Chapter 10

Approaching health through the prism of stigma: research in seven European countries

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Introduction

The "prostitute's" body is inscribed as a site of disease and a source of contagion; these webs of signification affect the research and interventions designed as well as the interpretation of results. Yet, stereotypes about sex work also change and we describe shifts in the imagery since the 1980s, when an AIDS panic was projected on to sex workers who, it was feared, would infect everyone else. This fear was soon dispelled through a lack of corroborative evidence.

Nevertheless, AIDS has been linked more recently with specific types of sex workers, who silently cross borders and bring diseases with them. This figure of the "migrant" is blamed for many of the problems of globalisation and considered a threat to national identity and cohesion. Migration raises questions about trafficking, inequality and the morality of commerce that have been compared to earlier concerns about a white slave trade (Doezema 1999).

Shifting representations of disease and sex work are described in this, the first of two chapters on stigma, with reference to a twenty-year history of AIDS. At one level, this short summary simply shows that the more things change, the more they stay the same. European sex workers will most likely acquire and then transmit the virus that causes AIDS (1980s); in fact, they do not (1990s); then perhaps it is only foreigners or some other sex workers that will both suffer and cause this problem (2000s). If the story is already written, what alternatives can be produced and considered? Our short account demonstrates the historical specificity of the stigma attached to prostitution as well as its remarkably uniform contours. We ask whether research on health and disease in a European network for HIV prevention in prostitution (Europap) can do more than reproduce this stigma. In the second of these two chapters, we look at the relationships between stigma and health over time, related to women's careers in the sex industry and their life course more generally, so as to tease apart the many senses of the term stigma and their multiple

relationships to health. Such an approach may help specify the scope for change and the effectiveness of interventions.

AIDS and sex work in Europe: the "core"

In the 1980s, it was thought that sex workers in Europe might be at increased risk of HIV/AIDS, which could lead to inappropriate political responses such as forced regulation and testing. Epidemiological research has focused on transmission from prostitutes to their partners and a notional general population. It was suggested that a small number of people having high numbers of sexual partners could be seen as a core group who would play a disproportionate role in transmission (Yorke et al, 1978; Thomas and Tucker, 1996). The degree to which those with a high rate of partner change, such as prostitutes, mix with those with a relatively low rate of partner change can have an important impact on the pattern of spread.

Concepts of core groups are linked to older images of reservoirs and pools of infection which were important in attempts to control disease in many countries, including most of Europe at various times (Harsin 1985, Walkowitz 1980). However, for much of the twentieth century prior to the AIDS epidemic and excluding periods of war, prostitutes in many European countries were considered less central to the transmission of infection. General programmes addressed "professionals" and "amateurs" alike (Wigfield, 1972). Towards the end of the twentieth century, explosive epidemics of HIV among prostitutes in some non-western countries, together with epidemics of poverty and drug use in the west, led to a renewed interest in the transmission of infection from prostitutes.

Appeals to core groups in this environment have been contradictory. Images of core transmission re-established "the prostitute" as a timeless unitary "transmitter" of infection – in Rwanda and London alike. At the same time, they promoted extensive empirical investigation demonstrating, to the contrary, that the role of prostitutes varied from one place and time to another and could not be understood independently of the social context.

Contemporary investigations and interventions are also linked to broader political approaches to prostitution. For example, sex workers are still subject to compulsory registration in some European countries for the purposes of screening and treatment and many other sex workers have no access to health care. Such policies have been considered at best irrelevant to disease control and, at

worst, to exacerbate public health problems (Rosenberg and Weiner, 1988). New approaches have been developed over the past decade within the European Union and are in the process of implementation and evaluation, as discussed by other contributors to this book.

Perversely, the prejudice that labelled prostitutes core transmitters of disease also led to financial support for hundreds of projects, most of which work on the basis of harm minimisation and promote safer working environments in prostitution. Many project workers in Europe came to see the "core" image as part of the problem for sex workers: it equated prostitution with disease in a way that justified discriminatory policies and stigmatisation. As project workers developed close links with sex workers over a number of years they found that this discrimination was related to a variety of health problems. In this way, images of prostitutes as transmitters of disease both stigmatised sex workers and led to projects that were keen to counter this stigma because it had detrimental effects on health.

In the 1990s it became clear that sex workers in Europe were not playing a key role in spreading disease, and the AIDS panic about prostitution abated. Yet, stigma persists and new panics emerge that lead to policies attempting once more to control disease through policing categories of people: we hear of potential pockets of infection in immigrant prostitutes alongside news of traffic in people, and concerns about protecting the borders around "Fortress Europe". At the same time, support for HIV prevention projects is threatened.

European collaborative research

In the late 1980s a research project in nine European centres was established to look at HIV risk in prostitution. [2] The results were hard to interpret. Criminal and other sanctions make it impossible to enumerate the relevant population and so samples are inevitably biased. Data are commonly drawn from captive or highly visible groups such as prostitutes who work in poor neighbourhoods or those in contact with state institutions such as police, prisons and health services. It is not even easy to agree upon a common definition of prostitute (Day and Ward 1994).

