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Structural Barriers to Receiving Health Care Services for Female Sex Workers in Russia

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Abstract

Female sex workers in Russia have been particularly vulnerable to recent social, political, and economic changes. In this article, we describe the facilitators and barriers for sex workers receiving health care services in St. Petersburg, Russia. We conducted observations at medical institutions and nongovernmental organizations and in-depth interviews with 29 female sex workers. We identified the following barriers: poverty, not having documents, lack of anonymity in testing, and the official registration system. We identified the following facilitators: intervention by family members, social connections within the health care system, and referral services from a nongovernmental organization. Our findings indicate a need for reassessing policies and designing programs that better facilitate the use of health care services for the most vulnerable populations. This should include the expansion of support systems and outreach services designed to help female sex workers navigate the health care system.

Keywords

Europe; Eastern; health care; access to; HIV/AIDS; sex workers

The Soviet Union was highly successful in the control of infectious diseases and the provision of basic public health and medical services to its people (United States Public Health Mission, 1957). Morbidity rates dropped after the socialist revolution. This was partly because of the Soviet Union's efforts to prevent and treat syphilis and other sexually transmitted infections (STIs) through setting up testing centers in the cities, sending out medical teams to rural areas, and providing health education and promotion activities (Maystrakh, 1956). The Soviet Union controlled the spread of STIs through the provision of free and high-quality testing and treatment services, contact tracing mechanisms, routine screening of vulnerable populations, required patient records, and the enforcement of testing and treatment through criminal and civil sanctions (Monitoring the AIDS Pandemic Network [MAP], 1998).

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The Russian Federation became an independent, successor nation state after the collapse of the Soviet Union in 1991. Russia remains one of the largest countries in the world, with a population of 146 million people. During the 1990s and early 2000s, Russia experienced political changes, reforms in the social welfare systems (including health care services), a series of economic crises, and a demographic crisis. There were also documented increases in what some have called “diseases of capitalism” and “diseases of the West,” such as STIs, and “deviant social behaviors,” such as alcoholism, prostitution, and drug use (Atlani, Carael, Brunet, Frasca, & Chaika, 2000; Goodwin et al., 2003; MAP, 1998). The human immunodeficiency virus and acquired immunodeficiency syndrome (HIV/AIDS) epidemic was documented in Russia later than in many countries in Western Europe and North America. Russia began seeing its first cases of HIV/AIDS around the same time as the Soviet Union was coming to an end (Federal AIDS Center, 2006).

Since the end of the Soviet Union, there has been an influx of international organizations and the emergence of nongovernmental organizations (NGOs) in Russia designed to address some of the social and public health problems in the country. One of the major goals of outside aid was to create a civil and democratic society (Hemment, 2004). These NGOs often competed with one another for limited financial resources (Hemment). Despite the outside assistance, public health institutions in Russia were, and continue to be, largely state-run institutions. Civil society and state-governed entities do not always work closely with one another, and their complementary roles in society are not well defined. Although there do exist examples of effective joint ventures, tensions remain between the perceived government responsibility and the role of nongovernmental, often Western-funded, agendas (Mendelson, 2001).

The transition period was difficult for many Russians, and some groups were particularly vulnerable to the social, political, and economic changes over the past two decades. Across industrialized nations, the HIV epidemic disproportionately affects the marginal and poor (Baldwin, 2005). Throughout Eastern and Central Europe, the effects of a political and legal environment on the social exclusion of vulnerable populations, namely drug users, sex workers, and people living with HIV, are evident (Godinho & Veen, 2006). The HIV epidemic provides a reason to focus on marginalized groups, to examine their behaviors, and to address their health concerns (Baldwin; Berger, 2004; Gurvich, 2005). This increased attention to marginalized populations does not necessarily translate into improved conditions or adequate services. In fact, in some instances, the increase in attention paid to these populations might cause them to retreat further into society’s margins (Berger). The experiences of these specific populations warrant additional exploration to illuminate the effects that marginalization has on their use of HIV services.

