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## POLICY BRIEF

# Reducing the Burden of HIV and HCV among Sex Workers Who Use Drugs in France

**Konstantinos Angoumis<sup>1</sup>, Amanda Langston<sup>1</sup>, Kristin Mosler<sup>1</sup>, Clémentine Rialland<sup>1</sup>, Mathilde Veys<sup>1</sup>, Jessica Neicun<sup>1,2</sup>**

<sup>1</sup> Department of International Health, Governance and Leadership in European Public Health Master, Faculty of Health Medicine and Life Sciences, Maastricht University, Maastricht, the Netherlands. *These authors contributed equally to this work;*

<sup>2</sup> Research Centre, Centre Hospitalier de l'Université de Montréal (CHUM), Montréal, QC, Canada.

**Corresponding author:** Konstantinos Angoumis,  
Address: Brouwersweg 100, 6216EG Maastricht (NL)  
Email: k.angoumis@student.maastrichtuniversity.nl



## Abstract

### Context:

The far-reaching effects of the Covid-19 pandemic exacerbated the adverse working and living conditions of Sex Workers (SWs) in France. These consequences, coupled with illicit drug use, and reduced access to prevention measures raise concerns for the transmission of the Human Immunodeficiency virus (HIV) and Hepatitis C virus (HCV) among Sex Workers Who Use Drugs (SWWUD), creating an urgent call for targeted interventions. There is an acute need for accessible, ongoing care for SWWUD to prevent HIV and HCV infections and mitigate adverse health effects. Current French health services such as harm reduction and HIV/HCV prevention services often operate separately and seldom address SWs and People Who Use Drugs (PWUD) simultaneously. Given the compounding set of challenges that SWWUD face, a holistic approach to policy interventions must be considered.

### Policy Options:

Firstly, integrated services are particularly effective in promoting harm reduction and improving the health of their users. When these services include substance use care and HIV services, uptake of these interventions and primary care utilisation increases due to enhanced accessibility. Secondly, pre-exposure prophylaxis (PrEP) and needle and syringe programs (NSP) are clinically effective prevention methods that, when coupled with point-of-care-testing (POCT), can reduce the prevalence of HIV and HCV and improve the monitoring of these viruses. Finally, willingness to engage with health services is impacted by the attitudes of healthcare staff. Sensitisation training can promote trauma-informed care, a non-judgemental approach in health workers, encouraging SWWUD to seek care and achieve better health outcomes.

### Recommendations:

A three-pronged approach to implementing integrated services is recommended. First, facilitating access to care can be attained through the linkage of patients to treatment, primary care, sexual and reproductive health, and social services. Existing service providers can be supported with interdisciplinary teams and telemedicine to reduce care fragmentation. Additionally, prevention and testing measures can be enhanced through the coordinated provision of needle and syringe programs, point-of-care testing, PrEP, and harm reduction supplies. These services should be linked to established integrated service centres to ensure a continuum of care. Finally, peer leaders may deliver sensitisation training for service providers to reduce stigma and improve understanding of the unique health needs of SWWUD. Integrated service providers should further employ peer leaders as peer navigators to promote the vision of community empowerment and inclusion.

**Keywords:** *Hepatitis C Virus, Human Immunodeficiency virus, Injection drug use, Integrated care, Prevention, Sex workers who use drugs, Stigmatisation, Treatment*



## Introduction

The Covid-19 pandemic has significantly impacted the working and living conditions and health of Sex Workers (SWs) worldwide. This crisis has made apparent the socioeconomic challenges most SWs face due to systematic discrimination and societal exclusion (1). Various lockdown rules and mobility restrictions resulted in the loss of income for many SWs, creating a dangerous cycle of vulnerability (2).

Laws governing sex work in France contribute to the ongoing health challenges faced by those who work in the industry (3). In 2016, the Nordic Model was introduced, which criminalises the purchase of SWs services and positions them as victims (3). This criminalisation is linked to adverse health among SWs, namely, sexually transmitted infections, violence, poor access to health care, and risks of homelessness (4).

