venues that offer pole or lap dancing. Such establishments boarder the grey area between entertainment and sex work, and whilst many such establishments have strict 'no touch' policies, often re-enforced by security staff, it can be a fine line and a number of venues may offer 'extra' services to clients willing to pay and seeking sexual activities. It can be difficult to access such venues, as the owners/managers will often deny such additional services are being offered, for fear of loosing their licenses, and often outreach to such venues will need to be covert. However, one 'way in' is through a dancer who may be working at the venue and is familiar with your project/service, and may be able to facilitate access for your team.

Saunas & Massage Parlours

Many saunas and massage institutions do not provide sexual services, so you have to be careful in approaching them. But safe sex norms are sometimes more difficult to apply in situations where there is no openness about what is really happening, and others are organised and known to be sex working venues.

There is a difference between working in an overtly gay sauna and a regular private or municipal sauna. In gay saunas it is theoretically possible to come to an arrangement with the managers/owners so that your outreach work is explicit, has their official blessing, and can stretch to putting up posters or providing free condoms and lubricant, or even running clinical services. In regular saunas it is highly unlikely that such overt work will be possible.

It is, of course, true that many saunas rely on a clientele seeking sexual contact, to remain profitable, and that upwards of 60% of those present at any time may be men seeking

sex. Moreover, unless they are naïve in the extreme, it is likely that the owner/attendants will be aware that sexual activity of various kinds (including the selling of sex) takes place in the sauna. The crucial consideration, however, is that in such situation sexual activity is tolerated to a greater or lesser degree, only so long as it is reasonably discreet. If outreach workers try to get cooperation from managers of regular or municipal saunas, they are in effect making an issue of the sex and forcing the managers to take action.

Unless the managers are very enlightened, this action is unlikely to be positive. It would therefore seem that any outreach in non-gay saunas has to be covert and conducted with great sensitivity. The notion of sex being tolerated as long as nobody makes an issue of it may extend to overtly gay saunas, which fear officials/police interference.

It may also be the case that in heterosexual saunas, where women sell sex, the managers/owners are aware that sex is sold (in fact some saunas are known to be places to go and buy sex), such managers/owners may be unsupportive of outreach workers, so their main focus is on making profit. Health/outreach workers should consider this is the motivation factor of the managers/owners when trying to gain co-operation from these individuals, and present their proposals in such a way that the outreach will enhance their business. It is often far easier to establish an arrangement with the managers/owners in such venues, who will provide a space for the outreach team to chat with the women, in the reception or a room away from the main sauna, however, in gay saunas, workers will often need to undress and enter the actual sauna in order to meet the men selling sex.

Health/outreach workers need to be clear that they are doing outreach in saunas for valid reasons, not just because there happen to be a lot of sex workers there or because it seems superficially like an attractive option; being an HIV worker in a gay environment does not automatically mean that you are able to do any effective HIV prevention. It may be starting the obvious, but it is difficult handing out condoms and leaflets to naked individuals. Workers might even consider it compromising to have to take such materials into a sauna environment. Slow familiarization, with sex working contacts and ensuring one-to-one discussion (possible referral to your project/service) may be the best strategy.

Approaching men/women in an unambiguous way, while simultaneously deflecting the advances of other men (in some saunas, especially those in which your outreach work is

discreet and without the knowledge of the managers/owners) is clearly not easy. There is also the danger that an inappropriate approach might cause a man to complain to the management, which would cause problems for you as an outreach worker and risk compromising everyone else present (since, as in other PSEs, outreach workers are privileged guests, not participants). This reinforces the need for caution and a long period of observation since familiarity with the venue users (i.e. who's selling sex and who isn't) and general sauna etiquette is something that cannot be achieved overnight. Don't forget that if you make a mess of things in a sauna, you can't beat a hasty retreat (as might be possible on the street), especially in a gay sauna, where you may also need to get dressed!

Obviously, work in saunas which are exclusive male, can only be undertaken by male staff, and in gay saunas heterosexual male staff members may feel uncomfortable, especially if needing to be naked. Staffing availability may therefore be an issue, and as with other forms of outreach, it is best undertaken in pairs, and ideally not alone. As with other PSEs, workers need to consider whether it is professional to use the sauna for their own person use at other times.

Brothels & Private Clubs

The way brothels and private sex clubs are organized will differ across Europe, but follow some general working practices, that is in most sex workers will take a client to a room to give sexual services for a fixed period of time. The client pays the house, or 'management', and the sex worker receives a percentage. Extra money may be earned by the sex worker for providing extra services, socializing and drinking alcohol with the client, or giving extra sexual services once alone with the client. In the Netherlands, an increasing number of brothels officially only n to work as 'facilitator', in order to avoid an official

Because the organisation of the sale of sex is still, in the main, illegal across most of Europe, a great many of these brothels and sex clubs will operate discretely and front as other types of establishment, such as an unlicensed massage parlour or an indoor escort or introduction agency. In many male sex work establishments there maybe a concentration of men selling sex working there, with perhaps 5 – 15 young men per shift (depending on the size of the premises), and most operate a day (from noon till 7 or 8pm) and night (from

7 – 2am) shift system. The London experience of these types of establishments suggests that they often have a large number of immigrant men, although this many vary outside of the UK, elsewhere in Europe.

The establishment will be responsible for the recruitment and selection of customers, who will visit the premises in response to expensive and glitzy advertising in the gay and/or local press, and/or via a website on the Internet. The standard layout of such establishments is for a reception/waiting area, to which clients are first shown upon arrival. This is usually adjoined by an area of the establishment where the sex workers wait between clients. It is usually fitted with rudimentary cooking and showering facilities, and a television. Often this room is fitted with a one-way mirror, which facilitates the clients anonymous viewing of the sex workers available when making his selection shortly after arrival.

There will then be a number of bedrooms, in which the sex occurs. The benefits for the sex worker of working in this way are that the establishment is responsible for all overheads and on costs (advertising, etc.). It is also safer than working on the streets or in a PSE, as there are other sex workers on the premises (should a client turn nasty), and to some extent clients have been pre-screened (often particularly intoxicated customers will be turned away for example). It also allows the sex worker to have a clear distinction between the home and work place, unlike independent [male] sex workers, who many of whom work from home.

The other main significant benefit is the concept of a peer network, these sex workers are not working in isolation, their work enables them to relate with and socialise with other sex workers. This is a useful resource for health/outreach workers to tap when undertaking outreach to such establishments, especially to directing newer inexperienced sex workers to learn from more experienced sex workers. Health/outreach workers can often facilitate this process during an effective outreach session.

The significant draw back to this is that sex workers in these establishments are not considered employees, that is the brothel or sex club owner or manager will argue that they are self employed masseurs or entertainers who hire rooms by the hour, and reside on the premises for the duration of their working day. This means they are not protected by any European work related legislation, such as the Working Time Directive or minimum

wage – if a sex worker is not picked by a single client for the duration of his/her shift, they will not be paid. The other significant draw back for the sex worker is that the establishment will keep normally at least 50% of any monies the customers pay for services rendered.

There is also evidence from some European countries, that some women working in such establishments may be trafficked or working against their will, and their movements maybe controlled by the owner/manager – health/outreach workers need to consider therefore that these women may not be able to access health services, and may require some screening services (where possible) to be delivered within the work space.

The relationship with the managers/owners of these establishments is actually the fundamental key to this work, as they are the gatekeepers that allow entry into this potentially very productive type of outreach work. The central factor to remember when making initial approaches with these individuals is that their primary consideration is about running a profitable business, not necessary the welfare or sexual well being of the men and/or women working for them.

Whatever approach you adopt when opening negotiations, bear this is mind. Your proposals must be attractive to them, your inroads to facilitate access for outreach must appear to cause minimum disruption to their business, and in some way, perhaps enhance it (it may increase their client base if it is that they can say their workers receive regular check ups for example).

It may be best to try and foster this relationship over time, expect that when approaching a new brothel, it will take time to get a foot through the door. If you have contact already with some of the sex workers at the brothel/sex club, this may be helpful, especially if they are willing to introduce you to the managers/owners. A first step will be to try and establish enough contact to facilitate information about your project/service being disseminated to the sex workers. This will usually at least get you past the front door to the reception area.

Condoms and the provision of other safer sex materials, such as lubricant can be used as a bartering tool to allow deeper penetration, and perhaps even access to the sex workers. In countries and parts of Europe where brothels/sex clubs are illegal and these

establishments are fronting as unlicensed massage parlour or indoor escort agencies, they are often reluctant to keep large quantities of condoms on the premises, for fear that they may be cited as evidence that sex was being sold during a police raid. Sex workers will therefore be expected to supply their own condoms (if in the workers possession during a raid, it could be claimed the condoms are for a sex workers personal use).

Offering to supply the sex workers with these condoms on a regular basis can be an effective and powerful tool, which can be used to barter access to them. Often, this may start as just being allowed through to the rest room, and the opportunity to disseminate safer sex materials and resources to the collective audience of workers. Over time, this may develop into gaining permission from the owners/managers to wait in the reception afterwards, and give the sex workers the opportunity to talk in semi-private, for a one-to-one. Obviously, this will be dependant on the layout of the establishment, and how busy the reception is, if there are a large number of clients waiting, this might not be feasible.

The aim would be for the relationship with the brothel/sex club owners/managers to develop over time, and for them to appreciate the value of your intervention and realise that it does not prevent profit, if anything it potentially enhances it, as clients appreciate that some provision is being made for the welfare needs of the sex workers. In this way, health workers can begin to negotiate ways to enhance the benefit of this type of outreach.

Find out by conversation with the sex workers and the owners/managers when is the best time to visit the establishment, when is it quietest. Performing outreach visits at this time may allow you to use one of the bedrooms as a private space to see each of the sex workers in turn for one-to-one counselling. This allows some very constructive work to be undertaken, including assessment and harm reduction counselling, as well as the opportunity to gather accurate recording data on the sex workers seen – most will not object to workers actually explaining that they maintain confidential statistics of the outreach sessions, and completing said record with them.

When you have this private space for one-to-one counselling, it is also a chance to check out with sex workers, especially new contacts, their motivation for selling sex. The ENMP pilot survey (Gaffney, Mai, & Pryce, 2003) showed that for many young men selling sex in brothels, selling sex was a short term activity, often in response to acute financial crisis,

and that in such off street settings, a higher proportion of men tend to be migrant workers. It may therefore be an opportunity to discuss choices with the sex worker, inform them of their rights. If it is that due to immigration status or financial situations they feel they have no choice but to sell sex, as health/outreach workers, you may be able to help the sex worker explore other options and alternatives. Should these options be limited, or financially not as attractive as sex work, or should the sex worker feel they are making an informed choice about selling sex, then as health/outreach workers, there is a responsibility to ensure they do so as safely as possible.

Ensure that the sex worker has been adequately vaccinated against Hepatitis A and B, and if not direct them towards a local facility where this may be accessed. You might also recommend a regular sexual health screening from the same facility if available. There is also the opportunity to check their confidence of negotiating with clients – it may be they are very new to sex work and still quite naïve. A successful way of achieving this is through the use of peer facilitators, directing them to talk with more experienced workers within the same establishment who can impart some ‘tricks of the trade’.

You may also be able to facilitate specific group work activities collectively with the sex workers in the establishment, such as safer sex talks, STI slide shows, etc. It is important when working in these establishments to also work in pairs. It depends on the relationship with the managers/owners, but there are no practical reasons (apart from perhaps scaring customers in the reception area) if a female worker is one of the pair (when working with male sex workers) or a male health worker when working in a female establishment. For personal and professional reasons, it is advisable never to be completely alone with a sex worker in a room on the premises. Always carry ID, it is rare, but if raided you may need to establish you are not a sex worker, and always have a manager on call.

However, as with the previous section dealing with working in bars and clubs, it is important not to be seen to be over familiar with owners/managers of brothels, for fear of ostracising the sex workers. Once an understanding has been developed enough to facilitate you being given a private space in which to conduct your sessions, it is important to ensure that trust is maintained with the sex workers. It is important to remind them constantly that discussions and any information recorded about them is strictly confidential, that none of the information is ever shared with or shown to the owners/managers. There is a

fine balance to be maintained between appeasing the owners/managers and remaining trusted by the sex workers, which health workers must develop as this type of outreach progresses.

Window Prostitution

Particularly famous in the 'red light' district of Amsterdam, but also found in other European cities, sex workers (mainly women or transgender) present themselves to clients sitting behind a 'shop' window. Sexual services are provided in a small room just behind the window, and to show other clients they are 'busy' a curtain is closed on the window. In general, sex workers in this form of prostitution spend less time with a client, and earn less on drinks. The average number of clients is higher than in a club. While access to window sex workers may be easy (due to their high visibility) you may compromise their business by being seen in the window with them.

Window sex workers have to pay a daily rent for the window. If no clients show up, they will lose money. Therefore it is important for you to keep a low profile, and if you want to discuss health issues in more detail, you can negotiate a good time to visit or refer them back into your project/service or other facility.

Private Houses & Flats

Selling sex from private premises is increasing, and is organized in different ways in different parts of Europe, and there are differences between men and women selling sex in this way.

For female sex workers, many will lease or hire 'working flats' from which to operate, and often have several women working from the flat at the same time, sharing a maid or receptionist (this is often an older former sex worker, who organizes the work, takes bookings from clients and receives them on arrival). In many parts of Europe, working in this way is illegal, as more than one woman working on the premises could be seen as a brothel, despite the fact that working in this way allows for some degree of safety for the women, which would not be afforded from working in isolation.

There are occasions when such working flats are referred to as ‘walk-up’ – there may be several flats in the same building, often located in the known sex working district of the city or town (Soho in London, UK for example), with a woman who will entice potential clients from the street, either from a booth or doorway, and persuade the men to ‘walk-up’ for sex. There is evidence from certain cities to show that these flats can often be very ‘controlled’, with a criminal element who organize the work and may even traffic women to work on the premises – these venues can be difficult for outreach teams to access, and if they do, it may be difficult for the women working there to access your project or clinical services, so it may be important to consider what clinical elements of sexual health service can be provided on outreach within the venue.

Mostly publicity for working flats is made through advertisements in local newspapers, the Internet, magazines, through ‘carding’ (the placing of advertisements in local phone boxes/booths). It can be difficult access such venues, and often the first point of contact is the same as their clients, through the telephone. Once you start to establish contact, you will begin to develop trust, the sex workers themselves will inform you of new premises opening up, or a movement of premises.

Safety is a prominent issue for ‘indoor work’ – even 2-3 women working from the same premises may be subject to attack from gangs or violent clients, and sometimes the role of the outreach team (particularly with new premises) is to advise them on safety features, such as video entry phones, alarm buttons, a big dog or other security measures that maybe helpful.

For men selling sex indoors, they will advertise their services using the gay press or local newspapers, calling themselves escorts or masseurs, although few actually have massage qualifications, and in some countries, their advertising may be extremely sexually explicit, and be obvious that sex is being sold. A few limit themselves to out-calls only (visiting clients), but the majority allow clients to visit them at their apartments. While the majority of European countries have legal rulings, which criminalise the controlled selling of sex, and all activities associated with the selling of sex, these men sell sex discretely, and therefore tend not to draw unwanted attention to their activities by law enforcement agencies.

Unlike with female sex workers, who tend to use ‘working flats’, separate from those

apartments at which they reside, the majority of independent male sex workers sell sex from the same apartment at which they live. This can have implications for both the sex workers physical and psychological health, although (unlike with female sex work), acts of violence and/or abuse against male sex workers working independently from flats is very rare across most of the European countries.

However, there is the potential for violence, as arrangements are made directly between the sex worker and the customer, without the intervention or knowledge of a third party. Again, similar to their female colleagues, outreach teams who visit men selling sex from flats/apartments may want to discuss safety arrangements and tips as an integral component of their harm minimisation strategy.

In addition to the potential of threat of violence, there are the psychological effects, which can be experienced by independent indoor sex workers. As previously stated, it is common for female indoor workers to have 'working flats', a venue or premises which the women will hire for the specific purpose of selling sex. This creates a clear demarcation between work and private life, the women can 'leave the job' and return to a living environment, which is not associated with her sex work. For the majority of independent indoor male sex workers, they live and work at the same premises, so this demarcation does not exist.

This can sometimes have a very direct effect on the individual sex worker. For some, they can develop an almost clinical detachment – their apartment will be very clean and functional, and will lack personal effects, such as photographs or mementos, which might give a clue or some insight to a visiting customer, about the person behind the sex worker. This form of invisible clinical barrier helps the sex worker to create this sense of demarcation, but can have a negative effect on the psyche in the long term.

Linked to the notion of this clinical detachment, a number of the workers have few or no real friends, or established social networks, often because of fear of stigma and/or shame attached to their involvement in sex work. Another factor is the level of competition, that there are many independent indoor sex workers advertising in the gay press (there are now even free gay press supplements within popular papers specifically for the purpose of escorts/masseurs posting their display photo adverts). This sense of isolation and the competitive nature of the business can also be a factor why some men that sell sex

as independent indoor workers are reluctant to access services and projects, especially those which have a drop-in service.

While they acknowledge their isolation and the notion that having the opportunity to discuss their sex work with other sex workers may be beneficial, and help develop a similar level of peer network as is experienced by bar/club or brothel working men, they are often reticent about actually engaging in this process, for the simple fact that they don't want to physically meet the competition! This can have a negative effect on their sexual health and ability to sustain safer sexually practices, as research has identified that a lack of a peer reference framework for socially marginalised groups can lead to increased risk taking behaviours (de Graaf, Vanwesenbeek, van Zessen, Straver, & Visser, 1994).

These are all important factors, which should be considered by outreach workers wanting to develop work with this type of sex worker. There are a number of ways to establish contact with independent indoor male sex workers. Many place advertisements in the local gay press, by establishing contact initially with the publications, then teams may be able to facilitate being around on the days the sex workers come to place their adverts, thus ensuring direct contact. In addition, it may be that the publication is just happy to have some of your service leaflets and printed information available to give to persons, rather than allowing the team into their offices. Alternatively, they may allow you to place an advert for your service within the escorts/masseurs pages, usually not for free, but at a negotiated, significantly reduced rate.

The most effective way to reach this specific group of indoor sex workers is to telephone their adverts directly. This form of 'cold calling' can be difficult and feel uncomfortable for inexperienced outreach workers. You should think of what you are going to say, so it remains concise and understandable, it is often a good idea to write this down, so you have a script card to work from. It is important within the first few minutes of any cold call, that you have established where you are from, the purpose of your call, whether the young man is actually selling sex, and that you are not a client or the police. The phone conversation should be kept brief, so as not to block the sex workers line (and potential work), and be just enough to get them interested enough to consent to a home visit.

Cold calling adverts can be a time consuming piece of work, and adequate time should be set aside for this, it is best practice to set aside a few hours before the time you actually plan to undertake the home visits. Early to mid-afternoon is normally the best time for cold

calling, calling in the morning, many of the sex workers may still be sleeping, at college/school or in the gym, calling in the evening, many will be working or preparing for work, and will not want to be visited, however, trying to arrange visits for late afternoon, many sex workers will be available.

As a service/project you need to consider whether you will visit a sex worker once, as in introductory visit, to establish contact, take some condoms, and promote your project/service, or whether you will visit regularly, to maintain contact and a regular supply of condoms for the sex worker. The frequency of visiting can have an effect on how long you may wish to spend on each visit. If just a one off visit, then you may want to consider a slightly longer visit, to ensure you provide all the information and empower the sex worker to access your service/project. In this case the number of visits that you may be able to make in one outreach session will be limited, to perhaps 2-3 visits. If planning to undertake regular visits, once contact is established, then a shorter contact time may be possible, facilitating more visits per session.

The following points need to be considered if planning to undertake outreach visits to independent indoor workers:

- When cold calling, keep your contact with the sex worker brief, remember this is their business line and they may not want it blocked and to be losing potential clients. Be clear about your message, either to quickly and concisely impart information about your project/service, or to arrange a visit to the sex worker.
- If arranging a visit to the sex worker, initially just take the general area in which the sex worker is living, do not push for the full address upon initial contact, as most sex workers will be reluctant to give this level of detail on a first contact. Say you will call (from your mobile phone) when actually in the area, a few minutes before you intend to knock on their door. This also gives the sex worker the opportunity to decline your visit, having had time to think about it following your initial telephone contact with them. It is also very important to inform the sex worker how many outreach workers will be visiting, and the gender of these workers – again this reduces the element of surprise and allows the sex worker to remain in control about the visit.
- You may need to decide as a team whether you will leave message on voicemail services, and the content of such messages. When cold calling, at least fifty percent of the numbers you call will be diverted to voicemail. If you leave messages, you may want to consider who else may be hearing the message, other than the sex worker,

especially is on a landline, rather than a personal mobile – the last thing you want on an initial contact is a sex worker returning your call and accusing your service of disclosing their profession to a flatmate or partner. Therefore, have a clear and justifiable policy about messages left and their content, which the team and project/service should be signed up to.

- Always ensure that visits to independent indoor sex workers are with two members of the outreach team, this provides person safety for the team, and prevents any accusations of professional misconduct. Always provide an on-call manager with details of the locations you are going to visit, keep your mobile phone switched on, and ensure that you call in at the end of your session. Your project/service should have a clear and established procedure for this to ensure worker safety, and so the manager is clear what their responsibilities are, should you not call in by the agreed time.
- Decide on the format of your visits before undertaking the work. As previously stated, some projects undertake only a one off visit, to introduce their services, and then leave it for the sex worker to establish additional contact, or access the service. Other projects/services will perform regular home visits, delivering condoms, and adding the sex worker onto their visiting list. Have a clear understanding of what you are offering before commencing this type of outreach.
- Consider how long you will actually spend on each visit, because of the isolation previously discussed, some independent indoor [male] sex workers will greatly appreciate the opportunity to discuss the work they do with understanding persons, it may have been the first real opportunity they have had to do so, and they may want to talk for hours. It may be necessary to state when arranging the visit or upon arrival, that you have other visits arranged and therefore can only spend 30 minutes with them, creating a time boundary to limit the contact. Conversely, some sex workers may invite you to visit, but upon your arrive feel uncomfortable, and rush you along before you have imparted all the information you wanted to give them – workers need to be sensitive to these varied reactions, and tailor their intervention accordingly.
- When in the sex workers apartment, remember, not only is it their work space, but for some, also their home, and that as an outreach worker you are a guest within their space, and should respect this at all times.
- Finally, if undertaking home visits, be prepared for any eventuality, have a clear outreach policy that would guide outreach workers in their practice, what if they came across an underage child with the sex worker, or drug use, or a firearm, etc. It

is rare that anything unusual would occur, but it is always when you least expect it, that these things occur, so it is best to have thought them through in advance.

Escort Services

Escort services are found in most cities in the world. Modern communications technologies and the web have mostly replaced the traditional book with pictures in an office, lowering the risk for employers. Sexual services are given in a hotel, or at the clients' house. Escorts are paid by the hour, and sometimes a client rents an escort to go out, or for a short holiday. This group of sex workers can be difficult to reach, but if they work in other forms of sex work as well, teams may have contact with them through other venues. If you can contact the management of the escort services, you may gain access through them.

Safety issues are important as well in this form of sex work, and often the escort organisers provide transport and safety. The sex worker does the safer sex negotiations, but a safer sex policy from the management would facilitate this.

Escort services operate in much the same way as brothels, only the sex workers are not actually on the business premises, and most of the men buying the sex contact the agencies via the telephone or email and again rarely visit the premises. Once a selection has been made by the client, the escort organisers will contact the sex worker and give them the assignment details – where to go, who to meet, and what to charge.

