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Factors mediating HIV risk among female sex workers in Europe: a systematic review and ecological analysis

Lucy Platt,1 Emma Jolley,1 Tim Rhodes,1 Vivian Hope,1,2 Alisher Latypov,3,4 Lucy Reynolds,1 David Wilson5

ABSTRACT

Objectives: We reviewed the epidemiology of HIV and selected sexually transmitted infections (STIs) among female sex workers (FSWs) in WHO-defined Europe. There were three objectives: (1) to assess the prevalence of HIV and STIs (chlamydia, syphilis and gonorrhoea); (2) to describe structural and individual-level risk factors associated with prevalence and (3) to examine the relationship between structural-level factors and national estimates of HIV prevalence among FSWs.

Design: A systematic search of published and unpublished literature measuring HIV/STIs and risk factors among FSWs, identified through electronic databases published since 2005. ‘Best’ estimates of HIV prevalence were calculated from the systematic review to provide national level estimates of HIV. Associations between HIV prevalence and selected structural-level indicators were assessed using linear regression models.

Studies reviewed: Of the 1993 papers identified in the search, 73 peer-reviewed and grey literature documents were identified as meeting our criteria of which 63 papers provided unique estimates of HIV and STI prevalence and nine reported multivariate risk factors for HIV/STI among FSWs. The review shows how HIV remains low among FSWs who do not inject drugs. Injecting drugs is the primary individual-level risk factor for HIV among FSWs in Europe and HIV is highest in the East where prevalence among people who inject drugs is also high.

Conclusions: Findings show that HIV prevention interventions should be nested inside strategies that address the social welfare of sex workers, highlighting in turn the need to target the social determinants of health and inequality, including regarding access to services, experience of violence and migration. Future epidemiological and intervention studies of HIV among vulnerable populations need to better systematically delineate how microenvironmental and macroenvironmental factors combine to increase or reduce HIV/STI risk.

ARTICLE SUMMARY

Article focus

- A systematic review to identify and synthesise the prevalence estimates and risk factors for HIV and selected STIs among female sex workers (FSWs) in Europe.
- An ecological analysis to examine the relationship between structural-level risk factors and national estimates of HIV prevalence among FSWs in Europe.

Key messages

- The review shows how HIV remains low among FSWs who do not inject drugs. Injecting drugs is the primary individual-level risk factor for HIV among FSWs in Europe and HIV is highest in the East where prevalence among people who inject drugs is also high.
- FSWs are vulnerable to multiple forms of violence as well remain sexually vulnerable. Interventions need to address broader occupational and personal health concerns, including location where sex is sold, tackling violence, as well as low levels of condom and contraceptive use with non-paying partners.
- Targeted interventions need to be embedded within broader structural policies that improve the social welfare of sex workers and tackle social determinants of health, including improving access to services, reducing harms associated with enforcement and migration.

INTRODUCTION

While globally the number of new HIV infections has declined over the last decade, in Europe they have continued to increase. By 2012 there were over 1.5 million individual HIV case reports, with over half a million diagnoses reported in the Past 5 years. The epidemiology of HIV in Europe suggests a concentrated epidemic with the burden of HIV cases among men who have sex with men in the West and people who...
inject drugs (PWID) in the East. The epidemic in the East is fuelling the continuing increase in new HIV cases in Europe: between 2006 and 2011 an average of 273 cases per million people were recorded in the East compared with 74 and 11 in the West and Centre, respectively. While drug injecting is the main exposure in Europe: between 2006 and 2011 an average of 273 cases per million people were recorded in the East compared with 74 and 11 in the West and Centre, respectively. While drug injecting is the main exposure...
combined the MESH terms “sex worker” and “prostitute” with the free words “sex work*” “prostitut*”, “entertainment worker*”, “(exchang* adj3 sex)”, “(sell* adj3 sex)”, “(sold* adj3 sex)”, “(sex adj3 money)”, “(transaction* adj3 sex)”, “(commerc adj3 sex)”, “(surviv* adj3 sex)”, “(sex adj3 drug*)”, “sex trade”, “sex industry”, “(sex* servic*)”, “brothel*”, “red-light”, “solicit*”, “bar girl*”, “hostess*”, “escort*”, “masseu*” with “OR”.

Reference lists of found articles were also searched and experts in the field consulted to identify other relevant studies. We conducted a systematic search of websites of research institutes, service providers and donor organisations working with SWs across the region. Conference abstracts from the International Conference on the Reduction of Drug-Related Harm were searched (2005–2010) and the International AIDS Conference (2006, 2008 and 2010). Where no HIV estimates were available we also looked further back and included estimates published up to 2000.

Study selection and eligibility
We included reports written in English, Spanish, French and Russian published from 2000 to 2011 based on studies undertaken in WHO-defined Europe that reported rates on: HIV prevalence or incidence; syphilis, chlamydia and gonorrhoea. A FSW was defined as a woman who has ever exchanged sex for money, drugs or goods. Studies were included if they reported crude or adjusted associations.

