“HIV/AIDS and STD prevention and national borders”
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Information paper

on the

Model Programme

“Street work on AIDS prevention in the cross-border area
Federal Republic of Germany/Poland and Federal Republic of Germany/Czech Republic
in collaboration with the Federal Government and the Governments of Saxony,
Mecklenburg-Vorpommern and Brandenburg,
WHO, European Commission, Social Pedagogic Institute”
(“Street work in the cross-border area ...”)

April 1995

The information paper was made possible by the
Federal Ministry of Health of the Federal Republic of Germany
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Addresses 37
Published by
Social Pedagogic Institute, Berlin, 1995
Research Unit
Stresemannstraße 30
D-10963 Berlin
Fax: 030/251 60 94, Tel.: 030/251 60 93
Fax: 0049/30/251 60 94, Tel.: 0049/30/251 60 93
Printed copies
1000

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Printing
Albdruck
Foreword

At conferences on “Bi-national Cooperation in the field of HIV/AIDS and STD Prevention” and problems of cross-border prostitution and drug scenes, participants have often asked for an overview, in the languages of the countries concerned, of the Model Programme presented at those conferences. The Model Programme is called: “Street work for AIDS prevention in the cross-border area Federal Republic of Germany/Poland and Federal Republic of Germany/Czech Republic in collaboration with the Federal Government and the Land Governments of Saxony, Mecklenburg-Vorpommern and Brandenburg, WHO, European Commission, Social Pedagogic Institute” (abbreviated to “Street work in the cross-border area ...”).

In addition, questions have been asked during many discussions with experts from home and abroad about the background to the Model Programme. For instance little is yet known, particularly in Poland and the Czech Republic, of the work going on in the Federal Republic of Germany and other western states under model programmes. There has also been much demand for information on street work as a method of social work.

All these requests and enquiries have prompted us to prepare a multilingual information paper on the Model Programme “Street work in the cross-border area ...” and related issues. Thus the present information paper is more than just a presentation of the Model Programme. It contains sections on the target setting, structure and development of the Model Programme and the first results of the work of the street worker teams. There follows a series of short articles explaining a number of issues that often crop up in connection with the Model Programme.

In accordance with the binational approach of the street worker teams, all the contributions in this information paper are provided in the languages of the states participating in the implementation of the Model Programme, that is to say in German, Polish and Czech. We should like to take this opportunity to thank our translators as well as the Polish and Czech staff members (model workers) who took the trouble to check all the translations, adding to them here and there in the light of their day-to-day work experience.

We should also like to thank all the model workers who, with tremendous dedication, have succeeded in building up contacts in the prostitution and drug scenes and establishing initial cooperation among a wide variety of institutes and organizations on both sides of the border. Thanks to them it has been possible for the first time to make a comprehensive and reliable assessment of what is happening in the region. The coordinator of the Saxony street worker team has played an important role; through her work and activities on the spot she has monitored and crucially supported the teams in the implementation of their mandate.

We should also like to thank our project leader Professor Dr Heckmann and our colleague Rudolf Netzelmann for their support.

Finally a special word of thanks is due to those members of the Federal Ministry of Health and the Robert Koch Institute concerned with the Model Programme. Without them the information paper would not have appeared in its present form.

Dipl.-Soz. Beate Leopold/Dipl.-Soz. Elfriede Steffan

Scientific monitoring of the Model Programme:
SPI Berlin, Research Unit
Introduction

HIV/AIDS is a problem that knows no borders. This has been shown by studies throughout the world and confirmed at international conferences. Where there is any exchange, whether economic, military, cultural, scientific or human, there are sexual relations – and where there are unprotected sexual relations, there are sexually transmitted diseases. The fact and process of the internationalization of the AIDS crisis are finding echoes in the programmes of supranational organizations, for example in the “Europe against AIDS” programme of the European Union and the “Global Programme on AIDS” of the World Health Organization (WHO).

In studying the social and economic impact of AIDS in Europe, we first have to ask “which Europe”? If we mean the Europe of the European Union we are talking, for the time being, of a mere 15 states; if we are considering the Europe of the Council of Europe, we are dealing with the affairs of a faster growing number of member states: and if, finally, we are contemplating WHO’s “European Region” we are already looking at the problems of over 50 Member States.

The Europe of this map reveals a wide variety of different political, economic and social conditions. It extends from Greenland to Vladivostock, from Portugal to Scandinavia; it also covers the Asian part of the former Soviet Union, where the people feel themselves to be Europeans, and for historical reasons it also takes in Turkey and Israel.

The designations and the presentation of material on this map of the WHO, European Region Member States (as at 31 August 1989) do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities or concerning the delimitation of its frontiers or boundaries. Dotted lines represent approximate border lines for which there may not yet be full agreement.
From the point of view of the health care system, and considering that this is an infectious disease of epidemic proportions, there would seem to be a need to draw up a pan-European strategy, a European approach to AIDS policy. Today we know something of the different spread patterns of the epidemic in southern, northern, central and eastern Europe, and we find different political approaches in different parts of the world. Even within the European region there are substantial differences in the approach to, and understanding of prevention. They range from broad target-group-specific primary prevention to mass screening and partner check-ups. While some European states have successfully brought nongovernmental organizations, initiatives and self-help groups into prevention work, others prefer a preventive approach based on traditional control measures by public health services.

If the further spread of HIV/AIDS is to be prevented, neither time nor money should be wasted on measures of questionable value in terms of HIV/AIDS prevention. The low prevalence areas of central and eastern Europe can benefit from the experience and mistakes made in other parts of Europe in the development of sound prevention strategies. For their part, western European states should not adopt a passive wait-and-see attitude, nor should they transfer to other countries, without further reflection, prevention strategies that have worked for them. Only in international dialogue and through concerted action do we have any hope of Europe’s low prevalence areas remaining just that. If we as Europeans fail to learn this lesson we run the risk of the epidemiological patterns of rapidly growing HIV prevalence currently found in parts of Asia developing in Europe too, certainly in the central and eastern parts.

In some border areas within the European Union, and to a still greater extent along the external EU borders with the newly independent states of central and eastern Europe, HIV-relevant border problems are apparent and already the subject of public interest and debate. However, adequate measures in response to these problems are rare. The main obstacle is not a lack of technical knowledge or professionalism, but the continuing shortage of personnel and materials; and, as everywhere, religious affiliations and deep-seated prejudices, which may influence national/regional health policies, must be taken seriously and polarization must be avoided.

For the countries of Europe, their governments, AIDS specialists and health professionals as a whole, it is important to assess the pan-European situation, to highlight successful examples of practical AIDS prevention and to develop cross-border methods of prevention. This should be regarded as preparation for and the initial stage of an overall strategy for Europe which facilitates joint investments in this area of health policy, on which joint interventions can be built, and which reflects a general AIDS policy in harmony with the ethical beliefs and moral traditions of Europe.

Professor Dr W. Heckmann
Model Programme “Street work in the cross-border area ...”

I. Risks in the area of prostitution

The prostitution of foreigners, largely from Third World countries, has been a feature of the prostitution scene in big cities of the Federal Republic of Germany since the early seventies. Despite the unimaginably high cost to the women of travelling to the Federal Republic of Germany, prostitution has often offered them a way out of poverty. The distance from their home countries and the cost of returning has meant that they have had to extend their stay in Germany for as long as possible.

In many cities the health authorities have responded to this development catering to, among others, many foreign women at their venereal diseases counselling centres with a view to preventing the spread of sexually transmitted diseases. The care offered by the medical/venereological services, and in some cases by social counselling services, is available to the prostitutes largely anonymously and free of charge, and is brought to their attention through outreach social work in clubs, bars, etc. and on the streets. Interpreters are often available both at the centres and “in the field”, depending on the nationality most widely represented.

With the unification of Germany and the opening up of borders within Europe prostitution scenes have grown up in the new federal states (former GDR) and in the border regions with the neighbouring countries of Poland and the Czech Republic where many women from Poland, the Czech Republic, Slovakia, Romania, Bulgaria and the CIS countries work. The main incentive in the emergence of cross-border prostitution scenes has been the prosperity gap. The disparity in living conditions is of equal interest to both parties involved in this “business”: for the party seeking to earn money through prostitution, i.e. for the pimps and prostitutes on account of the above-average earnings potential, and for the party seeking to purchase the services of prostitutes, i.e. the clients on account of the above-average services they obtain for their money. Furthermore, the fact of crossing the border has advantages in itself: clients and prostitutes alike can remain anonymous, different legal systems offer greater freedom on one or other side of the border, etc.

With the expansion of prostitution along the borders, an – in places dramatic – increase in sexually transmitted diseases, especially gonorrhoea and syphilis, was observed in the border regions of the Czech Republic. This suggested that within prostitution, too, sexual intercourse was taking place mostly without condoms, hence the higher risk of transmission of STDs and HIV/AIDS. The development of cross-border prostitution was clearly a source of concern from the point of view of HIV/AIDS prevention.

Added to this, the regions on each side of the borders were often not up to coping with these problems. The mainly small borough and rural councils with their low population density either did not have the financial resources and facilities to address these problems adequately, or they did not feel any responsibility for the largely foreign clientele.

But even in metropolises like Berlin, where there is a long tradition of looking after foreign prostitutes, this new generation of foreign prostitutes was difficult or impossible to reach through existing services. With the relative proximity of the borders the prostitutes were commuting on a weekly or daily basis between their homes and the place of prostitution, which made access to them extremely difficult.

II. Risks from intravenous drug use

There are many correlations between drugs such as cannabis, opium/derivatives and synthetic substances, and international borders in general and the borders of former western Europe and the former “eastern bloc” in particular. For one thing, the main trading and smuggling routes for these drugs now...
Intravenous drug addiction  
Addiction to injectable drugs (e.g. heroin, “Polish soup”, “Polish compote”, morphine, etc. Cocaine can also be injected).

HIV risk of intravenous drug addiction  
Information on sexually transmitted diseases and HIV/AIDS  
Appendix: p. 32

Model Programme  
In accordance with the Basic Constitutional Law of the Federal Republic of Germany, the Länder and district and local authorities are responsible for the care of the sick. In response to new challenges such as AIDS, the Federal Government can initiate new programmes or projects to give new impetus to regular care. Through the model work new care concepts are tried out and existing ones developed. Model programmes are always for a fixed term and are scientifically monitored. The present Model Programme builds on substance on this basic idea, but on account of its form of funding is not exclusively a model programme of the Government of the Federal Republic of Germany.