These problems make it difficult to generalise or compare results, and estimates of prevalence cannot be considered representative of a wider population of sex workers. Nonetheless, at the time, the results of this research were important in suggesting a

relatively low risk of HIV among sex workers in Europe. They counteracted widespread prejudice and also showed that infection in sex workers reflected rates in other population groups as well as specific risk factors such as injecting drug use.

The policy consequences of these and other findings were historically contingent. Around 1990 the virtual absence of HIV in sex workers did not lead to funds being withdrawn; on the contrary, HIV prevention programmes were set up nationally and at the European level. The most widespread public health approach across Europe advocated harm minimisation to maintain the low levels of HIV and other sexually transmitted infections; this platform was based on a social definition of health encompassing notions of well-being, human rights and, in particular, safer working conditions.

Europap

Europap began in this climate and was formally established in 1993. Rather than pursue larger epidemiological studies, which could never overcome biases because of the legal penalties attached to sex work, we established a network for health promotion with sex workers (see Introduction). We developed and shared models of good practice, including manuals for appropriate health services and staff training. Within the network, the focus was as much on barriers to health care as levels of HIV or other infections. During the decade, Europap as a whole attempted to promote accessible and appropriate holistic services based on principles of harm minimisation. That, in turn, meant understanding the issues faced in different sectors of work and different countries by women (largely) who came themselves from all over the world and from highly diverse social circumstances. The majority were poor and disqualified from many forms of work for a variety of reasons including family obligations, lack of education and lack of documentation.

By 2000 much had changed in Europe. Further integration of the European Union and imminent enlargement had been accompanied by devastating economic crises, especially in the ex-Warsaw Pact countries of Eastern Europe and the newly independent states of the former Soviet Union.

Many, but not all, of these countries privatised state assets, withdrew industrial and social subsidies and deregulated trade and the labour market (see Chapter 1). As a result both capital and certain types of labour became highly mobile. Increasing

inequalities within and between nation states along with high unemployment in some countries and increasing job insecurity promoted migration as people searched for work. Yet, restrictions on mobility limited migration into "Fortress Europe" and also some forms of movement within the European Union so that the informal sector grew to incorporate those who could not migrate or work legally in the formal economy.

These changes prompted us to ask whether health issues had altered for sex workers and whether our health promotion programmes were still appropriate to the circumstances. By the second half of the 1990s stateless migrants were increasingly stigmatised as carriers of HIV because, it was thought, they came from areas of high HIV prevalence. But what was the evidence?

Further Research

We designed a survey to look at the prevalence of different health problems among sex workers, which we piloted between 1999 and 2000. This caused extensive debate within the Europap network, which included different views both about prostitution itself and about appropriate health interventions.

Harm minimisation had provided the middle ground for pragmatic interventions on the part of Europap that gradually broadened over the decade, from a focus on sexual health and known individual risk behaviours to a study of risk environments, especially at work, where multiple forms of violence and exploitation intersected to the detriment of workers.

This health care focus was the major concern of the programme. Yet, for some participants in the network, harm minimisation also meant an end to prostitution, understood as a form of violence against women. For others, any research on sexually transmitted infections among sex workers, especially HIV, was stigmatising per se. They were concerned that the survey might be detrimental to health insofar as it would merely reconstruct negative stereotypes about sex work and disease. Many argued that the programme should focus on the particular vulnerability of migrant sex workers and develop services to meet their needs.

The majority agreed about the importance of a rights-based approach to service provision for sex workers arguing for occupational, civil and human rights more broadly. But we disagreed about the inevitably stigmatising nature of research on

health. Failure to monitor the results of screening, we argued, could be as damaging as, or more damaging than, the stigma of disease. Moreover, the exclusive focus on migrants proposed by some participants could equally feed into pre-existing prejudices and exacerbate divisions among sex workers by linking a type of sex worker with AIDS control.

In what follows, we argue our case in relation to a Europe that changed significantly during the 1990s. By 2000, the new paradigm that considered migrants to be particularly at risk and of risk to others already existed and circulated widely, at least in the popular press. It should, we thought, be evaluated along with our programmes designed on the basis of research into conditions the previous decade.

Between 2001 and 2002, we conducted a survey of over 500 sex workers in contact with projects in seven cities.[3] Sampling varied by centre, but was opportunistic, based on sequential clinic attendees or outreach contacts. Participants were asked for basic information on background, sex work, migration and health, and this was linked, with consent, to results of health screening. As stigma is so difficult to define, especially across such a wide range of social and cultural settings, we explored participants' ideas through a number of direct and indirect questions.

We asked participants to describe the worst and best things about prostitution, and also what advice they would give to a sister or daughter who was considering sex work, a question we have previously found to reveal something of their own attitudes. In the survey we measured the prevalence of HIV and other sexually transmitted infections; access to health care (as indicated by rates of hepatitis B vaccination, HIV and cervical smear screening); drug and alcohol use; and violence. All these questions were placed in the context of demographic and background information such as age and family, along with a description of individual experiences of sex work. All information was confidential and anonymity guaranteed.

