HIV Prevention Among Vulnerable Populations: The Pathfinder International Approach
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Ellen Israel, CNM, MPH
Senior Reproductive Health Advisor, Pathfinder International

Carlos Laudari, MD, MPH
Director, Pathfinder do Brasil Association

Cecilia Simonetti, MPH
Senior Communication and Health Advisor, Pathfinder do Brasil Association

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### List of Acronyms

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<th>Acronym</th>
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<tr>
<td>AIDS</td>
<td>Acquired Immunodeficiency Syndrome</td>
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<tr>
<td>ART</td>
<td>Antiretroviral Therapy</td>
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<tr>
<td>ARV</td>
<td>Anti-Retroviral Drugs</td>
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<td>ASRH</td>
<td>Adolescent Sexual &amp; Reproductive Health</td>
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<td>BCC</td>
<td>Behavior Change Communication</td>
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<tr>
<td>CBO</td>
<td>Community-Based Organization</td>
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<tr>
<td>CDC</td>
<td>Centers for Disease Control and Prevention</td>
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<tr>
<td>CETAD</td>
<td>Centro de Estudios e Terapia do Abuso de Drogas</td>
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<td>CHW</td>
<td>Community Health Workers</td>
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<td>CSW</td>
<td>Commercial Sex Workers</td>
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<td>FP</td>
<td>Family Planning</td>
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<td>HAART</td>
<td>Highly Active Antiretroviral Therapy</td>
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<td>EMG</td>
<td>Emerging Markets Group</td>
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<td>FSW</td>
<td>Female Sex Workers</td>
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<td>HBC</td>
<td>Home-Based Care</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>IDU</td>
<td>Injecting Drug User</td>
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<tr>
<td>M&amp;E</td>
<td>Monitoring &amp; Evaluation</td>
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<tr>
<td>MCH</td>
<td>Maternal and Child Health</td>
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<td>MOH</td>
<td>Ministry of Health</td>
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<td>MSM</td>
<td>Men who have Sex with other Men</td>
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<td>OI</td>
<td>Opportunistic Infection</td>
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<td>PHE</td>
<td>Peer Health Educator(s)</td>
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<td>PLWHA</td>
<td>People Living With HIV/AIDS</td>
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<td>PMTCT</td>
<td>Prevention of Mother-To-Child Transmission</td>
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<td>SRH</td>
<td>Sexual and Reproductive Health</td>
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<td>STI</td>
<td>Sexually Transmitted Infection(s)</td>
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<td>SW</td>
<td>Sex Worker</td>
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<td>TOT</td>
<td>Training of Trainers</td>
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<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
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<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<td>UNGASS</td>
<td>UN General Assembly Special Session</td>
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<td>VCT</td>
<td>Voluntary (HIV) Counseling and Testing</td>
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Executive Summary

Three particular populations in most countries are highly vulnerable to HIV infection: sex workers, men who have sex with other men, and injecting drug users. All over the world, legal frameworks, social stigma, and discrimination have rendered these populations voiceless in the decision-making processes that affect their lives, including those related to HIV. On the other hand, in places where they have been encouraged, or have fought to participate actively in prevention programming, these vulnerable groups have been among the most efficient players in slowing or even stopping the epidemic.

Based on several thorough situational assessments of the levels of individual, programmatic, and social vulnerability in which they live, effective HIV prevention strategies for these groups should integrate three key elements: 1) identify, develop, and pursue effective interventions that promote individual behavior and social change; 2) guarantee equal access to comprehensive quality health services; and 3) promote respect of fundamental human rights. This technical guidance offers insight and suggestions for designing such programs. It recognizes that vulnerability itself must be understood - especially of the groups addressed - followed by practical action planning and intervention based on that understanding. It requires the full participation and guidance of each of these groups. Such a client-centered approach to prevention is an urgent priority within the anti-AIDS movement.

This technical guidance should serve as a practical guide for Pathfinder International country offices, local partners, collaborating agencies, and others, for implementing effective interventions aimed at the reduction of HIV and AIDS among the most vulnerable and susceptible groups. It promises to have a measurable and positive impact on the lives of those we intend to support.
Introduction

The challenge of HIV prevention

In spite of recent government and civil society efforts that have noticeably improved AIDS-related morbidity and mortality, the expanding numbers of people infected with HIV is a major concern. A welcome increase in access to AIDS treatment has been offset by a dangerous decline in HIV prevention interventions. In its 2006 *Report on the Global AIDS Epidemic*, UNAIDS asserts that implementation of comprehensive HIV prevention measures could avert 28 million new infections between 2005 and 2015 - more than half of those projected to occur during this period. Yet, after more than 25 years since the epidemic began, those populations most vulnerable to HIV infection have not yet been effectively reached by prevention interventions, not necessarily because of lack of efficient approaches, but rather - and most unfortunately - because political commitment/willingness/interest is lacking among many policy-makers to implement strategies that have proven successful all over the world.

This is of particular importance for those populations experiencing rapidly rising or already high HIV infection rates. These include sex workers (SW), men who have sex with men (MSM, including gay men, transvestites, transsexuals, and bisexual men), and injecting drug users (IDU). These groups are the focus of this technical guidance.

While it is well understood that these particular groups are more susceptible to HIV infection because of their behavioral, cognitive, and programmatic environments, they are among the most stigmatized and discriminated-against populations in society. In fact, they are often victims of “layered” stigma. On top of the already existing social stigma against SW, MSM, and IDU, the association with AIDS, as well as with race, gender, and poverty contributes additional layers of discrimination.

In most countries SW, MSM, and IDU are excluded from meaningful participation in the decision-making processes that design, implement, monitor, and evaluate HIV prevention interventions. As a result, resources directed to their specific HIV prevention needs and interests are vastly disproportional to their risk of becoming infected. Work around the world has shown that effective prevention strategies focusing on those most vulnerable populations must necessarily adopt an approach that combines:

1. Community-determined and led actions to change individual and social behaviors that reduce risk of HIV infection;
2. A guarantee of equal access to comprehensive quality health services, including care, support and treatment; and
3. Promotion of respect for fundamental human rights, while empowering vulnerable groups to focus on the “enabling environment,” particularly the underlying conditions that make marginalized communities vulnerable to HIV/AIDS.
The challenge lies in reaching a balance of outputs from each of these three strategic components - dealing equally and simultaneously with individual knowledge and behavior; providing access to quality, relevant, and friendly counseling and health services; and empowering the community to address the underlying structural barriers that increase their vulnerability. All the while, program design must be predicated on protection of human rights, considering the specific needs and interests of the served population. Ensuring success in the four strategic areas poses one of the biggest challenges in intensifying the scale and scope of HIV prevention.

International Efforts

In 2001, during the UN General Assembly Special Session (UNGASS) on HIV/AIDS, a Declaration of Commitment on HIV/AIDS identified the prevention of HIV infection as the key response to the epidemic (see Box 1). To address crucial prevention issues, signatory governments to the 2001 Declaration committed themselves to a detailed set of targets and programs.

As follow-up to the 2001 Declaration, UNAIDS published the “Policy Position Paper for Intensifying HIV Prevention” in 2005, a key resource document presenting a set of principles for effective HIV prevention (see Box 2).

Similarly, Pathfinder International’s 2005-2008 Organizational HIV/AIDS strategy argues that effective HIV programming must (see Appendix A):

• Be based on evidence;
• Provide comprehensive and integrated services;
• Protect individual human rights;
• Provide universal access to quality HIV prevention, treatment, and care.

Despite the apparent political commitment demonstrated by these declarations, most governments failed to achieve the agreed-upon set of both international and national indicators by 2006. That year the UN’s new draft declaration voiced concern about the slow progress, but did little to demonstrate real political leadership in the fight against the pandemic. The document did mention the concept of “vulnerable groups” and proposed intensified efforts to eliminate all forms of discrimination and to ensure fundamental freedoms, as well as to scale up prevention, treatment, care and support efforts. But, by not naming the groups that have the highest vulnerability to HIV/AIDS, the UN Draft Declaration failed to address their specific needs and to counter the stigma and discrimination fueling the epidemic, thereby further violating people’s fundamental human rights.

Box 1. UN General Assembly Special Session on HIV/AIDS 2001 Declaration of Commitment

1. Prevention, care, support and treatment are mutually reinforcing elements, and must be integrated into a comprehensive response.

2. To stop the spread of the epidemic, the prevention goals set out in the Declaration must be achieved, and all countries must emphasize prevention in education, nutrition, information and health-care services.

3. Care, support, and treatment contribute to prevention through voluntary and confidential HIV testing, and by providing vulnerable people and those living with HIV/AIDS with health-care services, information, and preventive supplies.

4. Culture, family, ethics, and religion are important factors in prevention and in treatment, care and support, given the particularities of each country, as well as the need to respect human rights.

5. There are some negative economic, social, cultural, political, financial and legal factors that hamper awareness, education, prevention, care, treatment, and support.

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1 Press release: International Civil Society Denounces UN Meeting on AIDS as a Failure. <asia@healthgap.org>. 2006.
Likewise, although the 2006 Draft Declaration acknowledged the current feminization of the epidemic worldwide, conservative governments have prevented efforts to recognize the specific need to empower girls to protect themselves from HIV infection, e.g. through education and laws punishing rape and sexual coercion.

Some conservative governments continue to promote abstinence only and faithfulness programs, despite absence of scientific proof of their effectiveness. In fact, sound evidence shows that they cause infection and death by ignoring the need for youth and married women (two highly vulnerable groups) to prepare themselves for safer sex. To prioritize such strategies without promoting condom use promotes the spread of the AIDS virus and other sexually transmitted infections (STI). Such limited interventions are far removed from the reality of most countries and cultures.

Consequently, organized HIV/AIDS civil society groups and some governments have increased their own commitment to promote, maintain, and surpass the important achievements of past years. More than ever, acknowledgment of human rights and the recognition that sexuality and reproduction are included in those rights, must be the ethical paradigm, as well as the practical necessity, in the design, implementation, and strengthening of HIV/AIDS prevention interventions, particularly with vulnerable groups, like SW, MSM, and IDU.

**Strategies and Tactics**

**Thinking strategically - risk versus vulnerability**

In the first decade of the AIDS epidemic, the term “at risk group” was applied to those social groups in which the first cases of the disease were diagnosed - MSM, SW and IDU. Individuals thus labeled had their humanity questioned, were presented as the only ones susceptible to the disease, and were considered dangerous. As a result, the general population failed to identify themselves as “at risk.” Not surprisingly, that period was marked by limited drug research and large scale increase in social stigma and prejudice.

In the early 90s, the term “at risk group” drew criticism, particularly from the organized gay movement in some Northern countries, because it implied that all members of those groups were at risk, rather than that “behaviors” of some group members were risky. Instead, the concept of “risk behavior” emerged, pointing to specific characteristics and behaviors that could maximize the susceptibility of individuals to HIV infection.

Unfortunately the concept of risk behavior also has limitations. With its focus on the responsibility and protection of individuals, the concept does not take into account the sociocultural construction of risk. e.g., what in their environment drives people to take risks, (e.g., hiding their sexuality or drug use, getting paid more for sex without a condom, the power inequities in social and interpersonal relationships). More importantly, what in their environment can help them not to take risks?

