



SEXUALITY AND DEVELOPMENT:

Brazilian national response to HIV/AIDS amongst sex workers

Cristina Pimenta, Sonia Corrêa, Ivia Maksud, Soraya Deminicis, and Jose Miguel Olivar

Study Report



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@ ABIA, 2010

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EXECUTIVE SUMMARY

The specific objectives of the study were to explore and analyze consistencies and mismatches between existing official Brazilian policy guidelines and program implementation in the area of HIV/AIDS prevention and health care among female sex workers. Data analysis and major findings discussed throughout the report are organized around five major themes as follows:

- 1) STD/HIV/AIDS prevention policies and programs directed at sex workers evolved in the last two decades;
- 2) The political legitimacy of key civil society actors directly engaged with commercial sex and the impact of the epidemics on persons involved in the activity and, the emergence of other related agendas at play in the public policy scenario;
- 3) The effects of political pressures exerted by these actors on the state since very early in the pandemics, and the resulting adjustment of public health policies to the demands and health needs of sex workers;
- 4) The experience and perception of female sex workers concerning public health services and HIV prevention initiatives; and
- 5) The perceptions of health policy managers about HIV prevention among sex workers and providers, and the status of current discussions about this question.

Based on the above themes, some of the most important findings are:

- a) The National STD/HIV/AIDS prevention policies and programs directed at sex workers adopted in Brazil since the late 1980s have had significant positive effects in opening spaces for prostitutes to participate as citizens, provide visibility to their experiences, promote human rights, and thus contribute to overcoming stigma and discrimination related to sex work. In the late 1990's and early 2000's the shift towards a specific national strategy to respond to the AIDS epidemic among women inevitably implied a policy shift that included prevention and treatment guidelines specifically geared to sex workers.

- b) With regard to the discontinuity of USAID funds in 2005, in the interviews conducted, research participants by and large positively appraised the decision to suspend the agreement even though most of them were not aware of the side effects suffered. Many underlined their support to the primacy of national sovereignty over the impositions of another country whose views were contrary to our human rights principles and legislation. But, it should be said, that most people had not enough information or clarity about the problems caused by the discontinuity of funding.
- c) While the observation of services performed by the study was not exhaustive it shows that both in Porto Alegre and Rio de Janeiro the quality of the public health response to the needs of sex workers' prevention and healthcare remains limited and poor. When asked about scope and quality of services provided to prostitutes, health managers say that by and large, it is restricted to health promotion.
- d) Prejudice, stigma, and discrimination are recurrent themes in the interviews with health professionals in Porto Alegre and Rio de Janeiro. Although health managers and professionals interviewed demonstrated great sensitivity about issues of stigma, prejudice, and discrimination, biases were also identified in the ways they portray sex workers.
- e) Over and above the debate on universality vs. differential treatment, several health managers and professionals interviewed consider that the HIV/AIDS policy has been losing vigor.
- f) Finally, the impacts of the discontinuity of USAID funds in 2005 were examined. The report takes into account that the suspension of funds did not directly affect public program budgets, but the sustainability of nongovernmental organizations (NGOs) involved in prevention projects. Even though public health program managers didn't mention the issue, in the NGO community the episode was intensely experienced.

Quotes translated from Sex Workers in Porto Alegre and Rio de Janeiro which reflect important issues related to health services:

"I've always donated blood ... but the last time, the nurse in charge began to ask me about my sexual behavior and, I ended -up telling her that I was a call girl; she said: well then, you can't donate blood."

"Are you asking if we need special services for prostitutes? Not at all! On the contrary, they should create services for married women because they need special attention; they are the ones who can't use condoms with their husbands..."

“If we need special health service hours for prostitutes? Well if you work on a night shift and you’re not a prostitute, you go to a health service at regular times ... don’t you? This means there are no priority services for women that work at night...So should there be special services for prostitutes? Simply because she is attractive and an expensive woman? Other women, who work overnight or around the clock, still have to line up at the health service unit during the day to see a doctor. Why should we have special services? We are not helpless ...”

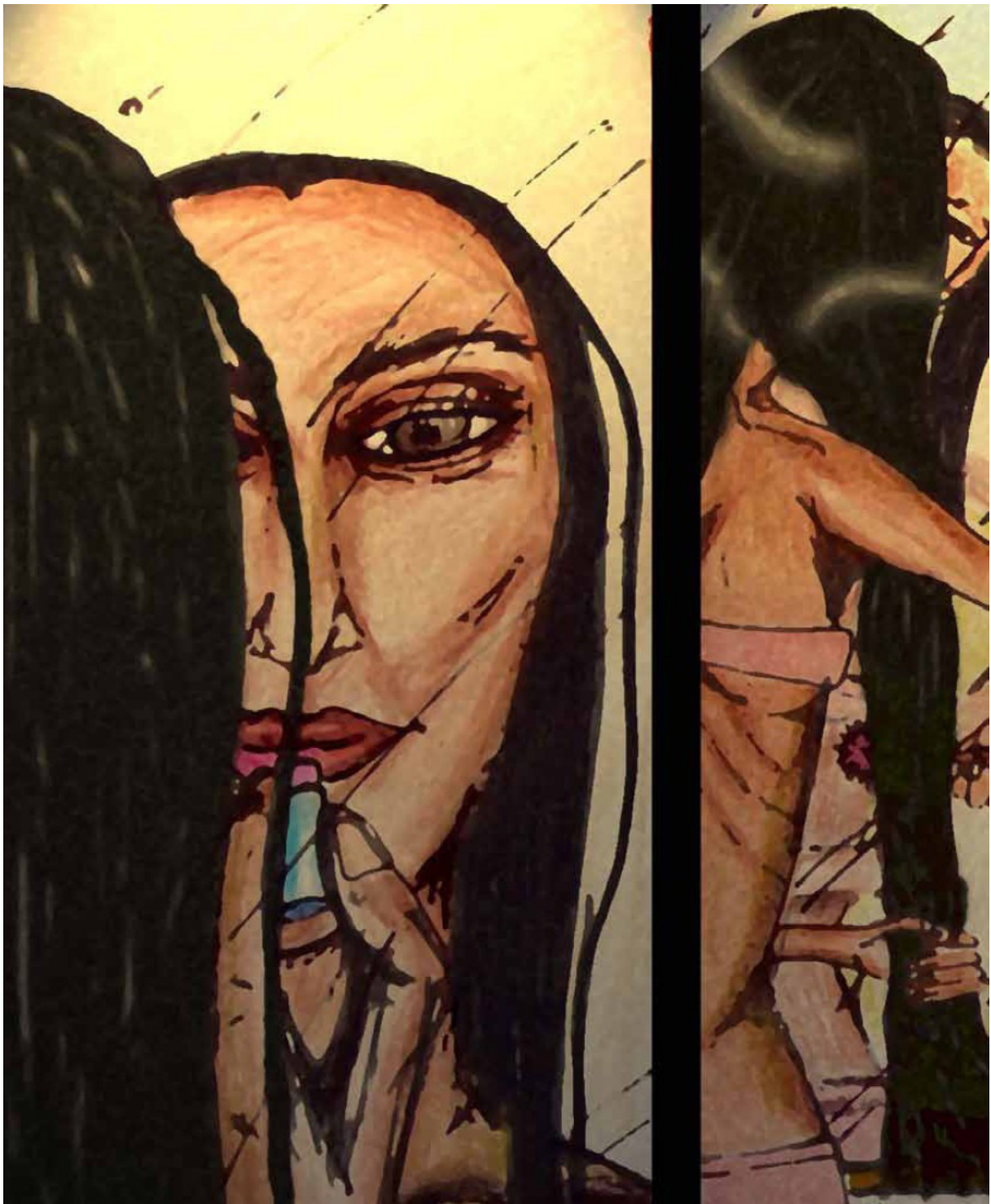




1. INTRODUCTION

The following report presents the main findings of a case study conducted during 2008–2009 by The Brazilian Interdisciplinary AIDS Association (ABIA), which is one component of a global research initiative sponsored by the Institute for Development Studies' (IDS) Sexuality and Development Programme. The study retraced the trajectory and examined the present state of the Brazilian response to HIV/AIDS transmission by sex workers, in particular female prostitutes. The research looked into the HIV/AIDS prevention strategies adopted during the last 20 years and the epidemiological impacts and responses of the health system to this particular group. It also examined policy implementation aspects through observations and interviews, such as access to and quality of services and prevention programs in two locations: Rio de Janeiro and Porto Alegre.

The research began in April 2008 when a preliminary study protocol was defined, specifying relevant issues to be explored and identifying key informants to be interviewed. The assessment of the policy trajectory and the literature review were conducted during 2008. Data collection concentrated on the review of policy documents and interviews to assess the perception of federal level officials and national sex worker leaders. In the second phase of the research, in 2009, direct field work was conducted at local levels in Rio de Janeiro and Porto Alegre.