Model programmes as instruments of health promotion  
Appendix: p. 25

Prevention  
(Latin: praevenire – come before) prophylactic measures.

Fundamental thoughts on prevention of HIV/AIDS and STDs  
Appendix: p. 23

pass through eastern Europe to the lucrative markets of western Europe. Secondly, there are areas of cultivation and production centres in the countries of the former eastern bloc. The areas of cultivation produce in the first instance for western markets. In some of these states, for example Poland, drug production has grown up for the domestic market and given rise to specific patterns of use.

Though less apparent than in the field of prostitution, the prosperity gap and differences in legislation on either side of national borders also play an important role for drug users and small dealers. For example, the opium-based substance produced in Poland and known as “Polish soup” or “Polish compote” costs in Poland the equivalent of only DM 1–DM 2 a shot. But the same quantity will fetch up to DM 10 on the neighbouring German market. Small dealers in particular can do good business here. But German intravenous drug addicts, who mostly use heroine to meet their requirements at a cost of several hundred marks a day in Germany, also travel to the border as drug tourists for supplies of the comparatively cheap Polish substances. Polish drug addicts frequently cross the border to finance their drug needs through theft on the German side of the border.

While in the Czech Republic the use of injectable drugs has not played any part so far in the spread of HIV/AIDS, intravenous drug addicts make up the largest group of HIV-infected people in Poland, and in Germany the second largest. A potential intermingling or spread of these scenes could, therefore, with risky behaviour patterns in the use of injecting equipment or in sex, lead to a rise in the incidence of HIV/AIDS.

III. Prevention of HIV/AIDS and STDs through education and the promotion of health awareness  
The Model Programme “Street work in the cross-border area ...” was set up to address and prevent potential infection risks from HIV and STDs through cross-border social work. The proposed form of cooperation with institutions in the neighbouring states of Poland and the Czech Republic was completely uncharted territory.

Along the German borders with Poland and the Czech Republic six model projects were set up to analyse the situation for potential risk factors with regard to HIV and STD transmission and, through street work, to disseminate in the cross-border prostitution and drug scenes information on HIV and STD transmission and the availability of preventive services. In addition, through the model projects a binational cooperation network is to be built up in each region among the institutions and bodies concerned at the various levels in order to be able to offer appropriate assistance to prostitutes and drug addicts.

Target groups  
The target group of this work encompasses all people, irrespective of nationality, who could be at risk directly or indirectly of becoming infected with HIV/AIDS and STDs or might exert influence on events that could lead to the risk of infection:

- women and girls working as prostitutes in the border areas;
- male prostitutes;
- friends and relatives of the prostitutes;
- pimps, club operators, agency staff, etc;
- clients who visit prostitutes in these areas;
- users of intravenously injectable drugs.

Building a cooperative network  
Work on the ground requires a cooperative network of institutions offering screening, counselling and support to the above-mentioned target groups. Institutions concerned with the target groups for other reasons (e.g. police and customs) should be included in the cooperation as far as possible. The organizations concerned are:

- bodies involved in health promotion (local health authorities, doctors, hospitals, AIDS counselling centres, STD counselling centres);
local government bodies (mayors, town councils, public order authorities);
- police and customs authorities;
- others (associations, etc.).

**Funding**

The Model Programme has been made possible through a broad-based alliance of regional, national and international organizations and institutions. The institutions which support and fund it are set out below:

- Commission of the European Communities (CEC DG V);
- World Health Organization (WHO, Global Programme on AIDS, GPA/EURO);
- Federal Ministry of Health (BMG) of the Federal Republic of Germany,
- Ministry for Social Affairs, Health and the Family of Saxony;
- Ministry for Social Affairs of Mecklenburg-Vorpommern;
- Ministry for Labour, Social Affairs, Health and Women of Brandenburg;
- Social Pedagogic Institute (SPI), Berlin

From the outset the Model Programme was planned for a limited period only. It was launched on 15 December 1993 and a fresh application has to be submitted each year. A term of at least three years is the aim.

**IV. Model Programme: its development and structure**

Six project locations were chosen in whose catchment areas prostitution and drug scenes were known or thought to have developed on both sides of the borders. The six project locations are all on the German side of the border for technical reasons. Direct promotion of projects in Poland and the Czech Republic was unfortunately not possible in this case owing to the promotion guidelines of the Commission of the European Communities and of the Federal Republic of Germany. The projects were placed with established organizations operating in the social and health fields in each location.

In total there are 17 staff working in these 6 projects. There are five binational teams with German and Czech or German and Polish members in each. The sixth team aims to become binational. There is one team working in Mecklenburg-Vorpommern (Wolgast), one in Brandenburg (Frankfurt/Oder) and four teams working in Saxony (Görlitz, Zittau, Dippoldiswalde, Oelsnitz).

The Model Programme “Street work in the cross-border area ...”
Funded by: EU, WHO, BMG, Saxony, Mecklenburg-Vorpommern, Brandenburg

SPI, Berlin: Scientific monitoring
RKI AIDS Centre: Training

Monitoring by experts of the Tripartite Commission from Poland, Czech Republic, Germany
Given the complex and sensitive areas of operation and the binational mandate, a special training programme was devised for the staff. It was realized from the outset that it would be difficult to find staff who had a qualification in social work combined with street work experience. In job interviews the focus was therefore placed on applicants’ aptitude for street work, that is, applicants had to be without prejudice vis-à-vis the target groups and possess good interpersonal skills.

Ideally, all the staff members should have been bilingual from the outset, either German/Polish or German/Czech. But this proved impossible to achieve. However, many of the team members do have at least a basic knowledge of the other language and there are joint language courses. Some of the team members also speak Russian which is useful in street work, given the composition of the clientele.

Team members are trained in accordance with the specific requirements of the Model Programme by the AIDS Centre at the Robert Koch Institute (formerly the Federal Health Authority, Berlin) on behalf of the German Federal Ministry of Health.

Scientific monitoring of the Model Programme, which is carried out by the Social Pedagogic Institute (SPI) Berlin, on behalf of the Federal Ministry of Health, comprises reflection and training tasks in addition to evaluation. For example, as well as gathering data for reporting purposes, they arrange team consultations in the field and coordination meetings with the model workers, at which the focus is on an exchange of experience on the work, associated problems and their solution.

For the four model projects situated in Saxony, the Land Ministry for Social Affairs, Health and the Family (SMS) carries out its own coordination, enabling very intensive support of the model projects. Coordination of the Brandenburg and Mecklenburg-Vorpommern teams is carried out by the Social Pedagogic Institute (SPI), Berlin.

**Tripartite Commission**

At the initiative of the Polish AIDS coordinator, a Tripartite Commission was set up to enhance cooperation in the field of HIV/AIDS prevention in the cross-border area between Poland, Germany and the Czech Republic. The Commission is made up of Polish, Czech and German experts who monitor the substantive aspects of the work in the border areas as well as acting as official cooperation partners for the model projects. At the Commission’s first meeting, for example, it was agreed to exchange educational material on HIV/AIDS prevention in order to appraise it for use in the multilingual border areas. Close observation in the regions concerned was also agreed, in addition to the exchange of epidemiological data.

**V. The work of the model projects: progress report 1994**

**Networks**

HIV/AIDS and STD prevention which directly addresses target groups at particular risk cannot be successful without the availability of medical care, legal support and, above all, social support. The project teams of the Model Programme have therefore made their work known in many meetings with institutions on both sides of the borders, especially the method of street working which until then was fairly unusual in these regions. Even in this contact phase some important cooperation partners have been acquired, such as doctors and clinics who are ready to offer prostitutes the necessary check-ups.

In order to deepen and broaden this cooperation all the project teams held regional conferences in November/December 1994 with representatives of specialist institutions and other bodies from both sides of the borders. The further expansion and consolidation of a strong binational cooperation network, which is necessary to the work, will continue to have high priority in future model work.
Regional focuses

On account of differences in regional developments the presentation will be divided into three areas:

− development of prostitution along the German/Czech border (Oelsnitz, Dippoldiswalde and Zittau);

− development of prostitution along the German/Polish border (Frankfurt/Oder, Wolgast and to some extent Görlitz); and

− development of drug scenes in the area around the German/Polish border (Görlitz and to some extent Wolgast).

Work in prostitution scenes along the German/Czech border (Oelsnitz, Dippoldiswalde and Zittau)

The work of the three project teams operating along the German/Czech border focuses on cross-border prostitution.

Since May/June 1994 the teams have been working in the scene making direct contact with prostitutes. As a rule the model workers are in the field twice a week on set days from early afternoon until late in the evening, that is, they go to car parks, street areas, clubs, etc. which are frequented regularly by a number of prostitutes for the purpose of soliciting. Their arrival is now awaited by many women who have specific questions or problems they would like to discuss with the street workers. The street workers distribute educational material on HIV/AIDS and STDs in various languages as well as condoms and water-soluble lubricants, arrange venereological screening and tests for HIV/AIDS and STDs and, where necessary, social support. Many of the prostitutes clearly appreciate the services offered, and the project workers are accepted by both the prostitutes and the pimps. The team workers are often the prostitutes’ only contacts outside the milieu.

Most of the prostitutes contacted had never or hardly ever been for VD screening because they could not afford the fee and the distance they had to travel for free screening was too great. Fear of venereal diseases apparently leads some prostitutes to take penicillin, which is procured for them by the pimps.

This practice, though widespread, is pointless as a protection against venereal diseases and may cause the symptoms of disease to be suppressed or an existing infection to go untreated. Hence there is the danger that infected prostitutes who engage in unprotected sexual intercourse will pass on an infection that they themselves have not noticed. So the teams try to arrange or initiate free (and anonymous) venereological screening and tests.

