HIV Service Utilization among Female Sex Workers in St. Petersburg, Russia:

Individual and Contextual Influences on Access to Testing and Treatment Services

Elizabeth Jane King

A dissertation submitted to the faculty of the University of North Carolina at Chapel Hill in partial fulfillment of the requirements for the degree of Doctor of Philosophy in the School of Public Health (Department of Health Behavior and Health Education).

Chapel Hill
2010

Approved by:
Suzanne Maman, PhD (Chair)
J. Michael Bowling, PhD
Kathryn (Beth) Moracco, PhD
Michele Rivkin-Fish, PhD
Ivana Vuletić, PhD
Abstract

Elizabeth Jane King

HIV Service Utilization among Female Sex Workers in St. Petersburg, Russia: Individual and Contextual Influences on Access to Testing and Treatment Services

(Under the direction of Suzanne Maman)

Introduction: Female sex workers, especially women who are injection drug users, are particularly vulnerable to HIV in St. Petersburg, Russia. Factors that influence the utilization of services by this marginalized population have not been adequately explored. The objective of this mixed-methods study was to gain a better understanding of the facilitators and barriers to accessing HIV services for female sex workers. The research was guided by the theoretical perspectives of the Health Belief Model and Structural Violence.

Methods: Fieldwork in St. Petersburg consisted of participant observations of HIV services, and 29 in-depth, semi-structured interviews and 152 structured interviews with female sex workers. Qualitative data were coded in Atlas.ti and multivariable logistic regression was performed using SAS 9.2 to determine which factors were associated with recent HIV testing.

Results: The mixed-methods findings showed that perceived barriers to getting an HIV test revolved around fear of learning the results, worrying that other people would think they were sick, and the distance needed to travel to obtain services. Quantitative data
demonstrated that if a female sex worker reported knowing someone who has HIV then she was more likely to have had a recent HIV test [OR=6.31, 95% CI (1.06, 37.44)]. The results of this study revealed that female sex workers experience stigma, discrimination, and physical violence. Participants discussed the fear or being treated poorly by health care providers because of their status as sex workers, drug users, and HIV-infected. Results from the quantitative data analysis indicated that female sex workers who perceived stigma associated with HIV to be high were less likely to have received a recent HIV test [OR=0.90, 95% CI (0.84, 0.97)]. There are structural barriers embedded within the health care and state system that participants struggle to negotiate with, and in many cases are limited by their social marginalization to access the care they need.

Conclusions: Results from this study highlight the need to improve access to HIV services for marginalized populations, further expand outreach services for sex workers on the streets and in brothels, address stigma in the health care system, and develop innovative ways to provide support to marginalized populations in negotiating the utilization of HIV services.
Acknowledgements

My sincere thanks go to my dissertation committee for guidance through this process. Foremost, I would like to express my deepest appreciation to my academic advisor and dissertation chair, Suzanne Maman, whose steadfast support and objective encouragement proved invaluable in helping me to develop my scholarly pursuits. I learned a lot from working with Suzanne on an array of HIV-related projects, and this dissertation research benefited tremendously from her thoughtful feedback and mentorship. I am very grateful to my other dissertation committee members for their unique contributions and support in this multidisciplinary endeavor— to Mike Bowling for his patience and guidance in completing the statistical analyses; to Beth Moracco for her help with use of behavioral theory and survey development, and for support with the statistical analysis; to Michele Rivkin-Fish for her ongoing feedback and support since the formation of research ideas and funding proposals, and for guiding me through new theoretical terrain during my doctoral studies; and to Ivana Vuletić for her dedication to helping me communicate my ideas to an interdisciplinary audience, and for her unwavering support over the course of my time at UNC.

I am obliged to the faculty and staff in the Department of Health Behavior and Health Education who have supported me through my doctoral studies— especially to Jo Anne Earp for being a caring and involved Departmental Chair and to Susan Ennett for being a supportive Director of Graduate Studies. Additionally, I would like to
acknowledge Viktoria Ivanovna Dudina, my host mentor at St. Petersburg State University.

My research would not have been possible without the financial assistance from the following sources: U.S. Department of Education Fulbright-Hays Doctoral Dissertation Abroad Fellowship, UNC Gillings School of Global Public Health Travel Award, UNC Center for Slavic, Eurasian, and East European Studies Foreign Language and Area Studies Fellowship, and UNC Graduate School Royster Society of Fellows Dissertation Completion Fellowship.

I am blessed to have had the support of so many wonderful people during my doctoral program. I would like to thank my parents, Jon and Suzanne and my brothers, Loren and Dean for cheering me on. I cannot thank my mom and dad enough for their unrelenting encouragement and support, and for making the journey to Russia to visit me during my fieldwork. While too many to name here, the colleagues and friends I have met during the doctoral program at UNC have made the entire voyage that much more worth its undertaking. They, along with many other friends scattered around the globe, have been wonderful sources of inspiration and reminders of why public health research is important. I am especially grateful to Sarah Wyckoff and Bahby Banks for being such generous friends and colleagues throughout this endeavor: engaging in thoughtful discussion during each phase of this process, providing countless pep talks and incalculable hours of comradeship in the libraries, and offering multitudes of logistical support. I would also like to thank Marie Donahue, Andrea Heckert, and Laurie Abler for lending their ears for reflection, eyes for editing dissertation text, and homes during times of transition between international travels. My friends in Russia have helped to make St.
Petersburg home for me over the course of many years. I am especially grateful for the support during my dissertation fieldwork to Alexander Glebov, Svetlana Palamodova, Marina Stratanovich, and Natalya Yatsenko for helping me process, navigate, and contextualize throughout the research process, and for making sure I had fun when I was not conducting research.

I would like to acknowledge the NGO outreach workers, especially Irina Maslova, in St. Petersburg who allowed me into their vans, accompanied me to interview sites, helped with surveying, and provided further insight into my research questions. My research would not have been possible without their cooperation.

Finally, my heartfelt thanks go to the women who participated in this research project for sharing their time and stories with me, and entrusting me to represent them in this dissertation. I present my dissertation findings as a modest contribution to the efforts to better their lives and the lives of those around them.
Table of Contents

List of Tables ....................................................................................................................... x

List of Figures ......................................................................................................................... xi

List of Abbreviations .............................................................................................................. xii

CHAPTER 1: INTRODUCTION ................................................................................................. 1

CHAPTER 2: BACKGROUND AND SIGNIFICANCE ................................................................. 4

  2.1 Society in Transition ...................................................................................................... 4

  2.2 HIV/AIDS in St. Petersburg, Russia ............................................................................... 5

  2.3 Female IDUs in St. Petersburg, Russia .......................................................................... 8

  2.4 Sex Work in the Russian Federation .......................................................................... 8

  2.5 Sex Work and Injection Drug Use among Women: More Partners, Less Condom Use, and More Needle Sharing ................................................................. 10

  2.6 Female IDUs’ HIV Risk Influenced by Male Sexual Partners: Partner’s Drug Use and Partner Violence ......................................................................................... 11

  2.7 Marginalization and Vulnerability ............................................................................. 12

  2.8 HIV Services in Russia ............................................................................................. 17

  2.9 Accessing HIV Prevention Services: Experiences of Female IDUs and Sex Workers ......................................................................................................................... 24

CHAPTER 3: THEORETICAL FRAMEWORK ......................................................................... 26

  3.1 Health Belief Model ..................................................................................................... 27

  3.2 Structural Violence ..................................................................................................... 28

  3.3 Conceptual Model: Health Belief Model and Structural Violence ............................ 30

  3.4 Research Aims ........................................................................................................... 33

CHAPTER 4: RESEARCH DESIGN AND METHODS ............................................................... 34
List of Tables

Table

1. Health Belief Model Constructs as Determinants of HIV Testing.............28
2. Socio-demographic Characteristics of Street-based Sex Workers..............68
3. HIV Testing Behaviors among Street-based Female Sex Workers..............70
4. HIV-positive Participants.................................................................71
5. Mixed-methods Findings based on the Constructs of the
   Health Belief Model..............................................................................73
6. Barriers to Getting an HIV Test.........................................................80
7. Benefits to Getting an HIV Test..........................................................85
8. Associations between Individual-level Factors and Recent HIV Testing.....92
9. Associations between Perceived Stigma and Recent HIV Testing............106
List of Figures

Figure

1. Structure of the Services for Preventing and Confronting HIV/AIDS in the Russian Federation
   ........................................................................................................19

2. Conceptual Model for Looking at Utilization of HIV Services:
   Health Belief Model and Structural Violence..........................................32
**List of Abbreviations**

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>Acquired immunodeficiency syndrome</td>
</tr>
<tr>
<td>ARV</td>
<td>Antiretroviral (medication)</td>
</tr>
<tr>
<td>HBM</td>
<td>Health Belief Model</td>
</tr>
<tr>
<td>HIV</td>
<td>Human immunodeficiency virus</td>
</tr>
<tr>
<td>IDU</td>
<td>Injection drug user</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-governmental organization</td>
</tr>
<tr>
<td>PMTCT</td>
<td>Prevention of mother-to-child transmission</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually transmitted infection</td>
</tr>
</tbody>
</table>
CHAPTER 1: INTRODUCTION

Human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) is an increasing concern for Russia and in particular for St. Petersburg, which has one of the highest prevalence and incidence rates of HIV in the country (Onishchenko, 2005; Rakhmanova, 2007, Federal AIDS Centre, 2010). Women constitute an increasing proportion of new HIV infections in Russia (UNAIDS, 2005; Yakovleva, 2008). The HIV epidemic in Russia is concentrated primarily among injection drug users (IDU) (UNAIDS, 2005; Onishchenko, 2005; Sokolovskii et al., 2005; Volkova et al., 2006), and many female IDUs report engaging in sex work (Benotsch et al., 2004; Kozlov et al., 2006). The St. Petersburg City AIDS Center offers counseling and testing services and serves as a gateway for access to treatment and care, yet a significant number of people living with HIV/AIDS are not utilizing the services (Volkova, 2006; Yakovleva, 2008). Factors that influence the utilization of services by marginalized populations have not been adequately explored in Russia.

The objective of this study was to gain a better understanding of the facilitators and barriers to accessing HIV services for female sex workers in St. Petersburg, Russia. Recognizing that decisions around utilization of HIV services are influenced by both individual and social factors, two theoretical perspectives were used. The Health Belief Model guided the exploration of individual-level perceptions of susceptibility, severity, self-efficacy, barriers, benefits, and environmental cues believed to influence utilization of HIV prevention services. The framework of Structural Violence expanded the research
focus through the examination of the social, economic, political, and historical contexts in which female sex workers live and the impact these contexts have on access to HIV services. This study had the following specific aims:

1. To describe HIV prevention services currently available in St. Petersburg and the extent to which female sex workers are accessing them.

2. To explore the barriers and facilitators for female sex workers’ access to HIV services.

3. To identify correlates of uptake of HIV counseling and testing services among female sex workers.

The study used qualitative and quantitative methods to address these aims. Fieldwork in St. Petersburg consisted of participant observations of HIV services, and in-depth interviews and interviewer-administrated questionnaires among female sex workers. The qualitative and quantitative analyses were done simultaneously, which allowed continuous comparison of the findings from the two data sets.

The results are presented in this dissertation in four sections. The first section provides a description of the HIV services available for female sex workers in St. Petersburg. The second section provides a description of the female sex workers who participated in the in-depth interviews and/or the questionnaire, including demographic characteristics and information on past HIV testing. The third section explores the individual-level factors determined to influence utilization of services. The fourth section provides information on the layers of stigma and discrimination in female sex workers’ lives and describes how these factors are associated with access to services. The fifth section describes the structural barriers that female sex workers experience in trying to access HIV services and explains how women attempt to navigate this system.
The information gained from this study can be used to inform further research of marginalized populations, intervention strategies to improve access to HIV services, and policy decisions regarding the HIV/AIDS epidemic in Russia. The dissertation ends with a discussion of the research, program, and policy implications of the findings from this study.
CHAPTER 2: BACKGROUND AND SIGNIFICANCE

2.1 Society in Transition

The Soviet Union collapsed in 1991 and the Russian Federation at that time became the independent, successor nation state. 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 socialist social welfare systems, including health care services, a series of economic crises, demographic crisis, and documented increases in “diseases of capitalism” (such as sexually transmitted infections) and “deviant social behaviors” (such as alcoholism, prostitution, and drug use) (Lamptey et al., 1998; Atlani et al., 2000; Goodwin et al., 2003). The HIV epidemic was documented later in Russia than in many countries in Western Europe and North America, and the first cases appeared around the same time as the USSR was coming to an end (Latysheva, 1999; TPAA, 2003; AFEW, 2007).

Since the fall of Soviet power, numerous foreign, including United States, government-sponsored and non-governmental organizations (NGOs) have come to Russia to address the social and public health problems of a society in transition. One of the major goals of this influx of outside aid has been to create a civil society and build the basis for a democratic society (Hemment, 2004). However, it is important to note that
public health institutions in Russia have been and continue to be largely state-run institutions. Also, NGOs in Russia are often competing with one another for limited financial resources (Hemment, 2004). The relationship between civil society and state-governed entities remains to be resolved. While there do exist examples of effective joint ventures, tensions remain between perceived government responsibility and the role of non-governmental, often Western-funded, agendas (Mendelson, 2001).

St. Petersburg is the second largest city in Russia with an official population estimated at 4.7 million. It is located on the Gulf of Finland and the Neva River in the north-western part of European-Russia. St. Petersburg, once the capital of the Russian empire, remains an epicenter of cultural and intellectual activities in Russian society. Unfortunately, St. Petersburg is also one of the cities in which the Russian HIV epidemic is concentrated, as it is home to many of the country’s injection drug users, sex workers, homeless, and formerly incarcerated individuals. St. Petersburg is a port city and located on major highways both within Russia and to international destinations, thus creating an environment where risk behaviors such as involvement in transactional sex and selling of drugs are known to take place.

2.2 HIV/AIDS in St. Petersburg, Russia

The number of official HIV cases in the Russian Federation in 2009 was 516,167 (Federal AIDS Centre, 2010); however UNAIDS estimates the true number to be between 630,000 and 1,300,000 (UNAIDS, 2008). St. Petersburg has one of the largest numbers of registered cases in Russia (Onishchenko, 2005; Rakhmanova, 2007). In 2009, there were 42,468 registered cases in the city of St. Petersburg, with an additional 16,184
cases in the Leningradskai oblast’ (Federal AIDS Centre, 2010). At the beginning of 2006, official statistics showed that 0.6% of the population in St. Petersburg was HIV-positive (625.8 out of every 100,000 people are infected) (Volkova et al., 2006). It is estimated that these numbers are in fact four to five times higher than the official statistics (Volkova et al., 2006). More than 80% of those infected with HIV in Russia are under the age of 30 (Skvortsov, 2005). In 2005 in St. Petersburg, 88.6% of those testing positive for HIV indicated that they injected drugs (Volkova et al., 2006). Increase in drug use in Eastern Europe has been attributed to the change in drug trafficking routes, the economic crises, poor health determinants, a collapse in the health care system and “failing public health policies,” (Godinho and Veen, 2006). While the majority of cases of HIV are among IDUs, the sexual transmission of the virus is on the rise with commercial sex work seen as one of the reasons (Onishchenko, 2005; Sokolovskii et al., 2005).

Throughout Eastern Europe the rates for women are increasing faster than rates for men (UNAIDS/UNFPA/UNIFEM, 2004). It is estimated that 44% of registered HIV cases in Russia are among women (Yakovleva, 2008). Sexual transmission was indicated as the cause for 22% of females testing positive for HIV in 2005 in St. Petersburg (Volkova et al., 2006). It is believed that sexual transmission to women often comes from drug using partners in Russia (Onishchenko, 2005). HIV infection among women also has serious implications for transmission to children and child abandonment (Khaldeeva et al. 2003, Onishchenko, 2005; Hillis et al. 2007). A deeper understanding of women’s risk for HIV is necessary and prevention and treatment activities must take into account
gendered approaches. However, there remains a dearth of information about women’s risk for HIV in Russia.

Much of the attention on women’s risk for HIV in Russia has focused on mother-to-child transmission. The number of women giving birth who are HIV positive is on the increase in St. Petersburg and in 2002 there were 485 HIV-positive women presenting at the high-risk maternity hospitals in the city (Khaldeeva et al., 2004). In St. Petersburg in 2009, 682 infants were born to HIV-positive women (Federal AIDS Centre, 2010). One hundred fourteen of the 485 HIV-positive mothers did not receive prenatal care (Khaldeeva et al., 2004). HIV testing is part of routine prenatal care in Russia, so it is probable that the women had not received HIV testing and counseling services despite their risk for the disease. Current research in St. Petersburg demonstrates that HIV positive women are at high risk for abandoning their infants at time of delivery (Khaldeeva et al., 2004; Hillis et al., 2007). HIV-positive women who do not receive prenatal care are even more likely to abandon their infants than HIV-positive women who receive prenatal care (Khaldeeva et al., 2004; Hillis et al., 2007). An additional concern is that a significant number of HIV-positive mothers do not register with the City AIDS Center (which is the primary, government care and treatment service in St. Petersburg) and are not getting care for themselves or their infants (Rakhmanova, 2007). The situation with pregnant women in St. Petersburg provides evidence that women are not receiving the services that could best lead them to available treatment and care services and also help prevent the spread of the infection to others. Nonetheless, research on women’s risk and involvement with prevention services must expand beyond the focus on pregnancy. The lack of information on women’s testing experiences and encounters
with HIV services outside of prenatal and maternity care remains a major gap in the scientific literature.

2.3 Female IDUs in St. Petersburg, Russia

Europe, particularly Central and Eastern Europe, is home to one-third of the world’s heroin users and this has contributed immensely to the region’s HIV growing epidemic (Matic, 2006). High-risk intravenous drug use (IDU) and sexual practices are fueling the epidemic in St. Petersburg. 80% of registered HIV cases in Russia are among IDU (UNAIDS, 2005). Among IDU in St. Petersburg, 30% are HIV-positive (Sokolovskii et al., 2005). HIV risk among IDU includes both risky drug using behaviors and risky sexual behaviors (Rhodes et al., 1999). Drug users often do not have a permanent residency, are unemployed, lack health insurance, are not entitled to receive free health care, and do not have the resources necessary to utilize paid services for testing and treatment of sexually transmitted infections (STI) (Sokolovskii et al., 2005). Injection drug use has had a male face in Russia, but through the emerging research it is becoming clearer that women are also engaging in this risky behavior. In St. Petersburg, an estimated 40% of IDUs are female (Benotsch et al., 2004). Ninety percent (90%) of female IDUs in St. Petersburg have an STI (Sokolovskii et al., 2005).

2.4 Sex Work in the Russian Federation

Sex work is illegal in the Russian Federation. Some organizations have argued for the decriminalization of prostitution in order to raise the status of the women involved in the profession and thereby protect their rights and health. Many young women in Russia
who engage in sex work start injecting drugs, do not have a city registration (propiska), and do not have medical insurance. These factors lead to the neglect of one’s health in general and an increase in risk for HIV infection (Onishchenko, 2005). Research among sex workers in Saratov, Russia found that respondents reported the following motivations for engaging in sex work: to earn quick money for food, housing and medicine; to earn money for luxuries; to support a drug addiction; and to travel to foreign countries to find a husband (Aral & St. Lawrence, 2002). Women reported being from varying social backgrounds (Aral & St. Lawrence, 2002). There are different categories of sex workers in Russia. Street-level sex workers sometimes work with pimps and pay a portion of their earnings to them in return for permission to work in their area; otherwise they work alone as “freelancers” (Aral & St. Lawrence, 2002). Women who engage in the street-level sex work are thought to access health care services less and not use condoms as often as sex workers in escort services or in bars (Aral & St. Lawrence, 2002). Humanitarian Action (Gumanitarnoe Deistvie), a NGO in St. Petersburg providing services to street-based sex workers conducted a rapid assessment among their clients and found that 47.9% of the women tested positive for HIV (Humanitarian Action, 2006).

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). One study based in St. Petersburg showed that 37% of female IDUs have “traded sex for money or drugs” and 42% of these female IDUs engaging in sex work had partners who used drugs (Benotsch et al., 2004). Thirty two percent (32%) of female IDUs reported selling sex for money or drugs as compared to 4.9% of men IDU (Kozlov et al., 2006). Nearly half of the street-level sex workers in a
study on Saratov, Russia reported to be an IDU (Aral & St. Lawrence, 2002). A study among IDUs in three Russian cities (Moscow, Volgograd, and Barnaul) showed that sex work accounted for the majority of gender differences between male and female IDUs in regard to HIV risk behaviors (Platt et al., 2007).

2.5 Sex Work and Injection Drug Use among Women: More Partners, Less Condom Use, and More Needle Sharing

Given the documented overlap in involvement in drug use and sex work among some women in Russia, it is important to consider the interaction of these two risk behaviors. Studies to date have focused on individual behavior; however sex partner characteristics have not been adequately explored. Also, apart from anecdotal evidence, little is known about the contextual risk factors that place this population at increased risk of involvement in unsafe drug use and sexual behaviors. Overall, women-specific risks have not been adequately addressed in the epidemiological research conducted on HIV-infected individuals in St. Petersburg. However, we know from research in other settings that the risk factors for HIV among both IDUs and sex workers may be different for women than for men. These differences in risk behaviors have important implications for targeting prevention services for women.

A study among IDUs in San Francisco found that female IDUs are more likely to use unclean needles and have partners who use drugs than male IDUs (Evans et al., 2003). Female IDUs also reported having more sexual partners over their lifetime and not always using a condom than their male IDU peers (Evans et al., 2003). A study in China (a country with an epidemic also concentrated among IDUs), showed that female IDUs have different risk factors for HIV than male IDU (Choi et al., 2006). Female IDUs
were more likely than male IDUs to use unclean needles, have multiple sex partners, and to have STIs (Choi et al., 2006). Other predictors of HIV risk in this sample included: having an IDU sex partner and lack of resources (Choi et al., 2006). Fifty seven percent of the female IDUs are sex workers, and this group is significantly more likely to engage in HIV risk behaviors than the non-sex workers, including: engaging in sex with multiple partners and not using a condom (Choi et al., 2006).

A study among IDUs in three Russian cities (Moscow, Volgograd, and Barnaul) showed that sex work accounted for the majority of gender differences between male and female IDUs in regard to HIV risk behaviors (Platt et al., 2007). Sex workers were more likely than non-sex workers to have multiple sexual partners, other than clients (Platt et al., 2007). The sex workers were significantly more likely to have an STI than the non-sex workers (Platt et al., 2007).

### 2.6 Female IDUs’ HIV Risk Influenced by Male Sexual Partners: Partner’s Drug Use and Partner Violence

Partnership characteristics influence HIV risk among women. Among Chinese IDUs “injection risk of female IDU frequently occurs within the context of an intimate relationship involving regular sex partners,” (Choi et al., 2006). One factor that affects women’s involvement in HIV risk behaviors is intimate partner violence and this includes condom use and condom negotiation (Wingood & DiClemente, 1997). Violence may have an impact on the negotiation of other risk taking behaviors, including needle sharing. This may be especially true given that female IDUs are often at risk because of their male partners’ engagement in risk behaviors. We have little epidemiological information on violence and HIV risk in the Russian context; however this area warrants further
exploration because of what we know from the international literature. Also, a recent WHO report indicates that sex workers in Russia are at increased risk for HIV because of their exposure to violence from partners and clients (WHO, 2005).

A second risk factor is the drug use of sex partners. Women in California reported that they often borrowed needles from their sex partners and that they were often introduced to drug use by their sexual partner (Evans et al., 2003). Female IDUs in China were found to more often involve in HIV risk behaviors if their sex partner was an IDU (Choi et al., 2006). One study in Russia found that while female IDUs were more likely than male IDUs to have a drug injecting partner; non-sex workers were significantly more likely to have partners who used drugs (Platt et al., 2007). However, we do not have this information about female IDUs in St. Petersburg. Studies in other settings among IDUs have concluded that female IDUs are more likely to have a drug injecting partner than male IDUs, and that sex work may be a factor in this association. In fact, one study found that “increased risk in females was explained by having an injection partner who was also a sexual partner” (Evans et al., 2003). There remains a lack of conclusive evidence regarding how association between the involvement in sex work and HIV risk behaviors may be mediated by the partner’s use of drugs.

2.7 Marginalization and Vulnerability

While the transition period has been difficult for many Russians, some groups have been particularly vulnerable to the social, political and economic changes over the past two decades. As in other societies, marginalization places subpopulations at risk for poor health outcomes and diseases, such as HIV/AIDS. Throughout Eastern and Central Europe, we are witnessing the effects of marginalization and social discrimination on
certain groups’ inclusion in health promoting activities, such as HIV prevention services.

“The policy and regulatory environment in the area is unfavourable to the most vulnerable people, such as drug users, commercial sex workers and people living with HIV/AIDS, leading to their exclusion (Godinho & Veen, 2006, p.31). In epidemiology, the terms “hidden populations” or “hard to reach populations” are often used to categorize marginalized groups, highlighting the difficulty in reaching these populations for inclusion into research or prevention and treatment programs.

The epidemic across industrialized nations has disproportionately affected certain groups of the population, most often those that are marginalized and stigmatized. In a review of HIV prevention and control policies across industrialized nations, Baldwin (2005) comments that “as it grew apparent that the epidemic did not especially threaten average First World citizens, the disease grew more “normal” in the sense that, like many others, it was becoming an affliction of the marginal and poor, of ethnic minorities, and the poor” (p.29). However, there may be a positive side to the focus on high-risk groups for HIV prevention. The HIV/AIDS epidemic provided a reason to look at the marginalized groups; to examine their behaviors and address their health concerns (Baldwin, 2005; Berger, 2004). The Russian research literature also discusses the importance of the shift from the “war against drugs” (and thus, drug users) to the “war against AIDS” and how this framing of the issue brought the concerns of drug users into societal discourse (Gurvich, 2005). IDUs and sex workers used to be ignored in Russian health initiatives, but now these groups of people have been pushed in the spotlight of epidemiologists working on HIV in the country. Baldwin (2005) argues that if AIDS were cured then it would be back to a life of being ignored by the medical and public
health community for these populations (p.33). This may offer the opportunity to attract researchers and research dollars for work with marginalized populations. However, this does not always translate into improved conditions or even adequate services for marginalized populations. In fact, in some instances, the increase in attention paid to these marginalized groups can cause them to retreat further into society’s marginality and stigmatization (Berger, 2004). The experiences of “target populations” of HIV services warrant further exploration in order to illuminate the processes of marginality and stigmatization, and the effects that these influences have on the utilization of available services.

Michele Berger (2004) applies the idea of intersectional stigma to understanding how marginalized populations are affected by the additional stigma of the HIV/AIDS. In her study of political participation of HIV-positive women in Detroit, she analyzed the following categories of stigma: drug use, sex work, sexual trauma and the HIV/AIDS virus (Berger, 2004). “Intersectional stigma points to an understanding that women are not only marginalized, and socially situated (shaped by race, class, and gender), but that the category of “HIV-positive person” is loaded (from a stigma standpoint) with effectively negative perceptions about groups of people with the virus (for example, IDUs, crack cocaine users, prostitutes, lower-income women) (Berger, 2004, p. 24). For the women in Berger’s study, a variety of factors contributed to their marginalization and the stigma they perceived in regard to their behaviors, social status and eventually their HIV status. For these women, stigma was a barrier to their political participation (Berger, 2004). In this way, stigma perpetuates the marginalization that certain groups experience and as a result serves as a barrier to resources in a society. The marginalization of women
involved in sex work and drug use makes intervention efforts and advocacy for structural change difficult (Gollub, 2008). Berger’s framework for understanding political participation is a useful lens for considering the utilization of and participation in HIV services by marginalized groups in St. Petersburg.