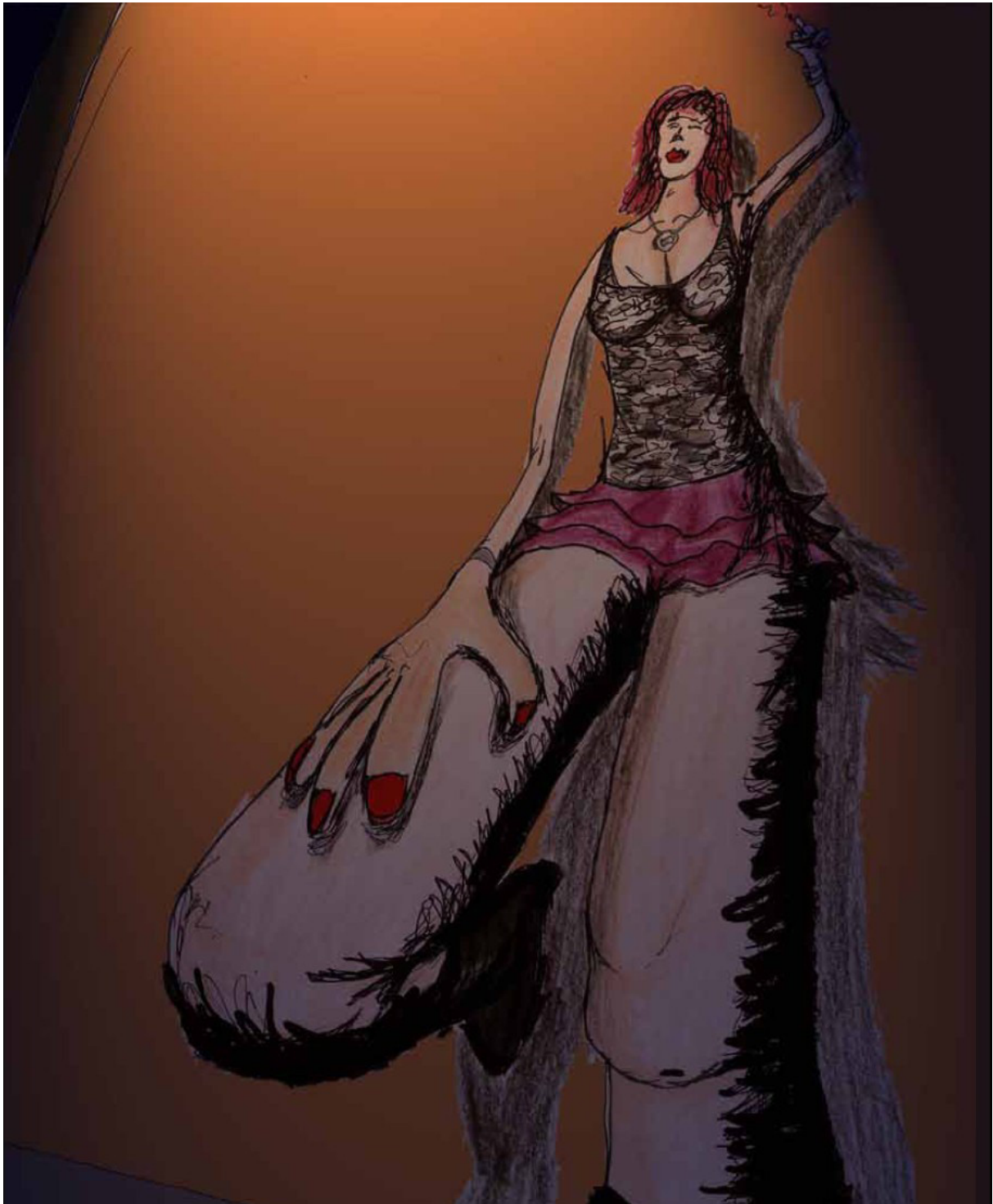


2. METHODS

Data collection was carried out through both primary and secondary sources of information. Secondary sources included: a) review of governmental policy documents and reports related to HIV/AIDS prevention policies in Brazil, which includes the outcome of consultations with civil society organizations; b) review of relevant existing literature on public policy prevention response to HIV/AIDS among sex workers. Primary sources of information encompassed interviews with: a) health policy officials from the federal, state, and municipal levels, and health professionals; b) key informants engaged in the historical construction of the Brazilian sex work movement; c) organized and unorganized sex workers, whose perceptions and opinions were collected in both focus group discussions and short surveys; and d) limited participant observation in public health services and focus groups with sex workers.¹ Empirical data was collected in Rio de Janeiro, the capital of the state of Rio de Janeiro, and Porto Alegre, the capital of the state of Rio Grande do Sul.

Observations on the terminology used in this report should also be made. The report uses both the term prostitutes and sex workers. This choice is related to the fact that the Brazilian sex work movement, (or at least its more visible and organized sector) has selected prostitutes as their term of choice. The reason behind this choice is that, in their opinion, the terms sex work or sex workers aim to sanitize prostitution. However since prostitute is a term that applies exclusively to women engaged in the sex market, in the Brazilian political landscape the term sex professional (*profissionais do sexo*) is used to name men, travestites and transsexuals engaged in sex work. In order to avoid the addition of a new terminology we have opted to translate “*profissionais do sexo*” as sex workers, even when distinctions could be made. The other term requiring clarification is *travestite*, which is a native word that is used by persons who have undergone body modifications to alter their appearance of gender but not necessarily surgical sex-reassignment.

¹ There was an initial expectation by the researchers to interview sex workers regardless of gender or sexual identity. Nevertheless, most of the interviewees were women. To fulfill the study objectives, the interview, focus groups, and survey guidelines aimed at covering the history of the sex worker movement and of HIV/AIDS prevention programs and projects, the impact caused by the retraction of funds from USAID, the effects of decentralization rules of the Brazilian Public Health System; the aspect relating to the terminologies used for identification or self identification of persons engaged in sex work, and finally, the experience of sex workers in what concerns access to prevention (condom distribution), HIV treatment, and health care at large.



3. CONTEXTUAL ANALYSIS

3.1 Epidemiological trends

It is estimated that in Brazil 630,000 people (aged 15–49) live with HIV, a figure that corresponds to a national prevalence rate of approximately 0.61 percent. Brazil accounts for more than one third of the total number of people living with HIV in Latin America and sexual transmission remains the most common form of HIV transmission in Brazil. At first, Brazil's epidemic (in the early 1980s) affected mainly men who had sex with men, people who had blood transfusions, and injecting drug users. However, heterosexual transmission of HIV has grown significantly in the mid to late 1990s leading to an increase in numbers of AIDS cases among the female population which is directly reflected in the male to female ratio of AIDS cases. In the last decades, the ratio changed from 15 males to 1 female (15:1) in 1986, to 1.5 males to 1 female (1.5:1) in 2007. In the case of populations in very vulnerable contexts such as men who have sex with men (MSM), commercial sex workers, and injecting drug users, the HIV prevalence rate is above 5 percent. This pattern of transmission and prevalence classifies Brazil under the criteria of concentrated epidemic as defined by the World Health Organization (WHO). The age groups most affected by the epidemic continue to be those between the ages of 20 and 49, in both sexes, in all regions of the country, with a more recent increase of cases in the population over the age of 50. A total of 506,499 AIDS cases had been identified by the Health Ministry up until June 2008, with 65.8 percent of cases among men and 34.2 percent among women. Two hundred thousand people are presently undergoing treatment for AIDS with antiretroviral therapy (ART).

The Health Ministry's epidemiological reports and the 2008 UNGASS report have emphasized the growth of the epidemic among Brazilian women in recent years through heterosexual transmission. Moreover, in the 13 to 19 age group, the ratio between men and women has been inverted with 6 male AIDS cases for every 10 female AIDS cases (M/F ratio = 6:10).

Even though the rate of HIV infection in Brazil has stabilized around 22,000 to 25,000 new cases per year, greater vulnerability to HIV infection still persists in the case of specific groups such as MSM, injecting drug users (IDUs) and sex workers. The higher level of vulnerability is related to both social determinants – such as gender, class and race inequalities and patterns of discrimination – and unsafe sexual practices.

It is estimated that one percent of the Brazilian female population (aged 15 to 49) – roughly half a million people – is engaged in commercial or transactional sex (Szwarcwald *et al.*, 2005). Female sex workers are considered to be one of the subgroups of the Brazilian population that is exposed to higher levels of social and programmatic vulnerability to HIV infection. A study carried out between 2000 and 2001, in some Brazilian state capitals, estimated the HIV prevalence rate for sex workers to be 6.4

percent (Health Ministry, 2004). While this rate is much lower than the 17.8 percent estimated in 1996, it is still 14 times higher than the prevalence rate detected for the Brazilian female population at large (Szwarcwald & Souza Jr., 2006).

3.2 Historical perspectives of policies and programs

3.2.1 The prostitution debate in Brazil since the 19th century

Prostitution has been an issue debated in Brazil since the second half of the 19th century. Since those early days a controversy between abolitionists and proponents of state regulation of sex work can be identified. However, as underscored by Pereira (2005)², Brazil, unlike neighboring countries – such as Argentina, Uruguay and Colombia – never adopted the so called French model that precisely defined the prostitution zones and established rigorous sanitary control of women engaged in the sex trade. But the Brazilian state did not adopt an abolitionist policy either. Thus, in the beginning of the 20th century ardent abolitionists, such as Evaristo de Moraes, sharply criticized this absence of a clear policy regarding prostitution and “trafficking in white women.” To this extent, as was well analyzed by the same author (Pereira, 2005), this “absence of policy” resulted in a model that combined police and legal measures and health interventions to contain venereal diseases, especially syphilis. It is not an exaggeration to state that sanitary regulation has been the most remarkable aspect of state intervention in the sex market. This longstanding logic of state intervention also explains the nature of the Brazilian penal legislation, which does not penalize prostitution *per se*, but the commercial exploitation of the activity.