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**Box 2. UNAIDS Policy Position Paper for Intensifying HIV Prevention, 2005**

1. All HIV prevention efforts/programs must have as their fundamental basis the promotion, protection, and respect of human rights, including gender equality.

2. HIV prevention programs must be differentiated and locally-adapted to the relevant epidemiological, economic, social, and cultural contexts in which they are implemented.

3. HIV prevention actions must be evidence-informed, based on what is known and proven to be effective, and investment to expand the evidence base should be strengthened.

4. HIV prevention programs must be comprehensive in scope, using the full range of policy and programmatic interventions known to be effective.

5. HIV prevention is for life; therefore, both delivery of existing interventions, as well as research and development of new technologies, require a long-term and sustained effort, recognizing that results will only be seen over the longer-term and need to be maintained.

6. HIV prevention programming must be at a coverage, scale, and intensity that are enough to make a critical difference.

7. Community participation of those for whom HIV prevention programs are planned is critical for their impact.
In 1996, with the publication of the book “AIDS in the World II,” Jonathan Mann and Daniel Tarantola introduced the concept of “vulnerability” and expanded the arsenal of knowledge necessary for a broader response to the epidemic in the social, economic, and political arenas.

According to UNAIDS, “risk can be defined as the probability of an individual becoming infected by HIV, either through his or her own actions, knowingly or not, or via another person’s actions. For example, injecting drugs using contaminated needles or having unprotected sex with multiple partners, Vulnerability to HIV reflects an individual’s or community’s inability to control their risk of HIV infection. Poverty, gender inequality, and displacement as a result of conflict or natural disasters are all examples of social and economic factors that can enhance people’s vulnerability to HIV infection. Both risk and vulnerability need to be addressed in planning comprehensive responses to the epidemic.”

In the prevention of HIV/AIDS, the influence of vulnerability is now widely integrated into the elaboration of strategic responses. This concept enabled a qualitative leap in designing prevention action proposals, since it shifts emphasis from the individual towards a careful look at the social/cultural context in which the subject lives, without overlooking his/her needs or rights.

The concept of vulnerability illuminates how inequity, stigma, discrimination, and violence can accelerate the spread of AIDS, as well as the reasons why some individuals or groups are automatically more vulnerable to HIV infection.

To better understand the influence of vulnerability on HIV infection, and to adequately apply it when designing prevention strategies, Mann and collaborators defined three interdependent and interactive vulnerability components:

- Individual vulnerability
- Programmatic (or political) vulnerability
- Social (or collective) vulnerability

**Individual vulnerability**

Individual vulnerability derives from personal behaviors, knowledge, and attributes that affect the possibility of preventing HIV infection. Such behaviors and attributes are linked to the social environment where individuals live, and they reflect a level of self-awareness and the potential power to change one’s personal behavior. Key factors related to individual vulnerability that can be effectively addressed by prevention interventions with SW, MSM, and IDU include awareness and behavioral factors, personal characteristics, and social relations (see Box 3).

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2 Oxford University Press.
Box 3. Vulnerability Factors to Address in Prevention Interventions

**Individual vulnerability involves:**

Awareness of:
- Reproductive and sexual health and sexuality;
- HIV transmission mechanisms;
- Condom availability;
- Health and education services, including counseling, voluntary HIV testing, and STI treatment;
- The right to services and confidentiality;
- Attraction to the same sex;
- Reproductive and sexual rights.

Behavioral factors, personal characteristics, and social relations, including:
- Emotional development;
- Ability to negotiate sexual practices, including safer sex and condom use, especially in situations involving age and gender inequities;
- History of discrimination;
- Self-esteem;
- Perception of risk and social norms;
- History of risky sexual behavior;
- Use of drugs, including alcohol;
- Perception of personal safety within the social environment and social networking.

**Programmatic vulnerability reduction involves:**

The availability of:
- Unbiased information/education on sexuality, sexual and reproductive rights and health;
- Diagnosis and treatment services for STIs;
- HIV testing and counseling linked to clinical services;
- Condoms and other prevention commodities;
- Health staff trained and sensitized to provide appropriate services to vulnerable groups;
- Health staff with knowledge, skills and comfort in talking about different sexual practices without judgment;
- Programs showing the risks related to sharing needles and syringes and addressing harm reduction and treatment with confidentiality for IDU;
- Implementation of the “three ones” approach* recommended by UNAIDS.

**Social vulnerability is:**

Enhanced by the presence of:
- Widespread stigma and discrimination against members of vulnerable groups;
- Significant gender inequities built into the culture and reinforced with social norms;
- Social values that restrict discussion/education around sexuality, particularly for adolescents;
- Dominant religious and traditional beliefs that closely monitor sexuality and gender relations and forbid and condemn commercial sex, same sex couples, or drug abuse;

Reduced by the presence of:
- Construction of a stigma and discrimination-free social environment;
- Effectively addressing issues of gender, sexuality, and poverty.

* Consultation on Harmonization of International AIDS Funding: End-of-Meeting Agreement, Washington, DC 2004: This agreement, reached by UNAIDS in collaboration with national HIV/AIDS programs, bilateral and multilateral donors, and civil society organizations, spells out the “Three Ones” principles for concerted AIDS action at the country level: Promote attention to sexual and reproductive health priorities within a coordinated and coherent response to HIV/AIDS that builds upon the principles of one national HIV/AIDS framework, one broad-based multisectoral HIV/AIDS coordinating body, and one agreed country-level monitoring and evaluation system.
Programmatic vulnerability
By their design, programs and services can increase or reduce vulnerability to HIV/AIDS among those people most susceptible. Programmatic vulnerability relates to the quality of information, education, and communication in a program, as well as the existence of quality medical and social services that are easy to access, periodically monitored and evaluated. Quality programs must adopt effective mechanisms to eliminate discrimination (see Box 3).

Social vulnerability
Social vulnerability incorporates those social factors that influence the capacity to reduce individual vulnerability. It focuses on policies and laws, like the criminalization of SW, MSM, and IDU in some countries. It also includes the sociocultural and economic environment and factors such as level of education, income, employment rates, equity status for women and minority groups, religious beliefs, race, sexual orientation, geographical or regional origin. For vulnerable populations like SW, MSM, and IDU, the key social factors to address are stigma and discrimination, gender, and sexuality. (See Box 3).

Stigma and discrimination:
Reducing the stigma and discrimination associated with both HIV/AIDS and a marginalized group is fundamental for any HIV prevention strategy. Stigma refers to a negative mark or characteristic differentiating some people from others. Such a mark may not be visible, and most often individuals are stigmatized due to their behaviors, physical attributes, or social conditions.

The driving forces behind HIV-related stigma include lack of knowledge, distorted beliefs or fears about HIV transmission, and collective denial that stigma exists. As a consequence, stigma is manifested on three different levels:
- Individual (guilt, isolation, shame, denial of HIV positive status)
- Programmatic (condemnation, expelling HIV+ children from school, HIV screening tests for job applicants, loss of job), and
- Social (punishment, exclusion, rejection, violence)

Especially in the health sector, stigma and discrimination against HIV-infected people and most vulnerable populations of SW, MSM, and IDU is serious. The health sector should therefore be one of the first places where concrete interventions against stigma and discrimination are undertaken.

Gender:
The idea that STI are primarily transmitted by women still prevails, despite the fact that it is easier for a HIV+ man to infect a woman than the reverse. Married women are frequently suspected if they ask their husbands to use condoms, which is probably why many women become infected with HIV.

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Box 4. Sexual Rights

- Right to sexual freedom is the ability of individuals to express their sexual potential. However, this expression excludes any form of coercion, exploitation, or abuse at any stage or situation of life. This is the freedom from any form of discrimination, independent of sex, gender, sexual orientation, age, race, ethnic origin, social class, religion, and mental or physical disabilities.
- Right to sexual autonomy, personal integrity and bodily safety, which involves one’s ability to make autonomous decisions regarding his/her own sexual life in a context of personal and social ethics, free of any type of coercion, torture, or violence.
- Right to sexual privacy allows an individual to freely act or behave regarding intimacy, provided s/he does not interfere with others’ sexual rights.
- Right to sexual pleasure, including self-eroticism, is a source of physical, psychological, intellectual and spiritual well-being.
- Right to sexual expression is much more than erotic pleasure or sexual intercourse. Every individual has the right to express his/her sexuality through communication, contacts, emotional expression and love.
HIV at home. Women testing positive during antenatal care are blamed, as the first in the household to be identified. Cultural norms condoning men having different sexual partners and refusing to use condoms contribute significantly to spreading HIV and are especially hard to change in most societies.

Gender and power inequities contribute to increased HIV vulnerability of individuals and groups. Women's position within the society, usually submissive to men, greatly increases their individual vulnerability to HIV/AIDS. In many countries and all regions, cultural and ethnic beliefs, taboos, and myths can place the woman in extremely vulnerable conditions. For example, in parts of Africa it is believed that when infected by HIV, a man can free himself from the disease through sexual intercourse with a virgin. Such beliefs lead to rape of younger women, girls, and even infants. These examples show us how power imbalance increases vulnerability for many people.

Sexuality:
Being mostly sexually transmitted, the HIV/AIDS epidemic reinforces the misconceptions that gay men, transvestites, transsexuals, and sex workers are responsible for transmission of the disease, and that anyone infected is promiscuous. Healthy development of sexuality depends on satisfaction of fundamental human needs, such as desire for contact, intimacy, emotional expression, pleasure, affection, and love.

Sexual health, as with health in general, must be understood as a basic human right based on freedom, dignity, and equity for all. All sexual rights should be recognized, promoted, respected and defended to ensure healthy sexuality and stop the AIDS epidemic (see Box 4). This will be important for the willing participation of those most vulnerable in HIV prevention programs.

Poverty:
The poorest people have the greatest probability of acquiring HIV/AIDS worldwide, since they are seldom reached by prevention strategies, have little or no access to counseling, treatment, and care services, and are discriminated against by society. While poverty increases HIV/AIDS vulnerability, the epidemic itself increases poverty among infected people, their families, and communities. Prevention programs should therefore give utmost priority to addressing the most destitute members of vulnerable populations.

Empowering communities to promote an enabling environment
To promote any change that is primarily social, effective organizing and networking of those affected is crucial. Networks of SW, MSM, and IDU must work to ensure their human rights and assert their own health demands and protection. Their alliances with public health, law and policy, and human rights communities are critical to reducing stigma and allowing them to emerge from isolation and hiding and receive the information, services, and resources they need. Networks and “ownership” of prevention programs lead to sustainable
behavior change in vulnerable populations. But where they are isolated, focusing on protecting their anonymity, information, and services must still be made available and strategies found to prevent their infection.

In some countries, conservative policies and political pressure have increasingly jeopardized important achievements in HIV prevention made in recent years. For example, many anti-condom campaigns have ties to conservative funders and religious or “cultural norms.” Where illegal activity increases vulnerability (use of drugs, sex work, homosexuality), harmful laws must be challenged if they block access to information and health care that are important to preventing HIV.

Working with SW, MSM, and IDU communities requires a community development approach. Understanding the principles of this approach helps to support organizing for prevention among vulnerable groups.