The sex worker registers with the service, usually completing a profiling form, which provides essential personal information, body type, hair colour, nationality, range of acceptable sexual practices, etc., and provides a series of photographs. The sex worker once registered with the agency, will give their availability, and state whether they are willing to see clients at their premises and/or visit paying partners at their home, hotels or work places, the later of which is most common.

Like with brothels/unlicensed massage parlours, the sex workers registered with escort services are not technically employed by the service. Many of the services charge a 'joining' or 'registration' fee when the sex worker initially signs up with the service. This allows the service to claim it is acting merely as an introductory service. It charges hopeful

sex workers a set fee to register, and then charges clients a fee for each 'introduction' – this keeps the service just within the confines of the law, otherwise they could be charged as being nothing more than sophisticated pimps. Having said this, like with brothels/unlicensed massage parlours, escort services very obviously sell sex, and the clients that contact them are aware that is their purpose.

Many of the escort services charge higher fees than the brothels/unlicensed massage parlours, and often insist on several hours of payment for a single assignment, and set rates for 'overnights' (staying with the client until morning), as well as travel expenses (usually a taxi fare) for the sex worker to reach the clients destination on out calls. For these reasons, the type of client tends to be of a better calibre than those of the street, bar/club, PSE or brothel. However, the sex workers working for the service will be expected to match the higher standards of the customers, they will usually have to be very good looking, well educated and mannered, and fluent usually in the mother tongue of the country in which the service is located, as well as English.

Payment for services is sometimes made directly to the sex worker on completion of the assignment, but the set fee will have been negotiated in advance with the escort service at the time of the booking, and the sex worker will be aware what this amount totals. However, many escort services will also accept debit/credit card payment in advance at the time the booking is placed. Like with the brothel/unlicensed massage parlour, 'extra' sexual services offered by the sex worker may be negotiated between the sex worker and the client, and the sex worker will keep this extra money, or 'tip'. The benefit of working in this way for many sex workers is that they can potentially earn a lot of money, but assignments are not guaranteed, and the draw back is that there may be prolonged periods when there is no work, therefore no money.

Similar to brothels, escort services provisionally screen clients when they make the booking, any 'odd' requests or suspicious sounding men will be refused services, making it a safer way for men and women to work. The escort service will also have details of the assignment, and will expect the sex worker to report in after the assignment, usually directly in person to the office, with the agency's money from the assignment fees. If the sex worker does not call in, the escort service will attempt to trace them, which is an additional safety factor. Some agencies even employ drivers to deliver and collect the sex worker to and from assignments.

In reality, most escort service outreach work will not result in direct contact with the men and women selling sex. The best that is usually achieved is to have an initial meeting with the escort service managers/owners, and make them aware of the services you provide, leaving some information (leaflets, flyers, condom packs, etc.) which might be passed onto the sex workers registered with the service. If you are providing outreach from a project/service base the only way you may be able to monitor how effective this intervention has been, is to record how many of the new contacts using your service found out about it from their work with an escort service.

The Internet

The World Wide Web (www), chat-rooms and portals are the latest and most rapidly expanding medium through which sex is sold globally, and as such many projects and services are beginning to utilise this medium as a way of establishing contact with sex workers. Correlation has actually produced an on-line resource which gives guidance on development of this area of work

(<http://www.correlation-net.org/products/cd/loader.swf>).

However, it is worth noting a few valid points in this section regarding the specifics of using the World Wide Web in an outreach situation.

Many independent indoor sex workers advertise themselves on the Internet, and a considerable number have their picture and/or details registered with, and hosted by an escort service which is web based, or have their own websites, which are specific to their sex work. It seems to be that this is especially true for North European sex workers, and those in the Scandinavian countries, where more visible forms of commercial male sex work, such as on the street, in bars/clubs or in brothels/massage parlours do not exist, or not as overtly as in more Central or Southerly regions.

In addition to a website, many male sex workers especially, are beginning to cruise for business in chat rooms, areas of a commercial website and community sites/portals which have discussion rooms that facilitate 'real time' text based debate between registered users. Such sites tend to be gay, and whilst most Internet Service Providers (ISP) and

community websites regulate (through their terms and conditions of use which most members agree to when registering with the site) against any form of prostitution within the chat forums, the reality is it occurs constantly.

In fact a number of European sites (such as Gaydar and Gay Romeo) have become so tired of trying to regulate against escorts chatting for clients on line, they have actually now provided an escorts specific area to their sites.

Projects and services need to consider their political positions, often influenced by the nature of their funding before considering whether this is an area of outreach that they wish to explore. The Internet remains still very much unregulated, and most of the sites providing chat rooms or escort areas that would be used for the selling of sex, are linked to and will have what are called 'hyperlinks' (a direction connection which allows the web user to click an on screen button and be navigated directly to a different web site) to more hardcore (and potentially illegal) websites.

This needs to be considered if staff are using project/service IT facilities to access such sites, as

often this will contravene the IT security policies of larger umbrella organisations, which will prohibit the viewing of sexually explicit material on work PCs. It also has resource implications, in that the outreach team must have access to a PC, which is Internet compatible, and ideally have a secure digital connection, for faster connection to the web.

Trawling through websites and chat rooms can also be very time consuming, and yet yield little or no results, so in terms of gathering hardcore statistics, such as numbers of sex workers contacted on an outreach session, this can sometimes be difficult to substantiate.

Yet, the Internet is one of the most rapidly expanding media resources of the modern era, and as such new and innovative areas of outreach methodologies are being created and explored. A simple way to get started is to construct an email message, this can be sent to all the sex workers who use an email address in their more conventional newspaper advertisements, and also to men who may have a website from an Internet web search.

This is an excellent way to establish connection and perhaps enter into an email exchange of dialogue with sex workers.

Using a search engine (a web based device or resource which allows the Internet user to look for sites which pertain to key words or topics), look up terms such as male prostitute, escort, sex worker, rent boy, etc. This will often yield websites which are escorts services or those of individual sex workers, which will often have links to other related sites once you start to sort through them.

It is a good idea to develop (either from expertise within your team, the support of an IT department, or purchasing in expertise) a web site for your own project/service – this can be referred to within your initial email. The specific web address or URL can be given, allowing the sex worker to gain more in-depth information about your service/project, and keeping the initial email brief.

When establishing contact with sex workers in chat rooms, outreach workers need to consider (like with PSE or bar/club outreach), that the sex worker might be in the chat room because they looking for work, or his own private casual non-paying sexual contacts, or either, or both. Therefore, interventions may need to be brief and precise, again, having a website to refer to allows you to quickly send the URL, the sex worker can then access your details at a later time.

Many sex workers will have obvious screen names (such as dick4rent, etc.), but a few will be generic, and it will only be by observing the textual conversation of the general chat area that the sex worker can be identified by the outreach team as potentially working. Again security for health workers is an issue within chat rooms. Screen names of outreach workers should be obvious, and not appear to as though they are selling sex, or a customer wanting to purchase sex. To avoid accusations of the content of any discussion had 'online' with a sex worker, the service/project may wish to invest in scripting software, special programmes which will monitor the chat and transcribe the dialogue as it occurs, which can then be stored securely and confidentially as a report of the session.

Health/outreach workers should also avoid using their own person screen or user names, especially if this is a site that they may use personally when not at work, to cruise or obtain

potential sexual partners, as this could compromise their professional position.

Finally, there is no way to validate information given by users of the Internet, just as you may be a customer pretending to be an outreach worker, so might the sex worker be a client (or someone else) pretending to be a sex worker. Health/outreach staff therefore need to be very cautious when undertaking this type of outreach work. The purpose of outreach to chat rooms also needs to be decided, is it to just raise awareness of your service/project to potential service users, and perhaps facilitate access to the service, or is it going to 'outreach' in a virtual cyber environment, establishing dialogue with men and women selling sex and begin to counsel one-two-one in order to meet the health promotion and harm minimisations aims of your service? These are key issues, which teams need to address and resolve before commencing this type of outreach.

New Technologies

In addition to the Internet and World Wide Web, there are other types of new technologies that are utilised for selling sex or sexual services, such as on-line video streaming, DVD pornography, pay-to-view web cam shows, sex chat lines and G3 multi-media downloads to mobile phones and other hand held wireless portable devices.

Many of men and women promoting sexual services using these mediums could be considered by some projects/services as not true sex workers, as most are just providing a visual/fantasy display of sexual activities, rather than actually being paid for sex with clients. However, there is often a fine line dividing involvement in pornography/porn related technologies and movement into escort work. Certainly, with men selling sex, it has been observed that many also star in pornography movies and then promote their involvement on their on-line escort profiles, flaunting the concept of 'see the movie – now try the real thing'.

It can be difficult to access the men and women involved in this area of the commercial sex industry, experience of projects/services that have tried shows that often the people behind the technology (the gate keepers - the porn producers, web-maters, etc.) are reluctant to engage with health related services, frankly, their main motivation is profit and commercial interest. There is an increasing consumer demand of 'bareback sex' (that

is without condoms), and thus the usual approach of giving condoms as a way to gain access is highly unlikely to be successful as an intervention.

As projects/services offering a health services, it is perhaps more helpful to recognise and acknowledge the gatekeepers desire for profit and commerce and attempt to engage with this concept, in terms of their responsibility as an 'employer' for the health and safety of their models, and the prevention of potential costly legal suits if a model were to acquire a sexually transmitted infection (STI) or HIV whilst in production. Examples can be taken from the recent HIV outbreaks in the US and UK porn industries and the need for regular STI and HIV testing, to reduce risks.

It is suggested that health projects/services should agree a form of screening and testing and certification of results, in partnership with all stakeholders, including the sex workers/porn models, such that risk can be reduced. However, in the development of such protocols, it needs to be agreed what tests will be undertaken, how regularly and how results will be communicated, so as not to breach the confidentiality of the sex workers/porn models, but removing the chance of fraudulent certification. It will also need sign up from the sex workers/porn models of an adherence to safer sex with partners outside of work, and honest disclosure/withdrawal from the industry for a prescribed period if unsafe sex should occur with private partners. However, it is also important for all stakeholders to remember that no matter what precautions/measures are put in place, bareback sex will still run the possibility of potential infection transmission. A good example of such codes of conduct can be seen at the UK GAIKISS site (GAIKISS, 2008).

For those men/women who work independently, using new technologies such as web camera pay-to-view shows, projects/services may want to establish contact via email or on-line engagement, and provide more general advice.

New Trends

As well as the use of new technologies, there is also a developing trend of sex parties and swinger parties. These are parties (often arranged via the Internet) at which attendees (either as individuals or couples) attend the party for sex, as invited guests or paying guests. Increasing the organisers of such parties will ensure that sex workers are present

as guests (often the organisers will pay to have sex workers present to ensure some good looking people at the party) and therefore they can charge extra to other attendees for the fact that commercial sex may be available, or if a free to access party, guarantee some gorgeous attendees to attract large numbers of party goers. It may be therefore that either the sex worker is paid by the host to attend the party, but has choice as to whom they have sex with, or that the sex worker is invited and can 'work' whilst present, engaging with clients in a party atmosphere and charging them for services. Increasingly, sex workers themselves are taking on the role as organiser, this way they can income generate from the attendance fees and reduce the need to actually engage in sexual activity themselves.

It can be extremely difficult for health/outreach workers to provide any type of outreach initiative to/at such events/parties. If they are able to have contact with the organisers, then they may persuade them to accept condoms and information about the local services, to have available at the party, but it is not really possible to be present at/provide outreach at such events.

In parts of Europe (such as the UK), such parties have been linked to particular outbreaks of sexual infections (e.g. syphilis) and it may be that after the event, the project/service, if they gather clinical surveillance data that suggests a potential outbreak, can act as the conduit between the party organiser(s) and the public health agencies who may have a responsibility to investigate and contain such outbreaks.



Preparing for service provision

How sex work specific should services be?

These guidelines are developed for projects/services that are considering providing health services to sex workers and those in the commercial sex industry. Whether these proposed health services are sex worker specific or generic will depend your local situation. There are excellent examples from across Europe of sex worker specific health services, as well as projects/services that refer sex workers into generic health services, and many that are examples of a combination of the two approaches. Many sex worker specific services tend to focus on sexual health and gynaecological health, whilst primary health care and substance misuse services tend to be generic.

In all circumstances, the aim of initiatives (such as outreach) is to lower or remove barriers, enabling the men and women selling sex to access the health services, as and when they may require them. In many parts of Europe, sex workers are considered a hard to reach population, who have multiple health problems, very often related to their sexual health and/or substance misuse, and some do not access any services at all. There can be many barriers to access, perceived or real, such as stigma, attitude of healthcare professionals providing services, costs, immigration status and fear of 'governmental agencies', language, or understanding of services available.

Before embarking on the provision of health services or linking into the accessing of existing generic services, projects/services need to consider and be clear what they are offering, how comprehensive this healthcare should be, including problems that would normally be covered from primary care. Whilst sexual health is extremely important, and often the obvious focus of health interventions with sex workers, however, health needs to be considered in a holistic context, including psychological, sociological, and environmental issues. Whilst it maybe unrealistic to expect a project/service to be able to comprehensively provide all these health services, when considering interventions, said projects/services should have clear referral pathways and be able to sign post sex workers to appropriate alternative service providers.

The following sections provide some guidance and points that projects/services need to consider when planning interventions to access sex workers into healthcare services, or when considering delivering healthcare initiatives within outreach settings.

Basic attitude

Respect lies at the heart of all health initiatives with sex workers, and it is important that any staff working with sex workers have respect for the choices they make. People enter sex work for a variety of reasons and it is not the task of the health worker to make judgements about such reasons. If a sex worker wants to consider exiting from sex worker, it is the health workers responsibility to assist and advice, but by the same token, those who are making a positive choice should be supported to stay as healthily as possible.

The UK Network of Sex Work Projects (UKNSWP, 2007) has developed a set of core value statements, by which projects/services can work to provide services to sex workers, no matter what their theoretical or organisational stance on the notion of prostitution:

- Seek to promote the empowerment of sex workers including increasing their knowledge of their rights.
- Promote choice – including the choice to exit sex work and seek other forms of work.
- Sex work is of itself not inherently exploitative but individual situations may vary.
- Note that sex work is not indicative of the person's sexual orientation

- Recognise the diversity involved in sex work and acknowledge that there are not rigid boundaries between indoor/outdoor, etc.
- Acknowledge that children and young people do not choose sex work; this is child exploitation and may require child protection interventions
- Prevention is also part of the work of the majority of agencies

If projects/services are not actually providing health services directly, but undertaking interventions to outreach and access sex workers to existing services, they should consider providing some educational and learning activities to the healthcare providers of the services being referred to, in order that they can adhere to ethical framework identified above.

Policies and procedures

It is important to have in place policies and procedures, which will guide health/outreach workers practice when considering developing health services for sex workers.

Such policies and procedures should clearly state the objectives of the role and set a framework for professional conduct against which the objectives will be achieved. Where possible, for example within a new project or service which is developing, the outreach staff should be consulted with and involved in negotiating these documents, therefore allowing them some ownership of the boundaries against which their practice will be assessed.

The following is an example of the key areas, which should be covered by such policies and procedures. They may be contained within a single guiding operational document, or, as will be the case in larger projects or services, may draw upon elements of pre-existing employment policy. Where health/outreach staff are employed, drawn from an existing professional discipline (such as nursing or medical), it should be noted that professional codes of conduct specific to their profession might also apply.

Responsibilities:

- While most of the work undertaken will be of an informal nature (for example, on the streets or in pubs and clubs), as representatives of a project or service, project workers have a responsibility to conduct themselves with the utmost professionalism

at all times. This applies to dealings with other agencies, including the press.

- Workers should aim to respond to the need of sex workers. If a working relationship becomes impossible for any reason, appropriate referral to another worker/agency must be negotiated.
- Workers must respect the autonomy and dignity of the sex worker, irrespective of their age, race, class, sexual orientation, capabilities or HIV antibody status.
- Workers are responsible for negotiating and maintaining appropriate professional boundaries with sex workers and must not use sex workers to meet their own social, emotional or sexual needs. It is not acceptable for workers to have sex with sex workers.
- Workers must not impose any standards, values or beliefs upon sex workers. Nor should they encourage any course of action, which is harmful to the sex worker or others. It is acceptable to disclose one's own values and beliefs.
- Workers will be encouraged through support, supervision and training to develop ways of working which maximize this participation.
- Workers will be provided with opportunities for training throughout the life of the project or according to their role, and should make use of available supervision to identify further training needs.
- Workers must monitor and keep a diary/log of their work, being able to account to colleagues and managers for what they are doing and why. Access to the diary/log by the evaluator should be negotiated with the workers.
- Workers should recognize their limits and become familiar with appropriate referral agencies.

Confidentiality:

Confidentiality must be maintained with regard to any information of a personal nature concerning sex workers and colleagues, including name, address, biographical details and any other information, which might result in a sex worker's identity being disclosed.

Health/outreach workers must not reveal confidential information pertaining to sex workers or colleagues except to those upon whom they rely for support/supervision, and in this instance the identity of the individual(s) concerned must be thoroughly disguised. Should ethical dilemmas arise (e.g. possible danger to a third party), the situation should be discussed as soon as possible with the supervisor, manager or project co-ordinator.

Most health/outreach workers will also be bound by professional confidentiality. No information you get from an individual sex worker can be shared with another person without consent of the sex worker. Never give information to their colleagues, managers or third parties such as insurance companies. Where you work closely with other agencies you need clear policies on the exchange of information and ensure that sex workers provide informed consent. This applies to sex workers as with all other patients. Sex workers highly appreciate this attitude.

Anonymity:

In countries with repressive laws, sex workers are very suspicious of anybody who may represent the ‘authorities’. To avoid any misunderstanding about your role, health/outreach workers should avoid asking for any official identification papers of the sex worker. If undertaking medical tests, you can identify the sex worker by their date of birth, working place and the name they use there. Knowing the workers name is very handy when you need to contact somebody later on. Some projects use a unique identifier to keep information. Illegal immigrants will appreciate such an approach and providing reassurances will often lower barriers to engagement with such sex workers.

Free access:

There is a perception that street working or substance addicted sex workers will not have the cash needed to access healthcare, as opposed to indoor workers, who will be in a better financial position to pay for health services when required. However, this is a misconception, and in reality, many sex workers have periods of economic drought, at which times healthcare will be a low priority on their list of needs. When offering preventive services, such as health education materials, discussing the risks of certain sexual techniques, or screening for STI for an early diagnosis, the initiative often comes from the health worker. Many sex workers are not in possession of the correct paper work for coverage by health insurance. For these reasons a free access policy will lower the barrier considerably. Providing free preventive and treatment services is in the interests of the sex worker and the public health.

Safer Sex:

For the majority of projects/services providing sexual health initiatives to sex workers, the promotion of safer sex will be at the heart of all their health promotion activities. It is essential to promote the concept of safer sex (reducing the risk of pregnancy or onward transmission of STI) as opposed to 'safe' sex, as there are no prevention measures (other than absolute abstinence, which is unrealistic when selling sex) which can guarantee absolute security. Projects/services should also agree clear strategies for supporting sex workers when safer sex measures have been unsuccessful (e.g. condom breakage) through either provision of or referral to access for PEPSI (Post Exposure Prophylaxis following Sexual Intercourse) or emergency contraception – see section 8).

Projects/services may also be concerned that the promotion of the use of condoms may affect their funding, as a number of right wing conservative funders and those of certain religious beliefs will not support the promotion of condoms. Reference should be made to the UNAIDS document *Prevention & control of sexually transmitted infections: draft global strategy (Document A59/11 Add.2) May 2006 (WHO, 2006)*, which clearly states:

“The male condom, along with the female condom, are a key component of comprehensive prevention strategies, and both should be made readily and consistently available to all those who need them in order to reduce risks of sexual exposure to STIs including HIV.”

A final consideration for a safer sex policy/procedure is the response a project/service will take to those sex workers for who protected sex is either not an option (e.g. those working in the pornography industry) or those who choose not to engage in safer sex practices for the increased financial rewards 'bareback' sex may facilitate. In such circumstances, it is important for projects/services to have a clear position statement on such eventualities, which may be either that they will not work with such sex workers, as they can not be seen to condone unsafe sexual behaviour, or, more usefully, to respect the sex workers position and provide information on other ways to reduce risk, such as through regular STI screening, certification, withdrawal prior to ejection, etc.

Child Protection:

It is increasingly important for projects/services working with sex workers to have procedures in place to deal with child protection issues. This can be two fold, either because there is a possibility for encountering a young person engaged in sex work, or through outreach, coming across minors in what maybe deemed an inappropriate or 'at risk' environment. In those situations where the young person may be encountered engaging in sex work, projects/services need to be aware of their statutory obligations, which will be country specific and may vary. It is important in these situations to take a measured approach and not respond reactively in such a way that could mean the young person disengages with the service and disappears, or gives an impression to the other sex workers in the locality that you may be agents of the state. Therefore, your procedures should have clear reference to some kind of a assessment criteria, to measure how 'at risk' the young person maybe, and often it is useful in such situations to have a supervisor, manager or project co-ordinator who can be referred to, away from the actual situation, for advice and guidance. If the decision is that it may be more beneficial to work with the young person, and not remove them immediately to a place of safety, this should be clearly documented along with the rationale for this decision.

Where the decision is made to remove the young person to a place of safety, ideally this should be done with the consent of the young person. Explanation should be given as to why the health/outreach workers feel that removal is for the young sex workers own safety, and time should be spent providing counsel to assist them in reaching a conclusion that removal is the preferred option. This decision needs to be considered in the content of the venue, and should not be done in such a way as to place the health/outreach workers or young person at risk (say from a violent pimp or criminal flat/brothel owner). Procedures should include clear referral pathways for removal to an appropriate place of safety, including co-operation with the police or social services.

Where vulnerable young people may be encountered on the fringes of sex work, say the child of a sex worker is discovered whilst undertaking outreach to a brothel, the same risk assessments should be undertaken as highlighted in the paragraphs above. Health/outreach workers should remember that decision to remove the child/children to a place of safety may jeopardise the relationship with the sex worker or sex working venue. It is often more helpful to discuss your concerns with the appropriate adult sex workers within

the venue, and assist them to find solutions to remove the minor(s) to a more appropriate place.

Documentation is crucial when dealing with child protection issues, and health professionals should ensure they keep accurate and well written notes of their observations, assessments and decisions, and remember that these may be challenged (legally) at any time in the future. Guidance from specialist professionals, such as social services Child Protection Teams should be sought and documented.

Establishing a referral network

Delivering holistic healthcare means that projects/services will be considering the sex worker as a whole being, not just focusing on their sexual or physical health, but also psychological, economical and environmental aspects of their wider health status.

Professionals providing services to sex workers are often develop expertise around the issues of sex work, and sexual health promotion, and will develop a trusting relationship with sex workers, who will present with a wide range of issues that affect their health status. As health/outreach workers, it is important to recognise your limitations and have established clear referral pathways to a broad range of other experts, from dermatologists, gynaecologists and dentists, to counsellors, psychologists and mental health services, through to lawyers, accountants and benefit advisers.

As well as providing education and learning opportunities to sensitise other healthcare providers to working with sex workers, as mentioned previously at the beginning of this section, projects/services may wish to extend such initiatives to other groups, such as local police, if sympathetic, will then have friendly officers to which sex workers can be referred to report violent crime against them, for example.

If providing specific clinical services, projects/services will also need to think of the whole patient pathway, and have established clear referral pathways in order to be able to follow through care, for example, if offering HIV testing, what about follow up if a sex worker has a positive result, or if offering pregnancy testing, what about referral to obstetric or termination services – these measures should be in place before such clinical interventions are delivered/offered.

A network will gradually build up through the experiences projects/services encounter with the different situations and problems of sex workers. But be very clear: all these services can only be contacted with the full support of the individual sex worker, and in his or her interest.