HIV/AIDS is an increasing concern for Russia, and in particular for the city of St. Petersburg. St. Petersburg has one of the highest numbers of HIV infections in the country (Federal AIDS Center, 2010). Women constitute an increasing proportion of new HIV infections in the country, and currently make up 44% of the population living with HIV/AIDS (Joint United Nations Programme on HIV/AIDS [UNAIDS],). The HIV epidemic in Russia is concentrated primarily among injection drug users (UNAIDS), and many female injection drug users (IDU) report engaging in sex work (Benotsch et al., 2004; Kozlov et al.,

2006). Research shows that sex work accounted for the majority of gender differences between male and female IDU relative to HIV risk behaviors in Russia (Platt et al., 2007). There is growing concern over the implications for further spread of the HIV epidemic because of the overlap between engagement in sex work and injection drug use (Aral & St. Lawrence, 2002). However, there have been few research studies specifically with female sex workers in Russia.

Sex work is illegal in Russia. Some organizations have argued for the decriminalization of prostitution to raise the status of the women involved in the profession and thereby protect their rights and health. Women who engage in street-level sex work are thought to access health care services the least and not use condoms as often as sex workers in escort services or in bars (Aral & St. Lawrence, 2002). In St. Petersburg, 48% of street-based sex workers tested positive for HIV (World Health Organization, 2004). Although previous studies with female sex workers provide insight into their vulnerability for HIV, much less is known about the structural factors that influence these women's access to health services.

In 1990, the first AIDS centers appeared in Russia. They were designed to provide surveillance, testing services, prevention, counseling, and laboratories (Iushuk & Martynov, 2003). Anonymous testing for a fee has been available in the major cities in Russia since 1998 (MAP, 1998). The central state-run institution in St. Petersburg that provides diagnostics and HIV care is the Center for the Prevention and Fight against AIDS and Infectious Diseases, known locally as the City AIDS Center. In 2005, only 47.5% of people living with HIV/AIDS were registered and under dispensary surveillance with the City AIDS Center (Volkova, Davydov, & Ivanova, 2006).

The lack of resources, political commitment, and program innovation in Russia limit the prevention and control of HIV/AIDS (Matic, 2006). There are problems within the administrative framework for HIV service provision that are thought to negatively influence people's access to services (Burns, 2007; Twigg, 2006). It has been argued that one of the major reasons Russia has been unsuccessful in halting its growing HIV epidemic is because it failed to address the importance of harm reduction (Donoghoe, 2006). Harm reduction is the public health response aimed at reducing the negative consequences of drug use through the provision of clean needles, education on the prevention of overdose, and linkage to drug rehabilitation services. According to Russian law, free medical care and treatment for HIV-infected individuals is guaranteed (Onishchenko, 2005). Unfortunately, the populations most in need (including female sex workers) are not receiving HIV-related services.

The theoretical framework of structural violence guided our study. We examined the impact that the social, economic, political, and historical contexts in which female sex workers live has on access to HIV services. The concept of structural violence provides a theoretical framework for examining the broader, or distal factors that place certain groups at risk for poor health outcomes, including HIV infection, and inhibits groups from "reaching their full potential" (Farmer, Connors, & Simmons, 1996). This framework guided us in identifying the social position of female sex workers and in focusing attention on the social inequalities that limit sex workers' access to HIV services. The objective of this article is to provide a

better understanding of the facilitators of and barriers to accessing health care services, including HIV services, for female sex workers in St. Petersburg, Russia.

Methods

This article is based on fieldwork conducted in St. Petersburg, Russia from December 2008 through September 2009. The Institutional Review Board at the University of North Carolina–Chapel Hill and the Ethics Review Committee of St. Petersburg State University approved the study protocol and consent forms. We conducted observations and site visits to medical institutions where HIV services were provided and to NGOs providing harm-reduction, health education, and social support services to female sex workers and HIV-positive women. During these site visits, we held discussions with researchers, key personnel, and staff to more fully understand what services were provided, who utilized these services, what kinds of questions and concerns arose in the process of receiving HIV testing and treatment services, and how the service providers and experts described the motivations for HIV testing and treatment utilization. We visited places that sex workers talked about receiving services and places where they heard that HIV testing and treatment services existed. We used the information from these observations to contextualize the information gathered from the in-depth interviews.