After describing the setting for this survey, we present results that show no evidence for any association between HIV infection and migration. We also explore concerns about HIV infection in relation to other health problems and then return to the impact of these findings on debates within the Europap network.

Settings

Helsinki, Finland

The survey was carried out by the Pro-Tukipiste prostitute counselling centre in Helsinki who work with migrant and street sex workers. The centre distributes drugs paraphernalia to street workers, and has a mobile health unit and a pilot vaccination project. There are an estimated 4000 sex workers in Finland, including 1,700-1,800 non-Finnish women. Since the late 1990s, prostitution has been subjected to increasing state control and more restrictions have been applied to non-EU citizens. Most survey participants were older Russian women (median age 34) who had been working for about two years. In the past they had other jobs but high levels of unemployment led them to commute to and from Finland, where they were mostly based in bars.

Ghent, Belgium

Local recruitment took place through PASOP outreach to workplaces and included health screening and services. In Belgium, there are between one and two sex workers per 1000 population. Most participants were women in their twenties from Belgium and Western Europe (77 per cent) working in bars and private houses, but they were a diverse group including some who had worked for twenty years and some who had worked for less than one.

Dublin, Ireland

The research was carried out through the Baggot Street Health clinic, a specialist service for female sex workers, with a small number of women (38). In the early 1990s, there were between 100 and 600 known sex workers in the country but a booming economy has attracted increasing numbers of non-Irish women to Dublin. At the same time, repressive measures have driven sex work underground and, in particular, off the streets. Most participants were Irish women in their late twenties who worked as escorts or on the streets. They reported relatively low levels of education and cited financial reasons and having friends who were sex workers as reasons for entering the industry.

Lisbon, Portugal

The survey was conducted in the Lisbon drop-in counselling centre and clinic for sex workers. Prostitution is more or less tolerated in Portugal, with legal restrictions only on exploitation, aiding and abetting. Sex workers and clients are not directly criminalised. During the 1990s there was an increase in migrants from Africa (primarily Portugese speaking parts and West Africa), Spain and the United Kingdom and, more recently, there has been a small increase in migration from East Europe (Romania, Russia, Hungary and Bulgaria). There are close links between the sex and drug trades: 50-60 per cent of the street sex workers contacted by the local projects used heroin and cocaine.

Most participants in the research were African (51 per cent) or Portugese (44 per cent) in their late twenties, working on the streets. Most of the migrants had arrived very recently (median, 1 month) and nearly half had previously worked in the sex industry in Spain or Italy. Participants had low levels of education.

Madrid, Spain

The survey was conducted by the Medicos del Mundo mobile outreach unit, which provides health promotion, supplies and support for sex workers on the streets and working in local premises such as bars and saunas. Sex work in Spain is criminalised in much the same way as other European countries, with particular sanctions against management, trafficking, and under-age sex work. However, street workers are visible in many cities and tolerated to varying degrees. Participants (46) were mostly South American women in their thirties working in brothels (44 per cent) and bars (33 per cent). Most had arrived in Spain within the past year, and several combined prostitution with other work.

London, UK

The survey was conducted by the Europap Coordinating Centre with the Praed Street Project, which runs a clinic for sex workers. Data for a hundred consecutive new patients were collated for 2001-2. There is increased control of prostitution in the UK as a result of various legal reforms, including the criminalisation of advertising cards used by many sex workers, police offensives, and the growing repression and stigmatisation of migrants and asylum seekers.

At the same time there has been an increase in the numbers of migrants working in the industry, particularly but not exclusively, in London. Most participants were migrants (79 per cent) in their twenties who worked in flats or escort agencies. Many were from Eastern Europe and had arrived in the UK a few months earlier.

Amsterdam, The Netherlands

The survey was conducted by the Intermediary Project (Municipal Health Service, Amsterdam) in English, Spanish and Dutch with a hundred prostitutes working in brothels, windows and a drop-in centre for street workers. Sex work has been informally tolerated in The Netherlands to a much greater degree than other European countries and recently regulated to allow citizens of the European Union to work legally.

However, over the last two decades, prostitution has become a profession mostly practised by migrants working illegally. In the last decade numbers from Eastern and Central Europe have increased steeply, while numbers from Latin America have declined. Participants were mostly born outside Holland (78 per cent); one in five came from Eastern Europe or the former Soviet Union and one in three from South America. They had been in the Netherlands for an average of three years and, in contrast to other centres, a significant minority were transgender (15 per cent).

Results

This survey suffers the problems associated with the earlier study. Moreover, comparison of results cannot show what has changed even within the limits of such studies since the survey was conducted with fewer people and in some different centres. Nonetheless, the results are in line with broad trends in Europe and permit a few cautious generalisations to be made.

First of all, the workforce differed. Over half (56 per cent) of the 2001 participants were migrants, by comparison with less than a quarter (24 per cent) a decade earlier. Migrants also came from different countries. In 1991, most migrants came from other Western European countries but, in 2001, they came in roughly equal numbers from Africa, Eastern and Western Europe and, in smaller numbers, from a greater variety of countries in other parts of the world. There was a wide variation between sites in 2001 in the proportion, turnover and origin of migrants. In some centres, migrants had arrived very recently: the median time in the country

prior to interview was only one month in Lisbon, and four months in London. At the other extreme, migrants reported a median stay of five years in Ghent.

