Civil society organizations in the prevention of sexually transmitted infections among female sex workers, in Portugal[1]

As organizações da sociedade civil na prevenção das infeções sexualmente transmissíveis em trabalhadoras do sexo, em Portugal

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1 This article is part of the "Immigrants and social support services: citizenship technologies in Portugal" project, implemented between 2010 and 2013 by the Network Centre for Anthropological Research (CRIA) in Lisbon, financed by Fundação para a Ciência e Tecnologia (FCT).

Abstract

According to the European Centre for Disease Prevention and Control report (ECDC, 2013), which compares data on HIV prevalence among sex workers in 27 countries in Europe and Central Asia, Portugal is the country with the third highest prevalence of the infection among sex workers. The comparatively high prevalence of the infection among sex workers in Portugal contrasts with the reported use of means of prevention and diagnosis. The article will focus on one aspect of this phenomenon: the activity of civil society organizations working in the area of preventing STI in Portugal, in order to analyze how they relate to female sex workers and design the social support programs directed at them. This matter arises as pertinent since the discrepancy observed may indicate a formal compliance (but not necessarily a real one), from the sex workers, to a socially valued prevention rhetoric, which is channeled through the organizations. This discourse can be perceived as more or less valid, conditioning the practical implementation of means or prevention, which is an essential factor in analyzing the effectiveness of these preventive interventions.

Keywords: Civil Society Organizations; Female Sex Workers; Sexually Transmitted Infections; Migration.

DOI 10.1590/S0104-12902014000100006

Resumo

Segundo o relatório do Centro Europeu de Prevenção e Controlo das Doenças (ECDC, 2013), que compara dados relativos à prevalência do VIH em trabalhadores do sexo em 27 países da Europa e da Ásia Central, Portugal é o terceiro país com a maior prevalência da infeção entre essa população. A elevada prevalência comparativa da infeção entre os trabalhadores do sexo em Portugal contrasta com o uso reportado de meios de prevenção e diagnóstico. O artigo debruça-se sobre um dos aspetos desse fenómeno: a atividade das organizações da sociedade civil na área da prevenção das infeções sexualmente transmissíveis (IST) em Portugal, de modo a analisar como se relacionam com as trabalhadoras do sexo e concebem as ações de prevenção e o apoio social que lhes dirigem. Essa questão surge como pertinente à medida que a discrepância verificada poderá indicar uma adesão formal (mas não necessariamente real), por parte das trabalhadoras do sexo, a uma retórica socialmente valorizada de prevenção, a qual é canalizada pelas organizações. Esse discurso pode ser por si mais ou menos apreendido, condicionando a implementação prática dos meios de prevenção propostos. Estamos assim perante um potencial fator explicativo a considerar na análise crítica do nível de efetividade dessas ações.

Palavras-chave: Organizações da sociedade civil; Trabalhadoras do sexo; Infeções sexualmente transmissíveis; Imigração.

Introduction

This article is part of the "Immigrants and social support services: citizenship technologies in Portugal" project, implemented between 2010 and 2013 by the Network Centre for Anthropological Research (CRIA) in Lisbon, financed by the Science and Technology Foundation (FCT). The project aimed to critically evaluate social support programs developed by the support network in Portugal which monitor the integration of immigrants, assessing the extent to which they develop with regards the vulnerability/risk dichotomy: if, on the one hand, immigrants frequently appear with connotations of social issues such as deviance and lack of social skills, on the other, they can be represented as victims of potentially traumatic migratory processes, leading them into a situation of vulnerability and, therefore, in need of social interventions.

The project investigated the way in which social interventions, in this context, may turn into moral and cultural subjective civic normalization, distant from the ways in which immigrants perceive themselves and their existence. This phenomenon may lead to eventual incompatibility between the "cared for" and the "carers", thus compromising the effectiveness of interventions and, in the most extreme cases, resulting in phenomena of institutional violence. From this perspective, the article concentrates on the particular case of immigrant women working in the sex trade.

Prostitution

Sex work is considered to be any sexual service which is paid for. In this sense, sex work is related to "[...] commercial sexual services, performances or products (prostitution, pornography, striptease, erotic and so-called erotic dances)" (Oliveira, 2011, p. 14), and takes on various forms. In Portugal, it is estimated that prostitutes walking the street account for only 10% to 20% of the total number of women who prostitute themselves, meaning that the majority are "indoors". Indoor sex work, or prostitution is that which takes place between four walls and represents the largest share of prostitution activity in Portugal (Oliveira, 2004).