Criminalising the purchase of sex services has resulted in fewer clients and, therefore, a smaller client pool for SWs (5). With a decreased bargaining power, SWs who use drugs (SWWUD) are at increased risk of adverse health outcomes (3, 4). Further, SWs have to work longer hours and change

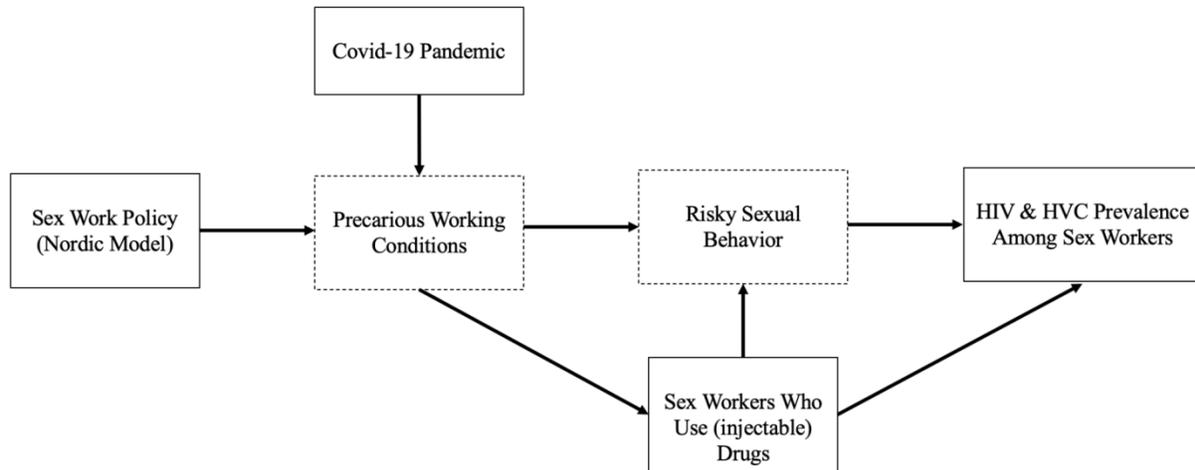
location regularly to avoid law enforcement (5). These changes coupled with an increase in social stigmatisation, have a direct negative impact in accessing healthcare for SWWUD (5).

Under the Nordic Model, SWs, SWs may feel pressured to accede to clients' requests to maintain their income and may engage in activities they previously would not have consented to (5). SWWUD are particularly vulnerable, as the use of drugs while working with unaccommodating clients can diminish their perception of danger and increase their likelihood of engaging in risky behaviors (5, 6). Interviews with SWs in France indicate that substance use has increased to cope with the stress of reduced income and worsened living conditions (5).

As displayed in figure 1, drug use and risky sexual behaviour are linked to increased Human Immunodeficiency Virus (HIV) and Hepatitis C Virus (HCV) prevalence in SWs (6, 7, 8). These challenging circumstances result in complex health and social needs (9). A review of studies conducted in 50 countries found that female SWs face 13.5-fold higher odds of acquiring HIV in comparison to the general population of

reproductive age (10). HCV is primarily transmitted through injection drug use and sexual intercourse, posing a dual risk of transmission for SWWUD (7, 8). Therefore,

there is an urgent demand for targeted interventions to mitigate adverse health outcomes for SWWUD in France.



**Figure 1:** Framework of the relationship between sex work policy and HIV/HCV prevalence among sex workers (adapted from Reeves et al. (6))

### Context

The Nordic model has so far only been implemented in smaller Northern European countries (Iceland, Norway, Sweden, Ireland) where the tradition of outside sex work is less widespread because of the cold weather. Even if considering France as a Southern country is debatable, the French context remains different from that of the countries where the Nordic Model has been implemented so far and the transferability of

these policies is questionable (11). The implementation of the 2016 law is therefore a unique case in this European region where neighbouring countries have for the most part decriminalised and/or regulated sex work (Belgium, Germany, Spain, Switzerland) (11). Despite the intention to protect SWs with this law, a decrease in the use of condoms and increased difficulties continuing treatment for those who are HIV positive have been observed since the



introduction of the Nordic model (5). Some associations working with SWs even reported an increase in HIV prevalence as a result of this law (11).

The introduction of the Nordic Model in France, combined with restricted services during Covid-19, made it difficult for SWs to access health services, continue testing and treatment for HIV and HCV, and engage with harm reduction services for illicit drug use (12). Since HIV and HCV prevention and care services operated in fragmented and deficient forms before Covid-19, the restriction or suspension of these stand-alone services exacerbated access barriers during the pandemic (13). There is a pressing need for continuous and accessible care for SWWUD to prevent infections with HIV and HCV and to mitigate resulting adverse health effects (12, 13).

