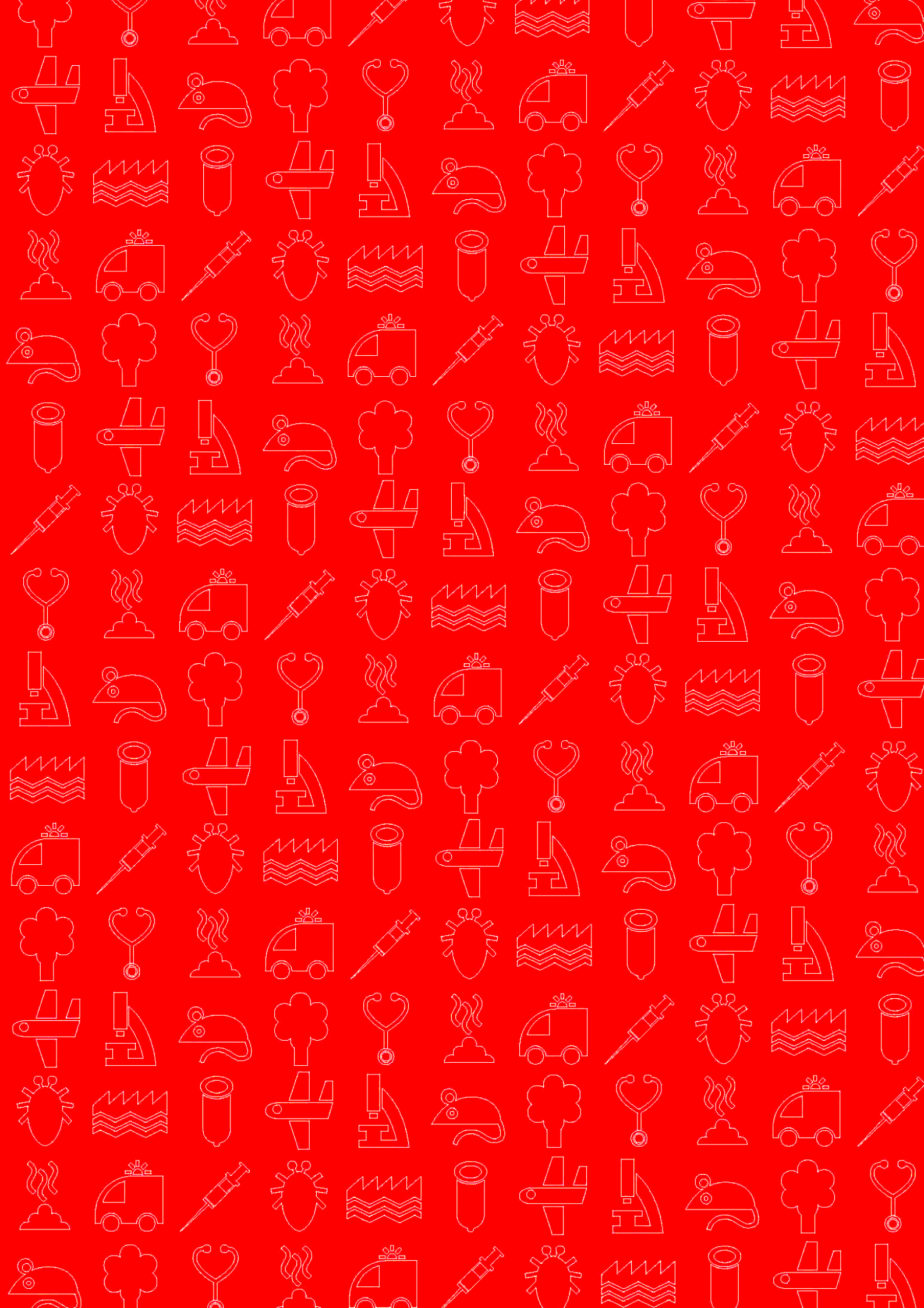
GGD Amsterdam



GGD Amsterdam

# Intermediary project for prostitutes

## ANNUAL REPORT

## 2005 - 2007

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## Contents

## Preface

If you believe that prostitutes are easily categorised in stereotypes, you need to think again. The image of victims of human traffickers and the image of independent prostitutes do reflect reality, but each prostitute is her own exception to the rule. Women, who are victims by the letter of the law, turn out to possess an enormous strength to survive difficult times, whilst the seemingly more independent fulfil subservient roles in the private sphere. However, the social isolation of prostitutes is stereotypical – isolation caused by secrecy towards family, friends, partners, and by leading a double life. In daily practice, prostitution operates as a subculture with its own rules and standards. It should be considered as a service provision based on a socially accepted demand, and a demand that is fairly significant to boot.