However, this does not mean that abolitionist positions have disappeared from the social fabric and public debate. Although state policy has never assumed an openly abolitionist approach, there have always been initiatives to rescue women involved in prostitution. For example, these initiatives were very prominent in the early 20th century, when the country was involved in international campaigns to combat “trafficking in white women” (Rago, 1985). In the second half of the 20th century, proposals and projects to rehabilitate prostitutes were organized by philanthropic groups, particularly religious groups. The best known example of this in more recent times is the Marginalized Women’s Pastoral, linked to the Catholic Church.³

² PEREIRA, C. S. Lavar, passar e receber visitas: debates sobre a regulamentação da prostituição e experiências de trabalho sexual em Buenos Aires e no Rio de Janeiro, fim do século XIX. Cad. Pagu [online]. 2005, n.25, pp. 25-54. ISSN 0104-8333. doi: 10.1590/S0104-83332005000200002.

³ The Marginalized Women’s Pastoral is a very old initiative of the Catholic Church geared to “rescuing” women prostitutes. If in the 1970s and 1980s, the Pastoral had in many places a fairly progressive line of work, it is currently basically focused on actions to fight child prostitution, sex trafficking, and “rescue”.

On the other hand, as analyzed by Rago⁴ (1985), Kushner⁵ (1996), and Pereira (2005), since the late 19th century prostitutes and prostitution were part of cultural landscape in the early period of Brazil's modernization and urbanization, ranging from slave or ex slave women who offered sexual services, to French, Italian, Spanish, and Polish (Jewish) migrant women who arrived in the country (specially to Rio de Janeiro and São Paulo) in large numbers starting in the second half of the 19 century.⁶ Rago and Kushner have also charted the history of the self-support association established by prostitutes of Jewish origin in Rio de Janeiro, whose positive results were evident such as the establishment of a “pension” for the prostitutes who no longer could work.⁷

However, a prostitutes' movement with explicit political objectives would only materialize much later, in the late 1970s, when a small group of São Paulo prostitutes (women and travestis) reacted in organized fashion to police repression against streetwalkers. From then on, efforts to mobilize against discrimination and violence, and for more social respect for the work of prostitutes slowly but continuously expanded. Those mobilizations were supported by artists and progressive religious groups (Catholic, Lutheran, and Anglican).⁸

The First National Meeting of Prostitutes was chaired by Gabriela Leite in 1987. This event is at the origin of the current Brazilian Prostitutes' Network. Significantly, the creation of a political movement of prostitutes coincided with the steps toward democratization and with the first confirmed AIDS cases in the country. As in other countries, at the early stage of the epidemic in Brazil, some population groups were identified as “risk groups”: people who had been submitted to blood transfusions (especially hemophiliacs), homosexuals, prostitutes, and injecting drug users – considered the main vectors for the expansion of the epidemic.

Undoubtedly, the moral panic caused by AIDS initially aggravated existing patterns of discrimination and stigmatization. However, the atmosphere of democratization experienced in the country, which allowed for an intense debate on citizenship and rights, negative and stigmatizing views and discourses related to gays, sex workers and their clients were swiftly and sharply contested. The emergence of public discourses

⁴ RAGO, M. *Do cabaré ao lar: a utopia da cidade disciplinar, Brasil 1890-1930*. Rio de Janeiro: Paz e Terra, 1985.

⁵ KUSHNER, B. *Baile de máscaras*. Rio de Janeiro: Imago, 1996.

⁶ As it is known, this implied a deep reconfiguration in terms of moral norms and the frontier between the public and private, in which the shift from religious-based moral norms to new parameters of biomedical sexual discipline has particular relevance.

⁷ Another very significant result achieved by this association was the creation of a cemetery for prostitutes, as the Jewish community did not accept that they be buried in the communal cemetery.

⁸ The Higher Institute for Religious Studies (ISER) was on that occasion the umbrella organization that offered space and strategic support to that initiative.

on women's condition and discrimination, as well as on female sexuality, which had an important impact on the debate around discrimination against prostitutes, should also be taken into account. These political and cultural dynamics opened the way for constructing a public HIV/AIDS policy based on nondiscriminatory principles, which has relied on the participation of civil society organizations since the late 1980s – within a logic that has combined collaboration and conflict.

In other words, the trajectory of the Brazilian policy in response to HIV/AIDS infection among sex workers had a peculiar profile if one takes into account the experience of other developing countries. It combined technical capacity, epidemiological surveillance, prevention, and treatment within an overall framework of respect for human rights. However, it is necessary to note that, in a continental country such as Brazil, translating national public policy guidelines into the realities of local health systems was, and continues to be, a huge challenge. Moreover, in recent years, Brazilian HIV/AIDS policy has been negatively affected by processes underway in the public health system, particularly decentralization and new managerial logics at the local level, which have compromised the quality of the response to the epidemic, including the two municipalities researched.

In addition, since the 1990s Brazil has adopted public policies regarding the sexual exploitation of children and adolescents and in trafficking in persons. Since the passing of the Children and Adolescents Statute (1990), a consolidation of children and adolescents' rights in the country, the issue of sexual abuse against children and adolescents (including prostitution) has been a nodal concern of the Brazilian state. In the late 1990s, the issue of sexual tourism and trafficking for sexual purposes gained visibility in the public debate.

In 2003, Brazil signed the Additional Protocol to Prevent, Suppress, and Punish Trafficking in Persons, Especially Women and Children, that supplements the UN Convention Against Transnational Organized Crime. This protocol was ratified by the National Congress in 2004; and since then, a number of institutional and legislative initiatives have unfolded, such as the creation of a group for the Program to Fight against Trafficking in Persons at the National Secretariat of the Ministry of Justice and the formulation of the National Plan to Combat Trafficking in Persons. Since 2005, specific legislation was also approved to address sexual crimes – pornography, sexual abuse, and trafficking and these various laws have been incorporated into the Penal Code in August 2009.

Concerning regulation and criminalization of sex work, two aspects of the new legislation are worth noting: the age of consent was increased from 14 to 18 (affecting the gravity of the offense and the nature of the criminal charge); and more specifically, the introduction of a chapter on domestic trafficking for sexual purpose, added to the changes made in March 2005, which in addition to addressing domestic trafficking,

began to deal with trafficking in persons, not just in women (this provision would be incorporated in the Penal Code in 2009, under Law 12015/2009)⁹.

Moreover, it should be noted that, between 2003 and 2008, these policies have received fairly generous funding from a variety of donors, including USAID and United Nation agencies (Oliveira, 2008; Piscitelli, 2008).^{10,11} As in other countries these policies and legislation are implemented in partnership with a broad and complex network of civil society organizations: NGOs supporting the rights of children and adolescents, religious institutions (such as the Marginalized Women Pastoral), and feminist organizations.

Although it is an exaggeration to say that an abolitionist wave is sweeping the country, there are signs that positions and views radically opposed to the exercise of prostitution as work are gaining space and legitimacy. Inevitably, this agenda crosses the HIV response policy. For example, in recent years, at local levels, HIV preventive actions among sex workers have been implemented in articulation with measures to suppress commercial sexual exploitation of children and adolescents and, in some cases, with projects to rescue adults from prostitution, or to provide training for other work. In the context of this study, it was not possible to examine the impact of anti-trafficking measure and potential abolitionist views on the response to HIV/AIDS in Brazil. However, contradictions and conflicts have unfolded in the period under examination, such as the emergence of different visions within the sex worker movement and controversies that arose in dialogues between the state and civil society on HIV/AIDS and prostitution. These tensions may eventually be interpreted as a consequence of this more complex policy scenario.¹²

⁹ The change in the age of consent is applicable to several crimes included in this chapter, including rape. According to Adriana Piscitelli, well-known researcher on the issue of prostitution, the creation of the crime of internal trafficking is particularly problematic, as the definition is vague because there are no borders to cross. Since prostitution is an activity with great mobility, displacements are used by the police and other institutions as “proof” that sex workers living outside their places of origin are victims of trafficking.

¹⁰ PISCITELLI, A. “Entre as ‘máfias’ e a ‘ajuda’: a construção de conhecimento sobre tráfico de pessoas”. *Cadernos PAGU* (31), July-December 2008: 29-64. OLIVEIRA, M. P. de. “Sobre armadilhas e cascas de banana: uma análise crítica da administração de Justiça em temas associados a Direitos Humanos”. *Cadernos PAGU* (31), July-December 2008: 125-150.

¹¹ These funds have been directly channeled by the embassy and consulates or through UNODOC, the UN agency to combat drugs.

¹² It is important to mention that it was only possible to detect the extension and relevance of the effects of the antitrafficking policy in terms of response to HIV among sex workers in the final stages of the study, i.e., during the second round of interviews with health managers and activists. For more detailed information on these policy changes and related tensions see *Politics of Prostitution in Brazil: Between “state neutrality” and “feminist troubles”* (Sonia Corrêa, forthcoming)

3.2.2 Building Brazilian response to HIV among sex workers (1989-2007)

In Brazil, the historical coincidence of the “*redemocratization*” process and the beginning of the HIV/AIDS epidemic favored communication between civil society actors engaged in constructing a response and the Ministry of Health. As time passed, these early dialogues built a continuing partnership in the design and implementation of HIV/AIDS prevention programs. In the late 1980s, when the National STD/AIDS Program was already established, the rapid expansion of HIV infections and pressure from organized groups led the National Program to develop specific HIV/AIDS prevention projects for women sex workers. Civil society actors were invited to participate in the design of these new initiatives. The group included Gabriela Leite, from the prostitutes’ movement, Roberto Chateaubriand, from the AIDS Prevention Support Group (GAPA/MG) from the State of Minas Gerais; Lourdes Barreto, from Belém, State of Pará Prostitutes’ Association; Laura Celeste, from São Paulo GAPA in addition to acknowledged researchers, consultants and sexuality specialists.

