Sex Work, HIV/AIDS, and Human Rights

in Central and Eastern Europe and Central Asia

Central and Eastern European
Harm Reduction Network

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A report from the Central and Eastern European Harm Reduction Network

July 2005

Organization information

The Central and Eastern European Harm Reduction Network (CEEHRN) is a regional network with a mission to support, develop, and advocate for harm reduction approaches in the field of drugs, HIV/AIDS, public health, and social exclusion by following the principles of humanism, tolerance, partnership, and respect for human rights and freedoms.

Founded in 1997, CEEHRN today unites more than 250 individuals and organizations from 25 countries of in Central and Eastern Europe and Central Asia. The network's members come from both the public and private sector and include government agencies, drug treatment and HIV specialists, harm reduction organizations, researchers, community groups and activists (notably, organizations of people living with HIV and drug users), as well as supporters and experts from outside the region. CEEHRN is governed by its members and through their elected representatives on the Steering Committee. The executive work is carried out by a Secretariat based in Vilnius, Lithuania.

The main activities of the network include advocacy for better policies on HIV/AIDS and drugs, informational support and exchange, and capacity building of members and other organizations involved in the field of reduction of drug-related harm in Central and Eastern Europe and Central Asia. CEEHRN members and their allies seek to reduce drug-related harm, including the transmission of HIV/AIDS and other blood-borne diseases, through facilitating the use of less repressive and less discriminative policies with respect to drug users and other vulnerable groups and populations, including sex workers. CEEHRN strives to work together with regional and national advocates and policymakers to ensure that national drug and HIV-related policies are rational, effective, and humanitarian—and based on scientific evidence. All policies should also protect the human rights of individuals.

More detailed information about CEEHRN may be found on its website: www.ceehrn.org.

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Foreword

Context

Although sex work has a long history in nearly every culture and society, sex workers have been rarely, if ever, free from persecution, stigma, and violence. In some countries, notably in Western Europe, government officials and policymakers have worked with sex workers and their representatives in an effort to ease discrimination and improve access to health care and other social services. Such efforts have at times been slow and inconsistent; they are, however, major accomplishments compared with most nations elsewhere in the world.

In Central and Eastern Europe and Central Asia, for example, sex workers remain among the most marginalized members of society. Policymakers and authorities view them as nuisances to be ignored or immoral lawbreakers rather than as individuals who can and should be protected from violence and receive social and economic assistance and support. At the same time, the surging HIV/AIDS epidemic in the region places sex workers at increasingly greater risk of infection not only from HIV, but also from other potentially debilitating conditions related to sex work and drug use.

This report provides an overview of these and other important issues that sex workers face in the region as well as to the political, economic, and social factors that influence policies and attitudes toward sex workers. It focuses primarily on existing laws and policies and their consequences from the perspective of HIV prevention and treatment. The report also offers recommendations designed to uphold sex workers' human rights and remove barriers that reduce their ability or willingness to obtain access to consistent and equitable health care and other social services.

Statement of principles

The efforts of CEEHRN and its allies with and on behalf of sex workers are based on the following definitions, principles, and goals:

- Sex work is defined as the unforced sale of sexual services for money or goods between consenting adults. Sex work includes street prostitution, escort service, telephone sex service, pornography, exotic dancing, and others.
- Sex workers should have the same rights and responsibilities as all other workers, and as every other citizen and resident.
- Protection of sex workers' rights is crucial for effective harm reduction, HIV/AIDS prevention, and treatment efforts at all levels—individual, community, and national. To ensure protection of these rights, sex workers should be able to work legally.

- Barriers preventing access to health, social, and drug treatment services need to be removed to improve the health and social well-being of sex workers.
- Activities related to sex work between consenting adults should be decriminalized. All national criminal laws relating to adult prostitution should be repealed. All regional and local regulations targeting sex workers to prosecute the practice of their trade should be repealed.
- Sex workers and other community members should have an active role in designing commercial regulations of the sex trade.
- Targeted, pragmatic, and comprehensive social programs must be developed in consultation with sex workers and implemented to improve relations between the police and sex workers as well as between sex workers and the community at large..
- Targeted, pragmatic, and comprehensive public health programs must be developed and implemented with the involvement of sex workers to raise awareness about safer sex; safer drug use; and HIV/AIDS prevention, treatment, and support.
- Governments throughout Central and Eastern Europe and Central Asia should review and revise accordingly existing laws and policies in the realms of illicit drug use and sex work with the goal of adopting policies in which their human rights commitments are upheld. These commitments include agreements such as the UN Declaration of Commitment on HIV/AIDS, the UN Millennium Declarations, the Convention on the Elimination of All Forms of Discrimination against Women, the Convention on Economic, Social and Cultural Rights, and other instruments of international human rights law.
- There is no reason to delay reform that helps protect the health and rights of sex workers and, by extension, society at large. The time to act is now!

Geographic focus

For the purposes of this report, the term "Central and Eastern Europe and Central Asia" or "CEE/CA" refers to all of the countries of the former Soviet Union as well as those in Central and Eastern Europe that previously were communist states. To varying extent, all of them have adopted market-based economies. Most are also democracies, although in some democracy exists in name only. The following 27 countries are part of the region of CEE/CA as defined by this report: Albania, Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Bulgaria, Croatia, the Czech Republic, Estonia, Georgia, Hungary, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, FYR Macedonia, Moldova, Poland, Romania, Russia, Serbia and Montenegro, Slovakia, Slovenia, Tajikistan, Turkmenistan, Ukraine, and Uzbekistan.

Note on terminology

The terms "sex worker" and "prostitute" are used interchangeably in this report to refer to individuals whose economic livelihood consists of accepting money in exchange for sex.

In the context of sex work in this report, "abolition" refers to an approach that aims to eliminate all forms of paid sex through legal prohibition; "decriminalization" refers to the repeal of all laws that criminalize the action of taking money for sex; and "regulation" refers to an intermediate approach that regards prostitution as inevitable and not explicitly prohibited, but nevertheless in need of special social controls and regulations.

Acronyms and abbreviations used in this report

AFEW	AIDS Foundation East-West
ART	antiretroviral treatment
CCM	Country Coordinating Mechanism
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CEE/CA	Central and Eastern Europe and Central Asia
CEEHRN	Central and Eastern European Harm Reduction Network
DFID	Department for International Development (U.K. government aid agency)
EU	European Union
FSU	former Soviet Union
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HCV	hepatitis C
HOPS	Healthy Options Project Skopje
IDU	injecting drug user
IHRD	International Harm Reduction Development Program
OHI	Open Health Institute
OSI	Open Society Institute
PSI	Population Services International
STI	sexually transmitted infection
UHRA	Ukrainian Harm Reduction Association
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Education, Scientific and Cultural Organization
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
VCT	voluntary counseling and testing
WHO	World Health Organization

Executive summary

Social and economic disarray in the wake of the dissolution of the Soviet Union severely limited many women's ability to support themselves, thus precipitating a surge in the number of sex workers across Central and Eastern Europe and Central Asia (CEE/CA). Soon thereafter, drug use and HIV/AIDS began reaching epidemic proportions in several countries of the region, notably in the former Soviet Union. This report, based on a comprehensive survey of organizations working with sex workers throughout CEE/CA, offers sobering proof that in most parts of the region, the plight of sex workers grows bleaker every day due to a lethal combination of economic desperation, surging health risks, discrimination, and violence.

As this report makes clear, these three developments—growing prevalence of sex work, drug use, and HIV—are increasingly intertwined. Sex workers are more likely to engage in high risk behaviors that greatly increase the possibility of HIV transmission, such as injecting drugs and unprotected sex. At the same time, they have limited access to the kind of services and assistance that can help them address these risk behaviors. This report illustrates how current policies and legislation fail to protect sex workers. National drug policies, including prohibition or restriction of harm reduction services; discrimination at health care services; police corruption; and wide-scale trafficking of women all serve to further marginalize sex workers. In cases where sex work is not technically illegal, it is still not tolerated and discrimination pervades. Such attitudes greatly impede sex workers' access to public health services, including drug treatment and HIV prevention services. These multiple vulnerabilities are also further compounded by underlying social issues such as lack of education and economic opportunities.

The aim of this report is to raise awareness on the key concerns and issues affecting sex workers to enable planning and implementation of appropriate health and social policies. The report focuses on the following: HIV/STI epidemiological history and trends in the CEE/CA region; behavioral practices in relation to sex work; relevant national legislation and policies, including human rights, and their enforcement; and existing services for sex workers in the region.

The findings suggest that as the HIV/AIDS epidemic gathers steam throughout much of CEE/CA, improving the health and well-being of sex workers becomes more critical than ever. Evidence indicates that the HIV epidemic in the region is currently concentrated among specific population groups such as injecting drug users (IDUs) and sex workers. The overlap between sex work and drug use doubles sex workers' vulnerability to acquisition and transmission of HIV. Targeted HIV interventions for sex workers and IDUs are needed to tackle HIV and prevent it from becoming a generalized epidemic. The health and safety of all citizens thus depends on working with and for sex workers to help them protect themselves from harm. This will require a greater commitment among all members of society to accept and support the provision of comprehensive, pragmatic services for those most in need. It also depends on the recognition

that enforcing international human rights standards is a cornerstone of efforts to remove stigma and discrimination and enable the full participation in society of all people.

This report is grounded in the understanding that sex workers have the rights to health and social support as do all members of society. This belief is at the heart of the recommendations derived from this report, summarized into the following categories: for policymakers, for health authorities, for law-enforcement authorities, for service providers, and for researchers.

The successful implementation of the recommendations specified in the report rely not only on policymakers and service providers, but also on the ability of sex workers to advocate for their own rights. In order for this to happen more consistently, obstacles that prevent sex workers from organizing among themselves into working collectives or unions need to be removed. As sex workers feel more comfortable and less fearful in general, they are able to work together more closely and consistently to advocate for their rights. As much as anything else, this development could have the most positive effect on their own health and the health of those in their lives. (*More extensive information about the recommendations may be found in Section 5, "Conclusions and Recommendations"*.)

Recommendations for policymakers

- Government officials from across the spectrum should summon greater levels of political will and commitment to address social marginalization, economic exclusion, and violence within broader governance.
- Mechanisms should be initiated, preferably in cooperation with human rights groups and civil society, to enhance the independent monitoring of human rights agreements; protect the rights of vulnerable populations; and punish violators.
- Repressive national legislation regarding drug use and the provision of effective interventions, such as harm reduction services, should be revised to reflect pragmatic, compassionate policies. Most importantly, harsh penalties for drug use should be eliminated because they restrict the ability and willingness of those at risk to obtain information and services to protect their own health and the health of those around them.
- Sex work should be decriminalized, and other national policies that negatively affect sex workers' human rights and access to health services should be revised or eliminated.
- Sex workers' involvement in all government-organized HIV/AIDS and human rights initiatives should be made a priority and guaranteed.

Recommendations for health authorities

- HIV testing must be voluntary and confidential for all individuals, including sex workers, IDUs, and others at high risk for contracting the virus.
- Harm reduction services, including needle/syringe exchange, should be available at all public health facilities.
- Migrants should have improved access to public health services.
- Policies and procedures in health care delivery that discriminate against IDUs and sex workers should be identified and removed.

Recommendations for law-enforcement authorities

- Policies should be implemented to help stem harassment and abuse of sex workers by the police.
- All members of the police and other law-enforcement entities should receive regular training on issues related to HIV, drug use, and the legal and human rights of all individuals, especially sex workers and other vulnerable groups. Police should also be expected to refer—but never in a coercive or threatening manner—sex workers and IDUs to programs, projects, and shelters where they can receive appropriate assistance.

Recommendations for service providers

- Programs targeting sex workers in general and specific groups within sex worker populations need to be expanded and diversified.
- Service providers should seek to establish better links with human rights organizations/activists and other stakeholders in the region as part of an enhanced effort to monitor violations.
- Better program monitoring and evaluation would be a useful step toward improving planning and service delivery in general.

Recommendations for external donors

- Donors, especially foreign development agencies, need to base their response and funding on the real situation on the ground and on scientific evidence—and not on domestic ideological considerations in their own countries.
- Staff at multilateral and bilateral aid entities—as well as public health system employees at all levels—should be encouraged to speak up in response to perceived mismanagement, misallocation of priorities, and discrimination. They should be able to note their objections confidentially and without risk of reprisals such as dismissal.
- The policies and programs of various donors should be better organized and coordinated to ensure continuity of service, especially in countries where service provision depends mostly on donor assistance.

Recommendations for researchers

- Researchers, scientists, national governments, and multilateral organizations should collaborate on the establishment of professional, sustainable research teams that publish more specific and accurate data on the HIV/AIDS epidemic and vulnerable populations, including sex workers, in CEE/CA.
- The effects of decriminalization of sex work should be carefully analyzed, and the results made widely available. Special attention should be paid to experiences in other countries of the region (notably Hungary and Latvia).

1. Introduction

Following the collapse of the Soviet Union some 15 years ago, the countries of Central and Eastern Europe and Central Asia (CEE/CA) experienced complex political, economic, and social changes in the 1990s that helped precipitate a significant rise in the number of people involved in sex work (*Lowndes et al, 2003*). The upheavals related to economic transition led to an increase in unemployment and a sharp decline in living standards; in many countries of the region, women were the first ones to lose their jobs and find themselves desperately trying to adjust to an environment in which the state no longer provided jobs or a basic level of financial assistance. Although the economies of some nations in CEE/CA, especially those that have joined the European Union (EU) or expect to do so shortly, have grown rapidly in recent years, high levels of unemployment, violence against women, and lack of an adequate child support infrastructure are more or less present in every country of the region. According to a 2000 report from the United Nations Education, Scientific and Cultural Organization (UNESCO), out of 26 million jobs that vanished in the decade after 1989, more than half—14 million—were women's jobs (*UNESCO, 2000*).

One of the main consequences has been that in many countries of the region, sex work represents the only way for significant numbers of young women to earn a living. In South Eastern Europe, for example, the difficult economic situation and lack of employment has meant that the sex industry is the primary area of work for women and adolescent girls trafficked from other countries (*UNHCR, UNICEF, 2002*). In Kyrgyzstan, Central Asia, women without education or professional training have few if any other options to support themselves (*Kurmanova, 2004*). For Baltic countries such as Latvia, economic changes caused by restoration of independence and the expansion of tourism and foreign investment, coupled with the continued high level of unemployment and corruption, are believed to be among the key explanations as to the increased level of women's involvement in commercial sex work. There is hope that many of the underlying factors, notably unsettled social welfare systems, will be addressed in nations linked to the EU. Other countries in the region, meanwhile, face a far bleaker future in terms of increasing income-generating opportunities and raising living standards, especially for women.

In the meantime, public health indicators remain depressed. The concurrent and interlinked rise in drug use and HIV transmission represents a particularly grave challenge. HIV rates have skyrocketed in most of the region since the mid-1990s, when the virus first made its appearances among communities of injecting drug users (IDUs). Sex work and injecting drug use in the region overlap: many sex workers inject drugs and many drug users, especially female, exchange sex for drugs or money to support their habit. Ongoing debates in epidemiological literature and policy forums center on whether sex workers represent a "bridging population" that can facilitate HIV transmission between communities of IDUs and the "general population". There is of yet no firm conclusion to this debate. Many analysts believe that the level of unprotected sex among sex workers may be lower than among the general population (*Europap/Tampep, 1999*), while

others argue that the potential of heterosexual transmission of HIV from sex workers to their male clients is dangerously high (*Lowndes et al, 2003*). Regardless, it is clear from both a public health and human rights perspective that protecting the so-called general population cannot and should not be the only aim of and expected benefit from increasing access to health care and HIV/STI prevention and treatment services among sex workers and drug users. The division into these groups exists only in epidemiological terminology; in real life, sex workers and drug users are integrated members of overall society, and protecting their health is an important goal in itself.

As daunting and potentially lethal as they are, HIV and sexually transmitted infections (STIs) are of course not the only health and welfare issues of constant concern to sex workers. They face violence on a daily basis and have limited or nonexistent legal protection. As in most other countries of the world, state policies addressing issues of sex work in the region are rarely driven by pragmatism, scientific evidence, and human rights concerns; instead, they are often restrictive and based on moral prejudice. Even when sex work is not technically illegal, it is frowned upon and its practitioners discriminated against and shunned by much of society. These attitudes greatly impede sex workers' access to public health services, including treatment for drug dependence as well as HIV prevention and treatment information and services. They also place sex workers in a position where their basic human rights can easily be violated and protection of these rights becomes difficult if not impossible.

The results of the surveys underpinning this report are shocking not only for the sheer number of people they translate into, but also for what they indicate about the desperation faced by many women. Much of the region, especially in Central Asia, comprises culturally conservative countries in which women who engage in any sex act outside of marriage are frequently abused, shunned, and ostracized by their families and society overall. That they would turn to—or be forced into—sex work provides some of the strongest proof possible that many nations' social and economic safety nets have frayed into irrelevance. Young women engaged in sex work are among the most vulnerable members of male-dominated societies from every perspective imaginable.

1.1 Background to the report

In an effort to determine the effectiveness of existing services for sex workers in the region, CEEHRN initiated a pilot region-wide survey among 26 harm reduction programs in 15 countries in March 2003. The research focused on legal regulation, epidemiology, and services for sex workers. The results of this small-scale survey demonstrated that

- programs lack knowledge about national legal regulations of sex work;
- in most countries, sex work is formally criminalized and/or sex workers are informally discriminated against through law-enforcement practices;
- services for sex workers are limited in scope and number; and
- criminalization of sex work is one of the main obstacles to effectively providing services for sex workers. (*Jiresova, 2003*)

The survey's conclusions were discussed at a CEEHRN strategic planning meeting in 2004, during which it was decided to undertake policy assessments in different areas and to develop recommendations for policy improvement, including sex work regulation. As identified then, the main objectives of the project were to review the following in CEE/CA nations: HIV/STI epidemiological history and trends; behavioral practices in relation to sex work; relevant national

legislation and policies, including those dealing with human rights, and their enforcement; and existing services for sex workers in the region. This report compiles the results of that review and offers a comprehensive snapshot of the important issues that directly affect sex workers across the legal, political, social, economic, and health spectrums.

1.2 Report structure

Section 1 introduces the project, outlines its aims and scope, and provides a brief description of methodology.

Section 2 gives an overview of the extent and diffusion of HIV and STIs associated with sex work and injecting drug use in CEE/CA. It summarizes HIV and STI case reports; HIV and STI prevalence derived from selected studies of sex workers; estimates of the size of sex worker populations; demographic data on sex workers; rates and trends of injecting drug use; and injecting and sexual risk behaviors among sex workers in the region.

Section 3 summarizes international treaties and provisions that are intended to regulate—or can be interpreted as influencing—responses to sex work at the international and national levels. It also discusses more general issues related to human rights; provides information on trafficking; considers the various forms of regulation of sex work in CEE/CA countries, from direct prohibition to explicit allowance of sex work; and includes a brief review of published and original data on human rights violations against sex workers.

Section 4 focuses on service provision for sex workers in the region. It reviews existing projects, target groups, and sources of funding; attempts to assess service coverage; and discusses existing advocacy efforts, including self-organizing of sex workers, which are geared toward increasing the amount and scope of effective services.

Section 5 includes recommendations for improving policies affecting sex workers as well as general and specific service provision.

Appendices at the end of the report contain extensive information and data presented in table format. The charts and tables are referred to throughout the report.

1.3 Methodology

The analysis was carried out in four stages: expert consultation; literature review; survey of projects; and expert follow-up consultation to develop recommendations.

Stages 1 and 4: Stakeholders were contacted and asked to provide information and observations about past and ongoing research and other relevant information on sex work, its relationship to drug use, and existing services offered to sex workers. Experts and stakeholders from the following entities were contacted via email and listservs:

- harm reduction programs that work with sex workers
- country offices of UNAIDS and other UN agencies
- human rights organizations at international, regional, and domestic levels
- international organizations and NGOs working in the field, such as the Open Society Institute's International Harm Reduction Development Program (IHRD), EUROPAP, TAMPEP, and AIDS Foundation East-West (AFEW)

At the final stage of the report (Stage 4), these stakeholders were contacted again and asked to provide feedback and to assist in the development of policy recommendations.

Stage 2: CEEHRN staff and consultants reviewed reports and information obtained from stakeholders as well as published English- and Russian-language research literature, abstracts from recent international conferences (including the International AIDS Conference and the International Conference of Drug-Related Harm), international agency and country assessment reports, and centrally registered HIV-surveillance data.

The literature searches for Section 2 of this report were undertaken on two electronic databases, Medline (OVID) and the International Bibliography of the Social Sciences.

English and Russian Internet resources were widely used to gather reports and current papers providing regional and international perspectives. Given that documentation on sex work, drug use, and HIV/AIDS is limited or often edited extensively prior to public dissemination, "grey literature" provided by experts was also analyzed.

Stage 3: A survey focusing on issues not covered by existing literature was carried out. A standardized survey instrument was developed to collect national and program data on

- legal regulations of sex work;
- epidemiological data on HIV, STIs and official and estimated number of sex workers, including drug injectors;
- demographic profile of sex workers;
- behavioral data on sex work and drug use;
- human rights of sex workers and their recognition and upholding by police, clients, and mass media;
- medical services for sex workers, including access to diagnostics and treatment of HIV and STIs;
- operations and effectiveness of existing low-threshold services for sex workers;
- peer education and support; and
- self-support groups, including advocacy organizations.

The standardized survey form also specifically asked respondents to identify other important issues in relation to sex work in their country.

The questionnaire was submitted to some 20 national respondents throughout the CEE/CA region. Each respondent was responsible for at least one, and in some cases two or more, of the 27 countries to be covered in the report. Data and responses were provided for the following 24 of the 27 countries: Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Bulgaria, Croatia, the Czech Republic, Estonia, Georgia, Hungary, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, FYR Macedonia, Moldova, Poland, Romania, Russia, Serbia and Montenegro, Slovakia, Tajikistan, Ukraine, and Uzbekistan. For various reasons, including lack of access, data were not collected for Albania, Slovenia, and Turkmenistan.

In addition to the national respondents, 39 service providers filled in separate questionnaires covering different parameters of their operations.

For the most part, national and program respondents collected data between July–October 2004. Data collection generally consisted of analyzing routine monitoring reports and national surveillance information. Methods of data collection and surveillance differed across individual countries, a situation that makes it difficult to obtain direct, systematic cross-country comparisons. However, although the information and data collected may not be appropriate for

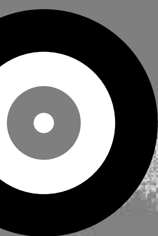
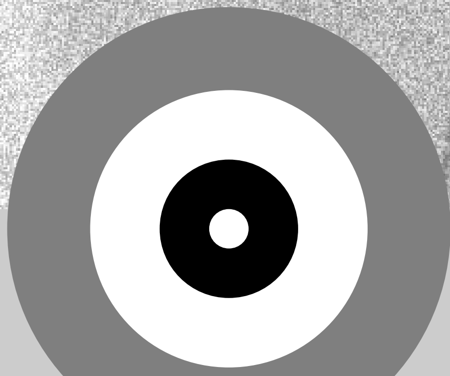
in-depth analysis, they met the report's overall goal of providing reasonably descriptive detail of sex work in each country.

Percentages presented in this report's narrative have been rounded to the nearest whole number, except with exceptionally small numbers or when specifically indicated otherwise. As a result, percentages may not add up to 100.

1.4 Structural and analytical limitations

CEEHRN acknowledges that both men and women are regularly involved in the provision of sexual services. The organization recognizes the important health and human rights issues affecting male sex workers in the CEE/CA—in addition to injecting drug use, these include the criminalization of homosexual behavior (legislation that is still present in some of the region's countries) and the high risk of HIV/STI transmission among men who have sex with men. However, this study targeted women only, primarily because evidence from the field indicates that the great majority of commercial sex workers in the region are women. CEEHRN recommends that additional research and analysis of male sex work be made a top future priority of organizations focusing on sex work issues in the region.

Due to certain limitations of this research (such as financial and lack of legal expertise among national respondents), this report was not intended to be a comprehensive in-depth legal analysis of national legislation. Furthermore, there was neither space in the survey nor expertise among respondents to directly consider parallel issues related to service provision, such as housing and income security, or to closely examine specific issues related to access to various services.

2. Sex Work and Associated Risk Behaviors

This section provides an overview of the extent and diffusion of HIV and STIs associated with sex work and injecting drug use in Central and Eastern Europe and Central Asia. It summarizes HIV and STI case reports; HIV and STI prevalence derived from selected studies of sex workers; estimates of the size of sex worker populations; demographic data on sex workers; rates and trends of injecting drug use; and injecting and sexual risk behaviors among sex workers in the region.

2.1 Extent of sex work in CEE/CA

Nearly all countries in CEE/CA have experienced an increase in sex work, largely stemming from economic necessity, in the wake of the collapse of the Soviet Union (*Konings, 1996; Loseva and Nashkhoev, 1999; Platt, 1998; AIDS Infoshare, 2001*). The rise in explicitly commercial sex work has occurred concurrently with a growing emphasis on the economic value of sexual relations in general, a development that reflects widening differentials in wealth (*Renton et al., 1998*). Many individuals have undoubtedly profited during the ongoing transitions to market-based economies, but the living standards of the majority, and in particular women, have declined.

The sex industry appears to be growing especially rapidly in the countries of Central Asia, which are the poorest parts of the former Soviet Union (*UNAIDS-CAR, 2000*). One report from the late 1990s indicated that 1 in 4 women in Kazakhstan would engage in sex work at some time in her life (*Thomas, 1997*). This estimate was supported a couple of years later by findings from a survey conducted by a pedagogical institute in Almaty; about 40% of respondents reported having at some time accepted financial remuneration for sex (*Schonning and Buzurukov, 1999*).

The available evidence clearly indicates that sex work is a common phenomenon in the region. However accurate estimates on the number of sex workers are difficult to obtain for a number of reasons, including the transient nature of sex work and of sex worker populations; ambiguous definitions as to what constitutes sex work; and the often-murky legislation regarding sex work that prevails in the region. Therefore, these factors should be considered when reviewing respondent-derived data in Table 7 (*in the Appendices*), which summarize recent estimates of the number of women involved in sex work and sex work prevalence.

2.2 Structure of sex work

Evidence from the published literature and from the project reports suggest that in CEE/CA and elsewhere, the sex work industry can be roughly divided into three distinct levels or types: street workers, apartment workers, and hotel ("elite") workers.

Street workers. The "lowest" and most dangerous level includes women who work on the streets, often in bus and railway stations. They are most likely to inject drugs, have lower rates of condom use, and be migrant workers, all factors that tend to isolate them from HIV and sexually transmitted infection (STI) prevention and care services. As a result, risky behaviors such as injecting drug use and unprotected sex are relatively high, as are rates of HIV and STI infection.

Apartment workers. The second group consists of women who usually work in groups under a manager, often a woman. They operate from apartments, saunas, or on the street. This type of sex work is more formalized and professional. Injection drug use is less common, and if it occurs it is more likely to be concealed from clients and management. Members of this group are also more likely to have greater access to treatment for STIs, although this access tends to be limited to private care services *(Konings, 1996)*.

Elite/hotel workers. Lastly, a third group comprises "elite" sex workers who tend to work from hotels and through advertisements in newspapers and magazines. They are least likely to be IDUs and often have relatively good access to treatment for STIs. Members of this group are often found to be one of the hardest groups to extend outreach services to because they may not associate themselves with other groups of sex workers and may also have security protection that monitors their activities *(AIDS Infoshare, 2001; O&K Marketing, 2000; Dreizin, 2000; UNAIDS-CAR, 2000; Schonning and Buzurukov, 1999; Oostvogels, 1999; Kurmanova, 1999; Loseva and Nashkhoev, 1999; Kurova, 1998; Platt, 1998; Oostvogels, 1997; Lakhumalani, 1997)*.

Project data, summarized in Table 9 in the Appendices, indicate that across the region the majority of sex workers served by harm reduction organizations work from the street. This corresponds with the published literature showing that IDU sex workers are more likely to work from the street than in more organized systems (hotels or apartments) where drug use is discouraged. There were also reports that sex workers are increasingly working through Internet sites; for obvious reasons, behavioral data on these individuals and estimates of their numbers are difficult to collect.

2.3 Demographic data

Studies indicate that sex workers in the region are young, often teenagers, and thus highly vulnerable to coercion and unable or unwilling to obtain access to comprehensive HIV and STI prevention information and services—or even unaware of what constitutes risky behavior. It is thought that approximately 80% of sex workers in the region are under 25 years old. For example, 95% of a sample of 383 sex workers interviewed in Estonia were 18 or younger (*UNICEF, 2000, 2001*); less dramatically, project data from Russia indicate the majority of sex workers are younger than 25. In Saratov oblast, Russia, 75% of 385 sex workers surveyed were between the ages of 20 and 29, and 10% were younger than 18 (*O&K Marketing, 2000*). In Balakovo 75% of street sex workers were under 25 and 20% were younger than 18. In Belarus, harm reduction projects estimated that nearly all of their clients in Minsk were between the ages of 15 and 30.

In a survey conducted in a medical center in Latvia (n=1,080), the average age of sex workers was 30.5 years, with 21% between the ages of 13 and 19 (*Kurova et al., 1998*). Of those responding to this study, 38% had been working as sex workers for less than a year. A survey of

96 sex workers in Lithuania indicated that the average age was 25 years, with ages ranging from 17 to 43 (*UNICEF, 2001*). According to project data from that country, most projects' clients were between 20 and 29 years old.

Project data from Central Asian countries indicated most clients were between the ages of 24 and 28. One survey, from Tashkent, Uzbekistan, showed that the majority of 180 officially registered sex workers were aged between 16 and 25 (*Thomas, 1997*).

Studies suggest that sex workers who inject drugs may be even younger than those who do not. Among sex workers accessing a needle and syringe exchange service in Volgograd, Russia (n=83), the age range was from 12 to 26 (*Ryabenko, 2001*). According to that survey, both the average length of drug use and the average period of sex work were four years. In a community-recruited survey of IDUs in Togliatti, Russia, of whom 37% were sex workers, the average age was 24 years, compared to 27 years for male non-sex working IDUs (P=0.0005) (*Platt et al., 2004*).