Papers were excluded if they reported a sample size less than 50 (except in countries where limited data were available) had unclear sampling methods, or they contained no primary data, although the references were searched to gather primary studies not identified by the search. Papers not fitting the inclusion criteria were set aside to aid interpretation of the systematic review findings. Figure 1 summarises the papers searched and retained in the review. Following full-text review 73 peer-reviewed and grey literature documents were identified as meeting our criteria of which 63 papers provided unique estimates of HIV and STI prevalence and nine papers report multivariate or univariate risk factors for HIV/STI among FSWs.

One author (LP) extracted data on: survey year; recruitment location; sample size; geographical coverage; condom use with clients and non-paying partners; experience of violence from clients or police and injecting drug use. The heterogeneity of studies with regard to definitions of sex work, sampling strategy and geographical diversity precluded statistical meta-analysis. We therefore undertook a narrative synthesis and described prevalence of HIV and STIs, presenting adjusted and
unadjusted associations differentiating between structural and individual-level risk factors. ‘Individual’ level factors were defined as those exogenous to the individual and his or her agency or practices, whereas ‘structural’ factors were defined as those exogenous to the individual and/or indirectly linked to individual agency or practices. We therefore incorporate all forms of social and environmental factors potentially affecting risk within the category of ‘structural’. We acknowledge at the outset unavoidable limits in distinguishing ‘individual’–level from ‘structural’–level factors given how these inevitably interplay, often indirectly and non-linearly. Our review conformed to the PRISMA checklist for systematic reviews.

Ecological analysis
Two authors (EJ and LP) independently assessed the quality of the studies reporting HIV prevalence estimates using a scoring system that graded the papers according to: sample size; wide geographic coverage; most recent study; population sampled and recruitment setting. We allocated up to three points each for most recent studies, population sampled, country coverage and for the range of settings sampled, and deducted one point for clinic only samples due to the potential for bias. ‘Best’ estimates were used to facilitate comparison of HIV prevalence estimates across the region. Linear regression models were used in order to assess the relationship between the outcome and the explanatory variable to examine the association visually. As well as allowing us to judge the existence of an association, in the event of an observed association it allowed us to judge the appropriateness of a straight line for representing the relationship or whether another type of relationship may exist between the outcome and explanatory variables. Separate regressions were run that focused on the central 50% of observations excluding extreme values that could unduly influence the linear regression model. All analyses used STATA V.12 (Stata Corp, College Station, Texas, USA).

RESULTS

HIV among FSWs
HIV prevalence among FSWs in West Europe is generally low, at 1% or less. Prevalence was higher in Italy and Spain among street samples that included migrants and transgender SWs. Prevalence of HIV is low in countries in Central Europe between 1% and 2% and in East Europe consistently higher ranging between 2.5% and 8% in Azerbaijan (Baku), 46 47 4.6% in Moldova (Chisinau) and 7.6% in Estonia (Tallinn). A lower prevalence was reported in Georgia and Armenia at less than 2%44 40 and 0% in Lithuania and Belarus. A higher prevalence was reported in 2009 in Minsk (Belarus) of 6.4%, where 15.5% of the sample reported injecting. In both the Russian Federation and Ukraine, prevalence varied significantly by city ranging from 2% to 62% in Tomsk and Togliatti, Russia and between zero in Uzhgorod, Kharkov and Chernitz and 42% in Donetsk, Ukraine. In the Netherlands, HIV prevalence was reported at 3.8% overall but far higher among women with a history of injecting drug use (13.6%) compared with those without (1.5%). In Spain, Portugal and the UK small samples of FSWs suggested higher HIV prevalence ranging between 4% and 24% among heroin or crack users. However, in the East in Azerbaijan (Baku), Moldova (Chisinau) and Estonia (Tallinn) high HIV prevalence was reported (2.5–8%) despite relatively lower levels of drug injecting (<10%). All studies are presented in table 1. Where multiple estimates are available the range of estimates are presented alongside the ‘best’ estimate.

Syphilis
Table 2 summarises prevalence of STIs. Prevalence of syphilis is highest among samples of FSWs in the East. Across the region, prevalence of syphilis is higher than HIV with the exception of Ukraine, although this varied considerably at a city level. In 2001, a high prevalence of syphilis was found among a group of migrant street SWs in Italy (12%), these cases were among migrants from Eastern Europe (countries not specified) and infection was attributed to past infection at home. In Greece there were no cases of HIV among off-street working FSWs in Athens, but a high prevalence of syphilis was observed (18%). Among this sample 20% were migrants from East Europe but prevalence did not differ by country of origin. In Russia and Moldova the data suggest a concurrent epidemic of syphilis and HIV among FSWs, with all such study samples including FSWs who inject drugs.