For example, in collaboration with the local health authority and with financial support from the district administration in Dresden, a mobile screening unit was set up for the Zittau area. With the support of the local health authority, a minibus was equipped for gynaecological/venereological screening and counselling. The health authority supplies one (female) doctor, one (female) nurse and screening materials, and organizes the necessary laboratory work, while the team provides counselling. The mobile screening unit parks in places frequented by prostitutes who are already well known to the prevention teams. The opportunity of free and anonymous screening for HIV and AIDS and the dates and times of screening are publicized in advance by means of flyers.
By now the service is well accepted by the prostitutes. They ask team workers when the mobile screening bus is due to come again and when it arrives the women are already waiting at the appointed stopping places to be examined or tested. To date sexually transmitted diseases have been detected in about 30% of the prostitutes screened. They were then treated by a registered doctor in the Czech Republic.

Another aspect of the work is to initiate venereological screening services for prostitutes. The Czech town of Cheb, for instance, is planning to set up a service on the strength of the team’s work in Oelsnitz.

Another important task for the teams is carrying out prevention campaigns for clients at regular intervals. So far the campaigns have been conducted on the German side of the border, at border crossings, and on the whole have been very well received. The vast majority of clients are German men who either live in the border areas or are staying in the region on business. In future it is planned to approach clients directly in discothèques, restaurants, etc.

**Scene observations**

Observations so far suggest that at least 3000 women are working as prostitutes in the border areas between the Czech Republic and Germany (Saxony). Given the high fluctuation of prostitutes and the impossibility of monitoring all street areas, clubs and brothels all the time, only a rough estimate can be made. It is possible that a great many more women are offering sexual services in this area.

From the observations of the teams and their contact with several hundred *prostitutes* quite a lot has been learned about the situation of women and their HIV/AIDS and STD risks.

The teams estimate that some 40–50% of the prostitutes are *Roma* from Slovakia or Romania and Russian-speaking women, e.g. Ukrainians. Hungarians are occasionally encountered. As a rule, these women have neither a residence permit nor health insurance in the Czech Republic, that is to say, they have to pay for preventive care and any therapy they might need. Between 50% and 60% are Czech women, most of whom live in or around the areas of prostitution. They usually have health insurance, but they normally have to pay for preventive check-ups themselves in the Czech Republic.

As a rule, the women offer sexual services for a starting price of DM 50 per half-hour. All the most commonly sought sexual practices (“manual gratification”, oral, vaginal, anal) and complete undressing are included in the half-hour. Apparently some women are willing in certain circumstances to offer the standard services for DM 30, or as little as DM 20. It is more expensive in hotels where in addition to the standard charge of DM 50 the client has to pay an “overnight fee” of between DM 10 for half an hour to the full overnight charge of DM 80. All in all, compared with Germany, the client here gets a great deal of service for very little money.
Since most of the prostitutes work with pimps, they keep only part of their income. Roma and Ukrainian women in particular frequently have to hand over up to 100% of their earnings to the pimps, who provide them with board and lodging. Some receive a small amount of pocket money as well. However, some women are able to keep a fairly large part of their earnings themselves, in very rare cases up to 100%. Many of the women feed their families by prostitution.

All the prostitutes contacted always try to work only with a condom, although some clients keep offering them more money to work “without”. Some of them claimed not to acquiesce, with few exceptions. But almost all of them always know other women who work “without”. Some prostitutes asked their clients to wear two condoms, as the condoms often tear or burst.

With the low level of vaginal secretion in prostitution, lubricants are important for improving the resistance of the condoms. Yet lubricants are little known, or else creams or oils are used which can destroy condoms. Distributing water-soluble lubricants is therefore an important part of the teams’ work in preventing HIV/AIDS and STD infections among prostitutes.

Some of the prostitutes contacted had only very sketchy knowledge of sexually transmitted diseases. According to the teams, the women do not go regularly for venereological screening. Nor would most of them be able to afford the cost of an examination (the equivalent of DM 60) as they have very little money of their own, and some of them have none at all.

**Work in prostitution scenes along the German/Polish border (Frankfurt/Oder and Wolgast)**

There are two project teams operating along the German/Polish border, mainly in cross-border prostitution scenes. The most striking difference compared with the situation along the German/Czech border is in the structure of the prostitution scenes. As far as we know, there is no street prostitution on any significant scale, yet there is a roaring trade in procurement at filling stations, bars, discothèques and agencies. Prostitution is also on offer in many hotels.

With these hidden structures it was very much more difficult for the project teams to make contacts. But thanks to the intensive work done by the Frankfurt/Oder team in particular, it has now proved possible to overcome some of the barriers.

The work of this team was twofold: first they made repeated visits to contact agencies where they knew there was direct prostitution, until the initial high level of mistrust on the part of the “agents” was overcome and access gained to the prostitutes; secondly, through personal contacts with some clients and prostitutes they were able to access other offers of prostitution.

As a result of the work of this German/Polish team a more accurate picture of prostitution in the border area between Germany and Poland was put together for the first time.

In the meantime the team has acted on the German side as go-between for prostitutes and local authorities. At the team’s initiative, anonymous free screening for prostitutes has now been set up in Frankfurt/Oder by the local public health authority. It is available to all prostitutes irrespective of their nationality.
Scene observations

It is very difficult to estimate how many women are engaged in prostitution along the Polish/German border because of the hidden structures. However, the team managed to establish the existence of about 100 contact agencies in the Polish border area between Szczecin and Gubin alone (concentrated on Szczecin with 60 agencies and Zielona Gora with 20 agencies).

In Zielona Gora the number of prostitutes was estimated at 200–250. Altogether we estimate that there are at least 800–1000 prostitutes working through agencies in this area. The contact agencies obtain clients through male procurers on the streets, advertisements in regional newspapers and leaflets in bureaux de change. But since filling stations, kiosks, snack bars and restaurants also arrange prostitution, the actual number of prostitutes is probably very much higher. Only isolated cases of male prostitution are known.

The vast majority of the women who engage in prostitution in the border area on both the German side and the Polish side, are Poles from various regions of Poland. That means that many of the prostitutes do not have their home in the regions close to the border in which they ply their trade. Occasionally Russian-speaking women, Bulgarians and Romanians are also encountered. Most of the women are between 20 and 25 years of age.

Prices in Germany and Poland are different. On the German side streets prices are known to start at DM 50, for one sexual service only. On the Polish side prices begin at DM 30 to DM 50 and apply, as on the German side, to one service only. The prostitutes are frequently offered DM 80 by German clients for “normal intercourse” without a condom. In German clubs, for example, prices are calculated according to room times. Twenty minutes to half-an-hour costs DM 150 to DM 200, one hour costs DM 300. These prices should be regarded as starting prices, as the prostitute negotiates the sexual service in the room.

In Poland starting prices in the agencies and clubs are DM 80 per hour for any sexual services the client may desire during this period of time. On the streets prices are very much lower. In winter women on the autobahn offer sexual services for as little as DM 25, but in summer from DM 40 to DM 50. The team noticed that sexual services on the streets were sometimes offered for as little as DM 10.

These price differences between the German and the Polish sides of the border are a considerable incentive for the – largely German – clientele to cross the border and take advantage of the sexual services on the Polish side. It can be assumed that the women operating in clubs and agencies on both sides of the border work for an organization or a pimp. How much of their takings the prostitutes can keep for themselves, however, varies widely. In German clubs prostitutes can normally keep half their earnings for themselves, in Poland only one-third or less. But there are also isolated cases of Polish women who work as home helps on the German side and offer prostitution. These women probably work on their own account, since it would hardly be possible for a pimp to supervise this area. Not all prostitutes have prostitution as their sole source of income. Women have been found for whom prostitution is only a secondary occupation.
Since condom use depends in the first instance on client behaviour, the same is true here as of the Czech/German border region. All the prostitutes contacted try to work exclusively with a condom, although some clients repeatedly offer them more money “without”. Some of the prostitutes said they took antibiotics (e.g., penicillin) to protect themselves against venereal diseases which, if anything, suggests non-regular use of condoms.

As already mentioned, lubricants play an important role in enhancing the resistance of condoms in the absence of vaginal secretion in prostitution, but here, too, they are generally unknown. In the Polish border area, too, publicizing water-based lubricants is therefore an important task for the teams for the prevention of HIV/AIDS and STD infections in the sphere of prostitution.

Venereological screening is free in Poland in the larger cities for Polish nationals, but is not available anonymously in venereological institutes. Many of the Polish prostitutes said they went privately to a doctor for screening at regular intervals for a fee of around DM 25. Being foreigners in Poland, Bulgarian and Romanian women and women from the CIS countries cannot be examined free of charge.

On the German side most of the prostitutes are not insured either. Here, too, screening services were insufficient in the border areas with the result that prostitutes would sometimes travel from the Frankfurt/Oder area to Berlin-Charlottenburg, Straubberg and Fürstenwald for screening in the STD counselling centres there. On the initiative of the project team “Bella Donna”, facilities have now been set up on the German side in Frankfurt/Oder. They are available to all prostitutes, irrespective of nationality, and they are anonymous and free of charge. Here, too, the vast majority of the clients are German men and foreign males living in Germany, and in the north Danes, Swedes and Norwegians as well.

**Work in drug scenes in the German/Polish border area**

Of the project teams working under the “Street work for AIDS prevention in the cross-border area …” programme, only the Görlitz team focuses on HIV/AIDS/STD prevention in the context of cross-border drug scenes. Though it can be assumed that the members of the other teams will in the course of their work learn about regional drug scenes, at this stage of the model work they are concentrating on investigating the prostitution scenes.

From Monday to Friday in the early afternoon, the Görlitz team visits the spots where the drug scene usually gathers. Information materials, clean injecting equipment and condoms are distributed, helpful conversations held and testing facilities made known. Arrangements may also be made for therapy and withdrawal facilities. The Görlitz team has obtained a good insight into the lives led by the intravenous drug addicts there.

**Scene observations**

So far the Model Programme only has knowledge of the drug scene in the Görlitz/Zgorzelec area. But there are known to be major drug scenes in other Polish cities as well, for example in Szczecin. On the German side, in regions close to the border, no drug scenes have come to light so far. However, there are estimated to be between 7500 and 9000 people living in Berlin (only about 1 hour’s drive from the Polish border) who are addicted to injectable drugs (largely heroin). A study of nearly 400 intravenous

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**Prevalence**

The prevalence rate is the total number of infected people expressed as a percentage of a defined population or test group.
drug addicts in Berlin found an HIV/AIDS prevalence of 15.1%. There are about 300 intravenous drug addicts in the Polish town of Zgorzelec of which 126 are HIV-positive, according to official statistics. For the whole of Poland an HIV/AIDS prevalence of 4% is assumed on the basis of a study of 800 intravenous drug addicts. Drug dealing goes on at a number of venues in public places, and in the private homes of many drug addicts (mainly “Polish soup” or “Polish compote” and amphetamines). As Zgorzelec is a centre of the southern Polish drug trade, drug users come from other places in the vicinity to buy and sell drugs. Occasionally Russian-speakers are encountered.