We conducted in-depth interviews with 29 female sex workers. We used a purposive sampling strategy, and conducted interviews until we established saturation of the data. We applied the following selection criteria: (a) female, (b) more than 18 years of age, (c) residing in St. Petersburg or Leningradskaia oblast', and (d) involved in sex work in St. Petersburg. We recruited informants through two nongovernmental organizations. We recruited 25 of the informants through an outreach van that provided health-promotion services. Four additional female sex workers were recruited through a social program for HIV-positive mothers so we would be sure to capture women who had more experience utilizing services for HIV-positive individuals.

With the consent of the participants, all interviews were audio-recorded. A native Russian-speaking professional transcriptionist transcribed all of the tape-recorded interviews. Interviews lasted between 25 and 45 minutes. The interview guide included descriptive, structural, and contrast questions (Spradley, 1979) on the following topics: perception of HIV risk, experiences in receiving health care services, participation in HIV-prevention programs, and experience in utilizing HIV testing services. If the participant disclosed a positive HIV serostatus, then she was probed on experience utilizing HIV care and treatment services.

The process of data analysis for this study was iterative. We discussed the data throughout the collection and analysis phases. We kept a journal and collected printed materials from the observations and site visits, continuously read through the transcripts, made memos, and began preliminary coding during the fieldwork. The information gathered from the observations and site visits became a useful platform for thinking about the relationships between female sex workers (as clients of services and patients in the health care setting),

NGO outreach workers, psychologists, social workers, health care providers, and researchers.

We imported the text documents into Atlas.ti (2010) for coding and analysis. We conducted the analysis with the texts in the original Russian, and then translated the selected quotes into English for inclusion in this article. The first step was to apply descriptive, deductive codes to each interview transcript and the field notes. We developed a codebook based on the research questions and theoretical constructs used to design the study. The second step was to use inductive codes that were based on ideas and salient information that stood out as we read the data multiple times.

We organized the data according to the codes, and then identified emerging themes from the data. We combined these emerging themes into overarching themes through an iterative reflection process, discussion of each of the codes and themes, and consideration of the specific aims of the research study. We triangulated the data by using information from the observations and the in-depth interviews. We confirmed the data from the in-depth interviews with female sex workers through the conversations with service providers and observations of health education activities and site visits to HIV testing and treatment service centers.

Results

The female sex workers in our study ranged in age from 21 to 38 years. Two of the participants were married at the time of the interview. About half (n = 15) of the women had children, though it was often the case that the children lived with a grandparent or another relative. The time spent in sex work ranged from 1.5 years to 11 years. All of the participants were either currently using or had a history of using injection drugs, namely heroin. The women who were currently using drugs talked about using daily, and many of them reported being addicted to heroin for many years. Some women talked about getting involved in sex work after they started using drugs, whereas others talked about being introduced to drugs after they became involved in sex work.

All of the women reported that they had been tested at least once for HIV. Women talked about being tested for HIV during pregnancy, or while in jail, at an STD clinic, on the outreach van, or in the hospital. Eleven of the 29 women disclosed during the interview that they had been diagnosed with HIV. The four women recruited through the program for HIV-positive mothers had received anti-retroviral medications during pregnancy to prevent transmission to their infants. Among the other HIV-positive participants, the only mention of receiving antiretroviral treatment was also during pregnancy.

Effects of the Social and Economic Collapse on the Health Care System

Participants throughout the course of fieldwork noted that the health care system in Russia suffers from being underfunded. The female sex workers mentioned the lack of quality medical equipment as a reason for the poor services received. Participants also commented on how doctors were not paid adequate salaries, making it harder to end the practice of informal payments for services and negatively affecting doctor–patient relationships. The

majority of participants openly placed blame on how the system was largely driven by money. Participants talked about the anticipated differences in care between the free, state-run health care centers and the private services available in the city: “If you have money, then they [doctors] will take care of you. If you don’t have money then they will not.” They believed that women received better care—and better treatment from the doctors—if they paid for services rather than receiving care at free health care centers.