Women’s attitudes towards and perceptions about HIV services are an example of a broader Russian phenomenon. In her research on women’s encounters with health care services in St. Petersburg, Michele Rivkin-Fish (2005) discovered that there is distrust among women towards the health care system. Women, in general, are vulnerable to experiences of abuse, incompetence, and conflict with providers in their encounters with health care services (Rivkin-Fish, 2005). In the Russian social context women’s sexuality is highly stigmatized (Rivkin-Fish, 2005). Women are often blamed for their illnesses because of what doctors’ label “promiscuous behavior” (Rivkin-Fish, 2005). Similar patterns are noted about women’s fears in utilizing HIV services. Women in Russia have reported that unequal social and economic status, including role in family, fear of violence, and unequal pay, affected their decisions around accessing HIV services (Burns, 2007). If this is the perception of women in the “general population”, then we can only imagine the additional layers of stigma and marginalization that drug use and sex work add, positioning women in an even more unfortunate position for accessing health care services.

HIV/AIDS remains a highly stigmatized disease in Russian society. Along with the spread of the infectious disease, an epidemic of a psychological and social disease,
termed *spidofobiia*, is embedded in Russian society where the general population associates fear, disgust and anger towards those living with the virus (Skvortsov, 2005).

Stigma towards marginalized populations is high in Russia. The general attitude is that people who contact HIV through injection drug use or sexual transmission are deserving of the disease (Balabanova et al., 2006). Stigma in turn keeps people who are at risk from seeking HIV prevention and testing services (Balabanova et al., 2006). Women who are not drug users and become infected through sexual transmission experience stigmatization because they do not fit into the prevention programs for “targeted populations” (Burns, 2007).

Stigma of people living with HIV and those in marginalized populations with increased risk for the disease has negative consequences for the prevention and treatment of the epidemic. Stigmatization of a group ascribes negative characteristics to its members and thereby allows discrimination of these groups to be justified (Skvortsov, 2005). IDUs in St. Petersburg experience discrimination from health care professionals and this adversely affects their access to HIV testing and treatment services (Orekhovsky et al. 2002; Sokolovskii et al., 2005). There is fear of stigma and discrimination associated with being registered at a narcological dispensary, thus making it more difficult for HIV prevention services to reach the population of IDUs (Onishchenko, 2005). Stigma and discrimination are major factors explaining why marginalized women do not seek available HIV prevention and treatment services (Burns, 2007).

Taking into account that marginalized populations are often at increased risk for HIV, programs in public health have been designed to address issues of social exclusion

---

1 A compound word: *SPID* in Russian means AIDS, *fobia*=phobia.
and discrimination. One model that has been used in Eastern Europe, and Russia specifically, is the community-based outreach and peer intervention, in which either active or former-IDUs serve to link IDUs with health care services (Donoghoe, 2006). Infectious disease hospitals have been one setting where these programs have succeeded because IDUs may attend these places for treatment (Donoghoe, 2006). NGOs have designed outreach programs to connect with IDUs and sex workers. Humanitarian Action uses a mobile outreach team to offer medical and psychological care and harm reduction activities (Humanitarian Action, 2006). While there is an attempt to bridge the connection between international organizations and local government institutions, there remains a separation between the two and it appears that non-governmental organizations, often supported by international donors, are addressing the concerns of the marginalized populations because they are the ones who are even less entitled to the government established services. The fact that often the programs for the most marginalized populations are supported by international agencies rather than local government is an indication of the Russian government’s reluctance to minimize the stigma associated with issues such as sex work and drug use.

2.8 HIV Services in Russia

The first AIDS centers appeared in Russia beginning in 1990 and included surveillance, testing services, prevention, counseling and laboratories (Iushuk & Martynov, 2003). The Russian Ministry of Health created the first federal AIDS program in 1993 (TPAA, 2003). However, the federal government failed to fund this program in 1996 and 1997 (TPAA, 2003). Anonymous testing has been available in the major cities
in Russia since 1998 for those who can afford to pay for the services (Lamptey et al., 1998). Figure 1 explains the national structure for the provision of HIV services in Russia.
Figure 1. Structure of the Services for Preventing and Confronting HIV/AIDS in the Russian Federation

Translation of figure found in Iushuk & Martynov, 2003
The central state-run institution in St. Petersburg that provides diagnostics and care regarding HIV is the “Center for the Prevention and Fight against AIDS and Infectious Diseases” (commonly referred to as the City AIDS Center). The Center provides 200 clinical in-patient beds, of which 25 are for hospice care. The epidemiological department tracks the epidemic in the city. Testing services are offered through the clinical department. Anonymous counseling and testing is offered. One can receive condoms and educational information and exchange syringes. The Center also operates mobile services, which provide home-based care for those who are on the Center’s registrar.

The procedures for receiving HIV counseling and testing services are outlined on the Center’s website (http://www.stop-spid.ru/spid.html). Testing and counseling services are offered on working days from 9am to 6pm. The client must first complete an anonymous questionnaire. Then he/she receives counseling from a doctor. Next the client pays for the analysis. He/she then receives the test and is given the results. One can also receive testing for hepatitis A, B, and C, and syphilis. The client has a choice of receiving the tests anonymously, except for syphilis, which is only offered if the client presents his/her passport. If testing is done anonymously, then results are given only verbally. However, if the client would like a certificate confirming results, he/she must present the appropriate documents (passport or registration card). This would mean that clients who do not have these documents would be ineligible to receiving this certificate. The cost of the test is 14 rubles (approximately $0.60), which is the cost of the testing kit. If a written certificate is obtained the cost is 190 rubles. Results for an HIV test are offered the
following day. Rapid testing is offered at an additional price and then results are available within a half hour, if the results are negative.

In 2005, only 47.5% of people living with HIV/AIDS in St. Petersburg were registered and under dispensary surveillance with the City AIDS Center (Volkova et al. 2006). The fact that over half of HIV-positive individuals are not receiving complete diagnostics and timely antiretroviral care is an important indicator that the health care services are not adequate (Volkova et al., 2006).

A study in two cities, Sverdlovsk and Nizhniy Novgorod, revealed numerous problems with the HIV testing and counseling services offered, including no pre-test counseling, post-test counseling covering only the status and fact that transmission to others was punishable under Russian law, clients’ feelings of alienation from the AIDS centers, not receiving test results, and pregnant women being told by their doctors they should have an abortion (Burns, 2007). Sex workers participating in a study in Saratov reported that long waits and lack of confidentiality were barriers to accessing publicly available health care services (Aral & St. Lawrence, 2002). They also reported that the high cost prevented them from accessing STI services at private clinics (Aral & St. Lawrence, 2002). Another issue that is problematic for the effectiveness of HIV services is that just over half of HIV-infected individuals across Russia are registered in the dispensary records of the AIDS centers (Onishchenko, 2005). This is problematic because it means that the rest of the population with HIV is not receiving treatment, counseling, and psychological support resulting in such things as preventable deaths, unwanted pregnancies, abandoned infants, and missed opportunities for prevention of mother-to-child transmission (Onishchenko, 2005).
By the end of 2007, 78% of people living with HIV/AIDS in Russia had registered with government AIDS Center and hospitals (Yakovleva, 2008). “The almost unlimited availability of resources, innovation and political commitment in western Europe, and the tragic absence of most or all of these ingredients in eastern Europe should be studied as thoroughly documented efforts to prevent and control HIV/AIDS in a variety of social, cultural, economic and political settings” (Matic, 2006, p.1). One reason that Russia has been unsuccessful in halting its growing HIV epidemic is because it has 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. This approach includes activities ranging from safer drug use (for example, clean needles or prevention of overdoses) to the promotion of abstinence from drug use. The lack of political commitment to HIV prevention and treatment, the structure of HIV service provision, and the poor availability and accessibility of HIV services have influenced the spread of HIV in Russia, especially among marginalized populations. There are few prevention programs in place in Eastern Europe and the ones that are in place have generally failed to address the most vulnerable populations (Matic, 2006). Women, in general, have been subject to stigmatization in the health care setting through victim-blaming and provider assumptions of sexual promiscuity among women (Rivkin-Fish, 1999).

The administrative structure of HIV services hinders the response to those most in need. Judith Twigg argues in the introduction to an edited volume on the HIV epidemic in Russia that “The rigid and persistent divisions of labor and authority that plagued the Soviet system will hinder the response to HIV unless these barriers can be effectively
eliminated; unchecked they will isolate HIV as relevant only narrowly with the confines of the health care sector.” (Twigg, 2006, p.5). The deficiencies within the administrative framework for HIV services negatively influence people’s access to prevention and treatment (Burns, 2007). Researchers in St. Petersburg highlight the fact that different specialists are left to deal with individual diseases (such as venereal disease doctor to address STIs and an infectious disease doctor to address HIV) and often their approaches to care do not coincide. They argue that comprehensive care for STIs is needed and ideally there would be one place where IDUs could receive care for drug dependency, STI testing and treatment, psychological counseling, etc. because IDUs are not receiving adequate care for their STIs (Sokolovskii et al., 2005).

Russia, unfortunately like many other countries, was late to recognize the extent of its HIV epidemic and has not done enough to address the impending concern. Harm reduction services, such as needle-exchange programs in Eastern Europe, are primarily funded by foreign donors and the domestic governments have done little to address these issues themselves (Matic, 2006; Burns, 2007). According to Russian law, free medical services for every citizen including free medical care and treatment for HIV-infected individuals are guaranteed (Onishchenko, 2005). Unfortunately, as research and program experience show, the marginalized populations, that seem to need the HIV services the most, are not entitled to these rights.
2.9 Accessing HIV Prevention Services: Experiences of Female IDUs and Sex Workers

Lack of access to important HIV prevention services, including testing and counseling, has been identified as a mechanism through which structural risk factors, including gender inequality and poverty, influence HIV risk in women (Krishnan et al., 2008). Research in numerous international settings has helped to identify barriers for women to access HIV testing and counseling services. Women report that fear of having her male partner find out that she was tested is a reason to not access the services (De Paoli et al., 2004). One barrier to accessing HIV testing services is the stigma associated with this behavior (De Paoli et al., 2004; Krishnan et al., 2008).

Research with female sex workers in international settings revealed several key factors influencing uptake of HIV testing and counseling. In China, environmental support (such as condom availability, support from manager and colleagues) was associated with HIV prevention behaviors, including being tested for HIV (Hong et al., 2008). A study in Canada showed that sex workers are less likely to access HIV services because of restrictive hours, stigma, lack of women-focused services, issues of confidentiality and disclosure (Shannon et al., 2007). The authors note that the lack of gender-specific harm reduction activities is especially salient when it comes to reaching substance-using women who are involved in sex work (Shannon et al., 2007). The fact that HIV prevention services have not been tailored to address the unique and specific concerns of women is highly problematic. Without proper attention to the gender aspects of the spread of the disease women do not feel comfortable using the available services. Understanding the individual-level and structural-level factors that influence whether or
not women access HIV services is a critical step in designing an effective intervention. Another study in the same setting in Canada demonstrated that misinformation and misconceptions about treatment were factors explaining why female drug users and sex workers did not utilize available HIV services (Shannon et al., 2005). Discrimination by staff at health care and testing centers inhibits female drug users and sex workers from accessing these services (Gollub, 2008). There are very little data available on barriers to health care utilization for marginalized women in Russia.
CHAPTER 3: THEORETICAL FRAMEWORK

Arguably, effective research should aim to bridge the divide between framing HIV as a social disease versus framing it as a behavioral disease. This would allow for the consideration of both the individual choices about behaviors and the context in which these behaviors occur. Therefore, this research study aimed to consider HIV prevention-seeking behaviors as both results of individual-level decisions, and as opportunities enabled and inhibited by societal influences. Two theoretical frameworks were selected as a lens through which marginalized women’s experiences with HIV testing and counseling services were explored. Taken from the health behavior and health education field within public health, the Health Belief Model (Janz et al., 2002) focuses the researcher’s attention on intrapersonal factors. Taken from the field of anthropology, the theoretical framework of Structural Violence encourages the researcher to focus attention on the position the individual has in society and the impact this power differential has on risk behavior and health seeking ability to overcome this risk. In combination, the two theories guide the researcher to explore external influences that shape the individual’s ability to engage in health-promoting behaviors. The structural violence perspective offers a lens through which individual decision making processes can be understood. Knowledge about these structural influences is critical to comprehending the individual health beliefs, given that these beliefs emerge from the opportunities and constraints embedded within the existing social structures. The behavioral choices and decision-making processes are limited by the structural violence in society (Farmer, 2005).
3.1 Health Belief Model

In a society where HIV testing and counseling remains voluntary, the decision to receive an HIV test or access HIV prevention services is ultimately an individual choice. The Health Belief Model (HBM) can guide in the understanding of individuals’ decisions about whether or not to receive HIV services. The HBM was developed by Hochbaum and colleagues in order to examine the influences on people’s decisions to seek tuberculosis screening (Janz et al., 2002). This cognitive theory assumes rationality. It is referred to as a value expectancy theory, in that an individual must place some value on avoiding illness and have the expectancy that a specific behavior can prevent or reduce the illness (Janz et al., 2002). There are five constructs in the original HBM, including: perceived susceptibility, perceived severity, perceived barriers, perceived benefit, and cues to action. The perceived threat of a disease is defined by one’s belief that there is chance he or she could contract the disease (susceptibility) and that the disease is serious (severity). Under this model, the decisions are made by weighing the benefits and barriers to adopting the advised health behaviors. The following table presents the various constructs as they relate to accessing HIV prevention services among female sex workers.
### Table 1. Health Belief Model Constructs as Determinants of HIV Testing

<table>
<thead>
<tr>
<th>HBM Theoretical Construct</th>
<th>Determinant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perceived Severity</td>
<td>The extent to which she believes that HIV is a serious health concern</td>
</tr>
<tr>
<td>Perceived Susceptibility</td>
<td>The extent to which she believes that she is at risk for becoming infected with HIV</td>
</tr>
<tr>
<td>Perceived Barriers</td>
<td>The belief that there are barriers to accessing HIV services</td>
</tr>
<tr>
<td>Perceived Benefits</td>
<td>The belief that there is value in accessing HIV services</td>
</tr>
<tr>
<td>Perceived Self-efficacy</td>
<td>The belief that one is able to go for HIV services</td>
</tr>
<tr>
<td>Cues to Action</td>
<td>Information in the environment that encourages female sex workers to access HIV services</td>
</tr>
</tbody>
</table>

The HBM has been used, or its constructs either implicitly or explicitly have been used, to guide studies on people’s access to HIV testing and counseling services in a number of international settings (Maguen et al., 2000; Maman et al., 2001; de Paoli et al., 2004; Macintyre et al., 2004; Zak-Place and Stern, 2004; Brown and van Hook, 2006; Rogers et al., 2006).

### 3.2 Structural Violence

The concept of *structural violence* provides a theoretical framework for examining the broader, or distal, factors which place certain groups at risk for HIV infection (Farmer 1996, 2005). Structural violence is defined as “the social structures-economic, political, legal, religious and cultural- that stop individuals, groups, and societies from reaching their full potential,” (Farmer 1996, 2005). This theoretical framework encourages investigation of HIV risk to move away from targeting the
individual behavioral risk factors and to recognize that using a condom, accessing clean needles, or not exchanging sex for money may not be options for all women. One of the reasons for some groups being at risk for getting HIV could be that certain populations do not have access to the necessary HIV prevention services, including testing and counseling. We need to look at the social, political, economic, and cultural contexts in which female IDUs and sex workers live in order to fully understand their risk for HIV. These ideas are important for considering disease vulnerability among marginalized populations. In his analysis of the HIV epidemic in the industrialized world, Baldwin writes, “[d]iscrimination, marginalization, stigmatization: all heightened vulnerability to HIV, it was now argued. The best-demonstrated cofactors were social inequalities. Without basic social change, so it was implied, the epidemic would rage on.” (Baldwin, 2005, p. 22).

Using the theoretical framework of structural violence, the proposed research examines the risk environment, which refers to the influence of social, economic and political changes on the HIV epidemic in Eastern European societies (Rhodes & Simic, 2005). There is a cyclical relationship between poverty and gender inequalities and these factors pose risk for women in regard to becoming infected with HIV (Krishnan et al., 2008). Research guided by the idea of structural violence will give us the rich, in-depth understanding of how the environment influences individual-level determinants of accessing HIV services; thereby elucidating much needed information on how prevention and treatment services can be tailored in the social context, and how to reach the most vulnerable populations with services.
Injection drug use and sex work are embedded within an environment in which salient structural factors are highlighted, namely: poverty, gender inequalities, stigma, discrimination, political transition, and changes in the health care system. The structural factors constitute the layers of “intersectional stigma” (Berger, 2004). These factors not only influence a woman’s engagement in IDU or sex work, but also have direct impact on the proximate behavioral factors that influence HIV risk. The structural factors also influence one’s ability to access HIV prevention services, which in turn influences engagement in HIV risk behavior. HIV prevention services, including testing and counseling, risk-reduction education, condom distribution, needle exchange services, offer individuals the opportunity to evaluate one’s risk behaviors, identify the means to reduce the risk, and the social support and resources to protect one’s self from infection. Structural factors influence marginalized populations access to HIV testing and counseling. The theoretical framework of structural violence acknowledges that these structural factors make some women more vulnerable to injection drug use, sex work, or both and also inhibit the individual’s agency to make safe behavioral choices and choices about accessing HIV services.

3.3 Conceptual Model: Health Belief Model and Structural Violence

In combining the theoretical frameworks at the individual–level and environmental-level, we obtain a more complex and comprehensive basis for understanding how and why female sex workers in St. Petersburg may or may not access HIV prevention services, including testing and counseling. Glanz et al. (2002) present the basis for a conceptual model based on the HBM that allows for consideration of
environmental influences. The social factors influence the association between individual health beliefs and the health seeking behavior (for example, getting tested for HIV). The conceptual model depicted below in Figure 2 guided the dissertation research:
Figure 2. Conceptual Model for Looking at Utilization of HIV Services: Health Belief Model and Structural Violence
3.4 Research Aims

The purpose of my dissertation research was to describe the experiences of female sex workers in accessing HIV testing services in St. Petersburg. The research had the following specific aims:

Specific Aim #1: To describe HIV prevention services currently available in St. Petersburg and the extent to which female sex workers are accessing them.

- To document the type of prevention services that are currently available
- To describe the clientele who use the HIV prevention services

Specific Aim #2: To explore the barriers and facilitators for female sex workers’ access to HIV services.

- To describe the individual and institutional barriers to female sex workers’ utilization of HIV services
- To describe individual and institutional facilitators to female sex workers’ utilization of HIV services
- To describe the experiences of female sex workers who have received HIV counseling and testing services at the AIDS Center

Specific Aim #3: To identify associated factors of uptake of HIV counseling and testing services among female sex workers

- To identify individual-level factors associated with accessing HIV counseling and testing services
- To identify the perceived environmental-level factors associated with accessing of HIV counseling and testing services
CHAPTER 4: RESEARCH DESIGN AND METHODS

4.1 Study Overview

This study is a mixed methods research which draws from quantitative and qualitative methods in public health and ethnographic methods in anthropology. Over the course of ten months, I conducted the fieldwork in St. Petersburg that consisted of ongoing participant observations, 29 in-depth, semi-structured interviews with female sex workers, and 152 structured interviews with female sex workers. I conducted all of the in-depth interviews in Russian using semi-structured interview guides. I trained a team of researchers and together we administered the questionnaires in Russian. Institutional Review Board approval was received at the University of North Carolina-Chapel Hill and St. Petersburg State University. All consent forms, interview guides, and the questionnaire (including revised versions) were prepared in English and Russian and submitted for review to the respective ethics review committees.

The proposed study was designed using a concurrent transformative strategy, meaning that the quantitative and qualitative methods complement each other and are guided by a theoretical perspective (Creswell, 2003). Triangulation of the data occurred during data collection and data analysis. The qualitative component began earlier than the quantitative component so that preliminary findings could be integrated into the final instruments for the quantitative component. Additional qualitative work was done during
the quantitative data collection. This allowed for further exploration and explanation of the preliminary trends noted in the quantitative data collection. Data analysis was done simultaneously, allowing for the opportunity to compare qualitative and quantitative data throughout the process. The results focus on the data that were best understood through the use of both the qualitative and quantitative data. Themes emerged from the analysis of the in-depth interviews and these were considered in terms of what quantitative data was collected.

4.2 Qualitative Study Methods

The first component was a qualitative study with three purposes: 1.) To describe HIV prevention services currently available in St. Petersburg and the extent to which female sex workers are accessing them (Specific Aim 1); 2.) To explore the barriers and facilitators for female sex workers accessing of HIV counseling and testing services; (Specific Aim 2) and 3.) To further inform the measures in the quantitative component of the study.

Ethnography

The study is grounded in ethnographic methodology. The goal of ethnography is to describe a community from the native points of view, to learn from the study population itself about the issues with which the researcher are concerned, and to begin to understand and make inferences about the group of people under study (Spradley, 1979). As an outsider, I needed to gain access to both the professional community working with marginalized populations of interest and the female sex workers who would be invited for participation in the study. I attempted to immerse myself into the community of outreach
work with female sex workers to the extent possible and used techniques that past researchers found successful in working with street-based sex workers (Berger, 2004). I had been traveling to Russia for HIV-related research for several years and over time had developed contacts with Russian researchers and nongovernmental organization representatives. It was through these contacts that I was introduced to the outreach teams with which I recruited participants. Also, my official affiliation as a visiting scholar at St. Petersburg State University contributed to my ability to connect with administrators and physicians at government medical facilities. The local affiliation also provided me with a status to which the interview participants could more easily relate. Sex work is illegal in Russia and injection drug use is common among street-based sex workers. More organized sex business is even more hidden and brothel-based sex workers have been very difficult to reach through health education and research activities. Partnering with local organizations already working with these populations was crucial for gaining entry into this community and also provided a certain level of protection during fieldwork. Nonetheless, I still needed to build rapport with potential participants, especially given that I was recruiting members of a very vulnerable population. I accompanied the outreach team on several preliminary outreach trips before conducting interviews. This allowed me to carefully plan out where the interviews could be held, continue to develop rapport with the outreach team, and become a familiar entity in the van before inviting women for more formal interviews.

The conceptualization of the research project was based on preliminary participant observations in spring 2008. I traveled with a psychiatrist and a social worker who provide outreach health services to sex workers in a mini-van. I had the opportunity
to talk with them about the women they serve, the problem of HIV among these women, their access to health services, and the goals of the organization. I observed the physical space of the mini-van, provision of harm reduction services, and consultations with the sex workers. These preliminary experiences helped shape my approach to recruitment, interviewing, and conducting participant observations. I then returned to St. Petersburg for ten months of fieldwork from December, 2008 through September, 2009.

In order to address specific aim #1, I conducted a series of site visits, participant observations and interviews. I visited the City AIDS Center, Center for HIV and Infectious Disease on Bumazhnaja Street, Botkin Infectious Disease Hospital, Doctors of the World’s program for HIV-positive mothers based at a city children’s infectious disease hospital, Humanitarian Action’s two outreach van programs, and Stellit’s outreach program. I conducted key informant interviews with representatives from these organizations.

The majority of my fieldwork observations were conducted with two NGO-based outreach programs (More information on these organizations is provided in a later section). I spent the most of my fieldwork time with the outreach team of the smaller van for Humanitarian Action that provides services such as clean needle and condom distribution and referral to health care services to female sex workers. This outreach team of four: two doctors, a driver, and a social worker, served as my primary introduction into the community of female sex workers. I also visited the organization’s larger bus that serves as a needle exchange and mobile clinic for injection drug users.

Additionally, I observed the outreach team of psychologists with the organization Stellit. Many of my visits on the outreach services with Stellit were very late at night;
therefore, I met different women than I had when traveling with Humanitarian Action. I also accompanied an outreach work of Stellit to the salony (apartment-based brothels). In order to gain access to the apartments where the sex workers are based, the outreach staff has had to make contact with and get the approval of the owners. The outreach worker then coordinated with the administrator (a woman who oversees the activities at the apartment) to visit the site. Unfortunately, I was not given permission to conduct interviews or administer surveys. However, I had the opportunity to observe a Stellit-led health education session and also engage in dialogue with the administrator and sex workers over tea in the kitchen area. This allowed me the opportunity to hear some of the women’s health concerns, ask about accessing services, and observe the structure of the establishments. Towards the end of my fieldwork, I was granted entrance to administer surveys and visit several apartments of a different owner.

MAMA+, a project of Doctors of the World-USA, is a program for HIV-positive mothers based at one of the main children’s infectious disease hospitals in the city. I had the opportunity to visit the site on several occasions for interviews with an infectious disease doctor, psychologists, social workers, and HIV-positive mothers enrolled in the program. I also observed the childcare facilities, interactions between support staff and program participants, and an education program for HIV-positive mothers.

My fieldwork included interviews with providers and observations at health care facilities with HIV services. I interviewed Dr. Aza Rakhmanova, a long-time infectious disease specialist in the city and one of the first AIDS medical specialists in Russia. We met on several occasions in the infectious disease hospital, at one of her lectures on treating patients with HIV to medical students, and in her home to discuss the City AIDS
Center’s efforts to bring female sex workers to their programs. Dr. Rakhmanova then introduced me to her granddaughter, a dentist at the City AIDS Center, so that I could have an organized tour of the facility. I visited the City Infectious Disease Hospital No. 30 named after S.P. Botkin (colloquially referred to as Botkin Hospital). Here I met with HIV specialists and was given a tour of the HIV ward by one of the doctors. I also visited the harm reduction clinic located on the territory of Botkin Hospital. Additionally, I visited the Center for HIV and Infectious Disease on Bumazhnaja Street. I met with two medical doctors who are involved in a prevention of mother-to-child transmission program.

I also conducted key informant interviews with a clinical researcher at the Medical Academy, a psychologist working with sex workers and HIV-positive women, an activist who has started a program for HIV-positive mothers who are not injection drug users, and Russian sociologists conducting research with female sex workers. I also collected fliers and any written materials from these organizations, service providers, and researchers. My goals during the site visits to organizations were to understand what services are provided, who utilizes these services, and what kinds of questions and concerns arise in the process of receiving HIV testing and treatment services. I focused on how the service providers and experts understand and describe HIV risk and the motivations for HIV testing.

The information from the observations provided context for interpreting the findings from the in-depth interviews and questionnaires. The site visits allowed me to more fully understand what female sex workers discussed during the interviews and the structure of the places where they have received services.
Data collection procedures: in-depth interviews with female sex workers

In order to achieve specific aim #2, I conducted 29 in-depth interviews with female sex workers. All interviews were conducted by me in Russian. A purposive sampling strategy was used. I conducted interviews until I felt I had reached saturation with the data: that is new patterns ceased to emerge from the interviews. The following selection criteria were applied: 1) female; 2) over 18 years of age; 3) residing in St. Petersburg or Leningradskaiia oblast’; and 4) involved in sex work in St. Petersburg. The exclusion criteria for participation in the qualitative study included: 1) not possessing the cognitive ability to provide consent; or 2) not being able to complete an interview in the Russian language. Informants were recruited through two nongovernmental organizations. The majority (n=25) were recruited through an outreach van providing harm reduction services. I developed a brief introductory script for the outreach workers, so that they could introduce the study to female sex workers seeking services from the outreach van. Outreach workers referred the women who were interested in participating to me for interviews. I explained the study in more detail and obtained verbal informed consent prior to starting the interviews. If someone expressed interest in participating, but was not available at that time we agreed upon a meeting time that coincided with the next scheduled outreach visit to that location. The outreach team allotted me the back section of the van to conduct the interviews, and they carried out the outreach services in the front part of the van. The two parts of the van are divided by a sliding door, providing a private space for the interview. I recruited four additional women for interviews through the MAMA+, a special program for HIV-positive mothers. The reason for including these women in the sample was to interview women who had more experience utilizing
services for HIV positive individuals. The psychologist working with HIV-positive mothers referred me to women who she knew to have been involved in sex work. I provided her with the recruitment script and she arranged for me to meet the women who expressed an interest in participating. I conducted these interviews in a private room at the organization’s office located within a children’s infectious disease hospital. With consent of participants, I tape-recorded the interviews and took notes.