These needs are further highlighted by goals set by the World Health Organization (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS). The WHO has an established global goal of eradicating HCV by 2030 via a reduction of 90% in new chronic infections and reducing mortality by 65% (14). UNAIDS'

established "95-95-95" targets for HIV foresees that by 2030, 95% of people infected know their status, 95% of diagnosed people are in treatment, and 95% of people in treatment have a suppressed viral load (15).

In 2022, 120,000 people were found to be HCV positive by the French health system, which is less than 0.3% of the French population. The distribution of HCV prevalence in France is uneven, disproportionately affecting people in high-risk groups, such as SWWUD (16). Likewise, SWWUD experience higher rates of HIV than the general population, with an estimated total of 172,700 people in France were living with HIV in 2018 (17). It is imperative to prioritise health interventions for SWs, as the prevalence of these infections are especially high among this population (7, 8, 10).

Therefore, this policy brief recommends developing and strengthening health services for SWWUD through integrated care, prioritising HIV/HCV testing, access to pre-exposure prophylaxis (PrEP), primary and reproductive health care, providing safe facilities, and empowering communities.



## Policy Options

Given the complex challenges that SWWUD face, a holistic approach to policy interventions must be considered. Health-oriented interventions must be accessible, person-centred, context-specific, and efficiently allocate resources based on areas of greatest need (18). Target-population-endorsed forms of HIV and HCV testing have been recommended to increase the monitoring and surveillance of infectious disease prevalence in this underserved population (19). Needle and syringe programs (NSPs) and regular access to PrEP have been proposed as clinically-effective HIV prevention methods for at-risk persons (20, 21). Additionally, linking disease-specific health services to primary care enables SWs to receive multidisciplinary health services without requiring multiple appointments (21). Finally, willingness to take up health services and the quality of services is profoundly influenced by the demeanour and sensitivity of care providers interacting with SWWUD (22). Thus, sensitisation training has been proposed to meet this need (18, 23).

## *Point-of-Care Testing and Prevention*

Point-of-care testing (POCT) is a sexual and reproductive health practice of providing testing and treatment for certain infections within one visit (19). This practice improves HIV and HCV control, prevention, and surveillance while maintaining affordability (19). POCT in the form of mobile, street-based HIV and HCV rapid testing has proven effective in European countries in increasing testing and treatment in difficult-to-reach populations (24-26). Mobile units equipped to test for HIV, and HCV can be situated in different locations and offered at off-peak hours to reach the target population (24, 25).

POCT can be coupled with PrEP to enhance HIV prevention care. PrEP is a clinically-recommended prevention strategy for key at-risk populations (21). PrEP enables SWWUD to have more control over transmission protection by reducing the occupational risk of acquiring HIV (27, 28). Strict adherence to prescription guidelines is necessary to maintain drug efficacy (29). To assist in maintaining efficacy, POCT can be offered to measure PrEP adherence and provide SWWUD with an improved understanding of whether their regimens are



in compliance to maintain protection against HIV (21).

NSPs are a third prevention measure for reducing drug risk-related harms such as HIV and HCV infection, as sharing needles is the leading risk factor for HIV/HCV among people who inject drugs (PWID) (30). In the case of HCV, the Cochrane Collaboration concluded that NSPs might reduce the risk of HCV acquisition by 76% in Europe (30). Next to fixed sites, mobile approaches such as street outreach or vending machines are suitable for targeted HIV/HCV prevention (20).

#### *Integrated Healthcare Services*

Integrated healthcare services offer whole-person care to SWWUD, addressing intersecting needs related to the social determinants of health (31). SWWUD often have high rates of comorbidities and co-existing psychosocial needs (32), and these services increase accessibility by providing multidisciplinary care simultaneously, allowing providers to address all needs during one appointment (31). Many facilities also employ peer leaders or peer navigators with shared lived experiences to provide compassionate care and reduce stigma

among staff (31). Telemedicine can also enhance existing services for people who use drugs (PWUD) by providing technical support and building rapport with patients to encourage ongoing engagement (33-36).

Low-threshold service models offer interdisciplinary care at no or low cost and increase accessibility by providing convenient locations and operating hours suitable for the target population, as well as removing eligibility requirements such as the need for government identification or sobriety (37). These services provide harm reduction supplies, drug treatment, sexual and reproductive health care, and primary health care (38, 39), and aim to be clinical, confidential, and non-judgmental (39). Adapted models of low-threshold services, in conjunction with integrated primary care, can effectively meet the complex needs of SWWUD by providing ongoing, collaborative care (40).