This is particularly relevant because the system in Russia has changed from one in which a citizen could count on getting free medical care to one in which money is required for quality care. One woman talked about her mother trying to convince her to utilize a clinic providing free HIV services:

> I didn’t want to go there at all. My mom is all like, “Go, go! Maybe there is something there.” You know, she still thinks that everything should be given for free like in the Soviet times. And I explained to her that now there is capitalism, and that now everything is a little different. Things are not like they were during those times … it is unlikely that anything can be done without money.

Poverty as a Barrier to Receiving Health Care Services

The sex workers in this study talked about poverty having a great influence over their lives. They talked about poverty as a reason for involvement in sex work. They spoke of the struggle to earn enough money to care for children, unstable housing, the inability to purchase basic goods, and not being able to pay for medical services. Participants viewed the private services to be of higher quality, and they said that in most cases they could not afford to utilize those services because of the cost:

> It is better not to get involved with our doctors. Or at least have some money so that you feel normal. I don’t have the money yet. … If you have the money, they [doctors] will do everything.

Women frequently had the perception that if they had money, they would have been treated better by doctors, and they could have then avoided the doctors who treated them poorly.

Lack of Official Documents as a Barrier to Getting Services

For women who would otherwise have accessed state-run health care facilities, the issue of a residence permit (*propiska*) or passport registration was a barrier to access. The propiska accounted for being registered at an address and allowed access to services, such as social benefits and medical care in the district. As described by one participant, if one did not have a propiska, then it was nearly impossible to get the free medical services. When asked about how often she went to the doctor for testing, she replied, “Well, it depends on the situation with money. I don’t have a residence permit. I have to pay money for everything.” The same problem arose if one did not have a passport. Another participant illustrated this idea when she explained why she had not been tested for HIV recently: “I have a problem with my documents. I don’t have a passport. … Thus, I cannot go to the doctor because I don’t have money for this.”

Medical Records and Official Registration

One notable characteristic of the Russian public health system was the process of registration. Sex workers in the study mentioned being registered as drug users, HIV-positive patients, and syphilis patients. Participants described how potential employers and other public institutions could have viewed their medical records. Registration was most often done because the participant "didn't have any money to pay for treatment; that is, to pay for anonymous treatment." It allowed access to free medical services related to the particular health category in which they were registered.

The women in the study were quick to point out the negative aspects of being registered as a drug user. Participants mentioned not being able to get a driver's license or having potential employers find out. They worried about being stopped by the police while they were working. They would have to show their documents and the police would see that they were registered drug users. The women also noted that it was problematic because once on the drug registration list, they would have to wait 5 years to get off of it. Moreover, participants described the stigma associated with being a registered drug user:

> If you get on the registration list, then it is simply over. You become a social outcast. … A normal person would not become registered because he would become a social outcast. You cannot get work, nothing anywhere. Everywhere it is written, "Registered at the narcology [dispensary]."

The desire to avoid being registered as having an STI, HIV, or a drug addiction was cited as a reason to avoid going to the doctor and being tested. One of the interviewed women said she did not go to the doctor out of fear of being registered as a drug user:

> I am afraid to go, to be registered. I am a teacher by education. So, if I am registered then it will be very difficult for me to find work. Therefore, I try with my own strength to decrease the dose, to use less.

Women discussed being able to avoid registering as a drug user either through paying for medical care or not receiving medical care.

The process of becoming registered was not always described as an active decision. The sex workers interviewed often used the passive form of "being registered." One participant commented about the syphilis registry: "I didn't have a choice. They automatically put me on the registry." When HIV-positive participants were asked about influences on their decision to register at the AIDS Center, they talked about being placed on the registration list. If a person were tested for HIV at the AIDS Center, a prenatal clinic, or as part of the government health care system and diagnosed with HIV, she would become a registered case, and this information would be included in her medical record.