The programs designed by these groups in partnership with the National STD/AIDS Program, started to be implemented in 1989, under the denomination of project “Previna.” At first, these health actions were geared to specific groups: sex workers, male homosexuals, drug users, and inmates and the methodology adopted was mostly based on “peer education”. In the specific case of sex workers, selected persons were trained as “health agents” or multipliers who contacted other prostitutes passing on information and materials on prevention. It was expected that information on HIV prevention would pass from peer educators/agents to peer prostitutes and from prostitute to sexual partners and clients, and eventually to the larger population. The program design was based on an epidemiological model, which aimed at impacting on “vectors of transmission” as a strategy to multiply quality information on the epidemic but also contain infection rates.

Throughout the 1980s, the expanding partnership with the state provided legitimacy and visibility for women prostitutes’ organizations and demands. In 1993 the National STD/AIDS Program signed a loan agreement with the World Bank. From 1994–1998, under the new guidelines of the first loan agreement (*AIDS I*), the strategy would change because the prevention perspective then adopted argued that it was necessary “to expand prevention actions and get there before the epidemic”. This translated into the National Program recognizing that it was not sufficient to intervene only in localities or groups that already presented high prevalence rates, but rather to target the wider population potentially at risk.

Under the *AIDS II* (1998–2002) program, human rights guidelines were consistently incorporated into Brazilian strategies to respond to the HIV epidemic. This was of key importance for creating more favorable conditions to systematically

challenge stigmatization and discrimination, including against travestis and sex workers. In addition, the decision was also made that prevention projects would be directly implemented by NGOs because both the Health Ministry and the World Bank were convinced that NGOs had more capacity to reach vulnerable groups and greater flexibility to work at the local level, even when the National Program kept in hand the core responsibility for outlining strategic policies and related norms. The transfer of financial resources to NGOs was implemented through a public bidding process that included a call for applications and the establishment of external committees to evaluate the project proposals presented. Since then, a wide range of NGOs across the country, including prostitutes' groups and associations, have implemented a number of HIV/AIDS prevention projects.

In addition, starting in the early 1990s, travesti leaders and groups gained more visibility in the Brazilian response to HIV/AIDS, initially as agents of HIV-positive programs and support houses and later as prevention activists. The first National Gathering of Travestis and Liberated Persons Against AIDS (ENTLAIDS) took place in 1993. In 1996, the National HIV/AIDS Program designed specific programs to reach out to MSM and travestis (who were also engaged with commercial sex) through the "SOMOS" project. Later, in 2003, the "Tulipa" project and network was established, with the main goal of identifying, sensitizing, and empowering travestis, transsexual and transgender leaderships and organizations. It aimed at creating five referral centers for these groups, one in each region of the country, which were designed to act as hubs to enhance capacity building and local social mobilization.

In early 2000, the decentralization of HIV/AIDS programs to state and municipal levels already underway was intensified – in accordance with the norms and logic of the Unified Health System (SUS). The *Esquina da Noite* (Night Street Corner) prevention program was launched, which required NGOs to get organized as consortia to receive federal funds. In the case of HIV prevention among persons involved in commercial sex, a national consortium was created. GAPA/MG entered into association with DAVIDA and Vitória Régia from Rio de Janeiro to cover the Southeast region, APPS and APROCE (Prostitutes Association of Ceará) covered the Northeast, and the Prostitution Studies Unit (NEP) was in charge of the South and GEMPAC of the Northern region.

The *Esquina da Noite* Project aimed at strengthening the National Prostitutes' Network, working with issues such as self-esteem, human rights, and sex work as a right. According to leaders directly engaged in the project, at that point in time it became very clear that, although it continued to be necessary, it was not sufficient to intervene in HIV prevention alone, rather it was necessary to link prevention work with other issues and demands put forward by the prostitutes' movement itself. Thus, starting in 2000, prevention initiatives were designed as entry points to consolidate the organization of the prostitutes' movement, including aspects concerning labor rights.

One result of these advocacy efforts was that, in 2002, the occupation “sex worker” was included in the Brazilian Occupation Classification (CBO) of the Ministry of Labor in 2002, thus, legitimizing this activity from the state perspective. Moreover, in 2003, a law provision was presented to Congress by Congressman Fernando Gabeira to regulate prostitution as labor, inspired by the German law of January 2002, which made payment of sexual services an obligation, and deleted the crime of inducing or persuading to sexual services from the penal code. In the Brazilian case, it would be necessary to remove inducing to prostitution from the Penal Code (art. 228), as well as prostitution houses/brothels (art. 229) and trafficking in women since it is only associated with women who would engage in sexual services (art. 231).

Legislative proposal by Congressman Fernando Gabeira – 2002

Provides for the right to demand payment for services of a sexual nature and revokes articles 228, 229, and 231 of the Penal Code.

The National Congress decrees:

Art. 1 Payment for services of a sexual nature can be demanded.

§ 1 Payment for services of a sexual nature is also demandable for the time in which the person remained available for those services, no matter whether or not this person was requested to provide the services.

§ 2 Payment for services of a sexual nature can only be demanded by the person who provided the service or who remained available for providing it.

Art. 2 Articles 228, 229, and 231 of the Penal Code are revoked.

Art. 3 This law shall come into force on the date of its publication.

It is also important to note that, in the early 2000’s HIV/AIDS prevention programs for sex workers were funded by both the National STD/AIDS Program and the Brazil-USAID cooperation agreement, through the AIDSCAP project. In 2005, the *Esquina da Noite* Project was underway when USAID decided to attach new contractual clauses to the agreement already signed with Brazil. Among them, the so-called “antiprostitution clause” added to PEPFAR in 2004, which required all recipients of US funding for HIV prevention projects to sign a formal statement condemning prostitution and pledging not to support the legalization of sex works or sex workers’ rights (Girard, 2004¹³). The clause was at odds with Brazilian legislation, which does not criminalize prostitutes, and contradicted main tenets of the National HIV/AIDS Program and, most principally, of the prostitutes’ movement itself.

¹³ GIRARD, F. (2004) *Global Implications of U.S. Domestic and International Policies on Sexuality*, Sexuality Policy Watch. Available online at <http://www.sxpolitics.org>.

The Brazilian government would not accept the restrictions imposed by USAID and the director of the National STD/AIDS Program¹⁴ convened an extraordinary meeting of the National AIDS Commission to discuss the matter. The Commission unanimously supported the National Program decision to reject funding associated with that clause imposed by USAID. As a consequence, USAID decided to discontinue funding to Brazilian projects on HIV/AIDS prevention and a tension emerged between the groups that had received funds to implement activities among sex workers and MSM and the AIDSCAP project. But despite tensions and pressures from Washington, the decision was made that projects underway would receive the totality of budgeted funds and would be allowed to conclude their activities by the end of 2005.

USAID – PEPFAR

In 2005 the Brazilian government turned down US\$ 40 million of USAID/PEPFAR money because preconditions stipulated that funds could not be disbursed to organizations that did not have an explicit antiprostitution policy. The director of Brazil's HIV/AIDS program explained: "Brazil has taken this decision in order to preserve its autonomy on issues related to HIV/AIDS as well as ethical and human rights principles." The Brazilian government and many organizations believed that adopting the US Government condition would be a serious barrier to helping sex workers protect themselves and their clients against HIV infection (<http://www.avert.org/pepfar.htm>). The Brazilian government's action can be seen as a radical assertion motivated by the need to keep sexuality in HIV and AIDS programming in order that prevention might be effective.

The concerns stress issues involved in bringing sexuality back into HIV and AIDS work. In general, sex positive approaches are needed, emphasizing consensual sexuality as pleasure and not denying analyses, policies, and programs that address safer sex in these terms.

After the suspension of USAID funds the *Sem Vergonha* project (Without Shame) was created and funded exclusively by the National HIV/AIDS Program. *Sem Vergonha* was designed as an umbrella project and focused mainly on capacity building of leaders of the National Prostitutes' Network as well as other people identified as potential leaders. In addition to capacity building, it invested in sustainability and advocacy actions. National coordination was carried out by the DAVIDA NGO and regional coordination by prostitutes' associations linked to the Brazilian Prostitutes' Network. The project mainly emphasized the enhancement of community leadership and political protagonism of prostitutes.

To summarize, although in the late 1980s and early 1990s the control of HIV/AIDS among "higher risks groups" was the main goal of prevention projects implemented by the Health Ministry, gradually the methodologies adopted left behind narrow behavioral approaches to include health promotion at large, education to ensure the protection of

¹⁴ At the time, Dr. Pedro Chequer, MD.

sex workers in relation to STDs in general, and AIDS specifically and, most principally, encompassed a strong participatory component. As the program evolved, aspects relating to citizenship, rights, and the strengthening of the prostitutes' movement gained space in policy design. The main reasoning behind this broadening of the policy focus was that HIV prevention outcomes could not be achieved in isolation from the promotion and respect of human rights and the elimination of stigma and discrimination affecting female sex workers, travestis, and transgender people engaged in commercial sex.

Since the late 1980s, the National HIV/AIDS program has wholly acknowledged that sex workers should have a voice as full citizens and be the protagonists of their own history. In a later phase the programs supported by the Health Ministry have expanded this guideline in terms of directly strengthening existing organizations and leadership as a strategy to ensure the political sustainability of social movements and to build their capacity and enable them to engage in dialogues with public officials and participate in the public health system accountability mechanisms.