Informed consent was obtained from each informant prior to the interview. Verbal consent was obtained in lieu of written informed consent in order to protect the anonymity of participation in the research project. I reviewed the consent form with each woman verbally and provided an opportunity for participants to ask questions. The participant was informed that answering the survey was completely voluntary and that all information would be kept strictly confidential. The participant was made aware that she could stop participating in the study at any point and could refuse to answer any of the items she did not want to. If the participant agreed to participate then I signed the consent form indicating that consent was obtained. A copy of the consent form with my local and UNC contact information, the contact information of my host mentor at St. Petersburg State University (SPSU) and the phone numbers of the UNC and SPSU review committees was made available to participants for them to take.

Women who participated in the interviews received a gift valued at 600 roubles ($20) for their time and information shared. Experts and service providers were not compensated for their participation. The interviews lasted between 25 to 45 minutes.

I used an interview guide that outlined the questions and suggested probes for the interviews. I developed the guide to address my research questions taking into account
my theoretical orientation. 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 getting HIV testing services. If the participant disclosed a positive HIV status then she was probed on her experience accessing HIV care and treatment services.

Data analysis of interviews and fieldnotes

The process of data analysis in qualitative research is iterative. I kept a journal and collected printed materials during the fieldwork. Throughout the course of my fieldwork I read through transcripts, made memos, and started preliminary coding. The information gathered from the participant 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. After leaving the field, I returned to these preliminary codes and generated ideas about overarching themes in my data.

A native Russian-speaker transcribed all of the tape-recorded interviews. I also saved the audio files to listen to during the analysis. The text documents were imported into Atlas.ti for further coding and analysis. Analysis was conducted with the texts in the original Russian and illustrative quotes have been translated into English for inclusion in this dissertation. The first step was to use descriptive, deductive codes. A codebook was developed based on the research questions and theoretical constructs used to design the study. The second step was to use inductive codes. These inductive codes were used to identify emerging themes from the data. These emerging themes were combined into
overarching themes from the iterative reflection process and consideration of the specific aims in the research.

4.3 Quantitative Study Methods

The second component was a quantitative study with a cross-sectional study design. The quantitative component was designed to identify correlates of uptake of HIV counseling and testing services among female sex workers/IDU (Specific Aim 3).

The quantitative component consisted of a cross-sectional, interviewer-administered questionnaire to 152 female sex workers. Before starting the data collection phase, I developed a preliminary instrument for the survey research. This was based on the theoretical frameworks, the available literature regarding female sex workers and IDU in St. Petersburg, and research among similar populations and their access to HIV prevention services in other settings. After patterns started to emerge in the qualitative data, I returned to the questionnaire and made changes to the measures accordingly. The quantitative survey covered demographics, utilization of HIV testing and treatment services, self-reported HIV status, individual-level and environmental-level factors that were hypothesized to be correlated with uptake of HIV testing.

Sample eligibility and size

Participants were eligible for the completion of the quantitative questionnaire if they were: 1) female; and 2) over 18 years of age; and 3) residing in St. Petersburg or Leningradskaya oblast’; and 4) had engaged in sex work in the past six months. Exclusion criteria for participation in the quantitative component of the study included: 1) not
possessing the cognitive ability to provide consent; or 2) not possessing the Russian language ability to complete an interviewer-administered questionnaire.

Surveys were administered to 152 female sex workers, including 139 street-based sex workers and 13 brothel-based sex workers.

**Recruitment and consent procedures**

Participants were recruited through two organizations that provided outreach services to female sex workers. The first organization was the same organization I worked with for the qualitative data collection. The second organization also provided services through an outreach van and offered condom distribution and referral to STD and HIV testing services. This second organization typically operated later in the evening, which enabled me to recruit a wider sample of sex workers. I traveled with these two organizations to all of the different regions of the city that they serve. I continued to sample women until I reached a point of sampling saturation, meaning that I was no longer getting any new participants in any of the regions.

I also visited apartment-based brothels (*salony*) in order to broaden the sample of sex workers. I was introduced to a brothel owner who was interested in the outreach workers’ health education program and invited me to visit his establishments. Although we were only able to administer the survey to 13 women, I spent many hours in these establishments and learned a lot from meeting the women who work in them and the people who run the brothels. Also, these are women who are rarely represented in any of the research in Russia, because it is an even more hidden population than the women who are working on the streets.
As in the qualitative component, outreach workers in the vans first approached potential participants with an invitation to participate. I, again, provided them with a recruitment script. If a woman was interested in completing the questionnaire, she would then meet with the interviewer to learn more about the study. In the brothels, I accompanied an outreach worker on his visit to the apartments. He introduced me as a visiting researcher. I then introduced the study to the group of women working that evening. As part of the study introduction the prospective participant learned that participation required completing a verbally-administered survey lasting approximately 15-20 minutes. If a woman expressed interest in participating, the interviewer then explained the study in more depth and obtained informed consent from each participant in the same manner that consent was obtained for the in-depth interviews. Participants who completed the survey received a cosmetic gift pack valued at 150 roubles (approximately $5).

**Data collection procedures**

We pre-tested the questionnaire with 10 women. I conducted half of these interviews myself and a Russian field worker that I hired for this study conducted the other half. We discussed each interview after it took place to ensure that the questions and response categories were appropriate. I trained three additional data collectors to help administer the survey. Since they were all trained interviewers and have participated in research with the same participants, I focused on the rationale and objectives of my study, eligibility criteria, data collection procedures, informed consent, and provided them with opportunities to practice administering the questionnaires.
Quantitative data was collected from May through September, 2009. Interviews were conducted in an isolated part of the outreach van or off on the side of the street, depending on participant’s preference and available private space. In the brothels, interviews were conducted in a private room. After obtaining informed consent, the data collector proceeded with the interviewer-administered questionnaire. Each quantitative interview took approximately 10 to 15 minutes to complete. I was present at times during the data collection process. I conducted about two thirds of the interviews myself.

**Measures**

I selected measures based on constructs from the conceptual model and previous studies from international settings and among Russian IDU and/or sex workers when available. For some constructs, existing scales and sub-scales that had been used among other populations were adapted for use with the target population in this study. For constructs for which there were not relevant existing scales, appropriate measures were created. Participants were asked a series of questions about HIV testing, including: ever been tested for HIV, time of last HIV test, location of last HIV test, ever having tested at certain locations, and if they had ever been diagnosed with HIV. For participants that reported being HIV-positive, the following information was collected: place of diagnosis, whether they were registered at the AIDS Center, and if they received any services at the AIDS Center in the previous year. HIV-positive participants were also asked three questions related to HIV stigma. The following information was also collected: detailed demographic information, including: age, residency, place of birth, years lived in St. Petersburg, marital status, children, experience using drugs, and length of time involved in sex work.
**Statistical analysis**

As the data were collected, I entered them into Microsoft Excel. Ten percent (10%) of the data were randomly selected for double entry and compared for accuracy. The cleaned data files were then imported in the statistical software used for the data analysis. All data analysis was conducted using the SAS 9.1 statistical software program.

The first step in the quantitative analysis was to provide descriptive statistics of the sample population. These data in themselves are important given that there has been such little research done with this specific population in St. Petersburg.

Secondly, Cronbach alphas were calculated for each of the scales to determine whether or not a composite score could be used. Two scales were used in the final analysis. The scale used to measure HIV-related stigma had a Cronbach alpha of 0.75 and included 13 items. The sex work-related stigma scale demonstrated a Cronbach alpha of 0.61 and included five items. For the constructs of the health belief model, items were used in place of scales because none of the scales showed a correlation of at least 0.60 and were therefore not determined to have internal consistency reliability in this study. The two-item scale for self-efficacy showed a Cronbach alpha of 0.53 as compared to the original 0.68 (Vermeer et al., 2008). The five-item scale used to measure perceived susceptibility demonstrated a Cronbach alpha of 0.51 in this study as compared to the original 0.72 (Lux and Petosa, 1995).

Individual items were used to measure perceived severity, perceived susceptibility, and perceived self-efficacy. Perceived severity was measured by the item “If I were to contract HIV, it would be bad for my health”. The measure was a binary variable: “high perceived severity” versus “low perceived severity”. Perceived
susceptibility was measured by the item “I think that I can get HIV”. This measure was also coded as binary: high perceived susceptibility versus low perceived susceptibility. Perceived self-efficacy was measured by the item “I could easily arrange to have an HIV test, if I wanted to”. This measure was coded as “having perceived self-efficacy” versus “not having perceived self-efficacy”.

Thirdly, logistic regression was used to determine which factors were significantly associated with the primary outcome variable of interest. The outcome variable of interest was HIV testing. Given that nearly all of the participants reported that they received an HIV test at some point, in the logistic regression analysis this variable was dichotomized as recent test versus no recent test. A recent HIV was defined as having an HIV test in the previous six months. Six months was the median amount of time of the most recent HIV test. Observations were excluded in the logistic regression analysis if a participant reported an HIV-positive status and had tested more than six months ago. This was based on the assumption that once diagnosed with HIV, a person would not seek an HIV test.

The items included as independent variables in the regression model were based on the a priori theoretical constructs and measured potential confounders, including age, residency, marital status, time spent in sex work, and the number of years using drugs. Age, time spent in sex work, and time spent using drugs were measured as continuous variables. Logit step tests were used to confirm the assumption of linearity. Based on this, age remained a continuous variable in the logistic regression models. However, the variables of time spent involved in sex work and using drugs violated the assumption of linearity in the logits. Time of sex work was categorized as being involved in sex work...
for at least five years or being involved in sex work for less than five years. Time of drug use was categorized as using drugs for more than four years or for up to four years.

The first model was designed to test the association between the constructs of the Health Belief Model and getting an HIV test in the past six months. Backward stepwise logistic regression was used. Non-significant variables that are not confounding were removed from the model. The variables that showed an odd ratio that was significant at the $p= .05$ level in the logistic regression model were considered to be significantly associated with having a recent HIV test. However, one variable (perceived barrier of test results taking too long) was eliminated from the model because it is strained from the temporal point of view.

The second logistic regression model included HIV-related stigma scale, sex work stigma scale, questions on being discriminated against in the health care setting, in order to assess the influence of the structural-level factors believed to influence testing. Both the HIV-related stigma scale and the sex work stigma scale were checked to ensure that they did not violate the assumption of linearity. All variables were included in the model and backward logistic regression was used determine the final model. The variables that showed an odd ratio that was significant at the $p=.05$ level in the logistic regression model were considered to be significantly associated with having a recent HIV test.

Finally, analysis was done to describe the sub-population of the sample who reported a positive HIV status (n=47). Additional descriptive analyses were also conducted if quantitative data were available to describe trends that emerged in the qualitative analysis.
4.4 Data Collection Challenges

There were numerous hurdles in the data collection process, including: broken down outreach vans, weather-related issues, ensuring that someone was available to accompany me to the field sites, police crackdowns on the streets, gaining trust among the participants, taking time away from their work/potential clients, alcohol and drug use inhibiting participation, and in the case of the brothel-based sex workers there was the need to gain the trust of the administrators. There were ultimately female sex workers whom we did not reach. There were brothel owners and administrators who would not allow any interviews to be conducted and in these instances I was only able to participate in the health education activities of the NGO. It remains unknown how many brothels exist that have not allowed NGO outreach workers to visit them, and the extent to which the sex workers at these places differ from the women that participated in this study. The female sex workers who work on the streets remain a very difficult population to reach. Given the safety concerns of researchers and potential vulnerability of sex workers, it was not feasible to recruit participants without going through a local outreach team.

Nonetheless, the recruitment efforts in this study were considerable. The data from the in-depth interviews reached saturation and therefore were concluded. Data collection for the quantitative component was terminated after several outreach visits during which no new potential participants were reached. Towards the end of data collection, I met with Russian social science and public health researchers to discuss recruitment strategies which they had used in previous research with female sex workers. They confirmed that I had accessed all feasible channels for recruitment.
CHAPTER 5: RESULTS

I present the study results in the following four sections. Descriptive results are presented in the first two sections. This first section includes information describing the HIV services available for sex workers. These results are based on participant observations and interviews with service providers, health care providers, and researchers in St. Petersburg. The second section provides descriptive information on the female sex workers themselves. These results are based on the in-depth interviews and the questionnaires.

The third, fourth, and fifth sections are organized according to emerging themes from the data collected in the qualitative and quantitative components. Section 6.3 focuses on individual-level factors that influence the utilization of HIV services and is drawn from questionnaires and in-depth interviews with female sex workers. The final two sections provide information on the context from which the individual health beliefs emerge. Section 6.4 describes the stigma and discrimination against sex workers and its impact on their access to HIV services. These data are also based on the results from the questionnaires and in-depth interviews with sex workers. Section 6.5 describes structural barriers experienced by sex workers and draws from the data collected from the questionnaires and in-depth interviews with female sex workers.
5.1 An Overview of HIV Services in St. Petersburg: From Prevention Programs for High-risk Behaviors to Support for Women Living with HIV

The description of HIV services in this section is based on visits to numerous program sites and meetings with researchers and service providers whose work either focuses on HIV prevention and treatment or addresses the public health needs of sex workers. The objective of this section is to provide readers with an in-depth understanding of current HIV prevention efforts in St. Petersburg which expands on the previously available scientific and grey literature. I also provide a broader understanding of Russia’s policies that influence the services that I observed.

The influence of Russian policies on HIV service provision

The provision of HIV services is embedded within a system influenced by post-Soviet bureaucracy, political discussions about the role of Western initiatives and democracy building activities, financial crises from the 1990s, and healthcare reform. Foreign donors have supported much of the HIV prevention and care activities in Russia. Some organizations have successfully partnered with Russian state institutions. Others have supported the development of the newly-formed nongovernmental sector (or civil society) in Russia. The relationships between these three groups are complicated and at times tense. The role of foreign aid is changing, as Russia transitions to a high middle-income country. The Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund) had committed millions of dollars to HIV prevention efforts in Russia. However, Russia is not longer defined as a “low-income country” and thus ineligible for Global Fund resources. Responsibility should now lay in the hands of the government for continuing to fund HIV programs. Russian public health practitioners are skeptical as to
whether the Russian government will indeed commit the resources needed to continue HIV prevention and treatment initiatives. The HIV community is worried about what this will mean for the progress made in getting people living with HIV on treatment and in reaching marginalized populations with prevention programs (such as needle exchange, condom distribution, and educational information). Russian law is ambiguous on harm reduction activities and the government has left enforcement decisions up to the city-level administrators. In St. Petersburg needle-exchange programs are not supported by the city, but in the words of local activists, “the city has turned a blind eye to these activities, allowing the programs to continue”. Outreach workers of the harm reduction programs I visited carry identification cards. When the police stopped the van, the staff would show the cards and the police would leave them be. I was told that it was not always so simple and that it took time to convince the police of the organization’s legitimacy. When asked what the local government supports, an outreach team member picked up a box of hygienic wipes. That is what the St. Petersburg government has offered in place of funding condoms or clean needles.

It is also important to note that in the Russian government’s policy that there is no substitution therapy available for injection drug users. Despite international pressure, Russian public health officials do not support methadone substitution therapy and have deemed it to be ineffective. This policy has made rehabilitation of injection drug users that are dependent on heroin very difficult. Also, in order to receive antiretroviral therapy a patient needs to have a plan to quit using drugs. The fact that many of the female sex workers based on the streets in St. Petersburg are injection drug users, this is yet another
important implication for understanding issues of access to and utilization of HIV services.

**City AIDS Center**

The structure of the City AIDS Center and the services the Center provides has been described earlier in the dissertation (see Background and Significance). My observations of the AIDS Center and interviews with physicians provide further insight into the specifics of female sex workers utilization of these services. The AIDS Center is the centralized location for HIV testing, care for people living with HIV/AIDS, and receiving antiretroviral medications. The AIDS Center is located near a metro station in the center of the city. There is a grey sign, typical of all government institutions, marking that it was the AIDS Center. In the entrance way there is the guard’s booth, a coat check where one can also purchase the ubiquitous blue shoe covers (for sanitation purposes, one must wear these when entering any part of a health care facility), and some posters for an HIV support group, a women’s HIV support group, and a drug treatment program. The doctors’ offices are on one of the upper-level stories and on the next floor are the laboratories. The epidemiologists are on the fourth floor and are in charge of tracking HIV cases in the city. There were a handful of people waiting in the corridor of the second floor; all men.

There are four steps in the official protocol for HIV testing at the City AIDS Center. The first is to register. This can be done anonymously for testing purposes. Secondly, a client selects whether to pay for a rapid test or have the free enzyme-linked immunosorbent assay (ELISA test) and wait several days to receive the results. Thirdly, the client receives pre-test counseling from an infectious disease doctor before the blood
is drawn. Lastly, the person returns for the results and receives post-test counseling. Counseling is for both people with positive diagnosis and those who test negative. If the ELISA test is done then the client must return to the AIDS Center for the test results; they cannot be given out any other way. When a person tests positive for HIV, he or she is asked to give the names and telephone contacts of sexual partners. The epidemiologist then contacts these people for testing.

If a person tests positive, then he or she can register with the AIDS Center. In addition to the clients that test positive for HIV at the City AIDS Center itself, other clients are referred from other hospitals and from antenatal clinics where testing happens routinely during pregnancy. Registration is not anonymous. One must provide his or her name, address, and telephone number. The staff note on patients’ card as to whether partners and family know of the client’s HIV status. The AIDS Center serves as an outpatient health care center (polyclinic). In addition to the dentist, the specialists that clients of the AIDS Center have access to include: dermatologist, gynecologist, neurologist, ophthalmologist, narcologist, psychologist, psychiatrist, and social worker. All doctors’ visits are free for people who are registered with the AIDS Center and many procedures are also performed at no cost to the patient. The doctors at the AIDS Center share the opinion that patients prefer to be treated at the AIDS Center because of the services offered and that they are treated better than they would be elsewhere. The providers also reported that there are not enough infectious disease doctors (currently eight) for the number of patients at the City AIDS Center.

However, providers at the City AIDS Center told me that it is difficult to draw patients to the facility. The head infectious disease specialist said that one of her main
concerns is how to reach people who have HIV, but are not coming to get services and who are not registered. They know that the numbers of people infected with HIV are higher than the number of cases registered and that many of the registered people living with HIV are not receiving services. The providers’ records indicated that there are approximately 35,000 registered cases at the City AIDS Center, but only 17,000 patients visit the center. Adherence to ARV medications is also a problem and something the clinicians at the AIDS Center are concerned with improving. Currently about half of the 3,000 patients on ARV are adhering to the therapy procedures according to the clinic records. Approximately 86% of registered cases are injection drug users and 7% of registered cases have identified themselves as men who have sex with men. Providers at the City AIDS Center reported that female sex workers usually do not come here for care, “they avoid medical services for whatever reasons,” and instead outreach teams usually work with them.

The City AIDS Center collaborates with USAID, Population Services International (PSI), and with HIV-positive groups at Botkin Hospital. The providers at the City AIDS Center reported that they do not partner with NGOs because they have differing approaches with regard to service provision. “We want to draw the patient here and NGOs are trying to give care at that very moment.” The City AIDS Center doctors admitted that vulnerable populations are afraid to come here because of the longstanding stigma and discrimination against drug users and HIV-positive patients in health care settings in Russia. The providers discussed that they view clients as patients in need of HIV care rather than as people in trouble for other reasons (for example, drug users or sex workers). While providers at the City AIDS Center reported that they treat everyone,
regardless of their behaviors, they did say that they advise patients that they must cease their drug use if they want to start antiretroviral therapy.

Botkin Infectious Disease Hospital

The S.P. Botkin City Infectious Disease Hospital No. 30 is located near one of the main squares in the city. It is a large, daunting complex with crumbling buildings. The HIV unit is located in a far back corner. The hallway walls were covered with HIV informational posters and brochures on ARV and HIV prevention were readily available. The women’s ward of the HIV unit included a large, bare room with four beds. There were three patients in the room at the time we visited. All of them appeared to be sleeping, though one woman raised her head to acknowledge our entrance. A French church had donated funds to open a small room in the corner of the unit that served as a chapel and a place to meet with a psychologist. The doctor reported that material goods are also handed out here, but that it is really not used that often. All three doctors that I met with at Botkin said that it is difficult to reach female sex workers. And if women do come they are reluctant to reveal that they work in the sex business, so often times it is only speculated that their patients are sex workers.

Botkin Hospital has a working relationship with the NGOs that provide outreach services to sex workers. Doctors of the World-France have helped to set up a harm reduction site on the premises of Botkin Hospital. Many of the doctors that work with outreach services are also employed at Botkin Hospital. These connections make the referrals easier and more effective. Clients come to the harm reduction program to exchange needles, get condoms, be tested for HIV and hepatitis, participate in trainings and seminars, and meet with a psychologist or social worker. The social worker in the
harm reduction program reported that most attempts to reach out to female sex workers have failed and that it is believed that outreach services may be the more efficient way to reach this population of women with services. He also reported that female sex workers often report in surveys that they are using condoms and do not share needles, but there have not been in-depth conversations about their risk behaviors.

“Hospital on Bumazhnaia”

The City Infectious Disease Hospital No. 10 is located on Bumazhnaia Street, and thus referred to simply as “Bumazhnaia”. While not as large as the Botkin Hospital or the City AIDS Center, female sex workers in the study reported being tested for HIV or hepatitis at this hospital. It is located relatively near the City AIDS Center and not far from a metro station. There are specialists at this hospital that work with patients who have HIV. The City AIDS Center may also refer patients to this hospital. As a state-run hospital, services are free of charge for residents of St. Petersburg. The doctors involved in the prevention of mother-to-child transmission (PMTCT) programs at this facility expressed concern that women who are at increased risk for HIV because of injection drug use are more likely not to come for prenatal care than other women. This also means that these women may not know their HIV status before giving birth. One of their concerns is that it is also hard to follow-up with women after they leave the maternity hospitals.

Humanitarian Action

In addition to the state-run health care facilities, much of the HIV service initiatives have been undertaken by non-governmental organizations. Humanitarian Action was started by Doctors of the World-France. Among its activities, this
organization operates mobile outreach units where people can receive HIV tests, consult with doctors, exchange needles, and receive condoms and educational materials. The larger bus remains in one location each evening. When outreach staff realized that sex workers were not coming to the bus because they were working and were not able to leave their spots, they commissioned this smaller bus to specifically serve female sex workers. The outreach van regularly spends five nights a week traveling the streets of St. Petersburg to the tochki (hotspots) where they distribute clean needles, condoms, pregnancy tests, vitamins, health education brochures, and referrals for STD clinics, hospitals, and drug rehabilitation programs. Humanitarian Action has three main target areas for their outreach services. They rotate their schedule so that they serve each region once or twice each week. The outreach team would make several rounds each evening. They usually stop at each main tochka for a longer period (ranging from 15 minutes to an hour) and then make shorter stops to distribute services to women who are standing along the streets. The outreach team determined their routes based on locations where there is a higher concentration of women working to increase the cost-effectiveness of the program. They also have to obtain permission from the district offices and chose traffic routes that allow for a van to stop at a public transportation stop or the side of the road. For example, the van is not able to travel around the very center of the city, but instead the activities are focused on the outer streets of the city. Also, they chose a set number of spots in order to establish relationships with and gain the trust of female sex workers at these spots.

There are only four outreach workers and they have full-time jobs outside of their evening work with Humanitarian Action, for example the two doctors work the early shifts at the hospital. The outreach staff estimates that they serve roughly 60% of street-
based sex workers. They assume they are reaching around 30% of all sex workers in the city, since they do not do work with women who work in escort services or apartment-based brothels.

**Stellit Outreach Program**

Stellit was founded as a research organization by psychologists and sociologists at St. Petersburg State University. In addition to the research the organization conducts, it provides services to vulnerable populations in St. Petersburg, including an outreach program for female sex workers. Stellit’s van is staffed by a driver, psychologist, and a volunteer outreach worker (usually a psychologist or social worker). The purposes of the outreach program are to provide educational materials, referrals to an STD clinic or the AIDS Center, condom distribution, and on-site psychological consultation. The van visits the same *tochki* at least once a week, allowing the outreach staff to develop trust and relationships with the clients they serve. While the organization does serve many of the same women that Humanitarian Action serves, the services are different. For purposes of distinction, Humanitarian Action’s services are medical while Stellit’s services psycho-social. They do not offer clean needles and do not have a medical doctor on the van.

Stellit has extended their outreach services to the apartment-based brothels (*salony*). The apartments are unmarked and located in residential buildings. A client calls an advertised number and is connected to the administrator (these women usually have several mobile phones for this purpose). They then agree on a service (for example telephone sex or a visit to the brothel) and price. In addition to the administrator a driver is also present. The driver also serves as a guard, and appears to be armed most of the time. I observed that between four and six women would be working in an apartment in
each evening. However, the number varies and I was told that at times there may be ten or more women working in one place. Some of the women live in the apartment in which they work, others have other housing and come to the apartment for work. Most of the women I met were not originally from St. Petersburg. Most came from other cities in Russia or the former Soviet Union, though not necessarily with the original intention of engaging in sex work.

A psychologist from Stellit visited these apartments as part of the outreach efforts. He brought condoms, hygienic napkins, and informational brochures to distribute the women. He explained the mission of Stellit and then held a question-and-answer session for the participants. Women were then offered the forms for a referral for free and anonymous STD testing or visit with gynecologist. Some of the women took this information, others said they still had the information from his last visit, and others said that they did not need the referral. None of the women I had the opportunity to speak with had experience using Stellit’s referral system. Women discussed reasons they had not followed up with a past referral and the main reasons given were either not having enough time or not feeling sick. The apartment-based sex workers are more hidden from outsiders and this makes outreach work more challenging. I witnessed some of these initial contacts between the outreach staff and the women working in these apartments. Women who were meeting the outreach worker for the first time expressed some skepticism and even shock that we would be visiting their work. One woman said after the information session that she was “admittedly shocked that [we] had simply entered the establishment, because the life she leads in here [the brothel] is entirely separate from her identity outside of work.”
MAMA+

MAMA+ is an initiative of the NGOs Doctors to Children and Healthright International. The goals of the MAMA+ project are to decrease the likelihood that an HIV-positive mother will transmit HIV to her newborn and to decrease the likelihood that a mother will abandon her newborn. Services provided include: psychological counseling, social worker/case management, access to ARV therapy, on-site childcare for infants and preschool children, support groups for mothers, support groups for partners, support groups for grandmothers (often the caregivers in these situations), material help such as infant formula, diapers and clothing, educational seminars, and clinical consultations. Housed on the first floor of one of the buildings in a children’s infectious disease hospital complex, the MAMA+ facility consists of a child care center, kitchen and conference room, where seminars, staff conversations, consultations, and socializing take place. There are also private offices for meetings with psychologists.