Prostitution is stigmatized because it calls into question cultural and moral values which regulate the female sex. In the 19th century, medical and criminological discourses consolidated the image of the prostitute as marginal, immoral and polluting. Currently, social discourses on women who prostitute themselves tend to clothe them as the victim (Parent and Coderre, 2000; Ribeiro et al., 2005), along with being at risk, especially when these discourses relate them to the propagation of sexually transmitted infections (STI) (Oliveira, 2011).

The lack of regulation and the stigma with which sex workers (SWs) are burdened constitute factors of social vulnerability and of health risks, as they are potential barriers to health care and to prevention, for reasons such as lack of confidence in the health care services and fear of discrimination. On the one hand, this situation contributes to the representation of SWs as a vulnerable population; on the other, social discourses associate prostitution with marginality, immorality and the risk of spreading STIs. The vulnerability/threat dichotomy thus marks the figure of the SW and public debate concerning sex work, in which the majority of civil society organizations stand out for their active role in social affirmation and empowerment.

Methodology

This article analyzes the way in which civil society organizations[2] which develop STI prevention projects with the population deal with the problem of sex work and sexual health. To do this, a qualitative analysis was conducted using the discourse of four members of civil society organizations which develop STI prevention projects aimed at SW in the metropolitan area of Lisbon, as well as that of an academic involved in an investigation-action project aimed at populations vulnerable to HIV infection and that of an SW, in non-directive interviews. Documental research concerning STI prevention and social support programs mainly developed by civil society organizations in Portugal was also carried out.

The interviewees were selected according to two basic criteria: relevance and diversity. It is impossible to deal with the subject of prevention and control of STIs in sex workers without referencing the organizations involved, given the scope and representation of their intervention. They are organizations which regularly appear as partner institutions in projects and studies in this area, and the activities they develop form, taken together, a significant part of the provision of support available to sex workers in the metropolitan area of Lisbon. On the other hand, the types of strategy they develop are diversified and enable them to capture different populations and contexts: if one organization deals more with those working the street, another deals with indoor work, while one organization develops professional training activities aiming to reorient the sex worker's activities, another attempts to reduce risks involved in carrying out these activities through offering a diversified set of social, legal and health care services in their facilities.

In order to obtain an external view, the interviews were complemented with an interview with an academic in a public institution with interventions in the area of STIs in the immigrant population and with immigrant sex workers, selected using a random process. The methodology adopted in conducting the interviews was an open, indirect approach, preceded by presenting the researchers and their aims.

Policies concerning prostitution

It was in the 19th century that the regulatory system came into force in most European countries, including Portugal. Prostitution was regulated by the State for public health reasons. In "tolerated" cases, the prostitutes were subject to health inspections, restrictions and police control motivated by con-

2 The understanding of civil society adopted in the article is that of a sphere between the State, the market and the private sphere (in detriment to a vision of civil society as a sphere independent of the State), basically focusing on "organized civil society" (in detriment to the intimate aspect and to the forms of communication which occur within this aspect) (Cohen and Arato, 1997). Thus, *"[...] the focus is on civil society as the societal sphere composed of more or less organized groups which intermediate between State/public authority, market and private sphere"* (Smismans, 2006, p. 7-8).

cerns for moral and public health, in an attempt to conceal prostitution, seen as a necessary evil, and to control the women held responsible for spreading venereal disease. The regulations suggested that the root of the evil lay in the prostitutes and that men should be protected from them (Corbin, 1978; Handman and Mossuz-Lavau, 2005; Ribeiro et al., 2005). In the 20th century, a prohibitionist model was imposed, based on the idea that prostitution was a morally reprehensible deviation, and on the supposition that prostitution degraded females and should, therefore, be prohibited (Manita and Oliveira, 2002; Nor, 2001). In Portugal, between 1963 and 1982, prostitution was a crime (Oliveira, 2011).