The review of documents produced by the National HIV/AIDS Program indicate that between 2000 and 2007 prevention projects directed at sex workers in Brazil have expanded and diversified, to subsequently decrease in terms of numbers and financial investments made.¹⁵ The largest number of projects was funded in the Southeast region and the North region was the least attended.¹⁶ The NGO documentation reviewed, on the other hand, does not provide sufficient and precise information about the activities performed and results of these projects. The only consistent data retrieved from NGOs' about the work with sex workers were informative and educational materials used in STD/HIV/AIDS prevention campaigns.¹⁷

3.3 Recent policy shifts (2007-2009)

From 2007 onwards policy design at the national level underwent some significant changes. Until then the STD/AIDS National Program operated as an umbrella macro policy encompassing specific strategies, but no national action plans had been designed to respond to the needs of specific groups in the population. The overall policy design combined universal actions in the area of epidemiological surveillance and treatment with public education initiatives and prevention projects geared to specific groups particularly vulnerable to HIV.

¹⁵ Table specifying NGO projects supported by the National AIDS Program can be found at: www.aids.gov.br (consulted in August 2008).

¹⁶ The state of Acre, for instance, which is located in the region, is the only state in the country where not even a single prevention project for sex workers has been funded since the beginning of federal support.

¹⁷ The documentation centers of two NGOs were researched. Brazilian Interdisciplinary AIDS Association (ABIA) and DAVIDA. Others did not have a documentation center.

But, in the late 1990s, when an increase in infections among women was identified, a discussion began about the need to have a specific HIV containment policy for the female population that should be closely articulated with the national women's health policy. From 2006 the feminization of the HIV epidemic and correlations between gender inequality (viewed in the conventional sense of male/female binary), violence, and HIV achieved new contours at the international level and started mobilizing specific international cooperation funds for this area of work¹⁸. In the national context, this move coincided with the consolidation of the Special Secretariat of Policies for Women, whose main agenda is the issue of gender violence. Renewed investments were therefore made to develop policy guidelines specifically geared to the HIV response in the female population.

In 2007, the Health Ministry, in partnership with the Special Secretariat of Policies for Women, presented the National Comprehensive Plan to Address the Feminization of STD/AIDS epidemic, aimed at responding to a gamut of situations that aggravate vulnerability to HIV among groups of the female population, and ensuring health care to women living with HIV. These guidelines also cover actions geared to men, in the sense that they include the relational dimension of gender. In parallel, at the national level and in some states, the so-called Men's Health Policy was being structured, mainly focused on STDs and prostate cancer prevention.

Regarding the case study, the most important aspect of this recent policy shift is that it also includes prevention and treatment guidelines specifically geared to sex workers. When it was launched in 2007, the Plan was well received by sex workers' organizations. According to Gabriela Leite, *"integrated actions are welcome. For the government and the women's movements to have prostitutes included in a global plan to address AIDS is another step to overcome the stigma, which is also present among women."* She added: *"it demonstrates we are all equal, although with different profiles."*

In 2007, state plans to address the feminization of the HIV/AIDS epidemic were initiated. By late 2007, just five states had finalized their policy documents, in 2009, twenty six state level plans had been approved. That same year the National Plan was revised through an Internet consultation open to civil society organizations. One key outcome of the revision was the emphasis on affirmative agendas for the most vulnerable segments of the female population: women living with HIV/AIDS, prostitutes, lesbians, and transsexuals.

The shift towards a specific national strategy to respond to the epidemic among women inevitably led to focusing on other specific groups. In 2008, in the context of the National Conference of Policies for the LGBT Population, the National Plan

¹⁸ A noticeable moment of this inflection was the Toronto AIDS Conference (2006) in which the theme "Gender, Violence and HIV" was highly visible.

to Address the STD/AIDS Epidemic among Gays, MSM, and Travestis was publicly presented. One of the positive aspects of this second plan was the definition of specific guidelines for the travesti population, a break through from the epidemiological logic that included them under the general denomination of MSM. From the viewpoint of the case study, once again the relevant aspect was that it should respond to the structural conditions that influence vulnerability to HIV, as well as the prevention needs of travestis and MSM, who often are involved in sex work.

However, these recent policy developments are not without tensions and conflicts. For instance, during consultations and subsequent debates on the National Comprehensive Plan to Address the Feminization of the STD/AIDS Epidemic, there were reactions against the inclusion of transsexual women, as some feminist groups strongly opposed this inclusion because they do not consider transsexuals “women”. But significantly enough there was no specific reaction against the inclusion of prostitutes.

Another relevant tension – to a large extent still unresolved – relates to the interpretation of epidemiological data. According to some analysts and observers, although the number of infections among women has increased considerably due to the growth of heterosexual transmission in the last decade, the high prevalence among men has continued¹⁹. The new epidemiological dynamic created tension between public health program officials, managers and activists because, due to the increase of cases among women (feminization of the epidemic), some program officials and managers stopped prioritizing actions geared only to MSM. In reality, the issue should not have been prioritizing one population to the detriment of another, but instead to focus on expanding women’s access to services and inputs, particularly the youngest, while also maintaining initiatives geared to MSM.

This process of reconfiguring the public policy response to HIV hereby described was undoubtedly determined by factors, actors, and processes that are unique to the Brazilian context. However, this reconfiguration also mirrors the international dynamic and debate underway in the same period within the framework of international agencies, especially UNAIDS and the Global Fund.

¹⁹ The AIDS epidemic in Brazil is characterized by continued high level of prevalence among MSM with estimated prevalence rates of 4.5% (2004); b) increasing prevalence among the female population or “feminization”. There are 213,714 women aged 15-49 living with HIV/AIDS in Brazil with an estimated prevalence of 0.28% (2004), and a prevalence of 0.41% for pregnant women (sentinel surveillance 2006). The male/female ratio of AIDS cases changed from 15:1 in 1995 to 1:1.6 in the year 2000. Moreover, in the 13 to 19 age group the ratio between men and women has become inverse, with 6 male AIDS cases for every 10 female AIDS cases (M/F ratio = 6:10). Cases concentrate in lower income girls and women with less formal schooling who have great difficulty in sustaining safer sexual practices due to gender and socioeconomic inequalities (Brazil UNGASS report 2008 – www.aids.gov.br).

Implementation of both the national plan to Combat the Feminisation of HIV and the national MSM plan began in the period during which the field work for this study was being carried out. It should be also noted that no systematic evaluation of the implementation of these new national policy guidelines is available²⁰. Some of the administrators interviewed during the research mentioned the National Integrated Plan to Address the Feminization of the STD/AIDS Epidemic as the reference for locally-developed HIV prevention policies for prostitutes. However, this policy foundation was not fully confirmed when we heard program and service level personnel.

It is also important to say that, in recent related policy discussions, questions have been raised in regard to the gender binary logic that characterizes the response to HIV/AIDS in Brazil at this stage. The main concern is that this new logic may deepen “differences” between travestis and transsexuals, or between prostitutes and other people involved in sex work, by crystallizing tension among groups as well as sexual identities²¹. There are also concerns about whether or not this binary division may hamper implementation of actions, especially in the realm of prevention²².

Transnational connections

Since the early days of the movement, Brazilian prostitutes’ organizations have established connections with activists in other countries. During the 1980s, these links were mainly with North American and European sex work leaders. In the 1990s, new connections were established, especially in Latin America, where the Latin American and Caribbean Sex Workers Network (RedTraSex) was created in 1997. Contacts with organizations from other regions of the world were made in the international arenas where policies to respond to the epidemic are discussed, especially after the Toronto AIDS Conference. At the global level, the most important connection has been the Global Network of Sex Work Projects, NSWP (www.nswp.org), established in 1992. Since the mid 2000s, the Brazilian Prostitutes’ Network and Gabriela Leite have been intensely engaged in the efforts to restructure and consolidate the NSWP.

Within the global framework of responses to the HIV/AIDS epidemic, in recent years, new connections have also been directly established between UN agencies and the Brazilian government. In 2006, the HIV/AIDS/STD Program sponsored an international consultation on prostitution and HIV, in partnership with UNAIDS and UNFPA. The participants included Latin American prostitutes’ organizations, RedTraSex, a European network of sex workers, the Asia Pacific Network of Sex Workers (whose representation included a man and a transsexual), and the NSWP. Two representatives from the US government AIDS program (PEPFAR) and at least one person connected to one of the global abolitionist networks, Coalition Against Trafficking in Women (CATW), were also present.

²⁰ There are indications that the implementation of the Integrated Plan to Address the Feminization of the STD/AIDS Epidemic faces some important obstacles. An evaluation of Plan implementation is currently underway.

²¹ For example, this criticism was made explicit at the Seminar “Transsexuality, Travestility, Health and Human Rights”, organized by the Commission on Citizenship and Reproduction in partnership with the Health Ministry (and also in collaboration with Sexuality Policy Watch), held in São Paulo, on March 24-25, 2010.

²² The evaluation of the new Brazilian policy strategy currently underway is quite urgent to evaluate the effectiveness of this new focalization logic. Its results can also, eventually, inform global debates as by now a similar binary logic has been adopted by the UNAIDS and the Global Fund policy frameworks.

Although the debates were very rich, inevitable tensions arose and it was not possible to reach consensus. The final draft document, prepared by UNAIDS and released in April 2007, was harshly criticized by sex workers networks attending the consultation mainly because it did not make the necessary distinction between trafficking and prostitution, among other deficiencies. This impasse led to the creation of a working group in the beginning of 2009 to revise the 2006 document. Gabriela Leite participates in this group as one of the NSWP representatives.

In 2007, the Latin American Consultation on HIV/AIDS and Sex Work was held in Lima and was much more productive. On that occasion, RedTraSex established an internal consensus on sex work as part of the sexual rights agenda, a position that has been defended by the network member organizations in transnational discussions on prostitution.

