

Results

Preliminary results on 181 patients, 12 months after the beginning of the study, showed that 72% of the patients used the card at least once in the medical practice. A majority of patients (62%) did not change their PIN, while 31% chose to modify it, and 7% removed it, thus allowing a complete free access to the data. The percentage of patients who entered a wrong PIN at least once was 18%, and a single case of card block (i.e. three consecutive erroneous PIN) was observed. No significant age or gender effects were found.

Conclusions

A vast majority of patients (93%) chose to keep a PIN to protect their health data. This rate, higher than the rate usually reported by other studies, is somewhat surprising. It might reflect an already acquired acceptance for the generalization of cards (i.e. bank cards) that allow the access to confidential information.

Health care systems without society? A sociological review of the theoretical models of social systems and their relationships to relevant environments applied in current research

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Background

Governance of systems of Health Care has received a lot of political and media attention in the past 30 years in most OECD countries. Parallel to the rising public interest the scientific analysis of these systems in their relevant physical and social environments has developed rapidly. Yet in most cases a profound sociological perspective to health system analysis is lacking—especially as it concerns the nature of health care as a specific subsystem in a functionally differentiated society, with the subsystems of politics, economy, science, education, and the media as its most relevant environments.

Methods

Since April 2006, the authors are conducting a systematic review of current contributions (2000–2006) to the mainstream of health systems analysis as an interdisciplinary field, with specific attention to sociological contributions. The search focuses on contributions in English and German in Journals listed in databases like Scirus, British Library Direct, ASSIA, Social Science Index, and Medline (CSA), and is supplemented by an internet search on books/book chapters. In a second phase, abstracts were rated on several dimensions to provide an overview and identify the most relevant contributions for in-depth qualitative analysis of the theoretical frameworks predominant in the field, planned as third phase for fall 2006.

Results

The search provided over 400 relevant journal contributions and over 100 contributions in books/book chapters. The poster will present the results of Phases 1 and 2 of the review, including an overview of the types of contributions, the main topics targeted by these contributions, the dominant theoretical frameworks, and sketch problem-oriented and disciplinary subdiscourses currently prevalent in the literature.

Conclusions

Health Care Systems Research currently is a multidisciplinary field with an extensive publication activity. But only few of the contributions seem to have a major focus on further development of basic concepts and theoretical frameworks, and the largest part is oriented at models from health economics—with their strengths, but also weaknesses ('economic reductionism'). Sociology and especially modern sociological systems theory are currently contributing only marginally. At least from a sociological perspective, Sociology seems to have the potential to contribute to a theoretical framework more appropriate to the complex dynamics of modern society—but most of these contributions still seem to be outstanding.

Track: Inequalities and Vulnerable Populations

Trends in educational inequalities in smoking cessation rates in Italy, 1980–2000

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Background

The effectiveness of anti-tobacco policies and interventions at the national level is often measured calculating the proportion of subjects who quit smoking or 'quit ratios', which are often derived retrospectively. This study aims to estimate trends of educational inequalities in smoking cessation in Italy between 1980 and 1999, and to evaluate the reliability of retrospective estimates of quit rates comparing two analogous surveys carried out 10 years apart.

Methods

We calculated rate ratios and rate differences of quitting smoking of high versus low educated for four consecutive 5 year periods between 1980 and 1999. Estimates of cessation rates derived from two different National Health Interview Surveys

(1990–1991 and 1999–2000) were compared for the period 1980–1984 and 1985–1989.

Results

Higher educated individuals were more likely to quit smoking than their lower educated counterparts, with rate ratios of quitting of high versus low educated ranging from 1.1 to 1.4, and rate differences (high minus low) ranging from 2.6 to 8.5 per 1000 person-years. Between 1980 and 2000, rates of quitting increased substantially among younger individuals, but the increase was larger among the higher educated: among 20–49-year-old males, absolute educational differences raised from 7.9 to 10.7 per 1000 person-years. A different pattern was observed among subjects aged 50–69, with higher rates among the high educated at the beginning of the time period and higher rates among the low educated afterwards. Similar estimates of educational differences in cessation rates were produced by the two surveys.

Conclusions

Quit rates increased over time in all educational groups among subjects aged 20–49, but the increase was greater among the high-educated. Retrospective estimates 15–20 years back in time may be validly derived on the basis of a single survey.

Preventive health care utilization among the unemployed; evidence from Croatia

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Background

Discussions about equity and health care consumption among the unemployed are far from being conclusive as different studies report conflicting results. The effects of unemployment on the use of preventive services have, however, so far not adequately caught the attention of researchers. Our study aims to analyse the effects of unemployment on the use of preventive programmes in Croatia.