Health/Outreach Workers' Profile

Whilst it is important to recognise that there is a wide diversity amongst the men and women that sell sex, so it should also be recognised that there is a wide diversity amongst health/outreach workers engaged in outreach work with these sex workers. The context of the health/outreach worker will often be related and specific to the needs of the employing service, and workers may be drawn from a wide range of professional backgrounds or experiences, again depending on the context of their outreach role.

However, some simple guidelines pertaining to the appointment and day-to-day management of health workers can be considered from a wider perspective. Development of clear and specific job descriptions and person specifications will ensure that health/outreach workers are clear of what is expected of them and the tasks in which they are to be involved. In developing such, managers should be mindful of the long term aims and potential developments of the project/service, there is a delicate balance to be struck between a job description so specific it stifles potential service development, as opposed to one that is so non-descript that health/outreach workers are unclear of their role and functions.

There is much debate in the field currently about the gender of health/outreach workers when working with specific sex working populations. Historically, it has been generally considered that projects/services focusing on interventions with mainly female sex workers should employ only female health workers, and similarly male staff to work with mainly male sex worker orientated projects. However, within this field of work, that may not always be possible, or even practicable or desired. Such decisions should be explored and agreed at a local level before jobs go to advert.

Further, it may be desirable to recruit a health/outreach worker from a specific cultural or

ethnic background, especially if trying to work with diverse populations of ethnic minority sex workers. For example, in recent years many western European countries have seen an increase in sex workers arriving from Eastern Europe, in particular Poland and therefore it may be of benefit to recruit a Polish health/outreach worker, who specifically engages with these sex workers, because they are culturally sensitive to the needs of this group. However, within the UK, many services working with sex workers have found that they are accessed by second or third generation UK Asians, who mostly live and sell sex within their own communities. These sex workers often seek engagement with services as far removed from their ethnic and cultural roots as possible, for fear of disclosure. Employing a health/outreach worker from a similar background could be fraught with problems, as their community is well networked and the sex worker may fear connectivity and potential exposure from such a worker.

Use of current or previously working men and women may also be problematic. The nature and social construct of the commercial sex industry, especially that which is off-street, is highly structured, complex and competitive. For these reasons, it may be difficult for a current or well known former sex worker to be accepted by and trusted by other sex workers. Professional (non sex working) health/outreach workers are often afforded greater respect due to their 'professional' status, which facilitates a degree of distance and creates a professional boundary, which supports the development of trust. A former or current sex worker may be seen as too much of a peer, which can create a tension related to mistrust or competitiveness, which may inhibit meaningful engagement.

On the overhand, an experienced and skilled current or former sex worker may be able through effective communication to reassure sex workers of their professionalism and their 'shared' experience can often be powerful and enabling for the sex workers with who they engage, especially with regard to health promotion related to the actual act of selling sex (safely), and there are many successful examples from across Europe of sex worker lead health projects/services.

It is essential that whatever health/outreach workers are employed to meet the specific needs of the project/service, they should not work alone (any form of outreach work in what ever setting or venue is best undertaken in pairs – no worker should ever work in isolation if at all possible). Where two health/outreach workers or more are undertaking

sessions together, differentiation between the workers in terms of seniority and level of responsibility on the one hand, and areas of work on the other, should be made. Where no such differentiation occurs and workers share a common role, the division of work should be discussed in full.

It is essential that health/outreach workers' roles be clarified in terms of the overall management structure of the project/service. In this way, concepts such as accountability and consultation can be fleshed out, and areas in which workers can expect to be consulted and involved in decision making (or not, as the case may be) can be delineated. Decisions will need to be made regarding general skills possessed by all workers and specific skills relevant to particular areas of work. Decisions also need to be made about which skills would be expected of a health worker on appointment (for example to be a qualified nurse), and which they can develop via in-service training (for example the skills of undertaking outreach).

The following checklist of skills and personal qualities offers a range of possibilities, by no means exhaustive. It should go without saying that no single person could possibly embody all of these skills and qualities: equally, the suggestions are subjective at times. Nevertheless, they may serve as a useful starting point for debate:

- Interpersonal communication
- Counselling
- Group work/facilitation
- Education/training experience
- Liaison and networking
- Time management
- Evaluation/record keeping/report writing
- Graphics and design
- A knowledge of community development techniques
- Experience of outreach or detached work
- Experience of working with sex workers/ young people/people with disability/people from ethnic minority communities or other potential target groups
- Strategic planning/knowledge of funding and policy issues
- An overview of health education strategies and structures
- A knowledge of the commercial sex industry, HIV and gay issues

- Information technology skills, including use of the Internet, and web design
- Persistence
- Sense of humour
- Enthusiasm and a commitment to the work
- Feeling comfortable about one's sexuality, and that of others
- A commitment to equal opportunities
- The ability to reflect on ones' own actions
- The ability to work with minimal supervision
- A non-judgemental approach
- The ability to relate to a wide range of people who have sex for money, which can incorporate young sex workers, young MSM, people who don't identify as gay or bisexual, SM people, gay Christians, older people, people who have been abused, and so on
- The ability to cope with stress
- A clear understanding of professional and personal boundaries, and the experience, responsibility, professionalism and stability to respect such boundaries
- Versatility and adaptability
- The strength to say no, and the ability to make appropriate referrals

In order to develop and increase their skills as well as share experiences of the work, it is important for health/outreach workers in the field to network with others in the field. It is therefore advisable to contact other teams in the country, and to meet at a regular basis to exchange information. In some countries networking between projects/services may be necessary to raise awareness of the importance of this work, and to help each other in getting proper funding. It is also important to work on a common health strategy, since many sex workers are highly mobile, and change work places from one region to another.

Service providers need a thorough knowledge of all health risks, need to liaise with a scene perhaps unfamiliar to them and need to develop and keep a referral network. Health services for sex workers should organise proper support and professional supervision for their team, and offer further education. Training should also promote self-reflection on beliefs, values and the way these can have an impact on your communication and effectiveness. Workers also need training in gender, sexuality, migration and cultural issues

and anti-discrimination practice. Exchanging experience with similar initiatives within a country or abroad may be a highly motivating tool.

The safety of health/outreach workers should be guaranteed. It is general not in the interest of the commercial sex industry to harm health and outreach workers, unless the gatekeepers of the industry feel threatened in some way by projects/services activities. Safety issues are discussed in "Hustling for Health", a separate EUROPAP document (EUROPAP/TEMPEP, 1998).

Sex worker involvement

Sex workers themselves have the best understanding of the work. Some types of sex work have all the characteristics of a professional activity. There are different levels of contribution that sex workers can make to a health project/service, ranging from advice on developing health promotion materials to setting up peer education and self help groups. Giving health education and delivering health services is a professional activity too. People who combine both health care and sex work professional skills will be extremely useful in developing sex work specific health services. Training of sex workers willing to play a role in health may be very supportive for the sex worker community as a whole.

However, as with the section above (health/outreach worker profile), avoid the involvement of workers unqualified for health services delivery for 'political' reasons. On the other hand, if projects/services employ sex workers, they should be properly paid, and incorporate into training programmes. Professional health/outreach workers need a thorough knowledge of health in all its aspects, will need to be extra vigilant regarding confidentiality, should be able to deal with unsuccessful health interventions, and most importantly, should be able to set aside all personal reflections and problems. It is best to recognise each other's skills, and to work out the best combination and collaboration between sex workers and health professionals in order to achieve the objective of making sex work more safe. The same holds for cultural mediators, who have the same cultural and linguistic background as the target population. They can be very helpful in promoting the general prevention messages, in stimulating sex workers to contact health professionals at regular intervals or when signs and symptoms occur.



Methods of service provision

The way your health services are organised depends a lot on the size of the target population, the number of colleagues you have, the financial means you have access to, the quality of the referral network around you, and the health system in your area. In this chapter we present an ideal picture, but we are aware of the limitations many projects experience.

Outreach

Outreach work is the basis on which a project/service can establish links with the sex worker community and its environment, and make contact with individual sex workers. This is where you learn from sex workers and communicate about their individual needs, tailoring your intervention to each person and setting. The team can facilitate risk reduction and promote access to health care.

Without this link, when a sex worker comes to a clinic, the health care worker may not understand the working conditions in the streets, in a brothel or a massage parlour. Often sex workers have no opportunity to leave the workplace. Working hours may be irregular, and not fit within the opening hours of a clinic. In addition, the motivation to seek health care, especially prevention, may be low, since many other daily problems/issues may

require more attention than health. In these circumstances outreach work may well be an answer. In brothels, hotels, private houses and massage parlours, health consultations can easily be organised on the spot. In the case of street prostitution, health services may rent premises in a location nearby, and the outreach workers can take the street workers there to do a consultation. Services offered in outreach may cover all basic medical care, with screening of blood, urine and gynaecological smears. In an outreach project in Ghent, a doctor and a nurse started to do outreach including a gynaecological examination more than 12 years ago, and their services are highly appreciated in the sex worker community

Especially in areas where working places are not centrally located, but scattered in and around the city, it may be helpful to bring the medical examinations to the working places. In populated inner city areas with an accessible health clinic, these services may be given in the clinic.

Mobile units & mobile clinics

Sex workers lifestyles are often chaotic, with no permanent place of residence, loneliness and lack of a specific working place. Therefore healthcare professionals need to find innovative ways to reach the target group and deliver them medical and social services as mentioned above. Mobile units are vans with basic medical equipment where you are able to do a simple medical examination and Sexually Transmitted Infection (STI) treatment, a basic laboratory conducting basic STI testing as well as HIV and hepatitis testing. Also those services that offer social support can provide educative materials or at least to have a discussion with sex workers, try to assist and to resolve their problems. Such mobile units can be driven to the areas where street based sex workers are actually working, and have the advantage of being as mobile as the sex workers, so the van can move as the working beat may move. One of the draw backs with a mobile unit is that it can sometimes draw unwanted attention to the sex workers, from the police or local residents unhappy that sex is being sold in the neighbourhood. It is important that the van is discreet, try to avoid obvious external markings on the vehicle.

An alternative to an actual van or vehicle is to have a mobile or 'satellite' clinic. This is

where the health professionals can take what equipment they need to a non-clinical location, such as a drop-in centre near the working beat or a brothel or working flat, and operate a basic screening service, with some offer of examinations and testing/treatment. The advantage of this is that it can often be more discrete than a mobile unit, whose vehicle may be obvious parked in a public street, whilst still providing the clinical service or an innovative way that takes the clinic or some of its clinical services out to the target population, in a way as to engage them in screening and treatment programmes and interventions.

How much you are able to offer clinically in mobile units or satellite clinics will depend on local support services, types of screening tests used and diagnostic services available, which will vary from project to project, depending on local protocols and procedures. However, this can be an effective way to engage with sex workers in the delivery of screening and treatment services.

Use of Internet and new technologies

The usage of the Internet is becoming a more and more common instrument of how people communicate, as an information source, a tool to aid service delivery or just for fun. Sex workers are no exception. Some studies have already proved a high percentage of Internet users among sex workers (especially male sex workers) who want to be informed about their potential risks. Due to that, there has began a trend to disseminated on-line information about STIs and their prevention, safer sex, services contact information, etc.

Other technologies also need to be considered, other than just the use of the Internet or development of static websites, such as multi-media messaging, more dynamic video streaming websites, such as YouTube (where information or health promotion video clips can be uploaded), and Short Messaging Services (SMS) to cellular phones, particularly interactive text messaging, where sex workers may be able to receive reminders of appointments, or results of screening text direct to their mobile phone.

For projects/services interested in exploring ways of utilising new technologies for e-Health or e-Counselling with sex workers, see the Correlation resource '10 Golden Rules' (<http://www.correlation-net.org/products/cd/loader.swf>). This resource contains new

strategies for e-Health, examples, guidelines and methodologies to professionalise, software and good practices for e-Health and e-Outreach. The Ten Golden Rules enable projects/services to start electronic outreach and e-Counselling to serve groups that are difficult to locate, difficult to recruit into services or difficult to retain within a service, such as sex workers.

Health education: Innovative ideas for HIV/STI prevention

When considering health promotion and health education for STI and HIV prevention with sex workers, projects/services need to consider the purpose of such information. It should be considered across three board areas:

- 1. Prevention** – Provision of information and advice that may prevent a sex worker from acquiring an infection or health related problem due to the way in which they work, the types of sexual activity undertaken and/or calculated risks taken in the context of their work. This will mostly involve impacting information in a way that will inform and advise, thereby providing knowledge, within the context of the working situation, to empower the sex worker to make an informed choice about reducing the risks of acquiring an infection.
- 2. Treatment** – Provision of information regarding a sexual infection or health condition, usually given at the time of diagnosis within a healthcare or consultation setting. Such resources will often act as an aid memoir, a ‘takeaway’ with the information that should be covered during the consultation and treatment – the nature of the condition, how it was most likely contracted, the treatment/management of the condition, potential complications, potential risks to others, importance of partner notification, prevention initiatives to reduce the risk of becoming re-infected or acquiring the condition again, etc.
- 3. Containment/Maintenance** – The provision of information to prevent the onward spread or potential exacerbation of a particular clinical condition, as would be given to a sex worker diagnosed with a long term condition such as hepatitis C or HIV. This information should include the nature of the condition, how it was most likely contracted, the treatment/management of the condition, potential complications, potential risk of onward transmission and initiatives to prevent this, and the need to inform sexual contacts and partners.

When planning the development of health education resources or initiatives, projects/ services should engage with sex workers and make sure that the resources/initiatives under development are appropriate for the context in which sex is sold. Whilst it is important to ensure the resources/initiatives are clinically correct, with accurate and evidence based facts, language, images, and advice given need to be contextually correct or sex workers will not engage and the messages will not be received and understood by the intended target audience.

It is generally accepted that the provision of basic information leaflets has little or no effect on behaviour change in relation to reducing risks. If possible, health education initiatives should be multi-faceted and key underlying messages need to be delivered via different mediums at the same time, for example, linking messages to a national or regional health promotion campaign, so that at the same time as sex workers may be receiving messages aimed at the wider general population through small media (newspapers, journals, magazines) and mass media (television, radio, etc.), services/ projects can interweave these messages with initiatives which place the campaign in the context of sex work.

The giving of information is a key, but how that information is delivered should not be limited, and projects/services need to be innovative in the resources and initiatives used to impart the facts, although obviously it is accepted this may be limited by finances and local protocols. However, where there is the possibility of some scope, consider the development of resources appropriate to the sex working context, such as credit card laminated key facts on STIs that can be easily slipped in a pocket if distributed on the street or in a PSE outreach setting. For escorts and those working from private flats, a series of health education SMS text messages could be delivered to sex workers mobile phones, or for those working in saunas or brothels, peer educators may be trained to act as a conduit for information (see below).

Presence in the field – continuity, reliability and flexibility

Effective service/projects inspire confidence in their service users, and will soon gain a good reputation within the local sex working community. In order to build and establish this level of confidence, projects/services would do well to consider the following:

1. Continuity – It takes time to establish trust, and in order to do this, health professionals need to ensure continuity of service provision. This continuity needs to be on several levels – a continuity of services offered, be clear what and how clinical interventions are being offered, and have clear referral pathways e.g. if offering pregnancy testing, then pathways should be available for referral to obstetric or termination services. As well, the services offered need continuity in terms of sustainability, therefore do not offer pregnancy testing just because surplus funding allowed a batch load of test kits to be provided, but with no funding available to continue this testing once the kits have run out – women using the service will be despondent if they present for a pregnancy test late, and find that you no longer offer the test, when they have been tested through the service previously. Many sex workers, by the very nature of their experiences, are distrusting of officials (such as health or social care workers) and not used to receiving a service without reciprocation, therefore it is important to have continuity of a small team of regular staff, this allows for relationships of trust to be developed over time, as the sex worker is met in an outreach setting or attends the clinic. Even the most welcoming and sex worker sensitive mainstream clinics and services present a barrier to access simply because of the lack of continuity of staff, being so large, the sex worker can often see a different professional(s) on each visit, making it difficult to establish a rapport and trust.

2. Reliability – Projects/services offering medical services or clinics need to ensure that they provide these services in a reliable way. It is important that services are available at regular times, which should be advertised and then adhered to, for example don't claim to be a seven day service, if clinics are only actually available Monday to Friday. As with continuity, health and social care professionals need to provide reliable information and not make false promises – know your limitations and don't try to be all things to all people, it will only result in disappointment. It is important that whilst health professionals working with sex workers should have an understanding and appreciation of the sex working context, they are not expected to be 'experts' on sex work, and should not attempt to be so when working with clients – sex workers are very savvy and will soon see a bluff. Don't

be afraid to check information with the sex worker, particularly in relation to the context of their work. For any form of outreach to be effective, it needs to be reliable, sex will still be sold on the street come rain or shine, therefore not undertaking a street outreach session due to bad weather is not acceptable, in the same way clinical services need to build a reliable provision to gain the trust and be utilised by sex workers.

3. Flexibility – Most sex work by its very nature is chaotic and fluid, and when delivering sexual health services to sex workers, professionals need to adopt a degree of flexibility that might not usually be afforded to service users. It will be important to plan clinics around times that sex workers will be able to attend – early morning appointments may not be successful if the sex worker has been working in a brothel till 2am. Clinical sessions also need to be structured considering flexibility, such that they can accommodate sex workers who may present as walk-in without an appointment or arrive late for their appointments. Treatment protocols may also need to be flexible in their application, expecting a sex worker with an infection not to engage in sexual activity for the full term of treatment and recovery is unrealistic – instead information needs to be provided with regard to infection risk, onward transmission and risk reducing behaviours (such as condom use) that will prevent onward transmission and allow for effective treatment to succeed.

Specific or general service provision (confidentiality, anonymity, free to access)

In general, society tends to hold a negative perception of sex work, and therefore of sex workers – most of these perceptions are based on the media presentation of sex workers being young women from disadvantaged backgrounds, plying her trade to ‘dirty’ old men on the streets, for money to support her drug abusing habit. ‘Ordinary’ citizens therefore begin to think of sex workers as unreliable, undesirable, unacceptable, a social problem to whom they look to the ‘state’ to solve. With the increasing right wing governmental responses and policy towards the regulation of sex work across Europe, and the increasing media and feminist portrayal of women as victims of sex abuse (by men) who need “rescuing”, who have often been trafficked into sex work, there is an increasing public perception of sex workers as disempowered abused victims. Both of these perspectives present highly stereotypical misconceptions of the reality of most sex

work, and neither recognise that men and transgender sex workers also work in the industry.

However, many sex workers themselves also recognise these perceptions and by osmosis therefore absorb these negative feelings and increasing feel stigmatised, which can be a significant barrier to accessing health services, believing that health and social staff will hold similar views. Therefore services which are sex worker specific can help offer reassurances to sex workers that the workers within these services are better informed, non-judgemental and will have a greater understanding of the local context of sex work and the local industry.

There are arguments however that main stream or generic services should also operate a non-judgemental approach to service users/patients, so no matter their personal circumstances, all service users/patients should be treated with equity and be able to access services without fear of recrimination of their lifestyle choices. Offering health services to sex workers that are linked/part of a wider generic service or are specific to the sex worker are both acceptable models, and in relativity, the model used or developed will depend very much on the local organisation of health and sexual health services and the context of the locality in which services are being offered. However, which ever model is utilised, the projects/services need to ensure they guarantee:

1. Confidentiality – in some countries (such as the United Kingdom) there will be statutory regulations in place that guarantee absolute anonymity and confidentiality for sex workers accessing sexual health services. Where such statutory regulations may not be in place projects/services would need to develop a policy of confidentiality and ensure that sex workers are made aware that the policy is applied in practice – offer reassurances that information obtained on the service user/patient will not be shared with a third party without their consent, except in exceptional circumstances, and make clear what those are (e.g. child protection issues).

2. Anonymity – Even where a strict confidentiality policy is in practice, some sex workers, especially those migrants with visa status issues, will still have anxieties about the recording of personal information. It is therefore best practice to guarantee anonymity within services, reassurance service users/patients that they do not have to provide ID papers or documents, do not need to use real names, and that information is not

shared with other authorities, such as immigration service. Allow sex workers to use their working or stage names, and don't pressure them to provide lots of personal information, especially at initial registration stages. However, it is also important to encourage those sex workers who use false information to record what registration details they have used, to ensure continuity of care should they return to the clinic again, in order to find their medical records. Some countries are now using advance in technology to allow the patient to maintain their own records on an electronic card, such patient held records give the sex worker direct control over the personal information recorded on them.

Contrary to common belief, sex workers often have no cash available and health care needs may be a lower priority than, for example, food or housing. When offering preventive services, such as health education materials, discussing the risks of certain sexual techniques, or screening for STI for early diagnosis, the initiative often comes from the health/outreach worker. Many sex workers are not in possession of the correct paper work for coverage by health insurance. For these reasons a free access policy will lower the barrier considerably. Providing free preventive and treatment services is in the interests of the sex worker and the public health.

Peer education and cultural mediation

Research suggests that people are more likely to hear and personalize messages, and thus to change their attitudes and behaviours, if they believe the messenger is similar to them and faces the same concerns and pressures (Ziersch, Gaffney, & Tomlinson, 2000). Peer education is a term widely used to describe a range of initiatives where people from a similar: age group, background, culture and/or social status educate each other about a variety of issues. Numerous studies have demonstrated that their peers influence youth's health behaviours—not only in regard to sexuality but also in regard to violence and substance misuse. Peer education draws on the credibility that young people have with their peers, leverages the power of role modelling, and provides flexibility in meeting the diverse needs of today's youth. Peer education can support young people in developing positive group norms and in making healthy decisions about sex.

The theoretical concepts outlined above in relation to peer education with youths have also been applied to other populations, including drug users, gay men and sex workers,

and shown to have a similar effect, that is supporting such populations in developing positive group norms and making healthy decisions to reduce work, through safer drug use and using condoms for penetrative sex.

It has been observed how higher mental functions develop through social interactions with significant people in a child's life, particularly parents, but also other adults. Through these interactions, a child comes to learn the habits of her/his culture, including speech patterns, written language and other symbolic knowledge through which the child derives meaning and it turn effects a child's construction of his or her knowledge. This key premise is often referred to as cultural mediation. Again, application of this concept has been shown have a place when working with sex workers, particularly in some of the more organised forms of sex work, such as the brothel, where a more experienced sex worker trained as a cultural mediator can be a useful link, introducing health/outreach workers to new sex workers within the brothel. Such individuals can also 'role model' safer behaviours and influence the cultural norm within the working environment.

However, as in the previous section on preparing for service provision, care needs to be taken to ensure that projects/services are not abusing the involvement of sex workers, and that peer educators and cultural mediators should not take the place of regular outreach workers. However, such positions may often be a conduit to greater involvement in the provision of services by sex workers and can be used as a way of gaining relevant experience that may lead to paid positions within projects/services.

Gadgets and gimmicks

In today's increasingly image conscious society, branding and marketing are becoming increasingly important when providing services. Social marketing concepts can be used when planning healthcare interventions with sex workers. Having an intriguing name and designing an attractive logo for your service or clinic is a way of beginning to create a brand that will help to position the intervention within the consciousness of your target population.

Where finances and local protocols allow, you may want to consider development of other marketing 'products' to help raise the profile and 'image' of your brand. Using

logo's and web site URLs or telephone numbers will allow for recognition of the 'brand' whilst not necessary needing to make reference to sex work, which may prevent engagement with the product by the sex worker. However, this does give scope to be creative when developing resources, that may be retained by sex workers longer than a simple business card or service leaflet. Examples of products that are useful for sex workers and can be branded with your logo and contact details for little outlay include: pocket condom cases, mobile phone covers, match boxes, cigarette lighters (although you may want to consider the negative message this could portray that you endorse smoking), umbrellas, waist/belt bags, etc.