3.4 Decentralization of the Brazilian public health system

Since the mid 1990s, when the Brazilian National HIV Program was consolidating, the Brazilian public health system – SUS (Unified Public Health System) has undergone a substantial transformation. Considering the particular object of the case study – the Brazilian response to HIV/AIDS among sex workers – one key element to be taken into account is that, since then, the rules of decentralization have moved from paper to reality, which means that – for better or for worse – the public health system today is decentralized. Decentralization of HIV/AIDS policies and related health services meant that while the Federal Government maintained its national authority on HIV/AIDS through the National HIV/AIDS Program (NAP) of the Health Ministry, presently called “Department of STD/HIV/AIDS and Viral Hepatitis”, health services and deliverables are now fundamentally under the responsibility of states and particularly municipalities, given that the official role of states is mostly planning and oversight²³.

The Department of STD/HIV/AIDS and Viral Hepatitis is still responsible for developing and updating all national technical guidelines and reaching a national consensus on diagnosis, treatment, and prevention procedures for adults and children living with HIV and AIDS, and for determining the application of new medications and technologies. It is responsible as well for the procurement of all antiretroviral drugs (ARVs) and their distribution to states and municipalities. In addition, the national department purchases and distributes 80 percent of all condoms available through public outlets (free of charge), the other 20 percent being the responsibility of Municipal Health Departments.

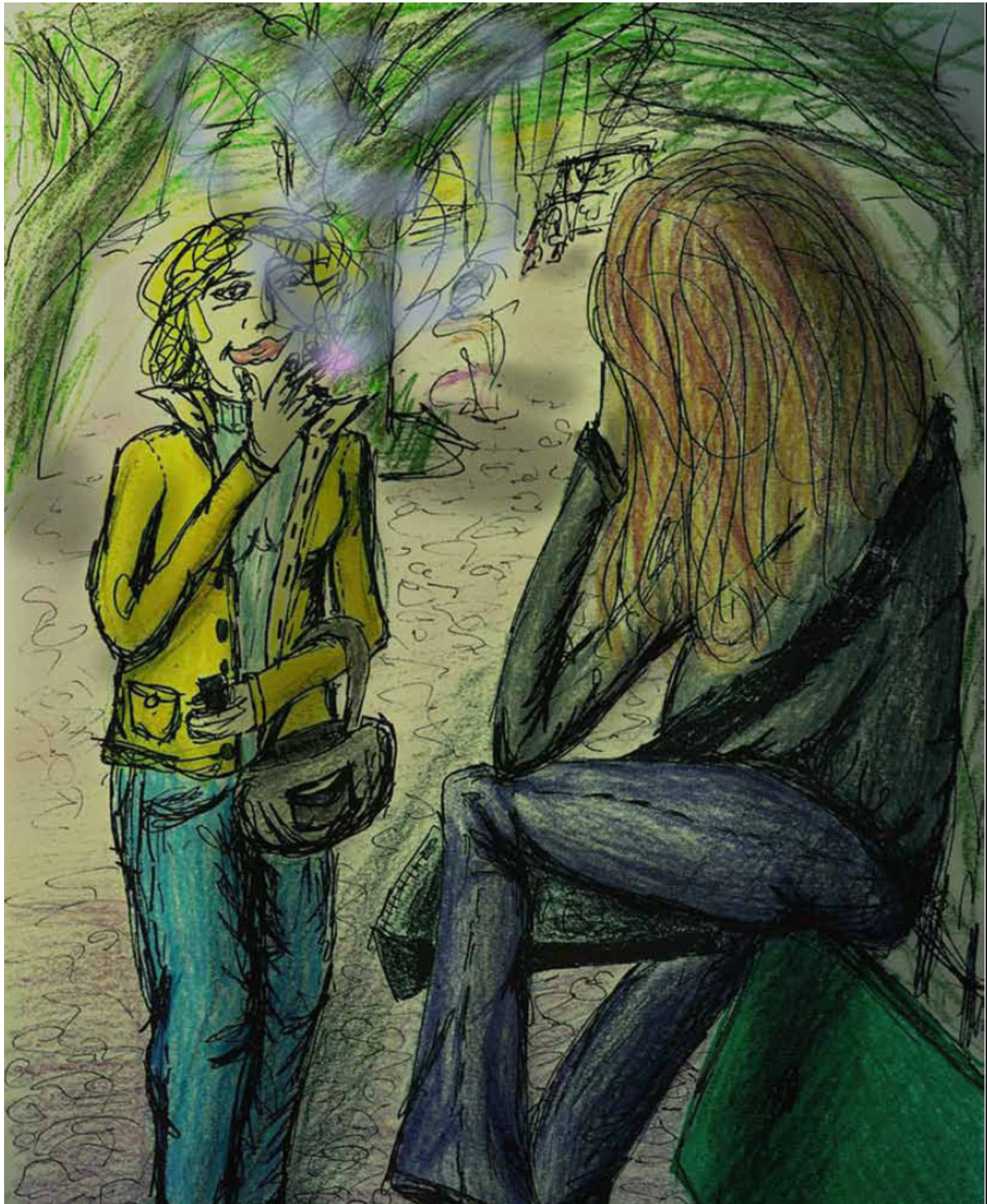
²³ On the ground the public health system reality is much more complicated, as in many cases the states still directly manage hospitals and other health units, and there are many conflicts of attribution and responsibilities between the two levels.

Since the year 2000, the National AIDS Program (NAP) and now the Department of STD, AIDS and Viral Hepatitis have been transferring funds to state level health departments and some municipalities for support of HIV/AIDS services and programs on a yearly basis, including funds for civil society organizations and community based systems. These transfers are guided by state level and municipal level planning tools, known as PAM (*Plano de Ação e Metas* – Action Plans and Goals). Nevertheless, with decentralization of these funds, NGOs and community based organizations have suffered from lack of technical and financial support.

There have been consistent setbacks in terms of both financial and technical support to the community sector due to lack of both operational and management capacity and political will on the part of some local governments. On the one hand, it is difficult to contract with, disburse funds, and monitor projects implemented by civil society organizations. On the other hand, there has also been a lack of capacity in NGOs to properly advocate for the continuity of their effective participation and implementation of community level interventions. This was one reason why the NAP decided in the mid 2000's to support the so called “strategic” programs such as those developed by the prostitutes’ and gay/MSM networks.

Even though from 2000 to 2007, the National AIDS Program allocated close to US\$ 120 million for NGO projects for HIV/AIDS prevention and support activities, direct funding from the federal government to NGOs during this period decreased from approximately US\$ 7-8 million per year in 2001 and 2003, to US\$ 3 million in 2007. This financial gap was to be covered by state and municipal level AIDS programs, which should have budgeted and allocated these amounts to local NGO projects. However, by and large, states and municipalities have not been able to fulfill this commitment.

Projects undertaken by NGOs that target the most vulnerable and affected populations, principally with regard to prevention, have fallen by almost 50 percent. In 2003 the National STD and AIDS Programme provided support to almost 1,000 projects implemented by civil society (NGOs), whereas today it supports less than half of NGOs (directly), whereby the resources are transferred to state and municipal health departments in accordance with National Health System policy. Generally speaking, this measure has caused greater obstacles in terms of the transferring of financial resources to NGOs working with HIV/AIDS (SIMOP/PN-DST/AIDS in 13/5/2008 – Planning Department – ASPLAN).



4. RESEARCH FINDINGS

4.1 HIV/AIDS/SDT prevention and health care: the experience of female prostitutes

This section presents findings from the assessment and investigation of HIV/AIDS/SDT prevention, health care and treatment provided to sex workers by the public health system in the cities of Rio de Janeiro and Porto Alegre. The objective was to collect data through participant observation, conduct additional interviews with health professionals and focus groups with sex workers, to look at how they perceive treatment and assistance services offered to sex workers, and to ascertain if they have actual access to available public health services.

Field work was carried out in Porto Alegre, in the beginning of 2009, and in Rio de Janeiro in two stages: in 2008 with relevant actors and other health professionals and in 2009 with women sex workers, health professionals, and service observation. The original methodology of the study included: focus groups with sex workers (ten women in each city), interviews with SUS administrators and health professionals, observation of some STD/AIDS health services which provide care to sex workers (women or travestis). Access to women and formation of focus groups were intermediated, in principle, by prostitutes' organizations in the two cities. Identification of services and health professionals would be done through the contacts of the field worker in Porto Alegre and ABIA in Rio de Janeiro. However, in the case of Rio de Janeiro, after a preliminary assessment of the possibilities and limitations of the area, it was concluded that it would have been very difficult to set up focus groups; instead, a small survey with sex workers was conducted.

Research in Porto Alegre was facilitated by the Prostitution Studies Unit (NEP), an organization founded in 1989 to promote female prostitutes' rights that is also a member of the Brazilian Prostitutes' Network. NEP carries out mobilization and advocacy work, as well as interventions related to healthcare, HIV prevention (including condom distribution), and legal support and follow-up services for prostitutes concerning rights violations and issues of access to health services.

Focus groups were organized after NEP workshops with sex workers, which are held on a regular basis²⁴. After one of these workshops, we asked participants if they would be willing to stay after the next workshop to take part in a focus group. However, on the date of the next workshop participants did not show up so the NEP team decided to make a concerted recruitment effort to ensure the presence of six women for a specific conversation on the research theme.

²⁴ The workshops are coordinated by NEP, by more experienced militant prostitutes or by people close to the movement.

