SUMMARY REPORT

ProSanté study 2010-2011

Study on health status, access to healthcare and to rights of prostitutes met in social and medical facilities

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French studies on the health of people working in prostitution are rare and mostly date back to the mid-1980s and the emergence of Aids. Research focused mainly on the serology of this population regarding HIV and other sexually transmitted diseases (STDs), rarely collecting data for a more general health overview. It is worth noting here that, since the start of the new millennium, the average profile of prostitutes has changed, particularly in terms of the persons concerned (women from Eastern Europe and China…) and the locations (moving away from big cities to ess visible locations). The impact of the 2003 internal security law on the increase of insecurity and violence endured by prostitutes may mean worsening general health for this population. The ProSanté study was therefore put in place, with a global health approach combining social and medical elements. Its aim is to better understand health determinants and their impact on health, in order to then improve prevention and access to healthcare of prostitutes.

The ProSanté study: social and medical components

The ProSanté study was carried out by the Fédération nationale des associations d'accueil et de réinsertion sociale (National Federation of Social Reintegration Associations - FNARS), a key player in combating exclusion, and the Institut de veille sanitaire (French Institute for Public Health Surveillance - InVS). This study was conducted upon request of the Ministry of Health to update knowledge on the health of prostitutes. In meeting these people in social facilities, the aims were to collect information on health status and on access to medical care and to rights of prostitutes, to collate data from health observations made during medical visits, and compare it to self-reported health, and finally to compare all data collected with those of the general population. Given the facilities approached, this study is not representative of the entire population of prostitutes in France. In particular, people who carry out "indoor" prostitution (over the Internet or telephone, or in bars, flats, massage parlours) are hardly represented.

The Social-Health part of the study was carried out in associations and coordinated by the FNARS. The medical part was carried out in Ciddist/CPEF (information, screening and diagnosis centres for sexually transmitted diseases/family planning or education centres) and coordinated by the InVS (see box 1). Data collection took place from June 2010 to March 2011.

Box 1 – ProSanté: a two-part study involving social and medical facilities

Social-Health component
The two types of anonymous questionnaire (one short and one long) designed by the FNARS in partnership with social facilities, contained questions on the respondent's social and demographic characteristics (age, gender, country of birth, education, family situation, accommodation, income, social relations) and on the following topics: prostitution activities, perception of health, state of health (consumption of psychoactive drugs, mental health, violence, sexuality and contraception, screening), access to healthcare and to rights (healthcare cover, medical monitoring).

Ten of the 12 participating associations* manage facilities or services that are specialised in the welcome and support of prostitutes. The two other associations are general oriented**, but also conduct activities with prostitutes.

Medical component
The anonymous medical questionnaire, designed by the InVS in partnership with Ciddist/CPEF doctors, aimed to collect the following information: social and demographic data (age, gender and country of birth), medical history (STDs, gynaecological/obstetrics, vaccinations, screenings), contraception and use of condoms, consumption of drugs, current state of health, test results (completed during a second stage) and concluding observations from the medical consultation (diagnosis and treatments, any vaccinations carried out, any medical referral deemed necessary).

The 15 participating medical structures (12 Ciddist*, 2 CPEF** and one doctor's surgery***) are geographically nearby the social facilities, with some having put in place partnerships prior to our study.

*ALC/Les Lucioles (Nice), Amicale du nid Paris (Paris), ARS/Antigone (Nancy), Amicale du nid Montpellier/La Babotte (Montpellier), L'Appart (Grenoble), Amicale du nid Rhône (Lyon), L'Embellie (Avignon), Amicale du nid Marseille (Marseille), Diaconat Protestant/Arcades (Valence), ADEFO/Le Pas (Dijon).
** ARIA's APUS centre (Lyon) and AIEM/Emergency department (Metz).

* Saint-Roch hospital (Nice), Saint-Louis hospital (Paris), Grenoble Cidag-Ciddist, Espace Perréal (Béziers), Bon Secours hospital (Metz), Dijon, 2 Cidag-Ciddist CG13 (Marseille), Saint-Eloi hospital (Montpellier), Pontiffroy (Metz), l'Hôtel-Dieu (Lyon), Henri Duffaut hospital (Avignon).
** Villemin hospital (Nancy) and Lyon.
*** APUS (Lyon).