Secondly, we have not detected any overall increase in HIV infection, and injecting drug use remains the major risk factor. [4] In 1991, 5% of 866 sex workers had HIV-1 and, in 2001, 4% of 493. However, there was an increase from 1% (9/756) to 3% (12/375) among non-injecting drug users. Variation by site was evident in both surveys. In the 1991 study, no HIV-1 was found in participants working in Antwerp, London, Copenhagen or Athens while 32 cases of infection were found in Madrid (29 among injecting drug users). In the 2001 survey, no infection was found in Helsinki or Madrid, one case was found in Dublin, two in Amsterdam and in London and thirteen in Lisbon; infection thus ranged from zero to 13.5 per cent across the seven sites.

In 2001, HIV-1 infection was significantly associated with being based in Portugal, a history of injecting drug use, working on the streets, and other infections (HIV-2, past hepatitis B and C, and syphilis infection), but not with being a migrant or originating in any particular part of the world.

Many of these factors are linked, with almost all the sex workers in the Lisbon sample working on the streets for example. In a multivariate analysis, putting all these variables together, the only factors significantly associated with HIV-1 were being recruited in Lisbon, and previous injecting drug use.

HIV and other health risks

HIV was not the only, or even most serious, health problem for women. Many participants were concerned primarily about violence at work; physical assaults were reported by between 20 per cent (in Ghent) and 50 per cent (in Helsinki) of women, attributed mostly to clients but also to managers, police and colleagues and included serious assaults involving the use of weapons and drugging.

Problems with alcohol and other drugs were widely reported: injecting drug use by 2 – 19 per cent of participants (by site), cigarette smoking by 43 – 77 per cent and problem alcohol use by 2 – 15 per cent. [5] Sexually transmitted infections were an occupational health issue. Collating information about acute infections from those who were screened revealed a wide variation, for example, the lowest rate of chlamydia was in Helsinki (2 per cent) and the

highest in Dublin (18 per cent), but again these results are based on small numbers and varied recruitment methods.

We assessed access to health care in various ways including coverage with vaccination and screening programmes, and access to a family doctor, defined by having a consultation within the past year. These are relatively crude indicators since recent entrants into sex work may not have had time to complete a vaccination course, and screening programmes vary widely across Europe. In some countries, access to a family doctor depends on social insurance schemes, which commonly exclude sex workers and migrants.

Nevertheless, results indicate that health care remained a problem in 2001. Hepatitis B vaccination had been completed by 2 per cent of participants in Helsinki and, at the other extreme, 44 per cent in Ghent. One in three women overall had never had a cervical smear. The numbers reporting a previous HIV screen ranged from a little more than half in Helsinki and Madrid, to almost all in Ghent and Dublin. Use of and access to a family doctor varied from 17 per cent in Lisbon to 95 per cent in Ghent.

Reported condom use remained very high; indeed, it was higher than in the 1991 study. However, seven participants (in Amsterdam, Lisbon and Madrid) reported the use of oil-based lubricants that may cause condom failure, a practice that was identified as a risk for HIV in the earlier study (Alary et al, 1993). This suggests continuing difficulties with health promotion.

We asked women about the worst aspects of their work, which we subsequently categorised. Most often, women complained about dirty, abusive, drunk and exploitative clients. Comments referred as much to stigma ("clients who treat you like a dog", "lack of respect from clients") as to health problems caused by clients ("a lot of men use you; the clients are aggressive", "men asking for sex without condoms", "fear of disease").

The next most common response concerned work conditions. Women spoke of financial exploitation in brothels and windows (Amsterdam, Ghent); they spoke of insults, humiliation and a lack of respect from managers (across all centres). They spoke of the cold outdoors and of requirements indoors to drink alcohol and work long hours, staying awake day and night. Some spoke of the drug culture at work, and some of the lack of money. Many said they had to be alert constantly to attempts to rob, assault or otherwise exploit them.

A third focus was the emotional and psychological parameters of the job. A sex worker in Amsterdam said: "you need a smiling face and you need to be polite to keep your clients. It is difficult to

get used to the job; it is difficult to get out of the job". Women spoke of "the psychological effects", "the lack of respect", "the degradation" and "'the humiliation" of the work. Across centres, women also spoke of their own distaste for the job: "I do not have much feeling left", "it is a heavy job for the mind", "it is dirty", "it is still a taboo" and "you feel less pure, less proud. We have to play games. Sometimes we are paid to be misused". Seven women from Dublin talked of "self-hatred". In addition, respondents spoke of the difficulties of keeping secrets and leading double lives which they said affected their personal relationships in particular: for example, a woman working in Ghent said, "people who know what you are doing look differently at you". These references to prejudice, discrimination, humiliation and distaste merged with the fourth and last set of comments about the content of the work itself, where some respondents expressed discomfort with their status as a commodity, with particular types of sexual services or sex with strangers and the effects this had on relationships with other men outside work.