#### *Sensitisation Training of Caregivers*

Stigma from healthcare providers is one of the most significant barriers to accessing care for SWs (22). This stigma can go as far as denial of care but most often takes the form of discomfort with treating SWs and



reduced quality of care after disclosing their occupation (22, 41). Thus, SWs are increasingly reluctant to discuss their occupation or to seek health services for fear of stigma (41). The stigma regarding HIV or sexually transmitted infections (STIs) status can perpetuate fear of occupation disclosure, placing SWWUD at risk of underdiagnosis and delayed treatment (38).

To address this stigma and provide adequate care, international guidelines on drug use and STIs recommend adequate sensitisation training for health workers (18, 23). Education for these caregivers should include knowledge of specific needs and associated risks of SWWUD, as well as the importance of being non-judgmental (18, 38, 23). Peer navigators, also called peer leaders, are those with lived experience of the targeted population; they can share significant knowledge and promote trauma-informed care (38). Peer navigators should facilitate this training, as peer-led trainings would enable caregivers to better understand the impact of stigma and other specific issues affecting the health of SWWUD (42).

## **Recommendations**

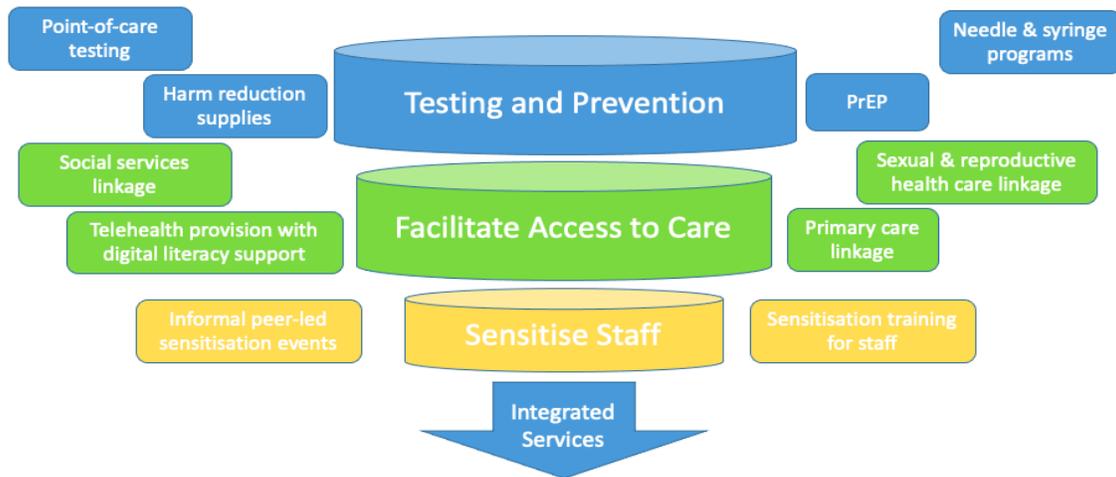
Based on the outlined policy options, a three-pronged approach to implementing integrated health services is recommended. Integrated services support the provision of both primary care and sex work-specific health services at target population-focused health centres. The three recommendations for overcoming fragmentation and promoting SWWUD health include: [1] HIV/HCV testing and prevention, [2] facilitating access to holistic care, and [3] sensitising health service staff to the unique needs of this population. Figure 2 displays an overview of the three components required to facilitate implementing the recommendation of integrating health services, with each component described in greater detail below.

### *Testing and Prevention*

PrEP counselling and prescriptions are integral to HIV-specific prevention measures. The WHO has developed the PrEP Implementation Tool consisting of several modules which aim to support different stakeholders in planning, introducing, and implementing oral PrEP

(43). Healthcare workers can be trained in PrEP prescription recommendations and equipped to disseminate the WHO's PrEP

Implementation Tool module tailored to PrEP users.



**Figure 2:** Funnel diagram of integrated health services components (Authors' work)

This will allow SWWUD to be empowered in taking control of their health. Secondly, testing is an important gateway to care, so establishing and expanding mobile HIV and HCV point-of-care testing complementary to health-centre-based testing sites is particularly important (24). Thirdly, NSPs should be promoted as a combined prevention measure for HIV and HCV. Integrating NSPs into existing healthcare centres will encourage the uptake of this service (20). Finally, the continued and more coordinated on-site distribution of harm reduction supplies at primary care centres will further the proposed prevention

strategies. The implementation of this recommendation, using a combination of these different components, seeks to reduce the transmission of HIV and HCV.