Methods

Questions regarding use of preventive health care services and employment status were incorporated in the 2003 Croatia Adult Health Survey. A multistage stratified sample design was adopted to define a representative sample (10 776 individuals) of the Croatian general adult population. Forward stepwise logistic regression was used for analysis. Odds ratios were estimated for the presence of associations of employment status and preventative health care services controlling for age, sex, region, marital status, level of education, occupation, and distance from health care facilities.

Results

All reported results were statistically significant at the level $P < 0.001$. Unemployment was found to be negatively associated with the use of preventive health care services in healthy adults during the year preceding the survey: blood pressure control (OR = 0.685, 95% CI = 0.677–0.692), blood sugar control (OR = 0.719, 95% CI = 0.709–0.729), attending general preventative examinations (OR = 0.472, 95% CI = 0.465–0.480), receiving doctor's advice for food habit change (OR = 0.968, 95% CI = 0.952–0.985), and tetanus immunization (OR = 0.846, 95% CI = 0.825–0.867).

Conclusions

If we accept the propositions that preventive health care services are beneficial to health and that unemployment is negatively associated with utilization, it might be argued that our study provides additional support to the finding that unemployment negatively influences health. The policy implications of arguments presented by this paper are clear. In order to achieve a more equitable distribution of preventive health care services, health care systems should provide additional attention to vulnerable groups such as the unemployed.

Predictors of health and health care utilization in relation to employment status

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Background

To increase the chances of re-employment the health care system could assist the unemployed in improving their health. This study explores the relationship between indicators of health, health care utilization, and employment status.

Methods

A questionnaire was sent to 1000 persons who had recently registered as unemployed and to a sample of 1000 persons from the Swedish population (combined response rate: 60.5%, $n = 1211$). Persons still unemployed or otherwise not employed (study group: $n = 416$) were compared with the employed population ($n = 414$). The re-employed were studied separately.

Mental health was measured with the Center for Epidemiological Studies Depression Scale (CES-D) and the Shirom–Melamed Burnout Questionnaire (SMBQ). The Alcohol Use Disorders Identification Test estimated hazardous drinking. Logistic regression analyses were performed to test the influence social and economic factors.

Results

A difference between the study and reference group was found for mental health, but not for hazardous drinking. The re-employed did not have poorer health. After adjusting for socio-demographic factors, work involvement, and social support, the OR was higher in the study group for scores on the SMBQ (OR = 1.58, 95% CI = 1.05–2.36). When considering economy the risk persisted for the CES-D (OR = 1.56, 95% CI = 1.05–2.33). The OR was higher in the study group for abstaining from seeking care (OR = 1.52, 95% CI = 1.08–2.14) and for contacting a physician (OR = 2.03, 95% CI = 1.46–2.82) but not when considering economic hardship and social network. Among those with unmet care needs, symptoms of depression were more present in the study group.

Conclusions

Persons who had recently been registered as unemployed had a higher risk of poor mental health and abstaining from seeking care. The health care system should be aware of the fact that some unemployed with poor mental health abstained from seeking care.

Economic hardship, and social network should be considered among health professionals treating patients with depressive symptoms.

Access to medical services of vulnerable or pauperized persons that do not hold medical insurance

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Background

In the Republic of Moldova the system of mandatory medical insurance was implemented since 2004. In this way, all employed people pay contributions equivalent to 2% from their salary, another 2% being paid by the employer. At the same time, the Government makes contributions to the Fund of the National Insurance Company for children, students, retirees, pregnant women, and handicapped people. About 75% of the country's population has insurance policies, and through them they have access medical services.

According to statistics, the University Center of Primary Health Care serves 16 616 persons of the population, of which 13620 hold insurance policies, equivalent to 82%. The people without insurance are part of the vulnerable, pauperized, and unemployed categories and they do not benefit from social security. They have to pay for the medical services as they use them. (The insurance fund has allocated only 50 cents per capita for the uninsured.)

Methods

This study includes the visits to the clinic and at home of a well determined sector of population (11996 persons) throughout the year of 2005. Thus, the uninsured persons have registered only 7.7% of all visits although they represent 25% of the studied population. All gathered data will be presented.

Results

It is proven that uninsured persons have very limited access to basic medical services. (All gathered data will be presented.)