Data from the projects that responded to the survey mirror those contained in most literature. The average age of sex workers contacted by the projects was between 20 and 30 years, but the majority of them were between 20 and 25. The lowest age was 13 years, and the highest was 40. More detailed information about sex workers under 18 years of age was provided by the projects in Minsk, Belarus (5% of the 150 sex workers surveyed); Tashkent, Uzbekistan (13% of 1,400 sex workers); and Odessa, Ukraine (10% of 600 sex workers).

Data summarizing the age of sex workers served by the projects are contained in Table 9 in the Appendices.

2.4 Categories of sexual partners

Sex workers routinely have sex with both paying customers and individuals who do not pay. Unlike the former, members of the latter category are generally people with whom sex workers interact on a regular basis; some may be boyfriends or husbands, others are casual friends or acquaintances. The level and extent of risky behaviors on the part of sex workers often differ greatly depending on the partner's category. Sex workers are less likely to use condoms with non-paying customers for numerous psychological, emotional, and physical reasons ranging from implicit trust to a desire to have a child. Whatever the reasons for this dichotomy in condom use, one of its major consequences is increased risk of HIV transmission to and from non-paying customers. This risk is further heightened by the fact that often there is little difference in rates of injecting drug use between paying and non-paying partners.

2.4 (i) Paying partners

As might be expected, across the region there is a wide range both in the number of clients reported by sex workers and the likelihood of having one or more regular non-paying partners. According to one survey of sex workers attending an STI clinic in Moscow, the range of clients per week was between three and 40, with an average of nine (*Loseva and Nashkhoev, 1999*). In Togliatti, Russia, female IDUs involved in sex work reported an average of two clients per day, over half of whom were new clients (*Lowndes et al., 2002*). In a study of 385 sex workers in Saratov, Russia, a range of 11-100 clients per month was reported; among married sex workers in that survey, 55% reported having had at least one casual partner besides their husband in the past month without receiving money (*O&K Marketing, 2000*). A cross-sectional survey of female detainees in a Moscow prison (n=400) showed that the mean number of male sex partners within the previous 12 months for women reporting sex work (n=190) was 168, versus two for

those not reporting sex work (p=<0.01) (*Khromova et al., 2002*). In Georgia, sex workers reported having between 8-10 clients each week (*Stvilia et al., 2003*).

A survey of 116 sex workers in three cities in Serbia (Belgrade, Nis, and Kragujevac) indicated that the mean number of clients per month varied between cities, with 46 reported in Belgrade, 8 in Nis, and 28 in Kragujevac (*UNICEF, 2002*). Nearly a third of those surveyed had permanent partners.

Data regarding the percentage of clients who inject drugs are of course much more difficult if not impossible to obtain. Often the only basis on which to know is when the client injects drugs with or in the presence of the sex worker. At least two surveys from Russia have attempted to address this question, though. In Volgograd, a survey of sex workers using a syringe exchange service indicated that 58% of clients were not IDUs (*Ryabenko, 2001*). Data from qualitative interviews carried out with female IDUs in Togliatti also indicated that the majority of clients were not IDUs (*Lowndes et al., 2002*).

2.4 (ii) Non-paying partners

In addition to husbands, boyfriends, and casual acquaintances, non-paying partners of sex workers may also include men who use force (including rape) or power to obtain sex. Such encounters can be brutal and violent, thus representing major threats to sex workers' overall health and well-being. In most countries of the former Soviet Union (FSU), there are anecdotal reports of police using sex workers' services. Observers have described a system known as "subotnik", which is a Soviet term referring to voluntary (but in fact obligatory) monthly civil service provided free of charge—in this situation, it refers to sex workers being obliged to provide free sexual services to the police in exchange for limiting harassment or avoiding arrest. One woman is often forced to service more than one person, often without condoms (*Lakhumalani, 1997; Platt, 1998; AIDS Infoshare, 2001; Andrushak and Khodakhevich, 2000*). Research conducted in Moscow examining the psychological profile of sex workers (n=242) indicated that 38% of women reported being raped by their clients on more than one occasion, and 18% reported being raped by the police (*Nashkhoev, 2002*).

As always, injecting drug use is another major health risk factor in many sex workers' lives. A study from St. Petersburg indicated that slightly less than half (42%) of non-paying partners of IDU sex workers were also IDUs (*Benotsch et al., 2004*).

The possibility of sex workers contracting and transmitting HIV to and from non-paying partners is also a major health-related concern in much of the region. Specific data about such transmission risks are scarce, but certainly they are a distinct likelihood given the fact that a large number of sex workers are married or in relationships in which they may not use condoms on a regular basis. 29% of sex workers surveyed in Saratov, Russia said they were married (*O&K Marketing, 2000*); in Balakovo, Russia, project workers estimated that 51% of their clients were married; and in St. Petersburg, 20% of sex workers surveyed were married or had permanent partners. A survey conducted in Lithuania among 96 street and agency sex workers revealed that 28% had a constant sexual partner; of those, 48% thought that their spouse/partner was sleeping with other women, 12% did not think so, and 40% did not know (*UNICEF, 2001*). In Georgia, a survey indicated that almost two-thirds of a small sample of sex workers (n=91) had a regular partner (*Stvilia et al., 2003*).

2.5 HIV cases in the region

The increase in sex work over the past 15 years has occurred at the same time that HIV has reached or threatens to reach epidemic levels in several parts of the region. In the FSU countries,

the majority of HIV cases to date have been associated with injecting drug use—itself a rapidly growing epidemic, especially among young people, in countries marked by weak economies, falling living standards, and deteriorating health and social services. Heroin and other opioids are widely available and relatively inexpensive because most countries are located along major drug-transit routes to Western Europe from Afghanistan, where most of the world's opium poppies are grown. Recent estimates indicate that over 75% of officially registered HIV cases are attributable to injecting drug use in Belarus, Estonia, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Moldova, Russia, Tajikistan, and Uzbekistan.

Until 10 years ago, HIV was almost nonexistent in the region—even though by the mid-1990s it had already reached epidemic proportions among the general population in several nations in sub-Saharan Africa and Southeast Asia and among specific population groups elsewhere, such as men who have sex with men in the United States. By the end of 2004, however, according to the Joint United Nations Programme on HIV/AIDS (UNAIDS), at least 1.4 million people were living with HIV/AIDS across CEE/CA, a nine-fold increase over a decade. Variations in HIV case reports are widespread across the entire CEE/CA region. Russia and Ukraine remain the most affected countries by far, with 311,000 and 77,000 officially registered HIV infections, respectively.[1] Estimates from UNAIDS and other organizations are often two or three times higher than the number of infections officially registered in each country; according to UNAIDS, prevalence among the adult population (ages 15-49) has reached 1% in Russia and 2% in Ukraine, the highest in Europe. While this prevalence remains far lower than those in excess of 20% that are found in parts of Africa, they are 10 times higher than in most of those in Western Europe and the United States, where HIV prevalence among the adult population has barely increased since the mid-1990s.

In 2002, the number of new HIV cases reports declined for the first time in Russia and Ukraine, a development linked to a reported decrease in cases among IDUs. There is some evidence to suggest that this does not represent a true decline but rather a decline in the number of HIV tests conducted among IDUs. Data are unclear as to the current significance of sexual transmission of HIV. However, public health observers and experts generally believe sexual transmission is a major concern for the future, especially among the sexual partners of IDUs and among IDUs involved in sex work. This is not surprising given the relatively high prevalence of STIs, particularly syphilis, among IDUs and IDU sex workers in these two countries and the lack of comprehensive interventions targeting sexual risk reduction. (These issues are discussed in greater detail below.)

In Central Europe, over half of reported HIV cases are registered in Poland, but in that country and its neighbors there has been no marked increase in reported HIV cases over the past five years. In the Czech Republic, Hungary, and Slovakia, adult HIV prevalence remains below 0.2%, with between 20%-40% of reported HIV cases having been diagnosed in foreigners, often migrants from FSU countries (*Hamers and Downs, 2003*).

HIV prevalence also remains relatively low in South Eastern Europe, but the actual number of cases may be considerably higher. Difficulties in data collection are related to inadequate testing availability, poor surveillance systems, and lingering political, economic, and social disruption caused by recent conflicts in the Balkans. According to UNAIDS, Romania has the highest number of HIV cases in the region—at least 10,000 are officially registered—followed by Serbia and Montenegro. The World Health Organization (WHO) estimates that actual HIV

[1] Russian data provided by the Federal AIDS Center, as of May 2005. Ukrainian data provided by the Ukrainian National AIDS Center, as of March 2005.

prevalence in this region may be 10 times higher than indicated by officially registered cases. The primary mode of HIV transmission in the region is sexual—except in Serbia and Montenegro, where a majority of cases to date are associated with injecting drug use.

HIV prevalence remains relatively low in Central Asia and the Caucasus, but it is rising more quickly in these countries than anywhere else in the CEE/CA region. As in South Eastern Europe, the actual number of people living with HIV in Central Asia is thought to be several times larger than officially registered. In Uzbekistan, for example, a total of 3,596 cases were registered at the end of 2003; UNAIDS, meanwhile, estimated that at least 11,000 people were living with HIV in Uzbekistan by then.

With the possible exception of some countries in Central Europe, lack of political leadership and HIV-related stigma and discrimination are major impediments to the development and implementation of effective HIV/AIDS policies and strategies in CEE/CA. Marginalized populations such as IDUs, sex workers, men who have sex with men, and Roma continue to be at greatest risk for contracting HIV. Many members of these groups remain unable or unwilling to access adequate health care or HIV prevention and treatment services because of outright discrimination (such as denial of care) or fear of harassment from authorities.

Overall HIV prevalence data are summarized in Table 1 in the Appendices. HIV infections associated with sex work are discussed later in this section.

2.6 STI cases in the region

Rates of most major STIs, including chlamydia, gonorrhea, and syphilis, soared across much of the region in the 1990s before leveling off at levels much higher than in most of the rest of the world. This represents a worrying trend for at least two important reasons. Firstly, the presence of STIs increases the likelihood of contracting HIV; secondly, high rates of STI are indicative of risk sexual behaviors.

Most public health officials are especially concerned about the increase in syphilis, which if left untreated can have adverse effects on an individual's long-term health. Relatively high rates of syphilis—over 100 cases per 100,000 population—have been reported in recent years within the general population in many CEE/CA countries, including Belarus, Bosnia and Herzegovina, Estonia, Kazakhstan, Moldova, Russia, and Ukraine. In the decade after the collapse of the Soviet Union, the rate of syphilis among the general population reached 277 cases per 100,000 in Russia; in Ukraine, 148 per 100,000; in Moldova, 198 per 100,000; and in Belarus, 199 per 100,000.[2] The highest increase in STI rates in Central Asia occurred in Kazakhstan, with a marked increase also noted in Kyrgyzstan. In the countries of South Eastern Europe, the reported rates of syphilis have been relatively low and stable since 1990.

Between 1998 and 2003, syphilis diagnoses declined throughout the region, but the notification of syphilis among rural populations is still growing. (*A summary of syphilis cases in CEE/CA is presented in Table 2 in the Appendices.*)

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[2] By comparison, reported cases of syphilis in the United Kingdom in the 1990s never exceeded 2.85 cases per 100,000. Even in the United States, which generally has poorer health statistics than Western Europe, the overall rate of syphilis in 2003 stood at 11.9 cases per 100,000 population, according to the U.S. Centers for Disease Control and Prevention. In both the United Kingdom and United States, rates were higher among certain specific populations, including men who have sex with men and people living with HIV/AIDS.

2.7 HIV infections associated with sex work

The number and percentage of HIV infections attributable to sex work across the region are difficult to determine with a significant degree of accuracy. For one thing, definitions of what constitutes "sex work" and a "sex worker" are not standardized across the region. In Russia, for example, the term used in national surveillance data for sex worker is "persons with casual sex partners", which is not specific enough to make any systematic inferences about the nature of the sex work.

It is also likely that existing data massively underestimate the number of HIV cases related to sex work, a situation directly linked to stigma, discrimination, inconsistent legal status, and substandard health care services. Both sex workers and clients may fail to disclose their behavior because they are ashamed or frightened of the possible consequences, such as denial of services, harassment, or incarceration. These threats may also act as a deterrent to get tested for HIV or to seek treatment for HIV-related conditions or STIs.

For these reasons, the data—summarizing national surveillance of HIV case reports among sex workers in the region—presented in Table 4 in the Appendices should be interpreted with caution. Even with this caveat, it is evident that HIV prevalence among sex workers far exceeds negligible levels from just a decade ago. Estimates in Table 4 suggest that HIV prevalence among sex workers in Russia, for example, has increased from 0% in 1995 to 0.1% nationally (*Ladnaya et al., 2002*) and was as high as 15% in 2000 in Moscow alone (*Pokrovsky, 2000-2001*).

Similar estimates from Ukraine show a marginal increase in HIV cases attributable to sex work, from 0.6% in 1998 (of n=54,166) to 0.8% in 1999 (of n=29,034) (*Dehne and Kobyshcha, 2000*). It is difficult to determine what proportion of HIV cases may be related to sexual transmission by an injecting drug use because the percentage of sex workers who inject drugs is not specified. Although there is a lack of systematic or reliable data, reports from Albania suggest that the number of people infected with HIV increased by 100% in 2000, the majority of whom were females trafficked for prostitution abroad (*Hazizaj et al., 2002*).

2.8 Prevalence of HIV and STIs among sex workers

High prevalence of STIs in the general population, and specifically among sex workers, indicate the potential for sexual transmission of HIV through sexual contact between sex workers and their partners (both clients and non-paying partners).

To date, HIV has spread more rapidly among IDUs than sex workers, especially in areas where rates of injecting drug use among sex workers are relatively low. Studies from several cities in Russia over the past decade show that HIV prevalence among IDUs can increase from negligible to nearly 50% or higher in less than two years.[3] Exponential increases have also been found in prisons, where injecting drug use and unprotected sex are common; in Russia, for example, HIV prevalence in prisons reportedly rose more than 30-fold from 1996 to 2003 (*Roshchupkin, 2003*).

Such data indicate that in general, HIV prevalence appears to be lower among sex workers than among members of some other high-risk populations in the region. However, HIV prevalence among sex workers is still quite significant, and it is rising in many areas. Until 1999, Kaliningrad

[3] According to a 2002 report from the UNDP, "HIV and Injecting Drug Use: A New Challenge to Sustainable Human Development". Available online: www.undp.org/hiv/publications/deany.htm.

oblast in Russia was the only place where a significant proportion (40%-80%) of sex workers was infected with HIV (*Momot et al., 1997*). More recently, as noted in Table 6 in the Appendices, the spread of HIV among sex worker populations has also been documented in several other cities in CEE/CA. Small-scale studies among sex workers in Moscow and St. Petersburg in Russia and Donetsk, Ukraine have reported HIV prevalence of around 15%. In another study in Yerevan, Armenia, nearly 8% of sex workers tested positive for HIV. In St. Petersburg and Yerevan, the majority of HIV-positive sex workers were IDUs, whereas among the small sample of women tested in Moscow, HIV prevalence did not differ significantly on account of whether or not sex workers also injected drugs (*Dehne and Kobyshcha, 2000*).

Outbreaks of HIV infection among sex workers have also been reported in cities in Kazakhstan (Temirtau), Latvia (Riga), Georgia (Tbilisi), and the Czech Republic (Prague). Little other comprehensive information is available regarding HIV rates among sex workers in the region (*Dehne and Kobyshcha, 2000*).

There is some evidence of the potential for sexual transmission of HIV from drug-injecting sex workers to their clients or partners. A survey of IDUs (n=426) in Togliatti, Russia showed that half of female IDUs were involved in sex work (*Rhodes et al., 2002*). While HIV prevalence did not differ between sex worker IDUs and non-sex worker IDUs (at ~60%), a recent history of STIs was significantly more common among IDUs involved in sex work (57%) than among IDUs not involved in sex work (17%; $p<0.0001$), despite 86% of sex workers reporting consistent condom use with clients (*Platt et al., 2004*). Similarly, in St. Petersburg a survey of female IDUs attending a needle and syringe exchange program indicated that 28% tested positive for syphilis (99 of 285), and that sex workers were nine times more likely to test positive for syphilis than non-sex workers (*Karapetyan et al., 2002*).

Selected studies of STI prevalence in samples of sex workers across the region are presented in Table 5 in the Appendices. In Russia, prevalence among surveyed sex workers in St. Petersburg and Moscow was nearly the same, at 33% and 35% respectively (*Borisenko et al.,1999; Kurova et al., 1998*); a survey in Kazakhstan reported a rate double that, at 70% (*Zhusupov, 2000*). Both Russia and Kazakhstan have extremely high rates of STIs among the general population, however; in two countries with relatively lower STI prevalence in the general population, Tajikistan and Estonia, prevalence amongst sex workers was found to be 7% and 5%, respectively (*Kurmanova, 2000; Dehne and Kobyshcha, 2000*). An exception to these coordinating factors can be found in Latvia, where a survey of 1,080 sex workers revealed high levels of gonorrhea (49%), syphilis (17%), and trichomoniasis (58%) despite a relatively low prevalence of STIs in the general population (*Kurova et al., 1998*).

Table 6 in the Appendices summarizes estimates of HIV, hepatitis C (HCV), and syphilis prevalence among sex workers and drug-injecting sex workers attending harm reduction programs across the region. The data show high prevalence of all three infections among sex workers in Russia—particularly St. Petersburg, where 48% of street sex workers were estimated to be HIV positive. It is important to note that the project reports do not offer a clear indication of whether or not sex worker respondents were IDUs; furthermore, most of the reports did not include information on whether prevalence was based on self-reported results or on tests conducted by the projects.

In Pavlodar, Kazakhstan, 12% of sex workers were thought to be HIV positive and 30% had hepatitis C, which indicates that sex workers are engaging in risky injecting or sex behavior. At the other end of the spectrum, there were no reported HIV cases among clients of projects in Zagreb (Croatia), Zenica (Bosnia and Herzegovina), and in two cities in Bulgaria (Burgas and Plovdiv).

2.9 Sex work and injecting drug use

Reports from harm reduction projects surveyed indicated that a high proportion of sex workers, especially those who work in the streets, were involved in drug use. Estimates from Russia ranged from 24% of sex worker clients injecting drugs in Nizhny Novgorod, 47% in Krasnoyarsk, 80% in Barnaul, and 95% in St. Petersburg. In Balakovo, a local harm reduction project estimated that 29% of sex workers accepted drugs as payment for sex work. A separate study in St. Petersburg estimated that there were as many as 11,100 female IDUs who were also sex workers (*Benotsch et al., 2004*).

In the Baltic states, one project estimated that 80% of street sex workers injected homemade opiates, heroin, or ephedrine. Lower proportions were reported in Tallinn, Estonia, where 10%-14% of organized street workers were estimated to inject amphetamines.

According to project data, frequency of injecting drug use among sex workers varies across South Eastern Europe. A project in Zenica, Bosnia and Herzegovina, reported that 8% of clients injected heroin or methadone; this proportion is similar to those reported by projects in the Croatian cities of Zagreb and Rijeka, where 4%-11% of project clients were thought to inject heroin. Meanwhile, in Strumica, Macedonia, approximately 50% of project clients reportedly injected heroin or methadone. In Bulgaria, injecting drug estimates among sex workers ranged from 5% in Plovdiv to 12% in Varna and 40% in Sofia, with heroin being the most commonly injected drug in all three cities.

A high overlap between drug use and sex work was also reported in Central Asia. In Dushanbe, Tajikistan, 75% of sex workers were thought to inject heroin or homemade opiates, while 22% of sex workers associated with a project in Tashkent, Uzbekistan injected drugs. In Kazakhstan, estimates ranged from 22%, in Shimkent, to 60% in Kostanai.

Other published literature supports the data from most projects that a key feature of sex work in the region is its close connection with injecting drug use. In Saratov, Russia, a report estimated that some 35% of sex workers were IDUs (*Dehne and Kobyshcha, 2000*). In Nikolaev, Ukraine, as many as 80% of street sex workers were estimated to be IDUs, according to a report published in 2000 (*UNAIDS, 2000*). Similarly, in a survey of street sex workers in Kaliningrad, Russia connected to a rehabilitation program, 90% of those surveyed injected drugs, with the age at first injection ranging from between 14 and 17 years old (*Dreizin, 2000*). In Lithuania, 11% (n=96) of street and agency sex workers surveyed reported injecting drugs (*UNICEF, 2001*).

Project estimates on the frequency of injecting drug use among sex workers are summarized in Table 8 in the Appendices.

2.10 Injecting risk behaviors

Sex workers who inject drugs are undoubtedly at a greater risk of negative health effects than their non-drug using counterparts. Risks include overdose, increased chance of contracting HIV and other blood-borne diseases through needle/syringe sharing as well as sexual transmission, and multiple vulnerabilities associated with police harassment and violence from clients. A study in Togliatti, Russia indicated that sex worker IDUs were more likely than non sex workers or male IDUs to report injecting with a used needle or syringe; they were also more likely to inject on a daily basis (*Platt et al., 2005*). In St. Petersburg, a survey of 100 female IDUs indicated that 37% had exchanged sex for money or drugs, and that 44% had shared injecting equipment in the previous four weeks (*Benotsch et al., 2004*).

Data from projects surveyed for this report also indicate high levels of risky injecting behaviors. In Krasnoyarsk, Russia, 100% of sex workers reported sharing injecting paraphernalia,

and 71% reported ever injecting with a used needle or syringe (n=~638). In St. Petersburg, 44% of a sample of sex workers (n=unknown) reported at least occasionally injecting with a used needle or syringe. In Vilnius, Lithuania, drawing up opiates from a communal pot was said to be common alongside injecting with used needles and syringes.

A rapid assessment report from Serbia and Montenegro also indicated risky injecting behavior among sex workers involved in injecting drug use. Of the 22% of sex workers in the assessment (n=116) who were currently injecting drugs, four-fifths reported sharing their drug-injecting equipment. In Belgrade, all of the sex workers aged 15 to 19 who were injecting drugs reported sharing their equipment (*Rhodes et al., 2004*). Project data from Belgrade indicated that 20% of drug-injecting sex workers inject with used needles and syringes.

The situation is similar in Central Asia, according to reports from projects. In Tajikistan, 96% of clients reported injecting with used needles and syringes, even when they were aware of the risk of HIV infection. In Kazakhstan, up to 70% reported sharing paraphernalia with their clients and among themselves; a project in the Kazakh city of Kostanai indicated that overdoses were common.

2.11 Sex work and condom use

For most sex workers, including those who do not inject drugs, the main potential HIV transmission mode is through unprotected sex. Condom use can drastically reduce this risk. However, studies suggest that condom use among sex workers in the region is inconsistent and influenced primarily by the organizational context of sex work. Researchers in Russia have noted that sex workers operating from hotels or through agencies were likely to be better educated about safer sex and in a better position to negotiate condom use than those working from the street (*Platoshina and Chaika, 1995; Kungurov et al., 1999; Dehne and Kobyshcha, 2000; AIDS Infoshare, 2001*). In Riga, Latvia, one study showed that knowledge of condom use remained low among sex workers working in railway stations and on the streets, and that most did not visit health services (*Kurova et al., 1998*).

In several rapid assessment studies, individuals providing services to sex workers in Central Asia have also reported inconsistent condom use among their clients (*Kurmanova, 1999; Kurmanova, 2000; Schonning and Buzurokov, 1999; Oostovegels, 2001*). In Karaganda, Kazakhstan, respondents estimated that regular condom use among their clients was between 30% and 40%. In Kazakhstan, reports suggest that the majority of male clients refuse to use condoms (*Thomas, 1996*). An assessment of sex workers in Shimkent indicated that 75% did not use condoms regularly (*Rodina and Valieva, 2002*).

In some cities and countries, condom availability is limited or otherwise difficult to ensure on a regular basis. Various economic factors also appear to influence condom usage by sex workers. In Turkmenistan, for example, condoms can be obtained free from a polyclinic, but only for persons who are registered as a user of the service (*Kurmanova, 1999*).

Project data indicated that street sex workers across the region consistently agree to work without a condom in exchange for additional money. Other reasons included pressure from clients, sometimes involving violence; low levels of awareness of the risks of HIV and STI transmission, especially among young sex workers and those on the street; the effects of drug use in clouding decision-making; and a lack of peer support among other sex workers in terms of reinforcing condom use.

A number of published studies also associate infrequent condom use with non-paying partners. In-depth interviews with 200 sex workers in Bulgaria, for example, found that condom

use was relatively consistent among customers but irregular or infrequent among boyfriends and casual partners (*Tchoudomirova et al., 1997*). Similarly, a survey of sex workers in Georgia showed high proportions of condom use with clients but not with non-paying regular partners. In that survey, 72% of respondents reported always using condoms with clients and 95% reported using a condom with their last client; however, only 18% reported using a condom during their most recent sexual act with a non-paying regular partner (*Stvilia et al., 2003*).

2.12 Internal and external migration in the context of sex work

Nearly all projects surveyed for this report said that a substantial proportion—often more than half—of their clients were migrants from rural areas, regional cities, or other countries in the region. Migrants are usually more likely than natives to be vulnerable to harassment and abuse from authorities and clients, often because they are reluctant to report violations (they may be illegal immigrants) or are unfamiliar with their surroundings. Their isolation may be exacerbated by a lack of family assistance or social support network, which also increases the possibility that they are unaware of services, such as harm reduction projects, that may be available to them. In many areas, a disproportionate percentage of sex workers are composed of women from socially and economically marginalized ethnic groups from within the country, such as Roma in several nations in Central and Eastern Europe, or from poorer neighboring countries (Central Asian women working in Russia and Central Europe).

In most countries of the region, women tend to migrate from poorer rural areas, work for a few months, and then return home with their earnings (*Lakhumalani, 1997; Platt, 1998; Loseva and Nashkhoev, 1999; Dehne and Kobyshcha, 2000; AIDS Infoshare, 2001; Naskhoev, 2002*). This pattern is reflected in the project data showing high numbers of sex workers in capital cities. Project reports suggested that there were between 30,000 and 150,000 sex workers in Moscow; at least 20,000 in St. Petersburg; 10,000-20,000 in Minsk, Belarus; 7,000-8,000 in Yerevan, Armenia; and 6,000 in Tashkent, Uzbekistan (*see Table 7 in the Appendices*). Projects also reported seasonal fluctuations of sex work, particular in port cities such as Odessa (Ukraine) and in capital cities. Street sex work in the region is also affected by seasonal changes; there is generally less work during the winter months.

In Dushanbe, Tajikistan, of the 2,725 sex workers registered at the Ministry of Interior, the majority came from rural areas (*Kurmanova, 2000*). One study reported that of 130 street sex workers surveyed in Moscow, only 9% had official residency permits for the city (*AIDS Infoshare, 2001*). Interviews conducted with 200 sex workers in Bulgaria (n=100) showed that 50% were Roma, approximately 25% were preparing to go abroad for sex work in the future, and about 50% were migrating within Bulgaria to work as sex workers (*Tchoudomirova et al., 1997*). Project reports from Skopje, Macedonia indicated that 40% of sex workers were Roma; in Sofia, Bulgaria, meanwhile, a majority were either Roma or from other countries in South Eastern Europe.

The recent ethnic conflicts and stagnant economies in the countries that formerly comprised Yugoslavia are considered major factors for the increase of migration as well as for increasing numbers of women becoming involved in sex work (*UNICEF, 2001*). At the same time, the trafficking of women has become widespread across the region, especially in South Eastern Europe. Reliable data are not available, but studies from the beginning of this decade estimated that some 30,000 young women had been trafficked from Albania to Western Europe to work in the sex industry (*UNICEF, 2001; Hazizaj, 2002*). More recent reports suggest that Belgrade is a major transit center for the trafficking of sex workers from Eastern to Western Europe (*Rhodes et al., 2004*).

Project estimates on the proportion of sex workers who are migrants are summarized in Table 9 in the Appendices.

3. Legal Regulations of Sex Work and the Human Rights of Sex Workers

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This section summarizes international treaties and provisions that are intended to regulate—or can be interpreted as influencing—responses to sex work at the international and national levels. It also discusses more general issues related to human rights; provides information on trafficking; considers the various forms of regulation of sex work in CEE/CA countries, from direct prohibition to explicit allowance of sex work; and includes a brief review of published and original data on human rights violations against sex workers.

Any discussion of human rights is useful only when one important caveat is clearly stated and understood: at a very basic level, human rights laws and agreements are largely worthless if not enforced. All CEE/CA countries have signed most, if not all, of the relevant international human rights agreements and have national laws on the books that forbid the withholding or violation of key rights to any individual. In many of these nations, however, especially those that were once part of the Soviet Union, human rights structures and enforcement mechanisms are weak, inefficient, or simply ignored. The overall human rights records of some governments—notably Belarus, Russia, Turkmenistan, and Uzbekistan—are appalling and may in fact be getting worse for a variety of reasons. In these and an even greater number of countries of the region, the rights of sex workers and other marginalized groups such as IDUs are routinely trampled upon, with predictably dire consequences.

Few doubt that human rights laws and agreements are necessary to serve as a framework in which to implement rights provisions. However, the ongoing denial of these rights on the ground clearly indicates that it is equally if not more important for the rights guaranteed therein to be enforced comprehensively and consistently by all—especially governments, law enforcement, and service providers. The most consistent and passionate advocates are usually those affected directly. Therefore, a key strategy for those working with sex workers should focus on creating the conditions for the effective mobilization of sex workers, IDUs, and others whose rights are denied or violated consistently. They are their own best advocates when it comes to seeking

policy reform and change, even in countries that seem ossified and rigid. The quality and scope of service provision for sex workers are also likely to be improved only when they are able and willing—ideally by forming coalitions of like-minded and supportive individuals and organizations—to identify what they need and why reform is necessary not only for them, but for society in general. Ensuring the health and well-being of the population at large is contingent upon improving the health and rights of those most at risk.