The prostitution sector can always count on media interest. During the past years, the media focus has been on victims of human trafficking, the practices of pimps and other exploiters, but particularly on the closure of a number of brothels and window brothels. At the same time, there has been a great deal of attention for the local authority's proposal to improve services for prostitutes and to provide good facilities for them.

In 2006, the Council agreed to the pre-advice on the policy document of council members Assante and Schaapman, with the name "Making the invisible visible; prostitution in Amsterdam in the year 2005". One of the recommendations in this policy document was to open a centre where prostitutes could go for social support and healthcare. At the local authority's initiative, the realisation of this Prostitution & Health Centre, P&G292, was started in 2006, in co-operation with HVO Querido and the Public Health Service Amsterdam (GGD Amsterdam). In April 2008, the Centre will be opened by the Councillor for Care.

At the end of December 2007, Amsterdam Council announced that one third of the windows in the Amsterdam Red-Light District would have to close, and a number of the operating licences of the prostitution businesses were withdrawn or refused. A large number of these prostitution businesses have meanwhile been closed, and the freed-up space has been taken up by up-and-coming talents from the fashion industry for example. With this measure, the local authority aims to halt the criminalisation of the window-prostitution areas. However, prostitutes are now forced to offer their services elsewhere, and for us it is important to maintain contact with these women.

## Introduction

In1988, the Council decided to appoint a confidential adviser who would work full-time as an outreach worker in the prostitution sector in order to inform and advise the foreign and Dutch prostitutes, and to familiarise them with the services inside and outside Amsterdam. Initially, this was a two-year project with just one person carrying out the outreach work. By now this "confidential adviser for prostitutes" project has a fixed place within the Public-Health-Service organisation, and the number of employees has been expanded to five persons. The work is carried out by public-health nurses (SVs) and Cultural Mediators in Prostitution (VIPs), who are jointly referred to as 'project employees' in this report. Making contact with prostitutes by means of outreach work in the Red-Light District and the sex clubs is one of their core tasks. They also conduct regular small-scale studies amongst prostitutes in relation to healthcare and their social circumstances.

Besides the so-called regular prostitution, i.e. the windows and the sex clubs, there is a range of diffuse types of prostitution. Since the legalisation of brothels in 2000, a large number of women started to work in escort services, in bars, or receive the client at home. The development of mobile telephones and the Internet has increased the grey area of the prostitution sector. Healthcare and social services have insufficient access to the prostitutes who attract their clients via mobiles or the Internet.
This report describes the activities of the 'confidential adviser for prostitutes in Amsterdam' project, and the collaboration with other organisations.
*A number of cases are described as illustrations, using fictitious names.*

## 1. Objective of the Project

During outreach work, the prostitutes are visited by the project employees at their place of work in the sex clubs or in the windows; the majority of the women have no objections to this.

One of the objectives is to offer help and information, but the principal objective is to improve their care for their own health. In view of the professional risks run by the women, the prevention of STIs[1]/HIV is paramount. There is also information and advice about contraception and about caring for their own health in general.

The project employees have a detection function in order to recognise the signals of exploitation of a prostitute by a third party, and to take action. The project serves as a co-ordination point for complaints by prostitutes, where the project employees offer support or refer to other service providers. They bridge the gap and form a link between the prostitutes and the local authority in order to report abuse and to improve the situation of the women.

The objectives are formulated as follows

- To obtain insight into the working and living conditions of prostitutes
- To help prostitutes to find their way in the service-provision circuit
- To improve prostitutes' access to services
- To inform prostitutes of their rights and obligations
- To support prostitutes when they report exploitation and abuse

[1] STI = Sexually Transmitted Infections.

## 2. Project Employees

The composition of the project's employees depends to a large extent on the situation in the prostitution sector. For decades the prostitution sector has been subject to changes, caused by the ever-changing groups of prostitutes from different countries and the changing political climate in relation to prostitution.

The public-health nurses (SV) work in the prostitution sector, together with cultural mediators (VIP) who speak the same language and have the same culture as the prostitutes. The cultural mediators are recruited in line with the origin of the prostitutes. In recent years there has been an increasing number of women from a range of central and eastern European countries. Together with a VIP it is possible to make contact with these prostitutes who could otherwise not be reached because of language barriers. The main objectives of outreach work together with a VIP are to improve the prostitutes' care for their own health and to help them find their way amongst the services.