The negative aspects of working were emphasised more than the positive in all centres and especially with reference to possible advice for a sister or daughter contemplating sex work. When women spoke of changes that they would like to see, suggestions included compulsory condom use, health cards and other forms of health care, cleanliness in men, rooms and bedding. Women also spoke of the need for equity and an end to exploitation in relation to physical safety (for example, more alarm systems, putting an end to police and client mistreatment) or social justice (the need for documentation, social security and pensions; the need for employment protection at the workplace).

Participants in Lisbon were somewhat more troubled by their work than those from other centres. Among forty responses about the worst and best aspects of work, twenty women explicitly claimed that there were no good things about prostitution and several explained that the money was the only compensation. One said: "I don't know any good things, not even the money is good. I only do it because I don't have [legal] papers". When they were asked what they would like to change, women in Lisbon more commonly reiterated the difficulties of sex work: "I would like just to have another job, not to change anything in this one"; "[I would like to] stop working. I would like to go to Spain, and work in a factory".

Most reacted against the possibility of their sisters or daughters working, to the extent that some refused to entertain the

idea of offering any advice at all. The vehemence of respondents was striking in the south generally. In Lisbon and Madrid, the vast majority said they would actively prevent their sisters or daughters from working and expressed horror at the thought. Thus, "I would tell her to quit because this life does not dignify a woman"; "I would not allow her to be a prostitute, because prostitution is not good"; "I would not let her, because prostitution disrupts your whole life". This majority narrowed to the north, in Helsinki, Amsterdam and Ghent.

Participants also spoke of positive aspects to the job. In particular, individuals referred to sociability, wealth, autonomy and independence. Respondents remarked on the confidence they had acquired in dealing with people and, occasionally, they spoke of enjoying their work. They pointed to their freedom outside work, with hobbies, leisure, financial freedom and enough time to spend with their children. A woman from Amsterdam explained: "I feel myself more grown-up. You meet different people. With some of them, I have very good sex, excitement, and I learn a lot about myself. You can earn a lot of money …"

Occasionally, sex workers commented on collaboration more generally, with police who protected them, colleagues and (other) professionals in counselling and allied work. At times, a particular value was placed on internationalism where women spoke of their far-flung networks and the languages they had learned. Thus one woman, working in Ghent, said, "I have learned many languages and cultures, made many social contacts, and I value my role in society in providing psychological help for men".

Most participants considered themselves to be in good health in response to pre-coded questions, ranging from 63 per cent in Lisbon to 79 per cent in Ghent.[6] It is unclear how stable these codes are over different settings and it seems likely that participants downplayed acute problems that had been resolved and ailments so prevalent in sex work as to be thought not worthy of mention.

Trends from Lisbon and London

To explore HIV and other health risks, we looked in more detail at trends in the data, focusing on Lisbon and London between 1991 and 2001. The Lisbon group participated in the first and second surveys, and recorded the highest level of HIV in our 2001 survey. Athough the numbers are small, the trend towards increased HIV risk for sex workers fits with national data. Portugal has the

highest AIDS incidence in Europe with 103 cases per million population compared with 60 or less in all other countries. There has also been an increase in syphilis, including vertical transmission. Surveillance is incomplete but the epidemic appears to be primarily heterosexual (European Centre for the Epidemiological Monitoring of AIDS, 2002). High rates of HIV and heterosexual transmission have been associated with migration from sub-Saharan Africa and yet, among sex workers at least, HIV is found less in migrants than in Portugese women even though sex work is increasingly practiced by non-nationals. In 2001, for example, 9 out of 42 Portugese women (21 per cent) and 4 out of 54 migrants (7 per cent) were found to have HIV-1 (see Table). Of the 10 women who reported ever injecting drugs, four had HIV, all of whom were Portugese.

Prevalence of HIV-1 infection in a sample of sex workers in Lisbon, comparing results from 1991 and 2001 by self reported injecting drug use and country of birth

		Prevalence of HIV	
		1991	2001
Injection drug use	Ever	0/4 (0%)	4/10 (40%)
	Never	3/77 (4%)	9/86 (10%)
Country of birth	Portugal	2/15 (13%)	9/42 (21%)
	Elsewhere	1/66 (2%)	4/54 (7%)
All		3/81 (4%)	13/96 (14%)

The higher prevalence of HIV infection in Lisbon workers is most likely to reflect risks of acquisition locally, given the overall prevalence in Portugal. It is not possible to provide definitive answers from our data about any increase of risk in sex work specifically or in particular types of sex worker. Local Portugese women had been working much longer than migrants when interviewed in Lisbon (median year of starting 1993, as compared to 2000) and those with HIV had started work earlier (median year 1995 compared to 2000), but these differences were not significant.