Chlamydia and gonorrhoea
Across West Europe, prevalence of chlamydia remains low at under 7% among FSWs. Two older studies in Italy suggested a prevalence of 14% of chlamydia among migrant FSWs and a high prevalence (45%) among off-street as well as street working FSWs in three cities in Serbia (Kosova) among samples recruited from STI clinics. Prevalence of gonorrhoea is reported at 5% or less across the region, with the exception of Georgia (12–18%) and a prevalence of chlamydia of just over 20%.
<table>
<thead>
<tr>
<th>Country</th>
<th>Area</th>
<th>Population sampled</th>
<th>Survey year</th>
<th>Studies</th>
<th>Injecting drug use</th>
<th>HIV (%)</th>
<th>Non-condom use</th>
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</thead>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>n</td>
<td>Range</td>
<td>Best</td>
<td>Violence</td>
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<td></td>
<td>n</td>
<td>Range</td>
<td>Best</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Austria</td>
<td>3</td>
<td>STI clinics</td>
<td>2002</td>
<td>1</td>
<td>1184</td>
<td>3%</td>
<td>1–4†</td>
</tr>
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<td>Belgium</td>
<td>1</td>
<td>N/A</td>
<td>2008</td>
<td>1</td>
<td>1016</td>
<td>N/A</td>
<td>0.3</td>
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<tr>
<td>France</td>
<td>1</td>
<td>Chinese sex workers</td>
<td>2008</td>
<td>1</td>
<td>46</td>
<td>N/A</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Germany</td>
<td>Nat</td>
<td>STI/VCT/private clinics</td>
<td>2002–2010–2011</td>
<td>2</td>
<td>290–3830</td>
<td>3%</td>
<td>0.2–0.3</td>
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<tr>
<td>Greece</td>
<td>1</td>
<td>STI clinic (migrants)</td>
<td>2005</td>
<td>1</td>
<td>299</td>
<td>0</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Italy</td>
<td>4</td>
<td>Street SWs at STI clinics</td>
<td>1992–2008</td>
<td>4</td>
<td>118–558</td>
<td>9%</td>
<td>1.6–8</td>
</tr>
<tr>
<td>The Netherlands</td>
<td>2</td>
<td>Street and off street*</td>
<td>2002–2005</td>
<td>2</td>
<td>399–1018</td>
<td>16%</td>
<td>0.5–13.6</td>
</tr>
<tr>
<td>Norway</td>
<td>1</td>
<td>Specialist STI clinic (MSWs)</td>
<td>2008</td>
<td>1</td>
<td>746</td>
<td>N/A</td>
<td>1</td>
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<tr>
<td>Portugal</td>
<td>1</td>
<td>Street (migrants)</td>
<td>2000–2001</td>
<td>1</td>
<td>96</td>
<td>50–60%</td>
<td>55%</td>
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<td>4</td>
<td>Street (migrants)</td>
<td>1998–2004</td>
<td>5</td>
<td>301–3149</td>
<td>1%</td>
<td>0.8–4.5</td>
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<td>Sweden</td>
<td>N/A</td>
<td>Prison</td>
<td>2006–2007</td>
<td>1</td>
<td>45</td>
<td>N/A</td>
<td>2.2</td>
</tr>
<tr>
<td>UK</td>
<td>5</td>
<td>Street/off-street (migrants)</td>
<td>1986–2009</td>
<td>5</td>
<td>25–268</td>
<td>4–96%</td>
<td>4% 0–24</td>
</tr>
<tr>
<td>Centre</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Bosnia and Herzegovina</td>
<td>1</td>
<td>N/A</td>
<td>2007</td>
<td>1</td>
<td>42</td>
<td>N/A</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Bulgaria</td>
<td>3</td>
<td>Street/off-street§</td>
<td>2005, 2008</td>
<td>2</td>
<td>799–874</td>
<td>2%</td>
<td>0.6–1.0</td>
</tr>
<tr>
<td>Croatia</td>
<td>1</td>
<td>NGO</td>
<td>2003–2005</td>
<td>1</td>
<td>43</td>
<td>36%</td>
<td>2</td>
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<tr>
<td>Czech Republic</td>
<td>2</td>
<td>Street</td>
<td>1999–2000</td>
<td>2</td>
<td>585–797</td>
<td>10%</td>
<td>0.1–0.7–1.2%</td>
</tr>
<tr>
<td>Israel</td>
<td>2</td>
<td>Off-street, illegal migrants</td>
<td>2008¶</td>
<td>2</td>
<td>43–300</td>
<td>0.1%</td>
<td>0–0.3</td>
</tr>
<tr>
<td>Hungary</td>
<td>N/A</td>
<td>Mobile clinic</td>
<td>2006</td>
<td>1</td>
<td>500</td>
<td>N/A</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Macedonia</td>
<td>Multi</td>
<td>N/A</td>
<td>2005–2007</td>
<td>3</td>
<td>48–67</td>
<td>7%</td>
<td>0–1.9</td>
</tr>
<tr>
<td>Montenegro</td>
<td>N/A</td>
<td>N/A**</td>
<td>2007</td>
<td>1</td>
<td>133</td>
<td>N/A</td>
<td>0.8</td>
</tr>
<tr>
<td>Poland</td>
<td>2</td>
<td>Clinic and community</td>
<td>2002–2005</td>
<td>2</td>
<td>250–650</td>
<td>2%</td>
<td>0–2</td>
</tr>
<tr>
<td>Romania</td>
<td>1</td>
<td>Street</td>
<td>2006</td>
<td>1</td>
<td>204</td>
<td>22%</td>
<td>1</td>
</tr>
<tr>
<td>Serbia</td>
<td>1</td>
<td>Street/off-street†</td>
<td>2010</td>
<td>1</td>
<td>250</td>
<td>27%</td>
<td>1</td>
</tr>
<tr>
<td>Serbia (Kosova)</td>
<td>1</td>
<td>Street/off-street (migrants‡)</td>
<td>2006</td>
<td>1</td>
<td>157</td>
<td>1%</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Turkey</td>
<td>3</td>
<td>Unregistered FSWs</td>
<td>2006–2007</td>
<td>1</td>
<td>252</td>
<td>2%</td>
<td>0.8</td>
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<tr>
<td>East</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Albania</td>
<td>1</td>
<td>Street/bars</td>
<td>2006</td>
<td>1</td>
<td>90</td>
<td>0.2%</td>
<td>1</td>
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<td>Armenia</td>
<td>Multi</td>
<td>VCT/STI clinics</td>
<td>2000–2007</td>
<td>3</td>
<td>168–250</td>
<td>0.4–1.2%</td>
<td>1% 0.4–1.2%</td>
</tr>
<tr>
<td>Azerbaijan</td>
<td>2</td>
<td>Street/off-street</td>
<td>2003–2008</td>
<td>2</td>
<td>200–300</td>
<td>1%</td>
<td>2.5–8.5</td>
</tr>
<tr>
<td>Belarus</td>
<td>1</td>
<td>Street/STI clinics</td>
<td>2004–2009</td>
<td>3</td>
<td>208–481</td>
<td>15.5%</td>
<td>15%</td>
</tr>
<tr>
<td>Estonia</td>
<td>1</td>
<td>Street/off-street (RDS)</td>
<td>2005–2006</td>
<td>1</td>
<td>227</td>
<td>7%</td>
<td>8</td>
</tr>
<tr>
<td>Georgia</td>
<td>2</td>
<td>Street/off-street (TLS)</td>
<td>2002–2009</td>
<td>7</td>
<td>114–160</td>
<td>1–6%</td>
<td>6% 0–1.9</td>
</tr>
<tr>
<td>Latvia</td>
<td>2</td>
<td>Street/off-street</td>
<td>2002–2004</td>
<td>2</td>
<td>92–990</td>
<td>53%</td>
<td>16–18</td>
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<tr>
<td>Lithuania</td>
<td>2</td>
<td>Street/AIDS centre</td>
<td>2005–2007</td>
<td>2</td>
<td>67–101</td>
<td>1%</td>
<td>0 (0)</td>
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<tr>
<td>Moldova</td>
<td>4</td>
<td>Harm reduction and RDS</td>
<td>2001–2009</td>
<td>4</td>
<td>151–300</td>
<td>11%</td>
<td>2.9–8.5</td>
</tr>
</tbody>
</table>