Continuous presence in area

Starting health services for sex workers in a certain area may often be on a pilot or trial basis, however, from the beginning the aim should be that if successful, a structured funding stream should be available to maintain the intervention.

A sex worker community is very dynamic, and every week new sex workers come in and others leave the community. Once you are familiar with the environment it is easier to see if newcomers have arrived, and to contact them whilst still new to sex work, when health education is thought to have the most influence.

One strategy could be to visit all working environments in your area on a regular basis, and to keep records/notes on who is working there. Some sex workers regularly change work places in the area. If you are doing a vaccination campaign, you can pick up some 'lost for follow-up' people through a regular presence in the local area. In other words, you should become a consistent player in the sex industry milieu.

Quality standards, evaluation and documentation

It is extremely important to maintain accurate records of all aspects of your work, and in most countries, a legal requirement to maintain medical records to certain standards and the storage of and access to those records will be dictated by statute. In addition to the medical records pertaining to the clinical services, services/projects would also be advised to maintain records of all outreach activities, including sex workers contacted,

whether known to the team or new, issues discussed and resources/safer sex materials distributed. For those service/projects that may run a drop-in or social support service in addition to clinical services, similar records should be maintained for these activities.

It is important for services/projects to develop a local protocol for record keeping. This should include agreement/guidance of what information will be recorded, why, where and for how long, and this information should be made known to the sex workers using the service. Where record sheets or databases are to be used for recording information, such protocols will be useful for developing templates and codes, which aid in the consistency of data recording, which will assist in subsequent audits of the recording information. Projects/services should consider why they are recording information to ensure they only collect what will be use, when audited to demonstrate their level activity or identify changes in reported behaviours within the sex working population.

Regular audit and analysis of the recorded data will help to ensure the quality of the interventions is maintained. Outcomes can be compared to the aims and objectives of the intervention or initiative, and this can be reported to funding bodies or published through annual reports to other services. Other factors such as detected rates of STIs from screening programmes, completion rates of vaccination programmes and numbers of condoms distributed can also be analysed and reported as quality markers. Regular feedback from service users, through comment cards or surveys should also be considered and encouraged, to check the service is meeting their needs and expectations and identify gaps that may require the development of new interventions.

Whilst there is no European regulatory body for services working with sex workers, in many member states there will be accreditation bodies for healthcare provision, and it is important that where such regulators exist services/projects comply with their standards. Membership of national or regional forums can also help maintain quality, as often such forums will have good practice guidelines, that can be used as measures of best practice that services can adhere to. Peer review from similar or like minded services/projects can also be helpful, and should be considered as facilitative, and not regarded with suspicion, as recommendation from such reviews can help to maintain standards and argue with funders for greater resources or capital developments.



Sexually Transmitted Infections (STI) & Human Immunodeficiency Virus (HIV)

The risk of acquiring a Sexually Transmitted Infection (STI) during sex work varies a lot even across Europe. Epidemiological research for HIV shows a low prevalence of HIV in sex worker populations in Europe, with the exception of IV drug users, where the risk lies in the sharing of contaminated injecting equipment, and in migrant sex workers from HIV endemic countries, who mostly acquired their infection not from sex work in Europe, but in their country of origin (Ward, Day, Mezzones, Dunlop, Donegan, & Farrar, 1993).

For other STIs there are less consistent data, but several studies show that the risks for an STI in sex workers is more related to unsafe sex with their private non-paying sexual contacts, rather than from paying sexual contacts (Sethi, Holden, Gaffney, Greene, & Ward, 2004). However, several studies have identified multiple (usually defined as more than two sexual partners in the last year) and concurrent sexual partners as risk factors for acquiring STIs, but those working in the field realize from practical experience it has more to do with the type of sexual activity practiced rather than number of sexual partners.

Unfavourable living and working conditions may also influence risk taking behaviours. In addition there is an intrinsic risk related to sex work, since condom failure is not exceptional, which may bring the sex worker in contact with body fluids from a person of unknown STI

status. A condom will not protect against all infections (such as herpes simplex virus (HSV) or human papilloma virus (HPV) – warts) or infestations such as scabies or pubic lice, so STIs are therefore considered as an occupational risk.

Other risk factors for STIs include: recent partner change (in past 3 months); non use of condoms; infections in sexual partners; presence of other STI; and, younger age (<25 years). In addition to these risk factors, epidemiological studies have also identified risk markers, which include: residence in or travel to a high prevalence area; low socioeconomic status; single (no regular sexual partner); and, previous STIs.

Therefore such factors and markers should be considered when assessing a sex workers risk of acquiring an STI. Evidence that suggests an STI may be present also includes:

- New genital symptoms have developed, particularly after recent sexual contact
- Following a sexual assault or rape
- If the sex worker is particularly young (teenager)
- If there are any signs of symptoms of an classic STIs (see later in this chapter)
- If there is any lower abdominal and pelvic pain/symptoms
- If the patients report dyspareunia (pain/discomfort when passing urine)
- If painful testicles (swelling and acute pain) in a man <35 years
- If any lumps, lesions or growths are seen in the genital area

In order to assist with risk assessment, it is essential to take an accurate history from the sex worker, which should include any signs and symptoms experienced by the sex worker if presenting with a problem, nature and duration of such symptoms. Document if asymptomatic, and note numbers of recent sexual partners, whether paying or non-paying, and country of original/contact with these partners (to assess whether recent sexual contact(s) are from a high prevalence area – current information on high prevalence areas can be obtained from the UNAIDS website (UNAIDS, 2007).

It will be important to document accurately the type of sexual activity which has occurred with recent sexual contacts, including whether a condom or barrier method was used, and if not, whether bodily fluids were exchanged. In order to assist health workers with such an assessment, the table found in appendix A draws together known risk factors for particular infections based on type of sexual activity and the sex workers role within that activity.

Screening and testing

“Screening is a public health service in which members of a defined population, who do not necessarily perceive they are at risk of, or are already affected by a disease or its complications, are asked a question or offered a test, to identify those individuals who are more likely to be helped than harmed by further tests or treatment to reduce the risk of a disease or its complications.”

UK National Screening Committee (2007)

Criteria for appraising the viability, effectiveness and appropriateness of a screening programme should be based on the WHO Report (Wilson & Jungner, 1968).

The following criteria should be met before screening for a condition is initiated:

The condition - should be an important health problem [HIV and STIs are some of the largest global health challenges]. The epidemiology and natural history of the condition, including development from latent to declared disease, should be adequately understood and there should be a detectable risk factor, or disease marker and a latent period or early symptomatic stage [these conditions are met with regard to HIV and STIs, the presence of various clinical indicators are reliable disease markers that an individual has acquired the infection]. All the cost-effective primary prevention interventions should have been implemented as far as practicable [public health campaigns continue to encourage safer sexual practices, safer intravenous drug use practices and screening of all human blood and tissue products to prevent the spread of the infection].

The Test - There should be a simple, safe, precise and validated screening test. The distribution of test values in the target population should be known and a suitable cut-off level defined and agreed [we are now on our fourth generation of HIV antibody screening tests, which met these criteria, for most other STIs there are also agreed and clinically validated diagnostic tests]. The test should be acceptable to the population [with recent advance in DNA technology, Nucleic Acid Amplification Test (NAAT) based diagnostics allow many STIs to be diagnosed from easily obtained, mostly non-invasive sampling methods (such as analysis of urine samples or self-taken vaginal swabs). Point of Care Testing (POCT) offers reliable, safe, easy to use, relatively non-invasive, and rapid detection of HIV antibodies]. There should be an agreed policy on the further diagnostic investigation

of the individuals with a positive test result and on the choices available to those individuals [there is access to appropriate treatments and follow up through a wide network of GUM or venereology clinics in and across the European Commission, to whom patients with reactive tests can be referred or follow up for treatment and care].

The Treatment - There should be effective treatment or intervention for patients identified through early detection, with evidence of early treatment leading to better outcomes than late treatment [there is clear clinical evidence to demonstrate the longer term health gains of diagnosis with HIV, and regular follow up, within the first two years of acquiring the infection. This is the same for most other STIs, indeed early diagnosis of some forms of cervical Human Papilloma Virus (HPV) had also been shown to reduce risk of cervical cancer]. There should be agreed evidence based policies covering which individuals should be offered treatment and the appropriate treatment to be offered [in many of the member states, there are nationally published treatment guidelines for HIV and STIs, and health professionals providing screening services should ensure they are familiar with and adhere to these guidelines]. Clinical management of the condition and the patient outcomes should be optimised by all health care providers prior to participation in a screening programme [it is therefore essential that all health professionals offering health services, particularly sexual health screening to sex workers are aware of the benefits of screening].

Health/outreach workers should have some idea of the local epidemiology of STIs in the sex worker population where they are providing services. General background data of the epidemiology of the population, and of the clients of sex workers are of equal importance. This knowledge may guide practitioners to the choice of screening tests, against national screening guidelines (where they exist). The decision will also depend on the organisation of the health services in your area. There is a range of health service delivery across Europe from hospital based clinics to outreach services with diagnostic facilities. Practitioners should decide what is a basic screening set in their area both for men and women. For example, serologic testing could include HIV, syphilis, hepatitis B virus (HBsAg, anti-HBs, anti-HBc), hepatitis A virus (HAV) and hepatitis C virus (HCV). Urine testing could include chlamydia and gonorrhoea. If further testing is possible, cervical, urethral, anal and throat swabs could be taken for gonorrhoea and chlamydia, and vaginal swabs for trichomonas, candida and bacterial vaginosis. A cervical smear could complete the set of tests, given

the relation between HPV and cervical cancer.

However, the epidemiological characteristics of a group cannot be assumed to be the same for every individual belonging to this group. During assessment you should make an estimate of the risk of the individual sex worker and his or her use of existing services. Maybe s/he is only working part-time, is a consistent condom user, did not recall any condom failure in the last period of sex work, and does not use any intravenous drugs. Maybe this sex worker accesses other services, for example a gynaecologist for her cervical smear. In general, if any test is done, it should be with the full consent and understanding of the individual sex worker. Deciding to test for STIs is done together with the sex worker, and implies individual risk assessment. Only in this way will appropriate risk assessment information be imparted to the sex worker enabling them to make informed decisions about risk taking. In less ideal circumstances, where communication with the sex worker is difficult, e.g. when there is not enough time, when there is a language problem, knowledge of the epidemiological context enables you to select the necessary tests. If some sex workers have barriers to reporting anal sex (which is the case in some cultures), but research shows that many sex workers may have rectal infection, you may communicate this to the sex worker and offer anal tests.

It would be inappropriate in a generic document such as this to attempt to make recommendations against the specific epidemiological data of individual regions, besides which, surveillance information would suggest that rates and patterns of STIs in sex working populations, in different regions is dynamic and ever changing, and therefore such recommendations would become out-dated quickly. However, to assist in areas where such data may not be readily available, the following list of individual sexually transmitted infections (adapted from BASHH screening guidelines (Ross, Ison, Carder, Lewis, Mercey, & Young, 2006)) makes specific screening and testing recommendations in relation to sex workers:

Gonorrhoea – infection of mucosal surfaces with *Neisseria gonorrhoeae* may be, and often is, asymptomatic. Screening procedures/protocols are influenced by sexual history. A wider number of sites may need to be tested in symptomatic compared with asymptomatic individuals to include the symptomatic sites. A history of condom use for intercourse is generally not an indication to omit screening for gonorrhoea. Test all sites

potentially exposed to infection as indicated by sexual history. Testing should generally proceed at sites apparently protected by consistent condom use.

Chlamydia trachomatis – owing to the frequent asymptomatic nature of genital *C.trachomatis* there is no difference in the screening guidelines for those showing symptoms to those who do not. Women should have cervical or vulval-vaginal (clinician or self taken) or first catch urine should be tested using a NAATs. For men, urethral swabs or first catch urine should be tested using a NAATs. Test of Cure (TOC) is not routinely recommended if standard treatments have been given, there is confirmation the patient has adhered to therapy and there is no risk of re-infection. However, if clinically indicated, ideally there should be a minimum of 3-5 weeks post treatment, as NAATs will demonstrate residual DNA/RNA even after successful treatment of the organism.

Syphilis – serological screening is recommended, and in patients presenting with primary or secondary lesions, direct detection of *T.pallidum* by examination of lesion exudate under dark ground microscopy. Recommended sites for testing with sex workers include clotted blood (serological screening), ulcer material (primary syphilis) and lesion material (secondary syphilis). The frequency of repeat testing depends on the sexual history, particularly type of sexual exposure and number of sexual partners. High risk exposure would include unprotected oral, anal or vaginal intercourse with a high risk partner, e.g., a partner suspected or proven to have syphilis, homosexual male with multiple partners, anonymous partners in saunas or other venues, partner just arrived from or living in a country of high prevalence of syphilis – therefore most commercial sex work would be considered 'high risk'. A repeat test is recommended in high risk groups three months after exposure.

Bacterial vaginosis (BV) – is a very common condition causing distressing vaginal symptoms, particularly an unpleasant discharge. A high proportion of women with BV are asymptomatic. BV has been associated with serious health outcomes including adverse pregnancy outcomes such as preterm delivery and low birth-weight babies as well as increased risk of pelvic inflammatory disease (PID) and post-abortion sepsis. BV has also been linked to increased rates of HIV acquisition. The aetiology is unknown but BV is associated with a change in vaginal ecology, resulting in an over growth of certain bacteria such as *Gardnerella vaginalis*. There are a variety of tests, which reflect the changes in

vaginal ecology, which can be used to diagnose BV, but there are two key diagnosis methods recommended for use in clinical practice, which require interpretation within the given clinical scenario of the presenting patient. Amel's criteria is dependant on the presence of three or more of the criteria considered consistent with BV, including: typical appearance of discharge at vaginal examination; vaginal discharge pH >4.5; positive 'whiff' test following the addition of potassium hydroxide to a sample of the discharge; and, clued cells on dark-ground microscopy of a saline mount preparation. The other most effective diagnostic test is the appearance of Gram-stained smear according to modified Ison-Hay scoring system, as follows:

| | |
|------------------|---|
| Grade 0 | epithelial cells with no bacteria |
| Grade I | normal vaginal flora (lactobacillus morphotypes alone) |
| Grade II | reduced numbers of lactobacillus morphotypes with a mixed bacterial flora |
| Grade III | mixed bacterial flora only, few or absent lactobacillus morphotypes |
| Grade IV | Gram positive cocci only |

Grade III above is consistent with BV. Screening is recommended in women presenting with a vaginal discharge, an offensive odour or any genital symptom; women found to have a copious discharge at examination; pregnant women with a history of previous pre-term labour (there is insufficient evidence to support routine screening of pregnant women without symptoms); women prior to a termination of pregnancy. Vaginal wall smear should be obtained following insertion of the speculum.

Chancroid – caused by infection with *Haemophilus ducreyi*, characterised by ano-genital ulceration and lymphadenitis with progressive bubo formation. It has a short incubation period (3-10 days) and is considered a tropical STI, rarely seen in Europe. Testing is recommended in all cases of ano-genital ulceration acquired overseas in areas of the world where chancroid is prevalent including Africa, Asia, Latin America, parts of the USA and the Caribbean. Tests should allow for isolation of causative agent *Haemophilus ducreyi*. Swab of exudate from the ano-genital ulcer should be plated on an appropriate culture media. NAATs are currently under development, but there are no commercial tests available as yet, however, experimental tests may be accessed through research laboratories. Microscopy

and serology are not recommended in direct patient management. Recent travel by an index patient with genital ulceration (or his/her sexual partner) to a part of the world where chancroid is endemic suggests that *H. ducreyi* infection should be considered as a cause of genital ulceration. The presence of a bubo will require aspiration to obtain a sample of ulcer material.

Donovanosis (granuloma inguinale) – is caused by infection with *Klebsiella granulomatis*, which produces ulceration at the primary site on inoculation which is usually genital but may be oral or at extra-genital locations. Prominent local lymphadenopathy can cause further ulcerative lesions in the skin overlying the nodes involved, and absence of treatment may lead to local spread, lymphoedema and genital mutilation. Another tropical STI, the disease is rare in Europe, but endemic in areas of India, Papua New Guinea, among Australian aboriginals, Brazil and South Africa. Screening is recommended for patients presenting with usual forms of ulceration where other causes have been excluded and a suggestive travel history (or that of recent sexual partner) is obtained. Diagnosis is usually by microscopy, detection of Donovan bodies, or through biopsy of removed friable tissue from lesions, using a 3-5mm punch or snip biopsy – this requires specialist diagnostic microscopy and patients are usually best managed in regional specialist units, as culture and NAATs tests are also not routinely available.

Lymphogranuloma venereum (LGV) – is caused by invasive serovars of *Chlamydia trichomatis*, and L1-3 strains cause considerable disturbance in the local lymph nodes of genital infection, creating characteristic painful swelling in the inguinal lymph nodes. Historically, patients would have acquired infections through travel to Asia, Africa, South America or the Caribbean. However, in recent years there have been a number of significant outbreaks in western Europe, acute proctitis is the key presenting symptom, with constipation, tenesmus and rectal discharge, and where lymphadenopathy is rare, particular in MSM and HIV positive gay populations. Widespread screening is not recommended, but testing for LGV is recommended when patients: present with an acute proctitis who have been at high risk; presenting with inguinal buboes (inflammatory lymph node swellings in the inguinal-femoral lymph gland group), and a suggestive travel history; patients with manifestations of late stage disease; and sexual contacts of confirmed cases of LGV. The method of choice is laboratory diagnosis by detection of *C. trachomatis* by NAATs, then specific DNA testing of the serovars L1-3 using real-time PCR. Sites for

testing include: ulcer material (if ulcer present); lymph node aspirate (may require injection and re-aspiration of saline); lymph node biopsy; rectal swabs (if proctitis is present); urine; urethral swab; rectal biopsy tissue; and/or clotted blood (for serology). Sites for testing will be determined by the clinical presentation and health professionals should consult with laboratory colleagues and specialists with regard to most suitable testing method. Patients should be screened if: they have a history of travel to, and sexual exposure in, an LGV endemic country by the index patient or his/her partner; MSM with high risk behaviour, in particular attendance at sex parties, anonymous sex, fisting and use of enemas; and, patients who are known contacts of the infection. Test of cure is necessary and should be provided 3-5 weeks after treatment. For those few patients who may extensive lesions or fistulas as a result of late treatment, surgical intervention may be required.

Trichomonas vaginalis (TV) – is a sexually transmitted protozoal parasite, and a common cause of vaginal discharge in women, in whom it may cause vulval irritation and inflammation, dysuria and inflammation of the exo-cervix. Most men, whilst believed to be carriers, are usually asymptomatic, although it has been associated with dysuria and urethral discharge. TV is associated with low socio-economic status and is more prevalent in developing countries. Diagnosis is most commonly by wet-mount preparation microscopy, which is 70% sensitive, but culture techniques are still regarded as the most sensitive and specific, however, PCR assays are currently in development, although not as yet commercially available. T.vaginalis is associated with adverse pregnancy outcomes and facilitation of the sexual transmission of HIV, however, further research is required to confirm these associations and at present screening of asymptomatic individuals for T.vaginalis is therefore not currently recommended. Women complaining of vaginal discharge should be tested for T.vaginalis and it is generally recommended that partners of infected women should be epidemiologically treated. A swab should be taken from the posterior fornix at the time of speculum examination. Men with urethral symptoms which persist after infection with gonorrhoeae, C.trachomatis and M.genitalium have been excluded or treated should be tested for T.vaginalis. Urethral swab or first catch urine samples are recommended. Test of cure is only required in those patients with symptoms that persist after treatment.

Vulvovaginal Candidiasis (vaginal thrush) – screening is not required for asymptomatic women. In the context of uncomplicated vulvovaginal candidiasis, routine microscopy

and culture is the standard test for symptomatic women, with a vaginal swab taken from the anterior fornix during speculum examination. Test of cure is only indicated after the treatment of persistent infection, and requires at least two negative cultures at least a week after treatment and with an interval of at least a week between cultures.

Genital Herpes Simplex Virus (HSV) – is the fourth most common sexually transmitted infection in the UK. There are two main types of herpes: HSV-2 is almost entirely associated with genital disease whereas HSV-1 is associated with both oropharyngeal (cold-sores) and genital disease. Differentiating between the genotypes may be helpful, as HSV-1 shows a milder natural history than HSV-2 and both symptomatic recurrences and asymptomatic sub-clinical shedding are less frequent. It is a life-long infection that can cause substantial morbidity to those infected and have serious consequences including neonatal herpes and increased risk for HIV acquisition and transmission. Screening of asymptomatic patients by either serological antibody testing or HSV detection in genital specimens is not recommended at present. Testing can be through assays used to detect antibodies against the antigenically unique glycoproteins gG1 and gG2, or by detection of HSV in genital lesions from cell culture or DNA detection using PCR. The recommended test will depend on: direct detection of genital lesions that could be due to HSV; antibody testing where history of recurrent genital symptoms of unknown aetiology when direct detection methods have repeatedly been negative; and, serological screening in asymptomatic partners of patients with a known HSV diagnosis where there is concern of transmission.

Hepatitis A, B and C – These three viruses cause acute infection of the liver that may manifest as an acute illness. Most cases are diagnosed only in retrospect on serological screening, and Hepatitis B and C can persist as chronic infections.

Hepatitis A virus (HAV) – is transmitted faeco-orally, therefore sexually is most likely transmitted by oral-anal contact (rimming). Diagnostic tests for HAV are recommended in anyone presenting with an acute illness or raised transaminase levels, suggesting acute hepatitis and in contacts of known cases (sexual, household or other close contacts). Screening of asymptomatic sex workers is recommended to ascertain their immune status and see if they meet the criteria for hepatitis A vaccination (where available).

Hepatitis B virus (HBV) – is transmitted vertically (mother to child), parenterally and sexually, but there is a much lower risk of household transmission, unless contacts of acute cases or highly infectious carriers. Those of greatest risk are MSM and injecting drug users, with an incubation period of 40-160 days with symptoms lasting up to 12 weeks. With a high proportion of infected adults being asymptomatic, however 5-10% of healthy and up to 40% of immunocompromised individuals will develop chronic infection. Infectivity usually lasts from approximately two weeks before the onset of jaundice until the loss of infective markers. Cirrhosis or cancer of the liver may develop in up to 20% of chronic carriers over a 10-50 year period.

Tests for HBV markers serve the dual purpose of diagnosis of those currently infected, and screening of those who are immune by natural infection, or identification of those who are still susceptible and should be vaccinated. Testing is recommended for anyone presenting with suspected acute hepatitis and those with the signs and symptoms of chronic liver disease, or abnormal liver function tests consistent with an acute or chronic hepatitis. Screening of asymptomatic sex workers is recommended to determine who should be given vaccine if susceptible. Tests used should be able to determine those who are already immune to infection, those who are currently infected (most will be chronic carriers), those who are naïve and require vaccination, and the antibody status of those with a history of previous vaccination.

Hepatitis C virus (HCV) – is mainly transmitted parenterally, although it is known that the virus can be transmitted sexually and vertically. Acute symptoms are rare at time of infection (less than ten percent of cases) with most infections developing a chronic infection (60-70%). As with HBV, cirrhosis and cancer of the liver can occur in about 20% of chronic carriers over a 10-50 year period. Diagnostic testing is recommended for any sex workers who present with a suspected acute hepatitis or for those with symptoms of chronic liver disease, such as jaundice, or abnormal liver function tests (LFTs). Routine screening is recommended if sex workers are also members of an identified ‘risk’ population, being those who currently or have previously injected intravenous drugs, recipients of blood/ blood products, needle-stick recipients, HIV positive sex workers and sexual partners of those known to have HCV.