Lower participation than expected for the Health-social component and participation bias for the medical component

Only 12 associations, instead of the 20 initially planned, took part in the study's Health-social component, and a total of 251 prostitutes, of which 166 women, 62 transgenders and 23 men. The study's population is only a partial reflection of the populations usually welcomed by the associations (for instance, no Romanian women, more transgenders…).

In total, 78 people took part in the medical part, of which a majority were women. A significant participation bias was observed between those people who had attended the medical consultation and those who had not. If certain variables (date of arrival in France, level of education and declared state of health) showed no difference between the two groups, those who were more willing to go to the medical consultation were young women born abroad whose administrative situation was unstable or illegal, who had no health benefits or only benefited from the French State's minimal cover (AME), who did not know where to go for anonymous and free HIV and STD screening, who had begun their prostitution activity less than twelve months previously, and reported to be afraid of HIV/Aids. Conversely, those people who declared that they suffered from a chronic health problem and that they took drugs rarely attended the consultation.

The study population: a wide variety of profiles

For most of the prostitutes who took part in the study (88%), the street is the main place in which they contact clients.

Women represent two-thirds of the people questioned. Over three-quarters (78%) of these people questioned have a foreign nationality and 14% neither speak nor understand French. These include the usual profiles observed by the field workers, i.e. French, African, Eastern European or Chinese women, South-American transgenders, and mostly French men.

Most of respondents (81%) are younger than 45 years of age, the age group that is the most represented being 25 to 34 years for men and women, and 35 to 44 years for transgenders. Chinese women, and French women even more so, set themselves apart by their more advanced age (41% of French prostitutes are 45+).

Another significant difference between the respondents is the time spent in prostitution: over five years for half of French and Bulgarian women and of transgenders. The median age for beginning prostitution is also very variable depending on nationality: under 25 years of age for sub-Saharan African and French women, and 38 years of age for the Chinese women.

Although a vast majority of respondents do not have a paid job in addition to their prostitution activities, most do not consider prostitution as an occupation (62%); In this respect, French women and transgenders set themselves apart, as more than half of them state that prostitution is an occupation.

Self-reported and observed health status

The Health-social component of the study questioned people on their perception of their health status, on their being a carrier of a chronic disease, and on their mental disorders.

From physical health…

Over half of the respondents (and of women) report that they are in fair, poor or very poor health condition, a proportion that is significantly higher than that of the general population, at equivalent age. According to the Insee study conducted in 2009 [1], 14% of women in the 25-34 age group report fair, poor or very poor health.

Over one third (35%) of people questioned report that they suffer from a chronic disease (28% of women and 70% of transgenders), including HIV/Aids, respiratory diseases, diabetes, mental disorders, or hepatitis (A, B or C). This proportion declared by the women is higher than that of the general population (20% of women in the 25-34 age group state that they suffer from a chronic illness or health issue [1]).

…to mental health

Sleeping problems and the use of sleeping pills are reported by a majority of participants, with no link to gender. Sleeping issues are much more frequent and the consumption of sleeping pills much higher than in the general population [2]. Feelings of anxiety or depression over the previous twelve months are widespread and suicidal thoughts are also much higher than in the general population (29% against approx. 4% [3]).

In the context of the medical component, the medical consultation consisted in a clinical examination on the one hand, and in biological testing on the other.

Clinical examination…

All those people who attended the medical consultation were weighed and measured: excess weight was observed in 26% of women in the 18-29 age group, and in 31% of 30-54 age group, proportions that are higher than in the general population. The clinical examination (general, genital and if necessary, proctologic) was normal in the vast majority of the people examined. The overall health status observed by the doctor was very good or good for 84% of attendees, and a fair, poor or very poor for the remaining 16%.

The difference found between observed and self-reported health status, for the same individuals, can be explained in part by the difficulty of doctors, during the medical consultation, in assessing their patients' mental health.

…and biological test results

The results of HIV and more general STD screening tests carried out in the context of the medical component of the study are difficult to interpret given that a certain number of HIV-positive people did not attend medical consultations.

Although one quarter of the people questioned during the medical consultation declared having already had an STD during their lifetime, i.e. a much higher proportion than the general population (20% of women against 9% of women in the 18-54 age group according to the KABP 2010 study [4]), very few STDs were diagnosed during the consultation: one Chlamydia infection in a woman (i.e. 1.6% of the 63 women tested, which is the same proportion as in the general population), one case of early latent syphilis in one transgender and no gonococcal infections.