While the MAMA+ program does not target female sex workers specifically, some women participating in the program have a history of involvement in sex work. Also, many of the women have a history of injection drug use. MAMA+ psychologists and social workers recruit women in antenatal clinics, maternity hospitals, and drug rehabilitation programs. Participants in the MAMA+ program reported that they found out about the program either through a visit by one of the staff at the maternity hospital or through word of mouth from other HIV-positive mothers at the hospital. The staff is well-connected to government services and can aid HIV-positive women in navigating the system, either through getting treatment for drug abuse, obtaining the necessary documents to enroll a child in nursery school, or referring a client to a specific doctor.
Additional services

Female sex workers who participated in the in-depth interviews reported receiving services at other organizations or institutions. Participants discussed places that they received help in trying to quit using drugs, including: religious organizations that provide drug rehabilitation programs, twelve-step programs, narcotics anonymous groups, the State Narcology Hospital, and local state narcology dispensaries. There are support groups for HIV-positive women and their children (for example, Innovation, a social organization for helping children born to HIV-positive parents). In addition to social and educational programs, this organization provides material support such as clothing. Some women talked about turning to the Orthodox Church, both for material help and for spiritual and emotional support. Many of the participants said that they were more likely to seek help from organizations that offer a tangible service, such as clean needles, condoms, diapers and formula for their infants, and clothing. Some women expressed hesitation in joining support groups. One woman explained that she was her own psychologist and questioned the benefit of sharing her problems with others. On the other hand, I witnessed numerous scenarios on the outreach vans when women would thank the staff for taking the time to listen to their problems and “for not forgetting people like us.” On several occasions, interview participants thanked me for listening to their stories, and commented that it was in some way beneficial to talk about issue that they usually do not discuss. Some women saw benefit to attending social organizations, especially if they targeteded children. One participant described how she could take her children to a playgroup and not have the child stigmatized because of his/her HIV status.
Summary of findings from observations

The overview of services presented in this study indicates that sex workers are an extremely difficult population to reach with HIV services. Discussions with NGO service providers and health care providers suggest that female injection drug users are even more difficult to reach than male injection drug users, and the involvement in sex work is one factor for this added impediment because female sex workers are even more marginalized from society and also the time that is needed to make enough money for survival. Providers at state health institutions, namely the City AIDS Center, experienced difficulty in encouraging female sex workers to utilize the available services. The providers at these institutions agreed that outreach services may be the most effective measures to date in reaching this population; however, the scope of these services is limited given in comparison to larger, stationary health care facilities.
5.2 Descriptive Information about the Study Participants

This section provides descriptive information on the sex workers who participated in this study. I first describe the female sex workers who participated in the in-depth interviews and interviewer-administered surveys. I then provide descriptive statistics on HIV testing among female sex workers based on the quantitative phase of the study.

5.2.i Demographic Information

Qualitative phase

Twenty nine (29) women participated in an in-depth interview. The women ranged in age between 21 years and 38 years. Two of the participants were married at the time, though others were divorced, widowed, or had been in a civil marriage at some time in their lives. About half (n=15) of the women had children, though it was often the case that the children lived with a grandparent or other relative. The 25 women recruited through the outreach van said that they were currently involved in sex work. The four women recruited through the program for HIV-positive mothers had a history of involvement in sex work, but none of them talked about current involvement. The time spent in the sex work business ranged from one and a half years to 11 years. All of the participants were either currently or had previously used injection drugs, namely heroin. All women reported that they had been tested for HIV, at least once. Women talked about being tested for HIV during pregnancy, 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 were infected with HIV. The four women recruited through the program for HIV-positive
mothers had received antiretroviral medications during pregnancy in order to prevent transmission to their infants. Among other HIV-positive informants the only mention of receiving antiretroviral treatment was also during pregnancy.

Quantitative phase

One hundred fifty two (152) female sex workers completed the interviewer-administered questionnaire. One hundred thirty nine (139) of the women were involved in street-based sex work and 13 of the women were involved in brothel-based sex work. Given that the nature of sex work and involvement in HIV-risk behaviors is different between these two subgroups of women, the quantitative analysis was limited to the street-based sex workers (n=139).

The average age of the sex workers interviewed was 28.9 years and ranged between 19 and 41 years of age. The average length of involvement in sex work was 5.26 years and ranged from two weeks to 20 years. All but one of the women reported that they have ever used injection drugs and 137 (99%) of the women reported current injecting drug use. The average time of drug use was 8.86 years, with a range of 8 months to 25 years of drug use.

Sixty two percent (62%) of the sample was unmarried. Eighty seven percent (87%) of the women were born in St. Petersburg, with the remaining number of women coming from different cities within Russia, Central Asia and Eastern Europe. About half of the women in the study had children (51%). Among those women who were born outside of St. Petersburg, the average amount of time lived in the city is 13.6 years. The majority of the women reported living in an apartment that they or their family owned. Eighteen percent (18%) of the women rented a room in the city, and an additional 28%
lived with friends or relatives. Three percent (3%) of the sample was currently without housing. Thirty six percent (36%) lived with their parents. It is not uncommon for young adults to live with their parents in St. Petersburg, where living space is limited and rent is expensive.
Table 2. Socio-demographic Characteristics of Street-based Sex Workers (n=139)

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>%</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unmarried</td>
<td>61.87</td>
<td>86</td>
</tr>
<tr>
<td>Married</td>
<td>17.27</td>
<td>24</td>
</tr>
<tr>
<td>Civil marriage</td>
<td>10.07</td>
<td>14</td>
</tr>
<tr>
<td>Divorced</td>
<td>8.63</td>
<td>12</td>
</tr>
<tr>
<td>Widowed</td>
<td>2.16</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Living Situation</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Own apartment</td>
<td>44.2</td>
<td>61</td>
</tr>
<tr>
<td>Rent room</td>
<td>17.39</td>
<td>24</td>
</tr>
<tr>
<td>Live with friends</td>
<td>17.39</td>
<td>24</td>
</tr>
<tr>
<td>Live with relatives</td>
<td>10.14</td>
<td>14</td>
</tr>
<tr>
<td>Rent apartment</td>
<td>7.97</td>
<td>11</td>
</tr>
<tr>
<td>No place to live</td>
<td>2.9</td>
<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Birthplace</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>St. Petersburg</td>
<td>87.05</td>
<td>121</td>
</tr>
<tr>
<td>Leningradskaya oblast'</td>
<td>2.88</td>
<td>4</td>
</tr>
<tr>
<td>Other Russian city</td>
<td>6.47</td>
<td>9</td>
</tr>
<tr>
<td>Central Asia</td>
<td>2.16</td>
<td>3</td>
</tr>
<tr>
<td>Ukraine</td>
<td>0.72</td>
<td>1</td>
</tr>
<tr>
<td>GDR</td>
<td>0.72</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Children</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>51.08</td>
<td>71</td>
</tr>
<tr>
<td>No</td>
<td>48.92</td>
<td>68</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Drug Use</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Lifetime use</td>
<td>99.28</td>
<td>138</td>
</tr>
<tr>
<td>Current use</td>
<td>98.56</td>
<td>137</td>
</tr>
<tr>
<td>Never used</td>
<td>1.44</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age</th>
<th>mean=28.9 years</th>
<th>range=19 to 41 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Years of using drugs</td>
<td>mean=8.86 years</td>
<td>range=.67 to 25 years</td>
</tr>
<tr>
<td>Years in Sex Work</td>
<td>mean=5.26 years</td>
<td>range=.04 to 20 years</td>
</tr>
</tbody>
</table>
5.2.ii HIV Testing among Participants

Nearly all of the participants in the quantitative phase reported ever being tested for HIV (98%, n=136). However, there was a large spectrum of the time of the last test, ranging from two weeks ago to eight years ago. The average time of the most recent HIV test was 16 months earlier. Having been tested for HIV six months ago was the median and mode answer to the question on most previous HIV test among the sex workers that participated in this study. Over half of the women (55.4%) last tested for HIV longer than six months ago.

Participants were asked to name the place they received their most recent HIV test. Responses included: hospitals, AIDS Center, STD clinic, jail, drug rehabilitation hospitals, outpatient care centers for drug addiction, polyclinics, maternity hospitals, women’s health centers, and outreach vans. Participants were also asked if they have ever tested at certain key locations in the city. The most common place for receiving an HIV test was in a hospital (76% of participants reported being tested there). Half of the women reported having tested for HIV during a pregnancy. Forty five percent (45%) had tested for HIV at an STI clinic. Thirty eight percent (38%) of the women sampled had been tested in jail. Approximately one-third of the women had ever tested at the City AIDS Center (33%). The least common place to receive an HIV test was during participation in a research study (11%).
Table 3. HIV Testing Behaviors among Street-based Female Sex Workers (n=139)

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>Tested for HIV</td>
<td>97.84</td>
<td>136</td>
</tr>
<tr>
<td>Testing Locations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital</td>
<td>75.94</td>
<td>101</td>
</tr>
<tr>
<td>Prenatal care</td>
<td>50.39</td>
<td>64</td>
</tr>
<tr>
<td>STD clinic</td>
<td>44.7</td>
<td>59</td>
</tr>
<tr>
<td>Jail</td>
<td>38.17</td>
<td>50</td>
</tr>
<tr>
<td>Polyclinic</td>
<td>37.12</td>
<td>49</td>
</tr>
<tr>
<td>Outreach van</td>
<td>35.34</td>
<td>47</td>
</tr>
<tr>
<td>AIDS Center</td>
<td>33.33</td>
<td>44</td>
</tr>
<tr>
<td>Research study</td>
<td>10.69</td>
<td>14</td>
</tr>
<tr>
<td>Other</td>
<td>6.77</td>
<td>9</td>
</tr>
</tbody>
</table>

Women were asked if they have ever been diagnosed with HIV. Over one-third of the sex workers in this study reported that they were infected with HIV (35%, n=47). The most common places to be diagnosed with HIV was the hospital (24%, n=11), jail (24%, n=11), the City AIDS Center (20%, n=9), and an outreach van (13%, n=6). As aforementioned, the City AIDS Center serves as a gateway to free HIV care and treatment services. The initial step in receiving this care is to register with the Center. Sixty six percent (66%) of the women who have HIV were registered with the City AIDS Center. Only 21% (n=10) had received services at the Center in the past year.
Table 4. HIV-positive Participants

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th></th>
<th>No</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>Diagnosed with HIV</td>
<td>34.56</td>
<td>47</td>
<td>64.66</td>
<td>89</td>
</tr>
<tr>
<td>Registered at AIDS Center</td>
<td>65.96</td>
<td>31</td>
<td>34.04</td>
<td>16</td>
</tr>
<tr>
<td>Received Services at the AIDS Center in past year</td>
<td>21.28</td>
<td>10</td>
<td>78.72</td>
<td>37</td>
</tr>
</tbody>
</table>

The results of this study indicate that HIV testing was high among female sex workers, but less than half of these women had been tested in the previous six months. Female sex workers reported testing for HIV at a variety of locations. The trends in testing locations suggest that testing for HIV was not always patient-initiated, and in some instances may have been routine testing. Over one-third of the female sex workers in the study had been diagnosed with HIV. Approximately two-thirds of the HIV-positive women said that they were registered at the City AIDS Center, and less than a quarter had received services in the past year. These statistics are below what the official records kept by providers at the City AIDS Center show for service utilization, indicating that female sex workers are even less likely than the general population of people living with HIV to access these services.
5.3 Individual-level Influences on Utilization of HIV Testing Services

In this section, I will present the results on the decision-making process for female sex workers getting an HIV test. The Health Belief Model served as a basis for understanding how sex workers’ utilization of HIV services may be influenced by their perceptions of severity of HIV infection, susceptibility to contracting HIV, benefits of testing, barriers to testing, self-efficacy in accessing the services, and exposure to cues to action. The descriptive results from the quantitative component and the data from the in-depth interviews provide insight into how each of these individual-level factors influences female sex workers use of HIV testing services and for HIV-positive sex workers, the use of HIV services at the City AIDS Center. Multivariable logistic regression provided additional information on which factors are associated with recent HIV testing. The following table depicts a summary of the mixed-methods findings related to the constructs of the Health Belief Model.
<table>
<thead>
<tr>
<th>Construct</th>
<th>Key Quantitative Findings</th>
<th>Key Qualitative Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perceived Susceptibility</td>
<td>•43% of HIV-negative participants greatly perceived themselves to be at risk for HIV</td>
<td>•Cognizant of risks, but many said that they are protecting themselves</td>
</tr>
<tr>
<td></td>
<td></td>
<td>•Left to chance/fate</td>
</tr>
<tr>
<td>Perceived Severity</td>
<td>•99% of the women perceived HIV to be a threat to their health.</td>
<td>•Some were very afraid, but others cited knowing PLWHA that did not have symptoms</td>
</tr>
<tr>
<td></td>
<td></td>
<td>•HIV-positive participants also had mixed perceptions</td>
</tr>
<tr>
<td>Perceived Self-efficacy</td>
<td>•35% had high perceived self-efficacy for going for an HIV test</td>
<td>•Recognized personal motivation as a factor in accessing services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>•Drug use inhibits one's ability to go for services</td>
</tr>
<tr>
<td>Perceived Barriers</td>
<td>•55% too nervous to get results</td>
<td>•Distance needed to travel</td>
</tr>
<tr>
<td></td>
<td>•49% worried about partner's reaction</td>
<td>•Time away from work/doing everything they can &quot;just to survive&quot;</td>
</tr>
<tr>
<td></td>
<td>•44% worried that people would think they were sick</td>
<td>•Fear of learning results, but also fear of having it documented</td>
</tr>
<tr>
<td>Perceived Benefits</td>
<td>•96% cited being able to protect others was a benefit of getting tested</td>
<td>•Wanting to protect others: partners, children</td>
</tr>
<tr>
<td></td>
<td>•95% said that they would want to know their status</td>
<td>•Concern about one's health</td>
</tr>
<tr>
<td></td>
<td></td>
<td>•Reassurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>•Necessary for obtaining documents</td>
</tr>
<tr>
<td>Cues to Actions</td>
<td>•94% had talked with someone about HIV</td>
<td>•Talked about among IDU, less with other FSW</td>
</tr>
<tr>
<td></td>
<td>•93% know PLWHA</td>
<td>•Majority felt that they were informed about HIV</td>
</tr>
<tr>
<td></td>
<td>•87% had received printed educational materials</td>
<td>•Not always discussed in-depth with peers</td>
</tr>
</tbody>
</table>

**Perceived severity**

Perceived severity of HIV infection was high among the female sex workers in this study. In the quantitative component, 99% of the women agreed that if she were to contract HIV, it would be bad for her health.

All of the women interviewed in the qualitative phase had heard of HIV. Some of the women perceived HIV to be very severe and to be a scary disease. When asked what she knew about HIV, one participant replied “I know something. I know that it is a scary illness and that one can die. There’s nothing good.” Another participant shared this
perception when asked if she had heard of the virus. “Of course. It can be transmitted sexually. It is very scary.” A third participant illustrated her level of perceived severity of HIV in the following: “especially AIDS. It is very scary. If other diseases can be treated, then AIDS… it is very difficult for relatives and foremost for yourself.”

Many participants associated HIV with death. “They [people with HIV] completely understand that they have a limited amount of time left: from five to seven years.” In fact, most the women talked about HIV as being the illness they fear most. This was a common perception, even among sex workers interviewed who had been diagnosed with other illnesses, such as syphilis or hepatitis. “One year ago I was in the hospital and I tested [for HIV]. I didn’t have anything. I had only hepatitis B and C. I mean, I know that HIV is bad.” When asked what health concern worried her the most, one participant replied “HIV, of course. To not become infected with it. Umm, I have hepatitis, but HIV…I really don’t want to get infected.”

Despite the widespread fear of HIV among the sex workers in the study, there were some women who talked about knowing people who had HIV and were not showing symptoms. As one participant discussed:

“Umm, well as much as I have talked about it, people don’t really feel HIV. They don’t feel it. I heard that… I was told that they don’t really feel it. Of course, that is, maybe with time something…some metamorphosis happens, some kind of metastasis, you know? The only, umm, the only thing that I paid attention is that a person who is sick with HIV is very, very thin, very much, simply a pale face, that paleness- it is very difficult.

Among HIV-positive sex workers the perceived severity of having the disease varied, though the majority of participants said that they do not have a lot of symptoms. Some women talked about it being the grimmest diagnosis they received. One participant
replied to an inquiry about what health concerns she has. “Well, what about health? I think that it cannot be worse. I have HIV for five years already.” Some participants talked about that they may have been afraid when they received the diagnosis, but that they are feeling okay and cited this as a reason for not utilizing HIV services. When asked if she were receiving any services at the AIDS Center after receiving her diagnosis, one HIV-positive participant replied “Then I didn’t go anywhere. I didn’t go anywhere, because I didn’t, like, need any of that. I was 18 and was not interested in that. I thought it was a mistake, things happen. And then when I ended up in jail, and there it [HIV diagnosis] was confirmed, umm, and all, then it all became clear.” The participant continued,

That is they told me that ‘you have a very bad monogram, it is very weak, very. You need to get services, you need to take medicine’. Since that maybe two or three years have already passed, but I don’t know. I don’t feel bad. If I was to feel bad, maybe then I would consult them. I don’t have weakness, tiredness, sleepiness, sweatiness- there is nothing.

Since she did not feel bad, she did not perceive her HIV-infection to be severe and therefore, was not going to take medication, despite the doctor’s recommendation.

Perceived susceptibility

Perceived susceptibility was high among participants, but not all completely agreed that they were at risk for HIV. Only 43% of HIV-negative participants completely agreed that they could become infected with HIV. The majority of women did not perceive themselves to be either too young or too healthy to become infected with HIV.

The qualitative data also highlight the mixed feelings that sex workers feel about their perceived susceptibility to HIV. The women interviewed recognized that they are involved in a profession that makes them vulnerable to contracting HIV. They also
recognize that drug use can make one susceptible to becoming infected with HIV. However, many of the women were quick to point out that they employ preventative measures, namely not sharing needles and using condoms, and that this means that they are not at risk for getting HIV.

Many of the sex workers said that were not susceptible to HIV because of the precautions they take. For example, as one sex worker described in the in-depth interview: “I think that if it is done only with condoms then probably, although no one is safe, of course. I think not, I watch all of this very closely, and I even take all precautions when using drugs. I don’t use other people’s things. Everything is my own, everything is clean and accurate.” When asked if she thought she was at risk for contracting HIV, one participant replied, “Honestly, I never once thought this. Well, because I, like, I don’t have contact without condoms. Even if something happens, suddenly they break, if this happens, well I am very careful.” Some women reflected on how they felt less susceptible now because they know more. “Well, at the current moment, I could not get infected. I am sure of this because I use protection, because I don’t use other people’s syringes, etc. I am kind of cautious. But I can think, that earlier it was a lot more, well… there wasn’t this, no one knew, and it was very easy. But now I am sure [that I cannot get HIV].”

All of the sex workers exhibited some knowledge about how HIV is transmitted during the qualitative interviews; however, there were some instances of confusion as to how susceptible they might in fact be to transmitting the infection. One woman talked about her sister being HIV-positive. She said that they use drugs together, but that they take precautionary steps:
Yes, but different needles. Well, you see, she can herself be sick, but cannot infect, or the other way around, she can infect, but she herself cannot be sick. It is apparent that she has the type of HIV that she cannot transmit. Because she lived with her husband, then they arrested him, he was in jail, and they didn’t find HIV in him. He was in jail for five years and then freed and they lived together again. Then they arrested him again and now he is free again and all the same he does not have HIV. This means that she herself can only be sick. She cannot infect others.

Another woman said that she did not believe she could get HIV because she does everything correctly. However, she did indicate that she is afraid to be infected by being around people with HIV, despite knowing that this could not happen.

Infected, those infected already here, and there they could have barely breathed on me and that would be all and I am also HIV-infected, although I know that this is a lie, this cannot be, and it is literally only if we had a glass of water and I cleaned my syringe and after me you cleaned yours, well then maybe then you and I could transmit the disease. But if everyone has their own bottles, everyone has their own water, and everyone has their own needles, then no.

Confusion around how HIV is transmitted, the exact measures that need to be taken to prevent HIV, and that harm reduction reduces but does not eliminate risk all contributed to the levels of participants’ perceived susceptibility to HIV.

When sex workers said that they did not perceive themselves to be at risk for getting HIV, then there was not a reason to test. As one participant replied to the question of whether or not she tested for HIV: “Very rarely. Um, maybe once in seven months, or in eight. Well something is needed…but if you use condoms, if they don’t break, if they are okay, why would I go test?” Another participant described how not feeling like she was at risk for HIV was a reason for not getting an HIV test.

Well, I don’t know, it is like... at first I, like, didn’t think about it and then I was in the hospital and then some time passed and I was confident, so why would I test? Maybe I needed to, I don’t know. But I do know that I simply... I cannot even understand why it is necessary. If I had the test, I know that it would be negative,
and that I cannot become infected. There is no point. If it is necessary to test for the hospital, then I will test, but to go especially for that. That is, I believe that there is no point because I know where I could become infected.

While everyone talked about trying to protect themselves from HIV and minimize their risk, some sex workers interviewed did perceive themselves to be at risk nonetheless.

Interviewer: Have you heard about how one gets HIV?

Participant: Of course. I am not fifteen years old! I am 26 and I have been working for eight of those.

Interviewer: What are your thoughts on whether or not you could become infected with HIV?

Participant: Easily! Um, well, of course, when I am feeling bad and really need something and there is nothing at hand, then it is possible, you take whatever... and well if you do this, then of course, you think that something could have been...

Many of the sex workers interviewed talked about their work as making them susceptible to HIV. A participant in the qualitative component talked about how there were times when she did not always follow all the steps of safe drug using behavior and that in fact, she may be susceptible to HIV.

You know, none of us are safe from that. It is exactly 50-50. We don’t follow all the rules. That exact same tube happens to be the one tube in which we boil. It happens that there is only one and it is forbidden to refuse it. That is at that center they explained to me that even due to that tube, even from that wad of cotton you can get infected with HIV...and you know how it is usually turns out? If everyone has his own needle, syringe, then that tube, umm, there is only one tube. And if everyone is boiling, then we all boil in that one. And there is only one cotton wad, you understand? Therefore it is 50-50, exactly 50-50. The possibility is very great.

Sixty percent (60%) of the female sex workers that participated in the quantitative component agreed that if it is their fate to get HIV, then they will become infected. As
one participant summed up how she perceived her risk for getting HIV or transmitting to others. She talked about feeling like she needed to disclose the risk to her clients: “I say, ‘Yes, I am involved in prostitution, are you prepared?’ I say, ‘I cannot be responsible... we are all under God, and sooner or later [we could get sick with HIV]...’”

Involvement in sex work and the risk involved was a discussed as a reason for getting HIV testing. One sex worker talked about reasons why she was tested and this included knowing that she is susceptible to HIV infection and spreading the disease. “Just to know, so that I could be confident that I don’t have it, so I could be at peace. Because I work with people and God forbid I could pass it to someone. That is working in this profession you have to think not only about yourself, but about those around you.”

Perceived barriers to HIV testing

The female sex workers in this study were asked to identify perceived barriers and benefits to being tested for HIV. The most common reasons cited for influencing the decision to test included: being too nervous to learn the results, being worried about the reaction of one’s sexual partner, being worried that people could think she was sick, and the distance needed to travel to the testing site. The following table presents the list of barriers and the percentage of women who perceived each item to be reason why she would not get an HIV test.
Table 6. Barriers to Getting an HIV Test

<table>
<thead>
<tr>
<th>Reasons not to get tested</th>
<th>% agreed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nervous to get results</td>
<td>54.68%</td>
</tr>
<tr>
<td>Worried about partner's reaction</td>
<td>48.48%</td>
</tr>
<tr>
<td>Worried people will think I am sick</td>
<td>43.88%</td>
</tr>
<tr>
<td>Too far from home</td>
<td>40.29%</td>
</tr>
<tr>
<td>It is not important to me</td>
<td>24.64%</td>
</tr>
<tr>
<td>Doubt confidentiality</td>
<td>23.74%</td>
</tr>
<tr>
<td>Can't leave work</td>
<td>15.11%</td>
</tr>
<tr>
<td>I am not at risk</td>
<td>14.39%</td>
</tr>
<tr>
<td>Results take too long</td>
<td>10.79%</td>
</tr>
<tr>
<td>Too expensive</td>
<td>8.15%</td>
</tr>
<tr>
<td>Don't know where to test</td>
<td>7.19%</td>
</tr>
<tr>
<td>Never thought of testing</td>
<td>4.32%</td>
</tr>
<tr>
<td>Afraid of needles</td>
<td>2.16%</td>
</tr>
</tbody>
</table>

The qualitative results also highlighted some of the aforementioned barriers and provide a more in-depth understanding as to how sex workers perceive barriers to getting tested for HIV. Time, distance, and money were major factors in these women’s lives.

As one participant illustrated: “But, I’ll repeat it again, having extra time doesn’t happen, since we are here [on the street] until late, and then we sleep, and then already...back here again, let’s say.” And she continued:

Although they say that there they give medicines for free, some kind of very expensive medicines. Well, it is just being a lazybones, just to go there. If it were just across the road, of course, then it would have all been done long ago. But since it is so far to travel— well this is the problem, probably. There is simply no money, and when there is, then some other kinds of issues come up. That is, like, how it always happens.
While testing could be done at many places nearer to home, the act of going to the AIDS Center, either for care or to participate in a prevention program, was not realistic because of the time and distance needed to travel.

The central location was not always a feasible option for the sex workers interviewed in this study. Participants talked about it being easier to get a blood test in the mobile clinic, rather than having to go to the AIDS Center.

In the bus, that bus went around, took the blood, and now, like I was sick, they took my blood. But in order for me to go somewhere, well... First, my residence permit is not for this district, so I would have to specially go to the other end of the city. When you use drugs— you are not up to doing this. If the occasion presents— like the bus came, there was an occasion, I immediately tested for everything, immediately checked everything, but to specially go somewhere— that is rare. So that someone would specially go somewhere to get tested— this is nonsense.

The time needed to travel as a barrier to getting services was especially true for women who lived in the suburbs of St. Petersburg, but worked in the city.

Because of the fact that I live outside the city— that is first. It is long enough to come here [to work]. And then it turns out that I am always busy with something during the day. My child comes home from school and, even by the time I make it here- it is about five o’clock. It turned out that somehow I haven’t made it. Simply put, it hasn’t worked out.

Some women have children and this also added to the time factor being a barrier to going to participate in any prevention activities.

One participant attributed not getting tested to the lifestyle she led and this included several perceived barriers. In response to why she has not gone for testing, she said “There are reasons. Well, since I was in the hospital, it seems I had a negative result. Well, since it is negative, I didn’t consult anywhere else. But, like, now I already want to, um, like, a lot of time has already passed, enough. I have been working on the
streets for awhile already. I think I need to go test already.” This participant continued by explaining any barriers she saw to getting tested. “Barriers? Yes and no. Sometimes there is simply not enough time to go. Well, and because of these drugs, because of this work, because of all this, you don’t get enough sleep.”

Not having the money to pay for a test at a facility that is closer to home was also mentioned as a barrier to testing for the female sex workers interviewed. For example, one participant mentioned that she will get tested when she has money. “Yeah, I plan to in the spring. When there is money— I will do it more often. I will need to go to get tested.” Also, financial reasons were a barrier to getting anonymous testing. “You know, I simply have not tested in a really long time. It has not been possible. We tested for a fee, and that is a lot of money. Umm, I’ll tell you when. I tested three years ago.”

Fear was another perceived barrier to testing. Many of the women talked about fear of learning that they had HIV as a deterrent to getting tested. As one participant described the fear of testing: “All the same it is scary. No matter how many times you get these tests, it is nonetheless scary. Umm, I don’t know, I tested last month. I will go this month. Nonetheless, it is scary.” In this case, the participant was tested for HIV despite her fears. It was not only fear of getting a positive test result, but the fear of what happens once you have that result on your record that was perceived as a barrier to getting tested. In response to the question of whether she had gone to the AIDS Center to be tested, one sex worker replied “No, I am afraid to go, to be registered.” If a person tests positive, then he or she is officially registered at the AIDS Center and this information is included in medical records.
Additional barriers emerged in the qualitative data that were not measured in the quantitative component. An HIV-positive woman talked about the complex structure of the AIDS Center as a perceived barrier to accessing services there. She said in response to a question about whether she was receiving treatment at the AIDS Center, “Of course not! For now, everything with me is seemingly normal. I can’t complain about my health. There it is also not so simple: you come and they are going to observe you. There is a list, there people come from all over, from all of Russia, therefore I don’t go.” Another woman talked about the complex nature of the system as a perceived barrier to being tested at the AIDS Center.