The project employees need to have specialised skills and special demands are imposed on them. Communication skills, contact skills, and a neutral attitude to the women's choice to work as a prostitutes are important conditions for being able to operate in the prostitution sector. The prostitutes are approached from an emancipatory vision, which is characterised on the one hand by linking the women's complaints or problems to their socialisation and social position, and on the other by the fact that the resulting actions are focused on emancipatory changes. An example of such an approach is the "Healthy and Strong in Sex Work" pilot project, which is reported on in this document. (7.1)

*Mira is a Hungarian woman, and she is 19 years old. Together with her sister she works in a window. Thanks to our Hungarian VIP we can communicate with them, and we have regular contact with the sisters. Their health is not great, they say they don't eat healthily and they drink litres of coca-cola a day. They regularly come to us for help; we have needed to arrange hospitalisation for both of them. Yet Mira seems an independent woman. Initially, we thought she was forced to work, but Mira denies this in the strongest possible terms. She says she works voluntarily and that she puts the money she earns in a bank account in her home country. She comes from a large Roma family, who are looking after her children and her sister's children. Mira works 16 hours a day,"her sister much less", she says. Together they live in a 'hotel' over the IJ. We cannot detect any real signals of forced prostitution in Mira; she can move freely, she can always call us, and when her sister doesn't feel like working, she simply goes home. However, other young women, compatriots of Mira, often do not have credit on their phones, but are phoned regularly themselves and all give us the same mobile number that appears to belong to a kind of 'Madame'. Yet these women too say they work independently, because "they are registered as self-employed with the Chamber of Commerce".*

## 3. Contact with Prostitutes

Outreach is still the most effective method of coming into contact with prostitutes. In most cases, the project employees are permitted into the window brothels, brothels, and sex clubs. The prostitutes are open to information, and have many questions themselves. Written information is also offered during these face-to-face contacts, and this information is available in fourteen different languages. The information material offers information and advice on health and provides an overview of addresses of service providers[2]. Depending on the nature of the women's enquiry, they are helped or referred to service providers inside or outside Amsterdam. In the event of sexual exploitation or exploitation by third parties, we make contact with the Vice Squad or with the Amsterdam Co-ordination Point for Human Trafficking, the ACM, in co-operation with or with permission from the victim.

Different statements are made about the number of women in prostitution. For example, approximately 8,000 prostitutes would work in Amsterdam on an annual basis. On a monthly basis this would mean 700 prostitutes working in Amsterdam, of which 25% work in the windows, 25% in sex clubs, 1% on the street, and the other 49% in the closed forms, including escorts, bars, private houses, and in the women's home. If these data are reliable, the project employees have contact with approximately 15% of prostitutes on an annual basis.

The regulations for legal prostitution businesses and the stricter checks on compliance with these regulations have led to a fall in the number of prostitutes in regular prostitution. At the same time, we note an increase in the Romanian, Hungarian, and Bulgarian women in window brothels and in the escort services; a number of these women is thought to work under coercion from pimps within an international criminal network. Romania and Bulgaria became Member States of the European Union in 2007, and this explains the increase in the number of women from these countries.

*Sunny is a Dutch, originally Romanian, woman of 30 years of age.*
*She tells us, "I was 13 when I ran away from home, and I did not go to school. I had all sorts of mysterious jobs, and I was involved with men from a young age. Twelve years ago, I ended up working in The Hague via a network of traffickers. I did not feel like a victim; we never saw the big boss, we only knew his name. His sidekicks came to collect the money each day. We work in a street in The Hague that was only worked by Latin American women in those days. So we, the only young Romanian women on that street, earned money like water. We had a 50:50 deal with the big boss, but still had a lot of money left over for us. One day, the police came to the street and picked us all up and took us to the police station. There were another 20 Romanian women at the station. I did not want to report anything. At the station I heard that the big boss had been picked up, and that made me cry. We were put on a plane and flown back to Romania. After I'd been there for two weeks, bored stiff and not earning any money, I left Romania again with a girlfriend, and arrived in Amsterdam in a roundabout way, because we did not dare go back to The Hague. I got to know a man, and married him. I had a child, and have meanwhile divorced. My ex had me sign loan contracts in my name when I could not read Dutch properly, which means I'm now saddled with an enormous debt. I'm working to pay off my debt, but that takes time now, because the work doesn't pay as well as it used to. I earn much less, and pay a lot of taxes. I want to continue doing this work for a while, because I want to give my child the best, and I cannot live on a nine to five job"*

[2] Most materials have been designed by STI Aids Netherlands and are distributed nationally.

The prostitution sector is often associated with criminality, such as the drugs and arms trade, tax fraud, and human trafficking. However, not all prostitutes who need to work for a pimp feel like a victim. In eastern European countries it is completely obvious that a prostitute has a pimp, whilst we have, quite rightly, criminalised this type of exploitation in law. International treaties in respect of human trafficking have little effect for as long as the rights of prostitutes are not put on the international agenda. In economically unstable countries women are often forced to work in the western sex industry under false pretences. During outreach work, we have contact with victims of human trafficking. Although they are informed they can make a report to the Vice Squad, their fear of the perpetrators is tremendous and they simply accept their situation. A good development in this policy is the opportunity for a third party to report abuse to the Vice Squad without being dependent on the victim making a report.