Conclusions

This category of population gets ill more often, being exposed to more hardship and having less resources. The illness usually proceeds to serious stages and can lead to death because these

people do not have access to medical diagnosis, treatment, and medication. Also in this category are registered more cases of tuberculosis, other contagious diseases, and social illnesses. The conclusions require that we look for ways to increase access of pauperized social groups to basic medical services.

Integration of home care services in the primary care level in Northern Bosnia-Herzegovina Sigiriya Aebischer-Perone

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Issue

In Bosnia-Herzegovina (BiH) elderly patients with chronic diseases, disabled, or terminally ill persons stayed at home without any support or needed to be hospitalized. Home and palliative care services did not exist or were provided by specialized services. Within the health reform a family medicine (FM) network has been implemented in Orasje (Northern BiH) since 2002. FM teams who care for their patients could extend their services to home care, but need additional skills and support.

Description

In the context of a FM implementation project (FaMI project), all nine FM teams of the municipality of Orasje were trained by the Orasje Dom Zdravlja (policlinic) in home care and further transmitted their knowledge to volunteers and relatives of patients. A home care network was set up through close collaboration with stakeholders of the community, Red Cross, social workers, and secondary care level to support these new activities. The teams were followed-up and financially supported by the project. Since then they provide home care to all patients in need and hold regular debriefing meetings. These services have been recognized by the health insurance fund that has taken over the cost of the activities from the Swiss Agency for Cooperation and Development.

Lessons

Collaboration between the different stakeholders of the community and health institutions succeeded to create an effective and sustainable home care network.

Conclusions

A comprehensive approach towards home care has been found within the FM structure, which extends its services to the patients at home. This approach provides comprehensive and affordable home care and could be implemented in other settings where FM teams are present.

How do differences in the population size of administrative regions between European countries affect geographic inequalities in mortality rates?

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Background

Comparison of geographic health inequalities between countries is readily achieved by comparing the variation in an outcome between countries. However, one may rightly question whether it is fair to make comparisons between countries with different internal geographic population structures.

Methods

Retrospective study of indirectly standardized mortality rates, aggregated by administrative regions within 20 European countries, 1990–1991. Poisson multilevel modelling allowed the variance between regions within countries to be modelled as a

function of the mean region population size and the inequality in region population sizes within each country. The inequality in region population size was measured using Gini coefficients. Deterministic models for the variance were compared with models allowing for uncertainty around these relationships.

Results

Regional inequalities in mortality rates can partly be explained by the population administrative structure. Modelling the variance either in terms of mean region population size or inequality in population size improved model fit. Although not conclusive, there is evidence that countries with either larger, or more unequally populated regions have greater variation in mortality rates. These relationships were significant ($P < 0.05$) in deterministic models, but not so when allowing for uncertainty. An increase of 0.5 million inhabitants in mean population size of regions corresponded to a 10% increase in standard deviation; mean size ranged between 0.1 (Switzerland) and 2.3 million (Germany). The Gini coefficient, measuring inequalities in population size between regions, ranged from 0.1 (Bulgaria) to 0.5 (Switzerland); an increase of 0.1 was accompanied by a 14% increase in standard deviation of the mortality rates.

Conclusions

When comparing inter-regional health inequalities between countries it may be important to consider differences in their administrative population structure. Apparently differing levels of geographical health inequalities between two countries may be owing to differences in geographical structure *per se*, rather than having any underlying epidemiological cause.

Inequalities in life expectancy by education over the period of socio-economic transition in Lithuania Ramune Kalediene

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Background

Educational attainment is a composite socio-economic variable, reflecting a number of influences on health status. The aim of this study was to analyse changes in life expectancy by level of education over the decade of major socio-economic transition in Lithuania.

Methods

Analysis was based on routine mortality statistics and census data for 1989 and 2001 for the entire country.

Results

Up to the age of 65 years, total life expectancy of males decreased significantly in 2001, as compared with 1989. Life expectancy of males with university education increased in the age groups 30–65, while life expectancy of lower educational groups declined, particularly of those with the lowest education. Life expectancy of university-educated males exceeded that of the group with primary education in both periods of investigation. This difference increased in 2001 as compared with 1989, from 11.7 to 16.8 years at age 25, respectively. For females, the same tendencies were observed: at age 25, differences in life expectancy between the lowest and the highest educational groups increased from 4.3 in 1989 to 15.2 years in 2001. Cardiovascular diseases were responsible for the greatest number of years lost in life expectancy by all educational categories in both 1998 and 2001 for males and females. The number of years of life lost owing to cardiovascular diseases decreased in majority of educational categories, particularly in lower secondary educational group. The most uniform increase in the years of life lost over the decade was observed owing to external causes of death. The higher education was associated with lower number of years of life lost, especially in females.