The abolitionist model is currently the most common in Europe, and is that which is still in force in Portugal. This model admits prostitution when it is a private business, but punishes commercial exploitation, considering it harmful to the human condition. It assumes that prostitution should be abolished and the prostitute or sex worker – term which substituted the former towards the end of the 20th century[3] – assumes the status of victim, especially of male domination. Although the sale of sexual services is not punished, it is not permitted in a legal form, thus maintaining the situation of exclusion and stigma (Cazals, 1995; Gil, 2008; Ribeiro et al., 2005; Weitzer, 2007). Moreover, SWs are sometimes denied access to health care services, they are often persecuted and are faced with criminal charges and detention (Brussa and Munk, 2010).

Between danger and vulnerability

This issue of vulnerability permeates sex work, which reflects on the social conditions of the sex trade and the way in which social support services provided to this population operate, especially those of civil society organizations. In Portugal, the vast majority of SWs are women and, of these, a large number are immigrants (Machado et al., 2002; Silva et al., 2005).

A CSO social worker interviewed stated that, although the place s/he worked did not develop projects specifically aimed at immigrant SWs, in reality, they ended up *working almost exclusively with immigrants, as around 80% to 90%* of the indoor sex workers they dealt with were immigrants. The document analysis and the interviews enabled it to be stated that these organizations, as a rule, do not develop social responses specifically conceived for immigrant SWs, be they male, female or transgender. Thus, immigrant SWs are covered by more general projects, developed for all SWs, regardless of nationality or legal situation in the country, although these projects may be carried out in partnership with organizations whose target population is immigrants, in order to respond to users who need support due to their status of immigrant. We cannot, then, talk of the "vulnerability" of all SWs.

Immigrant SWs are a group diversified by their status of legal or illegal resident in Portugal; by their country of origin, which confers a particular status upon them in the universe of the sex trade; by the length of time they have been on Portuguese territory; by their socio-economic status; by the social support networks they possess or are able to mobilize; by the type of sex work they practice etc. They provide various types of sexual services, which may be performed in different locations: prostitution in apartments, erotic dances and striptease in clubs, erotic telephone and internet chat etc.

Ribeiro et al. (2005) stated that clients' choices centered on Latin- American women, especially Brazilians. This preference was explained by the clients' perception of these women as "more affectionate", "more permissive", "more communicative", "more uninhibited", "more expressive", "more open", "hotter" and "sweeter". They are also more receptive to less conventional sexual practices, such as anal sex and sadomasochistic practices, as "[...] these women have a freer and less repressed relationship with their sexuality, which translates into internalizing less stigma" (Ribeiro et al., 2005, p. 52). One of the CSO social workers interviewed considers that:

3 The concept of sex work appeared in the United States in the 1970s. "The term sex work implies that we are dealing with an activity involving the provision of sexual services. This implies the defense of the professionalization of these activities, without stigma and so as to dignify this work performed by women, men and transsexuals." (Oliveira, 2011, p. 14).

There is an image of what is exotic, what is erotic, and Brazilian women have these connotations. Scientifically, I don't think we can run this risk, but I think this is something which exists in the minds of the men who seek them.

According to our informants, the arrival of Brazilian women in the Portuguese sex market, together with the preference of some clients, increased competition between SWs and, therefore, increased risky practices, as one of the arguments of prostitutes selling sexual services is the lack of attraction of protected sex. Although there are no statistics on sex worker nationality, in Portuguese society Brazilian women tend to be associated with sex work, which can lead to problems for Brazilian immigrants, as one SW interviewee reported:

It's very difficult to rent an apartment. The owner asks to see an employment contract, legalization, a guarantor. Today this happens less, as there are many apartments for sale or to rent, but when you say you are Brazilian they don't want to rent to you, as they straightaway think it will be used for socializing.

Although they recognize the diversity of this population, the majority of social workers from civil service organizations which deal with it who were interviewed described it as particularly vulnerable. In effect, many SWs are immigrants, particularly from Latin America and Eastern Europe and live in socio-economically precarious conditions, have reduced social and cultural capital, practice an activity which is not regulated by labor laws and is socially devalued or even stigmatized (Coelho, 2009; Silva et al., 2005), and are sometimes illegally resident in the country.

Without denying concrete situations of vulnerability, there appears to be, both in social representations and in academic discourse, vulnerabilization of immigrant prostitutes, along with pathologization of women who prostitute themselves (Coelho, 2009; Weitzer, 2007).