Continued
<table>
<thead>
<tr>
<th>Country</th>
<th>Area</th>
<th>Population sampled</th>
<th>Survey year</th>
<th>Studies n</th>
<th>Injecting drug use</th>
<th>HIV (%)</th>
<th>Non-condom use</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Russian Fed</td>
<td>17 Street STI clinics</td>
<td>2001–2009</td>
<td>9</td>
<td>66–1777</td>
<td>5–100%</td>
<td>8†</td>
<td>20–76%</td>
<td>1–20%</td>
</tr>
<tr>
<td>Ukraine</td>
<td>Multi Street</td>
<td>2002–2009</td>
<td>3</td>
<td>646–3248</td>
<td>15–24%</td>
<td>24%</td>
<td>12.9–20%</td>
<td>13†</td>
</tr>
<tr>
<td>Kazakhstan</td>
<td>6 Community</td>
<td>2005–2008</td>
<td>6</td>
<td>1960–3903</td>
<td>10–18%</td>
<td>12%</td>
<td>0.1–2.5</td>
<td>2†</td>
</tr>
<tr>
<td>Kyrgyzstan</td>
<td>1</td>
<td>2006</td>
<td>4</td>
<td>352</td>
<td>0.4–5%</td>
<td>5%</td>
<td>1.3–1.9</td>
<td>1†</td>
</tr>
<tr>
<td>Tajikistan</td>
<td>5</td>
<td>2006–2008</td>
<td>4</td>
<td>1200</td>
<td>0.3–2%</td>
<td>13%</td>
<td>1.6–3.7</td>
<td>4†</td>
</tr>
<tr>
<td>Uzbekistan</td>
<td>Nat FSWs and MSWs</td>
<td>2003–2007</td>
<td>3</td>
<td>407–2000</td>
<td>0–100%</td>
<td>7%</td>
<td>4.7–58.5</td>
<td>5</td>
</tr>
</tbody>
</table>

*Other refers to all non-paying partners. Seven never using condoms; 8 inconsistent use with steady partner; nine not always using condom for vaginal sex; 10 no condom use at last vaginal sex; 11 no condom use at last commercial sex; 12 inconsistent; 13 never using condoms in last 30 days; 14 inconsistent condom use for vaginal sex in last 7 days and 15 inconsistent for vaginal and anal sex.