Another important aspect of the Russian health care setting with regard to HIV/STI testing was that if a woman were eligible to get free testing at her local clinic, it meant that she would have to give up the possibility of anonymous testing: "If you want to test anonymously, there is a charge. You can pay and get tested, and not say anything. But if it is for free, then you have to provide documents." If a person utilized the free testing services as part of the state-sponsored health care system, then a positive diagnosis would officially be

put into her medical records. Participants discussed the pressure of being registered if one received an HIV-positive diagnosis at a government facility. One participant described what occurred when people she knew went for HIV testing and were pressured into registering their diagnosis:

> And the doctor, of course, immediately took that guy and said, “We need to register you,” in order not to let him slip by. They do not let these people slip by. Even if you test anonymously, even if you don’t have anything, they don’t let you slip by, and if they find something, then they may try to talk you into something.

Few of the HIV-positive sex workers talked about receiving HIV treatment and care services. Pregnancy appeared to be the major influence on the utilization of these services. HIV testing was often part of the protocol during antenatal care services, rather than something the women sought out. One participant explained that she learned of her HIV status during pregnancy, and that this was the first time she had tested for HIV:

> I tested for the first time when I registered [at the antenatal clinic]. I was literally three months pregnant. At first nothing at all showed up, and then it was positive. I was five months into the pregnancy. … I had not thought about this earlier. … This is how it is done. When you are registered, it is required that you are tested for HIV two times during pregnancy.

Whereas many of the participants discussed regularly visiting the AIDS Center while pregnant and with their children, they often stopped going if their children were found to be HIV negative.

Strategies for Negotiating the “System”: Connections, Family Support, and NGO Referral

In some instances the alternative to having money was to have connections in the health care system. Some of the participants talked about having relatives who worked as doctors or nurses. They discussed how these connections facilitated their entry into the system, helped them bypass long waiting times, or allowed them to test anonymously without a cost. For example, one woman told about her mother’s work as a surgeon. Her mother helped her at home when she was not feeling well and connected her with services in the hospital where she worked. Another participant disclosed that she used to be a nurse and still maintained connections to her former place of employment. Unfortunately, poverty and social marginalization were realities for many female sex workers. Therefore, they were not always able to negotiate better care by paying money or by relying on social connections.

Family support helped female sex workers be tested for HIV, engage in drug rehabilitation services, or receive medical care. Women who lived with their parents or grandparents talked about relying on them (most often their mothers) to support them, both financially and emotionally. This was especially true for women who had managed to go through drug rehabilitation or take prophylactic antiretroviral therapy during pregnancy. The sex workers interviewed who did not have family members to help them noted this absence. Two women talked about being orphans, how this had an impact on their involvement in sex work and drug use, and about the available social support in difficult times.

Additionally, some women commented on having severed ties with their relatives because of involvement with drugs and/or sex work. Many women knew that those without someone to help them navigate getting care and treatment were in more danger of mistreatment or of not getting treatment. One participant illustrated this idea with an example of how her mother facilitated care in the hospital, while she witnessed a woman next to her die because "no one visited her":

> I used drugs. I was staying in the hospital. They knew that I used. She was lying there like me, with respiratory pneumonia. Simply, my mom came to visit me … my mom came almost every day and she brought me food herself. I didn't eat in the cafeteria. And every day she asked how I am doing. If it were necessary to buy some kind of medicines … they [doctors] would say to me, "Oh, you need this medicine. It is very expensive, and you have no money." My mom would come and I would say, "Mom, there is some kind of medicine they suggest. It costs money." My mom would go ask the questions and they would say, "Don't worry. We will give her the necessary treatment." If it were not for my mom, they would have also shat on me.

The referral system offered by the outreach team provided the sex workers with another opportunity to negotiate the health care system. This allowed a sex worker to take a written referral to a specific STI clinic for an anonymous and free consultation and basic screening services. Participants reported that they were less afraid to go to the doctor if they had this referral. They said that they could talk about their risk behaviors because the doctors were prepared to hear about their involvement in sex work and drug use. When asked if she could talk to her doctors about her drug use or sex work, one participant said,

> Maybe because they work with "XXX organization" and they know exactly who we are when we come with these [referral] cards. They treat us nicely enough. If we were to compare, that is, if I was to go to an ordinary doctor and he would know who I am, it would be a huge difference. They treat us with more understanding.