3.1 International treaties

Many of the issues discussed in this report are referred to directly or indirectly in various human rights declarations and standards that are commonly accepted across the region—and are generally considered to be universal in nature, applicable to all individuals. They include the right to the highest attainable standard of health in relation to sexuality; the right to health and family planning; the right to life, freedom, integrity, and security; the right not to be assaulted or exploited sexually; the right not to be tortured or to be the object of cruel, inhuman, degrading punishment or treatment; the right not to be subject to sex-based discrimination; the right to privacy; the right to bodily integrity; and the right to pursue a satisfying and safe sexual life.

Several human rights treaties and other documents establish these universally applicable rights. With few exceptions, all of them have been signed by every country in the world, including those in CEE/CA. The agreements include the UN's Universal Declaration of Human Rights; the International Covenant on Civil and Political Rights; the International Covenant on Economic, Social and Cultural Rights; and the Convention on the Elimination of All Forms of Discrimination against Women. Two other agreements, the European Convention on Human Rights (and its five protocols) and the European Convention for the Prevention of Torture and Inhuman and degrading treatment and Punishment, do not apply to countries outside of Europe, including those in Central Asia.

Article 12 of the International Covenant on Economic, Social, Cultural and Political Rights recognizes the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. Furthermore, it outlines steps to be taken by member states to achieve the full realization of this right, including the implementation of measures designed to prevent the spread of disease and the elimination of discrimination in access to health care and treatment for all. The covenant includes sexual and reproductive health in this right and encourages gender equity. HIV/AIDS and most other diseases are not mentioned specifically in this covenant, but many analysts and policymakers have suggested that the agreement should be interpreted to include prevention, treatment, and care services for HIV/AIDS as a health right.

As indicated specifically in this agreement and at least tacitly in many other international human rights conventions, reproductive and sexual rights are essential for women and men to exercise their right to health. These rights include freedom of choice on the numbering and spacing of children and the forms of contraception; consistent and unimpeded access to information about reproductive services; the right to be protected from sexual harassment and

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[4] It should be noted that policymakers and government officials in a significant number of countries around the world, especially culturally conservative ones, do not necessarily accept or agree with all of these rights—depending on how they are interpreted. For example, many people consider abortion to be a reproductive right, but abortion is banned or discouraged in several nations, including some in CEE/CA.

abuse; the right to have a satisfying sexual life; and the right to be protected from sexual violence.[4] According to the Platform of Action adopted at the UN's Fourth World Conference on Women, held in Beijing, China, in 1995, "The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence."[5]

The importance of these rights was bolstered by a landmark decision by the International Criminal Tribunal for the Former Yugoslavia, which ruled that serious sexual assaults and rape were implicitly prohibited by the provisions in international human rights law that safeguard physical integrity (*Prosecutor v. Anto Furundzija*, 1999). The International Criminal Court subsequently followed suit, defining sexual slavery, forced prostitution, forced pregnancy, forced sterilization, and other forms of sexual violence as crimes against humanity or war crimes (*Rome Statute of the International Criminal Court*).

Although none of the above-mentioned conventions specifically address sex work, they theoretically protect sex workers in general because they are universally applicable to all people.

The major international convention that refers directly to sex work is the Convention for the Suppression of the Traffic in Persons and of the Exploitation of the Prostitution of Others, which was promulgated by the United Nations in 1949. The 75 state parties to this convention (including most CEE/CA countries, such as Albania, Azerbaijan, Belarus, Bosnia and Herzegovina, Bulgaria, Croatia, the Czech Republic, Hungary, Kyrgyzstan, Latvia, Macedonia, Poland, Romania, Russia, Slovakia, Slovenia, Tajikistan, and Ukraine)[6] agree to punish anyone who

- procures, entices or leads away, for purposes of prostitution, another person, even with the consent of that person;
- exploits the prostitution of another person, even with the consent of that person;
- keeps or manages, or knowingly finances or takes part in the financing of a brothel; and
- knowingly lets or rents a building . . . for the purposes of prostitution.

The intentions of this convention's framers may have been well-meaning, but the agreement has significant limitations. For one thing, although it recognizes the difficulties inherent in regulating consensual adult prostitution, it fails to acknowledge the differences between forced and voluntary prostitution—and therefore is rooted in the belief that sex work should end. In this respect it shares a fundamental flaw with some other international, regional, and national agreements designed to protect women; in their zeal to prohibit or limit behavior that may be dangerous to women, many protocols deny women the right to choose how they can and wish to make a living.

Many women are not coerced into sex work. Instead, they opt to engage in it for a variety of reasons that may or may not have to do with economic self-sufficiency, independence, or financial desperation. Whether for moral or health reasons, banning sex work is not generally an appropriate strategy and may even be counterproductive. Many women's rights to employment may be limited, and prohibition often pushes such behavior further underground, thus further jeopardizing sex workers' health and limiting their ability to advocate for their rights. Acceptance and recognition of prostitution as work of one's choice is needed to combat crime and economic

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[5] Additional information about the UN's Fourth World Conference on Women may be found online at www.un.org/womenwatch/daw/beijing/index.html.

[6] A list of the states that are party to the convention may be found online at www.unhchr.ch/html/menu3/b/treaty11a.htm.

disparity and to help ensure successful HIV/AIDS prevention efforts. In 1997, the Asia Pacific Women's Consultation on Prostitution adopted a statement in which human rights activists, academics, and lawyers urged governments to "recognize and validate the reality of women who are working in prostitution", and defined all labor performed by women in the sex industry as work. In 2004, members of the European Committee on Women's Rights and Gender Equality agreed to protect the legal rights of sex workers, and stated that any new legislation on prostitution must include these rights.

Unfortunately, such enlightened language is missing from many high-profile international human rights agreements. Another example of the potentially negative consequences—to women's rights—of otherwise well-meaning agreements may be found in the United Nations Protocol to Prevent, Suppress, and Punish Trafficking in Persons. Adopted in 2000, this convention created a clear and distinct global definition of trafficking in human beings. In Article 3, trafficking is defined as "the recruitment, transportation, transfer, harboring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation". The protocol's condemnation of coerced sex work is laudable. However, it did little to define unforced prostitution or to proclaim the necessity of recognizing and safeguarding sex workers' human rights.

Also of particular relevance to issues discussed in this report is the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), which is a. A broad-based non-discrimination treaty, CEDAW requires state parties (including all CEE/CA countries) to take all appropriate measures to remove obstacles and to foster the conditions necessary for women to realize their full potential as the equals of men. This convention also pays special attention to the issue of trafficking, with Article 6 mandating that all state parties "take all appropriate measures, including legislation, to suppress all forms of traffic in women".

Furthermore, General Recommendation 19 in CEDAW calls upon states to take measures to combat gender-based violence, which can impair the ability of women to access their human rights and fundamental freedoms—including the right to life; the right not to be subject to torture or cruel, inhuman, or degrading treatment or punishment; the right to legal protection; the right to liberty and security of person; the right to equal protection under the law; and the right to the highest attainable standard of health. Recommendation 19 recognizes the need for special protection of "prostitutes" because of their particular vulnerability to violence. CEDAW's General Recommendation 24, meanwhile, emphasizes the importance of states to closely consider the societal determinants of health, paying particular attention to the health needs and rights of women belonging to vulnerable and disadvantaged groups, including migrant women and women engaged in sex work.

Health and human rights have a reciprocal relationship—the right to health can only be achieved when individuals have the ability to obtain consistent and equitable access to health care and as well as to seek redress for human rights violations. This relationship underpins the importance, as stated previously, of removing legal prohibitions against sex work and

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[7] Here and elsewhere in this report, "criminalization" of sex work refers to specific, direct legal prohibition of offering or taking money in exchange for sex. Conversely, "decriminalization" refers to the repeal—or existing lack—of laws that criminalize sex work.

seeking to reduce stigma and discrimination against those engaged in it. Where sex work is criminalized,[7] sex workers' concerns about safety, security, and physical and psychological abuse are not integrated into the public legal and health sectors. When their activity is illegal or not regulated, sex workers often avoid any contact with law enforcement out of fear of persecution or harassment. Decriminalization of sex work is the first key step to effectively and comprehensively applying the international human rights framework to sex workers.

One additional international agreement of relevance to sex work is the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, which was adopted by the UN General Assembly in December 1990 and entered into force upon its 20th ratification in 2003. Although it does not specifically mention sex workers or prostitution, the agreement provides a broad definition of what constitutes a migrant worker and draws a distinction between migrant workers who are lawfully working within the host state and those in "irregular" situations (illegal). The convention obliges the state parties to guarantee all migrant workers, regardless of their legal status, a limited selection of social, economic, and cultural rights. All should have the right to non-discrimination with respect to remuneration and conditions of work, and the right to participate in trade unions. This is not a very widely ratified agreement at this point; as of June 2005, just 30 states worldwide had acceded to it or ratified it, including four from CEE/CA: Azerbaijan, Bosnia and Herzegovina, Kyrgyzstan, and Tajikistan. Ultimately, though, the convention's ability to help protect the rights of migrant sex workers will be greatly enhanced in countries where sex work itself is legalized.

Some observers believe that greater protection of the rights of sex workers would be obtained through a special UN-level international declaration that would contain an overall acceptable definition of sex work and would spell out the international human rights pertaining to sex work—and call upon governments to decriminalize sex work. Others, meanwhile, believe that such a strategy is unnecessary because CEDAW and the International Covenant on Economic, Social, Cultural and Political Rights in particular provide adequate protections for sex workers, assuming their provisions are enforced. They also express concern that a special overarching UN declaration might in fact be counterproductive given the current opprobrium-influenced political and social climate regarding sex work. In their opinion, the declaration would likely be much weaker than intended, thus undercutting the rights established by the other two existing conventions.

3.2 National regulations of commercial sex work

Laws and policies address sex work in a variety of different ways, from regulating individual sex work itself to seeking to prohibit organized sex work. In many CEE/CA countries where sex work itself is not criminalized, the practice of prostitution is effectively rendered impossible through restrictions on organizing, advertising, and living off the proceeds of sex work. Actions taken in the name of these restrictions often lead to unlawful detention, extortion, and other violations of sex workers' rights.

3.2 (i) Individual prostitution

The regulation of individual sex work differs from country to country in CEE/CA. Table 10 in the Appendices summarizes national legal regulation of sex work, related offenses (pimping, brothel-keeping, involvement in sex work), and trafficking. The three main legal frameworks for

the individual sex trade are direct prohibition, absence of regulation, and explicit allowance of sex work.

*Direct prohibition***.** Individual prostitution is illegal (it represents an administrative or criminal offense) in most countries of the region. While some states only levy an administrative fine for prostitution, in others criminal liability is applied to people involved in the sex trade. In three countries, Albania, Romania, and Ukraine, individual prostitution constitutes a criminal offense. In others, including Armenia, Belarus, Bosnia and Herzegovina, Croatia, Lithuania, Macedonia, Moldova, Russia, Serbia and Montenegro, Turkmenistan, and Uzbekistan, individual sex work is directly prohibited, with administrative liability in place for those prosecuted for individual prostitution.

*Absence of legal regulation***.** Respondents to the CEEHRN survey and experts from eleven countries—Azerbaijan, Bulgaria, the Czech Republic, Estonia, Georgia, Kazakhstan, Kyrgyzstan, Poland, Slovakia, Slovenia, and Tajikistan—said that they were unaware of any laws in their countries either directly prohibiting or directly allowing individual prostitution. Sex work is therefore considered "non-regulated" or "decriminalized".

Allowance and regulation of individual sex work. In two countries in the region, Hungary and Latvia, individual sex work is explicitly permitted under certain specific regulations.

As noted previously, it is important to recognize that the absence of legal prohibition does not mean that sex workers are not regularly abused, harassed, and detained as if it were directly prohibited. Analysis of country situations reveals that there may be no direct association between legal regulations and actual police practices in several places. While in some countries with more prohibitive legislation police may actually have a relatively soft approach to sex workers, in other countries the situation is quite the opposite: legislation does not imply prosecution of sex workers, but police treat them harshly nonetheless.

The rigor of law enforcement may depend on existing attitudes toward sex work in a country as well as traditional responses by police forces. For example, Belarus and Macedonia were identified as countries where individual prostitution is prohibited; in both countries, prostitution is considered to be a misdemeanor, punishable by a fine (*Law on Misdemeanors against Public Peace and Order of the Republic of Macedonia, Article 27; Administrative Code of the Republic of Belarus, Article 17.5*). However, such laws are enforced differently in the two countries. In Belarus, fines were levied against a total of 4,374 commercial sex workers in 2003 (according to the Ministry of Internal Affairs), while in Macedonia only 36 commercial sex workers were punished in 2002 (data for 2003 were not available from the Ministry of Interior). This difference is significant even taking into account the fact that the overall population of Belarus is five times larger than that of Macedonia. Police harassment is clearly a greater threat to sex workers in Belarus, a situation that greatly impedes HIV/STI prevention and care efforts among them and thus limits their right to health. Respondents from Belarus noted that due to the illegal status of commercial sex work and police crackdowns, this group is extremely difficult to reach with prevention messages and condoms.

National respondents from Russia indicated that although prostitution is an administrative offense, punishable by a fine (*Administrative Code of the Russian Federation, Article 6.11*), the article is rarely enforced in relation to sex workers because police often find it difficult to prove that sexual services have been sold. In reality, though, sex workers are often detained or arrested on the basis of other legal provisions covering breach of public order, hooliganism, or absence of residency permits (*see also Burris and Villena, 2002*).

The situation is not always better in countries where individual sex work is not explicitly

regulated, such as Kyrgyzstan. According to national respondents in that country, sub-legislative acts (directives and guidelines from the Ministry of Internal Affairs) and actual law-enforcement practices often contradict legislation specifically allowing individual sex work. Police regularly arrest sex workers on the street or simply threaten to arrest them in order to extort bribes. They are often detained on the basis of alleged breach of passport regime or breach of public order. The threat of such harassment continues to restrict sex workers' ability and inclination to access vital health services, including medical care and harm reduction.

3.2 (ii) Organized prostitution (including pimping and brothel-keeping)[8]

Existing legislation is much more restrictive toward organized prostitution, even in countries where prostitution itself is quasi-legal (Hungary and Latvia) or not regulated. Pimping is prohibited in all countries of CEE/CA (it is an administrative offense in Russia and a criminal offense in all other countries), with punishments varying from a fine to imprisonment (s*ee Table 10 in the Appendices for details*). Policymakers seem to agree with such restrictions; for example, a survey carried out in 2003 among 63 experts (law-enforcement officials, legislators, executive policymakers, medical specialists, etc) in Russia revealed that all 10 legislators questioned were in agreement that organized prostitution should remain illegal (*AIDS Infoshare, 2003*).

Generally, prostitution markets in the countries of the region seem to have a similar pattern: local prostitution is rarely carried out on an individual basis and is most often controlled by pimps. Harsh police practices towards sex workers contribute to sex workers' increased dependence on a third party, such as a pimp, to watch out for police and to negotiate sex workers' release from custody if detained or arrested. Research in Bulgaria revealed that less then 5% of the surveyed sex workers were working without a pimp (*Arsova, 2000*). Individual prostitution is not regulated by law in that country; however, as in all other parts of the region, pimping is a crime in Bulgaria—and is punishable by up to three years of imprisonment and a fine. Therefore, although individual prostitution is not illegal by itself, it is in reality often heavily restricted by provisions of Criminal Codes.

Reports from the region indicate that regardless of what the laws hold, the police are much keener to go after individual sex workers than pimps. In Belarus, for example, where individual sex work constitutes an administrative offense and pimping a criminal one, more than 4,000 individuals were held liable for prostitution in 2003, while only 347 pimps were charged that year (as per the Ministry of Internal Affairs). In Bulgaria, meanwhile, a police report from 2000 indicated that there had been only one pimp convicted over the previous 10 years and that even that lone sentence was ultimately suspended (*Arsova, 2000*).

Although the impact of regulations restricting brothel maintenance requires further investigation, a study in Russia suggests that inadvertent consequences of criminalization of brothel-keeping may include higher levels of mobility among sex workers (*Mariner, 2000*). This often translates into staff at sex worker and harm reduction projects losing contact with clients for extended periods of time, which directly reduces effective delivery of vital health, legal, and other services for them (*AFEW, 2003a*). Direct prohibition of brothel-keeping also means that sex workers are often forced to work more commonly on the streets or in their clients' cars, for example, which further endangers their health and safety and makes them easy targets for potentially corrupt and abusive police officers.

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[8] Brothel-keeping is defined as establishing permanent premises for the business of prostitution, finding prostitutes, and hiring support staff.

3.2 (iii) Trafficking in human beings

Most countries in the region apply criminal punishment for trafficking in human beings, a practice that includes a high percentage of women trafficked for the purposes of sex work. For example, Croatia, which is mainly a transit country for trafficking, in 2002 implemented a National Plan for Suppression of Trafficking in Human Beings. The national Criminal Act prohibits slavery (*Criminal Act of the Republic of Croatia, Article 175*), illegal transfer of persons across the state border (*Article 177*), and international prostitution (*Article 178*)—which includes coerced prostitution and luring someone into prostitution in another country.

In the Czech Republic, which is a country of destination, origin, and transit for trafficking in human beings, trafficking of persons for the purposes of sexual exploitation is prohibited by the Criminal Code and may be punished by one to five years' imprisonment (*Criminal Code of the Czech Republic, Article 246*). The prison sentence may be increased to a maximum of eight years if the trafficker was part of an organized group, trafficked a minor, or committed the crime with the intent to exploit the victim for purposes of prostitution (*Article 246(2)*). Seducing, hiring, or transporting an individual to or from a foreign country for the purposes of providing sexual intercourse is punishable under this provision.

In Estonia, there is no specific provision punishing "trafficking in humans" as a single crime. However, relevant articles are applicable to various activities regarding trafficking, including "enslaving" (*Penal Code of Estonia, Article 133*), "abduction" (*Article 134*), and "illegal crossing of a state border" (*Article 16*).

These laws are generally supported by policymakers and human rights advocates. However, in practice few countries of the region are able or willing to adequately respond to the problem of trafficking. For example, in Croatia only 16 people were convicted in 2002 for international prostitution. In Bosnia and Herzegovina, both a destination country for traffickers and a country of origin, government officials reportedly do little to protect women from traffickers, often accusing them of unwillingness to testify. According to a 2002 Human Rights Watch Report, even some members of the International Police Task Force purchased women from traffickers; they were subsequently punished with no more then "a slap on the wrist" (*Human Rights Watch, 2002*).

There is also a direct link between national laws prohibiting prostitution in the country of origin/destination and a trafficked woman's fear of exposure as a sex worker. In 2002, UNHCR, UNICEF and the Organization for Security and Cooperation in Europe conducted an analysis of existing trafficking trends in South Eastern Europe. The report concluded that since prostitution was illegal in Albania, Bosnia and Herzegovina, Moldova, Romania, and Serbia and Montenegro, the "threat of being exposed as a prostitute, i.e. being involved in an illegal activity, in the country of destination, next to the fear of violence and debt and being in the country illegally, are the most effective means of control used by the traffickers. These are also the major reasons why women do not try to contact the authorities. Corruption of the local police and other authorities and their links with the traffickers is another reason." (*UNHCR, UNICEF, 2002*).

3.2 (iv) Regulated sex work

Hungary and Latvia are the two countries in the region that regulate sex work via certain provisions and government resolutions. Since it cannot necessarily be stated that sex work is *legal*—the profession is not included in a list of officially registered professions in either country—the terms "quasi-legal" or "regulated" are more accurate.

Sex work has been quasi-legal in Latvia since November 1998, when the Cabinet of Ministers approved regulation N. 427 "Regulations to Limit Prostitution" (*Latvijas Vestnesis, 1998*); prior

to then, there were no provisions within Latvian law regulating sex work. In April 2001, an amended regulation was accepted by the Cabinet of Ministers. These regulations provided specific information regarding how and when the provision of sexual services was to be limited and controlled.

Below is a summary of these regulations:

- Anyone who wants to engage in sex work and is over 18 years old can approach a certified STI doctor and receive a Minister of Welfare–approved "health card". This card allows individuals to work in areas specially designated by the government. In cities or towns with fewer than 20,000 people, local governments are given the authority to designate the areas where the sex workers can work. Offers of sexual services or accepting commissions for sexual services outside of these specially designated areas are forbidden. The provision of sexual services cannot take place in an apartment or home, unless it belongs to the prostitute or the client, or in any apartment or other space where a minor is present or where other residents object to the activity.
- Sexual services cannot be offered or advertised through the mass media—including the Internet or in the press (except for publications of an erotic nature)—nor can they be offered or advertised through the involvement of other persons.
- Sex workers are obliged to submit to a monthly medical examination. The Ministry of Welfare determines what the examinations consist of; any relevant information—such as STI status and treatment—is noted on the prostitute's health card by a certified dermatovenerologist.
- People with HIV/AIDS are forbidden to engage in prostitution.
- A dermatovenerologist who has issued health cards shall once a month submit to the commander of the national police a list containing the registration numbers of all health cards that have been issued.
- Upon receiving a written request from the national police, a medical employee who has issued a health card, examined a prostitute, or assigned treatment to a prostitute shall provide the national police with the requested information within three working days. The national police may issue similar requests to the national register of sexually transmitted and contagious skin diseases, the Latvian Infectology Center (the AIDS Division), the AIDS Prevention Center, or other medical institutions specialize in the diagnosis, treatment, or care of STIs.
- The implementation of the regulations is supervised by officials who are assigned by the commander of the national police, in collaboration with the relevant local governments. The Inspectorate for Control over the Quality of Medical Care and Expert Analysis of Working Ability shall supervise the guidelines overseeing monthly medical examinations for prostitutes.

Violations of these regulations constitute a criminal offense, which is punishable by a fine or imprisonment. Repeated violations incur detention, forced labor, community work or a fine up to 50 times the minimum wage (*Dehne, 2000*).

Only individual sex work is allowed under Latvian law; management of sex work (including pimping) is prohibited by the Criminal Code of Latvia (*Article 165*), and may entail imprisonment for up to four years with or without confiscation of property. If such offense is performed by a group or in respect to minors, it may entail imprisonment up to eight years, with confiscation of

property; if individuals younger than 12 are involved, perpetrators could face imprisonment of up to 12 years along with property expropriation.

These regulations appear to indicate that sex workers in Latvia are better off when compared to other countries in the region, but this may not necessarily be true since police raids and client violence continue to occur. In a 2002 survey, 86% (n=162) of sex worker respondents in Latvia reported sexual violence toward them; this compared with 98% (n= 154) in Lithuania and 46% (n= 158) in Estonia (*Kalikov, 2002*). These data reinforce concerns regarding the fact that the information contained on official health cards is not considered completely confidential, as indicated by regulations requiring information-sharing among medical examiners and the police. Drug-use behavior is likely to be noted on the card, for instance, which could prompt arrest or harassment by the police. Such a fear could conceivably dissuade some sex workers from applying for an official health card and continuing to work outside the system, thus limiting their regular exposure to the health care system.

Although sex work has not been a criminal offense in Hungary since 1993, a law regulating sex work was enacted only in 1999. The basic rules are outlined in the "Act About the Organized Crime and Related Areas" (*Act 1999:LXXV, Section 7-11*). According to the act, sex work is not punishable under the law, with the following conditions:

- Similar to Latvia, local governments in Hungary have the authority to designate so-called tolerance zones where sex workers can work, provided the sex work activity in the local community (village, town, or city) is "common" or multitudinous. Local governments must designate such zones if the number of people living in the area is above 50,000 and sex work activity is continuous. Sex work is basically legal within these tolerance zones. Local governments cannot designate tolerance zones in "protected areas" (such as schools, universities, museums, childcare institutions, state administration offices, religious institutions, or diplomatic institutions) or in neighborhoods surrounding these areas.
- If a sex worker offers or provides service outside of a tolerance zone, she/he commits a minor criminal offense (*Act LXXV of 1999 on "The modification of regulation on the fight against organized crime and related phenomena"*). The same law envisages sanctions in case of absence of a valid health license or if sexual services are offered to minors (18 is the age of legal majority for involving a minor in sex work).[9] If the minor is under 14, the perpetrator will bear criminal liability sanctioned by the Penal Code (*Act IV of 1978*). It is also forbidden for the sex worker to accept a proposal from a minor who wishes to use his/her services.
- If a sex worker works outside a designated area, the police can arrest her/him. The biggest possible punishment is a fine, which is around US$100-$200. (A major drawback of this law from the perspective of sex workers is that if he or she tries to work outside of the specially designated area, the total amount of fines levied can quickly become very high. Furthermore, while it is true that the punishment cannot be a prison sentence, only a fine, the police can change the fine to a conditional prison sentence if the fines are not paid by the deadline. Therefore, while in theory sex work is not punishable, in practice the law is often used against sex workers.)

[9] It should be noted that the *age of legal majority for consent to sexual activity in Hungary is 14,* but this legal provision is not relevant in regards to payment for sex.

- In accordance with the 1999 Ministerial Statute (*Statute of the Health Minister, no:41/ 1999 (IX.8)*), sex workers have to undergo regular medical examinations at a local STI service center, where they are examined for syphilis, gonorrhea, HIV, chlamydia, and hepatitis B. If their test results are negative, they get a hygienic card, which is valid only in combination with their personal ID card. The hygienic card is valid for three months only.

As in other countries of the region, the Hungarian Criminal Code punishes pimps and brothel-keepers. Brothel maintenance is punishable by up to five years in prison, and from two to eight years if minors are employed. Pimping can entail imprisonment for up to three years and/or a ban from the geographical area.

According to the Hungarian Civil Liberties Union, which was the national respondent for this survey, the biggest problem with the regulation of sex work in Hungary is that the local governments refuse to designate tolerance zones, with some pilot exceptions. The reason is usually connected to the resistance among members of local communities who are concerned about real estate prices. Sometimes the big cities have competence problems as well. In Budapest, the main local government (the Budapest mayor's office) is prepared to designate tolerance zones, but the individual districts identified oppose this move. This leads to situations in which sex workers are being fined regularly, with fine accumulations leading to conditional prison sentences. Local human rights organizations and the Hungarian Prostitutes Association insist that every local government that does not designate a tolerance zone is breaking the law, but as of yet they have not been widely successful in their advocacy efforts.

Conclusive in-depth studies of the laws' impact on national public health have yet to be conducted in either Latvia or Hungary. Studies indicate, however, that similar approaches to street sex work in countries such as Australia have improved health indicators among sex workers and their clients (*Morton et al., 2002*). Meanwhile, other studies indicate that certain aspects of policies in Latvia and Hungary—such as mandatory HIV/STI testing and regular breaches of sex workers' privacy when their medical records are shared with the police—may further marginalize sex workers and worsen their access to STI treatment (*Dehne, 2000*). This once more emphasizes the importance of observing all human rights standards, such as access to voluntary and confidential testing and treatment, when implementing innovative public health policies. The following sub-section focuses on the broader aspects of human rights in the context of sex work in CEE/CA.

3.3 Human rights of sex workers

> *When they come after us, we lie down, stay quiet, tremble, and we fear.*
> — Ira, 27, a sex worker and IDU in Ukraine (*UHRA, 2004*)

3.3 (i) Police violations

Although laws regarding prostitution vary in the surveyed countries, police practices towards people involved in sex trade remain similar across the region. In all 27 surveyed countries, local observers and project staff report that police harassment represents one of the most significant factors contributing to sex workers' vulnerability to violence and health risks.

Police find numerous grounds for harassing sex workers, with documentation-related issues being the most common rationale. Most such offenses, such as lack of proper identification documents and residency permits, are minor ones that usually entail a court-ordered fine. However, sex workers are often detained illegally and whatever documents they might have are taken away, which renders them further vulnerable in future police raids. Sex workers who use drugs are particularly vulnerable during police raids. In many cases, police who are looking to make their quotas of drug-related arrests—one of the most insidious consequences of harsh drug policies—plant drugs on a sex worker who is a user.

But equally often, police do not even bother finding an excuse to harass sex workers or extort bribes—both are done as a matter of course. Even in countries where sex work is decriminalized, sex workers assume that they have to pay off police officers with money or sexual services.

The spectrum of police violations reported by national respondents or found in literature is impressive and dispiriting, ranging from verbal abuse and compulsory testing to illegal detentions, sexual exploitation and torture, including rape and multiple assaults. In the following anecdote, a sex worker in Uzbekistan captured a wide range of possible violations of human rights that sex workers face on a daily basis:

> *Say you work the highway. A police truck approaches. You are grabbed and forced inside. Of course, they [the police] curse you all the way. You spend some time in that truck because they drive you all over the city looking for others. Then they bring you to ROVD [a police station operated by the District Department for Interior Affairs], right in the hands of the superior at the anti-drugs and prostitution department. It's important to behave yourself, as otherwise you will probably be beaten. Police make you write why you were on the highway "prostituting yourself". They maintain you should admit in writing that you are a prostitute. Sometimes this is when you can try and bribe the officer with an offer of free sex... After you have admitted in writing, they can either let you go but keep your passport, or bring you to the STI clinic for compulsory tests. In the STI clinic, if you test positive for one thing or another, you can end up staying there for up to 30 days, and you have to pay for treatment. Of course you are tested for HIV. If you are "clean", then police pick you up from the STI clinic and return you to ROVD again. Then you have to write yet another paper saying that you will pay the administrative fine and will not work as a prostitute any longer. The court decides whether or not to fine you. After this you are a free bird. The police will not touch you for at least three days on the highway, because the STI clinic will not take you again in such a short period of time.*
>
> — a sex worker from Tashkent, Uzbekistan

This anecdote reinforces respondents' assertions that prostitutes working the streets and highways are at the highest risk for police raids and violence. And, as might be expected, street workers are the most likely to be impoverished (they are paid the least for their services, compared with other sex workers) in the first place. According to national respondents, some sex workers in Tajikistan received as little as 30 U.S. cents per service, while their "luckier" colleagues in Ukraine made perhaps US$5 per service. The respondents reported that those working the streets had less knowledge about HIV/STI transmission; practiced safer sex with clients less regularly; had

higher prevalence of injecting drug use, alcohol abuse, and STIs; were most in need of protection from volatile clients; and were relatively unfamiliar with their rights or able to take action to achieve them.