> The most negative and stereotyped aspects of sex work, in general, and walking the street, in particular, have been demonstrated by the different voices talking of sex work. The diverse discourses – of the media, institutional, popular and some scientific discourse – limit their ambit to poverty, marginalization, degradation, drugs and disease. At the moment, this topic is becoming more visible through the rhetoric of the struggle against human trafficking and sexual exploitation (Oliveira, 2011, p. 8-9).

Despite this, in contrast to this perspective, the academic interviewed stated:

I am not one of those people who assumes that because an individual is a migrant they are automatically more vulnerable [...] there is greater vulnerability because of the whole process [of immigration] with which these individuals have to struggle, but this does not make them an inevitably more vulnerable group.

An element of vulnerability of SWs working in clubs and pensions, indicated by several authors (Costa and Alves, 2001; Ribeiro et al., 2008; Sacramento, 2005), in addition to the informal nature of the activities, lies in the clients' constant search for novelty, obliging them to permanently circulate in different areas of the country, what is called in the slang of the profession "uma praça", meaning they cannot stay in one place or one residence for any significant time. According to Ribeiro et al. (2005, 2008), sex work thus becomes informal work, largely practiced by immigrants, among whom are many women who are in the country illegally, hiding themselves in pensions, clubs or bars. Inside the clubs, the SWs are subject to a set of rules, usually internally enforced, which fit into no legal framework.

Prostitution is not regulated. The informality of sex work, to which is often added being illegally resident in the country, frequently poses an obstacle to health care and is a risk factor for STIs, due to fear of being identified by workers in the care institutions who could share data obtained with law enforcement leading to being deported from the country, inhibiting women in situations of illegal residence from seeking health care structures for diagnosis and support, as well as the reluctance or impossibility of getting to health care institutions, due to lack of knowledge, lack of trust in the system, poor self-esteem and subsequent negligence in relation to health care, or even due to fear of discrimination (Deschamps, 2006; Brussa and Munk, 2010; Sacramento, 2005, 2011), as one of the CSO social workers interviewed stated:

In relation to immigrants, access to health care is a difficult situation in Portugal [...] there is the fear of using the services and being identified to the SEF [Immigration and Border Control], fear of not being accepted, being stigmatized and going back to their home countries. If they have the courage to face all of this process, it is still not easy, there is the whole bureaucratic process, going to the Junta de Freguesia to get two proofs of residence there, voting card stating the person has lived there for more than 90 days [...] Then there is the issue of communication, obstacles, those who don't know the laws, memorandums which have been circulated, as there is a law which includes all of this, but sometimes it is not put into practice. Just getting to the practice is a bureaucratic process. Then, they are not totally aware of their own rights, so they are afraid, they don't know the law, they are in a new country, a different country.

Difficulties in accessing health care may contribute to, and reinforce, the vulnerability in relation to STIs, which has been referred to by several authors (Ribeiro et al., 2005, 2008; Ribeiro and Sacramento, 2005) who observed that the isolation and social characteristics of this population make it easier for them to develop inter-personal difficulties and psychological discomfort, which enhances risky behavior with regards STIs as the multiplicity of sexual partners, and the pressure from the clients to have unprotected sexual relations increases the risk of contracting an STI. One CSO social worker we interviewed describes this situation:

There are reports of clients who are very insistent about not using protection and it is sometimes difficult for someone without any money to resist. Of course, it is always emphasized that they have to think about themselves, look after themselves, put their health first, it is the most important thing, but the current situation does not help. One agrees, another doesn't, try here, try there, but our objective here is to empower the women in relation to the client.

Contexts and situations of risk

According to Beck (1992), we are experiencing a stage of modernity in which individual and collective risk, although monitored and controlled by contemporary society, tend to escape social institutions of control and protection. Seeking excitement through taking risks can be understood as a way of escaping social control mechanisms (Rojek, 1995; Maia, 2010c). There is a risk culture which, in some places, takes on a dimension of transgression (Lagunes, 1998; Maia, 2010b; Ribeiro, 2003). The relationship between SWs and clients is often marked by the mismatch between the formers' interest in safety and the taste for risk belonging to a large part of the latter (Oliveira, 2004; Ribeiro e col., 2005; Sacramento, 2005).