## 4. Outreach Work at Prostitution Sites

*Laila is a Dutch woman of 22 years old and she is a second-generation Moroccan. Each day she works in the window; she is cheerfully stoned, and likes to have a chat. Her boyfriend's name is tattooed on her breast. Initially, Laila appeared to be very independent. After a few months she phoned with the message that she wants to leave her boyfriend, he beat her, and spent all her money on drugs. "He's hit the wall", she said. Laila lived together with her boyfriend outside the city, but when she left him, he came to visit her, and bothered her whilst she was working. Laila wanted to live in Amsterdam, but didn't know how to arrange her move. She stopped using drugs, and started to work in a club to pay off her debts. Now she has started to gamble. Her sister lives in Amsterdam, but doesn't want her there. Laila can sublet from a friend of her sister. During our contacts, she has taken initiatives, and has put herself on Amsterdam's housing list. She also has a new GP, and after a couple of conversations this GP referred Laila to social work for more counselling.*

Outreach work requires geographical knowledge of the prostitution sector. Window prostitution is concentrated in three different areas in Amsterdam – the Singel district, the Pijp, and in the Red-Light District in the centre. The prostitution sites in these neighbourhoods are visited alternately in the afternoons or in the evenings, and contacts are made with the prostitutes. Our project employees require knowledge of the social position of the prostitutes and up-to-date knowledge of current prostitution policy.

**Table 1** **Outreach work in window prostitution in 2005 - 2007**
**Contacts with prostitutes by nationality**

| Netherlands | Other EU | Central/Eastern Europe | Latin America | (North) Africa | Asia | Total |
|---|---|---|---|---|---|---|
| 289 | 246 | 529** | 487* | 199 | 59 | **1809** |
| 16% | 14 % | 29% | 27% | 11% | 3% | 100% |

* Of which 24 transgender
** Predominantly from Romania (142), Hungary (134), Bulgaria (150)

In 2005, 2006 and 2007, outreach work in the window-prostitution areas produced a total of 1809 contacts with prostitutes. Table 1 demonstrates that window prostitution in Amsterdam is characterised by a variety of nationalities. Most of the eastern European prostitutes originate from Hungary, Romania, and Bulgaria.

The conversations with the women last an average of 15 minutes, and they general concern questions the women have about their health, their position within the current prostitution policy, safe sex, and other work-related topics.
The possibility of other work is also brought up regularly. Usually, the women arrange this themselves and they find different work. It becomes more difficult for them if they have large debts, which induce them to decide to continue with prostitution work. Requests for support with exploring the labour market, debt rescheduling, and other social support issues are referred to the PMW of the Scarlet Cord.
During outreach work there are discussions about the profession, and the women talk about their domestic situations and the reasons why they chose prostitution work. For most women, money is the main motivator for working in prostitution. Some say they find the work exciting, but also taxing as they get older, and to limit themselves to simple SM session.

*For Marta the choice to work in Amsterdam's prostitution was a simple one.*
*In Ecuador she had worked in a bar that was frequented by many tourists, but she had earned little. On the recommendation from a girlfriend she came to Amsterdam, whilst her children were with her mother. Marta had set herself a target "to earn the costs for her school-age children within three years, enabling them to attend university, and then return to Ecuador". However, life in the Netherlands is not cheap, and saving money took longer than she had anticipated. She met her current partner, an older man with whom she moved in. She married him, and by now she has been away from home for eight years. Marta is now 40, her husband is retired, and her children study at Quito University. "I have grown apart from my children to some extent," says Marta, "I see them once a year when we go on holiday, and fortunately they adore my husband. My children see my husband as a benefactor, because they believe they can study thanks to him". She doesn't disabuse them of that idea, because she doesn't like to tell her children that she works in prostitution. Marta would like to continue working for another five years, because she believes her husband's pension is not enough. "Oh well", she laughs, "and then there will be grandchildren and who knows what I will do".*

Prostitutes generally start with the caveat that "they don't want to do this work for too long", because the work is demanding, but above all because it is not a socially accepted profession. They expect that their environment does not consider them worthy, and they apologise by saying that they have to do this work, but not for too long. At the same time they say they are proud of their work and that they feel strong, they believe they carry out a type of social work. They also feel a certain power, because they are their own boss and they decide what happens in an interaction with the client.

## 5. STI Examinations at Prostitution Sites

Every three months, an STI study is conducted in a sex club or at a window-prostitution site. A date is agreed with the Manager of the sex club or of the window brothel, and the prostitutes are offered the opportunity to be examined. Participating in the examination is completely voluntary. In each window-prostitution site, the operator made a room available, and the women came for the examination on appointment. One of the operators purchased a gynaecological chair for the STI examinations at his site. The on-site examinations are conducted in a non-clinical environment, which makes the interaction between the project employee and the prostitute informal yet professional.
It facilitates conversations, and there is room for personal attention and advice, which can lead to a bond of trust.