†Range provided as sample stratified by FSWs who are registered, illegal FSWs, unregistered FSW and FSWs recruited from STI clinic.

‡Weighted mean.

(1) Physical or sexual violence; (2) physical violence; (3) forced to have sex; (4) ever forced to have sex; (5) experience physical or sexual violence during last year, in Batumi 13% refers to physical violence only; (6) experienced violence or been threatened.

§Includes 16% MSWs +Includes 12.5% Transgender SWs.

††Date of publication, no data available on year of study.

**Includes MSWs (n=14). In Norway and Uzbekistan % MSW in sample not specified.

†††Includes MSWs (22%) and Transsexuals (16%).

‡‡‡Mostly migrants from Bulgaria, Albania, Moldova, Ukraine.

FSW, female sex worker; MSW, male sex worker; N/A, not available; Nat, National β refers to region; RDS, respondent driven sampling; STI, sexually transmitted infection; TLS, time location sampling; VCT, Voluntary Counselling and Testing.
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<tr>
<th>Country</th>
<th>City</th>
<th>Population</th>
<th>Year</th>
<th>n</th>
<th>Syphilis (%)</th>
<th>Chlamydia (%)</th>
<th>Gonorrhoea (%)</th>
<th>HIV (%)</th>
<th>Reference</th>
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<td>West</td>
<td>Belgium</td>
<td>Ghent</td>
<td>Off-street (40% migrants)</td>
<td>1998–2003</td>
<td>950</td>
<td>7</td>
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<td></td>
<td>Italy</td>
<td>Bologna</td>
<td>FSW inc migrants</td>
<td>1995–1999</td>
<td>558</td>
<td>12</td>
<td>1</td>
<td>2</td>
<td>57</td>
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<td></td>
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<td>Migrant FSWs</td>
<td>1998–2000</td>
<td>101</td>
<td>14</td>
<td></td>
<td></td>
<td>87</td>
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<td></td>
<td>Greece</td>
<td>Athens</td>
<td>STI clinic (migrants)</td>
<td>2005</td>
<td>299</td>
<td>18</td>
<td>0</td>
<td>0</td>
<td>32</td>
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<td></td>
<td>Spain</td>
<td>Madrid</td>
<td>FSW inc migrants</td>
<td>1998–2003</td>
<td>66</td>
<td>3</td>
<td>0</td>
<td>29</td>
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<td></td>
<td></td>
<td>Barcelona</td>
<td>FSWs (street)</td>
<td>2002–2003</td>
<td>301</td>
<td>5</td>
<td>4</td>
<td></td>
<td>33</td>
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<tr>
<td></td>
<td>UK</td>
<td>London</td>
<td>Street/off-street (migrants)</td>
<td>2007–2008</td>
<td>268</td>
<td>2</td>
<td></td>
<td>2</td>
<td>1</td>
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<tr>
<td>Centre</td>
<td>Bulgaria</td>
<td>8 cities</td>
<td>Street/off-street†</td>
<td>2005</td>
<td>799</td>
<td>10</td>
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<td>5</td>
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<td>Tel Aviv</td>
<td>FSWs (off-street)</td>
<td></td>
<td>300</td>
<td>6</td>
<td></td>
<td>5</td>
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<td>Belgrade</td>
<td>FSW, MSW, Trans</td>
<td>2010</td>
<td>250</td>
<td>4</td>
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<td>66</td>
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<td>Serbia (Kosova)</td>
<td>Ferizaj, Urosevac, Prizren</td>
<td>Migrant FSWs (street/indoor)</td>
<td>2006</td>
<td>153</td>
<td>45</td>
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<td>Turkey</td>
<td>Ankara, Istanbul, Izmir, Gaziantep</td>
<td>Unregistered FSWs</td>
<td>2006–2007</td>
<td>252</td>
<td>7.5</td>
<td>1.2</td>
<td>2.8</td>
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<td>Registered FSWs</td>
<td>1997–1998</td>
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<td>East</td>
<td>Albania</td>
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<td>Street/bar</td>
<td>2011</td>
<td>90</td>
<td>6</td>
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<td>Azerbaijan</td>
<td>Baku, Gandja, Sumgait</td>
<td>Street/off-street</td>
<td>2001</td>
<td>200</td>
<td>9</td>
<td>3</td>
<td>47</td>
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<td></td>
<td>Kyrgyzstan</td>
<td>Bishkek, Osh</td>
<td></td>
<td>2006</td>
<td>352</td>
<td>34.9</td>
<td>1.4</td>
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<td></td>
<td>Georgia</td>
<td>Tbilisi, Batumi</td>
<td>Street/off-street (TLS)</td>
<td>2002–2006</td>
<td>160</td>
<td>34.1</td>
<td>22–23</td>
<td>12–18</td>
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<td></td>
<td>Russia</td>
<td>Moscow</td>
<td>Street (5% PWID)</td>
<td>2001</td>
<td>147</td>
<td>26</td>
<td>14</td>
<td></td>
<td>47</td>
</tr>
<tr>
<td></td>
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<td>Street (27% PWID)</td>
<td>2001</td>
<td>151</td>
<td>22</td>
<td>15</td>
<td></td>
<td>47</td>
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<tr>
<td></td>
<td></td>
<td>Moscow, Volgograd, Barnaul</td>
<td>Street (100% PWID)</td>
<td>2003</td>
<td>98</td>
<td>16</td>
<td>7</td>
<td></td>
<td>85</td>
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<tr>
<td></td>
<td>Ukraine</td>
<td>15 cities</td>
<td>Street (24% PWID)</td>
<td>2009</td>
<td>2278</td>
<td>4.4</td>
<td>12.9</td>
<td></td>
<td>53</td>
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</table>