Community development interventions empower community members to undertake actions for local structural change actively. These interventions promote the potential social competencies of individuals, groups, and institutions so they can overcome structural barriers that, for example, deny sex workers and gay men access to resources and participation in social, economic, political and cultural relations. For effective results, community development interventions should promote interactions between individuals and their social networks to enhance social integration, social capital, and social inclusion (see Box 5).

### Empowering highly vulnerable groups

People living with increased vulnerability to HIV infection are as varied as the general population, differing in age, gender, education, and sexual orientation, in addition to having different occupations and professions. However, as discussed, some individuals and groups face greater stigmatization than others, independent of their HIV status. On the one hand, children, youth, women, and truck drivers, are generally not stigmatized by society, despite the fact that they face high individual, programmatic and social vulnerability to HIV/AIDS. They become stigmatized only when they are thought to be living with HIV or to have developed AIDS. On the other hand, male and female sex workers, MSM, and IDU are victims of strong social stigma, independent of their HIV status, and this ingrained and harmful stigmatization considerably increases their vulnerability to HIV infection.

The widening awareness and commitment of governments, donors, and NGOs to fight the AIDS epidemic has created an opportunity to overcome barriers, laws, and attitudes that keep vulnerable groups isolated. This new climate can bring those groups out of the darkness of “illegality” and “immorality,” and into the light, where problems can be solved on a human and realistic level.

All vulnerable groups must develop their own organizations for prevention and rights recognition. Such civil society organizations can give voice to the

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**Box 5. A Model for Community Empowerment**

Community development strategies focus on interactions between individuals and their social networks, which produce or reinforce:

- **Social integration or group cohesion,** with individuals motivated to belong to a group. Group cohesion is strengthened by the belief that the group helps to achieve specific objectives. Retention of individuals in the group will depend on the level of satisfaction that they get by participating in the group;

- **Social capital,** with groups interacting as networks in the pursuit of common social benefits;

- **Social inclusion,** with individuals, groups, and networks participating in decision-making, so that their rights are acknowledged, prioritized, and achieved.
community and develop a network of partnerships with other community-based and government entities. This may be the most ambitious intervention and, in the long run, offer the greatest potential for impact on community-led structural changes. It promotes all pivotal components of collective empowerment of vulnerable groups: social integration, social capital and social inclusion (see Box 5).

Each of these components forms an integral part of a total package of interventions. Many key activities are intended to overlap, and all are designed to address individual, programmatic and social vulnerabilities of the community served, including subgroups, such as brothel or street based SW, transgender individuals, bisexual men, or non-injecting or injecting drug users.

**Behavior change**

It is not easy to convince people that by changing their behavior they will reduce their vulnerability to HIV infection. Behavior change is a complex process that takes time. Individual choice cannot change behavior alone, but social and economic factors, such as gender, cultural norms, and poverty must be addressed as well. The majority of HIV/AIDS prevention programs have achieved little progress beyond raising basic awareness about HIV transmission and, to a lesser extent, promoting the use of condoms.

**Behavior change communication**

Despite large sums invested in programs of Behavior Change Communication (BCC) over the last three decades, the adopted public health communication model has not achieved significant changes in individual or collective behavior in Africa, Asia, Latin America, or the Caribbean. By focusing on the dissemination of information related to “healthy” behaviors, which is usually designed without the participation of vulnerable group members, these efforts fail to change attitudes and mold behavior by simply providing large amounts of information.

In addition to “information,” many messages focus on what someone “must do” or “must not do” (e.g. “always use condoms“, “never share needles,” etc.). Such a strategy not only dismisses the health-related needs of vulnerable populations, but also tries to assume control over the social body, with behavioral mandates doomed to failure. Somebody else’s “must do’s” seldom have meaning in the priorities and daily struggles of vulnerable communities. For example, if a female sex worker doesn’t know if she will have food that day to feed her children, or she can make significantly more money, she will agree to sex without a condom even if she knows she may get HIV.

Cultural sensitivity within the AIDS epidemic means listening to and respecting the cultural diversity of individuals vulnerable to HIV/AIDS: their life styles, sexuality, values, norms, and rules for daily living. The process of developing

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**Box 6. Talking Points and Hot Spot Calendar**

Pathfinder International – Mukta Project, Pune, India

Pathfinder’s Mukta Project has developed multiple tools for project planning and implementation with their team of sex worker peer educators. The first tool - a “Peer Educator Talking Points” flip book - provides pictorial guidelines to remind peer educators about the important messages to be discussed with their social network during regular encounters. The community helped to identify the important messages as well as the pictures to best represent the message. The size is small, can be easily concealed in the palm of the hand, and is also used for data collection and tracking the number of contacts made each week. The “Hot Spot Calendar” was designed and developed with the sex worker community to help them plan their weekly work, as well as to track the risks and vulnerabilities of each of the 30 sex workers that the peer is responsible for following. The sex workers identified the primary risks and vulnerabilities of their community and helped to design the pictures representing these factors.
communication campaigns and educational materials absolutely must include the participation of the groups to be reached, if they are to be relevant and effective (see Box 6).

**Behavior change beyond the individual**

Behavior change interventions must address individual as well as societal change. Strategies adopted should recognize the influence of the environment on personal motivation and practices, and the consequent need to link behavior communication interventions with providing other services and for creating a more favorable social environment. Therefore, collective action (meetings, campaigns, advocacy, social mobilization) must be promoted to overcome stigma and prejudice associated with vulnerable populations, questioning the social and religious norms that perpetuate gender inequalities, as well as traditional views about what it means to be a man or a woman.

On the other hand, behavior change messages for those who do not identify themselves as vulnerable to HIV infection are better channeled anonymously, through hotlines, web sites, and large awareness-raising events, such as International AIDS Day, gay pride parades, music festivals, International Women’s Day, among others. This is an effective way to raise awareness and “desensitize” the larger society to behaviors that are not always accepted as mainstream.

**Comprehensive, Quality Health Services**

In designing HIV-prevention interventions for vulnerable groups, their access to quality, comprehensive health services, such as management of sexually-transmitted diseases and HIV voluntary counseling and testing (VCT), must be ensured. Sex workers, MSM, and IDU should receive medical services from providers preferred/chosen by themselves -- private, if affordable, or at public services with health workers adequately trained to deal with these clients’ specific needs and interests (e.g. able to show respect, uphold confidentiality, etc.). At the same time, respect and confidentiality cannot replace discussing sensitive topics of interest and health, like sexuality and sexual practices, domestic violence, and sexual orientation. When inter-personal confidence between vulnerable groups and health providers is promoted and well-established, there is hardly any topic that cannot be the subject of interesting and health-promoting interpersonal dialogue. Effective providers and counselors need to be able to talk frankly about sensitive issues to address the real practices and behaviors that make HIV transmission more likely.

Actually, ingrained stigma and discrimination are constant impediments to appropriate interaction between health providers and vulnerable populations. An alternative is care delivery at specialized clinics, normally run by local NGOs (in countries like Brazil and Mozambique, these services are provided by the public health system). However, despite the assurance of a stigma-free environment and the reinforcement of social integration, these NGO services tend to be project-dependent and generally not sustainable in the long run. These specialized
services can also have the negative effect of perpetuating social stigma by portraying SW, MSM, and IDU as “risk groups” in need of segregated services.

Quality Care and Treatment
Treatment for sexually-transmitted infections (STI), opportunistic infections (OI) (including Cotrimoxazole for prevention of OI), and Highly-Active Anti-Retroviral Treatment (HAART) should be stressed. All providers must be trained in accurate diagnosis and treatment of STI (including Hepatitis B and C), and the need for regular blood tests and laboratory studies for SW, MSM, and IDU. IDU should be guaranteed prejudice-free and appropriate medical treatment for abscesses and other infections and potentially life-threatening reactions associated with their drug use.

Referrals and access to care and treatment for HIV/AIDS
Referral information, linkages, systems for voluntary HIV counseling and testing and medical services must be part of any prevention or support program for vulnerable groups. Expediting access to lab services (CD4 counts, liver function tests), psychological support services, nutrition counseling and supplements, social services, physiotherapy (including eliminating barriers of affordability), are necessary referrals and services. Providers should be both savvy and capable of helping navigate those systems. Peer educators/community members must not just provide information, but actually accompany their peers to the services to provide courage against stigma and fear. Critical information, such as the availability of Cotrimoxazole, or the dangers of TB and HIV co-infection, and how to access effective treatment, must also be provided.

In-service training and sensitization
In-service training and sensitization teaches health workers to take their cues from vulnerable groups regarding the services they need, rather than deciding for them. Vulnerable populations should be the key designers of their own services and programs, sensitizing service providers and managers to designing services that will not “miss the mark” and block access. Providers must learn how to provide appropriate care for specific groups, such as transgender individuals, and reduce stigma and discrimination at health facilities. Community members need to be able to talk openly about the fabric of their lives, and providers need to be able to listen and not mandate. Peer counselors should be available in clinics to act as liaison between MSM or IDU and providers if needed. In Pathfinder’s Mukta Project in India, the presence of trained sex worker paramedics in clinics has strengthened community ownership and involvement. This active engagement in the design and provision of health services is necessary not only for client comfort, but also to create systems they will accept and in which they can actively participate.

A regular supply of prevention tools – IEC materials, condoms (male and female) and harm reduction supplies is critical for effective prevention efforts. Strategies to provide free as well as socially-marketed condoms should be considered and discussed with the community. The provision of these prevention tools must be carefully integrated into the outreach and behavior change strategy, as well as easily available at clinics, local community/drop in centers, and all venues where the community members congregate.
Specific Strategies for Individual Vulnerable Groups

Sex workers

Sex workers have been associated with the HIV/AIDS epidemic since its onset, due to the nature of their work. Governments have long debated the advantages and disadvantages of regulation, prohibition, or tolerance of prostitution. The majority of today's societies present “moral” and contradictory objections to prostitution: e.g., on the one hand, some countries recognize the sex industry as an important source of commerce; yet, they condemn earning money through sex.

Some governments, donors, and NGOs place trafficking of women and children in the same category as prostitution. Not only is this not the case, but it makes working with sex workers very difficult, because it leads directly to the call for elimination of both, which threatens the livelihood and even survival of many women who have chosen to do sex work. It also compounds the stigma by putting children into the picture.

In many countries, like Canada, Thailand, England, and Brazil, everything related to the management of sex work (such as owning a brothel) is illegal, while being a prostitute is not illegal. These “tolerant” systems are hypocritical, as they exploit prostitution but make their class organization and the possibility of fighting for labor protection and health and political rights extremely difficult. An important step forward in this respect has been recently achieved in Brazil. Following the recommendations of the regional Latin American and Caribbean Consultation on Prostitution, held in Lima, Peru, in February 2007, the Brazilian National AIDS Program, in collaboration with the National Network of Prostitutes, the National Articulation of Transgenders, and the National Network of Transsexuals, has implemented the National Consultation on STI/HIV/AIDS, Human Rights and Prostitution. Given its past experience and commitment to the issue, Pathfinder representatives in Brazil were invited to be participants in this important and historic meeting. Main recommendations emanating from the consultation include creation of a multi-ministerial committee to initiate discussion on the issue, as well as commitment from the Special Secretariat for Women’s Policies, linked to the President’s Cabinet, to encompass the needs and interests of prostitutes (women, transvestites and transsexuals alike) into its strategic planning.