Apart from isolated cases of prostitution in the pursuit of drugs acquisition, other drugs-related cross-border phenomena worth mentioning are crime in the pursuit of drugs acquisition and, resulting from it, the occasional detention of Polish drug users in German prisons.

There continues to be some evidence of cross-border drug trafficking: German “drug tourists”, most of whom probably come from areas close to the border, travel to Poland to buy “Polish compote”, and Polish drug users or small traffickers come to Germany to sell drugs. In addition to “Polish compote”, Polish amphetamines are said to be much in demand on the German side on account of their good quality and comparatively low price. Through this drug, too, contact with traffickers and thus access to other drugs could be established. For the time being, however, contacts between Polish and German drug users are still very irregular.

In the future the focus here, too, will be on building up a viable cooperation network with Polish institutions and other bodies. The aim should be a uniform approach to drug users and the establishment of urgently required services to reduce HIV/AIDS risk situations and behaviours. There are, for instance, on the Polish side no emergency shelters for homeless intravenous drug addicts and no anonymous counselling services. On the German side, HIV/AIDS preventive work must be set up, especially in the prisons.

VI. Conclusions and outlook

The most relevant aspects in the emergence of HIV/AIDS risks in border regions are those which relate to the differences between neighbouring states, especially the economic, social, legal and cultural differences.

For example, the prosperity gap along the borders with the countries of the former eastern bloc has led to the emergence of cross-border prostitution, the prostitutes coming from the poorer countries and their clients from the more prosperous ones. Owing to discrimination and stigmatization, prostitutes generally live socially very isolated lives. What is more, the relatively small communities along the borders are often unable to cope with the situation. This is where the Model Programme’s project teams come in.

Since border regions tend to be sparsely populated marginal areas with a correspondingly poor infrastructure on both sides of the border, there has generally been no access to scenes in which high HIV/AIDS/STD risk behaviour must be assumed to prevail. Consequently, one of the most important achievements of the project teams has been to prove that it is indeed possible to make contact with these scenes and to incorporate them in the longer term into prevention work. This success is also crucial to the setting up of binational cooperation networks among various institutions, especially within the social welfare and health care systems, which are necessary to further prevention.

The work of the project teams so far has shown that the activities evolved and the services offered are pointing the way towards getting a grip on the problems.

Close cross-border cooperation is particularly necessary with respect to STD and HIV/AIDS prevention. Readily accessible, free opportunities for counselling, care and medical screening must also be available to
people who do not have the nationality of the country concerned.
Appendix

1. HIV/AIDS and STDs in the participating states

HIV/AIDS in Europe*

A total of 128,267 AIDS cases for the WHO European Region were reported to the European Centre for the Epidemiological Monitoring of AIDS as at 30 September 1994, of which 123,281 were adults and 4,914 children. Forty-four out of fifty countries participated in the survey.

For the first time the total number of AIDS cases among intravenous drug users has attained the number of cases among male bisexuals and homosexuals. The percentage annual increase among homosexual and bisexual men is now lower than among intravenous drug users and heterosexuals.

Spread patterns of transmission methods differ from one country to another. In most European countries homosexual transmission is probable for the majority of AIDS cases. In some countries, for example Italy, Poland and Spain, intravenous drug use represents the predominant risk of infection.

On the basis of national estimates, HIV infections for the WHO European Region were calculated to number around 560,000 at the end of 1993, of which about 60,000 people have already died of AIDS.

* All data: European Centre for the Epidemiological Monitoring of AIDS, Quarterly Report No. 43.

Intravenous drug addiction
Addiction to injectable drugs (e.g. heroin, “Polish soup”, “Polish compote”, morphine, etc. Cocaine can also be injected).

HIV risk of intravenous drug addiction
Information on sexually transmitted diseases and HIV/AIDS

Appendix: p. 32
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* Figures not available on going to press

Total for Romania as at 30.6.1994; including 60 reported cases in 3rd quarter of 1994.
HIV/AIDS in the Federal Republic of Germany

On the basis of the notification obligation for laboratories, a total of 66,617 blood samples tested HIV-positive were reported to the AIDS Centre, after allowing for recognizable duplications. Of these, 47,138 (70.8%) were from men and 10,664 (16%) from women. In 8815 cases (13.2%) the person’s gender was unknown. There may be some duplication in these statistics and one cannot assume that all HIV-infected people have been tested. The total number of HIV-infected individuals in the Federal Republic of Germany is therefore estimated at between 50,000 and 60,000, and the probable number of new infections per year at between 2000 and 3000.

For 67.5% of reported cases (44,950 in absolute terms) no information on the possible method of transmission is available. The distribution of transmission methods should therefore be interpreted with caution. Among reported HIV cases for which an infection risk was given, homosexual or bisexual transmission ranks first in the Federal Republic of Germany with 14.4% (9623 cases), followed by intravenous drug addiction with 9% (5986 cases), heterosexual transmission with a total of 4.5% (3018 cases) and haemophiliacs with 2.8% (1852 cases). Mother-to-child transmission (API) accounts for 680 cases (1%) and blood transfusion for 509 cases (0.8%).

As at 31 December 1994, a total of 12,379 people had been reported to have AIDS in the Federal Republic of Germany since 1982, of which 11,168 (90.2%) were men and 1211 (9.8%) women. Since 1982 a total of 7522 people (60.8%) are reported to have died of AIDS. The AIDS Centre of the Robert Koch Institute, which gathers and publishes the epidemiological data, assumes that about 80% of AIDS cases in the Federal Republic of Germany are registered. About 2000 new cases are expected annually.

More information is available on methods of transmission for people with AIDS. Consequently, the picture of infection risks is much clearer for people with AIDS than for methods of transmission of HIV-infections.

For the 12,379 reported cases of AIDS in Germany, homosexual or bisexual transmission ranks first with 68.1% (8433 in absolute terms) of reported infection risks, followed by intravenous drug addiction with 14.1% (1745 cases) and heterosexual transmission with 6.3% (781 cases). Haemophiliacs account for 3.6% (442 cases) and in 2% of cases (249) infection is attributable to transmission through blood or blood products. Antenatally or perinatally infected children account for 0.6% of cases (75). The method of transmission is unknown in 5.3% of cases (654).

Diagram 1. Method of transmission for reported HIV confirmatory tests in the Federal Republic of Germany
59% of all people with AIDS live in the cities of West Berlin, Munich, Hamburg, Frankfurt/Main, Cologne and Düsseldorf.

* All data: AIDS Centre at the Robert Koch Institute (formerly Federal Health Authority) 1994, Berlin

**HIV/AIDS in Poland**

As at 1 June 1994, a total of 243 individuals in Poland were known to have AIDS; and as at 31 December 1993, 2864 people were known to be infected with HIV.

In estimating the number of unrecorded cases Poland has adopted the general line published by WHO. Accordingly, the actual number of people infected with HIV in Poland is three times as high, that is, between 8000 and 9000 individuals.

Of registered infection risks, intravenous drug addiction (IVDA) ranks first at 70% among the 2864 people in Poland known to be infected with HIV. For about 7% of those tested HIV-positive the method of transmission is assumed to be homosexual or bisexual intercourse, and for 2.6% heterosexual contact (including prostitution) is thought to be the probable cause of infection. Sixteen (0.6%) HIV-infected people are haemophiliacs and 11 HIV-positive cases (0.4%) have received blood. Five cases of mother-to-child transmission are known (0.2%). For 551 cases (19.3%) the method of transmission was not stated.

**Diagram 2. Infection risk of people with AIDS in the Federal Republic of Germany**

- Homo-/bisexual transmission
- IVDA
- Heterosexual transmission
- Haemophiliacs
- Blood transfusion
- Unknown

**Diagram 3. Methods of HIV transmission in Poland**

- IVDA
- Homo-/bisexual transmission
- Heterosexual transmission
- Haemophiliacs/blood transfusion/API
- Unknown

**Prostitution**

Sexual service in return for payment in money or kind.

**Probability of transmission of HIV and STDs in prostitution**

Appendix: p. 24
The majority (59%) of people infected with HIV live in the województwa with the major towns and conurbations: Warsaw, Katowice, Gdansk, Wroclaw, Zielona Gora, Bydgoszcz and Legnica. In Poland, too, more is known about methods of transmission for people with AIDS. Infection risks for those with AIDS give a somewhat different picture proportionally than the transmission methods of people infected with HIV.

Of registered infection risks among the 243 people with AIDS in Poland IVDA, at 44.8%, ranks first ahead of homosexual and bisexual transmission at 39.4%, and heterosexual transmission at 12%. Haemophiliacs and people infected as a result of blood transfusion account for 0.4% of all AIDS cases. The method of transmission is unknown in 2.9% of cases.

**Diagram 4. Infection risks of people with AIDS in Poland**

- IVDA: 44.80%
- Homo-/bisexual transmission: 39.40%
- Heterosexual transmission: 12.00%
- Unknown: 2.90%

* All information: National Institute of Hygiene 1994, Warszawa and European Centre for the Epidemiological Monitoring of AIDS, Quarterly Report No. 43 for infection risks of people with AIDS.

**HIV/AIDS in the Czech Republic***

As at 31 December 1994, a total of 208 people had been registered since 1985/1986 in the Czech Republic as HIV-infected, of which 180 were men and 28 were women. There were 58 known cases of AIDS.

The National Reference Laboratory on AIDS in Prague assumes that the number of unrecorded cases is very high. It estimated the actual number of HIV infections in the Czech Republic to be five to ten times higher than those recorded. If that is so, there could be between 1000 and 2000 HIV-infected individuals in the Czech Republic.