Testing should be done using a second or third generation ELISA anti-HCV or other immunoassay, and a positive result should be confirmed using a HCV RNA based test. Like with HIV, seroconversion for Hepatitis C can take up to 3 months, so antibody tests can give a false negative result when patients present with an acute hepatitis, however, detection of HCV RNA by a reverse transcriptase polymerase chain reaction (RT-PCR) or other genome amplification test will establish or exclude the diagnosis within a symptomatic patient at this time, and is effective as early as two weeks after infection. HCV-RNA tests should be repeated after 6 months to confirm whether the infection has become chronic.

Vaccination – should be offered to sex workers to protect against risks of hepatitis A and B infections (there is at time of writing no vaccination available to offer protection against hepatitis C). There are arguments for giving the initial dose of vaccination at the time of taking blood for screening, even before the results are known, as the vaccines are synthetic and will cause no adverse affect to a chronic carrier or someone with acquired immunity, benefiting the sex worker from reduced clinic visits, and increasing the chance of the sex worker completing the vaccination course. However, where resources are limited, projects/services may want to reduce the risk of giving an unnecessary vaccine dose if the serology shows acquired immunity, chronic infection or previous vaccination, and therefore not requiring vaccination. Many people are also needle phobic, so reducing the number of ‘needle’ punctures may be of benefit to such sex workers. Vaccination for hepatitis A can be given at time 0 for immediate protection and boosted at time 6 months for more lasting protection – there is no requirement for repeat serology after vaccination. Hepatitis B is given in 3 doses, using either the rapid regime (of benefit to ensure completion of the course with sex workers) of time 0, 7 days and 21 days. Alternatively, the more traditional course of time 0, 1 month and 2 months can be used, in both cases repeated serology to confirm success and protection should be undertaken 6-8 weeks after the final vaccine dose is administered, and with the rapid regime, a booster vaccine at one year is recommended. An antibody titre level of $>10\text{ mui/ml}$ is now considered to provide adequate protection against hepatitis B virus, and if the rapid regime has been used titre serology should be repeated after one year. In the case of sex workers, it may be advisable to repeat this serology on a yearly basis. If the titre post vaccination is $<10\text{ mui/ml}$ or after some time has lapsed, a booster dose of vaccine maybe offered, and serology repeated 6-8 weeks thereafter. Vaccination is something that can easily be offered in an outreach or community location, and projects/services working with sex workers should explore

the possibility of taking vaccination to sex workers, rather than expecting sex workers to come to the clinic for this. Use of a hepatitis log book or 'passport' may also help to ensure completion of vaccine course (it's a resource the sex worker can retain as a personal record and take from clinic to clinic if highly mobile).

Anogenital warts (human papilloma virus – HPV) – Anogenital warts are caused by the human papilloma virus (HPV), of which there are over 90 HPV types sequenced, although type 6 and 11 are thought to be the main cause of anogenital warts. These are referred to as low- risk HPV types because of the low or absent risk of cancer. Whilst there are numerous oncogenic (cancerous) types of warts virus, 70% of all cervical cancers are associated with HPV types 16 and 18, but it should be noted these are not the types of HPV which cause common anogenital warts. All sex workers attending for a screening should be assessed during examination for the presence of anogenital warts, regardless of sexual orientation or practices. Size, shape, number and location of any exophytic warts should be noted. Proctoscopic examination and noting of intra-anal warts in sex workers who have symptoms such as rectal bleeding or irritation, except for HIV positive sex workers who engage in rectal penetration, where routine proctoscopy is recommended, due to the increased incidence of anal carcinoma. It is difficult to distinguish anal intraepithelial neoplasia (AIN) from ordinary warts, and positive patients with anal warts should be referred for surgical biopsy. Diagnosis in clinical practice is mainly by visual examination using a good light source and if needed, aided by a magnifying glass, there is no need for HPV typing in routine practice. Where there is doubt to diagnosis, application of 5% acetic acid for examination of “aceto-white” lesions may occasionally justify the need with dysplastic warts to be biopsied, or to exclude warts as a diagnosis. There is however a high false-positive rate with the “aceto-white” test and it should not be used for routine screening. There is no requirement for test of cure, patients should be advised to self-refer if new lesions appear post treatment.

Vaccination – Two vaccines have recently been approved for use across Europe in the prevention of warts virus. Both are designed to be given before an individual is potentially exposed to the virus through engagement in sexual activity, and because of the association with warts and cervical intraepithelial neoplasia (CIN), are specifically targeted at girls. At the time of writing these guidelines, the national screening guidelines in the UK are only recommending vaccination for girls. There is debate and controversy with regard as to

whether boys should also be vaccinated (as the vector of infection in young women). There is further controversy as to what benefit the vaccines may offer adults, who have already engaged in sexual activity and may have been exposed to the virus, again, guidelines will vary at a national level, but for most of the adult sex workers many projects/services work with, access to this vaccine will most likely only be via a private clinic and they will need to pay for it.

Human Immunodeficiency Virus (HIV) – it should be routine practice to offer all sex workers an HIV test as part of normal STI screening. It is recommended that all new patients have a baseline HIV test done at time of attending a screening service and if necessary be repeated at 3 months from the time of any risk activity. People exposed to HIV should not be fully reassured until at least 3 months have passed during which they remain sero-negative (window period). The presence of clinical features suggestive of HIV infection (see box 1) or a particular increased risk should be noted (see box 2). Sex workers asked to return 3 months after suspected high - risk activity for HIV transmission frequently fail to re-attend. Thus, testing of such individuals should not be delayed for 3 months – recommend a baseline test and advise a repeat test at 3 months. Not delaying the initial test is particularly important in those at high risk of infection, previously untested individuals and those who are unwell or who may be seroconverting. In cases where HIV post-exposure prophylaxis (PEP) has been given a final 6 - month follow-up HIV test is recommended due to the fact that anti-retrovirals may delay seroconversion and detection of HIV antibodies. Those who exhibit clinical symptoms (of symptomatic HIV infection or seroconversion) should normally be assessed clinically by a senior clinician familiar with HIV medicine in order to ensure appropriate immediate investigation and management, including referral to a specialist centre if required.

Clinical Features That May Suggest Increased Risk Of HIV Infection

- Suspected primary infection with a seroconversion illness
- Any unusual manifestation of bacterial, fungal or viral disease:
 - infection with tuberculosis; suspected *Pneumocystis jirovecii* pneumonia; or suspected cerebral toxoplasmosis
 - oral/oesophageal candidiasis or oral hairy leucoplakia
- Persistent genital ulceration
- Presence of another blood borne or sexually transmitted infection, e.g. syphilis, hepatitis B, C
- Unusual tumours e.g. cerebral lymphoma, non-Hodgkin's lymphoma or Kaposi's sarcoma
- Unexplained thrombocytopenia or lymphopenia
- Unusual skin problems such as:
 - severe seborrheic dermatitis, psoriasis or molluscum contagiosum
 - re-occurring herpes zoster, multidermatomal herpes zoster or herpes zoster in a young person
- Persistent generalised lymphadenopathy or unexplained lymphoedema
- Neurological problems including peripheral neuropathy or focal signs due to a space occupying intra-cerebral lesion
- Unexplained weight loss or diarrhoea; night sweats; or pyrexia of unknown origin
- Any other unexplained ill health or diagnostic problem

Groups At Increased Risk And/Or Who May Require More In Depth Discussion

- Those at high risk of HIV infection
 - men who have sex with men
 - injecting drug users
 - people from countries with a high prevalence of HIV infection e.g. sub-Saharan Africa, SE Asia , Belize, and parts of Eastern Europe (UNAIDS, 2007)
 - sexual partners of the above
- Patients with a psychiatric history/ high level of anxiety/ sexual or relationship issues
- Sexual assault victims
- Those with occupational issues e.g. who currently or who may in the future perform exposure prone procedures

HIV tests should only be offered to sex workers aged 16 years or above. Should a sex worker attend under the age of 16 years, requesting an HIV test, they should be assessed and referred appropriately to a specialist paediatric HIV unit. Where sexual abuse may be suspected, the young person should be counselled and advised that the local child protection measures will need to be implemented. Ideally the health/outreach professional should discuss the reasons for the referral and try to gain their consent, although confidentiality may be breached if in the best interest of the young persons welfare. Any sex worker who, following initial assessment, deemed to be at high risk of a positive result, identifies during the pre-test discussion that they would react in a detrimental way to a reactive result, such as self harm, and who have no external support network should not be offered an HIV test. Such persons may require referral for formal counselling from a support service. It is at the health professional's discretion to refuse a test, where they have concerns about the sex workers motivation for HIV testing, the workers understanding of the test, their ability to cope with the outcome of the result of the test or any other

valid reason. The reason for refusal to test should be explained to the patient and fully documented in the clinical care records.

Ordinarily testing should be undertaken only with the sex worker's specific informed verbal consent, which should be documented in the clinical care records. Written information about and encouraging HIV testing should be provided in advance, and can be supplied in outreach situations. Pre test discussion (PTD) is appropriate for the majority of sex workers being tested with the aim of obtaining informed verbal consent. Those identified as being at high risk for HIV or those with particular concerns should be offered more in-depth pre-test discussion, with an experience health/outreach professional. A minority of individuals may require referral for formal counselling from a support service.

The primary purpose of PTD is to establish informed consent for the HIV test, which means the individual must be competent to consent. They should understand the purpose, risks and benefits of being tested and of not being tested, and they must give their consent voluntarily. The PTD should cover: confidentiality; a risk assessment, including date of most recent risk activity; information about HIV transmission and risk reduction; the benefits of testing, including access to current treatments, reduction of anxiety from knowing HIV status, reducing risk activities and possible forward transmission if tested positive; an explanation of the seroconversion window period; that negative results will not have a detrimental effect on life insurance or mortgages; and explanation of the test; and details of how the result will be given (if venous blood is required to be taken). Sex workers should be informed that their confidentiality will be protected according to local/country guidance.

In addition, confidentiality of positive results should be respected according to common law, Sexually Transmitted Infection (STI) regulations, Health Department guidance and the local data protection rules. Only in exceptional circumstances can confidentiality be breached. Partner disclosure is still evolving in case law and legal advice from a defence organisation may be needed in cases where partner notification without consent of the patient may become an issue. Sex workers should be reassured that a negative HIV test result, or the fact of having had a HIV test, should not affect an individual's future applications for insurance. Conversely a positive result could affect their ability to get life insurance, mortgages and other financial services and products.

There should be no circumstances within the practice of most sex worker projects/services for a sex worker to be tested without their consent. This would normally only occur with an unconscious (e.g. ventilated patient) within an acute clinical care setting, and highly unlikely that a practitioner from a sex worker project/service would be asked to test a patient in such a situation, and if such a request should ever arise, guidance should be sought from a senior health professional. Testing following a possible occupational exposure risk prior to commencing PEP (Post Exposure Prophylaxis) or PEPSE (Post Exposure Prophylaxis for Sexual Exposure) is recommended to prevent inadvertent and unplanned treatment of pre-existing HIV infection.

Only tests that have been quality controlled and approved should be used for testing, within Europe, these should be Conformité Européenne (CE) marked for diagnostic purposes. Screening assays should be able to detect both HIV 1 and HIV 2 antibodies and preferably p24 antigen as well (for earlier detection of HIV). Initial repeat testing of all positive tests should be referred to a specialist laboratory for confirmatory testing. When interpreting results, health professionals need to remember that no diagnostic test is 100%, and although fourth generation assays have sensitivities and specificities close to 100%, false positive and false negative tests can still occur. In many parts of Europe, with low HIV prevalence rates, as a general rule, low false positive screening tests (negative on confirmatory tests) tend to occur, whilst false negative (unless a person is in the window period) are extremely rare. POCT (Point of Care Tests) for HIV use rapid testing devices (RTDs). RTDs give results within about 20 minutes (or faster) and therefore allow results to be available within a single consultation, and may be appropriate for testing of sex workers in out reach locations.

Mandatory testing & certification

Increasingly, there is a request from sex workers and others working in the commercial sex industry, such as adult entertainers, for certification of STI screening and HIV testing results, often driven by a demand from industry stakeholders, such as brothel/club owners and porn directors/producers.

Mandatory testing quickly leads to an administrative struggle, resulting in the circulating false certificates, bribing of health professionals, etc. It can lead to sex workers being

tested for no reason or inappropriate tests, taking away health resources. Temporal removal of sex workers with a positive test from the work place without compensation may cause hardship or drive sex workers underground. But most importantly, mandatory testing takes away the responsibility of the individual to decide what is best for his/her health. Projects/services should therefore try to work with industry stakeholders and sex workers at a local to negate the demand for mandatory testing.

However, where such negotiations are unsuccessful or for increasingly litigious reasons, stakeholders demand mandatory testing, in order to provide a service to sex workers, some projects/services will consider offering a testing service. Case law in this area is evolving and there is no legal precedent as yet, but projects/services need to be careful about the issuing of certificates and the wording used on such documentation. As a guideline, the following points should be considered:

- Do not issue a 'certificate' – it carries cogitations that the health professional is certifying the sex worker as STI/HIV free. It is more appropriate to issue a 'letter of results' – this merely summarises what screening tests have been undertaken and the results obtained.
- To try and reduce the risk of false documentation circulating, ensure you confirm the identification of the sex worker being tested, ask to see photo ID such as a passport or driving licence, and note the details of this documentation on the results letter.
- Ensure that the results letter contains a clear and obvious explanation of the window period for each test documented, and is explicit that the letter does not mean the sex worker is infection free, as they could remain within one of these window periods.

Frequency of screening

The frequency of screening for STIs depends on the individual's number of sexual partners, types of sex that have occurred, condom use for sexual activities, and other associated risk factors.

There are several reasons to screen a sex worker regularly for STIs:

- Condom use is not 100% protective against transmission of STIs
- Most STIs are not self-limited and need treatment
- Many STIs can exist without noticeable signs and symptoms
- Many STIs are treatable, and early treatment prevents further spreading and the development of complications
- Private Sex with private non-paying partners is often without a condom

The frequency of screening advised in literature seems rather arbitrary. In some countries legislation exists with obligatory screening frequency, as is the case in Greece, where registered sex workers used to be obliged to come for a check-up twice a week, a period only extended a few years ago to once every two weeks. This period is based on the epidemiology of gonorrhoea, with a very short incubation period. Gonorrhoea, however, is less common than in the past, even within sex worker populations in Europe. It would therefore seem inappropriate to base screening frequency on gonorrhoea incubation periods.

Until 2001, sex workers in Germany were required to have a negative test for gonorrhoea every two weeks, and a negative serology for syphilis and HIV every three months (Stucker, Roghmann, Hoffmann, Segerling, & Altmeyer, 1997). In the Dutch 'handbook STD-prevention in prostitution' (www.pasop.info) three-monthly screening is accepted as a reasonable frequency. Belgian general practitioners propose an interval of three months for sex workers who always use a condom in their work and with their partner. The UK adult porn industry recommend, through their code of practice, that models are screened every 14 to 30 days (depending on type of sex film, bareback (without condoms) being more frequent (GAIKISS, 2008).

The risk of over-screening is that one might think that the screening offers some protection against disease. This may be true for the early detection of treatable diseases, such as chlamydia, but this is clearly not true for most viral diseases such as HIV, HBV, HSV and HPV. The basis of prevention is safe sex, and not regular screening. In conclusion, the frequency of screening should be based on local epidemiology with a clear rationale.

Follow up of screening

Testimonies of sex workers tested for STI, and particularly HIV, still exist, in which they describe how they were tested by a health worker, and left with a positive result without any further referral or help. This is unethical. A health/outreach professional undertaking any form of diagnostic or testing procedure should do so with a full understanding of the procedure and knowledge to treat or refer for treatment should a positive result be found.

This can raise some ethical considerations, as if essential, health/outreach professionals undertaking testing procedures are therefore responsible for ensuring adequate and appropriate follow-up. For example, where do you refer your illegal street worker? If you don't know, don't test. If a test is positive, you should be available to offer support and appropriate follow up. Confidentiality is extremely important, and you should carefully plan how to tell to the sex worker without bringing him or her in a difficult position in relation to his or her colleagues, or managers/pimps/brothel owners or other agents of control. Fortunately not all tests are positive. You may have pre-arranged referral for follow-up, and prepare to accompany the sex worker if she/he does not know the health system.

Results

Particularly in brothels or other organised forms of prostitution, pressure is high to disclose results to managers, club owners, pimps or even colleagues. Club owners argue that they are responsible for their clients. Colleagues may have to perform shows with sexual contacts amongst each other, and argue the need to be informed about test results. However, these are not reasons to breach medical confidence, and the only result will be that not only the individual sex worker, but the whole community, will lose confidence in the health system and avoid further contact, or if there is a justifiable public health risk, where in some countries, certain conditions may be 'notifiable' such as hepatitis A. Besides, safe sex techniques prevent the transmission of most STIs.

If someone really insists, and with the consent of the sex worker, you may issue a declaration where you write that they did attend the health services at a certain date. No results should be given. If there is a requirement for certification, follow the guidance

given above in the 'mandatory testing and certification' section. However, appreciate the risk of certificates is that these can be misused to declare a person disease-free, which is not possible, and may lead to a higher pressure to accept unsafe sex techniques. For the same reason results should be given personally to the sex worker, in the absence of others. When you need someone as an interpreter, try to assure confidentiality.

Treatment compliance & partner notification

Directly Observed Therapy (DOT) with single dose treatments is recommended where possible. If treatment is given, the working conditions should be discussed, possible alternative techniques may replace the usual advice of no sex. In the treatment of an STI two elements are important: the risk to ones own health, and the risk of transmission to someone else. The advice generally given is: no sex for two weeks, or no sex until symptoms or sores/lesions resolved. In the case of sex workers this would mean: no income for two weeks. Again, you should personalise your advice, even negotiate with your patient to decide together what is the best strategy of avoiding the risk of transmission of the STI during treatment.

Specific problems may arise in the case of chronic infection. Depending on the type of infection, and the type of sex work activities, recommendations will vary. For example, a sex worker who is HBe-antigen positive should be encouraged to avoid all risky sex techniques, where as sex workers with HIV mostly pose little risk to their clients if they use condoms. But in practice many sex workers have no immediate alternative income. If we simply say that there is no discussion possible, and even threaten the sex worker with involving the authorities, the most likely thing to happen is that we loose contact with him or her, and that s/he will work elsewhere, avoiding contact with any health worker.

If the best option may be to stop sex work, projects/services may be in a position to assist with finding alternatives, and underline the importance of safe sex guidelines for the time s/he still engages in sex work. However, ultimately it is the sex workers decision, it is not the health/outreach professional's role to police individuals sexual behaviours, merely to advise and provide correct and accurate information to help those individuals reached informed choices. It is important to remember that neither the sex worker nor the public health service can take away the reality of risk that clients take when buying sex. The

introduction of a syndromic approach may be indicated in some conditions. If it is not possible to perform any diagnostic test, you may consider treating the sex worker based on the signs and symptoms they present with. If you make use of flow-charts or treatment algorithms, you should ensure they are regularly updated for your local population.

It is also important to ensure effective treatment, telephone or outreach follow up should occur at an appropriate time after the completion of treatment, be that DOT or longer term therapies. Where oral anti-bacterial or viral medications have been administered, ensure no adverse side effects, such as vomiting or acute diarrhoea within 12 hours of taking the medication or during the course of the treatment, as this could suggest a treatment failure. Where longer term therapy has been given, such as a 7 or 10 day course of antibiotics, ensure that all tablets were taken, at the appropriately prescribed time, and that no dose have been missed, or that the course of treatment was not stopped earlier than prescribed, as again this could suggest potential treatment failure.

When discussing the treatment of a STI with a sex worker, you should pay attention to the role of the regular sexual partners. Many sex workers make a distinction in condom use between professional and private life. In private life the use of condoms is less consistent, increasing the risk of STI transmission. This should be discussed in a non-judgemental way, as with anybody else. You should discuss with the sex worker the best way to inform all persons involved in the episode of the STI, in the past and in the future, such as private partners, colleagues and identifiable clients, in order to treat them and to lower the risk of re-infection and further transmission. This may include targeted sexual health outreach to sex selling venues, but should be done sensitively to ensure not disclosing the identity of the index case sex worker.



Positive sex workers

Disclosure of status

Disclosure of HIV status is becoming a contentious issue in many countries, as case law begins to emerge and guidelines are developed. It is interesting at the time of writing that a male sex worker is being tried in Australia for the potential onward infection of HIV to his clients from his sex work. In a number of European countries, laws have emerged pertaining to the 'reckless transmission of HIV'. It is important to consider how different types of transmission can occur.

Deliberate (or intentional) – defines the HIV positive individual deliberately partaking of high risk behaviours with the intention to infect others, such as sharing needles or engaging in unprotected sexual activity, often not disclosing or being dishonest about their HIV status.

Reckless – this occurs when an HIV positive individual may engage in an activity that could transmit the virus, through carelessness, rather than with the intention of wanting to infect another individual. For example, having unprotected sex without disclosing their HIV status and the risks involved. Reckless implies that transmission could have occurred, but has happened in pursuit of sexual gratification rather than with the intent to infect the sexual partner.

Accidental – is the most common way that HIV is transmitted. This can occur where the individual is unaware that they are HIV positive, and therefore did not feel the need to take precautions to protect others, or they are aware of their HIV status but a condom was used for sex, however, condom failure occurred. However, there is some debate as to whether this last definition should be considered reckless transmission.

Much of the current case law rests around the issues of consent and disclosure. The argument is that if the HIV positive individual disclosed their status, their sexual partner can make an informed consensual decision to engage in sexual activity. Even where a condom is used, many consider this is reckless transmission where disclosure of status has not been forthcoming, as condoms are not 100% and do fail, and that knowing the HIV status, sexual partners might not have consented to sex.

This presents particular difficulties for projects/services working with HIV positive sex workers, or those who may test HIV positive. In some countries outside of Europe, where sex work is legalised and regulated, such as certain states in Australia, HIV positive sex workers must declare their status to potential clients. However, this could increase stigma and in some countries, place the sex worker at risk of physical harm or imprisonment.

It needs to be remembered that health/outreach professionals and project workers are not the sexual or moral police. Professionals should be familiar with the case law and recommendations in their locality, and should inform positive sex workers of this, providing correct and accurate information to help those individuals reach informed choices. It is important to remember that neither the sex worker nor the public health service can take away the reality of risk that clients take when buying sex.

For further information and to make reference to case law examples, please refer to the AVERT website (AVERT, 2008).

Access to treatment

The Declaration of Commitment on HIV/AIDS, unanimously endorsed by the UN General Assembly in 2001, embraced equitable access to care and treatment as a fundamental component of a comprehensive and effective global HIV response. The generalised

introduction of Anti-Retroviral therapy (ART) in 1996 has transformed the treatment of HIV and AIDS and transformed the lives of many people living in areas where the drugs are readily available.

In 2001 the European Commission adopted the Programme for Action: Accelerated action on HIV/AIDS, malaria and tuberculosis in the context of poverty reduction. However, access to treatment and ARTs varies across the European community and it is well documented that access to such treatments for migrants (documented or undocumented) is a particular problem, many of whom may be engaged in sex work.

Health/outreach professionals and project workers should be familiar with access to HIV treatment services in their locality, and be able to access sex workers to such services. This is of particular importance if HIV testing is being undertaken, as previously stated, it is essential to offer appropriate follow up to those who test positive.

Compliance and maintenance of anti-retroviral therapies

For HIV medication to work, remain effective and prevent development of HIV resistance, it is important for positive sex workers to take their ART as prescribed. Missing doses, taking the wrong dose, or taking the drugs in such a way as to affect their absorption may lead to fluctuations of the therapeutic regimes of the ART in the blood, allowing the virus to gain a competitive advantage over the therapy and develop a resistance, rendering the ART infective.