On the other hand, some governments, like Germany, Switzerland, Chile, and Austria, although regulating prostitution, place the industry under the control of the police rather than the mercantile codes. In Switzerland, a woman deciding to leave sex work needs to file a form in a police station and wait three years for a “good conduct” certificate.

In Greece and Austria, obligatory periodic medical certifications and compulsory HIV testing are barriers to female sex workers preserving their privacy and choosing their own preferred physicians. These medical certifications not only violate medical confidentiality, but also create a false sense of health protection from the State. In fact, they serve more to detect diseases rather than to prevent

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them. In other countries, where prostitution *per se* is illegal, like the USA (with the exception of the State of Nevada, where brothels and prostitution are legal, but regulated), even communication between two people with the intent of prostitution is considered a crime and can lead to long prison sentences. This creates hiding and isolation, compounded by an atmosphere of police bribery and coercion, which increases vulnerability to and spread of HIV.

The global movement for the promotion and protection of the rights of sex workers is initiating a new prostitution policy allowing sex workers to organize and represent themselves. In seeking the recognition of prostitution as a legal occupation, and defining their own professional activity and identity, prostitutes are stepping towards what is being called “self-determination of sex workers.”

*Increased HIV vulnerability for sex workers*
There are many factors contributing to HIV vulnerability for SW, which, if understood, can lead programmers to devise solutions that reduce risk and acknowledge the sex workers’ basic human rights.  

- As with MSM and IDU, health service personnel are rarely trained to provide services relevant to sex workers, including integrated services and responsiveness to their specific needs (e.g., where STI services for SW are provided apart from the general population, they reinforce stigmatization and do not meet the overall health needs of sex workers and their children and families. Difficulties in accessing public health facilities force sex workers to seek alternative healthcare treatment, mostly following traditional beliefs with no scientific basis and of minimal efficacy;
- Social marginalization associated with the life style of sex workers maximizes their exposure to violence;
- The clandestine nature of sex work makes the adoption of safer sex practices more difficult;

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• Gender inequality promotes submission to client pressure to engage in unsafe sex for more money, which makes safer sex difficult to negotiate;

• Lack of personal security in the working environment, and;

• High geographic mobility helps to interrupt accessing already established prevention and health interventions for sex workers.

**Effective HIV prevention strategies for sex workers**

HIV prevention programs for sex workers that focus solely on individual risk behavior won’t work unless the social context in which sex workers negotiate health behaviors is also addressed. While an individual sex worker may know about safer sex and have safer sex skills, she may also be plagued by perceived and real stigma, discrimination, and marginalization from community life and civil society. This social experience may undermine her self-confidence and ability to practice safer sex, particularly when confronted with ongoing resistance from sex partners (both commercial and regular partners) and economic pressures.

Conversely, HIV prevention interventions with sex workers can be highly effective, especially when strategies recognize their human rights, and the sex workers themselves play proactive roles in all program design, from strategy, to monitoring activities, to evaluating outcomes, to disseminating results. Sex workers should have a place on National AIDS Councils to provide their unique perspective and bring focus and action to their specific issues and needs, as well as to confront stigma among others responsible for AIDS policy and programs.

HIV/AIDS prevention among sex workers is greatly enhanced by strengthening their professional identity and by combating the male dominance (by brothel owners, pimps, clients, and partners) that overpowers this group almost everywhere. (In India, most brothel owners are women - generally former sex workers - but they tend to perpetuate the power structures they experienced during their own working years.) To achieve pride in their work, sex workers should be empowered to promote their own care and safety. In this regard, sex worker organizations are important tools for prevention, rights recognition, and addressing the occupational hazards of sex work.

The promotion of the female condom emerges as an important prevention strategy that recognizes the women as citizens and bearers of rights and obligations. The female condom increases autonomy in women’s professional activities, especially given the difficulties negotiating with clients reluctant to use the male condom.

**The role of peer educators**

Peer educators are generally accepted by their communities, are well-positioned to disseminate basic correct information regarding HIV/AIDS using a face-to-face approach, and can increase awareness about the epidemic and its effects on their lives. Peer educators can speak to the situation people live and work in, giving meaning to information and knowledge specific to group, sub-group or individual. Their presence favors real change in behaviors, beliefs, and attitudes.

Peer programs face real difficulties. Sex workers trained as peer educators may no longer consider themselves prostitutes, but want to view themselves as “health"
agents;” here is where self-stigma is revealed at its fullest.
Is it surprising that sex workers tend to take on the views of society, even when it includes self-condemnation? As a consequence, other sex workers then feel stigmatized and may stop being companions of the peer educators, losing the benefits of that relationship and becoming simply the target group of the project interventions. This is a dangerous development, as the peer educator gradually loses the social links that legitimize her interaction with her peers. Identification and training of peer educators, therefore, should take into consideration the existing intricate social networking of the community. Someone chosen as a peer educator must be able to withstand stigma and continue to stand with her peers and be given ongoing project support for that role. Peer educator and clinic provider training agendas should not only include technical aspects of the epidemic (medical, epidemiological, psycho-social), but must also discuss topics directly touching prostitution or MSM and IDU, as well as explore all the elements that make their lives so complex and challenging and make them targets for stigma and discrimination.  

For peer strategies to succeed, peer educators must accept their responsibilities as role models, adhering to skills and knowledge they have acquired regarding condom use with regular sexual partners and health seeking behavior.

**Supplemental skill building vs. “rehabilitation” of sex workers**
Experience has shown clearly that strategies that promote sex worker “rehabilitation” or “reintegration into society” offer a clear path to failure, since they reinforce nothing but self-stigma and prejudice. These strategies usually backfire and simply drive sex workers away and further underground, which enhances their vulnerability.

Unfortunately, this approach has been used too often in HIV prevention strategies targeting sex workers implemented either by government or civil society organizations and not run by sex workers themselves. It reveals an ingrained prejudice against sex work, while little or nothing is offered in terms of effective and sustained financial alternatives to sex workers’ life needs. Often, when sex workers return to their original families, they fall victim to even stronger discrimination and physical violence for the rest of their lives. On the other hand, offering trade and skills training to sex workers without strings, as a path to supplementary income and more economic independence (increasing her ability to reject unsafe sex), is not the same as offering these trainings as a way to “leave the trade.”

In some countries like Vietnam, rehabilitation camps are set up for sex workers and MSM who have been arrested. They receive some education and job skills.

training, but projects are generally under-funded, the job skills training obsolete, and there are few real alternatives to sex work offered. Overall, the experience reinforces stigma and isolation. Once discharged, most people return to sex work because they can’t make a living otherwise.

In India and Brazil, the operational experience of Pathfinder International has demonstrated that when sex workers feel free to talk with staff of prevention programs, many express excitement and satisfaction in doing sex work, because they are able to make a decent living and help themselves and their families.

Other actions that strengthen HIV prevention among sex workers include:

- **Community meetings**: Regular sex worker community meetings facilitate discussions about work, safety, and life issues affecting members of the group (police violence, inaccessibility of health services, safety with clients, care for children) and the development of action plans to confront these issues collectively. This activity is the most likely to guarantee the spontaneous formation of self-help groups. Health expert participation can be important initially to link social-survival issues and vulnerability to HIV infection. Also, health expert participation can support peer educators and counter the stigma that can make sex workers react negatively to peer comments and suggestions (e.g., self-stigmatizing feelings like “if you are one of us, we can get nothing useful from you”). Once sex worker groups realize their autonomy in their discussions and activities, there should be “a transfer of power” from the health or program expert to emerging leadership within the group.

To secure continued participation of sex workers in these community meetings, experts from related areas of interest (lawyers, social workers, beauticians, policy makers, journalists) should be invited, as they will broaden meeting discussions beyond medical issues and expose members to valuable information.

The frequency and timing of such meetings should be decided by the sex workers themselves, and amenities should be offered to participants (tea, soda, biscuits, etc.) Members should be encouraged to suggest themes for each discussion, so that all collective interests are addressed in the long run. Experience has shown that a balance of light issues (like beauty and fashion tips, and healthy cooking) with more substantial ones (safer sex practices, partner negotiation for condom use, legal assistance, gender-based violence) can keep the meetings from becoming too serious and potentially boring exercises. There should also be room for flexibility: if one participant wishes to discuss an urgent issue (e.g., domestic violence, internal community conflicts, drug abuse)9, it should receive priority - boosting group social integration - before moving into the scheduled topic of the day. Condom distribution should always happen at the end of the meetings, with the provision of individual quantities as requested.

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Ideally, community meetings should take place in a neutral “safe-haven,” but most often are held within health facilities, NGO offices, or the house of a sex worker. Whatever the venue, total confidentiality on what is discussed during these meetings must be ensured. Audio-visual equipment, including CD and DVD players, can play an important role in enticing sex workers to participate in the meetings, especially when they are also used for entertainment activities.

- **Encouraging artistic expression:** Videos and films can promote social integration with the external community, as well as strengthening sex worker organization. There is a long list of commercial films with sex workers as main characters that can be used to generate interesting discussion. Plays involving sex workers as actors to reinforce plot credibility are important to show sex work as work, to build self-esteem and self-acceptance, and to dialogue with the external community. They can also mobilize clients for safer sex if presented in public spaces. The humor derived from well-known, shared, recognizable daily situations can contribute to the assimilation of the information and reduction of self-stigma.

- **Skill-building workshops:** If responding to the interests of the community, these workshops (like literacy, beauty, fashion design and sewing, candle and soap-making workshops, making crafts, as well as opening of small businesses like market stalls or convenience stores) are very important in boosting self-esteem, promoting social integration and inclusion, and encouraging creativity. Additionally, the sale of products generated in these workshops is a potential source of income for sex workers, for sustainability of sex worker groups and associations, and for access to microcredit. Tutors or even “income-generating activity” enterprises can be hired or volunteer to conduct training sessions, including business skills.10

As in community meetings, skill-building workshops can stimulate group discussion and exchanges about gender issues, sexuality, and other vital topics of interest. Workshop tutors can be trained to facilitate this type of informal exchange. Condoms should always be distributed at the end of each session.

- **Community radio:** Although not commonly included in HIV prevention strategies with sex workers, the establishment of sex worker community radio is an easy, agile, dynamic and efficient channel for the dissemination of information to the community. What differentiates community radio from other commercial stations is the priority given to the interests and culture of a given group. In this case, sex workers and their organizations can adopt an ethical and political vision that supports the right of citizenship and the exercise of democracy for the group.

Programs broadcast by community radio are mainly educational, with a strong participatory approach, and with everyone in the entire community having the possibility of voicing his/her ideas and opinions. In most places in the developing world, low income populations, women and men of all ages, listen

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to the radio daily, so it is easy to understand the educational potential of community radio for disseminating quality, effective information on sexuality, reproductive health, HIV/AIDS prevention, and social integration of vulnerable and marginalized groups by reaching the broader community with the same messages.