HIV screening revealed one HIV-positive transgender and five other persons who already knew their status. According to the declarations in the Health-social part of the study, 27 of the 62 transgenders (44%), 3 of the 23 men (13%) and 2 of the 166 women (1.2%) declared that they were HIV-positive. The reported prevalence is higher in drug users than in those who do not use any. It is worth reminding that prevalence of HIV in the general population is around 0.35%.

HBs antigen, the marker for chronic Hepatitis B, was positive for 3 attendees, i.e. 4.2% of the 72 people tested, which is similar to the prevalence in people born abroad (4%). This proportion is much higher than the 0.65% observed in the general population in 2004 [5].

Finally, HBV antibody testing shows that over one third of attendees are not protected against this virus, which is sexually transmissible.

Most attendees (84%) returned for a second consultation to know the results of the screenings and to benefit from treatment or vaccination (against HBV or Diphtheria-Tetanos-Polio) or from a medical referral. Such a referral (GP, gynaecologist, hepatologist, infectious diseases specialist, tuberculosis specialist centres…) was deemed necessary for 50% of attendees.

Health determinants

Health results from the interaction of a certain number of determinants, which were explored in the two parts of the study. These are biological factors, environmental factors, lifestyle and behavioural factors, and the health system factor.

The health system: services not well known

Half of the foreign nationals questioned have a temporary residence permit (28%) or none at all (22%). 74% benefit from health insurance, but more than half has no supplementary health cover. The lack of health insurance concerns in particular Nigerian and Bulgarian women. Among those people who have no health insurance, one quarter has been in France for over three years and is therefore theoretically able to benefit from the existing health insurance systems (see box 2). Two reasons may explain this situation: poor knowledge of healthcare benefits and the language barrier.

Financial reasons, the language barrier and the lack of knowledge of a healthcare centre are among the reasons that pushed certain people to give up on healthcare over the previous twelve months. Additionally, the social network is very important for access to healthcare by illegal migrants. The more isolated a person is, the less he or she will have access to healthcare.

Box 2 – Legal context for access to healthcare in France

CMU (Couverture maladie universelle – Universal Health Cover): enables people who are not covered by a compulsory health insurance to take advantage of the social security system for health expenditures. Conditions of access: to have been legally residing in France for over 3 months.

AME (Aide médicale d'État – State Medical Healthcare): enables illegal migrants to benefit from access to healthcare. Conditions of access: to have been residing in France for over 3 months and have income below a certain threshold (e.g. for a single person, the annual threshold at 1 July 2012 was €7,934).

CMU-C (Couverture maladie universelle complémentaire – Supplementary Universal Health Cover): free supplementary health cover. Conditions of access: to have been residing in France for over 3 months and have income below a certain threshold (same as the AME).

Health cover of EU nationals
EU citizens who come to live in France may either use the social security regime applicable in their country of origin, or the French system. Depending on their status (employee, retired, student), the rules applicable to them differ.

Behaviours and lifestyles

In terms of food, the study showed that many respondents reported they did not eat enough, the proportion being twice as high for sub-Saharan Africans than for all other nationalities.

Daily alcohol consumption is higher than that of the general population, at equivalent ages. This observation is true for both men and women, except Chinese women who do not drink alcohol.

Similarly, the respondents generally smoke more than the general population, at equivalent ages. Nearly half of women (46%) report that they are smokers, compared to 36% of women in the 26-34 age group and 34% of the 35-44 age group in the general population [6]. The same applies for men, with 65% of smokers among men questioned for ProSanté. Some nationalities clearly set themselves apart: nearly all central and eastern Europeans smoke, while the reverse is true of Sub-Saharan and Chinese women.

Discussions with the participating social structures show that such differences in smoking and drinking are partly due to cultural specificities.

Contraception and sexuality: higher number of abortions than in the general population

The proportion of women (61%) who have already had to undergo an abortion is very high and much greater than what is observed in the general population. In the ProSanté study, nearly half (45%) of the 18-24 age group and two-thirds (64%) of the 25-54 age group have already undergone an abortion, whereas these proportions are respectively of 12% and 24% in the general population [4].