Physical violence. Two-thirds (66%) of sex workers surveyed by the Vilnius Addictive Disorders Center in Lithuania testified that they had experienced physical violence from police. In Nizhny Novgorod, Russia, the Oblast AIDS Center reported that every third sex worker interviewed had experienced some kind of violence, and 21% explicitly reported police brutality.

Detentions based on lack of documents. In Bulgaria, as in other countries in the region, the police reportedly arrest large numbers of sex workers on the grounds of passport control. This is perceived as an admissible, even socially desirable action on the part of the authorities (*Arsova, 2000*). The situation is perhaps most dire for sex workers in Russia, where the system of "propiska" (residency requirements) is strictly enforced in many cities. This system mandates the placement of a stamp in one's internal passport that indicates he or she is allowed to reside in the area; the lack of such a stamp frequently provides police with the grounds for arresting or detaining sex workers.

Coercion for sex. The national respondent from Bosnia and Herzegovina reported several cases of rape by police. Many cases of this type of police brutality and intolerance allegedly occurred in a zone between two cantons (or regions) of the country. Police from another canton reportedly forced street sex workers residing in a different canton to provide them with free sexual services. The same respondent also reported that sex workers working in night clubs and bars also faced sexual coercion from police officers posing as clients. The respondent noted that policemen in the country often have mutual agreements with bar owners in which the owners offer the services of the bar's sex workers in exchange for not reporting that prostitution occurs there. (Prostitution is illegal in Bosnia and Herzegovina.)

A research study among sex workers in Moscow, Russia (n=242) concluded that 18% had been raped by the police (*Nashkhoev, 2002*). In Georgia, out of 160 interviewed street-based sex workers, 42% (n=67) reported experiencing either sexual or physical violence over the previous year. The youngest, those under the age of 19, suffered the most: 50% of those surveyed said they had experienced sexual or physical abuse. Overall, only 42 were willing to identify the perpetrator; of them, 26% identified the police (*Stvilia et al., 2003*).

A common feature of many post-Soviet countries—the system of "subotnik"—has been described earlier in this report earlier (*Section 2.4*). This type of obligatory free sexual services to the police is often reported in literature (*Lakhumalani, 1997; Platt, 1998; AIDS Infoshare, 2001; Andrushak et al., 2000*) and was mentioned in several country reports.

Bribes and extortion. Although pimping and soliciting are mainly illegal in most of the countries surveyed, police corruption is also alleged by some to extend to organized sex work. For example, in Kazakhstan, a Human Rights Watch report discussed witnesses' claims that police offered pimps protection from criminal prosecution in exchange for monetary payments and free sexual services (*Human Rights Watch, 2003*).

Similar developments were reported by a local NGO that works to protect the legal rights of sex workers in Bishkek, Kyrgyzstan. The most common problem cited by sex workers centered on rights' violations on the part of law enforcement agencies and the police—with most clients complaining about money extortion and illegal detention (*Tais Plus, 2004*).

A report from Russia, where sex work is an administrative offense, noted high levels of extortion. Policemen reportedly based their demands for bribes and sexual services on laws regulating "petty hooliganism" or for failing to possess the correct documents. (*Lowndes et al, 2003*).

Displacement of sex workers. Law-enforcement policies directed against street prostitution rarely reduce its overall frequency; instead, they merely lead to geographic redistribution across parts of the same town or city. Such displacement places sex workers under greater risk because they often may not know their new area or clients who frequent it. The policies also increase the likelihood that sex workers will need to work later at night, in more isolated and therefore dangerous areas, to avoid police attention. In turn, this is yet another reason that sex workers are particularly vulnerable to violence. The following anecdote from Kyrgyzstan provides a straightforward account of how displacement occurs and some of its consequences:

> *The police took with them two girls who they claimed did not work in the "right place". The police were very straightforward and said they needed money. The pimp paid. Now the girls are very afraid of police, in part because they will not let them work at all...*
> — volunteer report, Tais-Plus, Kyrgyzstan

Respondents from Poland also mentioned unwarranted and illegal deportation of sex workers from Poland by the police.

Compulsory HIV/STI testing. In the mid-1990s, at the height of one of the world's periodic HIV/AIDS panics, legislation mandating testing for HIV and STIs and prescribing criminal charges for transmission of sexual diseases was common in many CEE/CA countries. Most of these laws have been eased or abolished, but traditions of "legally enforced health" and improperly close links between health services and police remain strong.[10] Forced testing of arrested sex workers for STIs and HIV, as well as their hospitalization for compulsory STI treatment, has been reported in many countries, including Russia *(Lowndes et al., 2003; Lakhumalani, 1997; Platt, 1998; AIDS Infoshare, 2001*). Compulsory testing is so grounded in some of the countries' HIV/AIDS responses that sometimes service providers do not identify it as such. For example, an AIDS center in a Russian city reported the following in the survey: "Compulsory testing and treatment are absent. Meanwhile there is *obligatory* HIV testing for STIs patients, for IDUs, and at receipt in pre-detention." [Emphasis added by editors]

The Palmira project from Kyrgyzstan reported that in the wake of police raids, obligatory HIV testing is often carried out (and without pre-test counseling). Respondents from Poland mentioned cases in which sex workers were asked to show their HIV/STI test results to the police.

Apart from being obvious human rights violations, such practices can also lead to sex workers having deeply negative perceptions of public health services. They may be inclined to

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[10] According to AFEW, some of these harsh laws still remain, and are enforced, in parts of Central Asia. A rapid assessment report carried out in 2000 among sex workers in Dushanbe, Tajikistan indicated that Articles 125 and 126 of the Criminal Code are frequently used as a basis for arresting or detaining sex workers. Article 125 prohibits an individual from knowingly infecting another person with HIV; Article 126 prohibits knowingly infecting another person with an STI. According to the 2000 study, charges of violating one or both of these articles had been brought every year against at least one female in the sex industry. At that point, no cases had ever been brought before the court; however, such legislation may discourage a sex worker from seeking testing and treatment services because the crime requires that the accused know his or her diagnosis. Moreover, obtaining access to public-sector STI or HIV/AIDS services requires the registration of positive diagnoses, a development that can increase the likelihood of hospitalization, contact tracing, and possible job loss. (*AFEW, 2003a*)

avoid them in the future whenever possible, which could further limit comprehensive individual and country-wide responses to HIV/AIDS.

Substandard enforcement of laws in cases involving sex workers. Weak rule of law and oversight in most countries of CEE/CA further renders sex workers extremely vulnerable to illegal police actions, such as violations of due process, that are also firmly prohibited under international law (such as the International Covenant on Civil and Political Rights). Sex workers often believe the authorities are only there to hurt or harass them, regardless of the circumstances. Therefore, although rape is a crime in every single country surveyed, many sex workers do not seek justice or otherwise pursue their accusations through the national judicial systems. As pointed out by the AIDS Center in Vilnius, Lithuania, "The police practically do not register raping or robbery reported by sex workers, because by [their] definition sex workers cannot be raped."

3.3 (ii) Violence from pimps

In Nizhny Novgorod, Russia, the Oblast AIDS Center reported that one-third of sex workers surveyed experienced some kind of violence and that most of them (55%) experienced violence from their pimps.

A local expert in Bulgaria described the situation in which female sex workers often find themselves as follows: "In the worst cases, sex workers cannot choose whether, when, how, and where to work; whether to travel or not; and whether to visit a doctor or not. They are often victims of trafficking, rape, and regular violence [at the hands of] their immediate pimp or the organized group he is working for" (*Kandzhikova, 2004*).

Legalizing sex work can make it easier for sex workers to work on their own, without the need for a third party. If they still work under pimps, a decriminalized environment may also make it easier for them to report instances of physical and sexual violence from their pimps.

3.3 (iii) Violence from clients

Overall, around 80% of sex trade workers in CEE/CA countries reported experiencing physical violence from their clients. In-depth research conducted in Moscow, Russia examining the psychological profile of sex workers (n=242) indicated that 38% of women reported being raped by their clients on more than one occasion (*Nashkhoev, 2002*). In Nizhny Novgorod, Russia, the Oblast AIDS Center reported that one-third of sex workers in contact with its services experienced some kind of violence, with 23% of them saying their clients were responsible.

The national respondent from Bosnia and Herzegovina reported that sexual harassment, including rape, was the most common type of violence experienced by sex workers. The respondent noted that sex workers tried to protect each other in a variety of ways. Following the murder of one sex worker by a client a few years ago, sex workers in one Bosnian city stopped working the streets at night and were especially careful around highways and crossroads. In Latvia, street sex workers reportedly often write down the car numbers of their "bad dates" and relay that information to each other. Other common types of violence by clients, as cited by respondents in Bosnia and Herzegovina and other countries of the region, included beatings and forced anal and vaginal sex without condoms.

In Bulgaria, some sex workers said that they would rather work abroad because they believed that clients' attitude towards their profession was "more civilized" in other countries. As in many other countries, sex workers in Bulgaria said they often depended on their pimps to provide them with at least limited protection from clients' harassment or brutality, which included clients stealing their money and possessions and raping or kidnapping them.

In Kazakhstan, over 60% of street sex workers reported violence from clients. According to one study in Vilnius, Lithuania, 86% of sex workers reported being sexually abused by at least one client over a 12-month period in 2003.

In Georgia, out of 160 interviewed female street sex workers, 42% (n=67) reported experiencing either sexual or physical violence over the previous year. The highest percentage (50%) of them were 18 years old or younger. Only 42 out of the 160 surveyed said they were willing to identify the perpetrator; of them, 52% said the violence was committed by a client.

3.3 (iv) Mass media harassment

At times, sex workers' right to privacy and confidentiality have been abridged by the mass media in CEE/CA. Many newspapers have published their pictures, and their identities have on occasion been revealed on TV—both without their consent. Through such actions, media outlets often play a role in increasing stigma toward sex workers and reducing their ability and willingness to access vital health and legal services. A respondent from Bulgaria said that the national mass media rarely took into consideration the need for sex workers' confidentiality: "Usually, they [sex workers] are being photographed against their will, and without their consent. No efforts are taken to keep their identity a secret."

Although acknowledging that mass media violations do not happen frequently in Georgia, a national respondent from that country recalled one very significant case:

> *One of the sex workers asked us to help her deal with the policeman who was violating her and her colleagues' rights. He would always beat them, blackmail them, and use their services for free. Together with the sex worker, two staff social workers from "Tanadgoma" [an NGO that works with sex workers] contacted the head of the local Human Rights Committee and asked the commissioner to support the sex worker and protect her from any future actions of the offending policeman. The commissioner promised to help, but little did. We know that our visit to the commissioner was taped and filmed without our consent, and was soon shown on local TV. Consequently, the policeman recognized the sex worker and threatened her with even worse physical violence; her colleagues then turned away from her, ratted her to the police, and did not allow her to work with them for a long time.*
>
> — a national respondent in Tbilisi, Georgia

Respondents from Tallinn, Estonia reported that TV film footage of a police raid of sex workers openly showed the faces of those arrested, without obtaining their consent, and did not provide sex workers with the means to conceal their identities.

There are indications that the situation may be changing in a positive way. Many respondents mentioned a slight decrease in identity breaches by mass media over the past several years; respondents from Croatia, for example, reported that when journalists write stories about sex work, they are increasingly trying to protect them by using made-up names. In Kazakhstan, most media agencies reportedly emphasized protecting the identities of sex workers so that they can work with them in the future.

3.3 (v) Access to health services

Sex workers' right to the highest attainable standard of health, as outlined by the International Covenant on Economic, Social and Cultural Rights, is reportedly violated on a daily basis, largely because rigid government policies have the effect of pushing them further underground. While access to free medical services varies from country to country due to different national regulations, what became clear after reviewing a number of surveys was that sex workers were usually unwilling or unable to use public health systems. Literature and responses to the survey both revealed that when accessing treatment, most sex workers prefer not to disclose their occupation and that many are reluctant to access treatment facilities for a variety of reasons, including lack of money for fees or medication, lack of registration or insurance, fear of being detained for compulsory STI treatment, and concerns related to the stigma attached to their profession. When they can, many sex workers reportedly prefer to use "someone they know", even if this provider is not part of the national health system. A respondent from Kazakhstan stated that most of his country's sex workers had their own "trusted" medical doctors; those who were impoverished and unable to pay usually did not access the public health system at all.

As demonstrated in Table 9 in the Appendices, in many cities of the region a majority of sex workers are migrants. This often means that they have no health insurance and are ineligible for free or low-cost treatment. Sex workers without health insurance usually must contact private clinics and/or pay high prices for services, which most of them cannot afford. The biggest obstacles to obtaining health insurance are lack of proper identification documents or residency permits and lengthy administrative procedures. According to a survey of sex workers in Bishkek, Kyrgyzstan, conducted in early 2004, about 46% of 178 reported having no passport and 70% had no residency permit in Bishkek (*Tais Plus, 2004*). In Tallinn, Estonia, 90% of sex workers surveyed said they had no insurance card because they had never worked in an officially recognized profession (*Kalikov, 2002*).

The Health and Social Development Foundation in Sofia, Bulgaria reported that free access to medical care in that country was only available to insured citizens. However, due to the complexity of the insurance system, which requires monthly instalments, sex workers were generally unable to obtain access to it. With private medical practice usually beyond their reach, the only accessible medical services left for uninsured sex workers in Bulgaria are emergency departments in hospitals. A respondent from Bulgaria mentioned that there are a handful of low-threshold places for sex workers; most of them were located in Sofia, however, which means that sex workers in other areas do not have access to them.

According to the AIDS Center in Vilnius, Lithuania, most sex workers in that country are migrants and trafficked women. As a result, they lack official identification or permanent-residence documents, both of which are usually required to obtain health insurance.

In addition to migrants, sex worker IDUs represent an especially vulnerable sub-group. According to a survey conducted in 2004 by the Ukrainian Harm Reduction Association (UHRA) in 21 regions in Ukraine, sex worker IDUs and sex workers with HIV faced the highest level of discrimination when contacting health care providers. Examples of reported discrimination included negative and obstructive attitudes on the part of providers, negligence, high prices, and denial of provision of necessary health care services (*UHRA, 2004*). The following two examples are from that survey:

If you are an addict, this means it is over. I was staying at a tuberculosis clinic. My tuberculosis should have been operated [on]. As soon as they found out that I was an addict, I was refused.
— Zhenya (female)

The doctors' attitude is defeating. When I went to the first hospital, the doctor treating me said, "All addicts, absolutely all, are sick with AIDS even if nothing is found in the blood samples. Nobody will look after you. Get yourself a nurse, a nanny." Their attitude is full of disgust and alienation. They do not want to communicate with you, nothing at all...
— Galina (female)

Many sex workers say they rarely trust specialized health providers because of expensive or unnecessary charges for their services. In addition, they often distrust state medical facilities because of the perceived or real assumption that such facilities sometimes provide inaccurate diagnoses as part of an effort to extort money from patients. The following anecdote is from a sex worker in Georgia:

They give us inaccurate test results because they think that because we are sex workers we have a lot of money. Medical doctors just earn extra money when they identify us as sex workers. When I took another test at a different clinic, where I am not recognized as a sex worker, the results were different from the ones received during the [previous] testing.
— reported by the NGO "Tanadgoma", Tbilisi, Georgia

The reluctance of some sex workers to visit state clinics may also stem from perceived or real poor quality of services, which is often a consequence of the depleted and resource-starved state of health systems in many CEE/CA countries. The following two quotes from NGOs in the region illustrate that situation:

The system of the dispensaries at the moment is in a very poor economical situation and very often they don't have the necessary medical consumable materials.
— Health and Social Development Foundation, Sofia, Bulgaria

In Romania it is quite hard for anyone to receive good quality services from the public medical institutions. It does not matter if you have a medical insurance, a job or if you are still studying. For adequate services it is necessary to pay extra (tips) to the medical staff. The discriminatory situation is towards everyone and it does not matter if you are sex worker, drug user, migrant and so on.
— ARAS, Bucharest, Romania

Furthermore, the police reportedly are also often involved in bringing sex workers to clinics for compulsory testing and treatment. As might be expected, this has had the effect of increasing

the desire of sex workers to avoid any interaction with both the police and with health care professionals.

Most respondents mentioned that free HIV testing was rarely consensual. They also noted that pre- and post-test counseling was provided sporadically, if ever, unless sex workers attended specialized clinics linked to harm reduction or HIV prevention projects. The same was true with regard to STI testing. In Bulgaria, for example, STI testing and treatment were offered by public STI clinics, but it was neither free nor anonymous. Respondents from Belarus reported that although sex workers had free access to STI testing and treatment, the latter was not anonymous—and sex workers consequently rarely disclosed their profession.

Projects from Bulgaria, Belarus, Kazakhstan, Lithuania, and Tajikistan reported that STI treatment services in their countries were not always anonymous and confidential. Also, most individuals were required to pay for them, as described in the following anecdote:

> *Health services are very expensive; therefore, sex workers do not contact them at all and are forced to self-medicate. A visit to a gynecologist is a rarity for the same reason. In the case of drug treatment, which is supposed to be free of charge, people are asked to pay around $50 and even more for medications. That is exactly the case with the Dispensers for Skin and Venereal Diseases, where STI treatment is provided. In addition, it is believed that confidentiality is not guaranteed at all.*
> — NGO RAN, Dushanbe, Tajikistan

Projects from Belarus, Bulgaria and Uzbekistan also reported cases of compulsory treatment of STIs, especially syphilis. In Kazakhstan, sex workers said they had been coerced into STI treatment, for which they ended up paying.

3.3 (vi) Awareness of human rights and domestic legal issues

There is empirical evidence demonstrating a relatively low level of rights-based knowledge among sex workers. In many countries, sex workers are not aware of the legal regulations that apply to their work or of existing mechanisms designed to protect their rights. This comes as a little surprise given that it seems to sex workers as though protective laws and rights-based policies often do not apply to them. They often feel they would have little to gain by seeking legal redress for police corruption, discrimination (such as denial of health services), and lack of availability of prevention and treatment information for HIV and STIs.

A street survey carried out by the NGO "Tais Plus" in Bishkek, Kyrgyzstan inquired into sex workers' awareness regarding regulations of sex work in the country (individual adult sex work is not regulated by either the Criminal or Administrative Code). Out of 181 sex workers surveyed, three could not respond to the question; 39% (n=70) did not know the answer; 7% (n=13) did not understand the question or did not know what was meant by the word "liability"; and 17% believed that individual sex work could entail either administrative or criminal liability. Only 34% correctly indicated that there is no liability for individual sex work. Therefore, two-thirds of respondents did not know or held incorrect assumptions regarding situations in which they could be punished for their behavior. In the same survey, slightly more than one-third of respondents believed that they could be detained for sex work (*Tais Plus, 2004*).

Meanwhile, a study conducted in 2004 by the project "Palmira" in Kyrgyzstan demonstrated that when given the opportunity to have free legal advice, sex workers were still unwilling to

access it. They cited fear of retaliation as the main reason not to report instances of perceived or real violations of their rights (*Palmira, 2004*). Most sex workers interviewed said they wanted to document cases of police extorting money from them, but did not complain because they did not want to put their lives in danger.

"Tais Plus" from Kyrgyzstan also reported that over a three-year period its staff knew of only three cases in which sex workers sought to prosecute illegal law-enforcement practices. In 2000, a sex worker wrote a legal complaint about a police officer who was extorting money from her. But she ultimately withdrew her complaint in the face of pressure from the police and confidentiality breaches. In another case, a legal appeal from a sex worker was registered in March 2003, but no resolution had occurred as of 16 months later. According to "Tais Plus", there are two main reasons that sex workers are reluctant or unwilling to seek legal assistance. One is administrative—they lack the identification documents required to launch a proceeding. The other, which is more philosophical, stems from many sex workers' defiant rejection of the need for any protection or assistance from the justice system. This stance may in fact be an example of "legal realism" on their part, considering how unlikely or substandard protection would be in the first place.

The police often exploit sex workers' low level of legal awareness to extort bribes and spread fear among this highly marginalized population. Raising their legal awareness is therefore highly important, and it may also have the effect of increasing the visibility of crimes against them. At the same time, pressure should be placed on the police and other law-enforcement agencies (including the judiciary) to uphold their responsibility to protect all citizens in a forthright and non-discriminatory manner. They should be subject to significant disciplinary action when violations are uncovered—and those who report violations should be able to do so confidentially.

3.3 (vii) Public opinion

Prostitution has existed in every culture and society since mankind first became a social animal. This has not always made it an acceptable profession in the minds of many people. In most parts of the world—including countries in CEE/CA—sex work has always been stigmatized, and it remains so today. Individuals who might be relatively tolerant of most behaviors are often strongly opposed to sex work, viewing it as immoral, degrading, and shameful. At the same time, though, many of them have compassion for prostitutes and do not necessarily believe that conditions should be established that lead to harassment of sex workers.

Unfortunately, such anti-abuse attitudes are far too frequently ignored or subsumed under a chorus of strident distaste for not only the behavior, but for the participants as well. In many cases, conservative and judgmental public opinion regarding sex workers strongly influences the beliefs and decisions of legislators and policymakers, police, mass media, clients, and public health authorities. Hostile public opinion is not the primary focus of this study, but it is worthwhile noting the strikingly harsh—and often hypocritical—attitudes toward sex work among members of the general public.

According to a survey of residents of Bishkek, Kyrgyzstan conducted in 2001 by the NGO "Tais Plus", 11% of respondents agreed that sex workers should be *physically annihilated* (*Tais Plus, 2004*). Across the region, residents of neighborhoods where sex work occurs periodically submit written complaints to law-enforcement authorities demanding that the activities of sex workers be curtailed. Such complaints have been used by the police to justify harassment of sex workers, regardless of the legal or human rights issues involved. (*Into Focus, 2003*)

As reported by the national respondent in Hungary, the anti-prostitution movement in that country has grown stronger in recent years. The "Movement for a Prostitution-free Hungary" gets serious media coverage and public support. In 2004, for example, the biggest Hungarian daily newspaper rejected an opinion piece submitted by the Hungarian Civil Liberties Union in response to two large pieces in the newspaper that outlined the paper's explicit anti-prostitution stance.

Hostile public attitudes represent a major obstacle to the implementation of comprehensive services for sex workers. According to a survey conducted of organizations working with and for sex workers in three countries of Central Asia (Kyrgyzstan, Tajikistan, and Uzbekistan), negative public opinion was identified as a key factor that hindered their ability to provide services and support for sex workers and other marginalized groups, including IDUs (*AFEW, 2003*). In these nations and elsewhere in CEE/CA, women expressed shame and guilt for being involved in sex work, emotions that are largely determined by predominant social mores. It is undeniably difficult to seek out and expect human rights protections when living and working in societies in which one's behavior is condemned harshly, regardless of the circumstances.

4. HIV/STI and Harm Reduction Interventions among Sex Workers

This section aims to give an overview of existing HIV and STIs interventions among sex workers in CEE/CA; the extent to which they provide necessary services to this population; and the coverage that they are achieving. The section does not intend to give a detailed analysis of the existing services. Instead, it seeks to provide information and observations regarding the number of clients they cover, their specific needs, the types of services provided, and the obstacles they face, including the impact of overall trends and policies on individual project interventions.

4.1 Guidelines on service provision to sex workers

According to UNICEF, effective measures to prevent HIV and STI transmission among sex workers include the following (*UNICEF, 2001*):

- Provision of free/cheap, accessible services to prevent and treat STIs, which are often co-factors in HIV transmission both to and from sex workers. These should be linked to voluntary testing and counseling (VCT) services to encourage testing and promote safe practices.
- Implementation of condom promotion campaigns (which should include targeted media campaigns, condom distribution, and enhanced safer-sex negotiation skills) to assist all sex workers in their efforts to insist that all clients use condoms.
- Increasing the availability of needles, syringes, and other injecting equipment to sex workers who inject drugs. A key element should be needle/syringe provision or exchange in order to provide the tools needed to reduce the sharing of injecting equipment.
- Production and distribution of explicit, specific information for sex workers about

ways to protect themselves from contracting or transmitting HIV, and to motivate and assist them to use condoms regularly.

- Delivery of the above services by credible, trusted workers—often peers including ex or active sex workers—in attractive, accessible formats such as outreach, mobile services, and drop-in centers. This is part of an effort to reach sex workers in safe, "sex worker-friendly" locations that allow conversations and counseling on a wide range of issues of interest to the target group as well as assistance into alternative employment when desired.
- Empowerment of sex workers through the creation and support of groups to advocate for appropriate legal and police treatment, and to assist in improving sex workers' negotiation skills to protect themselves.
- Development of links and referrals between needle/syringe exchange projects, drug treatment programs, STI services, and other health, medical, legal, and social services for sex workers—to re-engage them with social systems and provide multiple opportunities for effective education on HIV prevention.

4.2 Brief history of harm reduction for sex workers

Nearly all international health organizations agree that harm reduction should be one of the most important elements of all national plans and strategies to fight HIV/AIDS. As defined by the International Harm Reduction Development program (IHRD) of the Open Society Institute (OSI), "Harm reduction is a pragmatic and humanistic approach to diminishing the individual and social harms associated with drug use especially the risk of HIV infection. It seeks to lessen the problems associated with drug use through methodologies that safeguard the dignity, humanity and human rights of people who use drugs."[11] This definition refers specifically to drug use, but harm reduction is generally used to apply to strategies employed to reduce the health and social harm from any potentially risky behavior, not just drug use.

With varying intensity by country, harm reduction strategies have been employed in the region since the early 1990s. The first harm reduction projects focused on HIV prevention and other services for IDUs. Before long, though, it became clear that many sex workers were using the services, a perhaps unsurprising development given the strong correlation between sex work and drug use. In recognition of the need to provide more targeted harm reduction services to sex workers, IHRD funded a pilot initiative for sex workers in CEE/CA in 2000. The initiative started with 33 organizations in 12 countries: Belarus, Bulgaria, Estonia, Latvia, Lithuania, Poland, Romania, Russia, Slovakia, Turkmenistan, Ukraine, and Uzbekistan. In just the first six months, more than 6,500 sex workers were reached at least once and provided with harm reduction information about HIV, STIs, and drug use. Approximately 6,200 (95%) of them were engaged more than once with follow-up information, education, counseling, and referrals. More than 5,100 sex workers were reported to be participating in needle and syringe exchange services (*IHRD and OSI, 2001*).

The number of harm reduction projects targeting sex workers and/or other high-risk sub-groups increased steadily after 2000. A needs assessment study by CEEHRN in 2002 identified

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[11] This definition and additional information about harm reduction may be found on the website of OSI's International Harm Reduction Development Program at www.soros.org/initiatives/ihrd.

42 projects targeting sex workers among 174 members of the network at that time. (In that year, CEEHRN started a thematic sub-network to facilitate exchange between projects working with sex workers.) A review in 2003 identified 37 projects targeting sex workers in Russia only (*Platt and Montgomery, 2003*). A wider CEEHRN survey of needle exchange programs focusing on data from that same year identified 237 harm reduction programs from 27 countries in the region, with 85 specifically identifying sex workers as a key target group, if not the primary one (*CEEHRN, 2004*).

4.3 Funding

This report originally was not intended to consider funding and sources of funding. In the course of information-gathering, however, it became clear that certain limitations in service provision stem primarily or at least partly from donor policies and conditions. Also, a previous CEEHRN needs assessment survey of 26 organizations working with sex workers, conducted in 2003, revealed that financial constraints represented one of the most important barriers to the development of effective services and achieving efficient coverage of the target populations (*Jiresova, 2003*).

For the reasons stated above, this report's authors decided to review available information on sources of funding in the region. One source was a 2004 survey from CEEHRN that covered 237 needle exchange programs in 27 countries of CEE/CA; a total of 85 of the programs explicitly targeted sex workers. Based on an examination of their operation and performance indicators in 2003, it was determined that almost half of harm reduction programs in the region were partially or fully funded by country authorities. National or local funding covered most expenses of the programs in some countries, including Croatia, the Czech Republic, Lithuania, and Poland. In those countries and elsewhere, direct national or local monetary or in-kind support constituted an important contribution to some projects that still largely relied on external donors.

The main external donors in the region in 2003, as reported by these 85 organizations,[12] included (in order of input[13]): IHRD (58 projects), USAID (nine projects), DFID (six projects), and OHI (four projects). Other funders included UNAIDS, UNDP, and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM).

In 2004, the funding situation in the region started to change. Eight of the region's 27 countries joined the European Union, which meant that they were no longer eligible for many grants from international donors and multilateral organizations. Another important development was the creation of the GFATM, which by its fourth round (by the end of 2004) had provided grants to 18 countries in the region, with a substantial proportion of the funds earmarked for prevention among marginalized populations. Additional GFATM assistance for the region will likely be approved in Round 5 later in 2005. In some countries, including

[12] The data here were reported by the organizations themselves, so sometimes it is difficult to determine the real source of funding. For example, most of the financial support to the Russian harm reduction organizations was provided by DFID, but the grants were administered by OHI.

[13] Estimates of the amount of funding from each individual donor were not available. The analysis was only based on the number of projects co-funded by the donor, and not on the amount of support provided.

Bulgaria, Kazakhstan and Kyrgyzstan, organizations that provide services to sex workers have received funds through the GFATM. However, the impact of GFATM assistance on sex workers' lives in these three countries and elsewhere is unclear so far, given that the grants have only recently begun to reach the countries.

The GFATM and EU notwithstanding, funding remains a struggle for harm reduction providers in many countries. For example, in Russia a 2002 review identified 75 harm reduction projects, 42 of which received an average of $28,000 from OSI/DFID (*Rhodes et al., 2004*). In 2003, however, funding from DFID was no longer available,[14] and the Open Health Institute (OHI)—OSI's successor national foundation in the country—stopped funding 11 projects because it did not receive expected support from the World Bank. As a result of these changes, the amount of assistance provided to these projects was reduced by an average of $14,000 (*Letyagina, 2003*). Unfortunately, promised GFATM and World Bank support failed to materialize that year, and the shortfalls were not covered by government sources or by other donors.

As this example shows, the policies of external donors can have a disproportionate impact on harm reduction projects in countries where national or local governments provide little or no funding for them. Donor policies can often stimulate such programs should funds be available, but conversely they can devastate a project's effectiveness should funding be suddenly eliminated or reduced drastically. Should the latter occur, important services for sex workers and IDUs may need to be limited or reduced.