The majority of those infected in the Czech Republic (58.2%) are homosexuals and bisexuals. The infection risk of heterosexual transmission was put at 16.8% of infected individuals. Haemophiliacs account for 8.2% of people with HIV and in 6.7% of cases infection had resulted from blood transfusion. In 1.9% of HIV cases the risk of infection was assumed to be IVDA. In 8.2% of known HIV infections the method of transmission is not known. Recently heterosexual transmission has shown the highest rate of increase for new infections.
Diagram 5. Methods of HIV transmission in the Czech Republic

147 (72%) of all known HIV infections were registered in the capital Prague and in Central Bohemia.

Information on the infection risk of people with AIDS in the Czech Republic gives a somewhat different picture than the methods of transmission for HIV infections.

Though homosexual and bisexual transmission also ranks first (65.5%) among people with AIDS in the Czech Republic, it is followed far behind in second place by infections by blood transfusion (9.1%).

Diagram 6. Infection risks of people with AIDS in the Czech Republic

7.3% of people with AIDS had become infected as a result of heterosexual intercourse, 5.5% are haemophiliacs and 3.6% intravenous drug addicts. The method of transmission is unknown for 9.5% of AIDS cases.

* All information: National Reference Laboratory on AIDS 1994, Prague and European Centre for the Epidemiological Monitoring of AIDS, Quarterly Report No. 43 for infection risks of people with AIDS.
Sexually transmitted diseases in the participating states

For sexually transmitted diseases there are no comparable epidemiological data for the countries covered by the Model Programme, and so we will dispense here with a presentation of available statistics.

In Poland and the Czech Republic until 1989, sexually transmitted diseases were treated only in venereological centres and all data were sent for central statistical recording. Since the fall of the Iron Curtain these diseases can also be treated by registered doctors, though many omit to notify them. The impact on the statistical recording of STDs has been substantial. It is therefore fair to assume that the marked reduction in STD cases shown in the statistics is not a true reflection of the situation.

No reliable data on STDs are available for the Federal Republic of Germany either. This is largely attributable to the different health systems and policies on the reporting of infectious diseases in operation in the two parts of Germany before unification. In the former German Democratic Republic the situation was similar to that in Poland and the Czech Republic in that sexually transmitted diseases were treated predominantly in venereological clinics or only by dermatologists, and the data was sent for central statistical recording.

After unification the health services in the new federal states were reformed in keeping with the system in the old states. Sexually transmitted diseases can now be treated by any registered doctor in the new federal states too.

While STDs continue to be notifiable, clinicians in the new federal states, like their colleagues in the old states, often omit to report cases. It is therefore assumed that in the country as a whole only 10% of gonorrhoea cases, for example, are actually recorded statistically.

What is more, not all the diseases that are significant in this context are covered by the STD statistics. Gonorrhoea and syphilis are the diseases most frequently recorded statistically, but other sexually transmitted diseases such as hepatitis B and papillomavirus infections are not usually mentioned in this connection. So, for the Federal Republic of Germany as well, it can be assumed that statistically recorded STD cases are not a reflection of the real situation.

The WHO Global Programme on AIDS, European Region, has been endeavouring for some time to establish a means of ensuring that national data on STD infections in Europe are recorded on a comparable basis, so that a picture of infections in Europe in this important area can be built up.
2. HIV/AIDS and STD prevention – some fundamental thoughts*

At the present time and for the foreseeable future, it is not possible either to prevent infection with HIV by means of a vaccine or to cure AIDS. Many other STDs, too, are diseases with serious health implications for which, with the exception of hepatitis B, no vaccines are yet available. While it is true that most STDs are treatable, they are often not recognized early enough or they progress asymptptomatically, and are thus passed on unwittingly.

Measures to prevent further HIV and STD infections must therefore target the individual, that is to say, people must be enabled to learn how to protect themselves against an infection with HIV or STDs. Prevention must be based on the principle that individuals are responsible for the consequences of their behaviour to themselves, those closest to them and to society as a whole. The aim of prevention should be to “make the healthier choice the easier choice” (WHO slogan).

Coercive measures and discrimination must be avoided. To treat individuals with dignity and to respect their individuality means inter alia going to meet them at the point they have reached in their development and tailoring the promotion of a healthy lifestyle to very different environments, without making value judgements on them.

Preventive measures which address groups of people thought to be at special risk link different levels:

**Prevention by influencing behaviour**

Interpersonal communication is a particularly effective method for persuading people to change risky behaviour. Moreover, in direct contact the psychological factors and social circumstances that affect an individual’s scope to adopt preventative behaviour become clear.

**Prevention by influencing the individual’s environment**

Individual and collective circumstances can assist as well as hamper efforts to change behaviours. Stabilization of living conditions should therefore be part of prevention work.

**Prevention by dismantling discrimination and criminalization**

Exclusion, discrimination and criminalization impede health-conscious behaviour on the part of the individuals and groups concerned. Prevention should therefore include the dismantling of discrimination and criminalization vis-à-vis groups of people at special risk from HIV/AIDS and STDs, such as drug addicts or prostitutes.

* This account is largely based on WHO’s prevention guidelines, see “Global Programme on AIDS”, Regional Office for Europe (publ.): “Taking up the challenge in the 90’s”, Copenhagen 1991.
3. Probability of the transmission of HIV/AIDS and STDs in prostitution

Prostitutes have always been associated with the spread of venereal diseases, and since the appearance of HIV/AIDS they have been regarded as a means of the spread of this disease as well. They are therefore among the most heavily HIV/STD-screened people in the world.

Various studies have come up with different results depending on the population screened. Some studies have concluded that the occurrence of STDs – and in some countries of HIV/AIDS – is disproportionately high among male and female prostitutes and their sex partners (including clients). Other studies have shown that prostitutes who have good health awareness and get their own way with clients in respect of protection against sexually transmitted diseases, are affected by STDs and HIV/AIDS on only a very small scale, in some cases disproportionately small. These prostitutes are usually said to be “working professionally”. For instance, a number of German studies have concluded that, epidemiologically, the occurrence of HIV/AIDS and STDs is not disproportionately high among professionally working female prostitutes in the Federal Republic of Germany. The European Working Group on HIV Infection in Female Prostitutes, in a European study conducted in 1993, found that HIV prevalence among female prostitutes and the probability of being exposed to the risk of HIV and STDs, is not disproportionately high among those who work professionally. For instance, a number of German studies have concluded that, epidemiologically, the occurrence of HIV/AIDS and STDs is not disproportionately high among professionally working female prostitutes in the Federal Republic of Germany. The European Working Group on HIV Infection in Female Prostitutes, in a European study conducted in 1993, found that HIV prevalence among female prostitutes was not intravenous drug addicts, on the whole, relatively low.

Contrary to a widely held belief, a necessary connection between prostitution and HIV/AIDS and STDs cannot be shown to exist, at least not in many European countries, and it is therefore wrong and amounts to the stigmatization of prostitutes to hold them responsible per se for the spread of HIV/AIDS and STDs.

This does not mean that prevention can be dispensed with in the sphere of prostitution, as the occupation of prostitute carries with it certain risk factors for the transmission of HIV and STDs. On the one hand, sexual practices carry varying risks of infection, for example anal intercourse is riskier than manual gratification. Secondly, there is a correlation between the working conditions of prostitutes and the probability of their being exposed to the risk of HIV and STDs. An insecure or fiercely competitive working environment, such as that observed in the border regions between Germany and the Czech Republic, and Germany and Poland, may mean that prostitutes cannot always get their own way on the consistent use of condoms. There is then a substantially higher risk that prostitutes will become infected with and pass on HIV or other sexually transmitted diseases. Unhygienic working conditions also increase the risk of infection.

Fierce competition on the streets or in the club/brothel increases the probability inter alia of the normal cost/benefit relationship being undercut either by the same service being offered more cheaply or by additional services being offered for the same fee. Additional services usually take the form of supplementary sexual practices or working without a condom. Insecure working conditions, that is, working in places without a social infrastructure and without the possibility of mutual protective measures such as noting the car registration numbers of (violent) clients, increases the probability of prostitutes being the victims of rape and other criminal offences. The absence of washing facilities and toilets makes it well nigh impossible to maintain even a modicum of intimate personal hygiene. Insecure or unhygienic working conditions are mostly to be found in street prostitution. But cheap brothels often do not offer proper standards of hygiene either.

For the successful prevention of HIV/AIDS and other sexually transmitted diseases, the right subjective and objective conditions must prevail in the sphere of prostitution, enabling the individuals involved to take the necessary protective measures. The responsibility lies both with the client and with the prostitute. Experience has shown, however, that responsibility for health is held to lie mainly with the prostitute, not only by the client but by the
public, and not only for her own health but for the client’s as well. The demands made of the prostitutes are as yet significantly higher than those made of the clients.

Crucial to the spread of safe sexual practices are, first, professional patterns of behaviour in prostitution, i.e. awareness of a potential risk of infection and of the precautions available, correct handling of condoms and lubricants, and of course, the consistent use of condoms. Professionalism in prostitution also means skilful handling of the client, in other words, knowing how to offer him attractive alternatives to the risky sexual practices desired, to skilfully “sell” him safer sex, to persuade even the reluctant client to use a rubber, and to master techniques for using a condom without the client even noticing.

Secondly, it is essential for safe working that prostitutes should have the independence and freedom of decision to reject both clients and risky sexual practices. That freedom can be severely restricted by prostitutes’ own drug addiction, their material circumstances or by external pressures. For example, the pressure of having to hand over a certain sum of money to pimps increases the likelihood of concessions being made to clients reluctant to use condoms.

Regional circumstances can also influence prostitutes’ ability to act in a health-conscious manner. The non-availability of medical screening may mean that prostitutes are not informed about their own health status; the absence of social support services may mean that prostitutes do not, for example, report criminal offences perpetrated against themselves to the authorities because they expect only discrimination and not assistance from institutions. The more often a prostitute experiences being deprived of rights and standing outside society, the more limited is her freedom to decide and the greater the likelihood of her being unable to reject risky sexual techniques.

From the point of view of health policy and HIV/AIDS prevention, prostitutes must be empowered to behave in a health-conscious manner. To do so they must be informed about the potential risks of infection and ways to avoid them. But, in addition, their working conditions must be such that they can put this knowledge into practice. In the interests of effective HIV/AIDS prevention, support and opt-out opportunities must continue to be made available to prostitutes.