Whilst HIV positive sex workers should be receiving support with their HIV drug therapy from specialist treatment centres, health workers and outreach project staff can assist with supporting them to adhere to their medication regimes. All people on long term therapies may occasionally miss a dose of the treatment, and it is important to support those with HIV through such experiences. Where missed doses are occurring frequently, it may be necessary to influence a review of the drug schedule, or a change of combination.

Other practical tips include assisting sex workers to keep a diary or journal, allowing them to avoid confusion over when the tablets should be taken, with what foods, etc., and tick off after each dose is taken. Alternatively, using alarms or reminders, some HIV services

have developed innovative SMS services, to which HIV positive individuals can subscribe, and receive timely reminders to take their medication, delivered to their mobile phones or pagers.

It is also important to ensure the safe and appropriate storage of ART medicines, and this maybe a particular concern for sex workers, working on the streets or from venues where they would not want managers/brothel owners or colleagues to know about their HIV status. However, it is important that medications are stored and transported appropriately, according to the pharmacists' recommendation, some for example may require refrigeration, others may interact if placed directly alongside other medications, or may begin to deteriorate if allowed to dry out when exposed to air. Health/outreach professionals should be familiar with the medications to assist positive sex workers to develop personal strategies and assist with adherence to their HIV regimes.

It is important for health/outreach professionals and those working in services/projects with migrant sex workers, especially those who may be undocumented, and who may test HIV positive to consider the implications of commencing anti-retroviral therapy, in relation to potential deportation, and access to availability and support to maintain the therapy if forcibly returned to their country of origin. This is not to say that where services have access to HIV testing and treatment for sex workers, they should not test and treat migrant sex workers, more it is about working with those affected individuals to develop contingency plans and coping strategies should they be forced to return home. This may include project staff researching access to treatment programmes via NGOs, etc., within the migrant sex workers country of origin.

Access to PEP

Post Exposure Prophylaxis (PEP) is a treatment to prevent a person becoming infected with HIV after (post) a situation where there has been a chance for HIV to enter the blood stream, such as a condom breaking at the point of ejaculation.

The key facts about PEP are:

- It could stop someone getting HIV
- It must be started as soon as possible after unsafe sex or a condom breaking – and definitely within 72hrs (3 days)
- It involves taking anti-HIV drugs for 4 weeks
- It has side effects – which can be severe
- It is not guaranteed to work

Studies have shown that by taking anti-HIV medication (anti-retrovirals) within 72 days of an exposure risk to HIV, there may be an opportunity to prevent infection by stopping the viral replication of the virus, and preventing it taking hold.

However, risk of HIV transmission are complex and multi-faceted, and depends on whether the partner (the person with whom the risk occurred) is HIV positive, against the risk of the exposure. Even when the source is known to have HIV, their infectivity (how infectious they are) can vary depending on a great number of factors. The following are likely to increase the risk of HIV transmission:

- Their plasma viral load (level of HIV in the blood), may be high particularly during early HIV infection, if they have just recently been infected themselves. Even when someone is in a dormant phase or taking anti-HIV medication, so their viral load is low or undetectable, there is still a slight risk. Measurement of viral load varies between blood and ejaculate, and someone with a low or undetectable blood viral load may have a higher viral load in their seminal fluid. However, with most commercial partners, sex workers are unlikely to have knowledge of such information.
- Breaks in the mucosal barrier or genital ulcers from disease or trauma, such as sexual assault or first penetration. Menstruation (periods) or other bleeding may also increase transmission risks.
- Catching another sexual infection at the same time. Studies have shown that acquiring another inflammatory condition such as gonorrhoea or chlamydia may increase the risk of infection with HIV also.

Situations in which PEP is likely to be considered:

- If a sexual partner is known to have HIV, and one of the following sexual acts has occurred:
 - Receptive anal intercourse (being fucked)
 - Insertive anal intercourse (fucking someone – active role)
 - Receptive vaginal intercourse (being fucked)
 - Insertive vaginal intercourse (fucking a woman)
 - Sucking someone and taking ejaculate (cum) in the mouth – PEP would be considered
 - Splash of semen (cum) in the eye – PEP would be considered

- If the sexual partner is of unknown HIV status and from a group or area of high risk, and one of the following acts has occurred:
 - Receptive anal intercourse (being fucked)
 - Insertive anal intercourse (fucking someone – active role) – PEP would be considered
 - Receptive vaginal intercourse (being fucked) – PEP would be considered
 - Insertive vaginal intercourse (fucking a woman) – PEP would be considered
 - Sucking someone and taking ejaculate (cum) in the mouth – PEP would be considered

- If the sexual partner is of unknown HIV status, but not from a high risk group or area, then PEP is only considered when:
 - Receptive anal sex (being fucked) has occurred

High risk groups for the purpose of PEP assessments included men who have sex with men (MSM), intravenous drug users, and recipients of blood transfusion in the developing world. High risk areas include areas of the globe with a high prevalence of HIV and emerging hot spots include parts of the United States, Latin America (especially Guyana & Belize), South East Asia, parts of the Caribbean, parts of Eastern European and sub-Saharan Africa (UNAIDS, 2007).

The sooner that PEP is started, the more likely it is to prevent infection. Most of the studies show that PEP has little effect after 72hrs, with the greatest effect if taken within 24hrs, but no later than 72hrs. Most PEP will be prescribed as a three drug combination, however, it is not guaranteed to work, even if taken properly, as it may be that the individual has been exposed to a strain of HIV which is resistant to the medication.

As with established HIV infection, combination therapy with at least three drugs is more effective than monotherapy or dual therapy regimens and therefore it is recommended that a triple drug combination is used for PEP. Studies have also shown that the side effects of antiretroviral drugs are less well tolerated in HIV negative persons than those with diagnosed HIV infection starting combination therapy. Many of these side effects, including nausea, headaches and diarrhoea can be symptomatically managed by using other medications to counter them. However, in most treatment centres, patients will be seen weekly in PEP clinics whilst on treatment. The optimal duration of PEP treatment is unknown, but all studies suggest at least 4 weeks treatment following exposure to potential HIV infection.

PEP may not be easily accessible in some countries, but even where it is available, access out of hours, evenings and at weekends may be problematic, yet these are the times when sex workers are most likely to need access to such treatments. Projects/services should be familiar with the accessibility of PEP in their locality and be able to advise sex workers of such. In order to assess whether PEP may be required, the level of risk, based on the chances of having been exposed to HIV following a period of unprotected sex or condom failure will need to be undertaken. Such an assessment should consider:

- The person the unsafe sex was with (to judge the chances they had HIV or not)
- The sex involved, when it happened, was it oral, vaginal or anal sex, who was inside who, did ejaculation occur
- Having an HIV test. Before someone is given PEP, a baseline HIV must be taken, to confirm negative HIV status, and will be tested again after the PEP treatment is completed, 3 and 6 months thereafter. PEP will not be supplied to someone who refuses to test for HIV.



Strategies for maintaining safer sex

Condoms & lubricants

One of the basic elements of keeping sex work safe is the correct use of condoms and lubricants. The consistent use of condoms will reduce the risk for HIV-transmission by at least 85% (NIAID, 2000). There is a general perception that sex workers are all experienced and most know how to effectively use condoms. That is true for many of them, however, there is a continuous inflow of new sex workers into the trade, and there is not always a good transfer of knowledge and expertise from the experienced sex worker to the novice.

When communicating with sex workers, health/outreach professionals and project staff should be aware of the fact that there is a wide range of experience, and may have to adapt their health advice to the level of knowledge of the sex worker. For example, many sex workers underestimate the risks of oral sex without a condom. One way of starting the discussion is enquiring about condom failure (slippage and breakage). Breakage and slippage risk lies between 0.4% and 2.3%.

Use social marketing techniques, to view the situation from the perspective of the sex worker. Taking a premise of 'you should always use a condom' will immediately create a barrier and ostracise the professional, who will be viewed as patronising. It is better to consider that the majority of sex workers want to maintain safer, effective condom use with

few or no accidents. Therefore, explore from their viewpoint situations and occasions when condoms may have failed, help them to consider what might have contributed towards the failure, was it an appropriate condom for the sexual activity, was the condom applied to the penis correctly, were the appropriate lubricants used, etc.? Having a wide range of available condom types and lubricants will better inform these discussions.

It is important to ensure that condoms provided by projects/services to sex workers meet approved quality and safety standards, look for the European CE mark and/or the British Standards (BSI) kite mark. Condoms have an expiry date, so stock should be rotated in storage and stored in a cool and dry place, away from exposure to sun or extreme heat, as this could dry the rubber and increase the risk of condom failure. The majority of condoms available in Europe are made from latex, with a few brands made from polyurethane.

Health professionals and outreach staff should also be familiar with the types and brands of condoms available, for example a thicker condom may provide added peace of mind during anal sex, although any thickness of condom is suitable, as long as used properly. It should also be remembered that condoms come in two main 'types', those that have a teated end and those without, that are plain ended. Many condoms come already with some lubricant coating them, all of which will be water soluble, and rarely these days contain a spermicide. While spermicides may give some added protection against pregnancy, and are thought to have some anti-viral properties, with most people, they cause localised skin irritation, and thereby increase the risk of exposure to infection.

With a host of condoms available on the market today, choice and variety can be used to encourage their continued use. Some even have chemically modified lubricants to increase sensitivity or have an anaesthetising effect to prolong the time before ejaculation. However, it is important to remember that with latex condoms, water or silicon based lubricants must be used. Any lubricant containing oil will weaken the condom and may increase the risk of breakage. For those condoms (including the female condom), made of polyurethane, oil based lubricants (such as massage oil) can be used – but if in doubt, it is always best to advise a sex worker to use a water based lube. Never use the following household products: mineral oils, suntan oils, margarine, coconut butter, burn ointments, baby oils, edible (cooking) oil, fish oil, haemorrhoid ointment, petroleum jelly, palm oil, dairy butter, insect repellents, rubbing alcohol.

Condoms and lubricant are an excellent barrier method to prevent pregnancy and reduce the transmission of sexually transmitted infections (STIs), but they are not 100% reliable. Some sex workers report condom failures, when the condom splits, bursts or comes off. Very rarely this is due to a fault with the condom, especially if CE or BSI kite marked brands are being used. Where condom failure is occurring regularly, it is most likely due to operator error, the wrong type of condom of sexual activity, not using enough lubricant or putting the condom on incorrectly. Projects/services should not assume that just because of the nature of the job, all sex workers are proficient or expert at using condoms, those who are young or very new to the work maybe naive, and where patterns of condom failure for individuals is occurring regularly, health professionals and outreach staff should be offering information, coaching and intervention, ensuring the sex worker knows how to apply the condom, use the correct lube, etc.

Learning to use condoms correctly is not difficult but does involve some specific steps. The checklist below describes the steps a user should take to use the condom with maximum effectiveness:

- Firstly, select the right condom for the type of sex. Whilst most condoms can be used for vaginal or anal penetration, some novelty condoms may not be strong enough, and flavoured condoms are best used mainly for oral sex.
- Check the pack or condom foil is intact and has not been interfered with (as this could affect the condom inside), many have a cellophane seal, which should not be broken. Also check the condoms are in date, they should be printed with an expiry date.
- Before opening the condom, it is important to ensure the man is fully erect. Occasionally when sex workers reach for condoms, the man can start to lose his erection, so the sex worker may need to provide additional stimulation. Many sex workers are skilled at unrolling a condom over the erect penis with their mouth, sometimes without informing the client.
- When the penis is hard and you are ready to roll on the condom, tear open the pack or foil carefully, avoid contact with nails, and advise that it is best not to use cutting implements (such as knives or scissors), as these may damage the condom.
- Squeeze the end of the condom between the first two fingers and thumb (to

push the air from the end). This is easily with a teat, but with a plain ended condom it's important to leave this slack, as a reservoir for the ejaculate. To prevent the exchange of sperm or microorganisms between sex partners, there should be no genital contact before a condom is put on.

- Roll the condom down the full length of the shaft, until the rim of the open end of the condom is at the base of the penis shaft. Once in place apply some water-based lubricant to the condom, rub it along the length of the shaft. If the sex last for a while, remember that additional lube may need to be added to prevent the condom drying (and increasing the risk of breakage).
- It is important to ensure that after ejaculation, the condom is removed safely, to avoid spilling any ejaculate, and then safely disposed of, in a waste bin, not down the toilet. After the condom is removed, genital contact should be avoided to prevent transfer of residual sperm or STI micro organisms on the glans or in the urethra.
- A condom should never be washed and reused as this can substantially weaken the latex.

It should be considered that condom use by sex workers may vary between their private and working lives, and that often condom use with non-paying sexual contacts is more exceptional, although STIs may be transmitted outside the work setting. Health professionals and outreach workers should discuss this when talking about condom usage with sex workers, but also not make any assumptions, many sex workers are aware of the risks and may have negotiated safety within their private relationships.

Condom failure

It is essential to discuss strategies with sex workers of coping with a condom failure or breakage during their paid sex. The consequence of this occurring can be devastating especially if a contingency plan has not been considered. For those who experience a condom break, there can be anxieties about the transmission of STIs, especially HIV (more so for male sex workers) and pregnancy, and for some women this can be a particular psychological problem, especially if they have been trying to become pregnant with a non-paying regular partner.

When discussing condom use, it may be sensible with female sex workers to consider

alternative forms of contraception as a safe guard as well, such as hormonal based contraceptive tablets or implants, as many part-time sex working women who work irregularly often rely only on condoms. Where this is not the case, and the condom is the only contraceptive method being used, it is important for women to know how to access emergency contraceptive and the time frames in which to do this. Access to emergency contraception will vary from country to country, so health professionals should be aware of what is available in their locality.

The single dose (progestogen) morning after pill can be take with effect up to 72hrs after the condom failure has occurred, although it is more effective the sooner it is taken after the event. Should the incident have occurred at a time when access to this treatment was not available (say the start of a long holiday weekend), then an IUD (intra-uterine device) can be inserted up to 5 days after the condom failure, but should only be done at a specialist centre by a trained healthcare professional. If such treatments are available, access to them (when and if needed) should be explained to the women.

Another risk after a condom failure is the transmission of sexual infections. Some women tend to thoroughly rinse the vagina when failure happens, since they feel dirty and want to get rid of the semen. However, aggressive rinsing may enhance the contact of the semen with the cervix, and thus facilitate transmission. Strong cleaning products may also damage the vaginal wall and cervix, also raising the transmission risk. It is recommended to sit on the toilet and let gravity do its work.

Health/outreach professionals should educate sex workers about the signs and symptoms of common infections, so that they can self monitor after a condom failure, and encourage them to attend a clinic for screening should any symptoms occur. Testing for bacterial STIs can be done two weeks follow a breakage, for syphilis and HIV 6 weeks later, and if negative, with repeat testing after 3 months. For those sex workers already vaccinated or known to have an acquired immunity to hepatitis B, there is no need for vaccination, for all others, vaccination as a preventive measure is advised.

Access to Post Exposure Prophylaxis (PEP) for HIV is discussed in the previous chapter (chapter 7), but it should be noted that local protocols will vary and some clinical services will not issue PEP in the event of condom failure for commercial sex workers, or for a

sexual exposure risk (only occupational exposure through needle stick injuries), so health professionals should be aware of their local protocols before advising sex workers.

Bareback sex and risk reduction

Bareback sex (the deliberate act of sex without a condom) is a contentious issue, especially in relation to commercial sex work. The legal issues surrounding disclosure of HIV status for positive sex workers has been discussed in the previous chapters, and for many health and outreach professionals, that a sex worker can choose not to use a condom with a client for sex is often difficult to comprehend and accept. However, it is important to remember that as health professionals, a non-judgemental stance must be adopted. Situations and circumstances change, and disapproval of behaviours or actions could present a barrier that may compromise clinical care.

Some sex workers would rather state that a condom broke or failed than admit to bareback sex, for fear of repercussion or judgement from the healthcare worker. Rather than be faced with this scenario, health professionals and outreach workers should adopt a neutral stance to condom use, discussing with sex workers the harm reduction benefits of their continued use, and providing the facts to help the sex worker make an informed choice, but then that choice needs to be respected in the context of the situation, even when it maybe to not use condoms.

The market place for the adult porn industry is increasingly more for bareback sex, despite recent high profile media issues about STI and HIV outbreaks in pockets of these industries. It needs to be remembered that for the men and women working as models on these productions, the pressure to conform to bareback filming necessitates access to work, and especially in gay porn, the transition between film work and escorting is a permeable distinction. Codes of conducts with regard to the frequency and type of STI and HIV screening, and disclosure of other 'high risk' activities off the film set are beginning to emerge, but health professionals and outreach workers may like to remind those men and women working these scenes that code of conduct are voluntary and not absolute, and whilst they may afford some very limited risk reduction, outbreak scenarios will occasional occur.

Alcohol and drug use

Alcohol and other mind altering substances can increase the risk of unsafe sexually practices, and thereby increase the risk of exposure to potential infection, pregnancy or serious physical harm. It is easy for health professionals to advise sex workers not to use such substances when working, however, it must be remembered that some sex workers will have an alcohol or substance dependency, and may need to work to finance these addictions, whilst others, such as those working in private clubs and bars, may be expected to drink with clients, whilst negotiating additional sexual services.

It is perhaps more useful for health professionals and outreach workers to explore with the sex worker the use of such substances within the context of the workers particular circumstances, and the affect it may or may not have in relations to risk and work. Obviously, if a sex worker is so inebriated that they have little control over their motor-neuron functions, then they are in potentially imminent danger of abuse from clients. However, many with a substance misuse problem will be able to function and ‘be in control’ whilst using. It is however important that professionals are aware of drug and alcohol services in their locality, and how to refer sex workers to such services, should they recognise that their alcohol or substance misuse is becoming a problem.

Perhaps those who are potentially more vulnerable are those sex workers who do not normally use such substances in the course of their sex work. It is advisable to discuss with them some safety considerations, such as not accepting drinks or substances from clients, especially if in their home or hotel room, as they may not know exactly what they are being given. If accepting a drink, ensure the sex worker has witnessed it come from a previously sealed bottle or can, and that the client is also drinking from the same bottle or can.

Targeting prevention towards clients

Increasingly, projects/services working with sex workers are aware that the sex workers often practice safer sex, and may question why interventions to improve knowledge amongst and change the behaviour of their paying partners are not being undertaken. Some projects in Europe do undertake such work alongside their outreach initiatives to sex workers, but this tends to be the exception rather than the norm. Often, this is

due to a funding issue, projects/services are funded to provide services to sex workers, and not their clients. There are also arguments to suggest that most clients can access mainstream services, and therefore there is not a need to provide specific specialist services for them.

However, services/projects need to consider the context of working with clients of sex workers. Some sex workers, especially those working in brothels or saunas have a low opinion of their clients. For outreach teams to be seen to be 'benefiting' clients through the provision of advice or services, may lead to resentment and disengagement by the sex workers. The contextual reality of the situation needs to be scrutinised by projects/services, and perhaps the sex workers in the venue consulted with and bought onboard before any interventions are initiated.

Research has shown that sex workers themselves are often the best educators to work with their clients, improving their knowledge, promoting sexual health and encouraging condom use (Day & Ward, 1990), therefore some services/projects benefit from providing peer education or sexual health programmes for sex workers, in the belief that this will have a beneficial effect for their paying partners.

In the current political climate, a number of projects/services with a strong prevention/exiting stance have sought funding to run rehabilitative services for men who purchase sexual services, often in partnership with law enforcement services. Examples include 'kerb crawling' schools, where men are "re-educated" about their ways, from the stance that their purchasing of sexual services from women only feeds into a continued cycle of abuse for these women, many of whom may have an alcohol or substance misuse problem, which is funded through their sex work.

Performance enhancing drugs

In the last decade, a number of pharmaceutical advances in the treatment of erectile dysfunction have led to the development of medications to aid blood flow to the penis, giving harder, longer lasting erections. Drugs such as Viagra, taken about half an hour before the intended sexual activity will give an effect lasting up to 4hrs, and Cialis can have a longer effect, of up to one or two days.

However, many (male) sex workers are using such drugs to assist with obtaining and achieving erections with clients to whom they are not particularly attracted, or to obtain an erection for performance purposes (e.g. in bars or sex shows) for longer, thereby potentially increasing their earning potential. There is some evidence from the US to suggest that small scales clinical trials with women do indicate increased blood flow and sensitivity to the clitoris and labia, and may be utilised by some female sex workers for this effect.

Whilst there appears to be no harmful long term physiological effect of taking such medications by men who do not have erectile dysfunction problems, there is increasing anecdotal evidence to show there may be psychological effects, that these young men find it difficult to obtain an erection when attracted to a non-paying sexual partner, without swallowing an enhancement pill, yet physiologically have no organic cause of erectile dysfunction.

Health/outreach professionals should also be aware of the side effects of such medications, such as sinus congestion, headache, facial flushing, stomach disturbances or short-lived changes in visions. It is also important to be aware of contra-indications of the drugs. For HIV positive sex workers taking a protease inhibitor, the level of erection drug in the blood can be increased, so they should be cautioned to take a lower dose. Amyl nitrates (poppers) lower blood pressure by causing vasodilation, in the same way as the erection drugs, and the combined effect can cause a life threatening sudden fall in blood pressure. Ecstasy combined with Viagra has been documented as causing a priapism, when the erection lasts longer than a few hours and may need emergency medical intervention to prevent long term tissue damage. Other recreational drugs, such as cocaine, crystal meth and speed can place extra strain on the heart if combined with erection enhancing medications, with the potential effect of causing blindness, stroke, cardiac arrest or death.

A number of 'herbal' or alternative preparations are available as cheaper non prescription alternatives to some of the erectile enhancing drugs, but sex workers should be counselled to avoid the temptation of using such preparations, although they may appear to be cheap, they are unregulated and it is impossible to tell what the active ingredients may actually be, and deaths have been linked to some of the fake pills.



Broader view on health

It is often the case that health issues for sex workers are reduced to questions of condoms and STI. In an overview of sex work specific health topics psychological, social, economic and legal issues are also important. In addition general health problems must be considered in a holistic approach. In most societies sex work is not considered as a morally acceptable form of income generation, and everybody involved in sex work will be influenced by the tension created by the imbalance between theory and practice. Many psychosocial problems have their roots in the refusal of society to see sex work as a morally accepted choice.

Stigma

The majority of European society considers sex work as a morally unacceptable activity. O'Neill (O'Neill, 2005) states:

“Prostitution is accepted by the bourgeoisie (it is not illegal) but the prostitute, the whore is not accepted, she is perceived as immoral, a danger, a threat to “normal” femininity and as a consequence suffers social exclusion, marginalisation and “whore stigma”.

This is often portrayed by the media image of prostitution, sex workers are presented as being 'high risk', viewed as the vectors of HIV and other STIs to wider society, as corrupting vulnerable men, destroying homes and families –such derogatory images and myths result in what O'Neill has cited as “whore stigma”.

To avoid this stigma, many sex workers live a double life of secrecy, distancing their working and private lives. As Sanders (Sanders, 2005) describes, this can result in sex workers adopting coping strategies that “include pseudonyms and creating job aliases, relying on geographical space between work and home and choosing a sex market with care...telling lies, isolating themselves from friendship networks and also by disclosing variations of partial truths about their money making activities.”