Donor assistance for harm reduction and sex worker services may also be influenced by policies and procedures that are not directly related to financial disbursement. This observation is particularly relevant in regards to one of the largest donors to the region in the field of health, the U.S. government, which supports health programs through the U.S. Agency for International Development (USAID). This agency often funds programs that provide services to sex workers and victims of trafficking; by law, however, USAID may not provide funding to "promote or advocate the legalization or practice of prostitution or sex trafficking". Recipients of funding must also have a policy explicitly opposing prostitution and sex trafficking. Initially, this latter requirement was only applied to NGOs not based in the United States; recently, though, the U.S. government announced plans to extend this requirement to all NGOs. This requirement has been the subject of considerable debate because its meaning is unclear and some groups are concerned that advocating on behalf of sex workers might violate the policy. Regardless, these restrictions offer clear evidence of the power and influence that can be wielded by conservative or judgmental policymakers who are firmly opposed to strategies that do not emphasize abstinence in dealing with all kinds of potentially risky behaviors.

Along the same lines, the U.S. government also does not allow USAID to purchase or distribute injecting equipment for needle/syringe exchange programs or related research programs. USAID does fund other services targeting IDUs, such as educational materials, counseling and testing, condom distribution, and safer sex education (*USAID Guidance, 2004*).

The United States has also pressured other countries to abandon needle/syringe exchange programs. It has, for example, opposed statements in support of needle exchange at the

[14] In 2003, DFID closed its bridging project, which was intended to support harm reduction in Russia before expected GFATM and World Bank assistance arrived.

Commission on Narcotics and Drugs and has also asked the UN Office on Drugs and Crime to remove from its website materials related to needle exchange.

These policies and developments threaten the stability of many harm reduction programs in CEE/CA because many governments look to the United States for guidance about how best to respond to the HIV/AIDS epidemic. It may be that U.S. domestic political concerns have the effect of further disrupting the fragile and far-too-limited system of services currently available for sex workers and other marginalized groups in resource-poor regions—countries that are, unlike the United States at the moment, struggling to deal with looming public health catastrophes related to HIV/AIDS.

4.4 Target groups

Most of the projects surveyed in this report provide services primarily to female sex workers. Project "Vstrecha" from Minsk, Belarus is the only one focusing on male sex workers. Seven other projects cover this sub-group as a part of a broader sex work population; they include projects in Minsk, Belarus; Sofia and Varna, Bulgaria; Osh, Kyrgyzstan; Strumica, Macedonia; Bucharest, Romania; Bratislava, Slovakia; and Dushanbe, Tajikistan.

Demographic characteristics of project clients are presented in detail in Section 2 of this report. Most of the clients are women aged 20-30 who work on the street. Among the surveyed projects, 56% reported considering IDUs as a specific group of sex workers. (*More detailed data regarding the percentage of sex worker IDUs covered by the projects are presented in Section 2 and in Table 8 in the Appendices.*) The majority of the projects reported that a large proportion (often at least 50%) of their clients were migrants from rural areas, regional cities or other countries in the region (*see Table 9 in the Appendices*).

4.5 Service coverage

There is no commonly accepted precise definition of the word "coverage" in the context of service provision. (Broadly speaking, it is often used to refer to two intertwined things: the extent to which targeted individuals in a delineated community have access to and utilize services; and the scope of such services.) Also, there are no particular international recommendations as to what constitutes effective coverage of sex worker populations. However, in 2000 the UNAIDS Task Force for HIV Prevention among IDUs in Central and Eastern Europe set a target of 60% coverage for harm reduction programs in the countries of the former Soviet Union. Many analysts consider this percentage to be at or near the threshold necessary to halt the transmission of HIV in a specific community, especially closely integrated ones such as IDUs.

In few places of the region has this target been reached by harm reduction projects in general or needle exchange services in particular. A 2004 review by the *United Nations Reference Group on HIV/AIDS Prevention and Care among IDU in Developing and Transitional Countries* revealed that across CEE/CA, 77 harm reduction programs out of 202 for whom data were available have an overall coverage <5% (e.g., Tirana, Albania: 0.07%). A total of 86 had coverage between 15% and 60% (e.g., Prague, Czech Rep: 16%; Minsk, Belarus: 22%; Bratislava, Slovakia: 26%), but only two projects were believed to have reached a proportion of IDU

clients over 60% (Plovdiv, Bulgaria: 70% and Lviv, Ukraine: 94%). These limited estimates are available for needle exchange projects only, with no specification breakdown into categories such as sex worker IDUs.

Given the absence of specific studies on coverage of sex worker populations in CEE/CA, this report's authors decided to analyze data available from the survey. For the purpose of this report, "coverage" was defined as the total number of clients (sex workers) contacted *at least once* by the projects as a percentage of the estimated number of sex workers in the cities where these projects work. Out of 39 services that provided information for the survey, the reports on both estimated numbers of sex workers in the city and clients reached by the service was available for 31 projects. (*The data are presented in Table 8 in the Appendices.*)

As can be seen in Table 8, estimates of sex worker populations in some cities differed widely (e.g., in Moscow, from 30,000 to 150,000); in such cases, an average of all submitted estimates was used. Some respondents only provided a minimum estimate of the number of sex workers (e.g., Omsk: >1,000) or estimates of one or more particular type of sex worker (e.g., St. Petersburg: 8,000 street workers). In these cases the authors relied on the available data only. Data were also not standardized in terms of number of clients. Some respondents could only indicate an approximate number (e.g., Barnaul: ~200), or a range (e.g., Yerevan: 1,000-1,300) of clients reached by their projects. In these cases the available data or an average number were used for calculation. The results of this analysis are summarized below.

The total estimated sex worker population in the communities where the 31 projects operated was about 148,000. Coverage from the projects extended to about 21,300 of them (14% of the total). The range of coverage levels extended from 100% (Tallinn, Estonia; Omsk, Russia; Bucharest, Romania; and Plovdiv and Varna, Bulgaria) to 5% (a project in Moscow).

According to these rough estimates derived from the survey data, 68% (n=21) of the projects in CEE/CA did not reach 60% of the total number of sex workers in the cities in which they work. One-third of these 21 projects reached 10% of sex workers or less; another third reached 11%-30% of sex workers; and the final third reached between 31%-60%. On the other hand, 32% reported covering 60% of potential clients or more. These are not bad results, especially compared with IDU population coverage data presented above. They also indicate that achieving reasonable coverage of sex workers is a realistic task for even small-scale projects.

It should be noted that data presented here may not be illustrative of the real situation in several places. For example, in large cities such as Moscow there are several harm reduction organizations targeting sex workers (*Platt, 2003*), but information for this survey was only provided by one project. In Skopje, Macedonia, meanwhile, the national respondent reported that although the overall estimate of sex workers in the city was 1,000 individuals, only about 100 of them worked in the streets—yet the local project reached nearly every member of this most vulnerable sub-group.

These are just two of the many examples from across the region indicating that information about coverage levels should be interpreted with great caution. Research and information limitations include lack of reliable estimates of the size of sex worker populations in the cities; varying and often not very advanced methods of data collection and monitoring of services; the absence of a standardized monitoring system and indicators; and inconsistent data supplied by projects for this report.

4.6 Project services

4.6 (i) Condom distribution, information, and counseling

Section 2 of this report discusses recent indications that sexual transmission of HIV is becoming more common, especially among sexual partners of IDUs and IDUs involved in sex work. Some of the studies reviewed in Section 2 reported high prevalence of STIs among IDU sex workers as well as limited coverage of IDUs and drug-using sex workers by harm reduction projects. Table 12 in the Appendices outlines the range of services offered to sex workers by projects in the region. Services that have been incorporated by all 39 surveyed projects are condom distribution (100%) and information and counseling (100%).

Various combinations of activities and strategies to increase sex workers' and clients' sexual health awareness are recommended as an integral part of existing HIV prevention interventions targeting sex workers. They include implementing condom promotion campaigns, which should include targeted media campaigns and enhanced safer-sex negotiation skills, and increasing the availability of condoms.

Inconsistent condom use among sex workers is also related to several other factors, many of which are particularly difficult to address. For example, clients often use physical threats or abuse to force sex workers to have sex without a condom; others clients, meanwhile, may offer to pay substantially more to have condom-free intercourse. Many sex workers are also less likely to use condoms with regular or non-paying partners, including husbands and boyfriends. (*For more details, see Section 2.11 above.*)

4.6 (ii) Needle and syringe programs

Sex workers who inject drugs face even greater stigma and are more vulnerable to health risks than non-drug users. Compared with other sex workers, a disproportionate number of sex worker IDUs work on the streets and earn less money; as a result, they often cannot afford to pay for health services. They subsequently have few if any contacts with the public health system. The worrying implications of such substandard access are compounded by the fact that injecting drug use and risk behaviors associated with it are among the major factors that can increase sex workers' vulnerability to HIV infection. As a result, it is important to offer access to harm reduction services (including needle and syringe programs, substitution treatment, prevention information, and referrals) in places where sex work is linked to injecting drug use. As discussed in Section 2, most projects reported injecting drug use among a significant proportion of sex worker clients. (*For more details, see Table 8 in the Appendices.*)

Needle and syringe exchange remains controversial in many parts of the world. As with so many other drug use- and sex-related issues, personal and public morality are never far from the heart of all discussion. Opponents, including influential policymakers in the U.S. government and certain key officials in CEE/CA nations (notably Russia), assert that needle exchange promotes illegal drug use, which they believe is always wrong and immoral. In their view, this consideration trumps any and all potential or real quantifiable health benefits, such as a reduction in HIV and STI transmission among IDUs. In response, supporters of needle exchange call opponents immoral for refusing to accept measures that can prevent illness and death. From a scientific and public health standpoint, however, there is no controversy: harm reduction (including needle and syringe exchange) is an effective public health intervention. Nearly all leading international organizations also support it.

Supporters appear to have prevailed in CEE/CA for the most part. Needle and syringe exchange is included as part of national programming on HIV/AIDS by most countries in the region, although scale up has been slow and halting in some areas. Among the 39 projects that participated in the survey, services targeting sex workers who inject drugs were provided by 33 (*see Table 12 in the Appendices*). The other six projects did not provide needle and syringe exchange despite the fact that some of them also reported significant levels of drug injecting among sex worker clients. For example, a project in Tashkent, Uzbekistan, reported that 30% of over 1,400 sex worker clients are also IDUs, and that 30% had acknowledged sharing needles and syringes. The project had not initiated needle/syringe exchange because it received the bulk of its funding from USAID, which does not permit the use of its funds for such activities (*see Section 4.3*).

In Moscow, the project Yasen of the NGO "NAN" blamed its lack of needle and syringe exchange on the fact that such activities were not sanctioned by city health authorities. The consequences, according to project staff, are a low level of awareness about the risks associated with injecting drug use and ongoing sharing of needles and syringes by clients. Other surveyed projects that did not provide needle and syringe services for various reasons include NGO "Jazas" (Belgrade, Serbia and Montenegro); NGO "Umbrella" (Krakow, Poland); and NGO "BelAYU" (Minsk, Belarus).

4.6 (iii) Voluntary HIV/STI counseling and testing

Epidemiological data presented and discussed in Section 2 indicate high prevalence of STIs and considerable prevalence of HIV and HCV among sex workers in CEE/CA (*see Table 6 in the Appendices*). Therefore, continual promotion and availability of primary health care; voluntary counseling and testing (VCT) services for HIV and STIs; and prompt, effective HIV/STI treatment remain important HIV prevention strategies in CEE/CA.

According to the data on total numbers of HIV tests performed annually for diagnostic purposes (unlinked anonymous tests and blood donations excluded) in 2002, the number of tests per 1,000 population varied considerably—from less than five in Albania, Armenia, Macedonia, Poland, and Tajikistan; to 30 in the Czech Republic; to over 100 in Russia. The most striking change (and a downward one) occurred in the early 1990s, when previous strategies of large-scale mandatory testing of various sub-populations were progressively abandoned.

Even today, though, the quality of HIV/STI testing varies across the region. It is not always free of charge, confidentiality is not always possible, and anonymous testing is still limited. In some countries, economic factors and the erratic availability of HIV test kits may also cause variability and limitations in the number of tests performed (*EuroHIV, 2002*). According to respondents from Tajikistan, there is no free HIV/STI testing available in that country, a situation that undoubtedly limits the number who get tested. The inclination and ability to be tested for HIV is not always more pervasive in wealthier countries of the region. For example, the NGO "Odysseus" in Slovakia reported that of 95 of 100 people surveyed in 2003 had considered getting an HIV test, but that only five had actually done so—and even they were tested only because they had donated blood,

Testing availability for high-risk groups, including sex workers, is not necessarily more extensive. For example, in Estonia the respondents said that there was only one organization, AIDS Information and Support Center, which offered free, confidential, and anonymous HIV and STIs testing and treatment services for sex workers. In Kazakhstan, survey respondents

reported that sex workers had access to testing—but that the free services in particular are not good quality.

Respondents from Armenia, Georgia, Kyrgyzstan, Russia, Tajikistan, Ukraine, and Uzbekistan reported instances of compulsory testing of HIV and STIs in their countries, mostly in the cases when sex workers were found to be injecting drugs and during police raids. In addition, forced HIV testing of STI patients was reported in Nizhny Novgorod, Russia.

In Latvia, a report prepared in April 2002 by the Drug Law and Health Policy Resource Network noted that although HIV testing is voluntary and protected under Latvian law, there were some incidents when medical officials conducted HIV tests without patients' permission. Furthermore, as noted in Section 3, sex workers are required to undergo regular medical examinations in Latvia and Hungary, countries in which commercial sex work is legal but highly regulated. In both nations, therefore, HIV testing is in reality not voluntary and anonymous for sex workers. This situation directly conflicts with the law, however, and many observers believe it represents a questionable practice from a human rights point of view—regardless of the merits of the legal, regulated policies governing sex work.

In Balakovo, Russia, there is a crisis center for vulnerable groups that provides a wide range of health services. At this program, which is part of the city's Comprehensive Plan on the Fight Against HIV/AIDS, sex workers and others can get free testing, counseling, and treatment referrals.

In Georgia, the NGO "Tanadgoma" cooperates with another organization, "Health Cabinet", to provide free, anonymous, and confidential testing services for HIV and STIs. Meanwhile, at the AIDS Centre in Nizhny Novgorod, Russia, sex workers can get the following free of charge: anonymous testing for HIV, syphilis, and hepatitis as well as counseling from different specialists (including those focusing on infectious diseases, skin and venereal diseases, gynecological concerns, oral care, and neuropathology). Additional counseling and treatment of STIs are provided in cooperation with the city's Institute for Skin and Venereal Diseases.

In Vilnius, Lithuania, the Social Disease Center "Demetra" (which operates through the AIDS Center) offers various services for sex workers, especially those working in the streets, including access to free condoms, sterile injecting equipment, and counseling and testing for HIV and STIs. It is, however, the only facility of its kind in the entire country.

4.6 (iv) Access to STI and HIV treatment

Given the role of STIs as a co-factor of HIV infection, high rates of STIs among sex workers can be interpreted as a precursor to a concurrent or looming HIV epidemic (*UNAIDS, 2002*). Therefore, prevention and treatment of STIs and promotion of general health care should be at the heart of HIV prevention efforts. But even in absence of HIV, high prevalence of STIs represents a major health threat for sex workers, and access to free and comprehensive treatment and care is essential.

Providing confidential and anonymous STI treatment services is a good way to encourage sex workers to use STI clinics/services. Data from the region show, however, that anonymous STI treatment is not free of charge in most cases. Concerns about anonymity and confidentiality are major reasons why many sex workers prefer to contact trusting doctors, even if they are not part of the public health system, and to utilize private clinics—which generally do a much better job of guaranteeing and enforcing anonymity and confidentiality. Most sex workers cannot afford private care, though, which is why service-delivery improvements through the public sector should be emphasized and prioritized.

Projects from Macedonia, Romania, Slovakia, and Ukraine stressed the need for more specialized services for sex workers in their countries. They pointed to a poor-quality and inadequate services in the public sector and a lack of professional health care providers who understand sex workers' needs and lifestyles.

The NGO ARAS reported that in Romania, its "Night by Night" initiative offered the only specialized medical services for sex workers. In partnership with other institutions, the initiative offers diagnostics and STI treatment to its sex worker clients. Also, in May 2004, ARAS helped create a partnership to provide comprehensive medical care for sex workers.

Many other projects in the region have also succeeded in developing similar partnerships with existing public health services and clinics. By providing specialized STI services for sex workers in existing public health institutions, they are able to utilize the facilities' full range of expertise and equipment. Such partnerships are a welcome development for the most part, but significant challenges must be overcome regarding procedures, staffing, client privacy, and strict guidelines concerning potential coercion.

In St. Petersburg, Russia, a network of friendly clinics (staffed by trusting doctors) provides the following services:

- At the City Hospital for Infectious Diseases No 30 ("Botkin Hospital"), out-patient care includes consultation with an infectious diseases doctor and testing for HIV, hepatitis B, HCV, and syphilis; in-patient care includes hospitalization and treatment for all infectious diseases, as well as drug treatment assistance.
- At the Clinic for Skin and Venereal Diseases (Kalinin, Kirov and Nevka districts), out-patient care includes examinations, treatment, and hospitalization if necessary.
- At the Centre for Reproductive Health of Young People ("Juventa"), out-patient care includes screening for and treatment of STIs as well as gynecological services.
- At the Medical Drug treatment Hospital, services include consultation and in-patient treatment for drug users.

The NGO "Marija" (Volgograd, Russia) distributes to sex workers the business cards of "trusting doctors" who provide anonymous and free medical services. The doctors have an agreement with the Dispensary for Skin and Venereal Diseases in which they can provide STI testing and treatment free of charge for 5-6 sex workers a month.

In Kyrgyzstan, the NGO "Podruga" offers clients referrals for free treatment of STIs to one of the three trusting doctors they cooperate with. Over a one-year period recently, a total of 415 sex workers were referred to the doctors, and 367 received treatment for STIs.

In Sofia, Bulgaria, there is a low-threshold STI clinic and four mobile medical units for vulnerable groups, including one specially designed for street sex workers. There are seven other mobile medical units planned for the entire country, to be funded by money from a GFATM grant; these units are expected to try to bridge the gap between marginalized groups and the health system.

Data from the projects covered by this survey did not provide more detailed information with regard to access to HIV treatment. However, according to the results of a region-wide survey published by CEEHRN ("Injecting Drug Users, HIV/AIDS Treatment and Primary Care in Central and Eastern Europe and Former Soviet Union"), access to antiretroviral treatment (ART) of any kind, particularly the triple-combination therapy considered as a standard of care by the WHO, is highly limited for all people with HIV across the region. WHO estimated

that at least 150,000 people in the region needed ART at the end of 2004, but that only 15,000 (10%) were receiving it.

Access to treatment is even more limited among members of high-risk, marginalized groups including sex workers, IDUs, men who have sex with men, prisoners and, in some settings, migrants or ethnic minority groups (*WHO, 2004b*). Discrimination is the major reason that, of those on ART now, the percentage of high-risk individuals is far lower than their proportion of individuals in need. In Russia, for example, recent data indicate that just 5% of HIV-positive Russians receiving ART are former or current drug users, even though they represent a significant majority of all infected.[15]

In order to improve the access to ART among these populations, it is necessary to increase effective and comprehensive service delivery and uncompromisingly address stigma and discrimination at all levels of society. Furthermore, the integration of harm reduction services into HIV treatment provision is crucial.

4.6 (v) Access to social services

The vulnerability of sex workers and their risk of contracting HIV/AIDS could be significantly reduced if access to social services were improved (*UNAIDS, 2002*). The linked conditions of poverty, limited economic opportunity, and lack of education seem to be the major driving forces for women to be involved in commercial sex, which is reflected in project data reporting sex work to be the only source of income for the vast majority of sex workers.

The NGO "Tanadgoma" in Georgia reported that of 2,408 sex workers consulted at the center from 2001-2003, 61% mentioned financial despair and 24% unemployment as the main reasons for their decision to become involved in the sex business. In Volgograd, Russia, the NGO "Marija" reported that of 220 sex workers interviewed in a survey conducted in August 2004, 94% said sex work was their only source of income. In Tbilisi, Georgia, out of 158 sex workers contacted by researchers in 2002/2003 (*Stvilia et al., 2003*), only about 10% reported having other sources of income. If they had other sources, they were generally from parental support or petty trade. The overwhelming majority (85%) of sex workers had dependents (children, parents, grandparents) whom they financially supported. Also, slightly more than one-half (52%) of the sex workers who had dependents were either divorced or separated, and most of them also reported that sex work was their only source of income.

> *I arrived in a city to find a job. Living in the countryside was impossible. Three kids looked at me with hope. Here I can do nothing. Three months I worked in a store and...what can I do with a daily salary?*
> — a sex worker from Tbilisi, Georgia, cited by the NGO "Tanadgoma"

According to the results of an HIV/AIDS/STI behavioral surveillance survey for sex workers, conducted in Latvia in 2002, only 41% of 92 sex workers surveyed had completed primary education. The NGO RAN in Tajikistan reported that 26% of 493 sex workers surveyed did not have any formal education, and that 49% had completed primary school only.

Such data indicate that helping sex workers develop new or additional skills, as part of an effort to broaden income-generating possibilities, could be an important priority for projects

[15] UNAIDS, "AIDS Epidemic Update, December 2004." Additional information available online at www.unaids.org.

throughout the region. These efforts would likely improve sex workers' economic and social situation and help to reduce their risk behaviors and vulnerability. This is especially important since sex workers who do not rely on sex work as their only source of income are less likely to acquire HIV than those who do (*Longo et al., 1997*).

Despite the obvious importance of socio-economic factors, there are virtually no services in the region providing sex workers with alternative employment opportunities or professional training. Of the respondents to this report, only one (the AIDS Information and Support Center in Tallinn, Estonia), said it had plans to offer skills such as foreign-language training and computer use in the near future. Another key problem is that even if a sex worker has marketable skills, she may not be able to get a job because of legal constraints. In some countries, officially recognized employment—not to mention access to various health and social services—is possible only with proper identification documents and residency permits. Many if not most sex workers do not have the required documentation, thus further limiting their ability to seek and retain another income-generation source. Obtaining the documents can take a long time, even if the individual is eligible for them. According to report data, securing an official identification passport in Bishkek, Kyrgyzstan, can take as long as 1-2 years.

Fifty-one percent of the projects surveyed said they offered various social services for sex workers, including health counseling and referral; assistance in obtaining personal documentation, social and humanitarian assistance, and psycho-social counselling. The AIDS Information and Support Center in Tallinn, Estonia said it provided an area in its drop-in center where sex workers are offered coffee, tea, or a hot meal as well as a place to take a shower and do laundry.

Migrants. Several projects reported that they served a large number of sex workers who are migrants (seasonal or residential). Data regarding migrants are partly reflected in Table 9 in the Appendices; however, no data were provided by the projects on specific services provided to this sub-group of sex workers. This elision clearly indicates the need for greater awareness about migrant issues among projects and other service providers, especially since sex workers who migrate or are mobile are often at higher risk for contracting HIV and other negative health effects than local sex workers (*Mann et al., 1996*). Migrants often work in the least-protected parts of the sex industry, such as on the streets. Their access to services and information is often limited by lack of civil and legal status; restricted freedom because they are bonded or trafficked; language limitations; cultural barriers; and heightened mistrust and fear of authorities.

Another notable development regarding sex work and migrants was not addressed directly in the survey, but deserves mention nonetheless. Since the fall of communism, many migrants from the region (especially countries of the former Soviet Union), have been providing sex services throughout Western Europe. Some of them migrated and chose to work in the sex industry of their own accord; others, though, were trafficked and forced into prostitution. Regardless of how and why they arrived in Western Europe, they are often not eligible for the wide range of public services and assistance provided to domestic sex workers. This discrepancy is a major concern of many NGOs and sex worker groups in Western Europe. Greater cooperation among governments, service providers, and advocacy organizations in Western Europe and CEE/CA would be helpful in identifying those most at risk and helping them to access harm reduction and other vital services.

Children of sex workers. Survey data indicated that a significant number of sex workers in the region have children. A project in Uzbekistan reported that that 61% of 250 sex workers covered by the project had children. Nearly the same percentage, 64% of 832 sex workers covered, was reported by respondents in Kyrgyzstan. Furthermore, more than one-third of them had more than one child. In Lithuania, 58% of 154 sex workers said they had children, with 26% reporting 2-3 children. In Macedonia, 56% of 53 sex workers surveyed said they had children.

In most cases, children of sex workers live in poverty; face stigma and social discrimination if their mothers' behavior is known; and have a greater-than-average likelihood of being exposed to potentially destructive behavior such as drug use. For all of these reasons, there is a great need for social services targeting them specifically. Little information was provided by the projects on this issue. Projects in Zenica, Bosnia and Herzegovina; Vilnius, Lithuania; and Tashkent, Uzbekistan were the only three out of the 39 total projects that reported offering specific social services to sex workers' children. The NGO "Margina" from Zenica, Bosnia and Herzegovina provided social assistance related to school activities and helped organize therapeutic activities, often in cooperation with other NGOs. The AIDS Center in Vilnius, Lithuania offered educational trainings covering topics on prevention of drug use, alcohol, STIs, and HIV/AIDS; at the time of the research, 36 women had passed these trainings. The center also helped sex workers with children to complete the documents necessary to obtain social welfare and to send their children to boarding school, if requested. Staff also provided supplies such as food, clothes, and hygienic products, and organized festive dinners for children.

4.6 (vi) Peer education

Effective peer education aims to create an enabling environment for sex workers to apply the assertive skills they need to negotiate safer sex and improve their living and working conditions. If implemented thoroughly and extensively, peer education strategies can eventually influence and change community social norms and activate program and policy changes at a higher level (*UNAIDS, 2002*). Peer-based approaches are generally more successful than those imposed from without a community, even if well-meaning, because they offer recognition of group members' inherent strengths and ability to help themselves.

Half of the surveyed projects in the region had implemented peer education. Sex workers serving as peer educators reportedly were involved in providing information on HIV/AIDS, STIs, and safer sex; distributing condoms; exchanging needles and syringes; accompanying sex workers to health facilities; and participating in focus groups and round tables. Peer educators were considered particularly helpful in reaching out to the most vulnerable sex workers who might otherwise not have interacted with the projects.

The AIDS Center in Lithuania reported that in 2003-2004, seven sex workers passed a professional training course for peer educators initiated by a newly established project, "Fenerate". In Balakovo, Russia, volunteers, who were sex workers, encouraged their colleagues to participate in focus groups and trainings. They distributed printed informational materials, carried out secondary needle exchange, and shared information gained during trainings and at outreach with their clients, pimps, and among themselves.

In Tallinn, Estonia, the AIDS Information and Support Center involved 18 sex workers as peer educators in its work. Sex workers were also involved in a project operated by Population Services International (PSI) in Tashkent, Uzbekistan.

Several surveyed organizations mentioned that they had difficulties involving sex workers as peer educators in their activities. The reasons given included lack of trust and respect from other sex workers, too much control from and dependency on pimps, and the inherent mobility of the sex work scene. Nevertheless, the projects all said they would continue their efforts to integrate peer education into their work and strengthen relationships with the sex work community by providing continuous trainings for sex workers and implementing activities that go beyond HIV and STI prevention needs.

4.6 (vii) Legal services and protection of human rights of sex workers

Section 3.4 of this report discusses in detail issues related to protecting the health, safety, and human rights of sex workers. It is clear that for a majority of sex workers in the region, day-to-day violence from police, clients, and pimps represents a greater concern than HIV and other health issues. This is an important factor to consider when planning interventions and services, including those targeted at HIV prevention. Mechanisms to keep sex workers safe and protect their human rights should ideally be central elements of all services. Unfortunately, due to various limitations, legal services for sex workers are not very developed in CEE/CA. Only 36% of projects (14 of 39) reported implementing activities to increase awareness of sex workers' rights, to provide direct legal assistance, or to create an enabling environment in which these rights are easier to obtain.

One of the 14 organizations is the NGO "Tais Plus" in Bishkek, Kyrgyzstan. In 2003 it started a pilot project ("Legal Support for People Involved in Sex Work") offering a wide range of services for sex workers, including direct legal assistance; PR campaigns (working with the media, participating in various conferences and publicizing the results, etc.); the development of info-educational materials for sex workers; and training sessions for volunteers. While developing these services, it worked closely with the municipal government, the police department, and lawyers and judges. In its first year, the project was involved in 76 legal cases targeting various individuals or sub-groups of people directly or indirectly involved with sex work—female sex workers, male sex workers, managers of sex work projects, IDUs, and hotel and bar owners.

Other projects/organizations that reported offering direct legal assistance were Senim in Shimkent, Kazakhstan; Humanitarian Action in St. Petersburg, Russia; RAN in Dushanbe, Tajikistan; Social Health in Poltava, Ukraine; and HOPS in Skopje, Macedonia. These projects provided services such as telephone hotlines and in-house consultations on legal rights, preparing legal documents, and mediating communications with governmental institutions.

The human rights of marginalized populations such as sex workers and drug users are not high on the priority lists of either national governments or most national human rights organizations. Harm reduction projects are therefore often the first point of contact for sex workers, drug users, and people living with HIV/AIDS who are seeking assistance for legal and human rights issues. In some countries, major human rights agencies have begun trying to change this situation by, for example, pursuing cases concerning human rights violations of traditionally marginalized populations. In Russia, the Moscow Helsinki Group runs a number of HIV/AIDS-related projects and recently became an active partner in the national harm reduction movement. These efforts are important, but should be more widespread and extensive. Some human rights agencies continue to turn a deaf ear to the problems of sex workers and IDUs, while others acknowledge that they lack the knowledge and skills required to reach out to and support these marginalized populations.