4. Model programmes as instruments of health promotion

In accordance with the Basic Constitutional Law of the Federal Republic of Germany, the Länder and district and local authorities are responsible for the care of the sick. In order to test new methods or be able to react more quickly to changed situations or new challenges in the health or social fields, special measures can, however, be set up on behalf of the Federal Government or a Land Government. They must be for a fixed term and be scientifically monitored.

In response to the threat of an AIDS epidemic in 1987, for example, seven model programmes were set up within the framework of the “Emergency Programme of the Federal Republic of Germany to Combat the Immune Deficiency Disease AIDS” (1987–1991). The programmes tested different methods of reducing the infection risk to the population in the medical, preventive and social spheres. Alongside education campaigns and medical research, the model programmes were an important instrument in coping with the AIDS crisis in the Federal Republic of Germany.

There were programmes that addressed broad sectors of the population (e.g. “Large-scale model: public health authorities”), programmes that addressed sectors of the population that were thought to be at increased risk (e.g. “Model programme: street work for long-term drug addicts”) and model programmes which were to come up with new findings in the areas of medical research and treatment and the development of adequate prevention strategies (e.g. “Model programme: AIDS and children”, “Model programme: women and AIDS”).

Lubricants
Substances which enhance the lubrication of condoms during intercourse. Fat-soluble lubricants destroy condoms!

Condoms
(also known as sheath, rubber, French letter, etc.) Means of protection against sexually transmitted diseases and pregnancy.

Information on sexually transmitted diseases and HIV/AIDS

Appendix: p. 32

HIV
Human Immunodeficiency Virus.

AIDS
Acquired Immune Deficiency Syndrome.
AIDS is caused by a virus (HIV).

Information on sexually transmitted diseases and HIV/AIDS

Appendix: p. 32

Prevention
(Latin: praeveni – come before) prophylactic measures.

Fundamental thoughts on prevention of HIV/AIDS and STDs

Appendix: p. 23

Outreach social work

Street work – a form of social work

Appendix: p. 26
These model programmes set out *inter alia* to:

- gather data on potentially risky behaviours in certain population groups (e.g. homosexuals, fixers) and combat discrimination against them;
- review the methods and concepts of social work to determine how far they could implement interpersonal prevention strategies in target groups classified as difficult to reach (e.g. open drug scenes);
- set up medical and *psychosocial* care services for HIV-infected people and people with AIDS and integrate them into the health care system, avoiding discrimination;
- carry out medical research into the process of the disease and, in parallel, translate the results into appropriate therapies.

These model measures generated important stimuli which crucially influenced the development of target-group-specific HIV/AIDS prevention as well as psychosocial and medical care for HIV-infected people and people with AIDS in the Federal Republic of Germany.

5. Street work – a form of social work

It is essentially the concept of reaching out to (potential) clients that distinguishes street work from other types of social work. Thus, street workers operate not only inside institutions, they make contacts within the living or working environment of their target groups.

The workplaces of the street worker are essentially the places frequented by the target group, whether it be railway stations, public squares, parks, amusement arcades, discothèques, bars, pubs, red-light districts, leisure amenities for young people or simply the street.

**Typical target groups**

In the Federal Republic of Germany street work is mainly undertaken among socially deprived and excluded target groups, mostly people or groups which are difficult or impossible to reach with conventional counselling and support services.

Typical street work target groups are:

- young people at informal meeting places who avoid conventional youth work amenities;
- gangs of youths, rockers, punks, skinheads, youths prepared to turn to violence;
- the homeless and itinerants;
- drug users in public and private living areas;
- girls and young women in social hot spots;
- female and male prostitutes;
- homosexuals in known meeting places.

As a rule, the street work target groups exhibit a pronounced hostility towards institutionalized social work.

Out of fear or as a result of unpleasant experiences with authorities or charitable organizations, conventional social counselling and support services are often shunned.
Types of work

Many forms of social work (single case work, group work and community work), in varying proportions, go to make up street work. For example, the care and counselling of individual members of target groups plays an important role in the daily routine of street workers. Street workers often target particular groups or pick up on elements of community work, for instance, when they try to prevent stigmatization or exclusion in their target group’s social environment.

Range of action of street work

Building and maintaining a network of contacts in each scene

Building up a network of contacts is one of the principal tasks of every street worker. Making contact can be more offensive or more defensive. The choice of contact strategy will depend on the personality of the street worker, the nature of the job, the work concept and the particular circumstances of the scene in question.

Building and maintaining an institutional network

If they are to be able to offer clients targeted support, street workers must maintain contact with all the institutions that could be relevant to their target group. These would include social, youth or health services, overnight accommodation facilities, women’s hostels, counselling and treatment centres, etc. Thus, without building and maintaining a broad-based institutional network, street work is not possible in the long term.

Task-specific or target-group-specific interventions

Street workers often have an institutionally prescribed mandate, such as crisis intervention in drug emergencies, prevention of violent crime, social reintegration, \textit{HIV/AIDS prevention}, preventive health care, etc. Hence, appropriate intervention options must be evolved to exercise the desired influence within the target group. However, this type of task-specific activity can and should not always be in the forefront, but should be dovetailed with other activities.

General social work

Street workers must have excellent up-to-date counselling skills in as many areas of social work as possible and possess broad-based social pedagogic skills so they can advise their clients on support institutions in the early stages of contact.

Representing the interests of the target group

Street workers are often the first or only people to concern themselves with the affairs of individual members of a scene or entire scenes, consequently they are better informed about the problems of their target group; and so they will represent the interests of those groups in the public domain and vis-à-vis those that hold the (sociopolitical) responsibility.

Concepts and approaches

Individual-based street work

The contact and personal relationship with the (potential) client is uppermost. Street workers minister on an individual basis, that is to say, they provide support as required in crises, counsel on a case-by-case basis, arrange specific assistance or provide moral support. In the Federal Republic of Germany this type of street work is frequently practised in the socially disintegrated drug scene.

Group-based street work

In the first instance, existing groups are addressed or attempts are made to initiate group coherence. This approach is applied in youth work, for example.

Service-based street work

Specific services are offered to the target group. They range from the exchange of syringes in the drug scene, distribution of \textit{condoms}, mobile screening services or special campaigns with the target group.

Multiplier-based street work

The street worker concentrates on initiating a sort of snowball effect, for example by setting up and supporting self-help initiatives. Approaches of this sort have

\begin{itemize}
  \item \textit{HIV} Human Immunodeficiency Virus.
  \item \textit{AIDS} Acquired Immune Deficiency Syndrome. AIDS is caused by a virus (HIV).
  \item Information on sexually transmitted diseases and HIV/AIDS
  \item Prevention (Latin: praevine – come before) prophylactic measures.
  \item Fundamental thoughts on prevention of HIV/AIDS and STDs
  \item Condoms (also known as sheath, rubber, French letter, etc.) Means of protection against sexually transmitted diseases and pregnancy.
  \item Information on sexually transmitted diseases and HIV/AIDS
\end{itemize}
emerged in the field of HIV/AIDS prevention in particular.

The choice of approach varies according to the structure of the scene targeted. For example, for young people within a relatively intact community a more service- or group-based approach would lend itself, whereas for work with socially disintegrated groups such as intravenous drug addicts in big city scenes where crime is high, a more individual-based approach would be more appropriate.

Demands on street workers

Heavy demands are placed on street workers. They must fulfil a number of personal requirements if they are to gain a foothold in the scene, more particularly:

− good communication skills;
− a fundamentally accepting or tolerant attitude towards the target group and norms typical of the scene;
− experience of dealing with the target group;
− ability to cope emotionally with subjects that play an important part in the targeted scene (e.g. sex, violence and aggression, nationalism, addiction and dependence).

In addition, broad-based technical knowledge is required. In the course of their work street workers must be competent both in social counselling (social assistance and other forms of subsistence support) and in the area of psychosocial support (life crises, experience of violence, difficulties with partners, family, sex, etc.).

Finally, mediation work between outsider groups on the one hand and institutions, the body politic and the public on the other requires the sort of personal and professional skills needed to operate in institutional and political contexts, as well as in the field of public relations.

Innovative potential of street work

Street workers are usually well aware of the reputation certain institutions have in the target group and what the decisive reasons are for the (non)acceptance of institutional services. The street worker can therefore give a better idea of the changes that are necessary to improve the low acceptance of certain services and institutions and thus establish better target group orientation.

This large innovative potential can only be properly tapped if institutions recognize that ultimately it is only in the context of a mutual exchange, in which the street workers’ back-up institutions are guided by the needs and interests of the target groups, that a positive influence can be brought to bear.
6. General legal situation of prostitutes

Federal Republic of Germany

The Federal Republic of Germany is a federation comprising sixteen federal states (Länder). (The Länder bordering on the Czech Republic are Bavaria and Saxony; and on Poland, Saxony, Brandenburg and Mecklenburg-Vorpommern. A city state that can be quickly reached from Poland and the Czech Republic is the federal capital of Berlin.)

The exercise of state powers and the performance of state tasks is a matter for the Länder, in so far as the Basic Law makes or admits no other provision. That means that legal provisions and implementing regulations in the same sectors may well, and indeed do, vary from one federal Land to another (e.g. in the health, education and social sectors, police and public order). However, the Länder laws may not be at variance with the Basic Law or any federal laws in force.

There is no special law in the Federal Republic of Germany governing prostitution alone. In various branches of law, however, there are laws dealing with certain aspects of prostitution. Prostitution is prohibited in the Federal Republic of Germany not in general, but only under the particular conditions of paragraph 184a of the Penal Code (Repeated engagement in prostitution in a prohibited place) and of paragraph 184b of the Penal Code (Prostitution harmful to young people).

Even minors who engage in prostitution are not themselves committing a criminal offence. It is the people that promote sexual acts, especially prostitution, by minors that make themselves liable to prosecution (paragraphs 180, 180a of the Penal Code).

The following statutory rules under penal law serve the purpose of suppressing prostitution: “Promotion of prostitution” (Penal Code, para 180a), “Procurement of women” (Penal Code, para 181a), “Trafficking in humans” and “Serious trafficking in humans” (Penal Code, paras 180b, 181); and the statutory rules of the Regulatory Offences Act: “Acts which cause gross offence and nuisance” and “Prohibited practice of prostitution; soliciting for prostitution (Regulatory Offences Act, paras 119, 120). With regard to procurement, a distinction is drawn under the provisions of para 181a of the Penal Code between exploitative, managing and pandering procurement. The penal regulations governing trafficking in humans are intended to improve protection against sexual exploitation under the Penal Code of foreign women and girls in particular. An offence under para 199 of the Regulatory Offences Act is committed by any person who in a public place offers, publicizes or extols opportunities to engage in sexual acts in such manner as to cause nuisance or grave offence.