The medical part of the study showed that the number of abortions was higher in those women who did not always use a condom when not conducting prostitution activities. This could be explained by the fact that these women do not use any other method of contraception either.

94% of the people interviewed report that they always use condoms with their clients, a behaviour that is more frequent in women than in men or transgenders. The medical part of the study clarifies that condoms are used systematically by a high proportion of women during vaginal or oral sex with clients (respectively 92% and 87%) and by 92% of men or transgenders during anal sex. Use of a condom during oral sex with clients is, however, much less systematic in men or transgenders.

Screening

Regarding screening for cervical cancer, the ProSanté study shows significant differences with the general population. One quarter of women aged 25+ (24%) – according to the Health-social part of the study – and one third (34%) according to the medical part – has never had a pap smear in their life, as compared with only 4% of women in the 25-65 age group in the general population according to the 2010 health Barometer [7]. It is worth noting that the current recommendation for women in the 25-65 age group is to have one pap smear every 3 years, once 2 annual smear tests show no abnormality.

Men and transgenders are better informed than women (96% and 97% vs. 65%) when it comes to knowing of a free and anonymous HIV- and/or STD-screening clinic (CDAG and/or Ciddist). With women doubtlessly having had more opportunities for being tested (pregnancies, gynaecological consultation…), screening for HIV, HBV and HCV is not gender-specific. It is much higher than in the general population, especially in HIV-testing, where 68% of those questioned in the ProSanté study have been screened in the last 12 months, against only 16% of men and women in the 18-54 age group in the general population [8]. Only Chinese women set themselves apart from the other nationalities on this point, with very few of them being screened for HIV and HCV.

For those people not having conducted HIV screening in the last 12 months, the main reasons given are that they do not

think they have exposed themselves to potential infection and the lack of knowledge of testing sites. Lack of income was not cited as a reason for not being screened.

Vaccinations: low vaccination coverage

Both parts of the study show that the respondents have a very sketchy knowledge of their vaccination status against Hepatitis B, and also show a low vaccination coverage, regardless of nationality. Both characteristics are observed in the general population to a lesser extent, with hepatitis infections remaining relatively unfamiliar [9].

Environment: violence experienced and social precariousness

In terms of violence, verbal and psychological abuse are the most reported: 64% of respondents have experienced them at least once in the past 12 months. Physical violence are a little less frequent, but can come from clients, passers-by, other prostitutes or police. One third of respondents have endured forced sexual relations over the course of their lifetime. These results are to be considered in relation to the findings of the 2010 Health Barometer [3], which describes violence as the risk factor most likely to lead to suicide attempts. According to the social structures and in comparison with what they hear from the prostitutes they take in, the amount of violence experienced by the prostitutes seems very broadly under-declared in the ProSanté study.

The persons interviewed in the study combine a number of factors of social precariousness, as evidenced by their social isolation (42% have no one to contact should they have problems) or housing conditions (39% live in precarious accommodation: hotel, collective housing, family / friends, street, squat).

Knowledge and need for information

The topics on which the respondents wish more information are HIV infection and Aids, access to healthcare, depression, and violence.

With regard to sexuality and contraception, significant lack of information is observed, more noticeable in foreign women. Around one quarter of the women questioned (only foreign women) wishes for better information on contraception. There is also a poor knowledge regarding emergency treatment in the event of a risk of exposure to HIV: 79% of men are informed of these treatments, against only 52% of women (and 61% of transgenders). Finally, half of women are ignorant of the fact that they can receive free information on contraception and abortion in CPEF [10].

Recommendations to professionals and public authorities

The recommendations that have been made here are relevant for both prevention and access to rights and healthcare. These recommendations are applicable to the healthcare professionals who are likely to meet prostitutes, whatever their field of specialisation (social, medical, paramedical, justice, police, etc.), as well as to the public authorities for the implementation of prevention programmes and to ensure access to common law mechanisms. These recommendations also encourage the implementation of local partnerships between associations, social and health actors, and institutions or local authorities in order to implement the most efficient network.

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To find out more

FNARS, InVS. Étude ProSanté 2010-2011. Étude sur l'état de santé, l'accès aux soins et l'accès aux droits des personnes en situation de prostitution rencontrées dans des structures sociales et médicales. Rapport. Saint-Maurice: Institut de veille sanitaire; 2013. 146 p. Disponible à partir de l'URL : http://www.invs.sante.fr

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