Conclusions

General policies for health promotion and disease prevention should be based on the realities, faced by lower educated groups, rather than on experiences, which are general for the total population or the class of society that has achieved an average education.

The impact on violence of mental health patients on their relatives

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Issue

Violence is a worldwide problem. Violence prevention is a noble task of psychiatric interventions. Until now this violence prevention is focused on inpatient treatment and neglects the impact of violent behaviour of mental health patients on their relatives at home. Relatives and especially children suffer a lot and have to learn how to cope.

Description

In three focus groups, consisting of relatives of mental health patients, a leaflet is developed, which supports relatives in their coping strategies with the problem of violent behaviour at home. The participation of the relatives enables them to help themselves and supports the empowerment of self-help groups which distribute this leaflet on a nationwide basis.

Lessons

The most important instructions of the leaflet are as follows: Talk to friends about your problems at home; Try to find the balance between nearness and distance to the patient; Take care of yourself; Try to collect as many information as possible about the mental health disease and inform the society about mental health diseases.

Conclusions

Relatives of mental health patients are a vulnerable group, especially when violence is involved. They can learn to support themselves and help themselves so that they stay healthy. With the development of a leaflet they share their knowledge with a lot of other relatives who can benefit from this empowerment strategy.

The Marienambulanz: an example of tackling inequity in health care

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Issue

Austria belongs to the richest countries in the world. Yet at the turn of the 21st century, the gap in health outcomes between those at the top and bottom ends of the social scale remains large and, in some areas, continues to widen. The reasons for these differences in health are, in many cases, avoidable and unjust.

Description

In 1999, the primary health care centre 'Marienambulanz' opened in Graz, a city with ~300 000 citizens. Since then the 'Marienambulanz' has offered medical and social assistance free of charge, to Austrian and non-Austrian citizens; to people with or without insurance; to those who have very little or no access to medical care. The 'Marienambulanz' presents an example of a successful cooperation between general practitioners (mainly volunteers), specialists, nurses, other health professionals, NGOs, secondary health services, and public institutions.

Lessons

In the past 6 years ~4500 persons from 70 nations have been counselled, treated, or accompanied by the multilingual team.

Every year the 'Marienambulanz' provides a range of services to a growing number of men (64%) and women (36%), at the average age of 30 years, one-third of them local people and two-thirds foreigners.

Conclusions

Since January 2006, the Marienambulanz has been accepted as contracting party by the Austrian Health Insurance. Even though the Marienambulanz is now on its way to integrate into the official health system it will continue to work with a broad definition of health. Time will tell, how the innovative example of closely linked general practice, primary prevention and health promotion activities, counselling and social support will be supported by the government to carry on addressing the needs of the significantly growing target groups.

Reproductive and newborn outcomes in Roma and non-Roma populations—cross-sectional study in East Slovakia

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Background

The Roma minority people are the most important ethnic group in the countries around CEE. Socio-economic conditions of this group differ significantly from other population groups. Information about the health of Roma is only available from a few scientific studies, which are very sparse, limited, and many times remain incomplete—usually owing to the problem of intercommunication between Roma minority and other population groups and cultural differences.

Methods

The data analysis of cross-sectional study included 2762 reports and personal questionnaires (711 Roma and 2051 non-Roma mothers). The data were obtained from the personal interviews directly in the obstetric departments around east Slovakia. Newborn data and prenatal data were derived from maternal and newborn obstetrics hospital reports. Maternal reports included reproductive parameters (e.g. type of delivery, gestation age, spontaneous abortion, and mother's weight increase). Personal questionnaires includes socio-demographic and health data of mothers (education, employment, marital status, smoking, ex-smoking, coffee, and alcohol abuse). To analyse the data *t*-test, regression analysis and adjusted OR were used.

Results

Significant differences were found regarding reproductive characteristics between Roma and non-Roma population groups. Roma minority mothers had more deliveries ($P < 0.001$) and lower mother's weight increase ($P < 0.001$). Substantial differences were also found regarding newborn parameters. Adjusted odds ratios (OR) for low birth weight (<2500 g) for Roma were 2.3 ($P < 0.01$) and for low birth-length (<45 cm) OR = 1.85 ($P < 0.05$). Noteworthy were also adjusted OR for chest and head circumference (both $P < 0.01$). OR for pre-term births and low gestational age for Roma were slightly significant after adjustment ($P < 0.05$).