Length of time in prostitution might increase HIV risk in accordance with the "common-sense" approach to prostitution that suggests the more partners you have, the more likely you are to be exposed to infection (see Day and Ward 1994 for a critique of this argument). But it is also plausible to suggest that this risk reflects historical associations with a time when there was less HIV related health promotion. It is possible too that these associations might reflect pre-existing vulnerabilities that lead both to HIV infection and to a relatively long career in sex work, such as poverty or drug use. The free text responses reported above suggest particular vulnerabilities in sex work, which interact to produce a risky environment. It may be recalled that women working in Lisbon were less likely to consider themselves to be in good health (above) by comparison with other sites. They also reported less education, a proxy measure we employed to assess poverty or social class in crude terms. It has been found consistently that educational status is a strong predictor of self-rated health (Kelleher et al. 2003) and so these two measures may reflect simply a general sense of disadvantage. The Lisbon workers were poor women with few work options. It is well established that poor people suffer worse health than the wealthy, and this applies at a general level to HIV illnesses as much as others. Despite the importance of these issues, trends from Lisbon can only demonstrate a lack of direct association between HIV infection and migrant status.

In London, as in other Europap centres, political and economic developments have promoted migration and heterogeneity in the work force. On the whole, this has been associated with growing repression, apparently targeted at illegal migrants but affecting all sex workers. Intense policing has led women to work in flats more often than on the streets. Baseline data on over 1,200 new patients at St Mary's Hospital between 1985 and 2000 indicate that these changes have not been associated with increased STI risk. This finding is all the more surprising given increasing migration from higher prevalence areas and increasing STI in the UK (Ward et al 2004). In this way, data from London provide further confirmation of the picture in Lisbon and the other centres participating in the 2001 survey: we found no evidence that migrants are at increased risk for HIV infection or other STIs. Injecting drug use remains the most important risk factor for HIV in European sex workers, whether in the West or East. Other findings from Europe support these conclusions (Rodriquez et al, 2002; Clavo et al, 2002).[7]

The Europap Story

Returning to the story of our network, we can now summarise the debate over health promotion in terms of the relationships between words and things. We were arguing about the way that labels constructed the world. Sex workers' comments from the seven sites show that a sense of vulnerability is derived from the labels attached to prostitutes. The power of these labels is reinforced by an interest in infection and assumptions about a sex worker "core group".

Yet, we were also arguing about the extent to which the world is constructed through labels. The results of our research challenge conventional wisdom because they provide no evidence that "migrant" sex workers are repositories of infection. In this way, results from Europap parallel the earlier 1991 study, which found no evidence that sex workers in general were diseased. Such evidence rebuts prevailing assumptions and they are also important to sex workers' assessments of the situation.

Participants in Europap, particularly sex workers but also project workers, constantly found themselves having to assess the risk of disease "against the grain" of common prejudice, sorting "real" risks from blame and stereotyping. They also talked of a range of occupational hazards. Without exception, risks of HIV or other infections were associated with problems of safety that might lead to assault, abuse, loss of earnings and criminal records. What then was the overall relevance of HIV risk by comparison with other health problems and what then was the relevance of health in general by comparison with social repression?

Some participants in Europap had argued for an approach focusing exclusively on repression and rights. It is possible that such an approach would have avoided reconstructing stigma because it does not feed into the prevalent discourse on disease and dishonour. Certainly, accounts in the last thirty years have attempted to guide discussion into the realm of labour relations, displacing the emphasis on aberrant sexual relations (or non-relations) that created "sewers" out of prostitute's bodies or reservoirs of "contagion".

Yet, these activities too can contribute to the reproduction of stigma, as indicated in Chapter 2, where the German reforms of labour conditions are considered to have marginalised sex workers once more through creating "special" employment conditions and contracts. Similarly, reports from The Netherlands indicate that

legal workers from within the EU are unhappy about the potential of labour reforms to simply increase surveillance of the workforce.

These different approaches all operate in an environment where labels are associated with stigma, and stigma with a range of health problems. Any work on migration, for example, can reinforce a sense of difference between "migrants" and "others" in which the migrant will be stigmatised. However, it is also possible to challenge these associations through investigating the phenomena to which labels refer. In this chapter we have shown that there is no empirical evidence to support contemporary readings of the "migrant sex worker" as a source of disease. Such evidence makes it more difficult to justify discrimination against migrant sex workers and indeed prompts a more nuanced political reading of the very category.

The most visible change in European sex industries over the past ten years has been increased geographical mobility. This has occurred unevenly, but follows the broad patterns of migration, for example source countries include those experiencing major social upheaval. Sex workers are a diverse group, and many have education and previous work experience but are unable or unwilling to work in very low paid and insecure alternatives. Others have few alternative ways of earning a living given restrictions on the rights of migrants to formal employment.

At the moment of writing, HIV control programmes in Europe are increasingly aimed at migrants in particular rather than sex workers in general. The reasons are to be found in part in the troubles encountered in finding the "core" associating all sex workers with the transmission of disease. But they may also be located in broader concerns about the territorial integrity of Europe, the effects of globalisation and the reshaping of health and other services for new and diverse national populations. The equation of trafficking and sex work has led to support for, and repression of, migrant sex workers just as the earlier core imagery supported and stigmatised sex workers more generally.