- **Working with brothel owners:** In countries where sex work is often based out of brothels, it may be important to work with brothel owners, who can be appealed to at least around the profit motive, (if women stay healthy they can work longer and clients will stay healthy), and who may possibly hold independent concern for the health of the women. Without their participation, it is often difficult to reach the women initially, or for them to get permission to come out for health services or for gatherings. In the Mukta project in India, several brothel owners and Tamasha Dancer managers were recruited as peer educators. Winning their confidence, proving that the project has no ties with the police, and engaging them in the work of the project when possible is important. Of course there are brothel situations in many countries where no common ground can be found with the owners and other strategies for reaching the women are needed. Each situation must be looked at individually to find the best way to uphold the interests of the sex workers.

- **Working with clients and regular sexual partners:** HIV prevention strategies with sex workers usually pay little attention to the specific informational needs of clients. A 2002 study by Guanira and collaborators in Peru found that 44 percent of men aged 18-29 years had paid for sex in the previous year. Of these, 45 percent said they did not consistently use condoms with sex workers. A 2003 Brazilian study of 3,000 sex workers found that, despite the overall high rates of condom use with clients (65 percent and more), sex workers reached by HIV prevention interventions did not show any significant difference from the general female population in terms of constant condom use with regular sexual partners (around 20 percent).

Negotiating condom use with clients, and in particular with regular sexual partners, can be a difficult skill to exercise. Gender inequity, poverty, domestic violence, illiteracy, young age, and society’s expectations of “married” or partnered couples, all play significant roles in perpetuating vulnerability of sex workers to HIV infection, no matter how aware they are of the benefits of condom use and genuinely willing to use them.

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11 Tamashas are traditional dancers who leave their villages and work in stationary or mobile performance groups in theatres or meeting places that double as sex work venues.


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**Box 7. Pathfinder Challenges the Anti-Prostitution Pledge**

In September 2004, the Bush Administration moved to enforce against legislation passed in 2003 that requires all organizations receiving US HIV/AIDS funding to have an organization-wide policy opposing prostitution in order to receive government grants. The policy also restricts the types of activities that can be conducted in programs targeting commercial sex workers, but makes no distinction between an organization’s use of private or public funds.

Pathfinder International subsequently joined a lawsuit in 2005 to challenge these restrictions, maintaining that this policy could undermine critical HIV prevention activities by hindering programs that target and collaborate with commercial sex workers and other vulnerable populations. If left unchallenged, the restrictions could also have opened the door to similar restrictions around abortion. In addition, Pathfinder joined the case to protect: a) the right of organizations to use their private funds without government interference; b) the right of organizations to develop the most effective programmatic approaches possible in addressing the HIV/AIDS pandemic; c) the right to due process under the law, as guaranteed by the Fifth Amendment; and d) the right to free speech.

The court ruled in favor of Pathfinder and its co-plaintiff, Alliance for Open Society International, finding the restriction unconstitutional. The US government then issued new rules for enforcing the pledge requirement, which do not solve the constitutional problems identified by the court. As a result, Pathfinder’s court challenge continues.
Regular sexual partners are probably the most difficult group to reach with condom promotion and HIV prevention messages. They can be unaware of their partner’s work, or are aware and avoid any contact with it. Or, like many women, they can fall into the social norm that there is no place for condoms in marital or committed (“love”) relationships. In these cases, protection depends on the empowerment of SW to influence promoting condom use with their sexual partners, and on the impact of HIV prevention messages on the general male population. In other cases, husbands actively promote their wives’ activities and protection. For example, in India, some husbands take care of the children at night when the wives are working; in other places, the husbands solicit business for their wives. The direct involvement of these men makes it easier to approach them about safer sex and condom use along with their partners.

- **Reaching street-based SW with information and services:** Street-based SW are generally much more difficult to reach than those who are brothel-based, although this is less true where SW are more organized and are less self-stigmatizing. By definition, they work more alone, are more isolated and hidden, and they may come from another community and be invested in their anonymity. They may be more vulnerable to violence and less able to negotiate condom use. In fact, in India a street-based SW can be arrested just for carrying a condom, as this is seen as evidence of “immoral behavior.”

Special assistance can involve peer educators aware of their circumstances, who connect with them on the street. Drop-in centers allow them to find others to network with for information, emotional and social support, and referral to health services when needed, e.g., mobile clinic services near where they work.

Just as with SW themselves, clients of brothel-based SW are easier to reach than those who are street-based. In both cases, it is preferable to use SW peer educators to interact individually with clients, rather than involving men in group discussions, where the lack of privacy can hinder their participation. They should receive leaflets promoting condom use and STI/HIV prevention messages. Male group discussions can be effective when conducted in their work environment, with members of community organizations, or within associations or unions (e.g., construction workers; miners; police; soldiers and sailors; taxi, rickshaw, and truck drivers).

- **Addressing police harassment:** Sensitization workshops conducted regularly with police management and members can prove highly beneficial in the long run, even in contexts where prostitution is considered illegal. It may help to involve local MOH leadership in approaching the police for collaboration.

The police are key to preventing violence and other SW rights violations. Some may be personally engaged in bribery, coercion, and violence against sex workers. But, wherever possible, the role of police as protectors of citizens from abuse and injury should be the context in which to enlist their protection and cooperation, as well as engaging their support in slowing the spread of AIDS by ensuring a safer environment. Finding common ground and avoiding confrontational exchange is important for the success of this intervention. Topics for discussion may include HIV prevention, sexuality, gender issues, stigma, and discrimination.
Police must be sensitized to the importance of not harassing sex workers who distribute condoms for prostitutes and their clients - a frequent event that generally breaks down the motivation of well-intentioned peer educators.

• **Advocacy for the rights of sex workers as citizens:** To halt their disenfranchisement, projects should work to guarantee that sex workers are able to claim the benefits to which all citizens are entitled, such as identification or voter cards, national health insurance, the ability to get their children into state-run schools, the right to housing, to clean water, and to police protection for their safety. In some countries, sex worker organizations have been recognized by the state and are able to receive benefits to develop their activities.

• **Promoting social integration and interaction with the society in general:** Actively fighting stigma and discrimination in the society can have an enormous impact on the empowerment of sex workers. To improve the social environment around marginalized populations, collective spaces can be established for interaction and integration and partnerships built with one another and with other groups also wrestling with female discrimination (e.g., women’s and human rights groups).

The implementation of community-wide cultural and social events should initially focus on including those more “open” segments, such as university teachers and students, local artists, and members of other social movements. In the implementation of Project Encounters in the city of Corumbá, Brazil, monthly parties (“Hot Pink Parties”) were jointly organized by the local sex work association and the university community to break down social barriers. These social gatherings received much attention from the local media, and after some time, they became a hit among the city’s university students.

Large manifestations, parades, fairs, celebrations where possible, support sex workers’ assertion that sex work is work, and that they deserve occupational safety and dignity. The participation of government leaders, celebrities, and prominent women helps raise the self-esteem and protection and safety of the sex workers, and helps the broader community be more open to information about sex workers, and about their similarities with the community, rather than their differences. In India, participation of sex workers in “International Women’s Day” and other national holidays (e.g., Republic Day) has garnered the support and participation of civil authorities, police and “Bollywood” celebrities.

• **Establishment of sex worker associations:** It is crucial to encourage the establishment of sex worker organizations that can give voice to the sex worker community and develop a network of partnerships with other community-based and governmental entities. This may be the most ambitious intervention and, in the long run, offer the greatest potential for impact on community-led structural changes. It promotes social integration, social capital and social inclusion, all pivotal components of collective empowerment of sex workers. In many situations though, a country’s legal framework or donor interests do not allow prevention interventions on that organizational level. Therefore,
each environment will require specific strategies and tactics for collective empowerment. Project Encounters (Pathfinder do Brasil in collaboration with the Population Council) supported the establishment of a sex work association in the city of Corumbá, which was recognized as a “best practice” by the National AIDS Program. Three years after the end of the project, the association is still actively engaged in designing and implementing their own HIV prevention and human rights projects, supported through municipal, state and federal funds.

Men who have sex with other men

According to UNAIDS, 5-10% of HIV infections worldwide are estimated to occur through sex between men. Men who have sex with other men (MSM), like female sex workers, have always been associated with the spread of HIV/AIDS. This has led to even greater social stigma and prejudice towards homosexual practices than already existed before the epidemic.

After 25 years, the social representations that initially identified American homosexuals as HIV “core transmitters of the gay plague” or “victims of sin” still exist today and cause intense individual suffering and low self-esteem all over the world. The Vatican has often criticized the rise of gay rights as a potential threat to the traditional model of the family. In June 2006 the Holy See said that homosexual partnerships, along with a host of other practices, are to be seen as a sign of the “eclipse [the absence] of God,” maybe one of the strongest images ever used to scorn a community so completely. In some Muslim countries, homosexual acts are illegal and punishable with death, as in the hideous public hanging of two gay teenagers in Iran not long ago. The outcry of international civil society has not been able to reach deafened political and conservative religious ears.

Yet, it should be remembered that the homosexual community was the catalyst of the very first and urgent public response to the epidemic, beyond the scope of health services, reversing the social ideas that have erroneously associated men that have sex with men with promiscuity and disease. The actions of the homosexual movement focusing on HIV/AIDS prevention and care have been characterized by quick and broad mobilization of activists and sympathizers, for the creation of innovative and efficient strategies like safer sex workshops. They also raise issues related to diversity, free expression of sexual orientation, sexuality, solidarity, citizenship and defense of human rights.

16 Family and Human Procreation. The Vatican, June 2006.
The strength of the homosexual organized movement in pushing for human rights policies is best exemplified by the recent stance of the Brazilian government, which is currently implementing a multi-ministerial program entitled “Brazil without Homophobia,” coordinated by the Special Secretary of Human Rights, linked directly to the President’s Cabinet. The program, thoroughly designed with the active participation of the Brazilian homosexual movement, delineates a series of actions that different sectors (Culture, Justice, Health, Education, etc.) are expected to put in place to counter the effects of the homophobia that exists within society. It is important to remember that Brazil, despite the openness of its population to sexual issues, is one of the leading countries in the number of homophobic crimes perpetrated against gays, transvestites, and transsexuals.

MSM – not all the same

The term MSM has been coined as a way to describe a wide range of practices and identities. Very often, this concept does not contemplate the variety of manifestations of sexuality among men in a single country or context. In some countries, the gay, bisexual, and transgender social movements argue that the concept of MSM is discriminatory, since it does not recognize this diversity and the different specific needs in terms of health and human rights. It is therefore fundamental to differentiate the homosexual practices (when two men have sexual relations) with the homosexual identities (the way some groups express their culture and lifestyles and that fulfill the specific sexuality of these people). The idea that some men that have sex with men still consider themselves heterosexuals (or simply men) must be taken into consideration when designing messages for prevention interventions.