The STI examination is conducted in accordance with the guidelines and the protocols from the STI policlinic. The results are passed on to the prostitute by telephone or in person; the results are not given to third parties. If treatment is required, the woman visits the policlinic. However, in some cases she can be difficult to contact, even though treatment is necessary, and the outreach workers will try to trace her in the area. Occasionally, a woman cannot be traced, and will have left, without treatment, to a destination unknown to us.

Table 2 STI examinations at prostitution sites 2005 – 2007
Number of prostitutes by nationality and age group

| Age | Netherlands | Other EU | Central/ Eastern Europe | Latin America | (North) Africa | Asia | Total (%) |
|---|---|---|---|---|---|---|---|
| < 20 | 31 | 2 | 26 | - | - | - | 59 10% |
| 20-24 | 79 | 5 | 59 | 8 | 4 | 4 | 159 26% |
| 25-29 | 66 | 9 | 40 | 13 | 14 | 3 | 145 24% |
| 30-39 | 42 | 16 | 35 | 32 | 8 | 7 | 140 23% |
| 40-49 | 43 | 5 | 5 | 27 | 6 | 5 | 91 15% |
| >50 | 10 | 1 | 3 | 4 | - | 1 | 19 3 % |
| Total | 271 | 38 | 168 | 81 | 32 | 20 | **610 100%** |

Table 2 categorises the number of prostitutes examined on site by nationality and age group. In this group, the percentage of women with a non-Dutch nationality is 55%. More than a third, 36%, is younger than 25 years of age, of which most are from the Netherlands and eastern Europe. In 2005 – 2007, a total of 408 STI consultations were carried out in the sex clubs, and a total of 456 STI consultations amongst women in the windows.

Table 3 Result STI examinations at prostitution sites 2005 - 2007
864 consultations amongst 610 prostitutes

| Consultations | 2005 N= 192 | 2006 N= 290 | 2007 N= 382 | Total N= 864 100% |
|---|---|---|---|---|
| Lues | 0 | 2 | 1 | 3* 0.3 % |
| Gonorrhoea | 5 | 1 | 5 | 11 1.3 % |
| Chlamydia | 14 | 24 | 26 | 64 7.4 % |
| Trichomonas | 0 | 1 | 1 | 2 0.2 % |
| HIV | 1 | 0 | 0 | 1 0.1 % |

* Lues latens

Prostitutes are often seen as the transmitters of STIs, but this view is not correct. The results from the STI examinations demonstrate that the STI percentage amongst prostitutes is lower than that of the other visitors to the Public Health Service Amsterdam STI policlinic[3].

During the 2005-2007 period, a total of 864 STI consultations were carried out amongst 610 prostitutes (See table 3). During the same period, the STI policlinic of the Public Health Service Amsterdam carried out 1332 STI consultations amongst prostitutes (See table 4). The STI percentage amongst the prostitutes who were examined on site is lower than the percentage amongst prostitutes in the STI policlinic. This may be because the prostitutes in the clubs and in the windows have regular examinations, because the project workers visit on site and they do not have the complaints related to a possible STI. However, other prostitutes do not attend regularly, and the reason for their visit to the STI policlinic is that they have run a risk, due to condom failure, unsafe sex contacts, or because they have STI symptoms or other complaints.

Table 4 STI examinations in the policlinic 2005 - 2007
Total number of consultations 1332

| Consultations | 2005 N= 439 | 2006 N= 427 | 2007 N= 466 | Total N= 1332 | 100% |
|---|---|---|---|---|---|
| Lues | 5 | 6 | 3 | 14* | 1% |
| Gonorrhoea | 16 | 19 | 20 | 55 | 4% |
| Chlamydia | 46 | 38 | 49 | 133 | 10% |
| Trichomonas | 6 | 8 | 4 | 18 | 1% |
| HIV | 4 | 0 | 1 | 5 | 0,4% |

* of which four women with Lues 1, two with Lues 2, two with Lues recens and four with Lues latens

## 6. Hepatitis-B Vaccination 2005-2007

The Hepatitis-B vaccination programme commenced in November 2002 - it is financed by the Dutch Ministry of Public Health, Welfare, and Sport, and is co-ordinated by GGD-Nederland. In Amsterdam, the Public Health Service, Infectious Diseases Department, is the co-ordinating body. Between November 2002 and January 2008, a total of 1440 prostitutes in Amsterdam participated in the vaccination programme. The women were recruited via the STI policlinic, at the prostitution sites, in the clubs, and in the windows.
During the 2005 - 2007 period, 748 prostitutes were given the first vaccination (see table 5), of whom 348 women received their first vaccination in the STI policlinic, and 400 women during outreach work at prostitution sites. In order to motivate them to complete the course of three vaccinations, the prostitutes were reminded by telephone or text message. Sending reminders is a type of 'assertive outreach', which is time consuming. A number of the women had mobile numbers that were no longer in use and could not be contacted, whilst other women reappeared again, sometimes years later, and could still be vaccinated at that time. Nevertheless, 51% received the complete course and a number of women are still in the scheme. The target compliance figure is 65%.