#### *Facilitate Access to Care*

Adequate access to healthcare and social services is vital to ensuring a cohesive patient pathway for treating communicable diseases and managing comorbidities (31). Thus, integrated care centres should be implemented in geographical areas where the SW community is well established. To reduce the fragmentation of services, primary care services already providing care



to this target population should be further equipped with interdisciplinary medical teams to provide sexual and reproductive health care linkages and linkages to social services (31). Using telemedicine services on-site is recommended to enhance the capacity of integrated health centres (33-36). However, low levels of digital health literacy among patients must be anticipated by training peer leaders in assisting patients with navigating these services (35). Mobile HIV and HCV testing services, organisations providing PrEP, and NSPs must be brought into united networks to ensure the whole patient pathway for holistic care is considered. Integrated care facilities foster collaboration between social service bodies and harm reduction organisations to provide in-house harm reduction supplies and services, point-of-care testing, peer navigators, and linkages to additional services when on-site provision is not possible (31).

#### *Staff Sensitisation*

Integrated care facilities need to be considered safe spaces by SWWUD to have a real impact. This requires strategies to combat stigma and discrimination by caregivers. These efforts can be realised by

employing peer leaders at integrated care centres to build trust with service users and share expertise through the facilitation of staff sensitisation training (44). These trainings would discuss a variety of scenarios that may be expected when working with this population and should address how to best respond to patients in a sensitive manner (44). Peer leaders are commonly recommended for delivering sensitisation training, as they help normalise the experiences of SWWUD and improve power relationships within the primary care practice (44). Furthermore, social events and platforms that encourage engagement between peer leaders and non-drug-using staff will support informal methods of reducing stigma and increasing understanding of the unique experiences of this population (44).

#### *Stakeholder Considerations*

Given the complexity of this health challenge and the comprehensive set of solutions, the involvement and collaboration of a wide range of stakeholders is required. This collaboration must be vertical, between the different levels of the state, and horizontal, integrating public and private actors.



Governmental ministries requiring varying degrees of consultation, support, and oversight include the Ministry for Gender Equality, Diversity and Equal Opportunities (MinGE), the Ministry of Health and Prevention (MinHP), and the Ministry of Secondary Education and Research (MinSER). MinGE and MinHP hold overlapping responsibilities for promoting and protecting the well-being of SWWUD, so increasing opportunities for collaboration encourages the identification of current gaps in care and recognising areas to improve resource efficiency. MinSER's consultation will support the development and implementation of sensitisation training by examining existing curriculums for suitability and areas requiring adaptation to suit the French context.

The French health system already comprises various care structures specific to sexual and reproductive health (CeGIDD) and to substance-use-related services (CAARUD, CSAPA). These facilities are managed by public hospitals and/or associations through partnerships. Nonetheless, fragmentation presents a central challenge for these care structures. Proposed recommendations aim to reinforce and improve the coordination

among these facilities while strengthening linkages to existing community-based services. Consultation from health associations and unions will provide insight into anticipated facilitation challenges for recommendations and will create a feedback platform to recognise strengths and weaknesses for each step of implementation.

Community-based services and associations must be pursued and strengthened to encourage a seamless network of service provision. These local or national associations (i.e., Gaïa Paris, Médecins du Monde, French Red Cross) have direct contact with SWWUD and are most capable of providing consultation for recommendation implementation strategies. However, these associations need public actors' coordination, funding, and support. International institutions and organisations (i.e., UNODC, UNAIDS, NSWP) can support national associations in providing continued advocacy pressure on their behalf. These organisations have placed pressure on actors to meet HIV and HCV reduction goals and are positioned to continue pressing for this aim through awareness campaigns, research, and informal demands.



Support from public authorities at the local level is necessary to ensure community-level feedback is received by national actors. These authorities, including municipal offices and regional health agencies, will facilitate the coordination of local activities and support them through material, human, and financial resources.

Finally, it is important to include representatives of the SWs communities, particularly those who belong to the SWWUD community. Through regular and thoughtful engagement, they should be encouraged to provide their insights for helping to shape this strategy in a way that addresses their specific needs and concerns. Including all listed stakeholders and fostering collaboration are prerequisites to implementing an effective and sustainable strategy. Appendices A and B display the varying degrees of interest and influence each stakeholder holds concerning this health challenge.