Various studies (Manita and Oliveira, 2002; Muianga, 2009; Ribeiro et al., 2005) have shown that, in general, prostitutes know the risks and the power of sexual self-determination, worry about their health and practice safe sex. On the other hand, clients often seek to experience risk through unprotected sex, which they used as a mechanism to seek excitement. Consequently, "[...] they play a decisive role in raising clients' awareness, many of whom have a manifest "propensity" or "taste" for unprotected sexual relations" (Ribeiro et al., 2005, p. 49). STI prevention programs developed over the past five years argue for taking into account both the SW and the client, although this is difficult in practice, access to clients can only be obtained through the providers of sexual services as they tend to "hide".

Some of the women we interviewed for the study conducted by Ribeiro et al. (2005) revealed they were shocked with the increased search for unprotected sex on the part of Portuguese clients, in contrast to the unquestioned use of protection in force in other work contexts they were familiar with. The clients are a fairly heterogeneous group, both with regards social level, regarding the motives behind their resorting to paying for sex and the type of interaction with the SWs. If there is one common denominator, it is the predisposition to risky sexual practices.

According to the SW interviewed, clients increasingly want to use protection.

I use [condoms for oral sex], and many clients request this, which they didn't before. [...] when you start touching them, some think you aren't going to put one on. But I have it in my hand, I'm prepared. I automatically take it out of the wrapper, put it in my hand and start work with it already in my hand.

And many clients are shocked, they think I'm not going to use it. This is good. [...]before, about 60% used condoms, and around 30% didn't want to, including at the beginning, but now they think a bit more. [...] The way things are today, you can't, and you don't need to [take risks]. The way you put it on is very important, he might not even notice, some people don't know how to put it on, they're rough, and then they don't get excited, it breaks the mood. [...] so, the way you put it on is important. Often I put it on and they ask if it's on already and I say yes. Professionalism is important, the way you communicate to the client how important the condom is.

Ribeiro et al. (2005) pointed out four reasons for deliberately seeking out danger: the hegemonic values of masculinity; situations of sexual "indigence" / "immaturity" (such as physical limitations or relationships which make the process of seducing the opposite sex more difficult, lack of knowledge and shame regarding sexuality); emotional ties which sometimes develop between the client and the SW, leading to relaxing of prevention and seeing the condom as an obstacle to intimacy; lack of knowledge of STIs and methods of preventing them, or even viewing HIV infection as a "disease only affecting others" (Ribeiro et al., 2005). Other authors in other relationship contexts, Maia (2009) and Parker (1994) also note similar reasons. Men tend to view facing risk as a way of overcoming limits and fear, a test of bravery and sexual power, an indicator of virility (Delicado and Gonçalves, 2007; Maia, 2009; Ribeiro, 2003; Sacramento, 2005), leading them to self-destructive lifestyles, in which risk is seen as something to be faced rather than something to be avoided (; Lagunes, 1998).

Tension between SW and client is almost always related to the client desiring certain practices, such as anal penetration or manipulation, to which the woman is not receptive, or to protection, which many clients refuse to use. Sometimes the women yield to such requests when they are in situations of economic insecurity or, more frequently, due to the urgent need to get money for drugs, in the case of SWs who are drug addicts, or due to lowered awareness and self-control in the case of women who are alcoholics (Oliveira, 2004; Ribeiro et al., 2005; Sacramento, 2005).

Another situation in which protection is abandoned occurs when a romantic relationship develops and the prostitutes find themselves emotionally involved (Oliveira, 2011). Agreeing to unprotected sex is explained by the symbolic significance of the trust this demonstrates and by feelings of love, as occurs in other populations (Maia, 2009, 2010a, 2010b). One of the CSO social workers interviewed referred to this situation:

Partners are an important part of prevention which is often forgotten. Often, the women use condoms with clients but then don't use them with their partner. This happens, not always, but it happens.

Civil society organizations in preventing STI in sex workers

The study by Ribeiro et al. (2005) indicates that access to public health care services is made more difficult by the social stigma with which prostitutes are burdened, by their high turnover and the mobility sex work often requires and by the impossibility of women without documents having access health care equal to those of other foreign citizens legally residing in the country, except in situations in which public health is endangered[4].