4.7 Advocacy and policy efforts

In addition to responses and interventions such as those described above in Section 4.6, additional emphasis should be placed on improving the policy environment and practices affecting sex workers. In many places, stigma and conservative social and cultural traditions severely limit the ease and apparent practicality of program and policy development. Therefore, it is important to raise awareness among governments, law-enforcement agencies, religious institutions, other civil society groups as well as the general public about the value and necessity of investing in locally appropriate ways of preventing HIV and STIs among sex workers. The majority of projects covered by this survey reported emphasizing the development of advocacy efforts aimed at creating a more favorable environment for their activities—efforts that include approaching local government officials, law enforcement agencies, and the media.

Regarding the relationship between the projects and law-enforcement entities, most of the projects described the attitude of these entities as "neutral"; this means that they do not officially support the projects' activities, but they do not necessarily obstruct them either (at least in terms of overall policy). Most of the projects reached verbal agreements with law-enforcement agencies after explaining the project's aims and activities. Only a few of the projects have regulated this relationship with a signed document, which in some cases was necessary. One example is the NGO ARAS from Bucharest, Romania:

> *At the beginning of the project (September 1999), we had no relation with the police and other authorities. After a while and after a lot of problems we realized that it was very important to explain what the purpose of the initiative is, and we signed an agreement with the municipal police. At this moment we can mention that we have minimal support from the police. We inform them about the goal and the project activities, places where the services are provided, and basic statistics about the clients. The police avoid having specific interventions in the places and at the times when the ARAS outreach workers meet clients. They do not press charges because of the used syringes that are in the possession of outreach workers, syringes that are collected in order to be burned.*

Other organizations reported having developed decent if not good models of cooperation with law-enforcement agencies. In Burgas, Bulgaria, the NGO Dose of Love said it sends regular information about its activities to the local municipality and police every six months, steps that help it maintain a good relationship with these institutions. LET, an organization in Zagreb, Croatia, formed a joint project with the police to clean up neighborhoods where syringes are often discarded.

Harm reduction projects in Poltava, Ukraine, reported having successfully obtained permission to monitor police actions/raids to document possible human rights violations of sex workers. Police officers usually inform them of the place and time of the raids in advance. They also collect statistics and cooperate in providing access to health services for sex workers by providing transportation and similar assistance. In return, the projects provide trainings for police representatives on tolerance, characteristics of social work with vulnerable populations; and psychological issues often affecting IDUs and sex workers.

Similarly, in Balakovo, Russia, the NGO NAN reported offering monthly trainings for police

officers on HIV/AIDS issues, including the principles and philosophy of harm reduction. Police also participate in the NGO's activities: In 2003, for example, 14 police officers volunteered to help plant trees in the Alley of Life, which is dedicated to increasing awareness about AIDS among the general population.

In St. Petersburg, Russia, the NGO Humanitarian Action initiated a training program on issues of harm reduction, HIV/AIDS, hepatitis, and STIs comprising a team of professional educators formed from psychologists working in the City Department of Internal Affairs. The main objective of the program was to change the attitude of law-enforcement entities and policies towards harm reduction programs.

In their advocacy efforts, some projects reported involving a wider spectrum of specialists into their harm reduction activities. For example, the NGO "Marija" (Volgograd, Russia) organizes seminars at which various specialists (social workers, psychologists, and educational workers) discuss key issue with government representatives. A Russian–German conference in Volgograd, titled "Improvement of public cooperation in protecting rights and interests of vulnerable groups", discussed the rights and interests of sex workers.

HOPS (Skopje, Macedonia) reported having established an excellent cooperative relationship with the Institute for Social Work and Politics at the University of Sts. Cyril and Methodius, through which harm reduction principles and issues related to working with marginalized groups are introduced to students.

4.8 Self-organizing

Helping enhance the ability and willingness of sex workers to organize among themselves should be a major priority of harm reduction projects and other organizations that work with sex workers. The support and assistance of projects, government agencies, and other entities and committed individuals are vital. However, only sex workers themselves are able to fully articulate what they want and need—and forcefully protect the human rights, health, and well-being of themselves and their peers. As noted by the authors of a study of such efforts:

> *Self-organization can help to overcome the problems of isolation and lack of self-esteem caused by marginalization and stigmatization. It can also help to promote and sustain safe sex and safer working conditions by increasing sex workers' control of their working environment. Some sex worker organizations have evolved into powerful self-advocacy forces which actively challenge human rights violations and causes of sex workers' vulnerability. Many strategies for improving conditions for sex workers have been developed and implemented by sex worker organizations, in many cases before HIV was identified and programs were funded*
>
> — (Longo et al., 1997)

Self-organizing of sex workers in CEE/CA is at best in the very initial phases of development. According to the survey data, there is neither a satisfactory level of self-organizing capacity nor the awareness among sex workers of the need for better organization of mutual efforts

aimed at advocating their rights. Projects reported very few self-support groups by and for sex workers.

In April 2004, for example, the NGO Odysseus from Bratislava, Slovakia started to facilitate a bimonthly self-support group for female sex workers. Over the first few months, however, it had only been attended by 2-4 sex workers at a time. The AIDS Center in Vilnius, Lithuania reported that in 2002, an organization comprising sex workers among its members was founded. Among its activities was the establishment of a self-support group that organized different activities such as group therapy and relaxation. The AIDS Center reported that 6-15 women attended but that the activities were not always well-developed, at least in part due to a lack of leadership among sex workers.

In Nikolaev, Ukraine, a public organization called Orchid was created with the support of a local charitable foundation, Blagodinist, to focus on issues related to protecting the rights of sex workers was created. Several members of Orchid reportedly had experience with sex work.

Because of the need for mutual help and better self-organization, some sex workers have created small informal groups within which they manage basic personal needs. In Poltava, Ukraine, for example, a small group of sex workers have organized themselves in such a way that they share their income, take care of each other when ill, and look after one of the women's child.

5. Conclusions and Recommendations

As the HIV/AIDS epidemic gathers steam throughout much of CEE/CA, improving the health, well-being, and human rights conditions of sex workers becomes even more critical than ever. They may be marginalized, discriminated against, and subjected to violence on a regular basis, but ignoring or even condoning such behavior could have ramifications far more devastating and immoral than just shocking disregard for the dignity and human rights of an isolated group of individuals. HIV has arrived in the region, and all are ultimately vulnerable. It is unclear whether sex workers represent a "bridge" between IDUs and the general population in terms of HIV transmission, but clearly the threat remains. The health and safety of all citizens thus depends on working with and for sex workers to help them protect themselves from harm. This will require a greater commitment among all members of society to accept and support the provision of comprehensive, pragmatic services for those most in need. It also depends on the recognition that enforcing international human rights standards is a cornerstone of efforts to remove stigma and discrimination.

More broadly, sex workers are and must viewed as members of society in general—and thus deserving of the same rights and services available to all. This belief is at the heart of all recommendations below, which are derived from the findings of this report. They are divided into interrelated yet distinct categories: for policymakers, for health authorities, for law-enforcement authorities, for service providers, and for researchers. Many of the recommendations are aimed at high-level decision-makers, project managers, or non-sex working individuals who otherwise can have a direct effect on sex workers' lives. Yet at the same time, it is important to recognize that all of the recommendations' success also relies to some extent on removing obstacles that prevent sex workers from organizing among themselves or being able to trust each other, let alone law enforcement or other authority figures. As sex workers feel more comfortable and less fearful in general, they are able to work together more closely and consistently to advocate for their rights. As much as anything else, this development could have a particularly positive effect on their own health and the health of those in their lives.

5.1 Recommendations for policymakers

- **Government officials from across the spectrum should summon greater levels of political will and commitment to address social marginalization, economic exclusion, and violence within broader governance.**

The findings of this report highlight the important role played by external factors in limiting the scope and effectiveness of HIV and STI prevention among sex workers in CEE/

CA. Among these factors are economical instability, poverty, high levels of unemployment, repressive policies and laws, social inequality, poor enforcement of human rights guarantees, widespread and widely tolerated violence against women, discrimination of migrants, and lack of adequate public health services. Governments must seek to address all of these issues in order reduce the impact of HIV/AIDS in their countries, especially among their most marginalized citizens.

- **Mechanisms should be initiated, preferably in cooperation with human rights groups and civil society, to enhance the independent monitoring of human rights agreements; protect the rights of vulnerable populations; and punish violators.**

The human rights of sex workers, especially those working on the streets and injecting drugs, are easily breached on a daily basis, especially by the police, pimps, clients, the mass media, and public health providers. Apart from being important in itself, guaranteeing the human rights of sex workers should be seen as an essential element of a country's overall HIV response. Sex workers' ability and willingness to access crucial harm reduction services are greatly limited when their rights are violated regularly. They deserve equal rights and justice—and the availability of appropriate legal assistance to obtain it.

- **Repressive national legislation regarding drug use and the provision of effective interventions, such as harm reduction services, should be revised to reflect pragmatic, compassionate policies. Most importantly, harsh penalties for drug use should be eliminated because they restrict the ability and willingness of those at risk to obtain information and services to protect their own health and the health of those around them.**

Epidemiological data confirm that injecting drug use remains the main mode of transmission of HIV in most countries of CEE/CA. As suggested by the UN Guidelines on HIV/AIDS and Human Rights, national legislation and policies should be adopted to create an enabling environment for an effective HIV response. Governments should reinforce their commitments to effective HIV prevention and care in general and particularly to harm reduction measures, as outlined in the UN Declaration of Commitment on HIV/AIDS.

- **Sex work should be decriminalized, and other national policies that negatively affect sex workers' human rights and access to health services should be revised or eliminated.**

Decriminalizing sex work is a vital first step toward increasing sex workers' access to health and HIV prevention services and reducing the violence and abuse they regularly face. Getting to that point might require different processes across CEE/CA because the legal status of sex work and sex workers varies by country. In countries where sex work is not criminalized, national and local authorities should strive to ensure that policies and procedures do not have the ultimate effect of violating sex workers' rights, such as arbitrary detention and harassment. In countries where sex work is legal, efforts should be made to properly regulate the industry and eliminate the existing obstacles for one to legally engage in sex work. Where commercial sex work is directly prohibited by law, policymakers are encouraged to closely examine the laws'

public health implications, which experience indicates are nearly always profoundly negative—and then to revise them in accordance with international human rights instruments.

All of these steps toward decriminalization should be taken in tandem with efforts to educate a potentially hostile general public as to the usefuleness and appropriateness of regulating sex work. Hungary and Latvia, where sex work has been decriminalized, can serve as helpful models, although certain policies in those countries should be changed (such as safeguarding confidentiality of health information and enforcing legislation mandating "tolerance zones" in which sex work can take place).

A concerted effort should be made to weaken the power of pimps when introducing or reforming regulations governing sex work. Pimps are often violent, coercive, and extortive; most sex workers' lives would improve immeasurably if they were able to end relationships with their pimps and work on their own. This step would also increase the likelihood of sex workers being able and willing to organize among themselves and create supportive peer networks.

- **Sex workers' involvement in all government-organized HIV/AIDS and human rights initiatives should be made a priority and guaranteed.**

Sex workers should be represented on human rights commissions; local and national HIV/AIDS planning organizations, including those dealing with prevention and treatment; and country coordinating mechanisms (CCMs) in countries where the GFATM operates. Furthermore, any and all policies that affect sex workers should be considered and introduced only with the participation and acceptance of sex worker representatives.

5.2 Recommendations for health authorities

- **HIV testing must be voluntary and confidential for all individuals, including sex workers, IDUs, and others at high risk for contracting the virus.**

Forced or compulsory testing, whether initiated by health or law-enforcement authorities, breeds distrust and fear among sex workers and members of other marginalized groups. They may therefore shun or avoid health facilities and treatment centers; as a consequence, they are less likely to be integrated into public health systems. This limits health authorities' ability to establish a comprehensive HIV/AIDS response.

- **Harm reduction services, including needle/syringe exchange, should be available at all public health facilities.**

The number and scope of existing harm reduction programs is far too limited in most of CEE/CA, especially in countries of the former Soviet Union. Public health facilities should offer such services as a matter of course as part of an overall effort to prevent the spread of HIV. The services available should include voluntary counseling and testing for HIV and STIs; condom promotion and availability; safer sex education; needle and syringe exchange; substitution treatment for drug dependence; and HIV and STI treatment. In particular, sex workers who inject drugs should be made aware of the availability of these services and how they can access them.

- **Migrants should have improved access to public health services.**

Internal or external migrants, who constitute a majority of sex workers in many parts of the region, are especially vulnerable to HIV and STIs, and their access to health services is very limited. Most often they have no health insurance due to lack of residence or identification documents, and are forced to contact private clinics and pay for services, which most of them cannot afford. Public health facilities should offer special low-threshold services for migrants regardless of their legal status; these should include free and anonymous HIV testing and counselling, treatment for medical conditions, and referrals to other appropriate social services.

- **Policies and procedures in health care delivery that discriminate against IDUs and sex workers should be identified and removed.**

The surveys for this report highlighted regular instances in which health care workers and medical professionals denied care to IDUs and sex workers. Such discriminatory actions represent a clear violation of individuals' right to health and should never be tolerated or countenanced for any reason whatsoever. Health authorities should implement training programs for all staff as well as monitoring mechanisms in which complaints are investigated thoroughly and confidentially.

Evidence also indicates that IDUs are routinely denied access to antiretroviral treatment (ART) or placed last on the list of priority patients. These practices are immoral and based on stigma, discrimination, and a lack of understanding as to the ability and willingness of most IDUs to comply with often-complicated treatment regimens. IDUs and sex workers must have equal access to ART and treatment for STIs and other conditions.

5.3 Recommendations for law-enforcement authorities

- **Zero-tolerance policies should be implemented to help stem harassment and abuse of sex workers by the police.**

In all countries surveyed, violations of sex workers' rights by police were cited as a persistent problem. Harassment and abuse often consist of physical violence, including beatings; illegal or unjustified detentions and arrests; coercion to sex; bribery and extortion; displacement of sex workers; enforcement of compulsory HIV/STI testing; and refusal to enforce laws that protect sex workers and others involved in sex work. Such a situation calls for immediate action by law-enforcement authorities across the region. Police officers found violating the rights of sex workers and all other people should be punished. Procedures should be established to monitor and guarantee complainants' safety and confidentiality, and public campaigns should be implemented to encourage citizens to report police abuse and harassment.

- **All members of the police and other law-enforcement entities should receive regular training on issues related to HIV, drug use, and the legal and human rights of all individuals, especially sex workers and other vulnerable groups. Police should also be expected to refer—but never in a coercive or threatening manner—sex workers and IDUs to programs, projects, and shelters where they can receive appropriate assistance**

Education efforts aimed at law enforcement would be particularly helpful because police officers have regular contact with sex workers and IDUs. With appropriate training and motivation, they could play very positive roles in HIV prevention efforts by providing health information as well as non-violent referral to health services. Already, there are examples in the region of close cooperation between the police and health entities, in particular harm reduction organizations. Top police department officials could speed up this process by facilitating regular meetings between police and public health services.

5.4 Recommendations for service providers

- **Programs targeting sex workers in general and specific groups within sex worker populations need to be expanded and diversified.**

Coverage of sex workers by service providers was estimated by this survey to be a little higher than coverage of IDUs by most harm reduction organizations. However, in most cases coverage still remains below the level—which some experts have stated is about 60% within a given community—to effectively control and reduce epidemics of HIV and STIs among sex workers. Service providers thus need to expand their outreach efforts as well as the range of services they offer, including access to condoms and needles/syringes and social services such as housing, child care, assistance with documentation, professional training, and legal education and assistance.

- **Service providers should seek to establish better links with human rights organizations/activists and other stakeholders in the region as part of an enhanced effort to monitor violations.**

Persistent human rights violations negatively affect sex workers in all countries, including violence, intimidation, arbitrary detention, and denial of services. Human rights organizations have often been reluctant to closely consider and monitor violations against sex workers, but there are signs that they are beginning to respond more appropriately. Service providers should actively seek the assistance of these organizations and work closely with them to publicize abuses and effect policy reform. They should also consider increasing their advocacy efforts among a wide range of other stakeholders—for example, from the education sector and among officials at local and national governments—as part of an effort to improve sex workers' health and safety.

- **Better program monitoring and evaluation would be a useful step toward improving planning and service delivery in general.**

Many projects are unable to gather reliable data about their programs on a regular basis. This can greatly limit their effectiveness and hinder local and national responses to HIV/AIDS. Lagging projects should seek financial and technical assistance to improve their monitoring and evaluation procedures; others, meanwhile, should remain vigilant that their procedures remain effective and thorough.

5.5 Recommendations for external donors

- **Donors, especially foreign development agencies, need to base their response and funding on the real situation on the ground and on scientific evidence—and not on domestic ideological considerations in their own countries.**

Donor policies can and do greatly influence the effectiveness of nations' HIV/AIDS response, especially in lower-income countries of the region. Donors should be encouraged to recognize and understand the nature of the epidemic and what type of interventions are the most appropriate and effective in preventing the spread of HIV and treating those living with HIV/AIDS. In CEE/CA this means they should support harm reduction services, including needle/syringe exchange, for IDUs—many of whom are sex workers. Withholding funds to address the main risk factors may be worse than providing no funds at all since such policies can have a direct effect on the overall national response

- **Staff at multilateral and bilateral aid entities—as well as public health system employees at all levels—should be encouraged to speak up in response to perceived mismanagement, misallocation of priorities, and discrimination. They should be able to note their objections confidentially and without risk of reprisals such as dismissal.**

Personnel involved with the GFATM, World Bank, UN agencies, and bilateral funders are often in the position to positively influence aid disbursal by national, regional, and local authorities. Their ability and willingness to help monitor aid and program development can ensure that funds and services reach the intended recipients. At the same time, though, international aid entities should not exercise undue control over national public health policies and priorities. Local officials should also feel as though they can criticize international funders without risk of losing their jobs or engagement in future activities.

- **The policies and programs of various donors should be better organized and coordinated to ensure continuity of service, especially in countries where service provision depends mostly on donor assistance.**

Often, donors base their support strategies on the assumption that responsibility for funding implementing interventions will be handed over to national governments after several years of donor operations. Unfortunately, however, this has not always been the case over the past decade in the region. In many cases, national governments are unprepared to take on projects because of financial or capacity restraints—especially a dearth of qualified staff at all levels—or because they did not receive expected support from other sources. Donors should strive to ensure flexibility so that vital service provision to vulnerable groups is not disrupted due to gaps in funding.

5.6 Recommendations for researchers

- **Researchers, scientists, national governments, and multilateral organizations should collaborate on the establishment of professional, sustainable research teams that publish more specific and accurate data on the HIV/AIDS epidemic and vulnerable populations, including sex workers, in CEE/CA.**

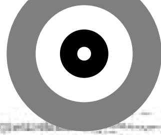
As evidenced by the responses to this report's questionnaire, data are often imprecise or difficult to obtain for a number of key HIV-related figures. These include, but are certainly not limited to, the following: total number of individuals infected with the virus; total number of IDUs across a country or region; transmission vectors and trends, especially regarding injecting drug use and sex; total number of sex workers, broken down by nation, region, and municipality; number of sex workers with HIV and/or STIs, HIV prevalence among sex workers, and infection trends; total number in need of antiretroviral therapy (including number of sex workers) and how many individuals are actually receiving the medicines; percentage of sex workers who have health insurance; and rates of police abuse and harassment against sex workers.

This list is by no means complete. Even by itself, though, it offers clear proof that current data-collection efforts are inadequate. All stakeholders involved have a vested interest in better information as to the scope and extent of the epidemic as well as those affected by it. A research institution or UN agency should perhaps take the lead in building up epidemiological and social research capacity on HIV/AIDS throughout CEE/CA. This effort may prove tricky and complicated given the wide-ranging political, economic, and social differences in the region—including, for example, the isolationist government in Turkmenistan and concerns elsewhere related to forced testing, confidentiality, and coercion. In the long run, though, comprehensive and appropriately targeted service delivery can only be achieved based on reasonably accurate data. Also, better data would help governments and donors plan for the future in terms of financial allocation, medicine procurement, and prevention messages.

- **The effects of decriminalization of sex work should be carefully analyzed, and the results made widely available. Special attention should be paid to experiences in other countries of the region (notably Hungary and Latvia).**

Many governments in CEE/CA are particularly reluctant to decriminalize sex work out of concern that sex worker populations and/or HIV and STI rates will skyrocket. Most studies elsewhere in the world indicate that neither effect occurs; in fact, it generally appears as though decriminalization improves sex workers' health and reduces HIV transmission among them. Other countries in the region may need additional convincing, however, and may also require blueprints based on decriminalization policies elsewhere and subsequent regulation of sex work.

The research should of course be conducted in a thoroughly objective manner and even suggest reforms to existing regulations in Hungary and Latvia. For example, there are concerns that in those two countries, mandatory HIV/STI testing of sex workers and lack of confidentiality of diagnosis may further marginalize sex workers and worsen their access to HIV and STI treatment. These are important human rights issues that must be addressed appropriately for decriminalization to achieve its most important goals: better health care for sex workers and reduction in abuse, harassment, and discrimination.



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Russia
Administrative Code of the Russian Federation, Article 6.11.

7. Appendices

Table 1

HIV case reports in CEE/CA, 1997-2003*

	1997	1998	1999	2000	2001	2002	2003	Rate per million in 2003	Cumu-lative total
Albania	3	5	4	10	20	26	21	6.6	119
Armenia	37	9	35	29	29	41	29	9.5	239
Azerbaijan	13	66	81	64	128	105	116	13.9	597
Bosnia and Herzegovina	2	23	9	2	6	8	12	2.9	70
Belarus	653	554	411	527	578	915	713	72.1	5,485
Bulgaria	30	26	27	49	40	43	63	8.0	465
Croatia	17	36	48	32	29	42	45	10.2	416
Czech Republic	63	31	50	57	51	50	61	6.0	662
Estonia	9	10	12	390	1,474	899	541	-	3,400
Georgia	18	24	34	79	93	95	100	19.5	475
Hungary	71	74	62	47	84	80	63	6.4	1,104
Kazakhstan	437	299	185	347	1,175	694	747	48.4	4,001
Kyrgyzstan	2	6	10	16	151	160	130	25.3	494
Latvia	25	162	242	466	807	542	403	174.7	2,710
Lithuania	31	52	66	65	72	397	110	31.9	845
Macedonia	0	9	5	7	5	4	1	0.5	64
Moldova	404	408	155	176	234	209	258	60.5	1,946
Poland	579	637	527	629	560	577	610	15.8	8495
Romania	650	648	364	290	440	335	244	10.9	5,708
Russia	4,377	4,062	19,851	59,281	87,177	50,529	39,470	275.5	268,367
Serbia and Montenegro	103	105	85	71	97	88	96	9.1	1,816
Slovakia	8	11	2	19	8	11	13	2.4	192
Slovenia	8	14	15	13	16	22	14	7.1	220
Tajikistan	1	1	0	7	34	29	42	6.7	119
Turkey	145	108	120	159	184	192	197	2.8	1,712
Turkmenistan	n/a	n/a	n/a	n/a	n/a	n/a	n/a	-	2
Ukraine	8,913	8,575	5,827	6,212	7,000	8,756	10,009	206.3	62,365
Uzbekistan	7	3	28	154	549	981	1,836	70.4	3,596
Total	16,594	15,942	28,229	69,195	101,003	55,944	65,831	-	375,684

Source: EuroHIV, "HIV/AIDS Surveillance in Europe". End-year report 2003. Saint-Maurice: Institut de Veille Sanitaire, 2004. No. 70.
n/a = not available

* The data include officially registered cases of HIV only. In most countries of the region, the true number of people living with HIV/AIDS is thought to be much higher.

Table 2

Syphilis diagnoses per 100,000 in CEE/CA, 1994 to 2003

	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Albania	0	0.03	0.06	0.54	0.26	0.32			0.32	0.19
Armenia	11.48	11.92	17.39	16.61	13.12	11.62	6.92	5.83		
Azerbaijan	8.27	8.84	7.13	9.14	7.26				2.95	
Belarus	71.98	148.66	209.57	197.7	163.03	127.86	103.34	79.08	57.75	47.79
Bosnia and Herzegovina									0.41	
Bulgaria	14.42	20.08	27.3	15.24	33.37	31.21	20.32	18.5		
Croatia	0.35	1.08	0.34	0.43	0.3	0.43	0.21	0.43	0.24	
Czech Republic	3.57	4.19	5.34	5.86	5.5	7.11	9.41			8.16
Estonia	56.6	69.68	66.39	76.03	73.54	57	43.42	29.64	21.02	15.61
Georgia	14.13	16.39	16.28	40.16	41.62	22.27	16.59	21.86	25.42	
Hungary	2.35	2.34	2.15	2.92	3.1	2.59	3.66	4.31		
Kazakhstan	32.73	122.39	229.88	257.87	220.47	167.31	148.38			
Kyrgyzstan	22.06	72.29	161.96	164.74	141.08	110.54	86.94	59.92		38.29
Latvia	59.67	93.7	125.52	121.9	105.98	63.27	42.18	24.69	28.39	32.96
Lithuania	57.55	90.96	101.37	84.87	62.79	45.28	31.68	23.88	11.49	12.52
Macedonia	0.1	0.05	0.25	0	0.15	0.1	0.15	0.1	0.05	
Moldova	118.07	174.5	200.62	188.04	155.3	115.33	97.27	85.89		
Poland	4.6	4.06	3.88	3.14	2.71	2.75	2.51	2.74	3.02	
Romania	29.04	35	32.2	34.17	34.46	36.86	45.17	56.01	57.01	43.54
Russia	85.25	176.8	262.73	275.38	233.38	185.83	164.54	143.2	120.67	
Serbia and Montenegro	0.95	1.44	1.25	1.03	0.82	0.73	0.71	1.92	0	
Slovakia	1.66	2.13	2.85	3.55	3.17	4.56	5.71			
Slovenia	2.27	2.36	2.31	1.45	2.01	0.55	0.55	1.21	0.66	0.56
Tajikistan	7.89	20.1	19.39	19.65	22.94	17.2	13.14	12.04	0.57	
Turkmenistan									0.71	
Ukraine	69	119	15.6	147.7	138.9	115.6	-	-	-	-
Uzbekistan	11.34	24.82	39.35	46.73	44.75	37.55	29.27	27.31		

Source: World Health Organization. Centralized Information System for Infectious Diseases — Communicable Diseases, Surveillance and Response. WHO European office; online: http://data.euro.who.int/cisid/.