The linkage between these sexual identities and the values and meanings of masculinities must be considered to build a gendered understanding of these phenomena. Frequently, the concept of sexual orientation is related to a specific kind of social identity, that is known as the Western gay identity and lifestyle that may not have an equivalent in some countries. Very often, programs and projects focused on this population are based on the Western gay identity, and they fail to reach those people at risk who do not identify themselves with this specific way of living or expression. Even worse, some programs can spread widely the notion that people who are not openly gay (that is, do not have a Western gay identity) are a major source of HIV transmission, since they live ‘double lives.’ It is only with the proper understanding of these key issues that we will be able to design and implement prevention programs in tune with the social and cultural meanings of the sexuality and gender of the specific groups. Creativity is needed to build programs that contemplate all the needs and interests of the variety of people represented under the MSM concept, without any kind of prejudice and with a socially/culturally sensitive approach.
“In Brazil, the transvestite and transsexual organizations definitively differentiate themselves from the gay community on the one hand, and from the MSM concept on other hand. Their main argument is that sexual orientation does not apply to them, since they have a “feminine” gender identity. Many, actually, consider themselves female heterosexuals, having specific ways of socialization and networking. It is known that they have distinct health and human rights needs, since they usually are the more discriminated against group. In other countries, this issue probably appears with other meanings, but it is important that HIV prevention programs respect this assumption, and promote better visibility and access for the transgender community. A recent policy related to the Brazilian health system guarantees that individuals be registered at health facilities using their social name (Mary, for example) instead of the name appearing in their national identity card (John, for example).

Situations that increase the vulnerability of MSM to HIV

- Homophobia (be it within the family or community circles, such as school, work, church, sports, and many other environments) is undoubtedly the most important factor contributing to the high vulnerability of MSM to HIV infection, and it is one of the primary obstacles to effective HIV prevention among this group;

- The low self-esteem, due to the negative values imposed by society on homosexuals, increases the likelihood of risky sexual behaviors, like cruising in isolated and dangerous places for casual sex, and being prey to police violence, theft, and even murder;

- Often, men who practice occasional homosexual sex do not, because of stigma, recognize themselves as homosexuals or bisexuals. This increases their vulnerability to HIV/AIDS, since they do not feel susceptible to the infection and, being outside of the MSM community, don’t have access to relevant preventative information;

- The gender role assignments that classify people’s sexuality as “active” and “passive” also interferes with the negotiation between male partners regarding condom use. Often “active” sexual partners refuse to use a condom, since they consider themselves heterosexuals;

- As discussed above, health services are organized without any input from the MSM community, and negative and punitive provider attitudes are not challenged or changed. Therefore services cannot address the particular needs, interests, and vulnerabilities of gays, transvestites, and transsexuals;

- Social and political organizing of MSM is very difficult in strongly homophobic or culturally conservative societies. Even establishing their own organizations to provide information that they can’t get from health services, or organizing forums for discussion and designing structural actions are all extremely difficult;

- Most MSM are also married and must live a hidden double life, which increases their own vulnerability as well as that of their wives and children. Recent studies in districts of Maharashtra, India show a range of 63-81% of the MSM as married;

Recent studies in districts of Maharashtra, India show a range of 63-81% of the MSM as married;
• Adolescent homosexuals are much more prone to physical abuse, discrimination at school, and domestic violence. Also, the recent improvements in AIDS-related morbidity and mortality due to more accessible treatment have caused a dangerous trend in reduced condom use among young gay men;

• Educational materials for HIV prevention, as well as mass campaign messages, are mainly directed at the heterosexual population, creating the false impression that homosexual intercourse is risk-free. A recent study conducted with truckers in India has shown that the message about female sex workers transmitting AIDS has been so effective that even “heterosexual” men prefer to have sexual relations with a man so they won’t be exposed to AIDS;

• Very low visibility of homosexual behavior in all male environments, like prisons, factories, mines, and military settings, which adds to the lack of political commitment in addressing MSM;

• The return in some countries, of the “bare-backing” (unprotected sex) practice between MSM, who knowingly expose themselves and their sexual partners to a higher risk of HIV infection;

• In the specific case of transvestites and transsexuals, deep social stigma excludes them and limits their job opportunities and acceptance in society, further increasing their vulnerability to HIV infection;

• Additionally, the use of silicon for body modeling may place transgender individuals under increased vulnerability due to the conditions under which such procedures take place. Usually, industrial silicon is injected at home, where sterilization of syringes and needles is not always done adequately, causing possible infection with HIV and other pathogenic organisms.

**Effective HIV prevention strategies for MSM**

Just as for sex workers, HIV prevention interventions for men that have sex with men should focus on:

• Behavioral interventions to promote safer sexual practices, especially those related to constant and correct condom use with all sexual partners (fixed, occasional, clients, women, wives, etc.);

• Guaranteeing equal access to comprehensive, quality, appropriate, health services, e.g., VCT, care for both HIV-positive and negative persons, prevention services for both HIV negatives and positives, potentially together, integration of prevention and treatment, and referral to other specialized services (psychological, physiotherapy, laboratory, STI services, etc.);

• Improvement of community development indicators, principally those related to social integration (e.g., counting on friends when medical services, money, shelter, or discussing police violence, etc., are needed);\(^{18}\)

• Development of educational and informational materials, addressing human rights alongside health issues. However, given the diversity of the various expressions of homosexuality (openly gay men, “closeted” gay men, bisexuals,

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\(^{18}\) AIDS and Men who have Sex with Men: UNAIDS Point of View. Best Practice Collection. UNAIDS, July 1998.
transgender or transsexual individuals, adolescents and older men, etc.), messages, and approaches may differ substantially for each specific group;

- Promotion of safe sex workshops. These were first initiated by the American gay community at the onset of the epidemic to disseminate a set of sexual practices and care components that would diminish or eliminate the risk of HIV infection. Such workshops are still one of the most effective ways to reduce vulnerability of MSM. The implementation of such meetings should be broadened in scope, and also cover structural issues that may be of interest to participants, like domestic and police violence, discrimination at school and in the work environment, relationships, bisexuality, marriage and fatherhood, living with HIV/AIDS - all examples of topics that can generate lively and critically important discussions.

The ultimate goal of these safer sex workshops is to move gradually from a gathering of individuals discussing safer sex practices and coping mechanisms into a more cohesive and empowered group that can jointly elaborate action plans to confront complex collective issues. Of particular importance is the implementation of meetings with adolescent gay men, where they will find a safe haven to openly share their inner feelings of discovering sexuality in a social and religious environment that constantly bombards them with guilt and shame. Effective strategies for emphasizing constant and correct condom use and water-based lubricants among adolescent gay men are particularly important.

In the beginning it is very likely that such community meetings will be only attended by openly gay men (the minority), while those still not comfortable with their sexuality (the majority) will feel more reluctant to participate. In this respect, peer face-to-face interventions in cruising areas (bars, bathhouses, parks) can play an important role in the accessibility to condoms and educational materials by a greater percent of the homosexual community. Selection and training of peer educators should be tackled with the same care as described above for sex worker peer educators.

- Training and sensitization of teachers on issues related to sexual diversity can help them review their vision and opinions on homosexuality and provide counseling and support to MSM adolescents to decrease their vulnerability. They can also collaborate through their work - in and out of school - in the eradication of social prejudice against MSM and promotion of tolerance. Likewise, they can work with parents to accept and support their children and their sexual orientation to keep them safe. Teachers are in a good position to be effective in this effort. They are invaluable in the design of educational material specifically addressing issues of interest to the MSM community (condom use, HIV voluntary counseling and testing, human rights, self-esteem, etc.) In Brazil, Pathfinder is embarking in an important partnership with the Ministry of Education, the National Association of Gays, Lesbians, and Transgenders, and two other local partners to implement a project addressing homophobia in the public school system. Planned activities include the implementation of nationwide qualitative research to assess levels of homophobia among students, teachers, and educational material currently in use, as well as the design and distribution of informational kits addressing topics of homophobia to 6,000 schools in the country;
• Just as for SW, police harassment against MSM can be reduced through sensitization workshops conducted with police members, even where homosexuality is illegal. Here as well, topics for discussion may include HIV prevention, sexuality, gender issues, and stigma and discrimination. The role of the police in protecting citizens from all sorts of abuse should be acknowledged, avoiding any type of confrontational exchange. However, as with SW, some police in some countries rob MSM and have forced sex with them on threat of violence, and this needs to be urgently addressed;

• Support to political manifestations of the homosexual community, like Gay Pride parades and rallies - in countries where homosexuality is not considered a crime - can greatly increase visibility of gay men and foster discussions on public policies to curb social homophobia. These events are also important spaces for the promotion of self-care, citizenship, and self-esteem. In Brazil, for example, the National HIV/AIDS Program annually allocates significant funding to support dozens of Gay Pride parades all over the country, as part of its rights-based policy.

**Male Sex Workers**

Addressing the specific needs and interests of male sex workers can further reduce the vulnerabilities of the general MSM population. In general, male sex workers tend to be either bisexual men or transgender individuals, and different approaches should be designed, depending on the target group being reached.

For both male and female sex workers, focus should be put on negotiation skills for condom use, avoiding or organizing against police harassment, and establishment of self-help groups. On the other hand, social stigma and prejudice make clients of male sex workers much more difficult to reach than those of SW. Male sex workers can be trained to be the main providers of HIV prevention messages to their clients.

Finally, it is effective to establish organizations of MSM, encouraging them to have a key place in HIV prevention and care programs. More importantly, these MSM community-based organizations should be encouraged to help define advocacy interventions leading to the de-criminalization of same-sex acts between consenting adults, as well as the passing of antidiscrimination policies against human rights violations based on sexual orientation. Networking is not only the right thing, but is the only way to empower them to decrease HIV transmission among MSM. These organizations should also be assisted in their efforts to lobby governments, National AIDS Programs and donors to include MSM in their HIV programming and funding priorities.

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Injecting drug users

It is widely recognized that injecting drug use plays a very important role in the HIV/AIDS epidemic, principally in Asia, Eastern Europe and the United States. In some countries, especially in Eastern Europe, and South East Asia, HIV infection primarily linked with drug use surpasses that linked to sexual transmission.

According to UNAIDS, injecting drug use is estimated to account for nearly one-third of new HIV infections outside sub-Saharan Africa, but less than 8 percent of injecting drug users are reached by HIV prevention services. Unfortunately, the scaling up of HIV prevention and -- even more so -- care and treatment for drug users is lagging behind in the overall AIDS response. Drug use is increasing in Africa, LAC, and other regions with related increases in HIV infection. Even where injecting drug use is declining in favor of other forms, high rates of unplanned sex with multiple partners continue to increase drug-related HIV.

Various studies from the United States and Europe have suggested that drug users are responsible for the majority of heterosexual transmission of HIV outside of Sub-Saharan Africa. Yet, while broad AIDS prevention campaigns have so far focused on sexual behavior and promotion of condom use, those interventions addressing drug users have been mainly focused on drug-injecting behavior. Consequently, these efforts have been able to reduce needle sharing but have failed to reduce risk-taking sexual behavior. Drug users continue to engage in unprotected sex even if they are aware of the risk of HIV transmission. This is particularly true in relation to steady sexual partners over casual sexual partners.

Illegal drug use is a social problem and should be dealt with as such. Excessive reliance on law enforcement and punishment is particularly counterproductive to decreasing high HIV transmission among IDU, as they are driven to hide, have no access to health services or information, and for other reasons stated above for SW and MSM.

Overall, injecting drug users belong to the most underserved group of civil society because of the high number of low-income people using illegal drugs in a more intensive and damaging manner. They are confronted with the illegality of their activities and stigmatizing attitudes, and those involved in severe drug consumption face great barriers to integrating socially and in the work world.

Factors such as poverty, limited opportunities, and repressive, punitive and discriminatory prevention policies increase the vulnerability of such groups to HIV/AIDS. Injecting drug use is increasingly common among sex workers, and that double risk warrants effective programming, addressing both risk factors with each group.