A different participant similarly explained, "He knew who I was and that, and that I am a drug user and I am a prostitute. All the same, he communicated with me very well." Another sex worker discussed how having a referral motivated her to go get tested, and that she would not have gone without this referral:

> You know why? Because when they give you the referrals then you specifically go with a goal. You need this. And when you go without the referral, you, well, drugs, they are that kind of thing. Every day you wake up and think about where I could find money. You are not thinking of anything else—not of the clinic, not about doctors, not about a gynecologist. You know? And when you have the referral, you are specifically going. You took it; that means go. Go find out what is happening in your body. I think that every drug user should know what is happening in her body.

However, there were also women who took the referrals but had not yet gone for an examination or testing. They cited not having enough time, lack of motivation, and not having any symptoms as reasons for not using the referrals.

Discussion

There were structural factors that influenced female sex workers' utilization of HIV testing and other health care services in St. Petersburg. The most salient barriers to accessing health care services were poverty, not having official documents, and facing a bureaucratic registration system. Female sex workers perceived the health care system itself to be in a state of poverty, which influenced how doctors treated patients and the quality of care available in the government facilities. The sex workers cited not having enough money to pay for anonymous testing or other services in private clinics, where care was perceived to be of higher quality. As described by the women in our study, if one could not pay for services, then there were two default options: access government services but risk being registered for HIV or drug use, or not access health care services.

The high cost of HIV-related and other health care services was also shown to be a barrier for sex workers in China (Hong et al., 2012), Nepal (Ghimire, Smith, & van Teijlingen, 2011), and Vietnam (Ngo et al., 2007). Issues of stigma and judgmental attitudes among health care providers were also barriers to getting health care for sex workers in several Asian and Western European countries (Ghimire et al.; Harris, Nilan, & Kirby, 2011; Hong et al.; Ngo et al.; Whitaker, Ryan, & Cox, 2011). Female sex workers reported issues related to their drug use as barriers to getting health care in studies in China (Hong et al.), Canada (Shannon, Bright, Gibson, & Tyndall, 2007), Ireland (Whitaker et al.), and Australia (Harris et al.). The researchers in the studies in Australia and Ireland reported that female sex workers felt the need to hide their involvement in sex work and drug use in the health care setting. Involvement in these activities was shown to be quite difficult for female sex workers in Russia because of the lack of anonymity and the official system of registration within the health care system.

The issue of private and public health services was discussed in studies with female sex workers in Nepal (Ghimire et al., 2011) and Vietnam (Ngo et al., 2007). Similar to findings in our study, lack of privacy was a reason the sex workers in those studies preferred to go to private clinics, yet the high cost of private clinics was a barrier to getting care. Similar to the Russian sex workers, women in Vietnam reported that poor care was a reason not to go to public health care centers. However, the sex workers in Nepal perceived the care at government services as being of better quality than private clinics. More research should be conducted in Russia to examine the anticipated and experienced differences in care received at public vs. private health care clinics.

The participants in our study discussed three specific strategies they had for negotiating the bureaucratic system when they could: rely on family for support, use connections within the system, or utilize a special referral system through an NGO. Poverty and social marginalization made overcoming structural barriers very difficult for many sex workers because they did not have access to enough money, social connections, or family support. To our knowledge, there has been little research into strategies for overcoming barriers to getting care among female sex workers. The few studies that have been published show results that are similar to our findings.

Research in Canada showed that drug-using sex workers were able to employ coping strategies including social networks and support, and challenging the stigma within the health care system (Logie, James, Tharao, & Loutfy, 2011). Female sex workers in Vietnam were shown to rely on friends for helping them access health care services (Ngo et al., 2007). Mellor and Lovell (2012) concluded from their research with female sex workers in England that "the significance of harm reduction services as a mechanism for facilitating access to health care should not be underestimated" (Recommendations section, p. 11), and that different strategies and approaches work differently for some sex workers. The commonalities among strategies to overcome barriers used by sex workers in these various settings suggest that there are ways public health interventions could be developed to support their utilization of health care services.