In addition, many sex workers may be migrant (documented or not) and also have the stigma and stereotypes which may be associated with being foreign and living in an alien country. They may experience psychosocial problems in adapting to the new society. Problems of legal status, poor access to services and few work opportunities create major stress. Many migrants suffer discrimination and racism. For male sex workers particularly, there may an additional layer of stigma related to their actual or perceived homosexuality. The male to female sex selling scene is very small and exclusive, so in reality the majority of men selling sex across Europe, are selling to other men. This includes large numbers of working guys who will have a heterosexual or bisexual identity, but restrict their commercial sexual activities to dominant or active roles, thus retaining (in their perception) a very masculine role. Yet they will often experience assumptions, from the public (and service providers) that they are gay, when many will have female regular non-paying partners.

Much of this stigma may be perceived, rather than actually experienced, but there is what is described as the “emotional consequences of stigma”, and in relation to sex work, this is often a fear or anxiety of 'being discovered.' This can create artificial constructs of guilt and shame which are then internalised by the sex worker and dictates their behaviour with regard to the management of risk, and potential avoidance of discovery.

It is important that health/outreach professionals working with sex workers have an understanding of these concepts, as often some of the stigmas experienced or perceived

can be a barrier for accessing services, for fear that health and social professionals may portray some of the negative stereotypes and make judgements on the workers behaviours or activities.

For service/projects that provide social support and assistance with voluntary exiting from sex work, consideration needs to be given to wider societies perceptions of prostitution. If helping to develop resumes or complete job applications, careful consideration needs to be given to ways in which past working history will be explained. Stigma may also be experienced in relation to housing and accommodation, discovery as a sex worker may jeopardise tenancy agreements and earnings from sex work are often not accepted by mortgage companies as suitable income.

Double life

The result of the stigma surrounding sex work is that sex workers often live in two worlds: the world of selling sex, and the private life. The separation of these two worlds may create a lot of psychosocial stress. In contrast to what most people experience, sex workers cannot always tell their family members about what happened in the last day or night of work. They cannot discuss the topics of interest to them. Regarding safe sex, private life is so much in contrast with work, where condom use is normal, that it is difficult to insist on the use with a private partner.

Violence, humiliation and lack of respect (including police)

From the interviews of 83 women with the EUROPAP questionnaire in 2001 in Ghent, lack of respect from their clients was mentioned among the worst things of sex work. If asked what they wanted to see changed, more respect from the clients was the first priority (Claeyssens, 2002). Similar findings have been found with focus groups of male sex workers, who described many of their paying partners as treating them like sexual objects, who should perform on demand, imposing a psychological burden on the sex worker (McKinney & Gaffney, 2000).

The taboo in society about sex work and the existing laws in most countries, make many policemen and others, believe that they have the right to be impolite, humiliating the women and men in the street. Lack of respect and violence are not far apart, and the constant

threat of violence may cause increased stress in the life of a sex worker. Some sex workers are forced or trafficked into prostitution, and experience violence from pimps, lover boys or partners. A recent study of migrant male sex workers in three European countries by the European Network Male Prostitution (ENMP) who found that 56% percent of men who experienced threats or actual assault in the cause of selling sex would not report this to the police for fear of a negative reaction, or even worse, reprisal against them for selling sex (Mai, Gaffney, & Pryce, 2003).

Sexual identity

As mentioned earlier, prejudice related to homosexuality can be a particular additional stigma experience by men who sell sex. Much of the published literature shows that many male sex workers start to sell sex from their mid to late teens, especially those working on street scenes. For these young men, coming to terms with their sexual identity can be confused or compounded by their involvement in sex work, and the additional stigma of prostitution, as well as being gay can result in some seeking escape through the use of alcohol or other substances. For those men working mainly off-street, who maybe slightly older, especially migrant men, who are selling sex, there can be additional issues if they are hetero or bisexual but selling sex to other men, and they may have problems with “gay sex”. This can occasionally lead to problems of overtly homophobia within working establishments such as bars, clubs and brothels, between the gay and non-gay workers.

Likewise, lesbian women may have problems with heterosexual sex, and heterosexual women may have difficulties with lesbian shows.

Mental well-being

As stated, the stigma and prejudices at a society level associated with sex work can take their toll psychologically on sex workers. Whilst there are few empirical studies to validate assumptions, anecdotal evidence would suggest that alcohol and substance misuse, depression, self-harm, eating disorders and other physiological markers of psychological distress may be higher in sex working populations than general populations within the European communities. That is not to say that sex work per say is a precursor to mental-ill health, but factors (such as stigma) may contribute to psychological problems experienced

by sex workers.

Often, local mental health services are naive to the issues of sex work and have little understanding or insight in the lives of sex workers. This can be a particular issue within drug using services, where issues of sex work or sex identity can often be ignored or overlooked by service providers. Health/outreach professionals and projects/services can assist by increasing awareness through training and partnership working, where possible, to dispel some of the taboos and establish referral pathways and networks to access sex workers experiencing mental distress to appropriate services, sensitising these services to their needs.

For some sex workers there is an association between their work and sexual dysfunction. It is not easy for the sex worker to find a skilled sex therapist who is able to place the sexual dysfunction in the wider context of sex work, and the personal history of the sex worker. Building a local database of good therapists may be helpful in these situations.

In some areas a considerable proportion of sex workers are transgender. This subgroup of sex workers has its own specific problems, including legal issues, discrimination and poor access to services. It is important to try and find reliable and sympathetic services who will assist them. There may be no specific transgender services available, but depending where the sex worker is on their transition journey, they may benefit from accessing more generic male or female sex worker projects/services, depending on suitability and acceptance from/of other service users.

Education & learning

Some projects/services come from a prevention and exiting service delivery model, whilst others work from a harm minimisation perspective, but it is important no matter the project/service position on sex work, that as service providers, health professionals are able to assist those men and women who may choose to reduce their involvement or want to exit completely from sex work. In order to achieve this, a local network of referral agencies should be developed. A number of projects are now beginning to offer courses and training to sex workers who want to exit, looking at the skills developed in sex work and finding creative ways to transition these into more regular forms of work.

It is important to remember though that for many sex workers, the work itself offers flexibility of hours and for some, high income. It can be difficult to find alternative work that offers the same. Many employers hold the same prejudices in relation to prostitution as the wider society, and this can be a barrier of access to work for some sex workers, especially if they are honest about their recent work history. For some jobs, such as those working with children or vulnerable adults, police checks are required, and if a sex worker has a record for soliciting or some other offence pertaining to their sex work, this can present a challenge. Projects/services should develop local networks and intelligence in order to assist sex workers in such situations, and refer them to services that maybe able to provide legal and professional counsel in these situations and scenarios.

Empowerment

Much of what is contained in these guidelines, research referenced in the literature, and the general societal and media portrayal of sex work actually contributes in some way to the stigma and prejudice of sex work. There are few examples of the positive sides of the work. However, even in what some may consider 'problematic' working sex environments, such as the street, many sex workers do describe the camaraderie of working with their peers, and as previously mentioned, the freedom and flexibility (in terms of the construct of work and labour rules and regulations) offered by sex work. In the main, across Europe, sex work is unregulated and therefore allows for these greater freedoms.

Many sex workers will also describe how they provide a 'public service' and in the course of their work develop skills as informal counsellors, sexual therapists, companions to the lonely or isolated or marriage guidance advisors! Large numbers of sex workers are open and transparent about their involvement in the work, and do not live the 'double life' of secrecy described earlier in this section. For some, as with more legitimate forms of work or labour, they seek recognition of their involvement in the work through unionisation or forming collectives of sex worker activists.

Sex worker activism within Europe, as with some other parts of the world, such as North and South America, India, and some African countries is growing. In 2002 a group of Dutch sex workers came together with the International Network of Sex Work Projects. A year later an Organising Committee was pulled together and began the planning of a

European Conference, and a year before the conference, work started on a Declaration and Manifesto. The conference was held in Brussels on October 2005 and pulled together 120 sex worker activists and 80 allies, for a two day event. During the conference, the Declaration of the Rights of Sex Workers in Europe was finalised, and launched alongside the Sex Workers in Europe Manifesto, which sets out what sex workers want from their societies and communities. Copies of both the Declaration and Manifesto can be viewed on the Sex Work Europe website (Sex Worker Europe, 2005).

The 'red umbrella' symbol has in recent years become recognised as the international symbol for sex worker activism. First used by sex workers in Venice, Italy, when during the 49th Venice Biennale of Art in 2001, they walked the streets together out and proud in a Red Umbrellas March. Using megaphones and red umbrellas, the sex workers drew attention to the bad working conditions and the human rights abuses they faced within the city.

In 2005 the International Committee on the Rights of Sex Workers in Europe (ICRSE) adopted the red umbrella as a symbol of resistance to discrimination. A march with almost 200 participants was organised as the closing event to the European Conference on Sex Work, Human Rights, Labour and Migration conference held in Brussels, Belgium. Since this day the red umbrella has been welcomed by sex worker activists and their allies around the world. What started as a simple idea is quickly becoming a global symbol for sex workers' rights.

Red is a colour of beauty and an umbrella is the resistance to the sky's and humans' attacks. It symbolizes protection from the abuse and discrimination faced by sex workers everywhere but it is also a symbol of their strength.



Other specific health issues related to sex work

This last section of the guidelines looks at more generalised health issues related to sex work. The list given is not exhaustive, but merely illustrates the diversity of issues which may impact on the health and well-being of men and women selling sex. Where projects/services identify specific issues or health problems not covered in these guidelines, as a general rule they should develop local guidelines, policies or procedures to ensure these are documented. This helps to build a library of knowledge, and allows consistency of approach when planning and delivery care in order to address these health challenges.

Female anogenital health

Some female workers wash too much and may use harsh chemicals. Repeated washing of the genitals in particular, but also of the skin and hands, can cause damage to the natural protective properties of the skin and mucous membranes, and may lead to conditions such as dermatitis, which in itself can actually increase the risk of infection. Sometimes, just the frequency of showers required between clients can cause drying of the skin. Health/outreach professionals may advise replacing highly perfumed products such as soaps and shower gels with pH balanced products, that will help maintain the natural flora of the skin.

Some women use chemical agents to clean the vagina after sexual contact, to dry the vagina prior to sex or to keep the vagina tight. Different agents may cause irritation of the vaginal mucous, and increase susceptibility to infection. It is best not to rinse the vagina or introduce any chemical substances. Where women do not accept this advice, they should be encouraged to rinse as little as possible. Some practitioners recommend the use of mildly acidic vaginal products that may protect against bacterial vaginosis

Where the women feels the need for persistent and unnecessary washing, health professionals and outreach workers might want to explore the reasons behind these behaviours, which may be related to internalised feelings of self worth, guilt or shame, and if appropriate refer to counselling services, or suggest less harmful practical alternatives.

Many female sex workers continue working during menstruation. Some use vaginal sponges to prevent blood loss during sexual contact. There are no data on the safety of this practice, but where used these women should be advised to use dry sponges without additives like spermicides and viricides, which can cause vaginal irritation. A sponge should never be longer in place than eight hours, only be used once, and best be used together with a lubricant to prevent vaginal dryness. Natural sponge is less hygienic, and are prone to parts being retained and leading to infection.

Sex workers who have anal sex should always use a sufficient amount of lubricant. They should avoid causing little wounds or fissures of the anal sphincter, since this will not easily heal, which creates discomfort, and an elevated risk of infection. When touching the anal area with fingers, good hand hygiene is important (wash with soap) to avoid the transmission of intestinal infections. Anal douching is widely used but carries the risk of damaging the rectum. However, health/outreach professionals should be familiar with these practices and the use of suppositories and enemas as well, and offer practical advice to sex workers to prevent risk of infection and/or rectal trauma. Sex workers should also be advised that the anal and rectal lining is a highly absorbent mucous membrane, so substances such as alcohol or cocaine which they allow to be placed inside the anal passage during sex play will quickly be absorbed into the blood stream in a concentrated form.

To prevent bladder infections (cystitis) it is recommended to drink sufficient amounts of clear liquid and to pass urine after a sexual contact. Certain natural fruit juices (such as cranberry juice) have also been shown to have a preventative and treatment affect against bladder infections. The passing of catheters can increase the risk of infection or urethral trauma if not used with care and adequately sterilised. Where health/outreach professionals are aware of women using such devices during their work, either on themselves or with clients, they should counsel them on the proper application/insertion technique.

Male anogenital health

As with women, many male sex workers will over wash, for many of the same reasons and with many of the same effects and negative outcomes (in terms of general skin health) as cited above. For guys, particularly those who are not circumcised and still have a foreskin, over-washing of the head of the penis and under the skin can cause irritation, localised erythraemia and may destroy the natural protective environment of the glans, leading to conditions such as balanitis.

Use of creams or sprays to increase sexual prowess or the strength and duration of the erection is also not advisable. Like the herbal or alternative forms of Viagra discussed earlier, such products are often unregulated and the exact nature of their active ingredients may be unknown, therefore health professionals should caution men selling sex away from the use of such products.

The use of cock-rings or bands maybe a safer alternative to help sustain an erection for a longer duration, rather than using pharmaceutical or chemical means, but men using such products should be experienced and familiar with their use, and health/outreach professionals may need to provide education around their safe application and duration of use, and what to do when something goes wrong, such as swelling that prevent removal of the ring.

As with women, those guys who have anal sex should always use a sufficient amount of lubricant. They should avoid causing little wounds or fissures of the anal sphincter, since this will not easily heal, which creates discomfort, and an elevated risk of infection. When touching the anal area with fingers, good hand hygiene is important (wash with soap) to

avoid the transmission of intestinal infections. Anal douching is widely used but carries the risk of damaging the rectum. However, health/outreach professionals should be familiar with these practices and the use of suppositories and enemas as well, and offer practical advice to sex workers to prevent risk of infection and/or rectal trauma. Sex workers should also be advised that the anal and rectal lining is a highly absorbent mucous membrane, so substances such as alcohol or cocaine which they allow to be placed inside the anal passage during sex play will quickly be absorbed into the blood stream in a concentrated form.

Again, as with their female colleagues, to prevent urethral irritation and potential bladder infections it is recommended to drink sufficient amounts of clear liquid and to pass urine after ejaculation. Certain natural fruit juices (such as cranberry juice) have also been shown to have a preventative and treatment affect against bladder infections. The passing of catheters can increase the risk of infection or urethral trauma if not used with care and adequately sterilised. This is the same with 'sounds' or 'probes' which are becoming increasing popular (a long thin solid tube, can be made of metal, plastic or silicone, and is inserted down the urethra via the meatus of the penis. Novelty ones are also available that can vibrate or light up to give a 'glow in the dark' erection), men should be warned about the risk of possible urethral stricture, or increased risk of developing NGU due to urethral irritation. Where health professionals are aware of men using such devices during their work, either on themselves or with clients, they should counsel them on the proper application/insertion technique. Remember as well that sharing of such devices without adequate cleaning in warm soapy water between insertions with different partners, will increase the risk of transmission of STIs and HIV.

Piercing, scarification & shaving

Piercing should happen in hygienic conditions, ideally through a licensed piercing parlour that adheres to standards of health and safety. Where piercing is self-administered or being done as part of the commercial sex act, care needs to be taken to ensure hygiene and infection control precautions are adhered to. Health/outreach professionals and outreach workers should discuss basic aseptic techniques to reduce the risk of infection and ensure that instrumentation used is clean and sterile, and not shared, to prevent infection with blood borne infections such as hepatitis B and C, or HIV. It should also be discussed that

some genital piercings may interfere with the proper use of condoms, and increase the risk of a tear or condom failure.

Scarification is the process of self cutting, to scar the skin deliberately, often for an artistic effect. Many ancient tribal cultures use forms of scarification as a branding or mark of the tribe. Some sex workers, especially those offering domination and S&M services may offer scarification as part of their commercial profile, as it can be a mildly painful experience, through which some clients gain sexual satisfaction. As with piercing, care needs to be taken to ensure basic aseptic technique is adhered to reduce the risk of infection and ensure that instrumentation used is clean and sterile, and not shared, to prevent infection with blood borne infections such as hepatitis B and C, or HIV. As the process can generate a large amount of blood, care should be taken if following the act of scarification, sexual intercourse occurs, as blood may find its way to the anal genital area increasing the risk of onwards transmission of blood borne infections.

Many sex workers will also shave their anogenital areas, for aesthetic reasons or because they feel it is more hygienic. Some sex workers will incorporate pubic shaving into their sex play with clients. If done properly, there should be little exposure to blood, but small nicks and cuts can occur and care should be taken if blood is present and sexual intercourse will follow thereafter. Obviously, razors and shaving implements should not be shared, and occasionally the skin in the pubic area can become irritated or develop a follicular rash in response to shaving. Health/outreach professionals should advise this can increase the risk of transmission of certain STIs, such as warts and herpes virus.

With all of these acts, health and outreach workers should be familiar with the legal rulings and regulations of their locality, as any act that potentially leaves a mark, such as puncturing the skin, may be deemed as an assault, even if consensual, and sex workers may need to be cautioned as to their rights and whether they could be at risk of legal action.

Contraception

The main objective of contraception is for women to avoid unwanted pregnancy and prevent the need for termination. In addition to this, it is important that the woman has a solid basis for her choice of contraception, and is able to manage the way in which it is administered.

Therefore, during conversation with the woman, health/outreach professionals must make sure that her needs for contraception are met. The objective is to avoid unwanted pregnancy. However, it is also important to ensure that she understands that no other contraceptive apart from condom protects against sexually transmitted infections.

The conversation must clarify:

- The need to avoid pregnancy
- Chances of serious side effects like thrombosis (blood clot)
- Medical contraindication like smoking, high blood pressure, overweight, thrombosis in immediate family
- Does she need a contraceptive that lasts over time?
- Does she want it to be visible or invisible?
- What does easily accessible mean to her?
- Whether expense matters
- Whether she is on medication that can reduce or eliminate the effect of the contraceptive

When this has been clarified, health professionals may proceed to suggest a possible contraceptive. Regardless, the most important fact is that the woman feels that she is a part of the process in order for her to actually use the contraceptive. It is also vital to consider whether or not a family doctor (GP) should be involved and whether or not the contraceptive should be distributed free of cost.

Permanent contraception is the safest option if the woman does not wish to get pregnant. It is important to achieve good communication about this.

For some women permanent contraception in addition to using a condom is out of the question. The reason for this could be that they associate use of the contraceptive with having a steady partner, and only the condom is a possibility when meeting clients. In these cases it is important to inform them of emergency contraception as an option. This is a tablet that is to be taken as quickly as possible and within 72 hours after unprotected intercourse or a split condom. The effect decreases after the first 24 hours, but effect is proven for 72 hours.

The possible contraceptives include: Contraceptive pill; contraceptive ring (NuvaRing); contraceptive stick (Implanon); contraceptive plaster (Evra); and contraceptive depository (DepoProvera), which all work in the same way: the ovulation stops, the mucous membranes in the uterus become so thin that a fertilised egg does not attach. The secretion that exists naturally in the uterus becomes so sticky that sperm cells cannot pass.

As regards the actual use of the contraceptive, how they are used and possible side effects differ:

The contraceptive pill - This is a tablet that has to be taken every day. For some this doesn't constitute a problem, for others it is difficult to remember to take the tablet every day. The contraceptive pill is however often the first alternative when starting with contraception. It is therefore very important to enquire as to whether the woman is comfortable taking a tablet a day. If not started the first day of menstruation it will take eight days before working.

Women starting the hormonal contraceptive pill should be counselled on the potential side effects. During the first three months they may experience what are classed as uncomfortable, yet harmless side effects: headache, dizziness, nausea, sadness, mood swings, reduced sex drive, dry mucous membrane, greasy hair, oily skin, increased weight, changed discharge. If the side effects persists for longer than three months and/or they become uncomfortable, a change of contraceptive pill is recommended.

Also, there is a greater chance of blood clot (thrombus) of the heart and brain when using hormonal contraception. It is therefore important to ensure women are familiar with which symptoms may occur: severe, unusual headache, difficulty speaking or seeing, coughing mucous containing blood, heavy pain in the middle of the chest, reduced strength in the left or the right side of the body, fits of cramps and/or fainting and a large painful swelling on the calf. If this occurs women should seek urgent emergency medical attention.

The contraceptive ring (NuvaRing) - This is a ring that is inserted into the vagina in the same way as a tampon. The ring is inserted during the first five days of the menstruation. It stays in the vagina for three weeks at which stage it should be taken out and thrown away.

During the fourth week the woman will have nothing in the vagina. The level of hormone is then supposed to fall low enough to start menstruating, but not low enough to get pregnant. The ring is unnoticeable during intercourse.

Contraceptive implant (Implanon, Jadelle) - Implanon is a little plastic stick that is inserted under the skin on the inside of the upper arm. Depending on which type of implant, it stays inside for three to five years. It is inserted between the first and fifth day of the menstruation. It should only be inserted and removed by a trained healthcare professional familiar with the procedure. Irregularities as regards menstrual bleeding is normal the first six months after implantation, and normally the menstruation stops after this.

Contraceptive plaster (Evra) - Evra is a skin coloured plaster that can be adhered on the dermis on the first day of the menstruation. The hormone is contained within the plaster's adhesive pad and are absorbed by the skin. This results in an even concentration of the hormone in the blood. The plaster is not recommended to women who weigh more than 90 kg as studies show increased frequency of pregnancy in this group.

The plaster is put on undamaged clean and dry skin the first day of the menstruation. It can be attached to the bottom, the outside of the upper arm, stomach or the upper part of back/chest - although never on the breasts. The plaster is to be pressed on to the skin for at least ten seconds, and it is important to check that the edges are firmly attached. The plaster is changed every week on the same day of the week for three weeks. On the fourth week, which is plaster free, the woman menstruates. The fifth week the plaster is put back on.

Contraceptive depository (Depo Provera) - This is an injection that is given intramuscularly, usually in the gluteus musculature, every 12 weeks. It can be given at any time of the menstruation cycle provided the woman knows she is not pregnant. Some prefer to inject it on the first day of the menstruation. If the injection is given when the woman is not menstruating it will take eight days before it works.

The contraceptive depository does not have the same side effects as associated with cardiovascular diseases, and can therefore be used by those who cannot use medicine containing oestrogen. For girls who are not fully developed the use of the contraceptive

depository can hinder the production of bone cells. This could in the long-term lead to increased tendency towards osteoporosis.

The bleeding is very irregular during the first six months. Most women lose the menstruation completely, whilst a quarter will experience frequent or continued bleeding for 12 months. It might help to give the injection after 10 rather than 12 weeks if the woman experiences slight bleeding. It could take up to 18 months after the last injection before the woman can get pregnant.

Progestagen only pill- This is a type of contraceptive pill that only contains progestagen. The effect is mainly on the cervical mucus, which becomes less penetrable for sperm cells. The effect lasts 24 hours, and the pill therefore has to be taken at the same time every day to achieve the desired effect. Older women experience a better effect of the pill, overweight women a lesser effect. If there has been more than 27 hours between two pills, the woman is to take another pill as soon as possible and then continue to take one pill every 24 hours. It will take two days before it works.

The greatest side effect is abnormal bleeding, particularly the first three months. Frequent and irregular bleeding is normal. 40% return to normal menstruation, 20% become amenorrhoeal and 40% experience an unpredictable bleeding pattern.

Levonorgestrel IUD (Mirena) - This is a progestagen based intrauterine device (IUD) suitable for women with uncomfortable menstruation. It can be an effective contraceptive and is increasingly be used by more women today, including young women who have not given birth. The health practitioner needs to be experienced at inserting the IUDs as this can be painful and there is a danger of perforation whilst inserting. This however, is very unlikely; 1-5 out of a 1000 cases. When inserting an IUD, infections can be transferred to the uterus. It is therefore important to have a good insertion technique and to screen for and treat a possible chlamydia infection.