I need to go to the doctor. To the doctor—those tests, if they learn that you, are for example, HIV-infected or something, then they send you away. Can you imagine, I would have to go from here to the Center to give blood, hell knows where, to hell and beyond. And it turns out that here you cannot be tested, in our district, I won’t even mention in our clinic. And it turns out we cannot test in our clinic, we cannot test in our district, they send you somewhere to the center. Sorry, but I would have to waste two hours just on the road.

There was confusion around the issue of treatment for HIV and feeling like one would not receive treatment was recognized as a barrier to getting tested. One participant talked about why she had not been tested for HIV in over a year.

I don’t know. It seems to me, honestly speaking...umm, if I have it [HIV], then it is not going to go away. I know that if I have it, I am not going to take pills five times a day. Of course not, if I stop using drugs, then I will, but I have not yet stopped. And when I stop, then, yes, I will get tested. But at the current moment, um, if I have it, it is not going to go away, why should I know about it? I don’t, like, give anyone my needle; I use condoms. I try not to infect anyone. That is... to get all upset an extra time, I don’t know— it doesn’t matter. You aren’t going to get rid of it.

Some women talked about the side effects of treatment observed in their friends as a barrier to receiving additional services once they were diagnosed with HIV. All HIV-
positive pregnant women or women with children reported willingness to be on ARV medications to prevent mother-to-child transmission; however, the side effects were discussed as a barrier to receiving further care for themselves.

While testing can be a single event, receiving care and treatment for HIV services is an on-going process. Therefore, the perceived barriers cited for not getting tested (namely time, distance, money, and lifestyle) were even more pertinent as barriers to getting treatment services. One HIV-positive participant described her situation and perceived barriers for not going to the AIDS Center related to her dependence on drugs and her need to work in order to survive.

Participant: What Center? I am not able to go there.

Interviewer: And what do you mean by “not able to go there”? 

Participant: Of course. Well, I get up, and I need to make money because if I don’t make money then I will not have anything to buy drugs with; and if I don’t have anything to buy drugs with—for me this is like air, like food, I cannot, I cannot get up from the bed. Therefore, my number one problem is to get up, make money, and get drugs. I shoot up not to get some kind of high, I shoot up in order just to live. I have been using for a long time, you understand?

The participant then continues later in the interview to explain why she did not take ARVs.

They offered some kind of treatment, but as I am saying, I again started using and I was not interested in that. Maybe, if I would have gone there... well first, it was very far from the place where I lived, you understand? That is, the road is very long. Secondly, there was no desire because I started using again. So what Center?! It was all about just getting to work so I could buy heroin, no getting to the Center.

Perceived benefits of HIV testing

In the quantitative component, the participants tended to agree that the reasons listed for testing were applicable to their own situations. Some participants hesitated in
response to being able to get treatment and were unsure as to the availability of treatment for HIV, but decided to answer that if it did exist they could receive it. The most common reasons indentified for getting tested for HIV were the desire to know one’s status and the ability to protect others. The following table presents the list of benefits to testing and the percentage of women who perceived each item to be a reason why she would get an HIV test.

Table 7. Benefits to Getting an HIV Test

<table>
<thead>
<tr>
<th>Reasons to get tested</th>
<th>% agreed</th>
</tr>
</thead>
<tbody>
<tr>
<td>If I tested positive, I could protect others</td>
<td>96.40%</td>
</tr>
<tr>
<td>Want to know status</td>
<td>94.96%</td>
</tr>
<tr>
<td>Want to stop worrying</td>
<td>86.33%</td>
</tr>
<tr>
<td>Important for job</td>
<td>83.45%</td>
</tr>
<tr>
<td>If I tested positive, I could get treatment</td>
<td>88.49%</td>
</tr>
</tbody>
</table>

Given that all of the sex workers who participated in the in-depth interviews had tested for HIV at some point in their lives, they were able to reflect on perceived benefits of testing. The qualitative data supported these same reasons and also went beyond to identify other reasons that female sex workers felt it was important to get tested for HIV. Some participants talked about needing to know their status for other people in their lives, namely their children, but also their male partners. As one participant explained why she was tested for HIV: “Of course. I give blood [for analysis] every month because my child is young. Of course, I must know what is what and why.” Another participant described wanting to know her status to protect her husband if she were HIV-positive.
Well, when I lived with my husband, well and just out of interest, because, like, I was also using, when he and I lived together, so I decided to get tested for myself and for him. And when I when I was working, well for my own health. I should know what’s with my health, right? Moreover, although I use condoms with everyone when I work, but, like, all the same, I am using drugs, anything could happen.

Participants talked about needing to know their HIV status in order to obtain certain documents. For example, one participant discussed needing to get tested for HIV for employment purposes or to get admitted to the hospital. “Well, for example, if I need to give test results somewhere, or if you want to become employed, or something else somewhere, or you get sick and go. Usually, it is rare that someone would specially go [for testing].” The benefits included having the proper documents for other needs, beyond learning one’s HIV status.

Some of the participants talked about wanting to know their HIV status for their own health. They talked about wanting to reassure themselves because they knew they were at risk for HIV. As one participant described, “Um, because, first, since I am involved in this non-sense [sex work], I get tested for myself, just for myself. I do this just for myself, in order to know, actually. Anything can just happen. I simply hear that girls are sick, and I all, I start worrying, of course. It is better I go get tested for everything.” Another participant described how she thought learning her status earlier would result in a better outcome.

Why? Because I am a drug user, a prostitute—that...syphilis can be treated, but HIV, excuse me...It is seems to me that the earlier I will know about it, the greater chance I have to live longer because I will know, I can, well for myself, well, how to say it exactly, I can control the process, take some kind of medicines. And if I will not know, it will happen more quickly...my immune system will drop, and well this kind of weather, I am usually on the street all the time: a cold, a cough, it seems I just get better and then boom, again.
Many of the sex workers in the study had not thought too much about getting an HIV test, but when it was convenient did recognize the value in getting the test and seized the opportunity. “No, there were not any concrete reasons, but simply just because, and even more so this type of work is so risky, why not get tested— I tested. Even more so, I tell you, it was convenient and free. I tested and went on. It was very nice.” Or as another woman explained, “And I give blood and go to the doctor. Even more so it is free, why not go?”

In some instances there were other benefits to getting tested for HIV, including involvement in a research study that provided compensation or enrollment in a program that also provided tangible support. One woman described how she regularly tested as part of her participation in an American program.

I go to the Americans. The American company, which is called “Nachalo [Beginning].” There the Americans are keeping statistics on us. That is you go there, give blood, answer some survey questions on the computer and they give you two plastic gift cards worth 500 roubles that you can spend at the store “Lenta”, that is you can buy stuff for 500 roubles there. And plus, I can bring someone else, and if I bring someone, then they give me another card. They have this enticement. But they need only people who are using.

Perceived self-efficacy

Thirty five percent (35%) were completely confident that they could arrange to be tested for HIV if they chose to do so and perceived self-efficacy was significantly associated with having a recent HIV test.

The qualitative data provided more explanation of the belief that one was able to go get a test and this perception’s influence on accessing services. During the in-depth interviews many of the women talked about personal motivation as a factor in whether or
not one regularly accesses HIV testing services. Most of these women discussed it in the context of saying that they just could not do it and did not provide much explanation, most often switching to external factors such as time, money or distance. Others blamed the drug use for affecting one’s motivation for doing anything related to caring about one’s health. One woman interviewed, who said that she mostly works in apartment-based venues, said that when no one makes a person get tested, then it all depends on that person herself. “On the street, of course, no one is going to demand these certificates [of clean health]. Then it already depends on the girl, how she takes care of herself. If she is interested in her health, then of course, she will go to be tested, otherwise, if not, then she will not.” This belief in one’s self to go access services was also an issue for HIV-positive women receiving care. Besides not feeling sick and therefore not thinking they needed services, women talked about simply not being able to go to the AIDS Center. One woman said that what she needed was for someone to take her hand and lead her there; that she would not do it on her own.

Yes, I need to plan to go. And so that somehow, with someone, so that someone would support me in this, in this trip. I will probably never go alone. If someone, somehow, desirably on transport...umm, like in my condition, using drugs, to travel in those buses, somewhere, in the subway, for me this is totally horrible. If someone could help me with this trip, let’s say, I would go without further ado.

There were instances when sex workers said that they knew preventing HIV and getting services depended on their own motivation and supported the idea that “it is all possible. If you, yourself, want it”; however, this was more often the case with HIV preventive behaviors rather than seeking services. On the other hand, some sex workers did say that while they have not used services, they know where they could go to get them if they needed them. For example, one participant said “I know that if some
questions arise, that I could go at any moment to the STD clinic or to Botkin hospital to get more information, more in-depth information.” But when asked if she had done this she replied “No, because there hasn’t yet been any need.” Another participant talked about not having the inner-strength to go for testing. “No, there are not any reasons. You know, I somehow related to all of this calmly. I am so quiet, don’t go anywhere. Just home and work, but to go somewhere—for that after all, requires a lot of strength, that some kind of great breakthrough is needed.” While not all women felt that they could access HIV services, there were some women who perceived that they had a choice in utilizing available sources and that the strength to do so was a personal motivator. The data from the in-depth interviews supported the findings from quantitative data that showed perceived self-efficacy to be an important influence on accessing HIV services.

Cues to action

Participants were asked several questions regarding cues to action. It is clear that this is a population that has been affected by the HIV epidemic in Russia. Ninety three percent (93%) said that they knew someone who had HIV/AIDS. While much stigma is evident and people may not want to disclose their own status, most participants reported engaging in some dialogue related to HIV. Nearly all of the women (94%) reported talking to someone about HIV. Most commonly HIV is discussed with friends and other sex workers, followed by discussions with doctors and social workers. Just over half of the sex workers said that they had ever discussed HIV with their husbands or sexual partners. Participants were least likely to discuss HIV with their clients (44%). Eighty seven percent (87%) of participants said that had received written materials about HIV. Approximately 94% of the women said that they had heard of the City AIDS Center.
Three quarters of participants said that other injection drug users had told them they had been to the Center, while just over half (58%) said that other sex workers had talked to them about receiving services at the Center. These data are reflective of discussions with sex workers during the in-depth interviews that HIV status is more openly talked about in their circles of drug using peers than it is among their peers in sex work.

The data from the in-depth interviews also revealed that the street-based sex workers were exposed to various types of information about HIV and HIV testing services—primarily printed brochures. There were printed materials on HIV facts, STDs, and safer drug use/overdose available in the bus and referral slips were offered for HIV testing services. All of the women said that they felt they were exposed to information about HIV. As one woman said “Yes, in my opinion, now one can go anywhere for a test. Where you pay, where it is anonymous—now days one can go anywhere. Moreover, there are advertisements everywhere; they show ads on television. That is, there are no secrets.” The female sex workers interviewed also talked about reading booklets and using the Internet to get information about HIV.

The sex workers talked about knowing people who had HIV, including: relatives, friends, other sex workers, and other drug users. One woman said in an interview “I have acquaintances who are sick, I know girls who stand [on the streets], work, who are sick.” Another participant talked about discussing HIV with other sex workers. “Of course. That is there are girls, who just started this profession. I try to transfer all of my experience to them, to warn them, that there are not only the obvious infections, but that there are also hidden sexual infections, that is why it is necessary to use condoms, etc.” Some women said that they openly discussed the issue of HIV with other sex workers.
“The girls even talk about it amongst themselves. We are here talking about it. Why hide something here? After all, we are not medical workers; it is not necessary to hide something from one another.” While not all participants talked about feeling comfortable talking about HIV with other sex workers, some participants did feel that they could discuss these issues with some of their peers.

Women talked about deciding to get tested because someone they found out someone they knew had HIV. For example, one sex worker told that “My friend told me that she was HIV-infected. Oh, there she is, by the way. She first learned and then told me. I was, like, kind of in shock and decided to get tested. Well and that is how I learned [that she too was positive].” Participants discussed their preference to get information about HIV from other people like them rather than from professionals. One participant talked about receiving information from other patients in the hospital.

Well, they [doctors] didn’t really discuss HIV. That is everything was learned from booklets, you will learn more from people with whom you are lying in the hospital than from doctors. The people you are lying with, who are ill, probably you will learn more information from them than from doctors. Doctors don’t have time. Well that is, I learned more in the hospital from these people.

HIV-positive mothers also talked about hearing about different HIV support programs from other women in the maternity hospitals. It is important to note that not all women talked about feeling comfortable talking about HIV—either their own status or the illness itself with other sex workers and in some cases family and friends.

Associations between Health Belief Model constructs and recent HIV testing

The outcome variable of interest is whether or not a participant has been tested for HIV within the past six months. Multivariable logistic regression was used to determine which individual-level factors were associated with recent HIV testing. The sample
included in this analysis was 105 female sex workers. HIV-positive sex workers who were tested more than six months prior were not included in the analysis. Of these 105 female sex workers, 59% (n=62) reported being tested for HIV within the past six months. The table below represents the final multivariable logistic regression model. The likelihood ratio estimate was 16.74 with seven degrees of freedom (p=.02).

Table 8. Associations between Individual-level Factors and Recent HIV Testing

<table>
<thead>
<tr>
<th>Factor</th>
<th>Unadjusted OR</th>
<th>Adjusted OR</th>
<th>95% CI</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perceived susceptibility</td>
<td>1.8</td>
<td>1.65</td>
<td>(0.62, 4.37)</td>
<td>p=.31</td>
</tr>
<tr>
<td>Perceived severity</td>
<td>1.59</td>
<td>1.21</td>
<td>(0.39, 3.79)</td>
<td>p=.74</td>
</tr>
<tr>
<td>Perceived self-efficacy</td>
<td>1.79</td>
<td>1.18</td>
<td>(0.38, 3.65)</td>
<td>p=.78</td>
</tr>
<tr>
<td>Perceived barrier: don't feel at risk</td>
<td>0.56</td>
<td>0.48</td>
<td>(0.14, 1.70)</td>
<td>p=.26</td>
</tr>
<tr>
<td>Perceived barrier: people will think I am sick</td>
<td>0.54</td>
<td>0.49</td>
<td>(0.20, 1.21)</td>
<td>p=.12</td>
</tr>
<tr>
<td><strong>Cue to action: know people with HIV</strong></td>
<td><strong>5.83</strong></td>
<td><strong>6.31</strong></td>
<td>(1.06, 37.44)</td>
<td>p=.04</td>
</tr>
<tr>
<td>Amount of time using drugs</td>
<td>0.39</td>
<td>0.25</td>
<td>(0.08, 0.73)</td>
<td>p=.01</td>
</tr>
</tbody>
</table>

In this analysis only one of the variables was significantly associated with recent HIV testing at the p<.05 level. The results indicate that a female sex worker was 6.3 times as likely to have had a recent HIV test if she reported knowing someone who has HIV than if she did not know anyone who has HIV [adjusted OR=6.31, 95% CI (1.06, 37.44)]. The length of time using drugs was also significant, and the only demographic variable to be significant in the model. Female sex workers were 75% less likely to have had a recent HIV test if they had been using drugs for more than four years compared to those who had been using drugs for less than four years [adjusted OR= 0.25, 95% CI (0.08, .073)]. The results demonstrate that the remaining theoretical constructs are associated with HIV testing in the anticipated direction, but due to the wide confidence intervals these results are inconclusive.
Summary of findings

Perceived severity of HIV was very high among female sex workers in St. Petersburg; however, it was not determined to be significantly associated with getting a recent HIV test. Qualitative data indicated that low perceived severity of the illness among women who were HIV-positive was a reason for not accessing services. While perceived susceptibility was not found to be significantly associated with having a recent HIV test, risk perception was discussed in the in-depth interviews as being an important factor influencing a decision about getting an HIV test. Most female sex workers in this study recognized that they could be at risk for HIV given their involvement in drug use and their work. Many women expressed the opinion that they were able to do something to prevent becoming infected. However, many participants talked about not always being able to follow the recommended prevention methods. The qualitative and quantitative results showed that the most common perceived barriers to getting an HIV test centered around fear of learning the results, worrying that other people would think they were sick, and that they would have to travel far to get the services. In-depth interviews with HIV-positive sex workers revealed that the most common barriers to receiving treatment and care services revolved around the time needed to access these services, the distance needed to travel, and that the lifestyle of drug use and needing to make money for survival impeded one’s ability to get care. While the majority of participants agreed that there are benefits to getting tested, none of the perceived benefits measured were significantly associated with having a recent HIV test. The qualitative data confirmed the trends of these perceived benefits, but also showed that female sex workers perceived the benefits of HIV testing to include obtaining necessary documents for further health care
services and that testing is a free service, so it should be used. While perceived self-efficacy was not significantly associated with having had a recent HIV test in the logistic regression model, the qualitative data emphasized the importance of believing that one was capable of accessing services and the belief that in order to get the care needed one would need to “be taken by the hand.” The overwhelming majority of participants in this study had been exposed to various cues to action including printed materials about prevention and available services, and discussions with professionals and peers about HIV. Female sex workers who reported knowing someone with HIV were more likely to have had a recent HIV test, suggesting the potential influence peers may have on the likelihood of getting tested.
5.4 Stigma and Discrimination

The results of this study highlight some of the layers of stigma and discrimination that female sex workers in St. Petersburg encounter, both in their everyday lives and specifically within the healthcare setting. In this section of the dissertation, I describe the types of stigma and discrimination sex workers experience, where they encounter the discrimination, how the stigma and discrimination manifests itself into verbal and physical violence, and how the fear of stigma and discrimination influence their decisions to access HIV services. I also include a discussion on perceived and experienced stigma of HIV among sex workers, and how perceptions correlate with HIV testing.

Perceived stigma and social isolation

Sex workers in St. Petersburg experience stigma and discrimination because of the work in which they engage and their involvement with injection drug use. The female sex workers in the quantitative component of the study report feeling stigmatized and socially isolated. Three quarters of the women reported that female sex workers are rejected by other people. And 77% of participants agreed that female sex workers are prone to being rejected by their families. Less than half (49%) of the sex workers interviewed in this study said that their families know about their work. However, 73% said that their friends do know about their involvement in sex work.

During the in-depth interviews some women talked about the fact that their families do not know and suggested reasons for hiding this aspect of their lives. One woman expressed fear in her mother finding out about her involvement in sex work.
Well, I have a normal family, I have a mother who is, well how to put it? Well, she has moral standards… I think that if I were to openly tell them that I am standing here then they wouldn’t allow me in the house. Because my mother would openly say that she doesn’t need me to be bringing dirt home. In theory, I understand her. In theory, she is right. Thus, I don’t want her to know about it [sex work].

Other participants reported that while they might not openly disclose their involvement in sex work, they expected that their family had an idea about their work. The majority of women said that their husbands or male partners knew of their involvement in sex work. In most instances the women said that their male partners were also using drugs. In some of these cases it is the woman who is bringing the money into the home through her involvement in sex work. Participants talked about not wanting to have their male partners involved in theft, so it is better that they themselves are involved in sex work.

Sex workers reported the need to keep their involvement in sex work hidden from people other than their families, including neighbors and friends. When asked how they perceive others to view their involvement in sex work, one woman gave the following response: “Badly, of course. Well, of course, with a negative attitude. Some turn away. Friends don’t want to socialize. Well, of course, good friends continue to socialize, but…and neighbors, well it is obvious that they view me poorly. They do not think well of me.” Another woman interviewed said “Oh, everyone treats me poorly! I am under the impression that all of my friends, with whom I hung out or who live in our courtyard, don’t consider me to be a human being. I am offended.” The same woman went on to say that while some sex workers do not hide their work, she does not feel that she can talk about it openly with people.
Some of the girls say ‘Yes, that’s who I am!’, but I do not think about myself that way. I am embarrassed if neighbors come. I try to hide so that no one sees me. If friends accuse me of this work, that is if one of them even still talks to me, then I argue and even try to prove...well not really try to prove it, but in some way try to argue against their ideas that I am somehow different. Well, yes, I use drugs, but I also live. I live at home. I bathe. I buy clothing. It’s just that I do this work and I do drugs, but nonetheless I also have a full life. It is just this stupid work!

Another participant described how she perceived society to relate to sex workers. “There are people who simply hate prostitutes and therefore they make fun of them. That is they buy their services for that reason, in order to make fun of them. Exactly to make fun of them— to tease them.” As illustrated by these participants the experienced stigma is attributed to both their involvement in sex work and also their drug use. The two are so intertwined in their lives that in many cases they were discussed as one identity.

Sex workers in the study had differing viewpoints on the role of friendships in their lives. Many of the participants commented about the fact that many of their friends are also involved in sex work. On the other hand, some participants did not want to consider these women to be friends. Women reported working alone, with sisters, with roommates, with friends, and in groups. One participant told me when asked if she could talk about her problems with her friends. She replied, “Do you think people like me have friends. What friends? I don’t have any friends.”

Violence against female sex workers

In addition to the negative social consequences of being involved in sex work, violence is an important concern for women involved in street-based sex work in St. Petersburg. The overwhelming majority (96%) of the women surveyed agreed that female
sex workers are subjected to physical violence. Ninety seven percent (97%) of the participants said that female sex workers face verbal abuse.

The qualitative data revealed that violence is the major problem associated with sex work. When asked about other concerns or difficulties with being involved in sex work, women identified problems including harassment from the police, having money stolen, concern about sexually transmitted infections, and decrease in income due to the most recent economic crisis. However, being physically attacked was the most cited problem and discussed as having the most severe consequences. One participant described some of the experiences she had and also witnessed with her friends.

When I started working, it happened. I was cheated out of money, there were cases when a whole crowd showed up and I had to jump down the stairs. I escaped from the second floor and hurt my leg. Or there were times when I would have to fight until the end so that I was not dragged into a car...One of my girlfriends came back all black and blue after three days. I opened the door and I couldn’t even see her face. In place of her face there was just one bruise. They beat her for three days. One of my other girlfriends had to jump from the fifth floor. She broke both legs....You are ready to do anything and it does matter because they need to beat you up, and that is all.

One sex worker explained that it is hard to escape the violence associated with this work.

“Well, they [clients] have tried some sexual assaults simply without paying. Or, well, there have been some threats. Well, all of that which is connected to this work has happened. But somehow you attempt to escape from these situations, but they have all happened”. Another participant also described the violence as being par for the course with this line of work.

Yes, problems occur very often. It often happens that girls are beaten up or taunted. Specifically, people mock them. I also had this experience. I arrived at an apartment where there were 10 people, even though only one person solicited me. He dragged me to the apartment and there were 10 people. I lucked out that it was on the first floor and there were no bars on the window. I escaped from there,
completely naked. I really thought that they were going to kill me because they started to choke me, beat me. Because, in reality, they were bastards. All the girls have gone through this. Each one has this kind of story. Without fail, each girl has this story, because there are a lot of perverts out there....Everyone tried to escape, to run away somewhere....it turns out differently for everyone.

In some cases the women do not live to tell about it, and the memories of these deaths remain with the women currently involved in sex work. One participant described a recent incident:

There were even cases when the police came to us because they found a pair of dead girls’ bodies. They found two dead bodies here in the suburbs. It was known that they were from the street because we have one small sign—we use the organization’s condoms and these condoms were found in the purses. If these types of condoms are found in the purse, then it is 100% certain that she is a prostitute from the street. There was an investigation, but the girl was so decomposed that she was unrecognizable. They could not even recognize her. It is very sad, of course. Her parents are probably going crazy...the person disappeared. But the body was completely maimed. They came to show us photos, but we couldn’t recognize her. It was difficult. It might be that the girls know one another among themselves. I, for example, know everyone from here to prospect Kultura [one of the main roads in the city]...but in this case, she could not be identified. It was very difficult.

While violence is omnipresent in street-based sex workers’ lives, the women feel that there is little to be done to avoid it. As one participant described what measures she took to avoid the violence: “Only on the psychological level, you try to make some kind of contact with the person. You talk about some specific topics in order to kind of soften him up. What else can I do? I am a woman. No matter how strong or weak I am, I could not compete with a man.” Sex workers in the study shared the opinion that safety comes with experience and learning to avoid situations that may result in violence. For example, the participants described strategies such as not going alone to apartments, not going to the suburbs, renting a room from someone else so that one is on her own territory, and
learning to identify characteristics of clients that should be avoided. The violence described by the interviewed sex workers shed light on the context in which these women live and work.

**Perceived stigma and discrimination in the health care setting**

The stigma and discrimination experienced by sex workers in their everyday lives was also apparent in their interactions with the medical community. In the quantitative component, 31% of participants agreed that doctors refuse to treat sex workers. Over half (51%) of the participants agreed that doctors refuse to treat injection drug users. Thirty percent (30%) of the women reported that they personally had been refused medical care. Less than half of the participants said that they had ever discussed their involvement in sex work with a health care professional. While the overwhelming majority of women (95%) reported that they can openly discuss their problems with doctors, it is less apparent that they will actually discuss all issues with the doctors. More than half (58%) said that they have not gone to a doctor when necessary because they were worried that the doctors would treat them badly.

In the in-depth interviews, sex workers reported that they do not want to tell their doctors about their work out of fear of being treated poorly.

*Interviewer: Have you ever discussed this with your gynecologist?*

*Participant: About my work?*

*Interviewer: Yes.*

*Participant: That I am a prostitute?*

*Interviewer: Yes. Have you discussed this?*
Participant: No. It seems to me that the she [gynecologist] would be biased against me and show disgust towards me. If, well, if she were to be understanding of the idea that I am a drug user, a sick person, but if she finds out this then I think that her attitude towards me will change, she will start to view me differently. That is why.

Another participant reported that while she might want to discuss the issues with her doctor, she is afraid what other patients would think. Since there is no privacy in hospitals, everyone would know. When asked if she told the doctors that she was involved in sex work when she tested for HIV, the participant explained why she denied it.

_They asked. But, I said that my boyfriend supports me, that he works, that he is also using [drugs], but he works, that he makes money on the side and feeds me....I thought that the nurses would be disgusted and that they would treat me badly in the hospital ward...I was lying there with women who were already 55 or 60, and I alone was the young one. There were four of us women, and I was the youngest. And the doctor came, sat on my bed, and started asking questions. Everyone heard everything. I might have been a bit more open, may have told her something, or asked questions myself, but the discussion took place right in the ward, in front of everyone....And if I were to say that I am a prostitute, the women’s ears would have certainly perked up. What do they think of us? That we are lazy, that we don’t want to work, it is simpler for us to spread our legs for money. They think that it is quick and easy money. It might be quick money, but it is not easy money. Definitely not easy!_

The results of this study reveal that sex workers experience another level of stigma and discrimination in the health care setting because of their concurrent use of injection drugs. One participant talked about going to a doctor and feeling like she received inadequate care after being hit by a car because the doctors knew she was a drug user.

_“Our doctors...you won’t believe it...when I went to the hospital after my accident. The hospital there was horrible! When they cut me...well doctors don’t know how to cut, look at this scar. When a doctor says “Doctors couldn’t make a cut like that”, I say “You think that I would have cut my own arm?” See, you understand, this is the attitude towards drug users.”_
Participants also reported that doctors have treated them badly when trying to draw blood because they see from their veins that they are drug users, they have been denied pain reliever, and they have been belittled.