Social discourses usually present prostitutes as slaves in the hands of pimps and club owners, losing sight of the relative bargaining power and strategic ability of women who choose, although under certain constraints, usually economic, to perform these activities, portraying them as victims without due contextualization. Women who prostitute themselves internalize the dominant norms and values, but reject the stereotypes and stigma with which they

4 Order nº 25,360/2001 establishes that foreigners residing illegally may only access National Health Care System services if they can prove, through documentary evidence issued by a Junta de Freguesia that they have been in Portugal for more than 90 days and can cover the expenses, except in situations in which public health is endangered. Some SNS establishments take the Ministry of Health severity even further, denying access to care on unlawful grounds, such as not being registered in the health center. HUMAN RIGHTS WATCH. Illegal immigrants' right to health. Report May 2010. Available: <www.observatoriodireitoshumanos.net/.../relatoriodireitosaude.pdf>. Accessed: 18 April 2011.

are targeted by the general public, clients, bosses and institutions. And they are increasingly challenging forms of exploitation, domination and violence (Ribeiro et al., 2008).

Civil society organizations have contributed to increased health literacy and knowledge of social rights in SWs, as well as to their increased empowerment. The interviews with the social workers from these organizations showed that victimization associated with the practice of prostitution exists, but is of a residual character. Apart from specific cases of sexual exploitation, the mainstream of organizations which support SWs view prostitution as an option freely chosen by those who practice it, irrespective of the reasons inherent to this choice, which are not questioned as they are understood to be a private element to each individual.

The organizations do not aim to "rescue sex workers from that life", but rather, above all, to minimize the potential risks inherent in this activity, namely those related to STIs. The concept of vulnerability adopted here is distant from a charitable/caring vision and aims to take on a scientifically based pragmatic character, based on World Health Organization and UNAID (Program dealing with HIV/AIDS in partnership with the United Nations) recommendations, which estimate that SWs and their clients, men who have sex with men, intravenous drug users and their partners, unemployed young people and the prison population are those most vulnerable to STIs (UNAIDS, 1999, 2012).

Civil society organizations act in a variety of ways in managing this issue and their social responses cover SWs as a whole, irrespective of nationality. As a rule, interventions in proximity to the physical "field", when CSO social workers operate in the locations where prostitution goes on, whether walking the street or indoors, are favored. Regular contact encourages trust between SWs and the CSO social workers, creating a context favorable to raising awareness of and preventing STIs. This is the case with the "Give sex workers a voice" project, developed by the Portuguese Activists for HIV/AIDS treatment - Pedro Santos (GAT), which undertook a significant intervention in the indoor context.

Other organizations, such as the Oblate Sisters (Irmãs Oblatas), New Faces, New Challenges (Novos Rostos Novos Desafios), the Positive (Positivo) and the APDES, divulge their services or distribute material in the outdoor, street walking context, with teams of CSO social workers often using vans. This work in the streets is complemented by governmental support, as in the case of the "Red Light" project, by the Positive Association, offering a holistic and integrated approach to sex work in their facilities in Cais do Sodré, based on the diversity of services which complemented it: appointments with doctors and nurses; psycho-social and legal support; information on STIs and material for their prevention.

When implementing their projects, the civil society organizations have financial support from the State, in the form of the National Coordination for HIV/AIDS Infection, ADIS/AIDS program – discontinued in 2012. When this project came to an end, support to the tertiary sector in the HIV/AIDS area was heavily reduced. There are a few government initiatives such as the Self-esteem health program, run by the Northern Regional Health Administration (ARS), the target population of which is sex workers.

To support and tailor their interventions, the organizations seek to develop studies identifying and diagnosing the main aspects inherent to STIs. In this ambit, the "PREVIH – HIV infection in men who have sex with men and sex workers: prevalence, determinants and preventative interventions and access to health care services", promoted by the GAT, in partnership with the Institute of Hygiene and Tropical Medicine, between 2009 and 2013 stands out. The interviews highlighted the fact that the organizations are essential partners in these studies, due to their being in a privileged position to gain access to SWs, due to their activities in proximity. This aspect favors using questionnaires, although this runs the risk of obtaining biased samples, as those who make use of civil society organizations are not necessarily representative of the universe of the population.

In the context of the project, 1,040 health workers were questioned, of whom 853 were female, corresponding to 82% of the total. Of these SWs, 460 (57.4%) worked walking the street, 301 (37.5%) operated indoors and 41 (5.1%) worked both outdoors, walking the street, and indoors; 91% stated they had used condoms with all clients in the last month, 8.3%

reported using them sometimes, and 0.7% admitted they rarely or never used condoms; 41.6% of the sex workers interviewed had had contact with prevention campaigns within the preceding year and 91.4% had received free condoms on at least one occasion; 67.5% had been tested and were aware of the result, with 6.6% of these having tested positive; 58.5% of seropositive sex workers who were aware of their situation stated they were undergoing treatment (Dias et al., 2013).