According to precedents, prostitution is deemed to be an “immoral” occupation. This view often leads, for example, under civil and social law to judgement that discriminates against prostitutes. Thus, according to paragraph 138 of the Civil Code, legal transactions contra bonos mores are null and void. On the basis of the supreme court definition of prostitution as an “immoral” occupation, it is not generally recognized as a job or a service. This means that the conclusion of a health insurance policy stating “prostitute” as the occupation is not accepted by insurance companies. Consequently, prostitutes cannot obtain health insurance if they are truthful about their occupation.

Foreigners from countries other than member states of the European Union who “are in breach of a legal provision or an official order applicable to prostitution” or endanger public health as a result of their behaviour, are liable to prosecution and may be ordered to leave the country (Aliens Act, paragraph 46, subparagraphs 3 and 5).

As a result of the federal structure of Germany, prostitution is regulated differently in different parts of the country. Thus, Land governments can pass statutory orders prohibiting prostitution in certain

City state
City having the status of a federal Land (Berlin, Hamburg, Bremen).

Prostitution
Sexual service in return for payment in money or kind.

Probability of transmission of HIV and STDs in prostitution

Appendix: p. 24
places, either completely or at certain times (Art. 297 Introductory Act to the Penal Code). Such prohibition can cover the instigation and practice of prostitution or only its practice, or it may be restricted to certain forms of prostitution, such as street prostitution. In practice this can give rise both to very strict orders which turn almost the entire urban area into a no-go area for all types of prostitution, as well as to fairly liberal orders which only prohibit street prostitution in certain places at certain times.

As a rule, zone prohibition orders are passed upon application by local authorities, so that different zone prohibition orders may exist within a single federal Land. Breaches of existing orders, i.e. practice and/or instigation of prostitution in a prohibited zone may be punished as a regulatory offence (Regulatory Offences Act, para 120). The amount of the fine to be imposed is laid down in each zone prohibition order. The repeated violation of a zone prohibition order falls within the statutory definition of paragraph 184a of the Penal Code.

Some cities and local authorities regard prohibited zones as not necessary and consequently have not passed any orders of this kind. In Berlin, for example, there are no prohibited zones for prostitution. Prostitutes cannot be prosecuted in this case, not even on account of a regulatory offence within the meaning of para 120 of the Regulatory Offences Act or an offence within the meaning of para 184a of the Penal Code.

In Germany it is the Länder which regulate police law. In principle the police may intervene whenever public safety and public order are under threat. Some Länder associate prostitution with a special threat to public safety and order and have therefore granted the police special powers of intervention in connection with prostitution.

The health sector, too, and with it measures and facilities for the prevention of sexually transmitted diseases, is in principle a matter for the individual Länder. At federal level, mandatory notification of certain infectious diseases and measures to prevent and combat transmissible diseases in humans are laid down in the Federal Control of Epidemics Act. The implementation and detailed formulation of those measures are the responsibility of the Land authorities or the competent health departments. This gives rise to widely varying regulations throughout the country, and consequently to different measures. Even though HIV/AIDS is not explicitly listed in the Federal Control of Epidemics Act, it is a transmissible disease within the meaning of the Act, consequently an order can be passed introducing appropriate measures, where the necessary preconditions have been met.

Certain measures for monitoring the health of prostitutes or services to promote health awareness among prostitutes derive from the Control of Venereal Diseases Act. According to this Act, a person with a venereal disease must seek treatment from a doctor without delay and must not engage in sexual intercourse at the infectious stage. The further spread of venereal disease may constitute the elements of bodily harm (Penal Code, paras 223 ff.). Likewise, the implementation of the Control of Venereal Diseases Act is the responsibility of the Land and local authorities, and has similarly given rise to different measures and sanctions. Thus, in some local authority areas voluntary screening is offered without any threat of sanctions, while in others screening is compulsory for prostitutes. The corresponding modalities and possible enforcement measures are therefore regulated differently in different parts of the country.

Czech Republic

In the Czech Republic legislation is uniform. There is no single law regulating prostitution. A controversial draft bill introduced by the Ministry of Justice (“Measures for the regulation of prostitution”) which provided for the establishment of prohibition zones and the regular medical screening of prostitutes, was rejected by Parliament in autumn 1994.

Prostitution is not prohibited in the Czech Republic either. It is a criminal offence, however, under paragraph 204 of the Penal Code (Procurement) to lead or incite a
person to prostitution (with or without the use of force) or to obtain advantage from prostitution. These offences carry gaol sentences of up to three years. The penalty is substantially higher when the person having been led or incited to prostitution is a minor.

Other provisions of the Penal Code can be applied to a number of acts which are (may be) connected with prostitution. A prostitute could, for example, be prosecuted for causing a “disturbance of the peace” (Penal Code, para 202 subpara 1). In certain circumstances she could also make herself liable to prosecution for “jeopardizing the moral education of the young” (Penal Code para 217). Though the principal intent here is to prosecute those who enable people under the age of eighteen to engage in prostitution, anyone who enables young people to acquire so-called asocial habits or interests may, under the terms of para 217 of the Penal Code, also be called to account.

The elements of the offence of “Deprivation of liberty” (Penal Code para 232) and “Trafficking in women” (Penal Code para 246) do not refer explicitly to prostitution but, like the provisions of the Penal Code mentioned above, may be applied within that field.

People who wittingly or unwittingly spread infectious diseases become liable for prosecution under paras 189 and 190 of the Penal Code. Under para 226 of the Penal Code, any person who “exposes another person, even through negligence, to the risk of infection with a venereal disease” is liable to imprisonment for up to six months. Prostitutes can of course also be in breach of this provision.

The Regulatory Offences Act 200/1990 (67/1993) of the Consolidated Statutes also contains provisions which both relate directly to the offer of sexual services and allow specific acts and behaviours of prostitutes to be classified as criminal offences. Paragraph 47 of the Regulatory Offences Act is of particular relevance in this context. Paragraph 47 subpara 1ch. refers directly to the offering of sexual acts. Under this clause, a violation is committed by any person “who in a place accessible to the public offers to engage in sexual services aimed directly at the gratification of sexual needs or in such place provides such services or organizes their provision”. The penalty for such acts can, under paragraph 47 subpara 2, be a fine of up to 15 000 Koruna. Any person who “publicly causes offence” can be punished under paragraph 47 subpara 1c. The maximum fine is 1000 Koruna.

A regulatory offence in the sphere of health and welfare (para 29 subpara 1h of the Regulatory Offences Act) is committed by any person who “violates a prohibition or fails to fulfil a duty imposed in connection with the prevention and occurrence of infectious diseases”.

**Poland**

In Poland, too, there is only one level of legislation and there is no special act regulating prostitution. Nor is prostitution prohibited in principle, though procuring, pimping and the promotion of prostitution are punishable offences (Penal Code, Art. 174 paras 1, 2) as are acts of indecency and trafficking in women and children in connection with prostitution (Introductory Act to the Penal Code, Art. IX, paras 1, 2).

A regulatory offence is committed by any person who “inopportune, conspicuously or in any other manner which offends against the public order offers another person illicit sexual practices in order to obtain pecuniary advantage” (Regulatory Offences Act, Art. 142). Furthermore, the facts constituting the offence of exposure to the risk of venereal disease can pertain for prostitutes. As in the Czech Republic, any person with a venereal disease who exposes another person to the risk of infection becomes liable to prosecution (Penal Code, Art. 162 para 1).

Similar to the practice adopted in many parts of the Federal Republic of Germany, prostitutes in Poland must go for medical check-ups. For example, an order of the Minister of Health and Social Welfare dated 2 September 1962, which is still in force, stipulates that “persons who are known by the police to engage in prostitution” must undergo medical examination for the purpose
of the detection of venereal diseases. Since the introduction of democracy in 1989, however, the police no longer ensure that prostitutes go for examination.

Under civil law, similarities can be found with German Civil Law and with German case law. In Poland, for instance, legal transactions which violate the principles of social coexistence, are null and void (Civil Code, Art. 58 para 2). Although there are no precedents in this regard, it is customarily recognized that prostitution violates these principles.

The regulations which affect prostitution are not excluded from the amendments foreseen under the planned reform of the Penal Code. There are plans for both easing and tightening the present definitions of criminal offences in connection with prostitution. For one thing, the intent to obtain pecuniary advantage is now linked to the offence of promoting prostitution, and it is planned to reduce the penalty for pimping (new Art. 205 paras 1, 2, 3). But new offences in connection with prostitution are also to be introduced into the Penal Code. For example, the new Penal Code will enact the present Art. IX of the Introductory Act in statutory form (Indecency, trafficking in women and children) and will for the first time make it an offence to induce others by force, threat, trickery or by taking advantage of states of dependence to engage in prostitution (new Art. 204). A date for the passing of the new penal code has not yet been fixed.

7. Information on sexually transmitted diseases and HIV/AIDS

What are “sexually transmitted diseases”?

Sexually transmitted diseases are infectious diseases which are passed from one person to another, mainly through sexual contact.

The following table, which is taken from a brochure of the German Federal Office for Health Education, gives an overview of sexually transmitted diseases, their symptoms, methods of transmission, disease process and points to note. AIDS is also a sexually transmitted disease. The relevant information on HIV/AIDS is given afterwards and is therefore not included in the table.