In Rio de Janeiro, there are three organizations working in the defense of prostitutes' rights in Rio de Janeiro: Amocavim (Vila Mimosa), Fio d'Alma (downtown and Campo de Santana), and DAVIDA (downtown and southern area). Their composition and ways of working are fairly varied and there are tensions among their leaders. We relied on the support and our partnership of DAVIDA, which is directed by Gabriela Leite, who also coordinates the Brazilian Prostitutes' Network, to carry out the research in Rio de Janeiro. In 2005, she created the fashion brand DASPU (see box below), internationally known as a strategy to give visibility and legitimacy to the work of prostitutes, and to raise funds for ensuring the sustainability of DAVIDA actions in defense of prostitutes' rights.

After conversations with the organization's team, we concluded it would not be possible to set up focus groups, so instead we relied on the help of a peer educator to identify women "turning tricks" on the streets to be individually interviewed. In addition, a downtown "sauna" was contacted to interview women involved in indoor sex work.

DASPU

In 2005, the DAVIDA NGO decided to launch a fashion brand inspired by clothes worn by prostitutes. The new brand was dubbed DASPU, an acronym for "Das Putas" (of whores). The name was inspired by an upper-class fashion shop located in São Paulo, called DASLU (of Lúcias). The latter was then under investigation for tax evasion. This project sought to expand financial resources to support DAVIDA's political activities and, above all, to raise a broad cultural debate on the imagery of prostitution in Brazilian society.

DASPU has been very successful as a cultural change project. Just after its launching, DASLU reacted, threatening DAVIDA and Gabriela Leite with a law suit for "defamatory attack on a good name." DASPU publicly stated it was not going to change its name, and DASLU gave up any legal action after acknowledging there was no consistent legal basis for it. This episode resulted in broad debates in the media (print and TV), making DASPU rapidly known to a very diverse audience. Later, they participated in Rio de Janeiro and São Paulo fashion weeks, and also at the 2008 International AIDS Conference in Mexico.

Above all, DASPU produces and sells T-shirts with messages and provocations on the issue of prostitution. Sensual collections inspired by prostitutes' working clothes are prepared for the fashion shows. Clothing design and T-shirt mottos break with both social movements' conventional political discourse and the politically correct approach. They provoke reflection not only on prostitution, but also on gender, sexuality, and the uses of the body and eroticism.

A market analysis made by a financial consulting firm showed that most people buying the clothes were not prostitutes, nor persons directly connected to the sex business, but students, artists, intellectuals, and people linked to discussions on sexuality and gender. Unfortunately, DASPU financial returns have not been sufficient to make up for the funding losses suffered by DAVIDA in recent years. Undoubtedly, it was a huge political success and promoted a spontaneous debate on prostitution in Brazil. For further information, visit <http://www.daspu.com.br>.

4.1.1 'Sex industry' territories

In Brazil, prostitution is not a crime and there is no state regulation. There are no legally established red-light districts outside of which prostitution is forbidden. Any place could potentially become the work space of a sex worker, particularly around residential neighborhoods, even though it is not widely accepted by the general public. In Porto Alegre and Rio de Janeiro, there are several areas where female prostitution is carried out, which have remained more or less stable throughout the history of these cities.

For example, in Porto Alegre these areas are located in the northern part of the city (Assis Brasil Avenue), where there are known spots for streetwalkers and nightclubs where prostitutes can be met. In the southern area of Porto Alegre, in the Ipanema neighborhood, the sex market resides along the Guaíba riverbank and on Oswaldo Cruz Avenue. In the central-eastern area, in the Cidade Baixa neighborhood, sex work takes place in nightclubs and “bars”. In Menino Deus neighborhood, there are traditional spots of travesti and female prostitution, while Parque da Redenção is known as a cruising area for gays and MSM. In several of these places the sexual transaction costs between R\$ 10 and R\$ 15, and thus represents so-called “low-income prostitution.”

Between the 1970s and 1990s, downtown street prostitution – involving both women and travestis – was sharply reduced under the scope of “modernization”. Today, the main places for female prostitution are private spaces or “public” indoor spaces such as “nightclubs” or “bars”, which might have private rooms or be close to hotels or hostels. Nightclubs and bars are concentrated along Farrapos Avenue, along with “houses” or “rooms”. The “houses” resemble the old brothels: salon, bar, pool room, television screens, and women wearing “work clothes”. Generally, these women are “permanent” workers. The agreements between these women and house owners tend to benefit the latter. The “rooms” are small offices spread through dozens of commercial buildings, where 1–5 women work (usually two). In general, these women are autonomous workers, who have entered into small partnerships, or pay a percentage of their earnings for using the room. In Porto Alegre, there are two buildings where all the offices are occupied by female prostitution services. For streetwalkers (low income prostitution), a trick may cost from R\$ 20 to R\$ 60 (1US\$=R\$1.7). Indoors, prices can go up to R\$ 150 and may reach R\$ 300.

In Rio de Janeiro, there are also several territories of both street and indoor prostitution. Along Copacabana Beach, known as the “whores’ beach,” there are several spots where sex tourism is prevalent, involving both women and travestis. Some of these places are very well-known and conspicuous, such as the nightclub *Help*²⁵ – for many years considered the center of sex tourism. Others are more discreet. In these

²⁵ The nightclub *Help* has just been closed down. A museum will be constructed at this site.

spots, tricks are more expensive and may reach R\$ 150²⁶. There is also prostitution in Ipanema and in Barra da Tijuca, wealthy areas of the city, where prices are much higher. As in Porto Alegre, “low income” prostitution is concentrated downtown, in areas with high circulation of people, such as squares and parks (Praça Tiradentes, with its traditional Hotel Paris, where about 500 women work), Campo de Santana, Central do Brasil train station, the famous Vila Mimosa and Praça Mauá “zones”, which have historically served the port area. In these areas, tricks vary from R\$ 10 to R\$100.

There are also *privês* (private places), or “leisure spaces”, and saunas. In these places, a portion of the clientele do not “buy sex”, they just go there to socialize with friends or perhaps get involved in seduction games with the “girls”. The women are not always “permanent” workers and the charge for sex services can be quite high. In turn, “saunas” are places exclusively dedicated to prostitution. They invest in a quality atmosphere and are rigorous in selecting and managing the women. They offer catalogues to their clients and develop relatively stable relations with the prostitutes. As discussed later, prostitutes often are submitted to typical working conditions, which might include compulsory health checkups. Sex transaction in luxury *privês* might cost over R\$ 1,000, while in saunas it costs from R\$ 100 to R\$ 150.

In both Porto Alegre and Rio de Janeiro, sex work networks are much more extensive and complex. They can be tracked through advertisements on stickers glued to telephone booths, distributed on streets, and through classified ads published in newspapers. There are also many specialized websites on the Internet and mobile phones. In the case of Rio de Janeiro, many websites are exclusively produced for foreigners. Finally, there are also informal networks, through which women, travestis, and men provide sexual services in a much more anonymous and discreet fashion, often only occasionally (for Rio de Janeiro see da Silva and Blanchette, 2009)²⁷.

Having this vast, complex, and diverse panorama as a backdrop the specific universe of this case study was limited to interviewing 18 female prostitutes who work on the streets and *privês* of central Porto Alegre (all of them associated with NEP) and 13 women who provide sex services in Rio de Janeiro, who during the period of our field study, were either working in Praça Mauá or a sauna also located downtown. All women are adults (over 18) and identified themselves, or were identified by activists of the sex work movement, as “prostitutes,” “sex workers”, or “call girls”. Their inclusion as research subjects was voluntary and did not result in any payment to them or the people who helped in our recruitment²⁸.

²⁶ On Copacabana, see the classical work by Gaspar (1985), as well as the more recent study by Silva and Banchette (2009).

²⁷ da SILVA, A. P and Blanchette. T (2009) *Amor Um Real Por Minuto - A prostituição como atividade econômica no Brasil urbano*. Available at <http://www.sxpolitics.org/pt/?p=1186>

²⁸ Maria (professional name), of Davida Group, helped us in identifying women interviewed in Praça Mauá and Praça Tiradentes. Josias de Freitas made the preliminary contacts that enabled us to hold the interviews at the downtown

Modalities of prostitution and rights violations

Under the coordination of DAVIDA a pilot research project, “Human Rights and Prostitution”, was conducted in 2007 with female prostitutes in Rio de Janeiro and with prostitutes associated with the Brazilian Prostitutes’ Network. The results were recently published by DAVIDA (2010)²⁹. The final report presents a framework that clusters the multiplicity of expressions of female prostitution in broader modalities to make it possible to better analyze the correlation between the conditions in which prostitution is exercised and the existence and degree of human rights abuses. The report defines three broad modalities: street prostitution, prostitution in saunas, and confined prostitution.

In the case of street prostitution, the following were identified as most frequent abuses: clients’ refusal to pay, the lack of recognition of prostitution as an occupation (on the part of police officers and other authorities), physical aggression in unsafe places, male client refusal to use a condom, fees charged by intermediaries, and violation of the right to freedom of movement (particularly on the part of the police).

In the case of saunas, the following abuses are listed: debts related to control over the prostitute’s income, fines, mechanisms to charge for services and reduce the duration of the sexual transaction to maximize profits.

Finally, in the case of confined prostitution, the study identified evidence of much more serious coercion and violence such as: arbitrary confinement for indebtedness; prostitutes coerced into using drugs; and lack of adequate physical, spatial, and hygienic conditions for sex work and rest periods. Confinement can result in a loss of their sense of time, and complete lack of access to healthcare services, including emergency services

It is interesting to use the modalities listed above to examine sex work in the two cities where the case study was performed. In Rio de Janeiro, perhaps the most significant case to be highlighted is Vila Mimosa II. This area of prostitution, in the central part of the city, is Brazil’s largest urban area of confined prostitution. According to several informants, Vila Mimosa is run by an association made up of establishment owners and pimps. There are several narratives of systematic violence and power abuse by those agents, including the abandonment of women with terminal illnesses, and beatings of clients and sex workers. Paradoxically, that association is one of the “cultural spots” in Rio de Janeiro and is funded by several state organizations that promote women’s health and rights (Simões, 2003)³⁰.