Participants reported being treated differently if doctors know about their sex work or drug use.

*Interviewer:* To what extent can you discuss your involvement in sex work or drug use with your doctor?

*Participant:* Oh, they are not interested in this. They don’t care about it.

*Interviewer:* Do they ever ask?

*Participant:* I even think that in those kinds of places, like the ordinary places, for all people, they even have a negative attitude. This is what I think. If you say something then the opposite will happen. They are not going to relate to it well, I think. So that they would say something to you or explain something to you? That is not going to happen.

*Interviewer:* Why do you think this?

*Participant:* Well, I simply...they also see. I come to give a blood test. One of them [health care worker] was normal and she called the other to come draw my blood. She says “Oh, let her draw her own blood!” You decide for yourself why.

**HIV-related stigma and discrimination**

There is even more stigma and discrimination in the lives of female sex workers who are HIV-positive. In the quantitative component, most of the women with HIV (64%) reported that they are afraid to tell others that they have the disease. Thirty seven percent (37%) said that they started to feel socially isolated once they learned that they had HIV. The majority (87%), however, reported that they can tell their doctors about their HIV status. Despite this, among the female sex workers in this study, those who are HIV-positive are more likely to have been refused medical care than those who are HIV-
negative (p=.04). Also, female sex workers who have HIV are more likely to be afraid of going to the doctor than the female sex workers who are not infected with HIV (p=.02).

Perceived stigma and discrimination against people living with HIV/AIDS was high among study participants in the quantitative component. Eighty three percent (83%) of the women surveyed agreed that people with HIV experience verbal abuse. And 74% believed that people with HIV are prone to physical violence. Social isolation of people living with HIV was a common perception among female sex workers. Forty percent (40%) of participants felt that people with HIV are rejected by their peers and 69% believed that people with HIV are at risk for being ejected from their homes. Only three percent completely agreed that people want to be friends with people living with HIV/AIDS.

The female sex workers in this study were asked about their opinions on people living with HIV. Six percent (6%) said that HIV-positive people should be punished, while 9% agreed that they should be isolated from society. However, 67% of participants thought that people with HIV deserve compassion. The belief is strong that the health care setting is a place where discrimination should not take place due to a patient’s HIV status, as 92% of the women agreed that people with HIV should be treated the same as other patients.

The survey results suggest that the women would not feel comfortable disclosing a positive HIV status and expressed concern about doctors’ confidentiality in regard to HIV testing. Nearly half (47%) of the female sex workers felt that they would be afraid to tell other people if they found out they were infected with HIV. Only 24% of participants
were completely confident that their doctors would not tell others if they received an HIV test.

The information from the in-depth interviews supports the conclusion that people decide not to disclose their HIV status and one of the reasons is because of the stigma attached to the illness. One HIV-positive woman explained why she tries not to let others know of her status.

*Participant: No. In general I hide it. I try to hide it from everyone. That is people close to me know, but those that I am not familiar with, I try to hide it from them.*

*Interviewer: You said that you try to hide your status. Are there any reasons for this?*

*Participant: Yes, because people have a very negative attitude towards this. I just know that they will treat me badly. If I am to openly tell people that I am HIV-infected, they will treat me badly. No one talks about this. They hide it.*

During the interviews, many sex workers said that they do not discuss HIV with their peers.

*Participant: “No, we don’t discuss this [HIV]. People don’t like to discuss who is sick...Well, they don’t like it. It is not pleasant to talk about it. People simply say that if we shoot up together then don’t touch my needle, I am sick. But that we would discuss it... no, that doesn’t happen.”*

*Interviewer: So a person just tells that he is sick and that is it?*

*Participant: Yes, that he is sick. No, we don’t discuss it.*

*Interviewer: Are there any reasons that you do not discuss?*

*Participant: It is unpleasant, maybe, to talk about that. I don’t know. We don’t touch that topic.*
Participants also talked about how some sex workers will disclose other people’s HIV status or even say people have the virus when they do not know. They cited reasons such as deterring clients and sexual partners, or just to gossip.

There are even girls among us... you know a client stopped, wants to take her, and she says “Don’t take her, she is an HIV-infected one”, umm, purposefully tells a client....No, otherwise just for that we don’t talk about it. All of sudden one or both say “You know, _____ has HIV!” and I say “How could you girls know this? She herself doesn’t even know it.” “umm, she went there and tested”. I say, “Did you go with her?—No” I say “Believe me, that kind of information, no one is going to tell.”

There were varying opinions in the qualitative data of how comfortable the participants felt at the City AIDS Center. Participants reported feeling like they were treated poorly at the AID Center because of their status as sex workers or drug users. However, in regard to stigma related to HIV, some HIV-positive participants felt more comfortable at the AIDS Center. One participant who is HIV-positive described why she prefers receiving care at the AIDS Center over other places.

Participant: If I broke my finger, then I would go to an ordinary clinic. If it is something internal, then I would go to the Center because in our society doctors don’t treat us [HIV-positive people] very well.

Interviewer: If you broke your finger and went to an ordinary clinic. Would you tell your doctor that you have HIV?

Participant: Yes.

Interviewer: How would your doctors treat you then?

Participant: They would put on gloves. Of course, not very well.

The fear of HIV-related stigma was cited as a reason not to go to the AIDS Center. One participant described why people may not go there to receive services.

You know, in general everyone immediately freaks out and they become nervous about that topic. That is when you start to ask a person, many people immediately
freak out, like “I don’t have it [HIV] and thank God”. That is, it psychologically
offends a person a little. Yes, she might admit it, but not everyone is going to
discuss it. A lot of people will immediately freak out….But very few go to the
Center, very few. That is everyone says “Well, so I have it, what can I do?”

Some of the women did say that they felt they could overcome their perceived
stigma in order to get the care if needed. One HIV-positive participant said that she is
able to bear with the mistreatment by doctors. She felt comfortable talking with her own
doctor, but she described a time when she had to see another doctor.

“A different doctor filled in. There was perhaps some kind of negative attitude on
his part. But in general, I do not feel this. Even if it is there, I try not to pay
attention to it. I live like it is. I don’t try to get stuck on that because I know
that if I do this nothing will come of it. What for? It is not necessary.”

Association between perceived stigma and discrimination and recent HIV testing

The results from the quantitative component provide further information on how
female sex workers’ perceived stigma and discrimination correlates with HIV testing.
The multivariable logistic regression model is presented in the table below. The
Likelihood ratio estimate of the model presented below was 28.03 (p<.0001, with 6
degrees of freedom).

| Table 9. Associations between Perceived Stigma and Recent HIV Testing |
|---------------------------------|----------|----------------|------------------|--------|
| Factor                          | Unadjusted OR | Adjusted OR | 95% CI           | p-value |
| Stigma related to HIV           | 0.95      | 0.9           | (0.84, 0.97)     | p=.006 |
| Stigma related to sex work      | 1.16      | 1.33          | (1.10, 1.60)     | p=.004 |
| Refused medical care            | 1.19      | 1.37          | (0.47, 3.99)     | p=.56  |
| Fear of being treated badly at the doctor | 1.87      | 2.45          | (0.92, 6.55)     | p=.07  |
| Amount of time using drugs      | 0.39      | 0.26          | (0.07, 0.91)     | p=.04  |
| Age                             | 0.89      | 0.88          | (0.78, 0.98)     | p=.02  |
These results indicate that the odds of having had a recent HIV test decreased 10% for every one unit change in perceived stigma associated with HIV [adjusted OR= 0.90, 95%CI (0.84, 0.97)]. The odds of having had a recent HIV test increased 33% for every one unit change in perceived stigma associated with sex work [adjusted OR=1.33, 95% (1.10, 1.60)]. Experienced discrimination, measured as having been refused medical care, was positively correlated with having had a recent HIV test. And fear of discrimination, measured as avoided medical care because of fear of how one would be treated, was also positively correlated. However, neither of these correlations was significant based on the results of this study. Age and the length of time using drugs were the only significant confounding variables in the model. The odds of having had a recent HIV test decreased 12% for every one unit change in age [adjusted OR=0.88, 95%CI (0.78, 0.98)]. Similarly, sex workers were 74% less likely to have had a recent HIV test if they had been using drugs for a longer period of time rather than a shorter period of time.

Summary of findings

The combined mixed methods results in this study indicated that there are many layers of stigma in the lives of female sex workers in St. Petersburg. Female sex workers experienced stigma related to their involvement in sex work, injection drug use, and HIV-status. They reported feeling stigmatized by society, neighbors, friends, family, and other sex workers. As evident through the results of this study, the stigma associated with sex work, drug use and HIV were internalized among many of the women. Nearly all of the women reported experiencing some type of discrimination in the health care setting and most often because of their involvement in sex work, drug use, and/or because they were HIV-positive. Female sex workers who were HIV-positive are more likely to have
experienced stigma in the health care system. The quantitative results of the study suggest that HIV-related stigma was negatively correlated with getting a recent HIV test. However, sex work-related stigma was positively correlated with getting a recent HIV test.
5.5 Female Sex workers’ Experiences Utilizing HIV Services: Structural Barriers and Strategies to Navigating the Health Care System

There are structural barriers to receiving HIV services in St. Petersburg. An emerging theme from the in-depth interviews was the process of negotiating the health care system in attempts to overcome these barriers. Sex workers in this study also reported barriers within the structure of the health care system for receiving other services, namely drug rehabilitation services and acute medical care. The barriers included: poverty, not having proper documents, lack of anonymity in testing, and having to be officially registered. Participants discussed how they overcame some of these barriers. Whether this means having to pay for services, having your family members intervene, using referral services, or becoming registered in the system, different negotiating techniques emerged from the data. In this section, I will describe the process of how female sex workers negotiate the system and make decisions about getting tested for HIV, seeking health care in general, and seeking HIV care and treatment services in particular.

Poverty as a barrier to receiving health care services

The sex workers in this study talked about poverty having a great influence over their life decisions, including reason for involvement in sex work, not being able to pay for medical services, caring for children, having a place to live, and purchasing basic goods. The most recent economic downturn in the country also had an impact on the level of financial security the women felt. “Now it is really bad with work. Now it became very difficult to make money. I don’t have a lot of extra money. Earlier it was easier. Just one year ago it was a lot simpler. It was simpler to make money. Now it is more difficult.”
Participants talked about the difference in care between the free, state-run health care centers versus the paid services now available in the city. While they perceived the paid services to be of higher-quality, they said that in most cases they cannot afford to utilize these services because of the cost.

Participant: A now, well honestly, I didn’t go because of that reason. God forbid that they would find anything. Our doctors would have cowed me. Our doctors are such that... that kind of medicine... it is better not get involved. Or at least have some money so that you feel normal. I don’t have it yet...

Interviewer: What kind of doctors?

Participant: Well, there are kind of like, everything is about money. I have in mind, the ordinary ones, the ones based on the residence permit (propiska). If you have money, they will do everything. If you do not, then the communication will be just like that. I, if I want to find something out, it is better that I come to the “Doctors” [referring to the outreach van doctors].

As illustrated in the above quote, women frequently had the perception that if they had money, they would be treated better by doctors, and they could then avoid the free health care and/or doctors that treat them poorly.

The outreach van where women were recruited provides referral services for free gynecological services. The participants discussed their preference for using the referral system over the typical state-run clinics. As one participant illustrated the perceived difference in the health care received depended on if one was in a position to pay for services.

Without a referral? Well, that was a long time ago. Honestly speaking, I don’t really respect our doctors. Because now this kind of system appeared in which everything is based on money. If you have money, then they will receive you as needed. If you don’t have it, then they won’t. And therefore, while there isn’t such an urgent need to visit them, I try not to go to them. I haven’t gone to those free ones in a long time.
Lack of official documents as a barrier to getting services

For women who would otherwise access state-run health care facilities, the issues of a residence permit (propiska) or passport registration become a barrier to access. As described by one participant, if one does not have a residence permit, then it is nearly impossible to get the free medical services. When asked about how often she goes to the doctor for testing, she replied, “Well, how it works out moneywise. I don’t have a residence permit. I have to pay money for everything.” The same problem arises if one does not have a passport. Another participant illustrated this idea when asked about whether she utilizes testing services. “No, I haven’t gone in a long time. First, I have a problem with my documents. I don’t have a passport. I lost it. I don’t have time, in general, to do it, therefore it works out that I cannot go to the doctor because I don’t have money for this.”

Effects of the social and economic collapse on the health care system

A discourse on poverty and its impact on access to and utilization of HIV testing and treatment services must include mention of the system itself. The health care system in Russia suffers from being underfunded. Doctors are not paid adequate salaries, and thus it remains difficult to stop bribes. Plus, the equipment is not always adequate in all of the clinics and hospitals.

I have a friend—we studied together—they discovered that he had cancer. He knew and thus he sought care there, he was in Botkin, but that was for a fee, he was in a for-pay ward, somehow the guys managed. Umm, yeah, I was at Botkin when he was there, so what? He died all the same. He had pancreatic cancer and the metastasis moved to his liver. Take what we have, if a person has money... medicine, clinic No.104, great specialist, but old equipment.
As illustrated in the above case, someone may have money but because of broken system adequate care is not always feasible. The participants in this study were quick to acknowledge that the low salary of doctors also affects doctor-patient relationships.

While participants did give examples of how doctors were at a disadvantage in helping because of low salaries and lack of up-to-date medical equipment, the majority of women were quicker to place blame on how the system is largely driven by money. This observation is particularly relevant because the system 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. Therefore, some participants reported being skeptical of the free services provided at places like the AIDS Center. One woman talked in the in-depth interview about her mom trying to convince her to go to the AIDS Center.

_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 from Soviet times that everything should be given for free. And I explain to her that now it is capitalism, that everything now is a little different, everything is not like it was during those times. And, like, I went there a couple of times. I wanted to get my teeth worked on. And then I understood that without money it is unlikely anything will be done there. Umm, this is how it appeared to me. I don’t know, in any case, she examined me, but this exam which she did, they could do this exam for me anywhere. In summary, it was useless—like I say, useless._

**Medical records, registration into the system: last resort options for vulnerable populations**

Another important aspect of the Russian health care setting with regard to HIV and other STI testing is that if a woman is eligible to get free testing at her local clinic, it means that she would have to give up the possibility of anonymous testing. “Yes, that is with the passport everything is free. If you want to test anonymously, I don’t know how it is in the clinic, if you want anonymous, there is a charge. You can pay and get tested, not
saying anything. But if you test for free, it is with documents. This I know for sure.” If a person utilizes the free testing services as part of the state-sponsored health care system, then a positive diagnosis would officially be put into their medical records. These records would be required for getting further health care and could even be shared with employers based on the type of work.

The Russian public health system includes a process of registration of cases. Sex workers in the study mentioned being registered as drug users, HIV-positive, during pregnancy, and having syphilis. When a person becomes registered he or she is then eligible for access to free medical services related to that particular status. In fact becoming registered is most often done because of financial necessity. As one participant explained why she registered as a drug user in the city: “Because I didn’t have any money to pay for treatment, for anonymous treatment.” Another woman discussed being registered as having syphilis and the reasons for having the diagnosis become an official record.

Participant: I am on the registry for syphilis.

Interviewer: And what does this mean?

Participant: I give blood every six months. I arrive there, give blood, they observe me, they check by blood tests. And if something is there, some kind of abnormalities, they prescribe free treatment or paid, anonymous. Free treatment is in the hospital....

Interviewer: And why did you decide to register?

Participant: No, I didn’t have a choice. They automatically put me on the registry. Interviewer: If I understood correctly, you are also on the narcology registry. Are you on this registry?

Participant: I am on the narcology registry.
Interviewer: What are the reasons for this?

Participant: In order to be admitted to the hospital and to receive free treatment. Due to this, I registered.

Another participant described her rational for registering as a drug user and what the process entails, including being tested for HIV as part of accessing medical care.

Interviewer: When you were in the hospital for drug rehab, did you also test for HIV?

Participant: Umm, in order to be admitted to the hospital, I already had tests. There, where I was admitted, they kind of already knew. Umm, I am registered, like, in the narcology department, therefore they admitted me for free. That is I go, take the referral, get tested and am admitted.

Interviewer: Is it required that you are tested for HIV in order to be admitted into the hospital?

Participant: For free of charge, yes. But if, for example, it is paid, then they do the tests there.

The woman continued by explaining the registration process:

Yes, well, there it is necessary to specifically become registered. I, umm, was admitted to the hospital, registered, I had to, like, go constantly for five years after that ...well, I was, like, registered. They check up on me. But only after five years, if I don’t have any slip ups, well, like, I don’t use, then they will take me off the registration list, and that is that. Many simply do not want to get on the registration list. Not everyone wants that.

The woman continued during the in-depth interview to explain how one could get taken off the registry. “Periodically, after some kind of set time I would have to go see a doctor. She needs to look to see that I don’t have anything, umm, like, that I am not using drugs. Umm, she looks and takes notes. If in the course of five years I don’t once get caught, then they take me off the list, and basically, that’s it.”
The women in the study were quick to point out the negative aspects of being registered. One participant discussed the negative aspects of being a registered drug user.

Well, for example, I want to get a driver’s license, I am registered at the narcology dispensary; they won’t give it to me. I cannot. For example, I want to become employed, a lot of people, who look, find out, for example if I am registered or not. Umm, in general, there are many minuses, if you are registered. Therefore, one doesn’t register...if possible it is better not to get on [the list], it is, basically, extra problems.

Another participant said that she did not want to become registered despite the free medical treatment. “Umm, why? You go, stand on the street [to work], the police pick you up, look it up- Aha! Drug user, on the registry. They put a check mark, after that check mark another five years, plus you have to be checked up on by the narcologist. And again, no one will take you for work.” One participant talked about the stigma associated with being registered as a drug user:

The fact that I am registered— that is it, as if it were written on the forehead that I am drug user- equal to that. Get on the registry and that is simply it, you become a social outcast...a normal person could not become registered because he turns out to be a social outcast. You cannot get work, nothing anywhere everywhere it is written “Registered at the narcology [dispensary]”. Everywhere! Even if you, oh, one of my friends, my classmate, also shoots up, he registered, and then 10 years passed, he was removed from the registry, but everywhere it is written that he is a drug user. Everywhere! We had the Soviet Union, and in that sense it has remained.

In fact, the desire to avoid being registered either as having an STI, HIV, or being a drug user was cited as a reason to avoid going to the doctor and being tested. One of the interviewed sex workers explained that she did not go to the doctor out of fear of being registered as a drug user:

Interviewer: Have you ever gone to the doctor for consultation?
Participant: No, I am afraid to go, to be registered. Because I am a teacher by education and accordingly, if I am registered then it will be very difficult for me to find work. Therefore, I try to with my own strength to decrease the dose, to use less.

In the in-depth interviews, women also talked about not wanting to get tested in the free state-run programs because of the fear of being placed on official registration lists. Participants discussed that they were only able to avoid registering as a drug user, either through paying for medical care or not receiving medical care.

In addition to the lack of choice in registering due to financial reasons, the process of becoming registered for different health status was not always an active decision. The sex workers interviewed often used the passive form of “being registered”; or when HIV-positive participants were asked about influences on their decision to register at the AIDS Center, they talked about being placed on the list. If a person gets tested for HIV at the AIDS Center, a prenatal clinic, or as part of government health care system and is diagnosed with HIV, he or she will become a registered case and this information is included in their medical record. The medical record can be viewed by potential employers, educational institutions, and other public institutions.

Becoming registered was a common association made with mention of the City AIDS Center during the in-depth interviews. When asked if they knew about the AIDS Center, in most instances the sex workers in the study talked about either being registered there or knowing someone who was registered there. For example:

Interviewer: Tell me, please, have you ever heard of the City AIDS Center?

Participant: Yes

Interviewer: What have you heard?
Participant: I heard that they put you on a registry, specifically on a registry, but specifically those for who have a result confirmed. Specifically for those who have confirmation. Oh, for example I have a neighbor, she has two small children, and um, they went to this center and they helped them with food and gave everyone pills. I kind of heard this. But she had a confirmed diagnosis.

While in cases like the aforementioned example the attitude towards being registered was neutral and perhaps even provides some benefits (for example food or medicine), some of the participants discussed the fear of becoming registered if they went to the City AIDS Center for testing or other services. As one participant described in the in-depth interview, people she knew had gone to be tested there.

And the doctor, of course, immediately took that guy and says “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 there is something, then they may try to talk you into something, because after all there is a legal responsibility.

As implied in the above quote, if you get tested at the AIDS Center and the result is positive they are going to register you because of the protocol for documenting HIV cases.

Few of the sex workers talked in the in-depth interviews about receiving services at the AIDS Center. One commonality that appeared to influence the visits to the AIDS Center, and perhaps chance of being registered was pregnancy. As one HIV-positive mother described, the decision to register at the AIDS Center if one is pregnant was not always perceived to be her own. And if you are registered with a prenatal clinic then the decision to test for HIV may also not be the woman's.

Interviewer: When did you find out about your HIV diagnosis?

Participant: During pregnancy.

Interviewer: And when did you test?
Participant: The first time, when I registered [pregnancy], I was literally three months pregnant—at first nothing at all showed up, and then—positive. Five months of pregnancy...

Interviewer: And had you ever tested for HIV before this?

Participant: I had not thought about this earlier.

Interviewer: And how did you decided to be tested while pregnant?

Participant: No, now this is how it is done: when you are registered, it is required that you are tested for HIV two times during pregnancy.

The newborn baby of a mother who is HIV-positive is automatically registered with the AIDS Center until a confirmatory negative diagnosis is given. This woman was registered at the local AIDS Center and her daughter continued to be under observation of doctors. Once a person is registered for something in the public health system and is receiving free medical care, he or she may be obligated to test for HIV, and would then be registered as having HIV if she tested positive.

Another HIV-positive woman talked about being registered with her daughter.

Interviewer: Are you registered [at the AIDS Center]?

Participant: Yes, we are registered, she and I.

Interviewer: And do you frequent the services at the Center?

Participant: Yes. We go every six months and if something is not right, the doctor, like, tells us everything. Um, the younger daughter has already been removed from the registry. Everything is okay. Yes, my younger daughter is one and half years old. And with the older daughter, we constantly go.

The woman talked about her involvement with the AIDS Center as a place that she could receive material and social help for her older daughter, who is also HIV-positive. She said that she has gone through drug rehabilitation for her heroin use and is trying to
abstain. She lives at home with her mother and daughters. This particular participant reflected on the positive aspects of being registered and thereby receiving services at the City AIDS Center.

While many of the women discussed visiting the AIDS Center according to a schedule while pregnant and with their children, this did not always continue once the children were removed from the registry (if after a certain amount of time the child tests negative, the child is unregistered). One HIV-positive mother illustrated this tendency with the following statement:

*I simply gave birth. I have twins, two children, they are three years old. I gave birth, like, went through medical check-ups. And since I am HIV-infected I went through, well for a year, for a year you are registered and you go through, together with my children, the children have blood tests and I test. Yeah, I went through those tests. One year... and then almost two, that is one and half years I have not consulted anywhere.*

Strategies for avoiding “the system”: money, connections, family support, NGO referral

If one pays for medical services then she may be able to avoid some of the bureaucracy involved in the health care system. One participant described that she could avoid long waiting list to get free state-run services by paying money. “I went to the gynecologist when I had that one abortion. But it was not official. I did that. Because if it is official then there is a line, well...I had money; I paid for the abortion and had the abortion.” Other participants described incidents where they or someone they knew was able to avoid dealing with the waiting lists or getting all the necessary documents. The difference between those who can and cannot bypass the bureaucracy is money; either their own or a family member who can pay it.
The alternative to having money is to have connections in the health care system. Some of the participants talked about having relatives who work as doctors or nurses, and that they can get them in for care and testing faster and without the official registration. One woman told about her mother’s work as a surgeon and how that she helped her at home if she was not feeling well, but could also refer her daughter to services within her hospital. 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 are realities for many female sex workers, and they are not always able to negotiate better care through social connections.

Another means through which sex workers manage to get to a doctor for testing, engage in drug rehabilitation services, or receive medical care is through the support of family. Women who lived with their parents or grandparents talked frequently about relying on them (most often their mothers) to support them, both financially and emotionally. This scenario was especially true for women who have managed to go through drug rehabilitation or take prophylaxis therapy during pregnancy. The sex workers in this study that did not have family members in their lives to help them noted this absence. Two women talked about being orphans during the in-depth interviews and how this had an impact on their involvement in sex work and drug use, and also not having support in difficult times. Other women commented on having severed ties with their relatives because of drug use or sex work. Many of the sex workers were cognizant of the fact that those without someone there to help them navigate getting care and treatment are in more danger of mistreatment, or no treatment. One participant illustrated
this idea with an example of how her mother helped her survive in the hospital, while she witnessed a woman next to her die without anyone there.

I used drugs. I was admitted to 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 herself brought food. I didn’t eat in the cafeteria. And every day she asked how I was doing. If it was 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 say “Mom, there is some kind of medicine they suggest, it costs money”. My mom would go ask these 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 shot on me and that is all. And like they say, I received the complete care... she asked all the doctors, all of them. Although my lungs hurt, they dug into my stomach, they dug in everywhere, and they checked me out. But I had my mom. And no one visited her [neighboring patient].

The referral system offered by the outreach team provided the sex workers with an opportunity to have help in negotiating the health care system. During the interviews, sex workers reported that they were less afraid to go to the doctor if they had this referral and 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 can talk to her doctors about her drug use or sex work, one participant said:

Maybe because they work with “Doctors of the World” and know who we are exactly, when we come with these cards [referral cards]. They treat us nice enough. If we were to compare. 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. I don’t feel insulted; in any case, I liked how they examined me.

A different participant explained the same idea as “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 interviewed discussed how having a referral motivated her to go get testing and examined.
Interviewer: So you have not gone anywhere without the referral?

Participants: No

Interviewer: Why is this?

Participant: You know why? Because when they give you the referral 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 where can I find money? You are not thinking of anything else, not of the clinic, not about doctors, not about a gynecologist; you understand? 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 his body. This is a must.

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 yet using the referrals.

Summary of findings

There are salient structural factors that influence the utilization of HIV testing and broader health care services among female sex workers. Participants identified not having money to pay for anonymous HIV testing or the perceived “better” services, that the system itself is in shambles, and the perception that free care is not quality and puts one in the position of being treated poorly by doctors. As described by the sex workers in the study, if one cannot otherwise negotiate the health care system there are two default options: getting tested/accessing care but risk being registered, or not getting tested/accessing care. The participants discussed the strategies they had for negotiating the bureaucratic system when they could, including: paying for services, relying on family for support, using connections within the system, or taking advantage of a special referral system through a nongovernmental organization. Poverty and social
marginalization make negotiating the system more difficult for many sex workers in St. Petersburg.
CHAPTER 6: DISCUSSION

6.1 Conclusions from Findings

The results of this study illuminate the individual and social factors influencing female sex workers’ HIV testing behaviors in St. Petersburg. Through examination of decisions around the utilization of HIV testing, HIV treatment, and health care services, the context in which female sex workers live emerges as a significant determinant of accessing these services. The structural violence which female sex workers suffer limits their health beliefs and health-seeking behaviors. The factors of structural violence shape the negotiation of the utilization of HIV services and the perceptions around HIV testing. The facilitators and barriers determined to influence access to HIV services among St. Petersburg sex workers demonstrate some consistency with findings in other settings. At the same time, the results of this study also highlight the specifics of the Russian context.