Situations that increase the vulnerability of IDU to HIV infection

- Sharing needles and syringes infected with the virus;
- Inadequate cleaning of needles and syringes belonging to different IDU kept in the same container can promote transmitting not only HIV, but also Hepatitis B and C;
- Unprotected and multiple-partner sexual practices that can accompany drug use, abusive alcohol consumption, and transmission to non-IDU partners;
- The legal framework adopted in the great majority of countries criminalizes drug use and contributes to sustained high levels of social stigma and discrimination against drug users, necessitating hiding, isolation, and moving underground;
- Lack of, or inadequate, HIV prevention messages specifically designed to address the very different needs and interests of IDU;
- Pathfinder’s VCT program in Moldova has seen difficulty with testing for IDU due to sensitive veins, or their not wanting blood to be drawn and not being considered a good bet for adherence. They are more likely to be passed up for ART and/or not provided additional needed support.

Effective HIV prevention strategies for IDU

Traditionally, three strategies have been adopted in the control of drug use, although only the last has proven effective for HIV prevention programming among IDU:

- **Offer reduction**: Actions by government and law enforcement to eradicate plantations, combat money laundering, stop drug shipments across and within borders, and generally try to reduce supply. However, the “War on Drugs” has not reduced the number of drug users, but has generated lots of crime, graft, official corruption, and driven drug users further underground.\(^{26}\)

- **Demand reduction**: Actions to diminish drug initiation and consumption, and making treatment available to addicted users – to reduce demand for drugs, e.g., methadone maintenance programs.

- **Harm reduction**: Actions to prevent harmful consequences to the health of users and their partners, BEFORE offering treatment and other alternatives to drug use.

Harm reduction is based on the assumption that reducing harm to the health of drug users (HIV transmission, Hepatitis B and C, and death by overdose), their families and their communities is primary (first things first!) before attempting to stop the drug use. Harm reduction is not focused on stopping drug use, but how to use them safely. As mentioned before, social behavior is not easy to change, particularly when physical addiction is added into the mix. So preventing harm

\(^{26}\) 14.7/100,000 people in the US are infected with HIV, and 25 percent of those are IDU. (World AIDS Conference, Toronto, 2006).
and infection should not wait until the behavior change has been completed. IDU should be able to access health services and information about HIV and other deadly infections openly and without fear and then be offered treatment and other social opportunities, as opposed to punishment, which drives people away from help and services.

One example: the Vietnam Government recently adopted a national policy of combined demand reduction and harm reduction, and made it a crime to harass IDU’s or sex workers who are trying to access preventive services.

Although the concept originated in England in 1926, it was in Holland, during the 1980s, that harm reduction interventions were effectively implemented by an association of drug users concerned with the high rates of hepatitis among IDU. As high rates of HIV prevalence among injecting drug users began to emerge in various countries, harm reduction became an important element in HIV prevention efforts as well.

Harm reduction is the most effective, (including cost-effective), approach to prevention of HIV/AIDS among drug users and has been widely and officially accepted across many countries, with notable exceptions (including the US). The strategy intends to reduce health damage in users who can not, do not want to, or are not able to stop using injecting drugs, and therefore share used needles and syringes and expose themselves to HIV/AIDS infection. The scope of harm reduction interventions is very broad and not only focused on the distribution or exchange of syringes and needles. In fact, harm reduction interventions can successfully be implemented with users of non-injecting drugs, like alcohol, marijuana, cocaine, crack cocaine, and others.

The intent of this approach is to minimize the preventable harm that can be inflicted with drug use, injecting or not. If drug users can access clean needles, or bleach to clean their needles and syringes without fear of imprisonment, then they can be reached with other services, including STI/HIV prevention, detoxification and/or drug substitutes.

In some countries, the cheaper and more addictive crack has replaced the use of injecting drugs. If risk of HIV infection through the sharing of syringes and needles has diminished in these settings, risk of infection through unprotected sex while high from drugs is still significant and should be addressed appropriately. Consequently, safer sex workshops are also of fundamental importance in reducing vulnerability of drug users to HIV infection and should be part of the role played by harm reduction agencies.

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The selection and training of qualified harm reduction community and facility agents is made more difficult by additional requirements. Besides gaining proficient knowledge of issues related to HIV prevention, sexuality, drug addiction, and interpersonal communication, they need to enjoy the total acceptance and trust of the group they serve and be free of all signs of prejudice. Additionally, they need to be trained in special skills on how to deal with dangerous, sometimes life-threatening situations, like police raids and intimidation from local drug dealers. Successful harm reduction programs have made use of ex-IDU as peer educators.

Promoting Harm Reduction: Harm reduction interventions can work more effectively if concomitant use is made of the following activities:

- Provision of information on how HIV is transmitted through sharing of injecting equipment or relaxing safer sex practices while intoxicated;
- Provision of free sterile injecting equipment, or needle exchange, and condoms;
- Bleach distribution programs.

The role of advocacy and social mobilization
As reported by UNAIDS, effective strategies to address HIV prevention among IDU are highly controversial in many countries. Thus, it is essential that interventions aiming at successful results include substantial efforts to overcome community fears and government concerns about the proposed initiatives. This can be achieved through well-designed advocacy and social mobilization interventions at various levels. Normally, it is useful to initiate those at the community where prevention interventions will be carried out, through formal and informal meetings, public information campaigns, involvement by programme managers in multisectoral AIDS and drugs committees and, in most cases, by carefully building relationships with selected representatives from the mass media.

Pathfinder’s experience in Brazil, working in collaboration with the Centro de Estudos e Terapia do Abuso de Drogas (CETAD) in Salvador, has shown the importance of addressing needs and interests of the whole neighborhood rather than just drug users individually. The adopted approach strengthened a wide range of services that, once established, provided a comprehensive set of drug and HIV-prevention activities as well as general health and social assistance. While the main objective was to provide services to injecting drug users, crack smokers and other non-injecting drug users, services also reached out to their families, sexual partners, neighbors and other people living in drug-using neighborhoods to increase understanding of drug users and increase social integration to support risk reduction.
In addition, the following interventions can enhance impact of HIV prevention among drug users:28 29

- Programs of peer educators, educated on all issues of STI and HIV transmission associated with injecting and other drug use/abuse. Peer educators should work in all places where IDU gather and live.

- Inviting IDU and ex-IDU into community development activities, and into planning and delivery of health services for IDU, so they become part of the solution and insert their perspective on the real problems and how to resolve them.

- Training health providers to root out stigma and provide confidential space for drug users to discuss their real health issues, so their vulnerability can be effectively addressed.

- Social mobilization activities, like soccer tournaments and music workshops, provide opportunities for a closer interaction between drug users and the population living in the same neighborhoods, greatly contributing to the reduction of social prejudice and stigma.

- Organization of meetings with parents and spouses of drug users to discuss issues like addiction, HIV/AIDS prevention, care, treatment, and support.

- Demand and develop drug treatment programs with no waiting time or cost barriers, and follow programs to support reintegration and act as safety nets.

- Involve local community health workers/agents in harm reduction strategies, which promote confidence among drug users to seek care at local health facilities.

- Make referrals to specialized medical, psychological and legal services, (with no fear of reprisals) and, if possible, providing support for transportation.

- Given the reluctance of drug users to seek services at specific facilities, the use of mobile harm reduction services can be highly effective in providing IEC messages and prevention commodities (condoms, syringes and needles) at the community level.

- Sensitization meetings with police to curb unnecessary violence towards drug users and the community where they live or gather.


Appendix A.

Pathfinder International Organizational
HIV/AIDS Strategy 2005

Principles for Action

1) Evidence-based programs and international standards inform Pathfinder’s principles and practice that all offices adhere to, while at the same time allowing for flexibility to innovate and take on new challenges according to cultural contexts. Pathfinder’s standards are based on scientific evidence and decades of experience in the countries in which we work.

2) Comprehensive and integrated approaches in facilities and in the community will be programmed, promoted, and linked to one another. Integrating sexual and reproductive health (SRH), including family planning (FP), and HIV/AIDS services expands the capacity and efficacy of health services by acknowledging a broader spectrum of interrelated health needs within the community. Pathfinder strives to make existing FP/ SRH/ MCH programs “AIDS competent,” while all HIV/AIDS programs address the broader FP/ SRH needs and rights of their clients. FP (especially dual protection with condoms), emergency contraception, and access to safe abortion services are key elements of HIV/AIDS programs. Providers of SRH will also be trained on the specific needs and interests of vulnerable groups, emphasizing gender, sexuality, and reduction of stigma and discrimination. There will be no separation between STI management and HIV/AIDS programs, as STI counseling, prevention, and management are some of the most effective HIV prevention interventions.

3) Rights protection for all people will be upheld, regardless of HIV status. The destructive potential of HIV/AIDS is greatly magnified among communities that have the least protection of their human rights. These include women, youth, SW, MSM, and IDU. A rights-based approach to HIV/AIDS activities provides vulnerable groups with additional tools to protect themselves and others against HIV, and helps to cope with the far-reaching impact of the epidemic. Pathfinder seeks to articulate and integrate human rights protection into its SRH and HIV/ AIDS strategies to effectively address the needs and rights of people affected by the epidemic, while also guaranteeing the full participation of people living with HIV/ AIDS (PLWHA) throughout program and services planning, implementation, and evaluation processes.

4) Universal access to accurate and high-quality prevention, voluntary counseling and testing (VCT), care, support, and treatment services should be available for all who need them. This includes support for the development of sustainable and affordable anti-retroviral treatment (ART) and opportunistic infections (OI) treatment, including the use of WHO-approved generic drugs, in order to increase access to treatment.
# Appendix B.