[3] Annual Report 2006 STI policlinic Public Health Service Amsterdam

| Table 5 | Prostitutes by nationality and Hepatitis-B vaccination 2005-2007 | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Netherlands | Other EU | Central/ Eastern Europe | Latin America | (North) Africa | Asia | Total (%) | |
| Blood sample + 1st vaccination | 258 | 57 | 260 | 110 | 42 | 21 | 748 | 100% |
| Immune | 7 | 9 | 44 | 28 | 15 | 6 | 109 | 15% |
| HBV carrier | 2 | 0 | 13 | 1 | 0 | 0 | 16 | 2% |
| Boosters | 249 | 48 | 203 | 81 | 27 | 15 | 623 | |
| 2nd vaccination | 176 | 33 | 144 | 62 | 22 | 13 | 450 | 72% |
| 3rd vaccination | 105 | 14 | 55 | 34 | 12 | 9 | 229 | 51% |
| Anticipated compliance: 65% A number of women are still in the vaccination programme | | | | | | | | |

## 7. Other Activities

Since the foundation of the project in 1988, we have worked together with other service providers in and outside Amsterdam. Important partners are the Vice Squad, social-work organisations, and Public Health Service Amsterdam prostitution projects outside Amsterdam.

Collaboration with international projects is not a core activity within the project, and usually takes place at the request of the other party. In 2005 and 2006, we collaborated with projects in Bulgaria and Serbia where outreach workers and service providers were trained in setting up STI prevention projects for prostitutes. During the past years, presentations on the Dutch prostitution policy have been given to groups of foreigners who came to Amsterdam on a working visit, such as service providers and politicians. Interviews were given to foreign media or they were given background information for making a documentary about prostitution.

### 7.1 Dutch language lessons for non-Dutch speaking prostitutes

In 2005, STIAids Netherlands received a request from ZonMw, the Netherlands organisation for health research and development, to develop an intervention for prostitutes that would go beyond STI/HIV prevention and that would contribute to increasing the independence and assertiveness of prostitutes.
In co-operation with healthcare organisations and various Public Health Service Amsterdam prostitution projects in the Netherlands, and with the Prostitute Information Centre (PIC) in Amsterdam, the pilot project "Healthy and Strong in Sex Work" was carried out. Themes were chosen for courses that would enhance the prostitutes' assertiveness. The offer consisted of a course in the Dutch language, a course on rights and obligations in the prostitution sector, a self-defence course, and a physical and sexual education course. After completion and documentation, the results of this pilot project were brought together in a manual, and this was offered to support organisations for the implementation of courses for prostitutes[4]
The Public Health Service Amsterdam project employees gave a Dutch language course to non-Dutch speaking prostitutes during this pilot phase. An earlier experience with Dutch language lessons for prostitutes in 2001 was particularly positive; a number of participants learned to speak good Dutch within one year.

[4] Manual Healthy and Strong in Sex Work, SANL 2007

| Table 6 | Average mark | |
|---|---|---|
| Self assessment by participants: | Before the course | After the course |
| a. How well do I speak Dutch | 3.8 | 7 |
| b. How well do I understand Dutch | 4.4 | 7.8 |
| c. How familiar am I with Dutch authorities that can help me | 3.9 | 6.9 |
| d. How well can I talk with my colleagues | 4.5 | 7.1 |
| e. How well can I talk with a client | 5.0 | 7.6 |
| f. How well can I tell my client what I don't want | 5.4 | 8.6 |
| g. How well do I know my own body | 5.3 | 7.5 |
| h. How well do I know Dutch customs | 3.9 | 7.2 |
| i. How well do I know what healthy eating is | 7.0 | 8.5 |
| j. How well do I know what healthy living is | 6.8 | 8.5 |
| **Total** | **4.7** | **7.7** |

This language course consisted of 50 lessons of two hours each, and a total of 19 women registered for the course. Of this group, a group of nine women remained who attended all the classes. At the start of the course, the working methods were very intensive in order to realise commitment from the participants. This happened by phoning the women, and reminding them of the next lesson. This recruitment method, as a type of assertive outreach, appeared necessary to motivate the participants to attend the lessons. Ten women stopped early due to long-term illness, a move abroad, or a long-term holiday abroad. For a number of drop-outs we do not have the reasons, but the high mobility of prostitutes is like to play a role. During the course, some cultural trips were organised to Volendam and the Zaanse Schans. Guest teachers were also invited, of whom a number participated in the ZonMw pilot project.