Perceptions of risk, barriers, and benefits, and their influence on accessing services

Nearly all of the female sex workers in this study had received an HIV test at some point (97%). However, the average HIV test was received 16 months earlier and over half (55%) had not received an HIV test in the previous six months. Given that street-based female sex workers are a highly vulnerable population for contracting HIV, it is important for these women to seek repeat HIV testing in order to learn one’s status and begin to receive the necessary care and treatment, if HIV-positive. Therefore, the
quantitative analysis focused on recent HIV testing, rather than ever having received an HIV test. The theoretical constructs from the Health Belief Model were useful in understanding the mechanisms of how individual-level factors may influence recent HIV testing among female sex workers in this study. In the multivariable logistic regression analysis the only factor that was statistically significant was that people who knew others living with HIV were more likely to have had a recent HIV test. While women talked about receiving brochures and talking with service providers about HIV, none of these cues to action were significantly correlated with HIV testing. The results of this study suggest that knowing that other people were infected may encourage female sex workers to be tested themselves. In this study, the barriers of finding time, traveling across the city (or in some cases from the suburbs to the city), and the expense associated with testing anonymously were salient issues for female sex workers’ decisions to test for HIV. While not conclusive, the quantitative results suggested that the perceived barriers of fear of people thinking she is ill and of the perception that she is not at risk are also associated with a less chance of having a recent test. These findings are consistent with studies regarding HIV testing among female sex workers in other settings (Ngo et al., 2007; Nguyen et al., 2008).

Women who are involved in street-based sex work and have accessed the outreach services already have a high knowledge-level about HIV risk, probably because of exposure to education materials. However, receiving this information was not found to be associated with getting a recent HIV test. Given that some participants in the in-depth interviews reported that there are circumstances in which they do not also practice safe sexual and drug using behaviors, their increased knowledge may be providing a false
sense of security. In these instances perceived susceptibility would be low and women would be less likely to get tested for HIV.

**Intersectional stigma, social marginalization, and discrimination in the health care setting: keeping women away from needed services**

Perceived stigma and discrimination perpetuate the marginalization of female sex workers and as a result serve as a barrier to accessing resources in society. In this study, female sex workers who perceive there to be more HIV-related stigma are significantly less likely to be utilizing HIV testing services. These findings are consistent with previous studies on HIV-related stigma as a barrier to services both among other populations in Russia (Orekhovsky et al., 2002; Sokolovskii et al., 2005; Balabanova et al., 2006) and among female sex workers in other settings (Shannon et al., 2007; Gollub, 2008). For many of the participants the stigma is intersectional (Berger, 2004); as the women report being discriminated against for their involvement in sex work, drug use, and for some a positive HIV status.

Paradoxically, in this study the more that the women perceived that stigma related to their involvement in sex work the more likely they were be tested for HIV. One explanation may be that sex workers may feel that they can better hide involvement in sex work from health care providers, but it is more difficult to hide an HIV status. Therefore, perceived stigma specific to sex work is not making women less likely to go for an HIV test. It is possible that is another variable, unmeasured in this study, which is confounding the association shown in this study. More studies are needed to more fully explain the relationship between higher perceived stigma related to sex work and greater probability of having a recent HIV test. They may be able to hide the sex work in the
health care settings, but it becomes harder to hide their injection drug use or HIV status. Hiding these statuses is made more difficult because of the registration system in the Russian health care system.

Female sex workers in the study who are HIV-positive (35%) are even more susceptible to stigma and discrimination. HIV-positive sex workers were more likely than those who do not have HIV to have experienced discrimination in the health care setting. The women in the study who had HIV reported that they were afraid of disclosing their status and feared the lack of their doctors keeping their HIV status confidential. The perceived stigma was not limited to the health care setting, given that female sex workers in this study experienced it in their families, among colleagues, from neighbors, from friends, and from clients. The stigma has become internalized to the extent that many female sex workers in the study consider stigma and discrimination against them to be part of their work.

The complexity of the layers of stigma and social marginalization unveil how difficult it is for a very vulnerable population to receive the kinds of services they are likely to need. Utilization of HIV services is negotiated through the complex system from which many female sex workers feel isolated. While continued efforts to address female sex workers’ perceptions about HIV risk and need for testing, the contexts in which these women live and the stigma against them that persists in the health care setting must be addressed. Larger picture issues must also be given more attention, including HIV testing procedures and drug policy in Russia.
Structural violence

Consistent with the theoretical framework of structural violence (Farmer 1996, 2005), there are social, political, and historical aspects to the current system for HIV service provision which may be deterring female sex workers from accessing them in St. Petersburg. The City AIDS Center continues to carry the impression of a centralized health care approach remnant of the socialist system among female sex workers interviewed in this study. The results of this study indicate that embedded within these perceptions are fear of stigma and discrimination enacted by service providers. These findings are consistent with previous research showing that stigma and discrimination are hindrances to getting HIV services (Orekhovsky et al., 2002; Onishchenko, 2005; Burns, 2007). This study’s 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 results of this study point out the change in attitudes towards state-sponsored health care services and emphasize the perception that free health care services are no longer idealized and in some cases better avoided.

Reflection on the experiences of female sex workers in the health care system indicates that a lot of effort is spent circumventing the state-sponsored health services, including the AIDS Center. The common perception is that no one would want to get the free care available if she could negotiate around it. The issue of being registered as a drug user is an especially salient example. Also, the fear of being registered as having HIV was also a reason to not get free HIV testing.
The results of this study indicate that some female sex workers have more successfully accessed health care services, including HIV testing and treatment programs. Having money and family support appear to be the most effective ways to “avoid” the system and get the care one needs. This is not surprising given what is known about how having money and connections help facilitate access to social services in post-Soviet Russia. This study highlights the experiences of socially marginalized populations in negotiating this system. The more marginalized a female sex worker is, the less likely she will be able to avoid having to register as a drug user in order to get medical care or to testing for HIV on public record. The female sex workers in this study talked about needing to register in order to receive free health care services. These findings are illustrative of the structural violence permeating society with regard to vulnerable populations’ access to HIV services.

**HIV prevention services in St. Petersburg**

The results indicate that there are various options for how female sex workers are learning their HIV status, including: state-run programs, NGO referral systems, private options, and routine testing. However, the service providers are not always collaborating in their efforts given that each institution or organization has specific objectives that do not always complement each other. Botkin Hospital and the Humanitarian Action outreach team have established a partnership, though this can largely be attributed to the fact that Doctors of the World-France has organized and funded both of these initiatives. On the other hand, the City AIDS Center aims to get people living with HIV into longer-term care and a centralized system of service provisions. The outreach teams are seen as
primarily concerned with providing services on-site; and while they do provide referral services, there is not a clear collaborative effort between outreach teams and the City AIDS Center. This situation has implications for female sex workers’ utilization of these services. For example, while an outreach team may more easily reach women on the streets, a mobile van cannot offer all of the services needed (as one would still need to go to the City AIDS Center in order to receive confirmatory HIV testing and be enrolled in a treatment program). While the referral system to STI clinics or the AIDS Center was reported to be effective for the women who have used it, not all female sex workers have used this service. HIV-positive participants in the study discussed preference for receiving services either off-site in the program they were enrolled in (for example, MAMA+) or at the Botkin Hospital. Despite having some shared goals, there does appear to be the need for more collaboration between the service programs if access to HIV services is to be improved for vulnerable populations.

The (in)voluntary aspects of HIV testing

The qualitative and quantitative results of this study indicate the complexity of HIV testing patterns. Some of the female sex workers reported that they received a client-initiated HIV test, namely at STD clinics, the City AIDS Center, or on the outreach van. Female sex workers reported in this study that they tested for HIV in situations of opt-out or routine testing, for example, as part of routine care in hospitals, in jails, or during antenatal care. Among those women who tested routinely, many felt that they did not have a choice in the matter; that it was part of the protocol. Also, the female sex workers reported very limited experiences in receiving counseling as part of the HIV testing
experience. The facts that very few women reported pre-test counseling, and the common perception was that testing was obligatory raise important concerns over the voluntariness of HIV testing and the implications of routine testing for women, especially those who test positive for HIV. These circumstances also provide little foundation for getting a woman into care when she does test positive for HIV. One of the concerns of the AIDS Center is that so few people registered as having HIV are receiving services, and this was also true for the female sex workers in this study (only 21%).

Russia’s HIV policies may be doing more harm than good

The findings in this study reveal concerns within the Russian government’s policy towards HIV prevention and treatment for vulnerable populations like female sex workers. These political and economic factors influence female sex workers access to services. Russia has failed to demonstrate its commitment to addressing the impending epidemic. Service providers in this research study confirmed that they are not receiving enough financial support to fulfill their roles in preventing the spread of HIV and providing care for those affected by HIV. The nongovernmental organizations struggle to survive through external grant monies, which are expected to be on the decrease given the end of the Global Fund’s support in Russia. The Russian government does not adequately support needle exchanges. At best, the organizations that provide these services remain under the radar, making it unlikely that the Russian government will fund such activities given the current political stance towards harm reduction. Also, given that Russian law forbids methadone substitution treatment, there is little hope for curbing the injection drug use problem that is the major cause of the HIV epidemic in St. Petersburg.
Many of the women in this study recognize that their drug use is inhibiting their access to health care. Given that there are limited effective drug rehabilitation programs in Russia and that drug users are so readily discriminated against in the health care setting, it makes the circumstance for receiving care for HIV even grimmer. Also, given that the women talk about needing to be involved in sex work to support their drug use, and in some cases their male partner’s drug use, they are even further removed from receiving services at any centralized health care setting. Addressing the injection drug use crisis in St. Petersburg is crucial to preventing more women from entering street-based sex work and helping current sex workers to cease their involvement.

The government health care services, including HIV services, also suffer from underfunding. In this study, health care providers at the City AIDS Center and Botkin Hospital cited the lack of financial resources as restricting the provision of services. The female sex workers in the study perceived the low salaries of health care providers to be one of the reasons for the discrimination and negative attitudes on the part of these providers.

6.2 Research Implications

This study highlights several areas that warrant further scientific study. First, these research findings have implications for how HIV testing behaviors should be measured. Asking about ever having been tested for HIV is not sufficient among street-based female sex workers in St. Petersburg. The time of last HIV test provides better information. It is also crucial to ask questions about the nature of HIV testing if the
research interest is in “health seeking behaviors”, given that many women may be tested without having specifically sought the test.

Secondly, further research is needed on the course of action that women take once they are diagnosed with HIV, paying particular attention to the differences between women who are tested in client-initiated HIV-testing versus women who are tested in routine or mandatory situations. Additionally, more longitudinal research studies are needed to better understand what comes next for female sex workers when they get an HIV-positive diagnosis in maternity hospitals, jails, and routine hospital visits. Research is needed to understand how circumstances of being tested (client-initiated, routine, or mandatory) influences a person’s likelihood of starting ARV therapy, receiving follow-up care at the City AIDS Center, or enrolling in support programs.

Thirdly, more research is urgently needed on HIV risk behaviors and access to HIV prevention services among apartment-based female sex workers. Almost no research has been conducted among these women. The anecdotal evidence and limited results from this study demonstrate that the little exposure these women have had to HIV prevention campaign activities. Therefore, more assessment on HIV knowledge and HIV risk behaviors is needed. This subpopulation of sex workers is even more hidden, and the women who work in these settings are less independent in choosing to participate in research (given the need for first getting consent from brothel owners and administrators). This makes recruitment for participation in research studies even more challenging. The first step in any research would be to convince the brothel owners to allow access to potential participants. Special attention is necessary to ensure that sex works in these establishments autonomously consent to participation, and that privacy of
interviews can be guaranteed. Snowball sampling is a potential data recruitment strategy; however, it would be important to consider that most female sex workers’ circle of colleagues may not extend beyond the apartment in which they work. In the past, former male clients of these establishments have been involved in the recruitment and researchers have collaborated with the police to accompany them on raids. These strategies require having certain connections with either male clients or the police and necessitate careful attention paid to ensure high ethical standards given the vulnerability of participants in these situations. Given that so little is understood about this population of female sex workers, qualitative, exploratory research would be extremely beneficial at this stage.

6.3 Program Implications

The results of this study should prove useful for developing new and improving existing HIV prevention and treatment programs for female sex workers in St. Petersburg. The information about where female sex workers are most likely to get tested for HIV and where they are first diagnosed with HIV is crucial to determining where to target interventions for enrolling these women into care and treatment programs. Knowledge about HIV is high, indicating that prevention efforts to-date have been successful in educating female sex worker about their risk behaviors for HIV infection. However, as shown in this study, female sex workers admit that there are instances when they are not able to exercise everything they know about HIV prevention. Therefore, further program components are warranted that focus on increasing female sex workers’ agency in making decisions about condom use and drug use. Given that this decision-
making process often does not depend only on the female sex worker and due to the power dynamics (gender, economic status) and high rates of violence against sex workers, interventions are needed with male clients and/or the community at-large. Community-level interventions have shown a significant reduction in risk behaviors (Kerrigan et al., 2006), limited decrease in violence (Wechsberg et al., 2006), and improved utilization of health care services (Gangopadhyay et al., 2005) among female sex workers. An intervention designed to empower sex workers to become able to make changes in their lives, such as the successful Sonagachi in India (Jana et al., 2004; Gangopadhyay et al., 2005), could improve the conditions female sex workers face in Russia. Like some of the current programs in St. Petersburg, the Sonagachi project promoted condom use, distributed condoms, and made referrals to clinics (Gangopadhyay et al., 2005). In addition, the Sonagachi intervention also focused on organizing women through empowerment to better their social, political, and economical conditions (Gangopadhyay et al., 2005). Interventions targeted at clients of sex workers are needed; however, successful examples of such programs are absent in the scientific literature. There is evidence to suggest that in some settings social networks among male clients influence condom use and may be an avenue for effective interventions (Barrington et al., 2009).

Also, female sex workers, especially HIV-positive women, may benefit from more information on treatment options and the importance of receiving continuous care. Many of the participants had misconceptions about ARVs and/or expressed uncertainty about whether treatment even existed. Also, many of the HIV-positive participants felt that as long as they were not experiencing any symptoms it was not necessary to seek any
care. PMTCT programs appear to be an effective means to get women involved in going to the AIDS Center. Therefore, these programs should contain components designed to increase adherence to HIV treatment for women in the longer term. It is important to note that programs with an educational component would only be a start to addressing the reasons female sex workers are not utilizing available services.

Peer-to-peer programs may be effective in addressing many aspects of HIV prevention among female sex workers. However, as demonstrated by the results of this study, not all female sex workers feel a connection to their peers and the nature of many of the relationships between colleagues is very complex. Programs that work with the family or another source of support of female sex workers may be more successful. However, any program that focuses on family support should recognize that stigma against the sex work and drug using behaviors is very high and not all women report having family members that support them, or in some cases the sex workers have been estranged from their families. In cases where women do not have a family or friend for support, a case management style program may be a solution. The model developed for HIV-positive mothers (for example, MAMA+, which has developed a case-management program for helping HIV-positive mothers receive services for themselves and their children) could be adapted to reach female sex workers who feel marginalized from the health care system and other social services. 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.
Interventions that are designed to reach female sex workers would be best achieved through an outreach service component. Based on the information gathered as part of this study, the programs in St. Petersburg that utilize outreach teams are most successful at establishing contact with sex workers. Efforts should be expanded to include more outreach to other venues for sex work, including apartment-based brothels. Given that currently not all HIV prevention and treatment services (namely ARV distribution) could be incorporated into outreach services, interventions are needed to connect these two groups into collaborative efforts in order to reduce barriers for sex workers to obtaining the necessary services. Female sex workers in this study reported fear of accessing services because of perceived stigma and discrimination. Interventions to reduce stigma in health care settings are imperative to encouraging sex workers, especially drug using and HIV-positive sex workers, to utilize available services. While interventions targeted directly towards health care providers may have some effect, the organization of the health care system and the historically marginalizing policies within the health care system (namely the registration of cases and system of documentation) must be addressed. As noted by other researchers, the success of HIV programs is highly dependent on changes in the overall health care system (Tkatchenko-Schmidt et al., 2010).

Interventions that have made great progress in improving the organization of care in Russia are limited. In addition to the frequent lack of accord between government and nongovernment services for HIV prevention noted in this study, there are other examples where the organization of the health care system has been a barrier to achieving the integration of vulnerable populations into the health care system. The directly observed
One successful model that should be considered in developing an approach to HIV service provision improvement is an integrated approach to mental health reform in Russia (Jenkins et al., 2007). Mental health service clients have long been marginalized in Russian society and mental health has continuously been a low priority in the health care system. The situational analysis at all levels of the mental health care system provided the researchers with necessary information about the barriers to system change (Jenkins et al., 2007). One of the reasons for the success of this project was continual communication with the stakeholders at all levels and the establishment of intersectoral collaboration at both the strategic (to gain political support) and operational levels (Jenkins et al., 2007). This initiative also included NGOs, and their collaboration with government institutions was important to the success of the program. The researchers acknowledged that there were legal, structural, and financial barriers inherent in the Russian health care system and that the process was lengthy and challenging. However, changes are possible through engagement of stakeholders at multiple levels and use of pilot programs to demonstrate success to other regions and also inform policy (Jenkins et al., 2007).

**6.4 Policy Implications**

Any research and program advancements will have limited success without accompanying change in HIV-related policy in Russia. Most importantly, much of the
HIV prevention and treatment efforts in St. Petersburg have been financed through the Global Fund. This funding source is coming to an end in Russia, given that the country has moved up in its economic ranking in the world. Therefore, among HIV activists and program organizers working with female sex workers in the city the foremost concern is how, or even if, their efforts will continue. The Russian government does not have a good track record of funding HIV efforts. It is crucial that funding for outreach services be maintained in order to provide services for female sex workers.

There is a definite link between involvement in sex work and injection drug use, and both of these have implications for health-related behaviors. Harm reduction activities are imperative to prevent HIV among both sex workers and injection drug users and should be given adequate funding and legal status if Russia is to curb its impending HIV epidemic. Equally important will be to include drug rehabilitation components into harm reduction activities. Many female sex workers began involvement in sex work as a result of their involvement in injection drug use. Also, many of these women talked about their dependency on drugs as dictating of their lives, both as reasons for sex work, but also that they cannot find the time and in some cases motivation for seeking out health care services. None of the participants in the study have experience in a successful drug rehabilitation program, despite having spent money and time, and in some cases forfeited their anonymity in the health care system. More attention to the drug rehabilitation system is urgently needed in Russia. Specifically, the drug rehabilitation policy in Russia needs to be more closely analyzed, especially the registration system currently in place that is a major barrier to receiving care for injection drug users. The female sex workers in this study reported that the negative consequences of becoming a registered drug user
were a barrier to accessing available services. Methadone replacement therapy is illegal in Russia. It is difficult to envision the epidemic of drug use currently threatening Russian society to be resolved without a reversal of this policy. Unless Russian policy makers acknowledge that current efforts to treat drug addiction are largely ineffective, it will remain difficult to address the primary prevention of involvement in sex work for female injection drug users and the prevention of HIV and treatment of people already infected with HIV. The gender dimensions of drug use must also continue to be analyzed in HIV policy. Many of the female sex workers in this study reported that they became involved in sex work after they started using drugs and even more of them discussed the need to be involved in sex work to be able to support their dependency on heroin. Some of the participants with male injection drug using partners also discussed they are involved in sex work to make money to support their dependency and their partners’ dependency as well. Female injection drug users are exposed to even more risk for HIV because of their involvement in sex work.

The results of this study also have implications for addressing current HIV testing policies in Russia. There are many instances when sex workers perceive that they do not have a choice in regard to HIV testing. Routine testing is done in hospitals, jails, and during pregnancy. Specific measures for ensuring that women have a choice in being tested for HIV need to be included in HIV testing protocols. Consent, confidentiality, and counseling need to be enforced in all HIV testing situations. There need to be more options for women to receive anonymous testing services. The price of these services should not be a barrier for women who need them the most.
6.5 Limitations of Study

As with all behavioral research studies there were limitations to the design and data collection in this study. This study is cross-sectional and therefore, explicit conclusions cannot be drawn regarding the casual pathway between the hypothesized factors and being tested for HIV. Given that the study focused on the perceptions of participant, all the information gathered is self-reported. A possibility exists of social desirability bias and recall bias in reporting perceptions and HIV status. Due to the high-level of stigma in society, some women may not have wanted to reveal their HIV status. Numerous measures were taken to minimize these biases including creating a comfortable and private atmosphere, forming questions in a non-judgmental manner, establishing trust with the interviewer, and reassuring women of anonymity; however, the reliability of self-reported answers cannot be fully guaranteed. Also, women were asked to reflect on perceptions that may have occurred in the past. For example, it might be that some women who had been tested will still report barriers that they felt were substantial, yet they were able to overcome. While the intentions were to measure the theoretical constructs with scales, many of these scales did not work in this study, despite having validity in other settings. This is attributable to the fact that for some items there was not a lot of variation in the answers given. Nonetheless, specific items were useful in explaining variance in decisions to test.

There were some limitations in the qualitative component that warrant discussion. The interview length was restricted by time in order to minimize disruption of outreach service activities and burdening women during the hours they normally work. Interviews
were not conducted with women who were known to be intoxicated so as to ensure ability to make an informed decision to consent. However, the fact that participants were active injection drug users did sometimes have an impact on their ability to participate for an extended period of time. As inherent in qualitative research, the findings are not meant to be generalizable to all sex workers in St. Petersburg, but rather to provide in-depth insight into the issues around barriers and facilitators to receiving and experience utilizing HIV services.

There were some limitations in the recruitment process that are unique to working with vulnerable populations. Recruitment was extremely difficult given that sex work is not legal in Russia and that there is stigma associated with this profession. Additionally, because of the close relationship between injection drug use and street-based sex work, all recruitment had to be done through existing professional outreach services due to safety concerns and issues of acceptance into the community. Therefore, recruitment for both the qualitative and quantitative study was limited by the routes of the mobile outreach van. Female sex workers who work in parts of the city where the outreach groups do not visit were not included in this study. There may also be female sex workers who do not access the outreach services, and these women were not included in this study. Given that the sex workers who participated in the study have at least accessed some HIV prevention services it can be assumed that this experience may influence their perceptions around HIV testing and treatment services, and also their behaviors in utilizing these services. It can be hypothesized that the barriers to utilizing testing and treatment services may be even greater for sex workers not being reached through current outreach activities. Given that participation was entirely voluntary and no information
was collected on women who declined an invitation to participate, no conclusions can be drawn on whether there were any differences between those who chose to participate and those who did not in either the in-depth interviews or questionnaires.

Lastly, limitations exist in this study around the limited success in reaching sex workers in apartment-based venues. The observations of HIV prevention activities in these venues and informal conversations with sex workers, administrators and brothel owners revealed the urgency of needing to reach these populations with HIV prevention services. The participants recruited at apartment-based brothels were not included in the final statistical analysis because of the small sample size. Recruitment was very limited because this population is even more hidden, in part due to the criminal nature of the business. Also, the sex workers in these establishments were not always allowed by the administrators to participate in interviews.

6.6 Strengths of Study

Despite the aforementioned limitations in this study, there are notable strengths in the study design and data collection procedures. The multidisciplinary approach to this research offered the opportunity to consider many facets of influences on HIV testing behaviors and to understand these behaviors within a specific context. The use of individual-level health behavior theory combined with the structural- and social-level theory provided a more comprehensive consideration of what factors influence female sex workers utilization of and access to HIV services. The mixed methods study design allowed for in-depth information from the qualitative component to complement the generalizable findings from the quantitative component. Since I was able to conduct the
interviews and observations of the services, preliminary analysis of data was used to inform further interview questions. Also, the mixed methods approach was used throughout the study (including conceptualization of ideas, data collection, and analysis) which allowed for more thorough triangulation of data and a truly iterative analysis process.

The data collection process was thorough and many barriers to recruitment were overcome in the process. It has already been mentioned that the population of female sex workers is a difficult population to reach and this is one of the reasons for the dearth of information in the scientific research about this group of vulnerable women. Agreeing with the existing outreach services to reach street-based sex workers proved invaluable in establishing initial contact with potential study participants. Subsequently, I built trust as an interviewer with participants because of my continuous presence on the outreach vans throughout the fieldwork and through the process of informed consent. While significantly fewer interviews were completed with women involved in apartment-based sex work, the information that was collected is an achievement given that this population is markedly difficult to reach in St. Petersburg. In fact, most of the limited research has been conducted through interviews with women who have left the business, rather than women who are currently involved. During the fieldwork, I met with Russian researchers who have conducted research with sex workers in order to discuss their recruitment strategies. I learned that the efforts of this current study meet or exceed previous attempts to conduct research with this difficult-to-reach population.
Appendix A: Qualitative Interview Guide (English and Russian Versions)

Thank you for taking the time to talk with me today. I am doing this research project to understand more about people’s experiences with HIV services in St. Petersburg and reasons for accessing them. I am interested in your experiences and opinions. There is no right or wrong answers. Please let me know if there are any questions that make you uncomfortable. Do you have any questions before we begin?

1. Basic demographic information including: age, residence, marital status, children, occupation, history of drug use and/or sex work, whether they have ever been tested for HIV (if status is unknown).

2. Please tell me a little about your life. How do you spend a typical day?

   Probes: Ask more specifically about any mention of drug use or sex work. Ask about reasons for involvement in sex work. Ask about drug use: how often, does she use drugs alone or with others (ask about these relationships).

3. How do you think other people view your involvement in sex work?

   Probe: Do you friends and family know of your work? Have you had any reactions from others about your work? What do you think they might say to others about your work? (probe for specific example)?

4. Please tell me about the last time you received health care services. Can you describe for me this experience in detail?

   Probe: Do what extent did you feel support from health care providers? How well are you able to discuss your problems openly during health care visits? Have you ever been refused services?

5. Tell me about a time when you participated in an HIV prevention program? (if respondent does not understand, you may give an example- trainings, individual counseling, etc.)

   Probes: Who provided these services? Describe the providers? Describe the other participants? What were your reasons for participating in these programs? To what extent did you feel you benefited from them?

   Alternative probes (if informant has not accessed prevention services): Describe the reasons you have not sought these services?
6. If you have been tested for HIV, could you please tell me about your experience getting these services?

   *Probes:* Describe the reasons you sought testing? Where were you tested for HIV, was is rapid testing, did you return for results? What was the pre-test counseling like? What was the post-test counseling like? How would you describe your comfort level with the counselor/medical personnel who conducted your testing?

7. Is there anything else you would like to add?
План интервью с женщинами с повышенным риском заражения инфекцией ВИЧ, в том числе вовлеченными в сферу сексуальных услуг и потребителями внутривенных наркотиков

Спасибо большое, что Вы согласились на интервью со мной сегодня. Мы проводим это исследование, чтобы лучше понять, как и по каким причинам женщины обращаются к услугам для предотвращения ВИЧ-инфекции. Меня интересует Ваше мнение и Ваш опыт. Нет правильных ответов на эти вопросы. Пожалуйста, если Вам будет неудобно отвечать на какой-либо вопрос, скажите мне и мы можем перейти к следующему вопросу. Есть ли у Вас какие-либо вопросы перед тем, как мы начнем наше интервью?

1. Основная демографическая информация: возраст, место жительства, семейное положение (замужем ли, имеет ли детей), профессия, опыт с наркотиками или секс-работой, делала ли когда-нибудь анализ на СПИД (диагноз не спрашивается)?

2. Раскажите мне, пожалуйста, немного о себе. Как Вы обычно проводите день?


3. (Задать этот вопрос, если известно, что женщина вовлечена в сферу оказания сексуальных услуг). По Вашему опыту, как относятся люди к Вашей работе в сфере оказания сексуальных услуг?

Дополнительные вопросы: Знают ли Ваши родственники и друзья о Вашей работе в сфере оказания сексуальных услуг? По-вашему мнению, что говорят другие о Вашей работе? Имели ли Вы какие-нибудь проблемы в связи с Вашей работой (попросите рассказать пример)?

4. Пожалуйста, расскажите мне о том, как Вы обращались за оказанием медицинских услуг в последнее время? Можете ли Вы мне рассказать подробнее об этом случае?