Table 3

HIV prevalence among sex workers from routine testing

Location	Year	Author	Sample size	% HIV
Bulgaria	1999/2000	Dehne and Kobyshcha, 2000	274	0.0
Czech Republic	1999/2000	Dehne and Kobyshcha, 2000	2,927	0.1
Georgia	1999/2000	Dehne and Kobyshcha, 2000	860	0.5
Russia	1995	Ladnaya et al., 2002	138,370*	0.0
Russia	1996	Ladnaya et al., 2002	135,504*	0.001
Russia	1997	Ladnaya et al., 2002	152,915*	0.02
Russia	1998	Ladnaya et al., 2002	172,927*	0.0
Russia	1999	Ladnaya et al., 2002	90,571*	0.1
Moscow, Russia	2000	Pokrovsky, 2001	n/a	15
Slovakia	2000	Dehne and Kobyshcha, 2000	75	0.0
Ukraine	1998	Dehne and Kobyshcha, 2000	54,166	0.6
Ukraine	1999	Dehne and Kobyshcha, 2000	29,034	0.8
Ukraine	1996	Konings, 1996	n/a	1993: 0.004% 1996: 0.4%

n/a = not available

* Sample defined as persons with casual sex partners

Table 4

HIV prevalence in samples of sex workers and drug injecting sex workers

Location	Year	Author	Sample Characteristic	Sample size	% HIV
Yerevan, Armenia	1999	Dehne and Kobyshcha, 2000	Sex workers attending STI clinic, mostly street workers	200	7.5
Yerevan, Armenia	2000	Dehne and Kobyshcha, 2000	Drug injecting street workers	128	2.3
Belarus	1998	Dehne and Kobyshcha, 2000	Women with multiple sex partners	1,800	0.0
Czech Republic and Slovakia	1998	Kacena et al., 1998	Urine testing for HIV using an enzyme immunoassay confirmed by World Bank	35	0
Georgia	2002	Stvilia et al., 2003	Female street-based sex workers	158	0.0
Latvia	1997	Kurova et al., 1998	Screening in private medical center	1,080	0.0
Riga, Latvia	1998	Dehne and Kobyshcha, 2000	Sex workers	198	0.5
Lithuania	2001	UNICEF, 2001	Street sex workers — estimation by Clinic for Social Diseases "Demetra"	n/a	2.5
Vilnius, Lithuania	2002	Kriksciukaityte, 2002	IDU street sex workers	142	1.4
Gdansk region, Poland	1992	Towianska et al., 1992	Sex workers attending STI clinic	349	0
Kaliningrad, Russia	1997	Dehne and Kobyshcha, 2000	Drug injecting sex workers	300	65
Kaliningrad, Russia	1997	Momot et al., 1997	Street sex workers	n/a	84.0
Moscow, Russia	2000	Dehne and Kobyshcha, 2000	Sex workers attending outreach	123	15.4
Moscow, Russia	2002	Shakarishvili et al., 2002	Cross-sectional study of homeless population with risky sexual behavior	400 (F-200, M-200)	1.0 overall; 3.0 among females reporting sex work
Moscow, Russia	2002	Khromova et al., 2002	Cross-sectional survey of female detainees aged 15-45 years. Among those, 47.5% reported exchanging sex for money (sex workers)	400 190 (sex workers)	2.8 (sex workers)
St. Petersburg, Russia	1998	Dehne and Kobyshcha, 2000	Drug injecting sex workers	83	0.0
St. Petersburg, Russia	1999	Dehne and Kobyshcha, 2000	Drug injecting sex workers	192	16.6
Togliatti, Russia	2001	Platt et al., 2004	Female IDU sex workers	77	62.0
Volgograd, Russia	2002	Ryabenko, 2002	Female IDUs sex workers	102	3.0
Donetsk, Ukraine	1999	Dehne and Kobyshcha, 2000	Sentinel surveillance	53	13.2
Odessa, Ukraine	1997	Dehne and Kobyshcha, 2000	Sex workers at drop-in center	240	2.5
Istanbul, Turkey	1996	Dehne and Kobyshcha, 2000	Unregistered non-Turkish prostitutes (Romanians, Russians, Ukrainians)	2,000	0.2

Table 5
STI prevalence in samples of sex workers

Location	Year	Author	Characteristics	Sample size	Prevalence	Notes
Tbilisi, Georgia	2003	Stvilia et al.	STI/HIV prevalence and behavioral survey of female street based sex workers	158	17.1% gonorrhea; 25.3% chlamydia; 27.8% syphilis	
Vilnius, Lithuania	2001	Brunet et al.	UNICEF report including data from STI service	96	97%	Health problems related to an STI over past 12 months
Kaliningrad, Russia	n/a	Brunet et al.	Syphilis prevalence survey among street sex workers	103	32%	32% were IDUs.
Moscow, Russia	1998	Salamov	Self reported STIs among street sex workers	70	31% (4) syphilis; 29% (20) gonorrhea 10%; chlamydia (10%)	22.8% (18) HBV or HCV
Moscow, Russia	1999	Borisenko et al.	Screening for syphilis and gonorrhea among sex workers attending a private STI clinic	149	35%	
Moscow, Russia	2000	Kurova et al.	Testing for HCV and HBV and syphilis among male and female sex workers.	n/a	26% HCV; 22% HBV; 33.3% syphilis	
Moscow, Russia	2001	Dehne and Kobyshcha	Referred by Department Internal Affairs	550	34%	
Moscow, Russia	2002	Shakarishvili et al.	Cross-sectional study of homeless population	200 (F) 200 (M)	32% syphilis; 11% Chlamydia; 17% gonorrhea; 21% HSV-2	
Moscow, Russia	2002	Khromova et al.	Cross-sectional survey of female detainees, 47.5% reported exchanging sex (sex workers)	400 190 (sex workers)	Syphilis: 41.2% (sex workers); 23.7% (non-sex workers) ($p < 0.01$). Gonorrhea: 29.5% (sex workers); 24.9% (non-sex workers) ($p < 0.05$). Any bacterial STI: 69.5% (sex workers); 48% (non-sex workers) ($p < 0.01$).	
Moscow, Russia	2003	Trubnikov	Female IDUs	82	84%	Reported STI symptoms

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Table 5, continued from previous page

Location	Year	Author	Characteristics	Sample size	Prevalence	Notes
Saratov, Russia	2000	O&K Marketing	Self administered questionnaire among sex workers	385	25%	Reported having an STI in past year; 50% continued sex work while being treated.
St. Petersburg, Russia	2001	Dehne and Kobyshcha	IDU street prostitutes	91	33%	
St. Petersburg, Russia	2002	Karapetyan et al., 2002	Female IDUs, of whom 66% had ever exchanged sex for drugs, goods or money	285	28% syphilis	Sex workers were 9 times more likely to have syphilis than non-sex workers (OR: 8.6 CI 2.5-31.2)
Volgograd, Russia	2001	Ryabenko	Screening of IDU sex workers attending syringe exchange project	83	30% syphilis; 24% gonorrhea	STI at one time
Odessa, Ukraine	2001	UNAIDS	Attending drop-in center	240	8%	

n/a = not available

Table 6

Project data: HIV/STI/HCV prevalence among sex workers and drug injecting sex workers in CEE/CA

Location	Year	Sample Characteristic	Sample size	HIV	Syphilis	HCV
Yerevan, Armenia	2002	Street sex workers, no pimps	4,000-5,000	3%	n/a	n/a
Minsk, Belarus	2002-2003	Street sex workers	1,200	4%	~ 4.2%	-
Zenica, Bosnia and Herzegovina	2004	Sex workers	64	0	4.7% (3)	6.3% (6)
Burgas, Bulgaria	2001	Street, apartment, club sex workers	1,000	0	6.0%	1.0%
Plovdiv, Bulgaria	n/a	Managed street	1,096	0	3.0%	0
Zagreb, Croatia	2004	Street sex workers	25	0	0	4% (1)
Tallinn, Estonia	2004	Sex workers	250	1.6% n=4	0.8% n=2	
Kostanai, Kazakhstan	2003	Sex workers	90-120	n=15	25%-30%	
Pavlodar, Kazakhstan	2003	Street sex workers	350-500	12%	8%	30.0%
Shimkent, Kazakhstan	2003	Street sex workers	800	n=14	n=22	n/a
Vilnius, Lithuania	2002	Street sex workers	150-200	n/a	n=40	n=60
Krasnoyarsk, Russia	2004	Sex workers (31% IDUs)	638	2.3%	10%	25%
Nizhny Novgorod, Russia	2004	Street sex workers (15% IDUs)	370	1.1%	14%	13%
St. Petersburg, Russia	2003	Street sex workers	8,000	48%	32%	-
Bratislava, Slovakia	2004	Street sex workers	~350	1 known case	n/a	n/a
Dushanbe, Tajikistan	2004	Sex work in streets, hostels, hotels, upon call	5000	14%	38%	79%
Odessa, Ukraine	2003	Sex workers, including street and mobile sex workers	2,500	35%	n/a	n/a
Poltava, Ukraine	2003	Mobile sex workers	n/a	Near 40%	70%	n/a

n/a = not available

Table 7

Estimates of sex workers and overall population working in selected CEE/CA cities

Location	Author	City Population	Estimated number of sex workers	Estimated prevalence of sex workers
Yerevan, Armenia	Dehne and Kobyshcha, 2001	1,200,000	7,000-8,000	0.6%
Yerevan, Armenia	HIV surveillance, 2002	1,305,000	4,000-5,000 (average: 4,500)	0.3%
Minsk, Belarus	IHRD, 2001	1,671,600	10,000-20,000 (average: 15,000)	0,9%
Zenica, Bosnia and Herzegovina	UNICEF, 2003	398,862	120-150	0.03%
Burgas, Bulgaria	Project estimate, 2004	199,470	1000	0.5%
Plovdiv, Bulgaria	Project estimate, 2004	344,326	1096	0.3%
Sofia, Bulgaria	Project estimate, 2004	1,220,000	300-340 (average: 320)	0.03%
Rijeka, Croatia	Project estimate, 2004	167,964	110-200 (average: 155)	0.1%
Zagreb, Croatia	Project estimate, 2004	694,100	170-250	0.03%
Tallinn, Estonia	RAR, 2003	400,000	2,500-3,000 (average: 2,750)	0.7%
Tbilisi, Georgia	Stvilia et al., 2003	1,398,968	2,408	0.2%
Budapest, Hungary	Dehne and Kobyshcha, 2001	1,900,000	3,000-5,000 (average: 4,000)	0.2%
Almaty, Kazakhstan	Thomas, 1996	1,150,000	2,500	0.2%
Kostanai, Kazakhstan	Project estimate, 2003-2004	220,000	280-350 (average: 265)	0.1%
Pavlodar, Kazakhstan	UNAIDS, 2000	342,500	350-500 (average: 425)	0.1%
Shimkent, Kazakhstan	Key informant, 2001	404,000	1,500	0.4%
Shimkent , Kazakhstan	Rodina, 2002	500,000	1,500	0.3%
Klaipeda, Lithuania	Key informant, 2004	202,480	250-350 (average: 300)	0.1%
Vilnius, Lithuania	RAR, 2001	322,861	1,000-3,000 (average: 2,000)	0.6%
Skopje, Macedonia	Key informants, mass media, 2003	469,800	1,000 (3,000 in Macedonia)	0.2%
Strumica, Macedonia	Qualitative research, 2003	45,300	80-100 (average: 90)	0.2%
Bucharest, Romania	Project estimate, 2004	1,926,334	500 (visible sex workers)*	0.03%
Balakovo, Russia	Research RAR, 2002	234,357	600	0.3%
Barnaul, Russia	AIDS Center observation, 2002	602,000	1,000	0.2%
Krasnoyarsk, Russia	Police, 2004	3,500,000	1,200	0.03%

Location	Author	City Population	Estimated number of sex workers	Estimated prevalence of sex workers
Moscow, Russia	AIDS Infoshare, 2001	8,800,000	30,000-150,000 (average: 90,000)	1%
Nizhny Novgorod, Russia	RAR, 2004	1,361,500	3,500-5,000	0.3%
Omsk, Russia	Key informants, 2004	1,157,600	>1000	0.1%
St, Petersburg, Russia	RAR, 2003	4,596,000	8,000 (street)	0.2%
St. Petersburg, Russia	Benotsch et al., 2004	4,596,000	11, 100 female IDU sex workers	0.2%
Volgograd, Russia	RAR, 2002	1,025,900	1,500	0.1%
Belgrade, Serbia and Montenegro	Mass media	1,594,483	3,000	0.2%
Bratislava, Slovakia	Project estimate, 2004	449,547	450	0.1%
Dushanbe, Tajikistan	City AIDS Center, 2003	602,000	5,000	0.8%
Dushanbe, Tajikistan	Kurmanova, 2000	582,400	2,725	0.5%
Ashgabad, Turkmenistan	Kurmanova, 1999	580,000	700	0.1%
Kiev, Ukraine	Kozlov, 2000	2,600,000	10,000	0.4%
Odessa, Ukraine	Ukrainian Institute of Social Research, 2003	1,029,000	2,500	0.2%
Poltava, Ukraine	Ukrainian Institute of Social Research, 2002	317,000	400	0.1%
Tashkent, Uzbekistan	RAR UNAIDS, 2003	2,121,000	6000	0.3%
Tashkent, Uzbekistan	Dehne and Kobyshcha, 2001	2,300,000	5,000	0.2%

* More accurate estimate will be available in late 2005, when ARAS will finish assessment of sex work population in Bucharest.

Table 8

Project data: Estimates of sex workers, drug use and type of drugs used among sex workers attending harm reduction programs in CEE/CA

Country	Site	Organization	City estimates of sex work	Clients reached by service	% Estimated coverage	% project clients who are IDUs	Type of drug used	Injecting risk behaviors
Armenia	Yerevan	Union for HIV Prevention	4,000-5,000 (average: 4,500)	1,000-1,300 (average: 1,150)	25.6	17	n/a	n/a
Belarus	Minsk	Vstrecha	300 (male sex workers)	150	50	40	n/a	n/a
	Minsk	BelAYU	10,000-20,000 (average: 15,000)	1,400-1,500 (average: 1,450)	9.7	n/a	n/a	n/a
Bosnia and Hercegovina	Zenica	Margina	120-150 (average: 135)	64	47.4	8	Heroin, methadone	Sharing of paraphernalia common and injecting with used needles/ syringes of sex partners.
Bulgaria	Plovdiv	Panacea Foundation	1,096	1,096	100	5	Heroin	Injecting with used needles and syringes common; overdose
	Burgas	Dose of Love Association	1,000	150	15	0	Stimulants	
	Sofia	Health and Social Development	300-340 (average: 315)	250	79.4	40	Heroin, glue	Injection with used needles/ syringes reported
	Varna	SOS Families in Risk Foundation	89	89	100	12	Heroin, marijuana	n/a
Croatia	Rijeka	NGO Terra	110-200 (average: 155)	11	7.1	11	Heroin	Sharing injecting paraphernalia common
	Zagreb	NGO LET	170-250 (average: 210)	25	11.9	4	Heroin and marijuana	No risky injecting behavior reported
Estonia	Tallinn	NGO AIDS Prevention and Support Center	2,500-3,000 (average: 2,750)	2,500-3,000 (average: 2,750)	100	10-14 (n=150)	Amphetamines	n/a
Kazakhstan	Kostanai	Pomosch	280-350 (average: 265)	90-120 (average: 105)	39.6	60	Heroin/ homemade opiates	Injecting with used needles/ syringes and overdoses are thought to be common due to poor-quality drugs.
	Pavlodar	Turan	350-500 (average: 425)	n/a	-	30	Heroin/ homemade opiates	Up to 70% reported sharing paraphernalia and water among themselves and clients.

Country	Site	Organization	City estimates of sex work	Clients reached by service	% Estimated coverage	% project clients who are IDUs	Type of drug used	Injecting risk behaviors
Kazakhstan	Shimkent	Senim	1,500	800	53.3	22	Heroin	Few reports of injecting with used needles/syringes; frequent reports of injecting with used paraphernalia
Lithuania	Klaipeda	Addictive Disorders Center	250-350	n/a	-	n/a	Opiates	Clients report that injecting with the same needle/syringes is common, despite awareness of risk of HIV infection
	Vilnius	AIDS Center	1,000-3,000 (average: 2,000)	150-250 (average: 200)	10	80	Homemade opiates, heroin, amphetamines	Drawing up opiates from communal pot is common; overdoses, especially among women, are common; injecting with used needles/syringes is common
Macedonia	Skopje	Healthy Options Project Skopje (HOPS)	1,000	100	10	47.1	Heroin, methadone	Injecting with used needles/syringes is common; sharing paraphernalia is common; abscesses are also common
	Strumica	IZBOR	80-100 (average: 90)	35	38.9	3	Heroin, methadone	Needle and syringe sharing used to be more regular, but it still happens.
Moldova	Beltsy	Youth for Rights to Life	n/a	108	-	n/a	n/a	n/a
Poland	Krakow	Prevention and Social Education Center	214	200	93.5	Few persons	n/a	n/a
Romania	Bucharest	Romanian Association against AIDS (ARAS)	500	500	100	35	Heroin	72.5% IDUs reported injecting with used needle/syringe in the last month (BSS Study made by Romanian Harm Reduction Network)
Russia	Balakovo	NAN	600	380	63.3	n/a	n/a	Research indicated that 48% (sample size unknown) injected drugs; 27% reported having overdoses and other health problems related to injecting drug use; 29% injected drugs as payment for sex work; no direct sharing of needles or syringes
	Barnaul	Siberian Initiative	1,000	~200	20.0	80	Heroin	n/a

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Table 8, continued from previous page

Country	Site	Organization	City estimates of sex work	Clients reached by service	% Estimated coverage	% project clients who are IDUs	Type of drug used	Injecting risk behaviors
Russia	Krasno-yarsk	Us against AIDS	1,200	638	53.2	47	Heroin	71% reported injecting used needles/syringes; 29% shared syringes with casual acquaintances; 43% injected with used needles/ syringes of close friends; 86% reused same needle/syringe more than once; 100% shared injecting paraphernalia; 14% injected with pre-filled syringes; 29% reported ever having overdosed
	Moscow	NAN	30,000-150,000 (average: 90,000)	4,320	4.8	n/a	Heroin/ vint	Due to the fact that there is no legal harm reduction program in Moscow, information is difficult to obtain about risky behavior among sex workers; injecting with used needles/syringes and sharing injecting paraphernalia is common
	Nizhny Novgorod	Oblast AIDS Center	3,500-5,000 (average: 4,250)	370	8.7	23.6	Homemade opiates/vint	No evidence of injecting with used needles/syringes or sharing paraphernalia; approximately 56% of sex workers who injected reported ever having overdosed, thought to be due to the poor-quality heroin
	Omsk	Future without drugs	>1,000	~1,000	100	n/a	n/a	Injecting with used needles/ syringes and overdoses are thought to be common
	St. Peters-burg	Humanita-rian Action	8000 (street)	n/a	-	95	Heroin	Injecting with used needles/ syringes: frequently – 27%; sometimes – 44%; never – 29%; Reuse of same needle/syringe: frequently – 2%; sometimes – 66%; never – 32%
	Tula	NAN	1,500	n/a	-	n/a	Heroin	Reports of injecting with used needles/syringes are rare but sharing paraphernalia is common
	Volgograd	Maria	1,500	220	14.7	n/a	Heroin, ephedrine	Injecting with used needles/ syringes and sharing paraphernalia is common; no incidences of overdose reported

Country	Site	Organization	City estimates of sex work	Clients reached by service	% Estimated coverage	% project clients who are IDUs	Type of drug used	Injecting risk behaviors
Serbia and Monte-negro	Bel-grade	JAZAS – Association against HIV/AIDS	3,000	2,000	66.7	n/a	Cannabis, heroin, ecstasy	19% inject with used needles/ syringes
Slovakia	Brati-slava	CA Odysseus	450	350	77.8	80	Heroin, vint	n/a
Tajikistan	Dushan-be	RAN	5.000	493	9.9	75	Heroin, homemade opiates	96% clients reported injecting with used needles/syringes although high awareness of HIV; 28% of clients reported periodically using common injecting equipment when injecting drugs.
Ukraine	Odessa	Doroga k Domu	2,500	600	24	n/a	Homemade opiates	58% report injecting with new needle/syringe each time they inject; 42% estimated that at least once every three months they injected with used needle/syringe
	Poltava	NGO Public Health	400	239	59.8	n/a	Homemade opiates, dimedrol, heroin, vint	n/a
Uzbeki-stan	Tash-kent	PSI	6,000	1,400	23.3	28	Heroin, hashish	n/a

n/a = not available

Table 9

Project data: Reported sexual risk behaviors and demographic characteristics of sex workers attending harm reduction programs in CEE/CA

Country	Site	Organization	Number	Sexual risk behavior	Location	Age	Characteristics
Armenia	Yerevan	Union for HIV Prevention	1,000-1,300	68% of clients refused condoms	Street	30% < 25 years	46% from Yerevan 13% married
Belarus	Minsk	Vstrecha	150	Will not use condoms for more money. 0% report always using condoms	Street, bar	15-30 years	Male sex workers, students
	Minsk	BelAYU	1,400-1,500	72.4% report using condoms with clients	Street, stations	20-30 years	Majority are migrants
Bosnia and Herze-govina	Zenica	Margina	64	Will not use condoms for more money		Average age: 23 years	Mostly migrants, some from Russia, Ukraine, Moldova
Bulgaria	Burgas	Dose of Love association	150	Will not use condoms to earn more	Brothels, apartments, organised street work	Average age: 23	90% are migrants
	Plovdiv	Panacea Foun-dation	1096	Will not use condoms to earn more	Street workers		32% not married
	Sofia	Health and Social Deve-lopment	250	Will not use condoms to earn more	Street workers	Average age: 20	Roma and other Southern and Eastern European migrants
	Varna	SOS Families in Risk Foundation	89	Will not use condoms to earn more, lack of solidarity among sex workers promoting condom use for fixed price	Street	16-37 years	
Croatia	Rijeka	NGO Terra	11	n/a	Managed and independent street sex workers	Average age: 24-25	Mostly local women, unmarried
	Zagreb	NGO LET	25	Some report of not using condoms on initiative of clients or pimps	Managed street sex work	Average age: 24-28	Mostly local, some Roma and from Bosnia and Herzegovina
Kazakhstan	Kostanai	Pomosch	90-120	Will not use condoms for more money or if threatened with violence	n/a	n/a	Majority from migrants from other cities
	Pavlodar	Turan	-	Majority of street workers do not use condoms because they are often under influence of alcohol		Average age: 26	

Country	Site	Organization	Number	Sexual risk behavior	Location	Age	Characteristics
Kazakhstan	Shimkent	Senim	800	Majority say they use condoms but do not carry them, thus likely to be inconsistent users; 70% say will not use condoms for more money	Street	Average age: 24-28	Majority from migrants from regional cities
Lithuania	Klaipeda	Addictive Disorders Center	250-350	Majority report consistent condom use but will work without if client insists or for more money	Port, street workers	Majority aged 17-20 years	Began sex work to support drug use
	Vilnius	AIDS Center	150-250	Majority report consistent condom use	Independent street workers	20-29 years	40% Lithuanian, 30% Polish
Macedonia	Skopje	Healthy Options Project Skopje (HOPS)	100	Sex without condom for more money is common	Managed street	30% < 25 years	Multiethnic: 30% Macedonian, 43% Roma, Serbian Turkish, Albanian
	Strumica	IZBOR	35	Low levels of awareness of STIs/HIV. Sex without condom for more money reported	Managed street	16-40 years	75% female 40% migrants from western Macedonia or elsewhere in CEE/FSU
Moldova	Beltsy	Youth for Rights to Life	108	n/a	Street, bar, apartment hotel	Average age: 24	Majority are married, migrants from rural areas
Romania	Bucharest	Romanian Association against AIDS (ARAS)	500	Management negotiates condom use though not enforced, and unprotected sex occurs frequently	Managed street workers	Average age: 20	Migrants from rural areas and regional towns
Russia	Balakovo	NAN	380	24% say clients often refuse condoms, pay more for no condoms	Street	74.5% < 25 years	51.5% married
	Barnaul	Siberian Initiative	~200	n/a	Street, apartment	n/a	n/a
	Krasno-yarsk	Us against AIDS	638	10% do not use condom with clients to earn more money	Street, apartment	60% 20-24 years	35% migrant workers from regions
	Moscow	NAN	4320	Most try to use condoms; refusal is initiative of client or due to sex worker's inadequate knowledge of HIV	Street	16-40 years	Majority from Ukraine, Moldova, Belarus, regions of Russia

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Table 9, continued from previous page

Country	Site	Organization	Number	Sexual risk behavior	Location	Age	Characteristics
Russia	Nizhny Novgorod	Oblast AIDS Centre	370	59% reported continuing working during treatment for STIs	Street, apartment	26% < 18 years	30% migrants from other cities
	Omsk	Future without drugs	~1,000	Will not use condom for more money	Street, apartment	n/a	n/a
	St. Petersburg	Humanitarian Action	n/a	Will not use condom for more money but 92% were carrying condoms	Street	17-37 years, average age: 24	Majority are inhabitants of city; 20% married or with permanent partners
	Tula	NAN	n/a	Will not use condom for more money; consider condom use as safety for client not themselves	Street	n/a	City residents
	Volgograd	Maria	220	Will not use condoms for more money	Street	19-30 years, average age: 24	50% inhabitants of city; 48% report not using condoms with non-paying partners
Serbia and Monte-negro	Belgrade	JAZAS – Asso-ciation against HIV/AIDS	2,000	Sex without condom for more money reported; mean number of clients per month 38.3	n/a	n/a	n/a
Slovakia	Bratislava	CA Odysseus	350	Sex without condom for more money	94% street	Average age: 27	8% male sex workers; majority from Bratislava
Tajikistan	Dushanbe	RAN	493	All types of sex services provided (oral, anal) depending on client	Street	13-40 years; majority between 17 and 25 years	57% not married
Ukraine	Odessa	Doroga k Domu	600	Most report high rates of condom use. Some reports of no condoms for extra money or careless when using drugs	Street-based (highways and in the port); mostworkinde-pendently	18-35 years	60% from other regions of Ukraine, Russian, Moldova. seasonal variation in numbers
	Poltava	NGO Public Health	239	Some reports of no condoms for extra money	Street (highways)	18-35 years	50% migrants from villages
Uzbekistan	Tashkent	PSI	1,400	Some reports of no condoms with clients for extra money. Low use of condoms with non paying partners	Majority street workers	63% 18-24 years	

n/a = not available

Table 10

Legal regulation of sex work

Data as of November 2004 - January 2005

Abbreviations: AC – Administrative Code; CC – Criminal Code; PC – Penal Code

Country	Individual prostitution	Pimping	Brothel-keeping	Involvement in/ coercion into prostitution	Trafficking
Albania	Criminal offence Article 113, PC Fine or imprisonment for up to 3 years.	Criminal offence Article 114, PC Fine or imprisonment for up to 5 years. *If committed with respect to a minor or forcefully*: imprisonment for 5-10 years.	Criminal offence Article 115, PC *Use of premises for prostitution* Fine or imprisonment for up to 10 years.	Criminal offence Article 114/a, PC Imprisonment for 7-15 years.	Criminal offence Article 114/b, PC *Trafficking of women for prostitution:* Imprisonment for 7-15 years. *When committed in complicity with other or repetitively or associated with maltreatment and threat to the injured women to commit different actions or causing serious harm to her health*: imprisonment for not less than 15 years. *When death is caused:* life imprisonment.
Armenia	Administrative offence Article 179.1, AC Fine. *Repeated offence within a year*: increased fine.	Criminal offence Article 262, CC Fine or correctional works for up to 1 year or detention for 1-3 months, or imprisonment for up to 5 years.	Criminal offence Article 262, CC *Brothel maintenance and pandering* Fine or correctional works for up to 1 year, or detention for the term of 1-3 months, or imprisonment for the term of up to 5 years.	Criminal offence Article 261, CC *Forcing someone into prostitution* Fine or correctional works up to 1 year or detention for the term of 1-3 months, or imprisonment for the term of up to 2 years. *If committed with respect to a minor or by an organized group*: a fine or correctional works up to 2 years, or imprisonment for 3-6 years.	Criminal offence Article 132, CC *Trafficking in human beings* Fine or correctional works up to 1 year or detention up to 2 months or imprisonment for the term of 1-4 years. *If organized by a group with prior agreement, by using force or threat, against minors, or against two or more persons*: correctional works of up to 2 years or imprisonment for 4-7 years. *If committed by an organized criminal group or caused death of victim or other serious consequences*: imprisonment for 5-8 years.

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Table 10, continued from previous page

Country	Individual prostitution	Pimping	Brothel-keeping	Involvement in/ coercion into prostitution	Trafficking
Azerbaijan	Not regulated	Criminal offence Article 243, CC Fine, correctional labor for 160-240 hours or imprisonment for up to 3 years. In case of aggravating circumstances (*against disabled person or person with physical or mental disorders or by an organized group*): imprisonment for 3-6 years.	Criminal offence Article 244, CC Assignment to community services for 200-240 hours or correctional labor up to 2 years or imprisonment up to 3 years. *If committed repeatedly; committed by a group conspiring in advance or by an organized group*: imprisonment for 3-6 years.	Criminal offence Article 243, CC Fine, correctional labor for 160-240 hours or imprisonment for up to 3 years. In case of aggravating circumstances (*against disabled person or person with physical or mental disorders or by an organized group*): imprisonment for 3-6 years. If in relation to minor: imprisonment from 3-8 years subject to presence of aggravating circumstances. (Article 171, CC)	Criminal offence Article 173, CC Imprisonment for 3-8 years. *If death of victim caused*: imprisonment for 8-12 years.
Belarus[1]	Administrative offence Article 17.5, AC Fine. *Repeated offence within a year:* increased fine.	Criminal offence Article 171, CC Imprisonment for 3-5 years. In case of aggravating conditions (*action related to trafficking a person cross border, committed repeatedly, against a minor, by official using his authority or by organized group*): imprisonment for 7-10 years with confiscation of property.	Criminal offence Article 171, CC Imprisonment for 3-5 years. In case of aggravating conditions (*action related to trafficking a person cross border, committed repeatedly, against a minor, by official using his authority or by organized group*): Imprisonment for 7-10 years with confiscation of property.	Criminal offence Article 171.1, CC Imprisonment for 1-3 years. In case of different aggravating conditions (*committed with a minor, repeated crime, committed using force or threatening using force, committed against a minor by parents, teacher or other person who is responsible for minor's upbringing or committed by organized group*): imprisonment varies from 3 to 10 years.	Criminal offence Article 181, CC 10-12 years of imprisonment with confiscation of property. *If committed by organized group or if a victim's death or serious injury caused:* imprisonment for 12-15 years. *If a person was kidnapped for sexual exploitation:* imprisonment for 5-15 years with confiscation of property. The punishment is imprisonment for 10-15 years in case of aggravating circumstances (*committed by organized group or if a victim's death or serious injury was caused*). (Article 182, CC)

[1] Data as of June 1, 2005 (after relevant amendments in Criminal Code from May 4, 2005).

Country	Individual prostitution	Pimping	Brothel-keeping	Involvement in/ coercion into prostitution	Trafficking
Bosnia and Herzegovina[2]	No regulation in national legislation; <u>administrative offence</u> (violation of public order) according to laws of the state entities.	No specific regulation in national legislation; <u>criminal offence</u> according to Criminal Codes of the state entities if regulated. *Federation of Bosnia and Herzegovina*: Article 210, CC Imprisonment for 1-5 years. Under aggravating circumstances (*committed using force, against a minor etc*): imprisonment for up to 15 years.	No specific provision	No specific regulation in national legislation; <u>criminal offence</u> according to Criminal Codes of the state entities if regulated. *Federation of Bosnia and Herzegovina:* Article 229, CC *Promoting prostitution among females:* Imprisonment for 3 months - 3 years. Imprisonment for 1-10 years in case of aggravating circumstances (*if committed against a juvenile female or by force, threat or fraud*).	<u>Criminal offence</u> Article 186, CC, Bosnia and Herzegovina Imprisonment for 1-10 years. *International procurement for prostitution*: imprisonment for 6 months – 5 years. *In relation to a minor*: imprisonment for 1-10 years. (Article 187, CC, Bosnia and Herzegovina)
Bulgaria	Not regulated	<u>Criminal offence</u> Article 155, PC Imprisonment up to 3 years and a fine.	<u>Criminal offence</u> Article 155, PC Imprisonment up to 5 years and a fine. *If the premises have been provided against payment or in the case of public advertisement for such purpose*: imprisonment for 1-6 years. *If committed against a minor*: imprisonment for 2-8 years. The court may also rule compulsory domicile.	<u>Criminal offence</u> Article 155, PC Imprisonment up to 3 years and a fine. *In case of involving minors*: imprisonment for 2-8 years.	<u>Criminal offence</u> Article 156, PC Imprisonment up to 10 years and a fine. In case of aggravating circumstances (*committed against a person under 18 years of age, the abducted person placed at disposal for acts of debauchery, or the abduction carried out for the purpose of placing the person at disposal for acts of debauchery abroad*): imprisonment for 3-12 years. Articles 159a, b, c might also be applied.

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[2] Bosnia and Herzegovina is a complex state consisting of two political entities, namely the Federation of Bosnia and Herzegovina and the Republika Srpska, with a special status granted to the Brcko District.