<table>
<thead>
<tr>
<th>Disease</th>
<th>Symptoms</th>
<th>Transmission</th>
<th>Disease process</th>
<th>Points to note</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-specific vaginitis</td>
<td>In women: watery, grey, fishy-smelling discharge accompanied by wet feeling In men: often only mild inflammation of the glans, reddening</td>
<td>By unprotected sexual contact, often through alternating anal and vaginal intercourse</td>
<td>Often in conjunction with other infections</td>
<td></td>
</tr>
<tr>
<td>Chlamydial infections</td>
<td>In women: one in two women with a chlamydial infection has no symptoms! When symptoms do arise they may include burning sensation when passing urine, pressure in the bladder, generalized abdominal pain, bleeding between periods, yellow, sticky or purulent discharge, pain during intercourse. The symptoms can become chronic if left untreated</td>
<td>Almost always as a result of unprotected sexual contact</td>
<td>Untreated it has serious consequences: inflammation of the fallopian tubes, which may cause infertility In pregnant women: baby infected at birth</td>
<td></td>
</tr>
<tr>
<td>Disease</td>
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<td>-----------------</td>
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<tr>
<td><strong>Genital warts</strong></td>
<td>In men: burning sensation when passing urine, glassy or milky discharge from the urethra. Often symptomless in men too</td>
<td>By unprotected sexual contact</td>
<td>Appearance of warts ca. 3 weeks after infection, but may be months afterwards</td>
<td></td>
</tr>
<tr>
<td><strong>Pubic lice</strong></td>
<td>Itching in the pubic hair, both lice and eggs are visible</td>
<td>Spread by sexual contact, but also from clothes, beds, hand towels</td>
<td>First signs, depending on the severity of the infestation, from a few days to 3–6 weeks after transmission</td>
<td>Clothing must also be treated (disinfected)</td>
</tr>
<tr>
<td><strong>Gonorrhoea</strong></td>
<td>In men and women: burning sensation when passing urine, purulent discharge, reddening. Women only: occasionally breakthrough bleeding, lower abdominal pain. Women may have no symptoms!</td>
<td>By unprotected sexual contact. When the pathogen comes into contact with warm, moist areas: mouth, vagina, penis, anus</td>
<td>In women: the infection remains unnoticed in many women. First signs 2 to 5 days after infection In men: typical signs after 2 to 5 days</td>
<td>Untreated gonorrhoea may lead to infertility</td>
</tr>
<tr>
<td><strong>Hepatitis B</strong></td>
<td>Nausea, loss of appetite, aching muscles, joint pain, itching, lethargy, yellowing of the conjunctiva, pale faeces, dark urine</td>
<td>Via all mucous membranes, i.e. through kissing, petting, unprotected sex, and via cutlery, saliva, blood or sperm</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Genital herpes</strong></td>
<td>Prickling or itching skin, redness, painful urination, burning, discharge, blisters which first itch then burst leaving ulcers</td>
<td>Through unprotected sex</td>
<td>The same for men and women: Blisters appear within 3 to 8 days after infection Burst blisters may lead to inflammation with fever</td>
<td></td>
</tr>
<tr>
<td><strong>Syphilis</strong></td>
<td>Primary phase: painless chancres on the genitals or anus which quickly disappear (does not indicate a cure) Secondary phase: enlarged lymph nodes and general malaise (aches and pains, fever, rash, hair loss) Tertiary phase: serious disorders and organ damage (bones, eyes, brain, heart)</td>
<td>Almost exclusively by unprotected sexual contact, infection is more likely through broken skin</td>
<td>The same for men and women: typical signs appear within 9 to 21 days after infection, the chancres disappear (even when untreated) within 1 to 5 weeks (does not indicate a cure), followed by the secondary phase with external symptoms and non-specific complaints Followed by transition to tertiary phase: damage to internal organs</td>
<td></td>
</tr>
<tr>
<td><strong>Trichomonas</strong></td>
<td>In women: painful urination, greyish yellow, frothy, offensive discharge, itching, burning In men: painful urination, frequent urge to pass urine</td>
<td>By unprotected sexual contact, but occasionally contracted from damp objects (toilets, at saunas and swimming pools, but seldom)</td>
<td>In women: usually clear signs soon after infection In men: infection may go unnoticed</td>
<td>Trichomonas are common</td>
</tr>
</tbody>
</table>
### Disease Symptoms Transmission Disease process Points to note

<table>
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</thead>
<tbody>
<tr>
<td>Chancroid (soft sore)</td>
<td>Painful, occasionally bleeding, purulent lumps or ulcers at the place of entry of the pathogen</td>
<td>By unprotected sexual contact, higher risk for wounds or skin injuries</td>
<td>The same for men and women: typical signs appear within about 3 to 7 days after infection</td>
<td></td>
</tr>
<tr>
<td>Fungal infections (candidiasis)</td>
<td>In women: redness, swelling, itching, a white discharge which may be crumbly, burning, painful urination In men: often fewer symptoms, redness of the glans with raised patches</td>
<td>Fungal infections of the vagina are not normally sexually transmitted: the yeast fungi which cause the infection are present virtually everywhere and may, given a physiological imbalance, lead to signs of disease, e.g. in the vagina. The latter can then be sexually transmitted</td>
<td>In women: clear signs soon after infection In men: less conspicuous signs</td>
<td>Susceptibility to fungi is increased by various drugs, including the contraceptive pill</td>
</tr>
</tbody>
</table>


Both the cumulative occurrence and non-treatment of sexually transmitted diseases can be contributory causes of cancers as late sequelae.

In order to curb sexually transmitted diseases it is important to recognize and treat every infection as early as possible. To that end, there must be health education and the availability of screening tests and therapy which take account of the taboo surrounding sexually transmitted diseases and do not discriminate against people that may be infected.

**What is AIDS?**

AIDS, too, is a disease that can be transmitted by sexual intercourse. There is as yet no cure. AIDS is an abbreviation for Acquired Immune Deficiency Syndrome. It is caused by the Human Immunodeficiency Virus (HIV).

Many individuals who are infected with the virus remain free of symptoms for years. They and others are unaware of the virus, yet HIV can be passed on to others immediately after infection. It can take up to ten years until signs of AIDS-related disease appear. The symptoms are manifold and may include lung infections, chronic vaginal or anal herpes, candidiasis of the mouth and oesophagus, and Kaposi’s sarcoma (a malignant type of cancer). But the clinical picture can only be reliably assessed for a link with AIDS by specially trained professionals.

The virus can cause infection only when mucous membranes come into direct contact with HIV-bearing body fluids such as:
- blood
- seminal fluid, or
- vaginal fluid

or through direct penetration into the bloodstream.

**Infection is possible**

*by sexual intercourse without a condom:*

In all unprotected sexual intercourse there is contact between potentially HIV-bearing body fluids and the mucous membranes in the vagina, bowel and on the penis.

If the concentration of the virus in the body fluid is high enough and the length of contact sufficiently long, transmission occurs. Visible injuries, the presence of blood...
and inflammation of the genitals increase the risk of infection.

Women are more likely to become infected than men during heterosexual intercourse.

* by sharing needles and syringes in intravenous drug use:

Traces of HIV-infected blood left on the needle or syringe are sufficient to pass HIV on to the next user many days later.

* in pregnancy or childbirth from an HIV-infected mother to the child:

It is not possible to predict in any single case the probability of an HIV-infected mother passing the virus to her unborn child. European studies assume an average risk of infection for the unborn child of 15% to 25%. With a course of drugs aimed at inhibiting viral multiplication during pregnancy and birth and, probably, through timely delivery by caesarean section, the risk of infection to the child can be reduced.

Another method of transmission from mother to child is in the mother’s milk. HIV-infected mothers are therefore advised against breast feeding.

* by transfusion of HIV-infected blood or blood products:

The risk of becoming infected from blood or blood products is extremely low in most European countries. All donated blood has been screened for HIV since 1985 in the Federal Republic of Germany, since 1986 in the Czech Republic (or former Czechoslovakia) and since 1987 in Poland. In Poland the demand for blood and blood products is met solely from domestic donations, in other words, no blood is imported. The Czech Republic (and former Czechoslovakia) has not imported any blood since 1986.

It is conceivable in principle that in very few cases an infected blood donation could go undetected. This can happen when blood is donated a very short time after exposure to the virus before antibodies are present which screening tests would detect. The probability of this happening is very remote.

The blood donation services try to detect possible risks by thorough counselling of donors. Blood donations are not taken from individuals who are at higher risk of HIV infection.

Means of protection

* during sexual contact:

In order to prevent transmission of HIV during sexual contact, a condom should be fitted to the penis before penetration of the vagina or anus. Of course the use of a condom also protects against other sexually transmitted diseases.

HIV is not transmitted during other sexual activities such as tenderness, caressing, embracing, massage or mutual masturbation.

* during intravenous drug use:

Syringes, cannulas and needles which others have already made use of should never be employed, only disposable syringes or a personal syringe which is always kept clean.

No casual risk of infection

HIV is only transmitted by an exchange of infected blood, infected sperm and infected vaginal fluid, so

NOT by coughing/sneezing
NOT by insect bites
NOT by sharing utensils.

There is no reason therefore to break off contact with an HIV-infected person for fear of infection or to alter day-to-day dealings.

HIV is definitely not transmitted through day-to-day interpersonal contact. Shaking hands, hugging, communal use of public amenities such as swimming pools and lavatories, even closer contact such as
cuddling and kissing carry no risk of infection with HIV.

There is no risk of infection when caring for an AIDS patient in the home if the normal rules of hygiene in caring for the sick are observed. Normal household hygiene is sufficient to protect against infection.

During contact with blood or faeces and when changing a dressing disposable gloves should be worn. Used dressings can be disposed of with normal household waste, soiled bed linen can be washed in the washing machine using normal detergent.

Should the skin ever come into contact with infected body fluids, it is sufficient to rub the affected area with a standard alcohol-based antiseptic.

**The HIV antibody test**

The test for HIV infection is also known as the “AIDS test”. The test indicates the presence of antibodies which the human immune system forms in response to the virus. If infection has occurred antibodies are present in the blood. In that case, the result of the test is “HIV positive”. A “positive” test result gives no indication of the progress of the infection or the onset of disease.

If no antibodies are found the test result is said to be “HIV negative”. A “negative” test result indicates only the immune status at the time the blood sample was taken and does not mean there is immunity against an HIV infection.

As a rule antibodies are formed within a few weeks after infection. In rare cases, however, they can take three to four months to form. It makes sense therefore to wait four months after the time of presumed infection before going for an HIV antibody test. Before then an infection cannot be diagnosed or ruled out with a sufficient degree of probability. If there are grounds to believe infection might have occurred within the previous four months, the further procedure should be discussed with the AIDS counselling centre or doctor concerned.

An interview with a counsellor should take place before every HIV antibody test to discuss not only whether the test is necessary, but also the consequences of a possible “positive” test result.
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“Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”

Excerpt from the Preamble of the WHO Constitution of 1946