The equation of sex work and trafficking has affected campaigns for rights in recent years since a large proportion of workers are illegal migrants. Even liberalisation in countries such as The Netherlands has therefore failed to speak to the majority of the workforce, and may have exacerbated their problems through constructing a legal and an illegal sector in place of previous shades of grey. It appears more legitimate to deport poor women when they are seen as victims of trafficking than when they are

seen as victims of neo-liberal economic policies in search of jobs, following the capital that has recently been rendered so mobile.

The equation between trafficking and sex work legitimises restrictions on the movement of people by assuming, once more, that sex workers are victims who have no choice over what they do, who are bought and sold by criminals or slave traders and who need to be rescued. In line with past legislation, the ostensible focus of this new wave of repression is the agent and often the client rather than the sex worker, but the practical effect is to distract attention away from work conditions, occupational and other rights (Butcher 2003). Clearly, there is little point in arguing about working conditions if you are trying to abolish slavery (prostitution).

The protean imagery of prostitution does not disappear but it has shifted to new sites of danger. The United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 set aside $15bn in aid in May 2003 (House of Representatives, 2003) but only to those that had a policy explicitly opposing prostitution and sex trafficking (as though they were synonymous, see Sec. 301). No funds, it is written, may be used to promote or advocate the legalisation or practice of prostitution or sex trafficking. [8] Comments in the news by Colin Powell even censored entire countries along with NGOs for not putting an end to "trafficking come prostitution".[9] Similar policies and views can be found in Europe. For example, at the end of 2002, a press release from Stockholm claimed, "Sex Industry receives EU funding: This is shown in a preliminary study of the financial support from EU to projects and organisations that are advocating legalisation of prostitution…" (Marianne Eriksson, Vansterpartiet, referring to Europap along with other networks for AIDS prevention).[10] This reporting threatens to undermine European Commission funding for projects that look broadly at health and have concluded that HIV prevention can be tackled as much by advocating worker' and migrants' rights as through leaflets on condom use.

The Europap debate had asked how to address stigma. As we have shown, views changed over time in the AIDS epidemic and, as we show in the next chapter, they also changed during the course of individual careers. However, much also stayed the same. It seems that the major risk for HIV in sex work continues to be injecting drug use. Even though migration is not a risk, it has provided a new rationale for continuing repression of all sex work together with appropriate service provision. Concerns about

migration provide new grounds for continuing to ignore sex worker claims to occupational, civil and human rights.

It will be hard to combat discrimination specific to sex workers along with the inseparable, multiple, overlapping attacks on expendable, mobile and disadvantaged populations. Immigration laws across Europe arguably affect more sex workers than prostitution-specific legislation and, of course, there are very many more poor migrants who work outside the sex industry. In this environment, the reconstruction of a "dangerous" core of the most different or deviant others, migrant sex workers, overlaps with restrictions on migration in general and concerns about the shape of the world today. So it is that the more things change, the more they stay the same: sex work continues to provide potent images of danger and anxiety.

Notes

[1] Europap health research group (2000-2001): Jacinta Azevedo, Sophie Day, Pippa Greer, Raija Laisi, Ruud Mak, Paula McDonnell, Angeles Rodriguez, Irene Santo, Thérèse van der Helm, Bettina van Heusden, Helen Ward.
[2] A sociological and epidemiological study of female sex workers, co-ordinated by Peter Piot, Antwerp (1989-1991; supported by DGXII, European Commission).
[3] Participating projects: PASOP (Ghent, Belgium), Protukipiste Prostitute Counselling Centre (Helsinki, Finland), Baggot Street Health Clinic (Dublin, Ireland), Counselling Centre (Lisbon, Portugal), Medicos del Mundo (Madrid, Spain), The Intermediary Project, Municipal Health Service (Amsterdam, The Netherlands), Praed Street Project (London, UK). See further below.
[4] There were few injecting drug users in the 2001 survey (22) and data on injecting history was not linked to HIV results in one centre.
[5] We used the CAGE scale based on four questions about alcohol use. (Mayfield et al, 1974)
[6] The question was, "For your age would you describe your state of health as: very good (1), fairly good (2), average (3), rather poor (4), very poor (5)", and we grouped the categories of very good and fairly good for analysis. On average just over 62% of women in the European Union report their health as good or very good according to one study. (EUROPA, 2003)
[7] There are exceptions. For example, a study in Moscow found a prevalence of around 15%, with no significant differences by reported use of drugs: 15.1% of 86 non IDU tested positive for HIV (Salamov & Detkova 2001).
[8] Included are "organizations advocating prostitution as an employment choice or which advocate or support the legalization of prostitution."
[9] BBC News, 11 June 2003: "Fifteen countries have been named by the United States for not making any significant efforts to stop human trafficking, which it describes as a form of modern-day slavery." Notably, the report also warned that problems could develop in post-war Iraq: "In many conflict situations criminal elements have exploited the breakdown of [the] rule of law and the desperation of

vulnerable families, and abducted, forced, or tricked individuals into prostitution." The news item concluded, "For the first time, countries that do not take actions to stop human trafficking face the loss of US assistance." (BBC, 2003)

[10] See also Eriksson, 2004.