The guest teachers worked with the participants on the perfect pronunciation of vowels in Dutch, they discussed the rights and obligations in prostitution, there was a theme lesson on sexual health "your body, your life", self-defence techniques were learned to deal with tricky customers, and the participants had a lesson about environmentally unfriendly products from some cosmetics giants.

The nine participants who dutifully attended all lessons reported considerable improvements for specific objectives. They were asked to assess their own level in nine areas with a mark before and after the course. On average, the participants moved three marks ahead. Their major progress was in their active and passive language skills (See table 6).

**7.2 Health education in the Roggeveen**

Since September 2007, project employees have given health and sexual health education to group meetings at the women's refuge, the Roggeveen. This has been in collaboration with social workers from the Human Trafficking unit, and these meetings have also been attended by the activities counsellor of the Roggeveen. One of the units of the Roggeveen is for women who are the victim of human trafficking and who worked in prostitution. The objective of the

education was to give the women a positive self image of their body and to approach their own sexuality in a positive manner. The format used was the one developed by the employees of the Rotterdam GGD (Public Health Service Rotterdam) prostitution project - "Healthy and Strong in Sex Work"[5].

Due to the experiences of the Public Health Service Rotterdam with similar groups of women and the fact that the women in the Roggeveen are vulnerable due to their experiences, it had been decided that these education meetings would not to deal explicitly with the theme of sexuality in combination with working in the sex industry. It had also been agreed that anyone could tell what they wanted to tell without feeling obliged to say anything at all about their own situation. At the end the meeting was evaluated with the women present, and there was time to ask questions. The education session was held once every six weeks, depending on the presence of a certain number of women. The meetings will be continued in 2008.

## 8. The Prostitution & Health Centre, P&G292

In 2005, council members Amma Asante and Karina Schaapman investigated the abuses in the prostitution sector. On 1 February 2006, the council agreed to the pre-advice to the policy document of these two council members, called 'Making the invisible visible, prostitution in Amsterdam in the year 2005". One of the recommendations of this policy document was to open a health centre for prostitutes and to realise an expansion of the shelter and support for victims of human trafficking. At the General Affairs committee meeting on 15 December 2005 this recommendation received unanimous support.

The local authority strives to use this centre to enhance and centralise social support and healthcare for prostitutes. A centrally located and accessible centre was created where prostitutes can go for social and medical help. In 2006, the preparations were started for the Prostitution & Health Centre, P&G292. The number of project employees has been expanded by 1.5 FTE. Where possible, the centre draws on existing organisations and structures in relation to its tasks. The Prostitution Social Work (PMW) of HVO Querido and the project employees of the Public Health Service Amsterdam will form the prostitution team in the new centre. At municipal level, there will be co-operation within a chain approach to service provision for prostitutes and combating human trafficking, in which various service providers and lobby organisations will participate. At the end of 2009 this chain approach will be evaluated. The official opening of P&G292 will take place in April 2008.

[5] Manual Healthy and Strong in Sex Work, SANL 2007

## Epilogue

The extent to which prostitutes are reached does not only depend on regular outreach work, as local or national prostitution policy will always remain an important factor in access. Daily life in prostitution, the safety of the women, their ways of working, their income, and contacts with their environment are strongly coloured by prostitution policy – be they properly considered policies or otherwise. A policy that is focused on reducing prostitution may have consequences for the safety of the prostitutes.

Prostitution has never been illegal in the Netherlands. In 2000, the prohibition on exploiting prostitution was lifted and brothel owners were given an operating licence. However, despite estimates that 20,000 women work in Dutch prostitution over a period of a year, there is still no major prostitution organisation. Such an organisation is required to fight for the acceptance and emancipation of the prostitute profession. During our visits to prostitutes we often discuss the dubious acceptance of their profession. One of them summarised it as follows "You <u>are</u> a wife or a housewife, you <u>are</u> a journalist, or whatever you are, and you will remain that for a long time. But you <u>are not</u> a prostitute; you do that work for a short while, preferably as anonymously as possible. You cannot be proud of it, because you know that your environment will respond negatively".

In 2007, a number of prostitution businesses in the Amsterdam Red-Light District were closed, because the owners did not pass the Bibob[6] test and needed to close their business. This meant that a number of women lost a relatively safe workplace. Prostitutes have become used to 'being put out of sight', and when they can no longer work somewhere, they find another place. The women who worked in the windows that were closed have disappeared without any form of protest. It would be utopia to think that prostitutes will head for the streets en masse to fight against exploitation and for acceptance. For now the lobby organisations are the ones fighting for the rights of prostitutes and for the time being they are the ones who negotiate with the authorities.