5-10% women experience that the body rejects the IUD. This normally happens in the first few months after being inserted, and it can happen without the woman noticing. You can offer a check-up 1-3 months after insertion, but this is not necessary. The woman can herself check that the threads are in place. Slight bleeding is normal the first few

months. When an amenorrhoea has lasted more than two months the woman should get a pregnancy test, possibly repeated after a month. If these are negative, the amenorrhoea is a result of the IUD, and she doesn't need any more tests. This type of IUD works for 5-7 years.

Copper IUD - Copper IUD is a good contraceptive for women who don't suffer from pain or heavy bleeding during menstruation. It is very effective, and is being used by many more women today - like the levonorgestrel IUD. The copper IUD is the safest non hormonal contraceptive existing today. You change the IUD every five years.

The copper IUD changes the environment in the uterus so that the sperm cells' movements are obstructed from fertilising the egg. If fertilisation still happens the IUD can hinder the egg from implantation in the uterus.

Should a woman still get pregnant when using the IUD, it has to be removed as quickly as possible. The chances of miscarriage are bigger if the IUD is left than if it is removed. If the threads retract upwards so you cannot feel them, the woman might be pregnant and a doctor should be consulted.

The Condom - The condom is to date the only contraceptive for men, other than vasectomy. Those female sex workers who choose the condom as the only contraceptive can also use emergency contraception in case of for example a split condom. The condom is the only contraceptive that also protects against sexually transmitted infections.

Pregnancy

A majority of female sex workers are between 20 and 30 years of age, and many will, at some point, wish to conceive. Where the woman is trying for pregnancy with a private non-paying partner, and chooses or needs to continue her sex work, it can present some complications, especially if a condom failure occurs. It maybe that she knows she is already pregnant and the condom failure places her at risk of STI acquisition. If she is not already aware of a pregnancy, then there is the risk she could conceive from the clients sperm other than her private partners, in which case emergency contraception needs to be considered.

However, it may not always be possible to be sure if she has conceived from sex with the private partner or when the condom failure occurs with paying partners. In such circumstances health professionals need to counsel and support the woman with the difficult decisions she will need to make. It is advisable in such situations that she consider emergency contraception, as following through with the pregnancy, unsure of the actual father, could lead to a decision for abortion, or not discovering who the father may be until the birth of the child, with possible unimaginable consequences.

It is important to raise these issues when discussing contraception in general, before addressing the wish to get pregnant. It could be advisable that the sex worker have no vaginal sex with a client in the two weeks surrounding ovulation until her pregnancy status is clear. Some women will choose to stop vaginal sex completely until they conceive. A further point of discussion may be the question whether to continue working during pregnancy, and for how long. Pregnancy as such is no contraindication for sex; however, some STI can be transmitted to the foetus. If there is blood loss, the woman should stop working and go and see a doctor. Other points to discuss: the use of alcohol and other drugs during pregnancy, prenatal controls, where to give birth, and is there health insurance for the mother and the child. For projects/services who are going to support sex workers through a pregnancy, they need to have referral centres and access to midwives to manage the care.

Aesthetics

Sex work in many parts of Europe can be very competitive, and large numbers of sex workers will undergo cosmetic procedures or surgery in order to improve their looks and help gain what they may consider a competitive advantage within the market place. For some transgender sex workers, these changes may also be a significant part of their transition process. For others, just as in all walks of life, the individual may be displeased with certain attributes of their physique and their sex work may afford them the finances to be able to make changes and enhancements through aesthetic procedures and corrective surgery.

Whatever the sex workers motivation, many will engage with this growing area of healthcare. Whilst it is probably not appropriate for sex worker specific projects/services to be offering this kind of service/treatment, health professionals within these projects/services should

have a general awareness of the issues and types and range of treatments and procedures available within their locality. This will ensure sex workers are counselled appropriately and referred to legitimate services where procedures will be conducted following appropriate levels of clinical governance and safety, and directed away from less reputable clinics.

It maybe that sex workers will present with post-procedural complications, such as infected surgical wounds, and may require assessment and treatment, or referral to primary care facilities. For some HIV positive sex workers, they may have side effects of certain HIV medications, such as lipodystrophy, which can cause disfiguring wastage from the face, especially around the cheeks and jaw line. In these circumstances, projects/services which also provide HIV treatment and care may be able to offer a service of aesthetic treatment will biochemical fillers such as Newfill.

Steroids and hormones

Many men who sell sex do not undergo necessarily aesthetic procedures, but will try to enhance their physique by combining steroids, either as tablets or injections, with a rigid gym regime, in order to build muscle mass quickly, tone up and have what they perceive to be an attractive body within a highly competitive market place.

It is not appropriate for health professionals to prescribe steroids to be used for these purposes, but in some countries within Europe, such medications can be purchased from the pharmacy without the need for a doctors prescription. In those circumstances it maybe necessary for health professionals to have an understanding of the usual doses, routes of administration and potential side effects of these drugs.

Most steroids are derived from the male hormone testosterone, which can rapidly increase muscle mass, but only if combined with the correct training regime in the gym. Many are taking in cycles, or by what is called 'stacking' – taking several different types of steroids that work in a combination.

Nearly all users of steroids will experience some side effects, these can include: acne (especially on the back); trouble sleeping; gut disturbances; hair loss (which doesn't grow back); growth of breast tissue ('bitch tits'); shrinkage of the genitalia; hypertension with risk

of stroke; raised cholesterol; liver, kidney and heart problems; and, mood changes with extreme irritability and aggression.

Many people also experience extreme depression when they stop using the steroids, which can include thoughts of suicide. The psychological effects of steroid use can be far reaching. Short term use may increase a sex workers self-esteem, and boost their sex drive, making them feel more sexually confident with clients and partners, but this could result in greater risk taking and increased risk of STI acquisition. Longer term, a body dysmorphic disorder can develop, where the sex worker see themselves as smaller than they really are, and becomes obsessed about their body size.

If injecting the steroids, there is also the risk of abscess or infection, or if sharing needles and equipment with others, HIV, hepatitis B and C infection. Illegal steroids can often be contaminated, diluted, fake or made for use with animals rather than humans. For sex workers thinking of starting a course of steroids, as health/outreach professionals it would be advisable to check their liver and kidney function and also blood cholesterol. Steroids should be avoided by those with diabetes, hypertension, glaucoma, cardiac conditions or any mental health problems. Advise users to drink plenty of water whilst taking steroids (up to 3 litres a day) to help clear waste products from the body caused by the steroids. They can also stunt growth and should not be used by those under 24 years of age.

Mixing steroids with alcohol or other recreational drugs is not a good idea. Other substances often have a sedating effect, and therefore the user is less likely to maintain their gym regime, and may begin to loose weight rather than bulk up. The combination can also strain the liver, and as steroids can affect mood, it is not wise to combine them with other drugs that alter the mental state.

For those HIV positive sex workers who maybe taking HIV treatments that also increase blood cholesterol levels, combining with steroids may have a serious affects and increase the risk of stroke or heart attack, so any steroid use, and the sex worker should be advised to discuss with their HIV physician.

Transgender sex workers will have specific health needs, and sometimes they will seek the help of health professionals working in sex worker projects/services. Most gender reassignment programmes are for male to female and include the administration of

feminising hormones, oestrogen and progesterone, which may help to develop female secondary sexual characteristics. In addition, prior to surgery, many will be using anti-androgen treatments, to reduce the effects of their own male sex hormone. There are risks attached to taking hormone therapy and such treatments should be medically supervised by experienced specialists in the field. However, many transgender sex workers will be acquiring hormones via the internet or from black market suppliers, and maybe placing themselves at risk. Gender reassignment is a specialist form of medicine, and it is important that services have referral pathways to the local specialist treatment centres.

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List of abbreviations

HIV Human Immunodeficiency Virus

HBV Hepatitis B Virus

HAV Hepatitis A Virus

HCV Hepatitis C Virus

HPV Human Papilloma Virus

HSV Herpes Simplex Virus

STI Sexually Transmitted Infection

SM Sado-masochistic

PEP Post Exposure Prophylaxis

IUD Intra Uterine Device






ENMP European Network Male Prostitution

EUROPAP European Network for HIV-STD Prevention in Prostitution

TAMPEP Transnational AIDS/STD prevention among migrant prostitutes in Europe

Appendix A


| Type of Sex | STI Risk | |
|---|--|--|
| Kissing – oral to oral contact | <ul style="list-style-type: none"> • HSV • HPV • Syphilis | |
| Massage – sensual touching of the body | Pubic lice and scabies | |
| Masturbation – stimulation of own or others genitals | There is little real risk of acquiring an STI from masturbation. | |
| Use of sex toys – this may include dildos, cock-rings, anal plugs, anal and vaginal beads, vibrators, etc. | There is little risk of acquiring an STI from use of sex toys, as long as they are cleaned between use and condoms changed if sharing toys between partners. Implements 'inserted' down orifices may cause trauma, tears, stricture or inflammation. | |
| Shaving – erotic role play where body hair is shaved during the sexual act | There is a potential risk of transmission of blood borne STIs such as HIV, hepatitis B and C and syphilis from sharing razors or other sharp objects which may be used for shaving. | |

| | Prevention |
|---|---|
|  | <ul style="list-style-type: none"> • Transmission maybe reduced if avoid kissing when cold-sores visible • Transmission may be reduced if avoid kissing fleshy lesions visible around the mouth, chin or lips • Oral syphilitic lesions are often painless and difficult to visualize, therefore avoidance may present problems – requires honesty of infected person if they are aware of their diagnosis, however, it is important to note that syphilis is rarely transmitted through |
|  | <p>There is a potential risk from close/intimate sensual contact, particularly within an erotic sexual context, of acquiring an infestation of lice or scabies. This risk would be increased if contact is with persons of low socioeconomic status (e.g. street homeless). Precautious should be taken if using oils for masturbation, to ensure hands and genitals are cleaned of oil before penetrative intercourse occurs, to prevent weakening of the condom.</p> |
|  | <p>However, precautious should be taken if using oils for masturbation, to ensure hands and genitals are cleaned of oil before penetrative intercourse occurs, to prevent weakening of the condom. It is also important to ensure any open wounds or sores on hand and fingers are covered by a waterproof dressing to prevent risk of infection.</p> |
|  | <p>Dildos & vibrators – ensure that condoms are used if sharing the dildo during a sexual session, and clean in warm soapy water between use, to care to dry thoroughly before placing into storage. Potentially, many bacterial and viral STIs can be transmitted from bodily fluids carried on the dildo if not cleaned or condoms not used when sharing between different sexual partners.</p> <p>Cock-rings – There are many different types of cock-ring, some that fit just at the base of the penial shaft and others that encompass the entire penis and scrotal sac. Precautions need to be taken in the same way as with dildos, to make sure that any bodily fluids which may spill onto the ring are washed off in warm soapy water between use/different partners. The other main concern with the use of cock-rings is that they may tear a condom if worn at the same time, can get caught on other genital jewellery (such as vaginal piercing) and the risk that swelling can occur to the extent that the penis may not become flaccid and a priapism can occur – if this happens the man should attend an emergency room for immediate assistance.</p> <p>Anal plugs – like with dildos, need to be washed</p> |
|  | <p>Shavers, blades and other sharp implements used for shaving or removing body hair should not be shared. Also take care where small nicks or cuts may occur during the shaving process, ensure cuts or sores on the hands are covered with a waterproof adhesive dressing.</p> |


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| <p>Use of sadomasochistic (SM) techniques/ bondage – sexual acts involving tying someone up, humiliation, and the application of pain for pleasure.</p> | <p>There is little risk of STIs from this type of activity, other than losing control of the sexual game which may result in unprotected penetration.</p> | |
| <p>Digitation (fingering) – the insertion of fingers into the vagina or anus for sexual pleasure.</p> | <p>Theoretically it may be possible to transmit infections from this activity. Warts virus around the finger beds (Witlow's) may transmit HPV from the fingers to the vagina or anus, although this is highly unlikely. Bodily fluids on the fingers (such as vaginal secretions or seminal fluid) may transmit bacterial and viral STIs, if then inserted into the vagina or anus, although again, it is very rare for infection to be acquired in this way.</p> | |
| <p>Oral sex: Rimming (licking around the anus) Active fellatio (sucking a penis) Receptive fellatio (penis being sucked) Cunnilingus (licking around and inside the vagina)</p> | <p>Rimming – the main risk from rimming is transmission of hepatitis A and B, but also other infectious such as enteric bacterial infections. Viral skin infections such as HPV and HSV may also be transmitted from rimming or being rimmed. There is little change of acquiring HIV from rimming or being rimmed, although if blood is present around the anus, there is a theoretical risk of transmission. Candida may also be triggered by rimming, especially if already immunocompromised.</p> <p>Nearly all STIs can be transmitted by sucking a penis, if a condom is not used. Bacterial infectious such as gonorrhoea and chlamydia may be easily transmitted from penis to throat, as may syphilis. Viral skin infections such as HPV and HSV may also be transmitted from the penis to the mouth, lips and chin. There is also an increasing body of evidence to show that HIV may be transmitted from sucking a penis, especially if seminal fluid (pre-cum) or ejaculate is taken into the mouth, and the risk is thought to increase if actual ejaculate is taken into the mouth and swallowed – although the risk is still very low.</p> | |

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|  | <p>Be sure to ensure that all parties involved are in agreement with the rules of the game, including code words that can be used to stop the game/activity. Sex workers may need to consider that they place themselves in a potentially vulnerable position if they allow a client with whom they are unfamiliar to tie them up or dominate them in some way. If the sex worker is being dominant, and this may include inflicting pain on the client, they need to be aware that laws and regulations across Europe vary with regard to such activity, and even if consensual, in some countries this could be seen as grievous bodily harm. Care should also be taken if any SM activity may result in a brake in the integrity of the skin, causing bleeding or sores, contact with such wounds should be avoided.</p> |
|  | <p>Ensure that hands are clean and free from bodily secretions before inserting into someone's vagina or anus. To reduce the potential spread of infections, single use finger covers (finger cots) can be worn or disposal gloves worn, although water based lubricant should be used if gloves are worn, and gloves should be used once only and changed between sexual partners. To prevent potential damage to the sensitive lining of the vaginal or anal walls, nails should be kept short.</p> |
|  | <p>Hepatitis transmission may be prevented through effective vaccination against hepatitis A and B. Viral skin infections such as HPV and HSV may be reduced if rimming is avoided at times when herpes or wart lesions may be visible. Risk of these and bacterial STIs may also be reduced by using a dental dam (oral shield), a form of barrier placed between the anus and tongue. When such resources may not be available, a flavoured condom cut along the length of its shaft and then stretched over the anus or non-porous food film (cling-film) may be used as an alternative substitute.</p> <p>One of the best ways to prevent STI transmission is for the penis being sucked to be covered by a condom. There are a wide range of flavoured condoms available and their use should be encouraged, especially with the sex workers paying clients. However, it should be remembered that the condom will only cover the head and shaft of the penis, so while this may prevent onwards transmission of gonorrhoea and chlamydia, syphilitic, herpes or wart lesions on the scrotal sac may rub against</p> |

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| Vaginal sex | The woman is most at risk from unprotected vaginal sex, although the male partner may also acquire genital infection from penetration without a condom. All STIs can be transmitted through unprotected vaginal sex. | |
| Anal sex | The receptive partner is most at risk from unprotected anal sex, although the insertive partner may acquire genital infection from insertion without a condom. All STIs can be transmitted through unprotected anal sex. Warts virus is easily transmitted by unprotected anal sex, and is one of the most common STIs in MSM, although it should be remembered that unprotected anal sex is the most common cause of onward HIV transmission for MSM, particularly for the receptive partner, and the risk increases if ejaculation occurs. Chlamydial infection and the associated condition LGV (lympho-granuloma venereum) can cause major inflammation and subsequent scarring of the inside of anus and penile ulcers, and is on the increase from unprotected anal sex between men. Gonorrhoea can also be transmitted through unprotected anal sex, and just the fact of taking sperm into the anus/rectum can cause an inflammation of the lining called proctitis. | |




A barrier method, such as a male or female condom, will protect against most bacterial sexual infections. However, the use of caps and diaphragms only offer very limited protection against the transmission of sexual infections. It should also be remembered that the condom only covers the shaft of the penis, therefore the base of shaft and scrotal sac may be vulnerable to infection, particularly syphilitic, herpes or wart lesions, and infestations such as pubic lice. Likewise, the labia and clitoris may be vulnerable to the same, from exposure to the base of the penile shaft and scrotal sac not covered by the condom. Currently clinical trials are underway into the use of vaginal gels with anti-viral properties to prevent the onward transmission of HIV, but at the time of writing, no such products are commercial available.




A barrier method, such as a male or female condom, will protect against most bacterial sexual infections. It should also be remembered that the condom only covers the shaft of the penis, therefore the base of shaft and scrotal sac may be vulnerable to infection, particularly syphilitic, herpes or wart lesions, and infestations such as pubic lice. Likewise, the perianal region may be vulnerable to the same, from exposure to the base of the penile shaft and scrotal sac not covered by the condom.

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| <p>Sadomasochist (SM) - including bondage, fisting, & spanking.</p> | <p>Most sadomasochistic activities involve inflicting pain or humiliation onto sexual partners, with one partner taking a dominant role and the other a subservient role. Most of these activities involve role play, and may include bondage, dressing up, etc. There is little or no risk of HIV transmission from most of these activities, unless they involve some form of penetration (oral or anal sex), where the risks will be as described for the activity above. Some more intense SM activities can involve drawing blood, from hard beatings, whipping, canning or actual scarification (deep cutting of the skin) – in such circumstances, blood to blood contact should be avoided, and thorough cleaning of tools/equipment should occur between use. Hepatitis B and C may also be transmitted from blood to blood contact. Fisting, if not done careful or by someone inexperienced can damage the lining of the rectum or vaginal and increase risk if then the recipient is fucked without a condom. It should be noted that fisting has been linked to an increase risk of lymphogranuloma venereum (LGV).</p> |
| <p>Watersports (urination)</p> | <p>There is no real risk of HIV transmission from watersports, either urinating onto another person, or being urinated on. Some people enjoy taking urine into their mouths, and often swallow. There may be some slight risk with this, especially if the active partner urinating is sexually aroused and may have cum or pre-cum in their urethra, or vaginal secretions which may be passed when they pee. There is also a slight risk if they have a bladder or urinary track infection, as blood may then be present in the urine, which could be a risk if swallowed. A number of individuals also like to be penetrated without a condom and then have their partner pee inside their rectum or vagina. This is obvious a risk for HIV transmission, the same risk as for receptive unprotected penetrative sex as described above. If taking urine into the mouth, there is a risk of hepatitis B transmission, but this can be reduced by being vaccinated. There is risk of syphilis, gonorrhoea, chlamydia, hepatitis B and C from engaging in unprotected sex, if taking urine in the rectum or vaginal or penetrating a partner with the intention of urinating inside them.</p> |



Setting limits and negotiating boundaries is the most important safety factor with SM activities. Sex workers need to be clear about the rules of the games and stay in control. Always have agreed codes or signals to indicate when one partner or the other wants to stop and respect these at all times. Where role play may lead to penetrative sexual activities, risks will be reduced by the use of condoms, although as previously cited, condoms do not protect against all sexual infections. Most sex workers take a dominant role when offering SM activities, but again, may need to be aware of the laws specific to the country, as inflicting potential bodily harm on another in some countries, even with their consent, can still be considered criminal activity.



Drinking plenty of clear fluids (water) prior to sexual games involving urination will help to ensure the urine is clean and fresh, alcohol and large amounts of coffee can lead to the urine being concentrated. Obviously urination should be avoided if either party suspects they may have a urinary tract infection or bladder infection. If penetrating a partner with the intention of urinating inside them, it will not be possible to wear a condom, although for female sex workers, if the client is wearing a condom when he penetrates vaginally, there is little real risk in urinating during the penetration. Vaccination against hepatitis B (see end of section 6) will protect against possible infection of hepatitis B from watersports.

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| <p>Scat/Brown (defecation)</p> | <p>There is no real risk of acquiring HIV from scat play. Theoretically, if you take faeces into the mouth, you might swallow small amounts of traces of blood, which could contain HIV. To reduce the risk entirely, faeces should not be taken into the mouth. However, faeces on the skin or genitalia do not really present an infection risk for HIV, unless of course visibly blood stained. The main risks from faeces play is hepatitis B and syphilis, if the faeces should have contact with a mucus membrane. Also, infection with hepatitis A can occur if swallowed faeces which contain the virus. Some intestinal parasites such as thread worm, tapeworm, giardia, and colitis amoebiasis may also be accidentally swallowed if having faeces play.</p> | |
| <p>Thigh fucking</p> | <p>There is no risk of HIV from rubbing bodies together or thigh fucking, even if ejaculation occurs. The main risk is skin viruses such as warts and herpes. Both can be transmitted by repeated, prolonged rubbing of infected skin cells over damaged (from the friction of the rubbing) areas of skin of a sexual partner. Once a person has been infected with either warts or herpes, they remain potentially infectious and viral shedding (transmission of the virus) can occur even when during an asymptomatic period (when no sores or lesions may be present).</p> | |
| <p>Use of catheters, piercing & scarification</p> | <p>There is little or no risk of HIV or STI transmission from most of these activities, if clean equipment is used and not shared during the activity. Piercing and scarification will draw blood – in such circumstances, blood to blood contact should be avoided, and thorough cleaning of tools/equipment should occur between use. Hepatitis B and C may also be transmitted from blood to blood contact.</p> | |

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|  | <p>Scat should be avoided if the defecating partner knows they have an intestinal infection, irritable bowel disease, colitis, haemorrhoids, or proctitis, as these conditions may increase the risk of blood being present in the faeces. Risk of hepatitis A & B infection can be prevented by vaccination, and risks of intestinal and other infections can be reduced by not swallowing faeces or taking them into the mouth.</p> |
|  | <p>It is best to avoid sexual contact when sore or wart lesions are present. Wait for herpes sores to have completely healed and reduce risk by using a condom. Always have wart lesions treated, and again reduce the risk by using a condom.</p> |
|  | <p>Setting limits and negotiating boundaries is the most important safety factor with these activities. Sex workers need to be clear about the rules of the games and stay in control. Always have agreed codes or signals to indicate when one partner or the other wants to stop and respect these at all times. Where activity may lead to penetrative sexual activities, risks will be reduced by the use of condoms, although as previously cited, condoms do not protect against all sexual infections. Infection from hepatitis B can be avoided by vaccination against this virus.</p> |

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Justin Gaffney was a Nurse Practitioner within a specialist sexual health promotion and HIV prevention project for male sex workers from 1994 till 2004, and was then appointed to Consultant Nurse in STI Control within the sexual health department of St Mary's Hospital, London, UK. Taking a break from clinical work, he entered health service management, and was Associate Director of Organisational Change at Imperial College Healthcare NHS Trust, London, UK, until the end of 2007. More recently he has established the health and social enterprise SohoBoyz, providing services to men selling sex in London. He is Chair of the Genito-Urinary Nurses Association (GUNA), Board member of the UK Network of Sex Work Projects (UKNSWP) and has a thriving private sexual health practice (www.metrosexual.co.uk).

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Back booklet:

This booklet has been compiled within the framework of the Correlation Project – European Network Social Inclusion & Health.

These guidelines are based on a former edition of the European Network for HIV-STD Prevention in Prostitution (EUROPAP), which published a first edition in July 2003. This update contains major changes, extensive amendments and additional chapters, which are based on the expertise of various experts in the field and the current knowledge in regard to the technical and medical issues, mentioned in this booklet.

The guidelines are meant for health and social workers who have had formal training in health issues, or developed practical experience through their work, and who deliver or intent to deliver health care and health promotion services to sex workers. Saying so, the guidelines focus on experienced and less-experienced colleagues in the field.



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