References

Alary M. Peeters M. Laga M. Piot P. Van den Hoek A. Van der Helm T. Fennema H. Roumeliotou A. Papaevangelou G. Komarou H. Worm A-M. Cardos J. Azevedo J. Brazao M. Day S. Ward H. Mezzone J. Farrar S. De Andres Medina R. (1993) HIV infection in European female sex workers: Epidemiological link with use of petroleum-based lubricants, *AIDS*;7(3):401-408

Butcher K. (2003) Confusion between prostitution and sex trafficking", *The Lancet*; 361:1983.

Clavo P, Belza MJ, Sanchez F, Rodriguez C, Menendez B, Moral G, Jeref N, Sanz S, Ballesteros J. (2002) Prevalence of STD, HIV and Hepatitis markers and risk behaviour in immigrant female sex workers in Madrid (MoPe C3489), in *Abstract Book of14th International AIDS Conference, Barcelona, July 2002 volume I*, Barcelona: 132.

Day S, Ward H. (1994) Female prostitution and sexually transmitted disease, In Lankinen KS, Bergstrom S, Makela PH, Peltomaa M (eds) *Health and disease in developing countries*. London: Macmillan Press: 95-104.

Doezema J. (1999) Loose women or lost women? The re-emergence of the myth of 'white slavery' in contemporary discourses of 'trafficking in women'. *Gender Issues*;18 (1)23-50.

Harsin J. (1985) *Policing Prostitution in Nineteenth Century Paris*. Princeton: Princeton University Press.

Kelleher C, Friel S, Nic Gabhainn S, Tay J. (2003) Socio-demographic predictors of self-rated health in the Republic of Ireland: findings from the National Survey on Lifestyle, Attitudes and Nutrition, SLAN. *Social Science and Medicine;*57(3):477-486.

Mayfield D, Mcleod G, Hall P. (1974) The CAGE questionnaire: validation of a new alcoholism screening instrument. *Am J Psychiatry*;131:1121-1123

Rodriguez C, del Romero J, Clavo P, Ballesteros J, Lillo A, Sanabria A, Castilla J. (2002) Decline in prevalence of HBV and HIV serologic markers and co-infection among voluntary testers. Madrid 1988-2000 (ThPe C7522), in *Abstract Book of14th International AIDS Conference, Barcelona, July 2002 volume I*, Barcelona: 466.

Rosenberg MJ, Weiner JM (1988) "Prostitutes and AIDS: A Health Department Priority?" *American Journal of Public Health* 78 (4): 418-423.

Thomas J C;Tucker M J. (1996) The development and use of the concept of a sexually transmitted disease core. *Journal of Infectious Diseases*;174(Suppl 2):S134-43

Walkowitz J. (1990) Prostitution and Victorian Society: Women, Class and the State, Cambridge: Cambridge University Press.

Ward H, Day S, Green A, Cooper K, Weber J (2004). Declining prevalence of STI in the London Sex Industry, 1985 to 2002. Sex Transm Inf (in press).

Wigfield S. (1972) 27 years of uninterrupted contact tracing: The `Tyneside Scheme', *Brit. J. Vener. Dis*. 48, 37-50.

Yorke JA, Hethcote HW, Nold A. (1978) Dynamics and control of the transmission of gonorrhea, *Sex Transm Dis* 1978;(5):51-56.

Websites and unpublished reports

BBC (2003) *US names human trafficking offenders*. Published Thursday, 12 June, 2003. **http://news.bbc.co.uk/go/pr/fr/-/1/hi/world/americas/2983222.stm** (accessed November 2003)

Eriksson M (2004). European Parliament Committee on Women's Rights and Equal Opportunities. Draft Report on the consequences of the sex industry in the European Union, 9 January (Rapporteur Marianne Eriksson). http://www.europarl.eu.int/meetdocs/committees/femm/20040119/519398en.pdf (accessed Jan 2004)

Europa (2003). Activities of the European Union: summaries of legislation; Public health: women's health. http://europa.eu.int/scadplus/leg/en/cha/c11558.htm (accessed November 2003)

Europap (2003). http://www.europap.net/ (accessed November 2003)

European Centre for the Epidemiological Monitoring of AIDS. (2002) *HIV/AIDS Surveillance in Europe*: Mid-year report 2002: No 67. http://www.eurohiv.org/AidsSurv/Rapport_67/contentsGB.htm (accessed November 2003)

House of Representatives (2003) *US leadership against HIV/AIDS, tuberculosis and malaria act, 2003* Resolution HR 1298 http://thomas.loc.gov/cgi-bin/query/D?c108:2:./temp/~c108CVxqg5 (accessed November 2003.)

Salamov GG, Detkova NV. (2001) HIV infection, viral hepatitis and syphilis in prostitutes, *Epidemiology and Infectious Diseases* (in Russian) 1:20-22, cited in European Centre for the Epidemiological Monitoring of AIDS. (2002) *HIV/AIDS Surveillance in Europe*: End of year report 2002: No 68. http://www.eurohiv.org/AidsSurv/ (accessed November 2003).