*Refers to prevalence of antibodies to *Treponema pallidum* and detect current and past infection with syphilis.
†Includes 16% MSWs TLS.
FSW, female sex worker; PWID, people who inject drugs; STI, sexually transmitted disease; TLS, Time Location Sampling.

Risk factors associated with HIV/STIs

Individual risk factors

Studies conducted in Ukraine and Uzbekistan examining risk factors for HIV among FSWs show more evidence of increased risk associated with injecting drug use.53 82 83 Among FSWs currently injecting drugs, the risk of HIV is higher among those who reported selling sex for drugs and injecting daily,83 and among those injecting home-made drugs in the Russian Federation.76 In Ukraine, having a sex partner who also injects drugs was associated with increased risk of HIV.53 Six studies reported associations with sexual risk behaviours including: unprotected sex with clients; numbers of clients; existence of a non-paying partner and sex with someone living with HIV.22 30 35 48 53 83 One study reported an association between type of contraceptive used and found that those relying on condoms as a main form of contraceptive had reduced odds of HIV compared with those that did not (figure 2).35

Structural risk factors

Four studies found increased odds of HIV associated with working on the street compared with other off-street venues.35 48 53 83 Four studies reported a protective effect of attendance at an HIV prevention programme35 53 88 or contact with an outreach team22 that included STI treatments. However, in Tashkent there was no protective effect from attendance at a needle or syringe programme.83 Two studies that analysed associations between migration and HIV adjusting for confounders suggested no difference in risk between local and migrant FSWs.22 53 Other factors relating to migration were important risk factors for HIV including language skills of migrants and access to health insurance (figure 3).35

Violence

We identified eight quantitative studies that reported experience of violence among FSWs across Europe. Definitions of violence varied, encompassing incidences of enacted physical, sexual as well as threatened violence. Incidences of violence were consistently high across the region, with more than 20% of samples reporting either physical or sexual violence in the last 12 months and some estimates reaching 76% in Russia.47 In Serbia (Kosova) 16% of FSWs reported being forced to have sex against their will in the last

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**Figure 2** Individual level risk factors associated with HIV/STIs among FSWs in Europe.
In Armenia, 30% of street SWs reported a lifetime experience of forced sex and 54% had experienced violence or been threatened by clients in Moldova. Younger SWs may be more vulnerable to violence; in Romania 46% of a sample of FSWs (aged 16–24 years) had been forced to have sex in the last 12 months.

**Condom use**

Condom use with clients was consistently higher among FSWs in West Europe (<17% reported inconsistent condom use with clients) compared with those in the East (0–78% inconsistent use) and Central European countries (ranging between 5% and 38% inconsistent condom use). Across all the countries condom use with non-paying partners was less common than with clients (Table 1).

**Ecological analysis**

Best HIV prevalence estimates were calculated for 39 countries across Europe, with a median prevalence of 1% (IQR 0–8%), and the highest prevalence (18%) reported in Latvia. Across the region the median prevalence of injecting was 6.5%, with the countries of highest prevalence of injecting in Portugal, Latvia and Croatia (see Table 1). Overall there was a higher prevalence of injecting in the East, and Centre than West. The median GINI coefficient was 0.34, with little difference across the subregions. Russia and Macedonia have the highest GINI coefficient, but there is little difference by subregion. The median female-to-male pay differential was 0.6; countries with the greatest pay differential include Norway, Moldova and Hungary. The median number of people imprisoned per 100 000 population is 137, with far higher numbers in the East compared with the other subregions. Kyrgyzstan, Ukraine, Kazakhstan, Belarus and Russia all have prison populations greater than 390/100 000. Across the region, Russia, Slovenia, Spain and Germany have the fewest number of SW targeted services (<0.2/1000 FSWs). Services were defined to include a wide range of sexual health, social support and legal services and exclude standard STI clinics and health services that treat non-sex working populations. Finland, Norway and Luxembourg have the largest number (>2.8). Structural indicators are summarised in the web appendix (Table S3).