According to a report published by the European Centre for Disease Prevention and Control (ECDC, 2013), comparing data regarding HIV prevalence in sex workers in 27 countries in Europe and Central Asia, Portugal is the country with the third highest prevalence of HIV infection in sex workers (8.9%), exceeded only by the Ukraine (9%) and by Latvia (22.2%). This high prevalence of HIV infection contrasts with reported use of means of prevention and diagnosis. The discrepancy found here may indicate formal (though not necessarily actual) adherence to the socially valued rhetoric of prevention, channeled by the organizations, on the part of sex workers. This discourse itself may be more or less well grasped, conditioning practices of using the proposed means of prevention. Thus, we are faced with a potential explanatory factor to consider when critically analyzing the effectiveness of these actions.

Despite the relevance placed on STIs, vulnerability to infection is not the only risk identified by the associated CSO social workers and activists interviewed, who highlighted the issue of violence – on the part of clients and on the part of institutions, both strengthened by the fact of the sex worker performing an activity which is outside of any legal framework: the practice of prostitution is not criminalized, but nor is it a formally recognized profession as such. In the case of the immigrant population, for whom the regularization process requires a legally recognized professional activity, this poses obvious difficulties, rendering the process impossible. For SWs in general, not paying social security contributions or tax, something inherent to their professional activities, places them in a social limbo, as they have no access to their duties as citizens, nor to the corresponding rights, in this case, social rights are acquired through such contributions.

Returning to the activities of civil society organizations, the coordination between themselves is well known, although these partnerships are not systematic. However, things appear to be evolving in this direction, with the creation, in 2011, of a Sex Work Network (RTS), coordinated by the GAT and the Piaget Agency for Development (APDES), an initiative of the latter. Here, organizations, and also some sex workers, meet in a, still embryonic, experience of participation. The objectives are to share good practice, maximize resources, promote debate, draw up documents together, promote awareness raising actions and monitor policies referring to sex work. Beyond investigation-action in preventing STIs and providing social support to SWs, the civil society organizations also seek to lobby regarding sex work in Portugal, thus adopting a multi-dimensional approach to this issue.

One issue which emerged as essential is SW participation in these organizations and in the projects/services directed towards them. The interviews showed how the organizations tend to use a pragmatic, non-discriminatory discourse aiming at the SWs' physical and mental well-being. To do this, they develop projects and offer services aiming to reduce risk and improve the conditions in which sex work takes place. However, the targets of their effort remain absent from the managerial and executive structures of these organizations and their involvement in projects is essentially as the destination, rather than collaborator, despite experiences of peer training and education.

The reduced participation of SWs in conceiving, executing and evaluating projects aimed at them fosters a notion of "well" which is not theirs, but rather that of those who control the policies and services, or work within them: that which political agents (who finance the projects) and managers and social workers from the organizations who implement them consider desirable for the SWs does not necessarily coincide with what they themselves consider desirable. This fact may produce dynamics of mutual manipulation; of the organizations towards the SWs, trying to promote specific behavior and referring them to services which they consider beneficial or have the responsibility of implementing, although not necessarily of interest to the SW; and of the SWs

towards the organizations, adopting an attitude which they believes corresponds to that which the CSO social workers regard as appropriate, but which does not correspond to their true way of being.

This situation is demonstrated by one of the CSO social workers interviewed, who refers to how SWs' discourse tends to sometimes try to meet the expectations they have of what the social worker expects to hear, as a way of obtaining specific goods or services. On the other hand, the social worker provides these goods or services with the aiming of promoting adherence to what is considered desirable behavior.

> *They end up by using, or trying to use, the teams around here, as it is much more practical to have someone come there bringing condoms and lube, but this is a strategy working with health issues, lower risk practices, referrals to health care and related services.*

The immigrant SW interviewed revealed an ambiguity of discourse which may be symptomatic of the propensity to fit in with what is seen as the dominant, socially valued rhetoric, although this discursive adherence does not correspond to actual adherence. If, on the one hand, it refers, in a sorrowful tone, to the "fall into prostitution", on the other it describes, in a fairly pragmatic way, a decision, based on a rational calculation of essentially economic costs/benefits, in which the issue of "moral decline" does not appear.