There are social, political, and historical aspects to the current system for health care and HIV service provision that might deter female sex workers from accessing them in St. Petersburg. The free, public services continued to impose the impression of a centralized health care approach reminiscent of the socialist system. Our findings indicate that embedded within these perceptions was fear of stigma and discrimination enacted by service providers. These findings are consistent with previous research showing that stigma and discrimination are hindrances to accessing HIV services in Russia (see for example, Burns, 2007; Onishchenko, 2005; Orekhovsky et al., 2002). Our findings are also consistent with the contention that there is distrust of the health care system in Russia, and that this is especially evident in regard to women's sexuality being stigmatized in the health care system (Rivkin-Fish, 2005): The more marginalized a female sex worker is, the less likely she will be able to avoid registration as a drug user to get medical care or to circumvent being tested for HIV on public record. The sex workers in our study talked about needing to register to receive free health care services because they had no alternatives.

The findings from our study reveal concerns with the Russian government's policy toward HIV prevention and treatment for the vulnerable population of female sex workers. Political and economic factors influence the women's access to services. Service providers in our study confirmed that they were not receiving enough financial support to fulfill their roles in preventing the spread of HIV and providing care for those affected by HIV. The NGOs struggle to survive through external grant monies, which are expected to decrease given the ending of the support of the Global Fund to Fight AIDS, Tuberculosis, and Malaria (2013) for HIV programs in Russia. The Russian government does not support needle-exchange services. In addition to the provision of clean needles, these services include a referral system for encouraging female sex workers to utilize HIV and STI testing centers and health care services. Given that there are limited effective drug rehabilitation programs in Russia and that drug users are readily discriminated against in the health care setting, it makes the circumstances for receiving HIV care even more dire.

The referral system for STI and HIV testing was reported to be effective for the women who had used it; however, not all female sex workers had done so. Even though the referral system is a good first step in connecting sex workers with health care services, the collaborative effort between the nongovernmental organizations and government health care centers, including HIV centers, should be strengthened. Although an outreach team might

more easily reach women on the streets, a mobile van cannot offer all of the services needed (one would still need to go to a government facility to receive confirmatory HIV testing and be enrolled in a treatment program). Increased collaboration and streamlined approaches might offer more comprehensive services, increase the sustainability of a referral system, and help support women in need of longer-term services, including drug rehabilitation services and HIV treatment and care.

Community-level interventions in other settings have shown a significant reduction in risk behaviors (Kerrigan et al., 2006), a limited decrease in violence (Wechsberg, Luseno, Lam, Parry, & Morojele, 2006), and improved utilization of heath care services (Gangopadhyay et al., 2005) among female sex workers. An intervention designed to empower sex workers to be able to make changes in their lives, such as the Sonagachi project in India (Gangopadhyay et al.), could improve the conditions of female sex workers in Russia. Like some of the current programs in St. Petersburg, the Sonagachi project promoted condom use, distributed condoms, and made referrals to clinics. In addition, the Sonagachi intervention also focused on organizing women through empowerment to better their social, political, and economic conditions (Gangopadhyay et al.).

Further research on intervention design and evaluation is needed with female sex workers in Russia; this could include peer-to-peer interventions. However, this might only work for women who feel connected to their peers, which might not include everybody. These types of programs are designed to help socially marginalized populations better navigate the complex, bureaucratic health care system by offering accompaniment on health care visits, referrals based on formal or even informal connections, and psychological support. One of the major strengths of our study was that it was field-based, rather than clinic-based, and therefore included some women who had not accessed services. Further research is urgently needed on access to health care services among other types of sex workers (for example, apartment-based sex workers). The results of our study provide important and novel information on identifying these structural barriers and the strategies female sex workers use to overcome them in St. Petersburg, Russia.

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