### **Limitations**

A first limitation of this paper is that the information on which the policy options and recommendations are based is not the result

of a systematic literature search, but only a selective representation of the current evidence. In addition, although the context was derived from reports and literature, the recommendations derived are not expert opinions. This could ultimately lead, for example, to inappropriate policy options being proposed, stakeholders not being fully captured, or inappropriate recommendations being made. Moreover, the needs of SWWUD could only be roughly identified through the existing reports and was not supported by a profound empirical data base. Finally, the actual feasibility of the recommendations was not thoroughly examined.

### **Conclusion**

SWWUD are frequently exposed to behavioural and structural violence, a situation exacerbated by the Covid-19 pandemic and the introduction of the Nordic Model in France. Illicit drug use combined with difficult working conditions has contributed to increased HIV and HCV risks posed to SWWUD. Insufficient access to holistic and non-judgemental care combined with discrimination and societal exclusion



endanger this population's health through underdiagnosis and delayed treatment. Such barriers threaten the achievement of HIV and HCV targets set by the WHO and UNAIDS. A strategy based on integrating health services embodied in this policy brief may advance change in current trajectories and improve the well-being of SWWUD. Looking forward, other measures focusing on macro-level structural change, such as decriminalising the purchase of sex services and population-wide anti-stigma campaigns, should be developed and combined with the health-service-oriented approaches developed in this policy brief.

### **Disclaimer:**

For the purpose of this policy brief, the operational definition of sex workers is provided by the Joint United Nations Programme on HIV and AIDS (UNAIDS) Guidance Note on HIV and Sex Work (45), which defines sex workers as *“female, male and transgender adults, over the age of 18, who receive money or goods in exchange for sexual services, either regularly or occasionally, and who may or may not self-identify as sex workers”* p(5).

### **Conflicts of interest**

None declared.

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**Appendix B: Stakeholder Composition, Interest, and Influence**

| <b>Levels</b>        | <b>Types of Stakeholders</b>       | <b>Stakeholders</b>                                                                                                                                                                                                                                                                | <b>Interest</b> | <b>Influence</b> |
|----------------------|------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|------------------|
| <b>International</b> | <b>International Institutions</b>  | Committee on the Elimination of Discrimination against Women (CEDAW), United Nations Office on Drugs and Crime (UNODC), European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), WHO, UNAIDS                                                                              | <b>Medium</b>   | <b>High</b>      |
|                      | <b>International Organisations</b> | NSWP, European Sex Workers' Rights Alliance (ESWRA), Red Umbrella Fund, International Network for People who Use Drugs (INPUD)                                                                                                                                                     | <b>High</b>     | <b>Medium</b>    |
| <b>National</b>      | <b>National Institutions</b>       | Ministère de la Santé et de la Prévention (Ministry of Health and Prevention (MinHP));<br><br>Ministère chargé de l'Égalité entre les Femmes et les Hommes, de la Diversité et de l'Égalité des chances (Ministry for Gender Equality, Diversity and Equal Opportunities (MinGE)); | <b>Medium</b>   | <b>High</b>      |

|              |                                        |                                                                                                                                        |             |               |
|--------------|----------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|-------------|---------------|
|              |                                        | Ministère de l'enseignement supérieur et de la recherche (Ministry of Secondary Education and Research (MinSER))                       |             |               |
|              | <b>National Associations</b>           | French Red Cross, Médecins du Monde, medical associations and unions                                                                   | <b>High</b> | <b>High</b>   |
| <b>Local</b> | <b>Local Public Authorities</b>        | Municipalities, Regional Agencies of Health; Departmental Commission for the Fight against Prostitution, Pimping and Human Trafficking | <b>High</b> | <b>High</b>   |
|              | <b>Community-based health services</b> | CAARUD, CSAPA, CeGIDD                                                                                                                  | <b>High</b> | <b>High</b>   |
|              | <b>Local Associations</b>              | Gaïa Paris, Les Lucioles                                                                                                               | <b>High</b> | <b>Medium</b> |
|              | <b>Community</b>                       | Community members, Sex Workers representatives, Peer-navigators, PWWUD, SWUDs                                                          | <b>High</b> | <b>Medium</b> |

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