## Pathfinder International HIV/AIDS Interventions with Vulnerable Groups

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<th>Project</th>
<th>Target Populations and Regions</th>
<th>Key Interventions</th>
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<td><strong>INDIA</strong></td>
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| **Mukta** 2004 to present | 14,000 FSW and 6,000 MSM in 11 districts of Maharashtra | • BCC and outreach through trained peer educators delivering STI and HIV/AIDS prevention messages and condoms, using pictorial education tools; peer educators attend national and international AIDS conferences.  
• Provide access to quality STI treatment through: 1) project-run health clinics; 2) outreach medical visits by teams of physicians, nurses, and trained paramedics from the sex worker community; 3) linkages with local physicians trained and sensitized by the project and with a project-run mobile clinic.  
• FSW and MSM trained and organized for community education and skills training. Statewide steering committees of FSW and MSM plan/implement events.  
• Individualized MIS system tracks sex workers.  
• Increased access to social entitlements (ration cards, voter IDs, etc.)  
• Advocacy with police, media, etc. to decrease violence, harassment, and discrimination.  
• Intensive capacity building and sensitization training for partner NGOs with a system of monthly monitoring and feedback. | Bill and Melinda Gates Foundation |
| **BRAZIL** | | | |
| **Pathfinder do Brasil** | “Encounters” – Prostitutes in Corumba, a city attracting thousands of transient fishermen “Se Ligue” – young gays & lesbians in Salvador, Bahia | • Established an association of sex workers as a local NGO, receiving municipal, state, and federal funding. Activities:  
   o Fashion/beauty workshops, music/dance festivals, safer sex workshops, self-esteem promotion, peer education activities, strategic planning exercise, sex-worker friendly health workers.  
   o Considered “best practice” by Brazilian HIV/AIDS Program (NAP).  
• Established a safe haven for young gay men, social integration and social capital activities, peer education, self-esteem promotion, safer sex workshops, personal counseling, group activities. Many members become social activists. | Population Council, NAP, Brazilian Network of Prostitutes, State & Municipal HIV/AIDS Coordinations Gay Group of Bahia |
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| **Pathfinder do Brasil, continued** | “Communidade” Drug users in Salvador, Bahia | • Established safe haven for drug users; promotion of awareness and adoption of harm reduction behaviors, including safe sex.  
• Activities, including community soccer championships, handcraft workshops; workshops for spouses of drug users; referrals for medical and psychological support.  
• Considered a “best practice” by UNAIDS. | Harm Reduction Association, Fátima Cavalcanti |
| | Collaboration with national networks representing people vulnerable to HIV/AIDS | • Pathfinder do Brasil provides technical assistance in building capacity and strategic planning for partners in the National AIDS Program, including Brazilian Association of Gays, Lesbians & Transvestites, National Articulation of Transgender Persons, Brazilian Network of Prostitutes, Brazilian Network of Harm Reduction, Brazilian Association of People Working with Harm Reduction, and Brazilian Network of Female PLWHA. |  |
| **MOLDOVA** |  |  |  |
| **Preventing HIV and Hepatitis B and C**  
2006 | The general population, vulnerable groups such as IDU, Sex Workers, and Migrant Workers | • Provider trainings include VCT TOT, and VCT covering stigma and discrimination.  
• Provide M&E tools and referrals sensitive to vulnerable groups.  
• Establish VCT sites at major health facilities through recruitment, training, operational, and material support.  
• Provide training in advocacy for policymakers. | USAID, EMG |
| **KENYA** |  |  |  |
| **APHIA II – Nairobi and Central Provinces**  
2006 | Female Sex Workers (FSW) and CSW | • HIV sensitization of FSW by PLWHA advocates with VCT encouragement and referrals to services.  
• BCC/IEC advocacy to increase self-risk perception and increase uptake of services and care and support of PLWHA.  
• Condom use, supply and negotiation with clients. | USAID, MOH, Linked PLWHA to support groups at KENWA |
| | Men away from home | • HIV sensitization at workplace by PLWHA advocates.  
• Linkages to Mobile VCT. | USAID, MMAAK – for MVCT services |
| | Administration Police and Police College | • HIV workplace advocacy to encourage health-seeking behavior, status disclosure, and uptake of services. | Provincial administration (DC, AP management) |
| | Prisoners, warders, other prison workers | • HIV sensitization and mobile VCT services; condom use demonstrations.  
• Workplace advocacy.  
• IEC materials distribution.  
• Form support groups. | USAID, MOH, Prison management |
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<tr>
<td><strong>APHIA II, continued</strong></td>
<td>Internally Displaced Persons</td>
<td>• CHW care and support (counseling, food, shelter).</td>
<td>Provincial administration, MOH</td>
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<td><strong>MOZAMBIQUE</strong></td>
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<tr>
<td><strong>100% Vida e Inclusao</strong> 2007 to present</td>
<td>FSW, MSM, and IDU</td>
<td>• Rapid geographical assessment to gather information related to sex worker and drug user behaviors. Select and train peer educators. • Provide VCT, including mobile VCT. • Distribute male and female condoms to internally displaced persons. • Provide referrals to other health services. • Train health providers; provide STI drugs not provided by MOH.</td>
<td>Population Services International, UNFPA, CDC</td>
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<td><strong>ETHIOPIA</strong></td>
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<td><strong>Integrated Youth-Friendly RH/FP &amp; HIV/AIDS Prevention</strong> 2005 to present</td>
<td>Youth and CSW in Gondar Town, Amhara</td>
<td>• Provide information on HIV/AIDS and STI prevention, control, and management. • Distribute condoms including through non-traditional channels. • Provide home-based care to very poor PLWHA. • Give referrals for VCT and STI treatment. • Provide ASRH information through peer promoters and youth center efforts.</td>
<td>SIDA</td>
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<tr>
<td><strong>AIDS Prevention Program for Commercial Sex Workers</strong> 2005 to present</td>
<td>CSW in Addis Ababa</td>
<td>• Counseling and education in HIV/AIDS prevention; use peer promoters. • Refer for STI diagnosis and treatment. • Provide home-based care. • Refer for VCT and ART. • School support for Orphaned and Vulnerable Children (OVC). • Income-generating activities for CSW.</td>
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<td><strong>Holistic HIV/AIDS Prevention and Control Program</strong> 2005 to present</td>
<td>Women (including CSW) in Dira Dawa</td>
<td>• Provide HIV/AIDS/STI education and counseling services. • Provide home-based care to the chronically ill • Refer for ARV and VCT. • Provide support/training to OVC and destitute women.</td>
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<td><strong>VIET NAM</strong></td>
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<tr>
<td><strong>VIET NAM HIV/AIDS Prevention, Care and Treatment: Forging Public-Private Linkages</strong> started in 2004</td>
<td>General population, esp. SW, MSM, and PLWHA.</td>
<td>• Strengthen training capacity of public sector in STI case management and HIV/AIDS counseling to reduce stigma. • Counseling and care to PLWHA. • Strengthen private providers and pharmacists/drug vendors in STI/HIV/AIDS &amp; standard precautions/infection prevention. • Provide IEC/BCC materials and STI/HIV/AIDS prevention and care services.</td>
<td>Buffet Foundation, Dutch Vietnam RPD TCV Health Program</td>
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| VIET NAM HIV/AIDS Prevention, Care and Treatment, continued            |                               | • Provide condoms for clients who visit project-trained private providers.  
• Provide essential equipment to public and private clinics.  
• Support private sector engagement in HIV/AIDS prevention, care/treatment services. |          |
| NIGERIA                                                                |                               |                                                                                                                                                                                                           | USAID    |
| Armed Forces Reproductive Health Care Project, started 2001            | Staff/family of Nigerian Army, Navy, and Air Force | • Advocacy to facilitate consensus building among military leaders on RH/HIV/AIDS programs.  
• Purchase and distribution of FP commodities to all service points.  
• IEC material on RH/FP information produced & distributed; seminars given.  
• Training of key project personnel in basic FP service provision, STI syndromic management, IPC and counseling, natural FP and a TOT course.  
• FLE conducted for secondary school students  
• Assessment of RH/FP services and supply equipment/commodities.  
• Trained doctors, midwives to provide FP to police force and families; Trained police officers in FP/STI syndromic management, IPC and counseling.  
• Advocacy with the police hierarchy and sensitization seminars at police colleges and with police families.  
• IEC materials disseminated. |          |
| Nigerian Police Force Health Project, started in 2001                  | Nigerian police personnel     | • Advocate with traditional and religious leaders, business executives, market associations, and brothel owners.  
• Train project staff, community-based workers and peer educators (including CSW peer educators) to provide quality RH services, including counseling and effective IEC campaigns.  
• Strengthen services through brothel-based clinics to CSW and their clients.  
• Reach couples and single adults through home-based visits.  
• Reach mothers and babies with MCH services. | USAID    |
| Promote RH/FP for residents of Aba in Abia State                      | CSW in brothels; men/women of reproductive age; in-school youth | • Provide workplace-based services and information on RH/FP to factory workers, churches and other groups.  
• Sensitisation activities for companies in Aba and outreach staff visited churches.  
• FLE activities in secondary schools. | USAID    |
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<tr>
<td>Improving Reproductive Health in Nigeria</td>
<td>Male and female CSW in brothels</td>
<td>• Educate CSW to use condoms and advocate with the brothel owners.</td>
<td>USAID</td>
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<tr>
<td>2006 to present</td>
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<td>• Train CSW PHE on FP/HIV/AIDS/STI, counseling and motivation, and use of all FP methods.</td>
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<td>• “Lady’s” forum to sensitize women on preventing HIV and pregnancy; Advocate to avoid pregnancy and “dumping baby syndrome.”</td>
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<tr>
<td></td>
<td></td>
<td>• Distribution of commodities.</td>
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Appendix B Footnotes


2 Advocates are one of the APHIA II NC cadres of outreach volunteers. They are people living with HIV who are trained to conduct outreach/community awareness activities on a wide range of issues involving HIV prevention, treatment and care. They accompany APHIA II drama group outreach workers to add personal testimonies and engage in Q&A with the public, conduct sensitization meetings at work places combined with mobile VCT services for the workforce, and they conduct informational and/or awareness-raising sessions in APHIA II-supported health facilities, in public events and with community group and individuals. The Advocates are equipped to refer persons to relevant health services and other APHIA II NC-supported cadres such as Community Health Workers and local CBO partners who provide HBC and OVC support.
About the Authors

Ellen Israel, CNM, MPH, is a nurse-midwife and Senior Reproductive Health Advisor with Pathfinder International. She has worked extensively in reproductive health, especially HIV (PMTCT, community home-based care for PLWHA, and vulnerable groups), safe motherhood, and abortion and postabortion care, in Africa, Asia, and Latin America. She has coauthored four other publications of this series: *HIV Transmission through Breastfeeding, Tapping Community Opinion on Postabortion Care Services, Integrating PMTCT into Existing Maternal, Child, and RH Programs, and The Essentials of Antiretroviral Therapy for Health Care and Program Managers*. She can be contacted at eisrael@pathfind.org.

Carlos Laudari, MD, MPH, is the President Director of the Pathfinder do Brasil Association. He has an educational background in Ob/Gyn (University of Campinas) and population and family health (Columbia University). From 1985-1995 he worked as Chief Technical Adviser for the Angolan Reproductive Health Program. From 1995-2003, he served as Regional Reproductive Health and HIV/AIDS Advisor with the UNFPA Country Support Team for Southern Africa, having accumulated experience working in Angola, São Tomé & Príncipe, Namibia, Guinea-Bissau, Swaziland, Lesotho, Mozambique, Mauritius, Malawi, The Seychelles, Kenya, Zambia, Zimbabwe, Bolivia and Brazil. He has provided assistance to the World Bank in the area of HIV/AIDS prevention among vulnerable groups in India and Bhutan. Presently he is a collaborator with the Brazilian Network of Prostitutes and the Brazilian Association of Gays, Lesbians and Transgenders. He can be contacted at claudari@pathfind.org.

Cecilia Simonetti, MPH, is the Technical Director and Senior Communication and Health Advisor with the Pathfinder do Brasil Association. She has an educational background in sociology, political sciences and collective health as well as expertise in communication and health, social mobilization and advocacy for SRH of young people and adults. She has particular skills in strategic planning and using a participatory approach in the development of cultural/gender responsive communication strategies around HIV/AIDS prevention. She has more than twenty years of experience in the field of sexual and reproductive health and has worked extensively in the following countries: Switzerland, Italy, Chile, Angola, Brazil, Guinea-Bissau, Mauritius, Malawi, Mozambique, Namibia, São Tomé & Príncipe, Ethiopia, the Seychelles, South Africa, Swaziland, Zambia, and Zimbabwe. She can be contacted at csimonetti@pathfind.org.

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