[6] Public Administration (Probity Screening) Act

**Justification**

**Subsidy**
Amsterdam Council
ZonMw, the Netherlands Centre for Health Research and Development

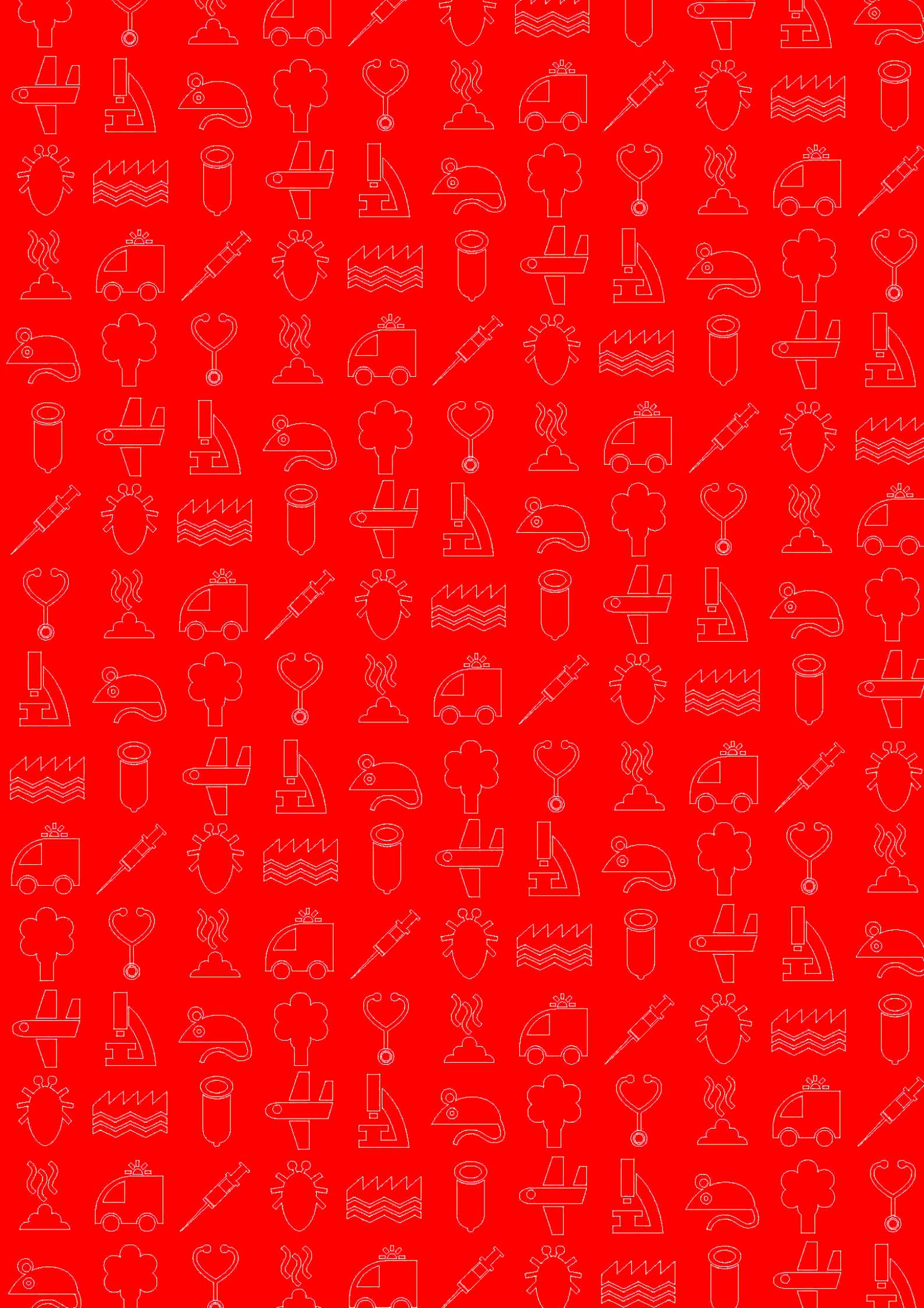
**Project employees**

| | |
|---|---|
| Thérèse van der Helm, co-ordinator | since 1988 |
| Marianne Craanen | since February 2005 |
| Annebel Tahey | since June 2007 |
| Mildred Monpellier | since May 2007 |
| Henk Sulman | 2003 to 2006 |
| Kim Visser | 2006 to 2007 |

Cultural Mediators In Prostitution

| | |
|---|---|
| Luz Padilla | since 1995 |
| Betty Piros | 2007 |
| Nina Valcheva | 2007 |

Supervisor Harold Thiesbrummel, doctor
Head STI policlinic



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