Conclusion

The design of social and health care policies in the field of sex work should: target clients in preventative campaigns; involve SWs in prevention projects directed at them (*peer-education approach*); guide policies and projects from a more holistic and comprehensive perspective; improve accessibility of national health care services for individuals without documents; and combat the social stigma with which this population is burdened and which brings about situations of fear, nervousness and depression (Ribeiro et al., 2005).

As Ribeiro et al. argue (2008), legalizing prostitution as sex work would enable associations, syndicates or legally constituted companies to be organized, enabling labor and social rights to be defended, such as means of prevention, public health defense mechanisms, Social Security payments and taxes, combatting underground economic practices, without medical-health support or taxation.

Self-organization by SWs appears, then, as an essential element in the defense of their interests and rights. The interviews showed that self-organization is not a reality due to a variety of potential causal factors which lack in-depth examination and clarification: political-institutional factors, such as the lack of a legal framework within which sex work can operate; social factors, such as discrimination associated with the activity; and individual factors, such as being demotivated regarding deeper civil involvement. All of these factors point to an open hypothesis in explaining the greater or lesser degree of self-organization in SWs, as, in the absence of a consistent associative movement, defending their rights basically falls to civil society organizations. This fact leads us to ask to what extent these organizations in fact represent SWs: are their objectives and the means used to achieve them in consonance with what sex workers understand as desirable for themselves? The question remains unanswered, requiring more in-depth investigation.

Regarding STIs, it remains to be evaluated whether the risky or protective behavior they report adopting actually conforms to reality, with regards condom use. In certain contexts, factors which propitiate risky behavior that take on greater weight in the eyes of SWs regarding protection from STIs may appear, for example, economic considerations, when a client pays more for unprotected sexual relations. To what extent will the SW openly admit this behavior to the CSO social worker, and how feasible it is to raise awareness for their reduction are pertinent issues in developing and executing policies, measures and programs for preventing STIs.

These organizations take on considerable responsibility, considering that they act not merely as service providers, but also as SW representatives. In the White Paper on Governance (European Commission, 2001), the European Commission refers to greater participation of organizations in government mechanisms, implying greater responsibility and demanding respect for the principles pf good

governance. European Union (EU) Social Policies, which inarguably influence Portuguese social practice, recommend the active involvement of citizens in political mechanisms which affect them, so as to promote empowerment, understood as the ability to generate their own change (International Labor Office, 2003). This is the greatest challenge to civil society organizations: promoting SW participation in policies and projects which involve them. This will require alterations in structures of power and responsibility in the heart of the organizations themselves, so as to integrate SWs as peers and not merely as users.

In the specific case of immigrant SWs, especially those who are not legally resident in Portugal, the issue becomes more complex, as developing the usual initiatives to control and prevent STIs, recommended and incentivized by the State, is not enough. In this case, it may even be necessary to take on positions in contrast to the institutional mainstream, in the sense of promoting illegal immigrants' access to health care in a more global perspective. This access is conditioned by practices rooted in health care service providers and other relevant institutions. The above mentioned case describes the bureaucratic process inherent in obtaining two proofs of residence, or lack of knowledge of the law on the part of administrative personnel in clinics, health centers and hospitals, which could be obstacles in access to legally enshrined rights.

One issue appears to be primary: States use exclusion to access to health care as a way of making life more difficult for immigrants, thus seeking to discourage illegal immigration, and this has negative effects not only on the immigrants themselves, but on public health, namely in the level of propagation of STIs. The Council of Europe Committee on Social Rights recognizes this fact when it stipulates that any legislation or practice which denies access to health care to foreign citizens in the national territory of member states, even if these citizens are there illegally, is contrary to the European Social Charter. In accordance with this principle, the Portuguese Constitution establishes the right of all citizens, including foreigners, to health care, irrespective of their economic, social or cultural condition. It is here that the political activism of civil society organizations regarding immigrant SWs' access to health care takes on most relevance. This activism may mean confrontation, which is not always "politically correct", with the state bodies which are usually the organizations' allies, facing them with the difficult dilemma of choosing between loyalty to their "patrons" and their duty to represent the interests of SWs.

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Received: 06/14/2013
Reviewed: 11/15/2013
Approved: 01/07/2014