There is a clear linear relationship between HIV prevalence among FSWs and increasing levels of injecting drug use across Europe. There is some evidence to suggest that countries with a higher GINI coefficient

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**Figure 3** Structural level risk factors associated with HIV/STIs among FSWs in Europe.
have higher HIV prevalence among FSWs. The graphical
distribution of gender pay differential and HIV prevalence
among FSWs suggests counter-intuitively that HIV
prevalence increases as pay differentials decrease.
Prevalence of HIV among FSWs increased with numbers
in prison per 100 000 population. There was no relation-
ship between HIV and numbers of SW-specific services
(see figure 4). Only injecting drug use (coefficient =
0.22, 95% CI 0.14 to 0.30, R^2=0.5, p ≤ 0.001) and prison
population (coefficient=0.0001, 95% CI 0.00003 to
0.0002, R^2=0.2, p=0.01, data not shown) were statistically
associated with HIV prevalence univariately in a linear
regression model.

DISCUSSION
This systematic review finds that HIV in Europe remains
low among FSWs who do not inject drugs (<1%) and
that drug injecting is the primary individual-level risk
factor for HIV among FSWs. HIV prevalence among
FSWs is highest in the East where prevalence is also
highest among PWID. Within high HIV prevalence
countries, such as Russia and Ukraine, there is a wide
variation in HIV among FSWs at a city level.

While evidence suggests that injecting risk practices
are the main transmission route of HIV among FSWs
who inject drugs,91 it is important to note evidence sug-
gest that sex work is associated with HIV seroconver-
sion among women who inject drugs.92 93 Our
findings underscore the importance of addressing sexual and not
only injecting risk practices among FSWs who inject. In
Estonia, for example, HIV was not associated with drug
injecting among FSWs who had correspondingly lower
hepatitis C prevalence, suggesting less risky injecting
practices.48 A similar pattern has been observed in
Russia: with reduced odds of HCV among FSWs who
inject drugs, but increased odds of syphilis pointing to
the potential for sexual transmission.54 85 In addition,
prevalence of gonorrhoea is between 10 and 100 times
higher than in general population samples,94 suggesting
that FSWs remain sexually vulnerable.

In all countries, where estimates were given, prevalence
of violence was higher than HIV. Emerging evidence
shows how violence may increase risk of HIV, for
example, by reducing self esteem and ability to negotiate
safer practices for fear of further violence, increasing
drug use to manage the stress of violence or forced
relocation of sex work to less familiar or safe areas.14 95–97
Legislation regulating sex work is a key structural deter-
mnant of violence and HIV risk. The practice of crimina-
lising activities related to sex work can reduce
opportunities for communication between FSWs and
often resulting in the concentration of sex work onto the
street.98 99 Several studies showed increased risk of HIV
associated with working on the street35 48 53 and other
evidence has documented increased risk of violence
among street workers compared with off-street
workers.100 Legislation may also influence community
attitudes towards SWs with criminalisation of sex
work reinforcing negative attitudes and violence towards
SWs and hinder the implementation of targeted
services.101 102 The ecological analysis showed evidence
of a clear linear relationship between increasing numbers
of people imprisoned and increased HIV prevalence

Figure 4  Linear association between structural indicators and HIV prevalence among female sex workers.

among FSWs. Prison, an effect of criminalisation of drug use and sex work, is well documented as an HIV risk environment among PWID\textsuperscript{103, 104} and other research has shown that criminalisation and enforcement-based approaches towards sex work can increase risk of both physical and sexual violence against SWs,\textsuperscript{14, 99, 105} as well as risk of STIs.\textsuperscript{12, 85} Despite this there is little quantitative data examining the effect of policing practices or enforcement on experience of violence, HIV or other adverse health outcomes among SWs.\textsuperscript{99}

Our ecological analysis found increased HIV prevalence to link with a higher GINI coefficient, while research elsewhere has also documented how inequalities in wealth may correlate with increased prevalence of HIV, gender inequalities, overall lower life expectancy and illegal drug use.\textsuperscript{106} The association we found between increased HIV prevalence and decreased gender pay differential is counter-intuitive, but may in part be explained by a relationship between the countries of the East with high burdens of HIV and lingering equal-labour, equal-wage policies in the public sector that were originally put in place during the time of the Soviet Union. These data are derived from the ratio of the female-to-male non-agricultural wages, which may not be appropriate in highly agricultural economies in parts of Central and Eastern Europe and Central Asia.\textsuperscript{107} Findings from the systematic review, suggest that while increased risk of HIV is not associated with originating from another country, structural factors such as lack of health insurance or language skills may. Policy changes including the removal of migration policies restricting migrants’ use of health services need to be removed to increase access to services alongside the provision of translated materials and interpreters to facilitate communication.