Conclusions

The results show great differences between Roma and non-Roma in reproductive and newborn basic health outcomes. However, strong factors with limiting ability of cross-sectional study, including precise definition of ethnicity, misreporting information particularly on alcohol issues, unbalanced structure of the study group when Roma create smaller number than non-Roma, still remain present. It would be interesting to explore whether factors such as nutrition intake, or prenatal

health care, can help further clarify the pathways linking ethnicity, socio-economic circumstances, and health.

Internal migration in Scotland and its impact on population health Denise Brown

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Background

Changes in population health and progress towards targeted reductions in inequalities are assessed on the basis of the comparison of area populations over time. However, population migration introduces problems into the measurement of population health. The aim of this study is to examine the relationship between internal migration patterns, deprivation, and population health.

Methods

The 2001 Scottish Census data were used to assess population change in 42 604 output areas (average population is 119) in the year preceding the Census. Depending on movement within the UK, output areas were classified as one of four types: as an increasing population (5%+ increase), as a decreasing population (5%+ decrease), or as a stable population (<5%

total change) with high or low turnover. Area deprivation was measured by the Scottish Index of Multiple Deprivation 2004. Our main outcome measure was directly standardized all cause mortality (2000–2002).

Results

In all four area types there was a steep mortality gradient across deprivation quintiles. Mortality for men in stable populations with low turnover was 123% higher in the most deprived quintile than in the least deprived, whilst for women this excess was 96%. Across the deprivation quintiles, mortality was higher, for men and women, in all other area types when compared with stable populations with low turnover. Mortality was highest in areas with increasing populations, for men and women, in all quintiles except the most deprived quintile where decreasing populations had markedly higher rates (mortality rate of 1194 per 100 000 in men and 1139 in women). As a result, excess mortality in the most deprived quintile was highest for decreasing populations: 180% for men and 137% for women.

Conclusions

Areas with net population inflow have higher mortality rates than other areas of comparable deprivation. Among the most deprived areas, areas with net population outflow have the highest mortality rates of all.

Track: Infectious Diseases

Project National Centre for Hygiene and Safety Ella Benedictus-Zoutman

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Issue

In The Netherlands, Municipal Health Services (MHS's) monitor hygiene in organizations at risk and advise professionals on hygienic improvements. In the past years, the standing of this Hygiene Control (HC) and the development of protocols lagged behind and needed a quality impulse. MHS's showed a wide variation in the quality of care and the range of organizations to which care was given.

Description

To improve quality of infection control, the project 'National Centre for Hygiene and Safety (NCHS)' started in June 2003 and was funded by Fonds OGZ, during a period of 3 years. The goal was to improve the quality of care by supporting professionals. The project consisted of two main components as follows:

- (i) Building a national centre.
- (ii) Structural implementation of the centre.

Results

The NCHS is hosted by the MHS in Amsterdam. The centre developed the following:

- (i) Protocols and guidelines for, among other things, tattoo shops, prostitution, day care centres, schools, and mass events.
- (ii) Instrument for priority setting in Public Health regions.
- (iii) Trainings for professionals in day care centres and MHS's.
- (iv) Consulting structure for professionals.

The Dutch Centre of Infectious Disease Control intends to continue the work of the NCHS after the project ends in June 2006. This ensures the strong connection between infection prevention and communicable disease control and offers opportunities for research.

Conclusions

The establishment of NCHS to improve the quality of HC gave an impulse to quality of care. It helped HC develop from a minor part of communicable disease control to a substantive, professional entity in public health care. The involvement of all MHS's in the consulting structure was important to gain support and enhance implementation of protocols. For further development of HC by MHS's, research and education needs improvement.

Male to male transactional sex and HIV/AIDS: the influence of gender biases on HIV-protection behaviour of male sex workers AP Andreas Pfister

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Background

In Europe, there is less research about male sex workers (MSW) than about female sex workers. This might be owing to the greater prevalence of female to male than male to male transactional sex. Despite this, the few existing studies on HIV-protection behaviour of MSW show that an important proportion of HIV-relevant sexual contacts are unsafe and therefore MSW also have to be focused by scientific research and HIV-prevention.

A Swiss study explored the impact of framing (definition of a situation) on HIV-protection behaviour of MSW. The results of the study shed light not only on how MSW frame sexual contacts. They also give insights about gender biases influencing the HIV-protection behaviour of MSW.

Methods

Data were collected in qualitative interviews with 15 MSW, included by theoretical sampling (age, education, sexual orientation, occupational status, workplace, and migration). Data were analysed along the principles of grounded theory.