Table 10, continued from previous page

Country	Individual prostitution	Pimping	Brothel-keeping	Involvement in/ coercion into prostitution	Trafficking
Croatia	Administrative offence Article 12, Law on Offences against Public Law and Order Fine or by imprisonment up to 30 days.	Criminal offence Article 195 (parts 1, 3, 4), Criminal Act Fine or imprisonment up to 1 year. *If in relation to a juvenile*: imprisonment for 0.5-5 years. *If in relation to a child*: imprisonment for 1-8 years.	No special provision against brothel-keeping but two other articles 195 and 175 of the Criminal Act might be applied.	Criminal offence Article 195 (parts 2, 3, 4), Criminal Act *If committed by using force or threatening to use force or by fraud*: fine or imprisonment up to 3 years. *If in relation to a juvenile*: imprisonment for 0.5-5 years. *If in relation to a child*: 1-8 years of imprisonment.	Criminal offence Article 175, Criminal Act Imprisonment for 1-10 years. *If committed against a minor or by a group or a criminal organization, or was committed to a larger number of people, or if one or more people have been killed,* imprisonment for not less than 5 years. *In case of international prostitution* (Article 178): Imprisonment for 0.5-5 years. *If international prostitution offence is committed by force or treat to use force or fraud*: 1-8 years of imprisonment. *If international prostitution act is committed against a child or a minor*: not less than 3 years of imprisonment.
Czech Republic	Prostitution itself is not regarded a crime, however, its practice is not regulated in law.	Criminal offence Article 204, CC Imprisonment for 3 years. *If committed by a member of an organized group or to person under 18 years of age*: imprisonment for 2-8 years. *If in relation to a person under 15 years of age*: imprisonment for 5-12 years.	No specific provision	No specific provision	Criminal offence Article 246, CC 1-5 years of imprisonment. *If committed by an organized group, against a minor or with aim to exploit for purposes of prostitution*: 3-8 years of imprisonment. *If heavy damage of health, death or other serious consequence caused, or committed intending to obtain considerable benefit*: imprisonment for 5-12 years.

Country	Individual prostitution	Pimping	Brothel-keeping	Involvement in/ coercion into prostitution	Trafficking
Estonia	Not regulated	Criminal offence Article 268, PC Pecuniary punishment or up to 3 years' imprisonment, or a fine to the extend of assets as a supplementary punishment.	Criminal offence Article 268, PC Pecuniary punishment or up to 3 years' imprisonment, or a fine to the extend of assets as a supplementary punishment.	Criminal offence Article 175-176, PC *If action is committed against a minor (no specific regulation in case of involving person above 18 years of old)* Pecuniary punishment or up to 5 years' imprisonment. *If committed by a legal person*: pecuniary punishment.	Criminal offence Article 134, PC Pecuniary punishment or up to 5 years imprisonment. *If committed against two or more persons, or against a person of less than 18 years of age:* imprisonment for 2-10 years.
Georgia	Not regulated	No specific provision	Criminal offence Article 254, CC Fine or imprisonment for up to 4 years.	Criminal offence Article 253, CC Fine or imprisonment up to 2 years. *If committed by an organized group*: imprisonment up to 5 years. *Involvement for a minor into prostitution*: imprisonment for 2-5 years. (Article 171, CC)	Criminal offence Article 143 and 172, CC Imprisonment for 5-12 years. Imprisonment for up to 20 years, *in case of aggravated circumstances*.

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Table 10, continued from previous page

Country	Individual prostitution	Pimping	Brothel-keeping	Involvement in/ coercion into prostitution	Trafficking
Hungary	Legal with many restrictions Since 1999, regulated by the Act 1999: Act LXXV of 1 September 1999 on the Rules of Intervention Against Organized Crime and the Individual Phenomena Related Thereto and related amendments Sex workers are allowed to provide services in tolerance zones only and not allowed to provide services in certain protected areas (e.g. close to schools, churches etc.) and have to have a valid medical certificate (article 7-14 of the 1999:LXXV Act). Violation of prostitution regulations is administrative offence and is subject to a fine or arrest for 1-60 days, (max. 90 days if the convicted has several cases and the sum of the days exceed 60) (Article 143, Act 1999: LXIX on administrative offences).	Criminal offence Section 206, PC *Living on earnings of prostitution* Imprisonment up to 3 years. Banishment can also take place as supplementary punishment.	Criminal offence Section 205, PC *Promotion of prostitution* Imprisonment up to 5 years. *If minors are employed or brothel keeping is part of criminal organization*: imprisonment for 2-8 years. *If premises are made available for prostitution*: imprisonment for up to 3 years.	Criminal offence Section 207, PC Imprisonment up to 3 years. *If the activity is business like*: imprisonment for 1-5 years. *If in relation to a minor, with violence or as part of a criminal organization*: 2-8 years of imprisonment.	Criminal offence Section 175/B, PC Imprisonment for 1-5 years. In case of aggravating circumstance (*committed against a minor, by criminal organization etc*), imprisonment for 2 years up to life imprisonment, depending on aggravation level.

Country	Individual prostitution	Pimping	Brothel-keeping	Involvement in/ coercion into prostitution	Trafficking
Kazakhstan	Not regulated	Criminal offence Article 271, CC Fine or imprisonment for up to 3 years *(for pandering under sordid motives).* Imprisonment for 3-5 years in case of aggravating circumstances *(committed by an organized group or by a person who has previously committed prostitution related crime).*	Criminal offence Article 271, CC Fine or imprisonment for up to 3 years. Imprisonment for 3-5 years in case of aggravating circumstances *(committed by an organized group or by a person who has previously committed prostitution related crime).*	Criminal offence Article 270, CC Fine or imprisonment for up to 5 years *(for recruiting for prostitution using violence or the threatened violence, using the dependant condition, blackmailing, destroying or damaging of the property or through fraud).* Imprisonment for 3-7 years in case of aggravating circumstances *(committed by an organized groups, repeated prostitution related crime).*	Criminal offence Article 128, CC Fine, restriction of liberty for up to 2 years, detention for up to 6 months or imprisonment for up to 1 year. Up to 5 years of imprisonment in case of aggravating circumstances (*committed by a group conspiring in advance or against a minor*). 3-8 years of imprisonment with or without confiscation of property *if committed by an organized group, or victims are trafficked cross border or transited through the country*.
Kyrgyzstan	Not regulated	No specific provision	Criminal offence Article 261, CC Fine or 2-5 years' imprisonment with confiscation of property.	Criminal offence Article 260, CC Fine or imprisonment for up to 3 years (*for recruiting for prostitution using physical violence or the threatened violence, blackmailing, destroying the property or through fraud*). Increased fine or 3-5 years' imprisonment *if committed by organized group.* *In case of involving a juvenile in prostitution (*Article 157, CC*):* arrest for 3-6 months or imprisonment for up to 3 years. Up to 5 years' imprisonment *if committed repeatedly or by using force or by threatening force.*	Criminal offence Article 124, CC 3-8 years of imprisonment with or without confiscation of property. 5-20 years of imprisonment with confiscation of property in case of aggravating and highly aggravating circumstances (*committed with more than one person, against a minor, repeatedly, by a group with conspiracy in advance, abusing one's power or position, against a dependent person, with illegal crossing border or by using or threatening to use violence which may threaten life and health*, *committed by an organized group, using weapon or narcotic or psychotropic substances, against a pregnant woman, by threatening or using violence which is dangerous to life and health, resulted in death or other serious circumstances through carelessness*).

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Table 10, continued from previous page

Country	Individual prostitution	Pimping	Brothel-keeping	Involvement in/ coercion into prostitution	Trafficking
Latvia	Legal with many restrictions Regulated by "Regulations to Limit Prostitution" adopted by the Cabinet of Ministers Regulation No 427 of November 4, 1998 which was replaced by Act No 210 in May 22, 2001. Not allowed for minors and juveniles, for foreigners; for persons without medical certificate, in groups, outside areas defined by local authority or in the place where a minor person is present; person providing sex work services should undergo medical examination every month etc. Violation of restriction is administrative offence and is punished by a fine. (Article 174.4, AC) If violation is repeated within one year, it is criminal offence and a person may be punished by custodial arrest, or community service, or a fine. (Article 163, CC)	Criminal offence Article 165, CC *Taking advantage of a person who is engaged in prostitution for purposes of material gain:* Imprisonment up to 4 years with or without confiscation of property. Imprisonment for up to 8 years with confiscation of property *if committed by a group pursuant to prior agreement or in respect to juvenile.* Imprisonment for 5-12 years with confiscation of property *if committed in respect to minors.*	Administrative or criminal offence Article 174.4, AC Fine. Custodial arrest, or community service, or a fine, if *violation is repeated within one year.* (Article 163, CC) *In case of a juvenile:* imprisonment for up to 6 years with or without confiscation of property. (Article 164, CC)	Criminal offence Article 164, CC Imprisonment for up to 3 years or detention or a fine with or without confiscation of property. Imprisonment for up to 5 years or fine with or without confiscation of property in case of aggravating circumstances (*committed by using someone's trust in bad faith, or by mean of fraud, or by taking advantage of the dependence of the person or of one's state of helpless*). *If in relation to a juvenile or a minor*: imprisonment varies from up to 6 years to 5-12 years, with or without confiscation of property.	Criminal offence Article 165.1, CC *Sending a person to a foreign state for sexual exploitation:* *If with consent*: imprisonment for up to 4 years. *If for purposes of enrichment or with respect to a juvenile*: imprisonment for up to 10 years, with or without confiscation of property. *If by an organized group or if with respect to a minor*, imprisonment for 8-15 years, with confiscation of property.

Country	Individual prostitution	Pimping	Brothel-keeping	Involvement in/ coercion into prostitution	Trafficking
Lithuania	Administrative offence Article 182(1), AC Fine. Increased fine or administrative arrest for up to 30 days in case of *repeated* offence.	Criminal offence Article 307, CC *Taking advantage of a person who is engaged in prostitution for purposes of material gain:* Fine, deprivation of liberty or arrest or imprisonment for up to 4 years. Up to 6 years' imprisonment *if a person organizes or manages prostitution*. 2-8 years' imprisonment *if committed against a minor.*	Administrative offence Article 182, AC A fine *(for den keeping, no specific mentioning of prostitution).* Increased fine or administrative arrest for up to 30 days *in case of repeated offence*.	Criminal offence Article 308, CC Fine or imprisonment for up to 3 years. Imprisonment for 2-7 years, *if committed against a minor, a person who is materially, due to position or in other way dependent, or by using physical or psychological violence or by fraud.*	Criminal offence Article 307, CC Imprisonment for up to 6 years *if a person has been trafficked cross border.* 2-8 years' imprisonment *if committed against a minor.*
Macedonia	Administrative offence Article 27, The Law on Misdemeanors Against Public Peace and Order Fine.	Criminal offence Article 191, CC Fine or imprisonment for up to 1 year. *If by using force or by serious threat to use force, forces or by deceit, or against juvenile*: imprisonment for 0.5-5 years. *If committed against a child*: imprisonment for 1-5 years. *Organizer of crimes* is punished by imprisonment for 1-10 years. Article 192: *Procuring a juvenile to sexual acts*: imprisonment for 3 months -5 years. *Enabling performing sexual acts with a juvenile*: Imprisonment for 3 months-3 years.	No specific provision	Criminal offence Article 191, CC *Recruiting, inducing, stimulation into prostitution*: Imprisonment for 0.5-5 years. *In case of a child:* imprisonment for 1-5 years. *Organizer of crimes* should be punished by 1-10 years' imprisonment.	Criminal offence Article 418/a, CC Imprisonment up to 4 years. *If committed against a child or a juvenile or by organized group*: imprisonment up to 5 years. *If in addition sexual services are used by known-trafficked person*: imprisonment for 0.5-5 years (*in case of juvenile or a child*: imprisonment for at least 5 years).

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Table 10, continued from previous page

Country	Individual prostitution	Pimping	Brothel-keeping	Involvement in/ coercion into prostitution	Trafficking
Moldova	Administrative offence Article 171/1, AC Fine or detention up to 20 days. Increased fine or detention for up to 30 days, *in case of repeated offence*.	Criminal offence Article 220, CC Fine or imprisonment for 2-5 years. *If in relation to* a *minor, or organized by organized criminal group or organization or resulted in serious consequences*: imprisonment for 4-7 years.	No specific provision	Criminal offence Article 220, CC Fine or imprisonment for 2-5 years. *If in relation to a minor, or organized by organized criminal group or organization or resulted in serious consequences*: imprisonment for 4-7 years.	Criminal offence Article 206, CC Imprisonment for 10-15 years. *By using force or by serious threat:* imprisonment for 15-20 years. *The repeated offence*: 20-25 years or life imprisonment.
Poland	Not regulated	Criminal offence Article 204, CC Imprisonment for up to 3 years. *If committed against a minor*: 1-10 years' imprisonment.	No specific regulation, however Article 204, CC could be applied	Criminal offence Article 204 and 203, CC Imprisonment for up to 3 years. 1-10 years of imprisonment, *if committed against a minor or force (violence), threats or illegal means or abuses a relationship of dependence used or advantage of critical circumstances taken.*	Criminal offence Article 253, CC Imprisonment for not less than 3 years.
Romania	Criminal offence Article 234, CC Imprisonment for 3 months to 1 year or fine.	Criminal offence Article 235 (parts 1 and 3), CC Imprisonment for 2-7 years and suspension of some rights. *If committed with a minor or with other crime*: imprisonment for 15-20 years.	No specific provision	Criminal offence Article 235 (parts 1 and 3), CC Imprisonment for 2-7 years and suspension of some rights. *If committed with a minor or with other crime*: imprisonment for 15-20 years.	Criminal offence Article 235 (parts 2 and 3), CC Imprisonment for 3-10 years and suspension of some rights. *If committed with a minor or with other crime*: imprisonment for 15-20 years.

Country	Individual prostitution	Pimping	Brothel-keeping	Involvement in/ coercion into pros-titution	Trafficking
Russia	Administrative offence Article 6.11, AC Fine.	Administrative offence Article 6.12. AC Fine or arrest for 10-15 fortnights.	Criminal offence Article 241, CC Fine or restriction of freedom for up to 3 years, or imprisonment for up to 5 years.	Criminal offence Article 240, CC Fine or restriction of freedom up to 3 years, or imprisonment up to 3 years. In case of aggravating circumstances (*using force, by displacement of a person cross border):* imprisonment for up to 6 years. *In the relation to a minor:* imprisonment for 3-8 years.	Criminal offence Article 127.1, CC Imprisonment for up to 5 years. *In case of aggravating circumstances, including in relation to a minor, using force or threatening force*: imprisonment for 3-10 years. *In case of threat to life or causing death or organized by a group: force*: imprisonment for 8-10 years.
Serbia and Montenegro	Administrative offence Article 14, Public Order Law Arrest for up to 30 days. *In case of minors*: arrest for 60 days.	Criminal offence Article 251, CC Imprisonment for 3 months to 5 years. *By using force or in case with minor*: imprisonment for 1-10 years.	Administrative offence Article 14, Public Order Law Arrest for up to 30 days. *In case with minors*: arrest for 60 days.	Criminal offence Article 251, CC Imprisonment for 3 months to 5 years. *By using force or in case with minor*: imprisonment for 1-10 years.	Criminal offence Article 111b, CC Imprisonment for 1 to 10 years.
Slovakia	Not regulated	Criminal offence Article 204, PC Imprisonment for 2-8 years.	No specific provision	Criminal offence Article 204, PC Imprisonment for up to 3 years. *If the act is conducted by violence, threat of violence or threat of other serious injury or by exploiting the distress or addiction of another:* imprisonment for 1-5 years. *If act is conducted by member of an organized group, or in case of minor*: imprisonment for 2-8 years.	Criminal offence Article 204, PC Imprisonment for 1-5 years. Imprisonment for 3 to 8 years, *if the perpetrator is a member of an organized group, commits such act to a woman under 18.*

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Table 10, continued from previous page

Country	Individual prostitution	Pimping	Brothel-keeping	Involvement in/ coercion into prostitution	Trafficking
Slovenia	Partly decriminalized in 2004	<u>Criminal offence</u> Article 185, PC Imprisonment for 3 months up to 5 years. *In case with a minor*: imprisonment for 1-10 years.	No specific regulation	<u>Criminal offence</u> Article186, PC Imprisonment for 3 months-5 years. *If committed by force, threat or deception*: imprisonment for 1-10 years.	<u>Criminal offence</u> Article 387, PC Imprisonment for 1-10 years.
Tajikistan	Not regulated	<u>Criminal offence</u> Article 239, CC Fine or imprisonment up to 5 years.	<u>Criminal offence</u> Article 239, CC Fine or imprisonment up to 5 years.	<u>Criminal offence</u> Article 238, CC Fine or restriction of freedom up to 3 years, or deprivation of freedom up to 2 years. *In case of repeated offence or offence organized by a group*: a fine or imprisonment for 2-5 years. *Involving a minor:* up to 1 year of correctional labor, or up to 2 years of imprisonment; *in case of aggravating circumstances*: imprisonment for up to 5 years with deprivation of some rights. (Article 166, CC)	<u>Criminal offence</u> Article 132, CC Fine or restriction of freedom up to 2 years or imprisonment for 2-5 years. In case of aggravating circumstances: imprisonment for up to 12 years.
Turkmenistan	<u>Administrative and criminal offence</u> Article number n/a, AC; Article 138, CC Fine. *In case of repeated offence within a year*: increased fine or correctional works for up to 2 years or imprisonment for up to 2 years.	<u>Criminal offence</u> Article 142, CC Imprisonment for 2-6 years with or without confiscation of property. *In case of repeated offence*: imprisonment for 3-8 years with or without confiscation of property.	<u>Criminal offence</u> Article 140, CC Imprisonment for up to 5 years with or without confiscation of property. *In case of repeated offence (e.g. in relation to a minor):* imprisonment for 3-8 years with or without confiscation of property.	<u>Criminal offence</u> Article 139, CC Correctional works for up to 2 years or imprisonment for up to 2 years. *In case of aggravating circumstances*: imprisonment for 3-8 years.	Not regulated

Country	Individual prostitution	Pimping	Brothel-keeping	Involvement in/ coercion into prostitution	Trafficking
Ukraine	Criminal offence Article 303, CC Fine or correctional works for 120 hours.	Criminal offence Articles 302-303, CC Fine or restrain of liberty for up to 2 years. *If committed in organized group*: imprisonment for 5-7 years.	Criminal offence Article 302, CC Fine or restrain of liberty up to 5 years. *If committed by organized group or by previously convicted person*: imprisonment up to 5 years. *If in relation to a minor:* imprisonment for 2-7 years.	Criminal offence Article 303, CC Fine or arrest for 6 months or imprisonment for 1-3 years. *If in relation to a minor or committed by organized group*: imprisonment for 3-5 years.	Criminal offence Article 149, CC Imprisonment for 3-8 years. In case of aggravating circumstances (*against a minor, organized by a group of people, committed repeatedly or in prior agreement, if child involved*): imprisonment for 5-15 years with or without confiscation of property.
Uzbekistan	Administrative offence Article 190, AC Fine. *In case of repeated offence within a year:* increased fine.	Criminal offence Article 131, CC Fine or correctional work for up to 3 years. *If minors involved; act done by earlier convicted person*: arrest up to 6 months or imprisonment up to 5 years.	Criminal offence Article 131, CC Fine or correctional work for up to 3 years. *If minors involved; act done by earlier convicted person*: arrest up to 6 months or imprisonment up to 5 years.	No specific regulation	Criminal offence Article 135, CC Imprisonment for 5-8 years.

Table 11
Estimated service coverage*

Site	Organization	Estimate of sex workers in the city (average)	Estimate of clients reached (average)	% Estimated coverage
Yerevan, Armenia	Union for HIV Prevention	4,500	1,150	25.6
Minsk, Belarus	Vstrecha	15,000	150	1
Zenica, Bosnia and Herzegovina	Margarina	135	64	47.4
Burgas, Bulgaria	Dose of Love association	1,000	150	15
Plovdiv, Bulgaria	Panacea Foundation	1,096	1,096	100
Sofia, Bulgaria	Health and Social Development	320	250	78.1
Rijeka, Croatia	NGO Terra	100	11	11
Zagreb, Croatia	NGO LET	210	25	11.9
Kostanai, Kazakhstan	Pomosch	315	105	33.3
Shimkent, Kazakhstan	Senim	1,500	800	53.3
Vilnius, Lithuania	AIDS Center	2,000	200	10
Skopje, Macedonia	Healthy Options Project Skopje (HOPS)	1,000	100	10
Strumica, Macedonia	IZBOR	90	35	38.9
Bucharest, Romania	Romanian Association against AIDS (ARAS)	500	500	100
Balakovo, Russia	NAN	600	380	63.3
Barnaul, Russia	Siberian Initiative	1,000	200	20
Krasnoyarsk, Russia	Us against AIDS	1,200	638	53.2
Moscow, Russia	NAN	90,000	4,320	4.8
Nizhny Novgorod, Russia	Oblast AIDS Center	4,250	370	8.7
Omsk, Russia	Future without drugs	1,000	1,000	100
Volgograd, Russia	Maria	1,500	220	14.7
Belgrade, Serbia and Montenegro	JAZAS — Association against HIV/AIDS	3,000	2,000	66.7
Bratislava, Slovakia	CA Odysseus	450	350	77.8
Dushanbe, Tajikistan	RAN	5,000	493	9.9
Odessa, Ukraine	Doroga k Domu	2,500	600	24
Poltava, Ukraine	NGO Public Health	400	239	59.8
Tashkent, Uzbekistan	PSI	6,000	1,400	23.3
total		**144,666**	**16,846**	**11.6**
average		**5,358**	**624**	**39.3**

* Source: Project reports to CEEHRN survey (2004).

Table 12

Project data: Services provided to sex workers, clients of the programs

Country	City	Organization	Project's services										
			Condom Distribution	Needle Exchange	Testing for HIV	Testing for HCV	Testing for and Treatment of STIs	Information and Consultation	Legal Assistance	Social Assistance to Children of Sex Workers	Other Social Assistance	Contacts with Medical Institutionss	Other
Armenia	Yerevan	Union for HIV Prevention	Yes	Yes	Yes	/	Yes	Yes	/	/	/	/	Yes[1]
Belarus	Minsk	Vstrecha	Yes	Yes	Yes	/	Yes	Yes	/	/	/	/	/
	Minsk	BelAYU	Yes	/	/	/	Yes	Yes	/	/	/	/	/
Bosnia and Herze-govina	Zenica	Margina	Yes	Yes	Yes	Yes	Yes[2]	Yes	/	Yes	Yes	Yes	Yes[3]
Bulgaria	Burgas	Dose of Love association	Yes	Yes	Yes	Yes	Yes	Yes	/	/	Yes	Yes	Yes[4]
	Pleven	Pleven 21st Century Foun-dation	Yes	Yes	Yes	Yes	Yes	Yes	/	/	Yes	Yes	/
	Plovdiv	Panacea Foun-dation	Yes	Yes	Yes	/	Yes	Yes	Yes	/	/	Yes	/
	Sofia	Health and Social Develop-ment	Yes	Yes	Yes	Yes	Yes	Yes	/	/	Yes	Yes	/
	Varna	SOS Families in Risk Foundation	Yes	Yes	/	/	/	Yes	/	/	/	Yes	/
Croatia	Rijeka	NGO Terra	Yes	Yes	Yes	Yes	/	Yes	/	/	Yes	Yes	/
	Zagreb	NGO LET	Yes	Yes	/	/	/	Yes	/	/	Yes	Yes	/
Estonia	Tallinn	NGO AIDS Prevention and Support Center	Yes	Yes	Yes	/	Yes	Yes	Yes	/	Yes	Yes	Yes[5]
Georgia	Tbilisi	Association Tanadgoma	Yes	/	Yes[6]	Yes[7]	Yes[8]	Yes	/	/	/	Yes	Yes[9]

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[1] Establishing self-support group.

[2] Test only for chlamydia, syphilis, gonorrhea.

[3] Free of charge standard gynecological exams and PAP tests.

[4] Ensure a free gynecological exams and free lubricants.

[5] In drop-in (daily center): shower, washing facilities, Internet, video, coffee-tea, cooking facilities; in near future – computer and language courses.

[6] Referral system to the AIDS Center.

[7] For prison inmates.

[8] Referral system to the "Healthy Cabinet".

[9] Primary screening with mobile laboratory – starting soon; Creation of Informational-Educational Materials targeted to each target group (commercial sex workers, IDUs in prisons, adolescents, general population).

Table 12, continued from previous page

Country	City	Organization	Project's services										
			Condom Distribution	Needle Exchange	Testing for HIV	Testing for HCV	Testing for and Treatment of STIs	Information and Consultation	Legal Assistance	Social Assistance to Children of Sex Workers	Other Social Assistance	Contacts with Medical Institutionss	Other
Kazakh-stan	Kostanai	Pomosch	Yes	Yes	Yes	/	/	Yes	/	/	/	Yes	/
	Pavlodar	Turan	Yes	Yes	Yes	/	Yes	Yes	Yes	/	/	Yes	/
	Shimkent	Senim	Yes	Yes	Yes	/	Yes	Yes	/	/	Yes	Yes	Yes[10]
Latvia	Riga	AIDS Prevention Center	Yes	Yes	Yes	/	Yes	Yes	/	/	Yes	/	/
Lithuania	Klaipeda	Addictive Disorders Center	Yes	Yes	/	/	/	Yes	/	/	Yes	Yes	/
	Vilnius	Addictive Disorders Center	Yes	Yes	/	/	/	Yes	/	/	Yes	Yes	/
	Vilnius	AIDS Center	Yes	Yes	Yes	Yes	Yes	Yes	/	Yes	Yes	Yes	/
Macedonia	Skopje	Healthy Options Project Skopje (HOPS)	Yes	Yes	Starting January 2005	Starting January 2005	Starting January 2005	Yes	Starting January 2005	/	Yes[11]	Yes	Yes[12]
	Strumica	IZBOR	Yes	Yes	/	/	/	Yes	/	/	Yes	/	/
Moldova	Beltsy	Youth for Rights to Life	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	Yes[13]
Poland	Krakow	UMBRELLA — Prevention and Social Edu-cation Center	Yes	n/a	/	/	/	Yes	/	/	Yes	Yes	/
Romania	Bucha-rest	Romanian Asso-ciation Against AIDS (ARAS)	Yes	Yes	Yes	Yes	Yes	Yes	/	/	Yes	Yes	Yes[14]
Russia	Balakovo	NAN	Yes	Yes	Yes	Yes	Yes	Yes	Yes	/	/	Yes	Yes[15]
	Barnaul	Siberian Initia-tive	Yes	Yes	Yes	Yes	Yes	Yes	Yes	/	/	Yes	/
	Krasno-yarsk	Us against AIDS	Yes	Yes	Yes	Yes	Yes	Yes	/	/	/	Yes	/

10 Exams for drug users – sex workers and gynecological exams.

11 Referrals and mediating with social services, helping and accompanying trough different procedures, financial help for different administrative costs, visiting the clients in their homes, psycho-social support; hygienically baskets etc.

12 Free gynecological exams and free contraception for clients without health insurance; Treatment of abscesses for drug users – sex workers; Drop-in center with different facilities (social, legal end medical services); Shower and washing facilities starting January 2005.

13 Diagnosis, informational materials and pharmaceutical goods distribution, consultancy etc.

14 Primary medical care, psychological support, vaccination for HAV, HBV, free transportation for medical and social services.

15 Individual consultation, group consultation, seminars, organization and carrying out peer training, distribution of information materials. Informing on business hours, location of medical institution, free-of-charge consultation and testing on STI in a cabinet of anonymous admission, free treatment under project guidelines.

Country	City	Organization	Project's services										
			Condom Distribution	Needle Exchange	Testing for HIV	Testing for HCV	Testing for and Treatment of STIs	Information and Consultation	Legal Assistance	Social Assistance to Children of Sex Workers	Other Social Assistance	Contacts with Medical Institutionss	Other
	Moscow	NAN	Yes	/	Yes	Yes	/	Yes	Yes	/	/	Yes	/
	Nizhny Novgorod	Oblast AIDS Center	Yes	Yes	Yes	Yes	Yes	Yes	/	/	/	Yes	/
	Omsk	Future without drugs	Yes	Yes	Yes	Yes	Yes	Yes	/	/	/	Yes	/
	St. Petersburg	Humanitarian Action	Yes	Yes	Yes	Yes	Yes	Yes	Yes	/	Yes	Yes	Yes[16]
	Tula	NAN	Yes					Yes	Yes	/	/	Yes	Yes[17]
	Volgograd	Maria	Yes	Yes	Yes	Yes	Yes	Yes	Yes	/	/	Yes	/
Serbia and Montenegro	Belgrade	JAZAS — Association against HIV/AIDS	Yes	/	Yes	/	/	Yes	/	/	/	/	/
Slovakia	Bratislava	CA Odysseus	Yes	Yes	Only every December	July - September 2004+	Tests for syphilis and assistance to treatment	Yes	Yes	/	Yes	Yes	/
Tajikistan	Dushanbe	RAN	Yes	Yes	Yes	Yes	/	Yes	Yes	/	/	/	/
Ukraine	Odessa	Doroga k Domu	Yes	Yes	Yes[18]	/	/	Yes	Yes	/	Yes[19]	Yes	Yes[20]
Ukraine	Poltava	NGO Public Health	Yes	Yes	Yes[21]	/	Yes[22]	Yes	Yes	/	Yes	Yes	Yes[23]
Uzbekistan	Tashkent	PSI	Yes	/	Yes	/	Yes	Yes	/	Yes	/	Yes	/

n/a = not available

[16] Medical and psycho-social support.

[17] Psychological help.

[18] Sending to free HIV testing, where women can take based on Clinic for Skin and Venereal Diseases. However, in Odessa, the Clinic for Skin and Venereal Diseases free testing is *not anonymous*, but paid testing can be made anonymous.

[19] Humanitarian assistance, distribution of medicines.

[20] Aid in purchase of laboratory materials for tests on HIV/STI (laboratory dyes, reactants) to medical institutions, purchase of medicines for the state hospitals and a tubercular clinic.

[21] Sending to Clinic for Skin and Venereal Diseases for free and anonymous HIV testing (in agreement with the Clinic for Skin and Venereal Diseases).

[22] Sending to a treatment in Clinic for Skin and Venereal Diseases and the Gynecological Department of the Fifth City Hospital (in agreement with the Fifth City Hospital).

[23] Work with potential clients — giving lectures and consultations in the transportation enterprises, military units, educational institutions.

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Sign on T-shirts says: "I'm doing protected sex"
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