We found that the presence of services for SWs may be associated with reduced HIV prevalence at certain levels, but when prevalence is higher this relationship becomes less clear. When restricting the analysis to the mid-range number of services, HIV prevalence appears to decline as the number of SW-specific services increase. The scatter of data points around the regression lines are not very evenly distributed, while a relationship may exist between the variables it may not be best represented by a straight line. There is a wealth of evidence globally showing the positive impact of specialist services in reducing risk of HIV and STIs among FSWs.\textsuperscript{12, 108} Countries reporting the fewest number of services include Russia and Germany, with Germany reporting very low prevalence of HIV among FSWs (0.2\%) compared with Russia (8\%). Our estimate of services does not take into account the type of services available or general STI clinics. Evidence from Russia suggests that interventions among SWs who inject drugs in the East, which may inflate the national HIV prevalence estimates used in the ecological analysis. Multivariate analyses examined HIV and STIs as outcomes, with some studies using composite measures of HIV and STIs.\textsuperscript{22, 28, 30, 35} These were included despite different STIs varying in transmission dynamics and lengths of infectivity to examine measures of vulnerability. The paucity of data on HIV prevalence meant that we had to include studies with small sample sizes (France, Macedonia, Sweden, Croatia and Israel) in order to increase the number of countries included in the ecological analysis creating variation in the reliability of national-level HIV estimates. The ecological analysis is further limited in that we cannot infer causality or relationships on an individual level. The descriptive linear nature of the relationships we examined are unlikely to be a true representation of complex, multilevel relationships and the small number of country reports prevented multivariate analysis adjusting for potential confounders is a further limitation.

CONCLUSIONS

In Europe, HIV vulnerability among FSWs links primarily to drug injecting. There is a particular need to monitor prevalence and risk among FSWs who also inject drugs, but not to the exclusion of focusing on the potential for sexual HIV transmission. We find that published epidemiological research lacks explicit focus in delineating structural risk factors potentially indirectly linked to HIV among FSWs, and note the need to better develop such measures. There is a similar tendency regarding research investigating HIV risk factors among PWID.\textsuperscript{2} Our review thus reiterates the need for improving the extent to which epidemiological studies seek to develop measures

LIMITATIONS

By limiting the search to literature published in four European languages we may have missed key studies. All estimates included in the review were rated highly with the exception of Sweden, Bosnia and Herzegovinia and Macedonia. The time frame of search was extended in order to identify better-quality estimates for Italy, Spain, Moldova and Portugal. This increased the range of field work within which data are presented back to 1998. It was also not possible to impose a standardised definition of sex work as an inclusion criterion in the review, since the definition varied widely and the possibility that some studies sampled women no longer engaging in sex work cannot be excluded. It is also likely that the use of TLS or RDS with a focus on recruiting street SWs may results in over-representation of FSWs who inject drugs in the East, which may inflate the national HIV prevalence estimates used in the ecological analysis. Multivariate analyses examined HIV and STIs as outcomes, with some studies using composite measures of HIV and STIs.\textsuperscript{22, 28, 30, 35} These were included despite different STIs varying in transmission dynamics and lengths of infectivity to examine measures of vulnerability. The paucity of data on HIV prevalence meant that we had to include studies with small sample sizes (France, Macedonia, Sweden, Croatia and Israel) in order to increase the number of countries included in the ecological analysis creating variation in the reliability of national-level HIV estimates. The ecological analysis is further limited in that we cannot infer causality or relationships on an individual level. The descriptive linear nature of the relationships we examined are unlikely to be a true representation of complex, multilevel relationships and the small number of country reports prevented multivariate analysis adjusting for potential confounders is a further limitation.
HIV among female sex workers in Europe: a systematic review

of social and structural context. Researching the delineation of causal pathways to HIV transmission demands a shift from binary epidemiological models of simple ‘cause and effect’ to ‘multilevel’ models, which emphasise HIV as an outcome of multiple contributing factors interacting together.19

While interventions and research tend to envisage the health of SWs narrowly in relation to HIV and STIs, our findings show the salience of broader occupational and personal health concerns, including addressing low levels of condom and contraceptive use with non-paying partners and vulnerability to multiple forms of violence especially among FSWs who inject drugs. Public health surveillance systems should be oriented towards monitoring indicators of social context that mediate risk of HIV among FSWs. Targeted HIV interventions should be embedded inside structural interventions that simultaneously address the social welfare of SWs and their social determinants of health to create a supportive environment that facilitates the safer practice of sex work and encourages positive health behaviours.

Contributors LP, TR and VH developed the methodology for the systematic review. LP, AL and VH reviewed the collected literature. LP and VH extracted the data. LR and EJ collated the structural indicators. LP and EJ conducted the data analysis. LP interpreted the data and drafted the manuscript. All authors reviewed the manuscript and commented on the data and interpretation. All authors gave approval for the manuscript to be submitted.

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