Дополнительные вопросы: В какой степени Вы чувствовали поддержку со стороны медицинских работников? Насколько откровенно Вы могли обсудить свои проблемы с медицинскими работниками? Вам когда-либо было отказано в получении медицинских услуг?
5. Участвовали ли Вы в какой-либо программе по профилактике ВИЧ-инфекции. (Если участник не понимает вопрос, можешь дать пример: тренинг, индивидуальное консультирование, и т.д.)

Дополнительные вопросы: Кто оказывал эти услуги? Опишите тех, кто оказывал эти услуги? Опишите других участников. По каким причинам Вы участвовали в этой программе? До какой степени Вы считаете, что вам было полезно участвовать в этой программе (в этих программах)?

Альтернативные вопросы (если участник никогда не участвовал в таких программах): Существуют ли какие-нибудь конкретные причины, по которым Вы не участвовали в таких программах?

6. Если Вы тестировались на ВИЧ-инфекцию, расскажите мне, пожалуйста, о своем опыте с этими услугами?

Дополнительные вопросы: Объясните мне причины, почему Вы решили пойти на тестирование крови на ВИЧ-инфекцию. Где Вы были тестированы? Вернулись ли Вы, чтобы получить результаты Вашего анализа? Как проходило консультирование до того как медицинский работник взял кровь для анализа? Как проходило консультирование когда Вы получили результат анализа? Как бы Вы описали свой уровень комфортности при общении с человеком, который проводил ваше тестирование?

Альтернативные вопросы: Существуют ли причины, почему Вы не тестировались на ВИЧ-инфекцию?

7. Может быть, Вы еще что-нибудь хотели бы добавить или дополнительно обсудить?
Appendix B: Quantitative Questionnaire (English and Russian Versions)

Instructions for the interviewer: Please, attentively, read and complete the following information about the participant.

Instructions to the participant: Thank you for agreeing to answer some questions for me today. I am interested in your opinion and experience. There are no right or wrong answers. Please let me know if you are uncomfortable answering a question and we will move on to the next question.

Instructions to the participant: First, I would like to know more about your experience receiving medical services.

1. Do you feel that you can talk openly about your problems with medical care providers?
   [ ]Yes  [ ]No

2. Have you ever discussed your trading sex for money with a health care professional?
   [ ]Yes  [ ]No

3. Has a health care provider ever refused to treat you?
   [ ]Yes  [ ]No

4. Have you ever not gone to the doctor because you worried they would not treat you well?
   [ ]Yes  [ ]No

5. Do your relatives know that you engage in sex work?
   [ ]Yes  [ ]No

6. Do your friends know that you engage in sex work?
   [ ]Yes  [ ]No

7. Have you ever injected drugs?_______________________________
   If yes, for how long?_____________________________________
   Do you currently use drugs?_______________________________

8. In your lifetime have you ever talked with anyone about HIV/AIDS?
   [ ]Yes  [ ]No
   If yes, then with whom have you talked to about HIV:
   _____with a doctor
   _____with a social worker
   _____with my husband
   _____with a parent
   _____with a client
   _____with a friend
   _____with other sex workers
   _____with a sexual partner other than client

9. Have you ever received printed materials with information on HIV testing services in St. Petersburg?
   [ ]Yes  [ ]No
10. Among your friends, do you know anyone who has HIV?
[ ] Yes    [ ] No

11. Have you ever heard of the City AIDS Center?
[ ] Yes    [ ] No

12. Have other people that you sometimes inject drugs with said that they have been tested for HIV at the City AIDS Center?
[ ] Yes    [ ] No    [ ] I don’t inject drugs with other people    [ ] I don’t inject drugs

13. Have other women that you sometimes work with said that they have been tested for HIV at the City AIDS Center?
[ ] Yes    [ ] No    [ ] I don’t work with other women

14. Have you ever been tested for HIV?
[ ] Yes---When were you most recently tested for HIV?________________(month, year)
[ ] No
[ ] don’t know

Instructions to the interviewer: If the participant responds that she has been tested for HIV give the following questions.

15. Where did you receive your most previous HIV test?

16. Have you ever been tested at the following places?
   ___when I participated in a project in the outreach van
   ___at an STD clinic
   ___during pregnancy
   ___City AIDS Center
   ___in jail
   ___in a hospital
   ___in a polyclinic
   ___in another place:_________________________________________________

17. Have you ever been told by a doctor or nurse that you have HIV?
[ ] Yes    [ ] No

Instructions to interviewer: If the participant answers that she has been told she has HIV, please ask the following questions.

18. Where did you first learn that you have HIV or AIDS?

19. Are you registered with the City AIDS Center?
[ ] Yes  [ ] No

20. Have you received any services at the AIDS Center in the past year?
[ ] Yes  [ ] No

Instructions to the interviewer: In asking the following questions, use cards with the response categories for the participant to see. Please read the following directions and then each statement. Circle the corresponding response for each statement.

Instructions to the interviewer: If the participant says that she has HIV/AIDS then ask the following 3 questions, otherwise, skip to question #24.

Instructions to participant: Now, I am going to read you statements and I would like for you to tell me the extent to which you agree with them. Please tell me if you Agree, Mildly Agree, Mildly Disagree or Disagree.

21. I am afraid to tell people that I have HIV.
Agree  Mildly Agree  Don’t Know  Mildly Disagree  Disagree

22. After I learned that I have HIV, I began to withdraw and feel isolated from others.
Agree  Mildly Agree  Don’t Know  Mildly Disagree  Disagree

23. I can openly tell my doctor that I have HIV.
Agree  Mildly Agree  Don’t Know  Mildly Disagree  Disagree

Instructions to participant: We ask the following questions to all participants, regardless of one’s HIV status. I am going to read you statements and I would like for you to tell me the extent to which you agree with them. Please tell me if you Agree, Mildly Agree, Mildly Disagree or Disagree.

24. I have close friends, with whom I can share my problems.
Agree  Mildly Agree  Don’t Know  Mildly Disagree  Disagree

25. Women who engage in sex work could be neglected by their families.
Agree  Mildly Agree  Don’t Know  Mildly Disagree  Disagree

26. Women who engage in sex work in this community face physical abuse
Agree  Mildly Agree  Don’t Know  Mildly Disagree  Disagree

27. Women who engage in sex work in this community face rejection from their peers.
Agree  Mildly Agree  Don’t Know  Mildly Disagree  Disagree

28. Women who engage in sex work in this community face verbal abuse or teasing.
29. Doctors can refuse to treat women who engage in sex work.

30. Doctors can refuse to treat people who inject drugs.

31. It would be bad for my health if I had HIV.

32. I don’t think that I can get HIV.

33. I am very healthy so my body can fight off an HIV infection.

34. I am too young to get an HIV infection.

35. I am not worried that I might get an HIV infection.

36. People in my country are safe from getting an HIV infection.

37. If it is my fate to get HIV, I will get it.

Instructions to participant: Now, I am going to list reasons for why some people might not want to be tested for HIV. Please think about yourself and whether or not these are true for you.

I would NOT get tested for HIV because:

38. Don’t think I’m at risk

Yes  No

39. Can’t leave work to get tested

Yes  No

40. Afraid of needle

Yes  No
41. Results take too long
Yes  No
42. Nervous to get results
Yes  No
43. Didn’t ever think of getting tested
Yes  No
44. Don’t know where to get tested
Yes  No
45. Not important to me
Yes  No
46. Worried about sexual partner’s reaction
Yes  No
47. Doubt confidentiality of test results
Yes  No
48. Worried people would think I was sick
Yes  No
49. The test is too expensive
Yes  No
50. Testing site too far from home
Yes  No

Instructions to participant: Now I am going to list some reasons why people may want to be tested for HIV. Please tell whether or not they are true for you.

51. I would want to know my status
Yes  No
52. I would not want to worry anymore
Yes  No
53. Knowing my status is important for my job
Yes  No
54. If I found out I was HIV positive I could receive treatment
Yes  No
55. If I found out I was HIV positive I could protect others
Yes  No
Instructions to participants: I am going to read you statements and I would like for you to tell me the extent to which you agree with them. Please tell me if you Agree, Mildly Agree, Mildly Disagree or Disagree.

56. I could easily arrange to have an HIV test if I wanted to.
   Agree    Mildly Agree    Don’t Know    Mildly Disagree    Disagree

57. If I wanted to have an HIV test, I would find it difficult to turn up for the appointment.
   Agree    Mildly Agree    Don’t Know    Mildly Disagree    Disagree

58. If I learned that I was HIV-positive, I would be afraid to tell other people.
   Agree    Mildly Agree    Don’t Know    Mildly Disagree    Disagree

59. My partner would be upset if he knew that I went to be tested for HIV
   Agree    Mildly Agree    Don’t Know    Mildly Disagree    Disagree

60. I worry that the doctors will tell other people that I was tested for HIV
   Agree    Mildly Agree    Don’t Know    Mildly Disagree    Disagree

Instructions to participant: Now I will read a few statements about how society may relate to people with HIV/AIDS. Please tell me the extent to which you agree with the following statements for your society.

61. People living with HIV/AIDS should be ashamed.
   Agree    Mildly Agree    Don’t Know    Mildly Disagree    Disagree

62. People who have HIV/AIDS deserve compassion.
   Agree    Mildly Agree    Don’t Know    Mildly Disagree    Disagree

63. People with AIDS should be treated similarly by health care professionals as people with other illnesses.
   Agree    Mildly Agree    Don’t Know    Mildly Disagree    Disagree

64. People living with HIV/AIDS in this community face neglect from their family.
   Agree    Mildly Agree    Don’t Know    Mildly Disagree    Disagree

65. People living with HIV/AIDS deserve to be punished.
   Agree    Mildly Agree    Don’t Know    Mildly Disagree    Disagree

66. People living with HIV/AIDS in this community face physical abuse.
   Agree    Mildly Agree    Don’t Know    Mildly Disagree    Disagree

67. People want to be friends with someone who has HIV/AIDS.
   Agree    Mildly Agree    Don’t Know    Mildly Disagree    Disagree

68. People living with HIV/AIDS in this community face ejection from their homes by their families.
   Agree    Mildly Agree    Don’t Know    Mildly Disagree    Disagree

69. Families of people living with HIV/AIDS should be ashamed.
Agree   Mildly Agree   Don’t Know   Mildly Disagree   Disagree

70. People with AIDS should be isolated from other people.
Agree   Mildly Agree   Don’t Know   Mildly Disagree   Disagree

71. People who have HIV/AIDS should be treated the same as everyone else.
Agree   Mildly Agree   Don’t Know   Mildly Disagree   Disagree

72. People living with HIV/AIDS in this community face rejection from their peers.
Agree   Mildly Agree   Don’t Know   Mildly Disagree   Disagree

73. People who have HIV/AIDS in this community face verbal abuse or teasing.
Agree   Mildly Agree   Don’t Know   Mildly Disagree   Disagree

Instructions to participant: Finally, I would like to ask you a few questions about yourself.

74. How old are you?__________________________________________

75. What is your marital status:___________________________________

76. Where were you born?_______________________________________

77. Do you have any children?

[ ] yes
[ ] no

78. Where do you currently live?

[ ] I own an apartment/home
[ ] I rent an apartment
[ ] I rent a room
[ ] I live with relatives
[ ] I live at friends’ place
[ ] I am without housing right now
79. Who do you currently live with? (check all that apply)

[ ] I live alone
[ ] with my husband
[ ] with a partner
[ ] with a male friend
[ ] with a female friend
[ ] with parent(s)
[ ] with children
[ ] with someone else: ____________________

80. How long have you been living in St. Petersburg? ____________________

81. How long have you been working in the field of sex work? ________________

Thank you for your time.
Вопросник

Инструкция интервьюеру: пожалуйста, внимательно заполните всю следующую информацию об участнике.

Инструкция участнику: Спасибо большое, что Вы согласились принять участие в этом исследовании. Меня интересует Ваше мнение и Ваш опыт. Пожалуйста, если Вам будет неудобно отвечать на какой-либо вопрос, скажите мне и мы можем перейти к следующему вопросу.

Инструкция участнику: Сначала, я бы хотела узнать больше о Вашем опыте по уходу медицинских услуг.

1. Можете ли Вы откровенно обсуждать свои проблемы с медицинскими работниками?
   - [ ] Да
   - [ ] Нет

2. Говорили ли Вы когда-либо врачу о том, что вы работаете в сфере оказания сексуальных услуг?
   - [ ] Да
   - [ ] Нет

3. Было ли Вам когда-либо отказано в получении медицинских услуг?
   - [ ] Да
   - [ ] Нет

4. Была ли у вас ситуация когда Вы нуждались в медицинской помощи, но не обратились за ней потому, что боялись как медицинские работники будут к вам относиться?
   - [ ] Да
   - [ ] Нет

5. Знайте ли ваши родственники о вашей работе в сфере оказания сексуальных услуг?
   - [ ] Да
   - [ ] Нет

6. Знайте ли ваши друзья о вашей работе в сфере оказания сексуальных услуг?
   - [ ] Да
   - [ ] Нет

7. Вы когда-либо в своей жизни употребляли наркотики внутривенно?

   Если да, то как долго Вы их употребляете?

   Употребляете ли Вы их в настоящее время?

8. Разговаривали ли Вы когда-нибудь с кем-нибудь о болезни ВИЧ/СПИД?
   - [ ] Да
   - [ ] Нет

   Если да, то с кем Вы разговаривали на этой теме?
   - с врачом
   - с социальным работником
   - с мужем
   - с родителем
   - [ ] Да
   - [ ] Нет

Документ одобрен ЭТИЧЕСКИМ КОМИТЕТОМ САНКТ-ПЕТЕРБУРГСКОГО ГОСУДАРСТВЕННОГО УНИВЕРСИТЕТА
С 25 ИЮНЯ 2009 ПО 29 ИЮНЯ 2010
9. Получали ли Вы когда-нибудь печатные материалы с информацией о тестировании на ВИЧ в Петербурге?
[ ] Да [ ] Нет

10. Есть ли среди ваших знакомых люди, больные ВИЧ-инфекцией?
[ ] Да [ ] Нет

11. Слышали ли Вы о Городском Центре по профилактике и борьбе со СПИД и инфекционными заболеваниями?
[ ] Да [ ] Нет

12. Говорили ли Вам когда-нибудь люди, с которыми Вы иногда употребляли наркотики, что они обследовались в СПИД-Центре?
[ ] Да [ ] Нет [ ] я не употребляю наркотики с другими людьми [ ] я не употребляю наркотики

13. Говорили ли Вам когда-нибудь другие секс-работницы, что они обследовались в СПИД-Центре?
[ ] Да [ ] Нет [ ] я никогда не сталкивалась с другими секс-работницами

14. Вы когда-нибудь сдавали анализ на ВИЧ-инфекцию?
[ ] Да → Когда в последний раз? ______________ (приблизительно месяц, год)
[ ] Нет

Инструкция интервьюеру: Если участник проходил обследование на ВИЧ, задайте следующие вопросы:

15. Где Вы в последний раз сдавали анализ на ВИЧ-инфекцию?

16. Проходили ли Вы когда-нибудь обследование на ВИЧ-инфекцию в следующих местах:
в микрорайоне [ ] Да [ ] Нет
в областной больнице [ ] Да [ ] Нет
во время беременности [ ] Да [ ] Нет
в Городском центре по борьбе с СПИДом [ ] Да [ ] Нет
в тюрьме [ ] Да [ ] Нет
в больнице [ ] Да [ ] Нет
в поликлинике [ ] Да [ ] Нет
когда участвовала в исследовании [ ] Да [ ] Нет
в другом месте:

17. Ставили ли Вам когда-нибудь диагноз ВИЧ/СПИД?
[ ] Да [ ] Нет
Инструкция интервьюеру: Если участница сказала, что у нее есть ВИЧ/СПИД, задайте следующие вопросы:

18. Где Вы впервые узнали, что у Вас ВИЧ или СПИД?
   — в микроавтобусе
   — в клинике-КВД
   — во время беременности
   — в Городском центре по борьбе с СПИДом
   — в тюрьме
   — в больнице
   — в поликлинике
   — когда участвовала в исследовании
   — в другом месте: ____________________________

19. Стоит ли Вы на учете в Центре по профилактике и борьбе со СПИД и инфекционными заболеваниями?
   [ ] Да   [ ] Нет

20. В последний год, получали ли Вы какие-либо услуги в СПИД-Центре?
   [ ] Да   [ ] Нет

Инструкция интервьюеру: Задавая следующие вопросы, используйте карточку для ответов.
Пожалуйста, прочитайте участнику инструкцию в виде карточки, затем читайте
пожалуйста высказывания, обводя соответствующий вариант его ответа на каждый вопрос.

Инструкция интервьюеру: Если участница сказала, что у нее есть ВИЧ/СПИД, задайте следующие 3 вопроса, если нет переходите к вопросу № 24:


21. Я боюсь рассказывать людям, что у меня ВИЧ-инфекция.
   Полнометно согласна Согласна Не знаю Не согласна Полнометно не согласна

22. После того как я узнала, что у меня есть ВИЧ-инфекция, я начала себя чувствовать одинокой среди людей.
   Полнометно согласна Согласна Не знаю Не согласна Полнометно не согласна

23. Я могу откровенно сказать своим врачам, что у меня ВИЧ-инфекция.
   Полнометно согласна Согласна Не знаю Не согласна Полнометно не согласна
Инструкция участникам. Читайте следующие вопросы всем участникам, несмотря на то, какой у них ВИЧ-статус. Я прочту Вам несколько утверждений и прошу сказать мне, насколько Вы согласны или не согласны с каждым из них. Здесь нет правильных или неправильных ответов. Я хочу узнать Ваше мнение. Когда я прочту утверждение, скажите мне, «полностью согласна», «согласна», «не знаю», «не согласна» или «полностью не согласна». Для простоты используйте карточку для ответов.

24. У меня есть близкие друзья, с которыми я могу делиться своими проблемами.
Полностью согласна Согласна Не знаю Не согласна Полностью не согласна

25. Женщины, вовлеченные в сферу оказания сексуальных услуг могут быть отвергнуты своей семьей.
Полностью согласна Согласна Не знаю Не согласна Полностью не согласна

26. Женщины, вовлеченные в сферу оказания сексуальных услуг, сталкиваются с физическим насилием.
Полностью согласна Согласна Не знаю Не согласна Полностью не согласна

27. Женщины, вовлеченные в сферу оказания сексуальных услуг, отвергаются другими людьми.
Полностью согласна Согласна Не знаю Не согласна Полностью не согласна

28. Женщины, вовлеченные в сферу оказания сексуальных услуг, сталкиваются с оскорблениями.
Полностью согласна Согласна Не знаю Не согласна Полностью не согласна

29. Врачи отказываются лечить женщин, вовлеченных в сферу оказания сексуальных услуг.
Полностью согласна Согласна Не знаю Не согласна Полностью не согласна

30. Врачи отказываются лечить людей, которые употребляют наркотики внутривенно.
Полностью согласна Согласна Не знаю Не согласна Полностью не согласна

31. Если бы я заболела ВИЧ-инфекцией, это было бы опасно для моего здоровья.
Полностью согласна Согласна Не знаю Не согласна Полностью не согласна

32. Я считаю, что я могу заразиться ВИЧ.
Полностью согласна Согласна Не знаю Не согласна Полностью не согласна
33. Я очень здорова, так что мой организм может справиться с ВИЧ-инфекцией.

Полностью согласна | Согласна | Не знаю | Не согласна | Полностью не согласна

34. Я слишком молод, чтобы заразиться ВИЧ.

Полностью согласна | Согласна | Не знаю | Не согласна | Полностью не согласна

35. Заражение ВИЧ меня не беспокоит.

Полностью согласна | Согласна | Не знаю | Не согласна | Полностью не согласна

36. Люди в нашей стране защищены от заражения ВИЧ-инфекцией.

Полностью согласна | Согласна | Не знаю | Не согласна | Полностью не согласна

37. Если мне суждено заболеть ВИЧ, то я заболею.

Полностью согласна | Согласна | Не знаю | Не согласна | Полностью не согласна

Инструкция участникам: Я прочитаю Вам список причин, по которым люди иногда не хотят проходить обследование на ВИЧ. Пожмите ваше утверждение, написанное на Ваче, ниже. Когда я прочитаю утверждение, скажите мне «да» или «нет».

Я бы не хотела тестироваться на ВИЧ потому, что:

38. Мне не кажется, что мне угрожает этот риск

Да | Нет

39. Я не могу оставить работу, чтобы сдать анализ на ВИЧ

Да | Нет

40. Я боюсь шприцев

Да | Нет

41. Слишком долго надо ждать результатов

Да | Нет

42. Я боюсь узнать результаты.

Да | Нет

43. Никогда не думала о том, что можно сдавать анализ на ВИЧ

Да | Нет
44. Не знаю где можно пройти обследование на ВИЧ  
Да  Нет

45. Для меня это сейчас не важно  
Да  Нет

46. Меня волнует реакция моего сексуального партнера  
Да  Нет

47. Я сомневаюсь в конфиденциальности результатов тестирования  
Да  Нет

48. Я боюсь того, что люди подумают, что я больна  
Да  Нет

49. Обследование на ВИЧ слишком дорого стоит  
Да  Нет

50. Место, где проводится обследование на ВИЧ, находится слишком далеко от моего дома  
Да  Нет

Инструкция участнику: Теперь я прочту Вам список причин, по которым люди иногда хотят пройти обследование на ВИЧ. Прошу Вас подумать о том, насколько они верны для Вас лично. Когда я прочту утверждение, скажите мне «да» или «нет».

Я бы хотела пройти тестирование на ВИЧ потому, что:

51. Я бы хотела знать свой ВИЧ-статус  
Да  Нет

52. Я бы хотела перестать переживать по этому поводу  
Да  Нет

53. Мне важно знать свой ВИЧ-статус для работы  
Да  Нет

54. Если бы узнала, что у меня ВИЧ, я могла бы получить лечение  
Да  Нет

55. Если бы узнала, что у меня ВИЧ, я могла бы предупредить других от заражения  
Да  Нет

56. Если бы я хотела сдать анализы на ВИЧ, мне было бы легко это организовать.
Полностью согласен Согласен Не знаю Не согласен Полностью не согласен

57. Даже если бы я хотела сдать анализы на ВИЧ, мне было бы трудно пойти на тестирование.
Полностью согласен Согласен Не знаю Не согласен Полностью не согласен

58. Если бы я узнала, что у меня ВИЧ, я бы побоялась сказать другим людям.
Полностью согласен Согласен Не знаю Не согласен Полностью не согласен

59. Мой муж/парнер расстроился бы, если бы узнал, что я сдавала анализ на ВИЧ.
Полностью согласен Согласен Не знаю Не согласен Полностью не согласен

60. Меня беспокоит вероятность того, что врачи могут сообщить другим людям о моем ВИЧ-статусе.
Полностью согласен Согласен Не знаю Не согласен Полностью не согласен

Инструкция участнику: Теперь я прочту Вам несколько утверждений о том, как общество может относиться к людям имеющим ВИЧ/СПИД. Прочитайте, пожалуйста, все утверждения.

61. Люди, имеющие ВИЧ/СПИД, должны стыдиться этого.
Полностью согласен Согласен Не знаю Не согласен Полностью не согласен

62. Люди, имеющие ВИЧ/СПИД, заслуживают сочувствия.
Полностью согласен Согласен Не знаю Не согласен Полностью не согласен

63. Медицинским работникам следует относиться к пациентам с ВИЧ/СПИД так же, как они относятся к пациентам с другими заболеваниями.
Полностью согласен Согласен Не знаю Не согласен Полностью не согласен

64. Люди, имеющие ВИЧ/СПИД, могут быть отвергнуты своей семьей.
Полностью согласен Согласен Не знаю Не согласен Полностью не согласен
65. Люди, имеющие ВИЧ / СПИД, заслуживают наказания.

Полностью согласна  | Согласна  | Не знаю  | Не согласна  | Полностью не согласна

66. Бывает, что люди, имеющие ВИЧ / СПИД, сталкиваются с физическим насилием.

Полностью согласна  | Согласна  | Не знаю  | Не согласна  | Полностью не согласна

67. Люди дружелюбно относятся к людям, имеющим ВИЧ/СПИД.

Полностью согласна  | Согласна  | Не знаю  | Не согласна  | Полностью не согласна

68. Бывает, что людей, имеющих ВИЧ / СПИД, выгоняют из дома.

Полностью согласна  | Согласна  | Не знаю  | Не согласна  | Полностью не согласна

69. Родственники людей, имеющих ВИЧ / СПИД, должны испытывать стыд.

Полностью согласна  | Согласна  | Не знаю  | Не согласна  | Полностью не согласна

70. Люди с ВИЧ / СПИДом должны быть изолированы от других людей.

Полностью согласна  | Согласна  | Не знаю  | Не согласна  | Полностью не согласна

71. Следует относиться к людям с ВИЧ/СПИД так же, как относиться ко всем остальным людям.

Полностью согласна  | Согласна  | Не знаю  | Не согласна  | Полностью не согласна

72. Люди, имеющие ВИЧ / СПИД, отвергаются своими друзьями.

Полностью согласна  | Согласна  | Не знаю  | Не согласна  | Полностью не согласна

73. Люди, имеющие ВИЧ / СПИД, сталкиваются с оскорблением.

Полностью согласна  | Согласна  | Не знаю  | Не согласна  | Полностью не согласна

Демографическая информация:

И напоследок, прошу Вас ответить на несколько вопросов о себе.

74. Ваш возраст: __________

75. Семейное положение: __________________________

76. Место рождения: __________________________
77. У вас есть дети?
[ ] Да
[ ] Нет

78. Где Вы сейчас живете?
[ ] живу в своей квартире
[ ] сниму квартиру
[ ] сниму комнату
[ ] живу у родственников
[ ] живу у друзей
[ ] нет жилья на данный момент

79. С кем Вы сейчас живете? (отметьте все подходящие варианты)
[ ] я живу одна
[ ] с мужем
[ ] с партнером
[ ] с другом
[ ] с подругой / подругами
[ ] с родителями
[ ] с детьми
[ ] с кем-то еще: ________________________

80. Сколько лет Вы живете в Санкт-Петербурге? ________________________

81. Сколько лет Вы работаете в сфере оказания сексуальных услуг? __________

Спасибо большое за Ваше участие!

ДОКУМЕНТ ОДОБРЕН
ЭТИЧЕСКИМ КОМИТЕТОМ
САНКТ-ПЕТЕРБУРГСКОГО
ГОСУДАРСТВЕННОГО УНИВЕРСИТЕТА
С 29 04 2009 П О 29 04 2010

165
Bibliography


Aral S and St. Lawrence J. The ecology of sex work and drug use in Saratov Oblast, Russia Sexually Transmitted Diseases Vol29 (12); pp798-805: 2002.


Latysheva M. “*Russkii patsient,*” *Segodnia* No.45: March 1, 1999.


Onishchenko GG. *Epidemiologicheskaia situatsiia, osnovnye prioritety i zadachi po protivodeistviu epidemii VICH/SPIDa v Rossiiskoi Federatsii.* Zdravookhranenie RF. No 2; pp 11-18, 2005.


Rakhmanova A. Sovmestnye initsiativy i effektivnoe partnerstvo AIDS Journal: SPID, Seks, Zdorov’e #64, 2007. [http://www.aidsjournal.ru/journal/64_1.html](http://www.aidsjournal.ru/journal/64_1.html)


Skvortsov NG. *Obshchestvennoe zдоров’e, stigmatizatsiia i sotsial’nyi kontrol’.* Russkii zhurnal “SPID, rak, i obshchestvennoe zдоров’e”. vol. 9 no.3 pp. 76-77. 2005.