Although open violence is not so evident in saunas, there are also controls and violations. In cities such as Rio de Janeiro, saunas are controlled by businesspeople and pimps, who produce a scenario similar to confined prostitution. Both in Rio de Janeiro (where the phenomenon is fairly widespread) and Porto Alegre, prostitutes report abusive control over their income and their time, as well as the existence of

“sauna”.

²⁹ DAVIDA. Direitos Humanos e Prostituição Feminina. (Human Rights and Female Prostitution): Rio de Janeiro, 2010.

³⁰ SIMÕES, S. *Vila Mimosa II: a construção do novo conceito de ‘zona’*. Master’s thesis. Rio de Janeiro State Federal University (UFF) Postgraduate Program in Anthropology and Political Science. Niterói, 2003.

what could be called a “privatized” sanitary regime. There are also reports of extreme physical violence on the part of “managers”.

In the case of street prostitution, if we consider areas such as “Praça da Alfândega” or “Garibaldi Street” in Porto Alegre, or “Praça Mauá” in Rio de Janeiro, women are subjected to insults by passersby, as well as complaints by neighborhood associations in those areas. However, the most flagrant abuses are inflicted by civil and military police, especially the latter in more recent years. Currently, formal police actions to curb and suppress “child prostitution”, contraband, and drug trafficking often result in abuses against sex workers who work in those same areas. In general, these abuses are “morally” justified (Olivar, 2010)³¹.

4.1.2 Sex workers' perception

The results from the interviews with sex workers are organized into three blocks. The first is devoted to report aspects related to healthcare and access to health services in general, and more specifically the issue of access to HIV testing. In the second block, the issue of HIV/AIDS prevention is specifically addressed by women interviewed. Finally, experiences of discrimination in health services, as reported by women interviewees, will be examined.

4.1.2.1 Access to and use of services: healthcare (at large) and HIV/AIDS testing

All sex workers interviewed in this study have relatively easy access to health services. They undergo regular gynecological examinations and periodic HIV tests. These women are greatly concerned with caring for their health and this is clearly related to their work. Most of them say that being in good health is key to their professional performance. Almost all of them recognize the risks of HIV and STDs as intrinsic to sex work. Hence, they are very concerned with their sexual health and seek gynecological services on a systematic basis. Among all the women interviewed, only one does not conform to this pattern.

Over 70 percent of the interviewees are tested for HIV on a regular basis (every three months). The others are tested every six months. However, because of the nature of our study, we could not deepen the analysis on this pattern of behavior, as to verify whether this conventional pattern was related to concrete risky practices, induced by the health policy, or just reflected a habit. For example, in the particular case of sex

³¹ OLIVAR, J. M. Guerras, trânsitos e apropriações: políticas da prostituição feminina de rua a partir das experiências de quatro militantes em Porto Alegre. PhD dissertation. Postgraduate Program in Social Anthropology, Rio Grande do Sul Federal University (UFRGS). Porto Alegre, 2010.

workers in Rio de Janeiro saunas, this regularity is in fact determined by the strict sanitary rules defined by the workplace, which pays for a gynecological clinic and laboratory to periodically examine and test the women that work there.

As this rule is part of the work regime, whoever refuses to be tested or to undergo periodic medical examinations, or who has tested positive for HIV, will have her contract suspended. However, it should be noted that in the group studied, these sanitary norms are viewed positively both by the women and the manager. The women say these measures do preserve the “house’s name” and make it easier for them to look after their health and well being³². Although we did not research other establishments of the same type, it is reasonable to assume the same rules are applied in other saunas and “houses” in Rio de Janeiro and Porto Alegre. This finding suggests that STD related sanitary controls that in the past were somehow imposed are now part of a routine in the private sector involved with the sex trade.

Most women interviewed in Porto Alegre, unlike in Rio de Janeiro, knew about and used public health system services, such as the Testing and Counseling Centers (CTAs), or hospitals (for example, President Vargas Hospital, Rede Conceição, and Fêmina Hospital). With few exceptions, they are tested for HIV at the Counseling and Testing Centers (CTAs) and seek out general healthcare in this public health network. Only two of the interviewees, who were both younger (around 25), did not know it was possible to be tested at the Public Health System Units (SUS). Also worth noting is that, in the specific case of the President Vargas Hospital, there is an agreement signed with NEP, which facilitates access of sex workers connected to the NGO to hospital services.

In Rio de Janeiro, only three women reported having recently used public health services to get HIV tests, and two of them were tested at a public service because they participated in a clinical survey called *Corrente da Saúde* (Health Chain, see item 4.2.2.3). Two other women reported accessing public clinics and hospitals for general healthcare, including gynecological care. The others resort to private services, as most of them have private health insurance and almost all reported that, whenever necessary, they pay directly for medical services. As already mentioned, sex workers working in saunas have HIV tests and periodic gynecological exams paid for by their establishment. On the whole, women interviewed in Rio de Janeiro did not know about the existence of public services for HIV tests and treatment. Most had never heard about the CTAs. Sometimes, when the interview was over, they asked the researcher for information on what these Centers were and where the services were located.

The fact that prostitutes in Porto Alegre have greater knowledge about and access to SUS services can be explained by the better quality of local public services and a

³² It is important to note that the manager was present at the interviews. This may have curbed somewhat sex workers’ accounts.

more consolidated tradition of citizens' participation. Undoubtedly, NEP's pedagogical and managerial action, such as the informal agreement with the President Vargas University Hospital, should also be taken into account. According to the experience of women interviewed in this case study, SUS services seem to be better structured to provide health care in Porto Alegre than in Rio de Janeiro, where the public health system has been historically more problematic. However, it should be noted that, in both cities, in recent years, the poor functioning of municipal health services and state hospitals, as well as the funding for the prevention work carried out by NGOs, have been the target of heavy criticism and ongoing protests. To this extent, the experience and perceptions of sex workers in Rio de Janeiro about the public health system – their lack of knowledge and access – were hardly surprising.

Nevertheless, these conclusions should be viewed carefully, as the number of women interviewed in both cities is too small to infer a broad and consistent evaluation of the public health system in each city. In addition, sex workers interviewed in Porto Alegre were connected to NEP and, thus, enjoyed more systematic access to information on services and, above all, had easier access to a large public hospital. While prostitutes interviewed in Rio de Janeiro had no link to any organization and, therefore, their experience and perception of the public health system generally corresponded to that of the population at large. It is very likely that if we had interviewed women in Porto Alegre who work in “houses” or “nightclubs”, without connections to NEP, results would have been similar to those in Rio de Janeiro. Similarly, if people interviewed in Rio de Janeiro were closer to organizations that advocate for prostitutes' rights, perhaps knowledge about testing and treatment services would have been greater.

Reasons to get tested and to take care of oneself

Porto Alegre sex workers talked about HIV testing in a different way than was reported by sex workers in Rio de Janeiro. While the first mainly referred to the periodicity of testing (three or six months), Rio de Janeiro prostitutes usually talked more about risk or vulnerability. For the women in Rio being “at risk” is the main reason to get tested. For example, two women aged 45-55 said they had not been tested in the last two years because they had not experienced “risky situations”, which means that they did not have any sexual relations without a condom. But the experience of risk has also been mentioned in Porto Alegre as woman said that that “*after a night of orgy and cocaine, I always wake up feeling sure I had put myself at risk*” and because of that she goes to NEP for guidance and to be referred to medical services. Finally, a married woman said she had never been tested for HIV because she only recently became a sex worker, but she realized that from now on she needed periodic testing and gynecological exams. Thus, prostitution is perceived by this woman as a risk factor, while sexual relations in the marriage seem automatically safe. This pattern of perception is confirmed by findings of other surveys on prostitution and HIV in Brazil (Araújo, 2006; Chacham et al., 2007; and Pasini, 2000)³³.

³³ ARAÚJO, R. *Prostituição: artes e manhas do ofício*. Goiânia: Cânone Editorial, 2006.

CHACHAM, A. S.; DINIZ, S. G.; MAIA, M. B.; GALATI, A. F.; MIRIM, L. A. Sexual and Reproductive Health Needs of Sex Workers: Two Feminist Projects in Brazil. *Reproductive Health Matters*, v. 15, p. 1-11, 2007.

PASINI, E. O uso do preservativo no cotidiano de prostitutas em ruas centrais de Porto Alegre. In FÁBREGAS-

4.1.3 Prevention: visible and invisible hands

Both In Porto Alegre and Rio de Janeiro, significant limitations in the provision of good-quality HIV prevention were identified. Women interviewed do not find systematic information, and often not even condoms, in public health services. One Porto Alegre interviewee told us television was the best source of information on prevention. Although sex workers in Porto Alegre had easier and more systematic access to health services, they consider existing prevention programs to be very poor, especially in the public health system because there are always big lines, waiting lists and more often than not no condoms.

By and large, condom distribution to sex workers at SUS units is very limited. Most health clinics have no condoms to provide. One interviewee said that in a health clinic she goes to the client must have a medical consultation before receiving condoms. It is widely assumed, however, that the lack of prevention programs in the SUS system itself would be compensated by the prevention work developed by NGOs. In the case of Porto Alegre, these organizations are GAPA, SOMOS, Nuances, Equality, and NEP itself, which distribute condoms in areas where male prostitutes (*michês*), travestis, and female prostitutes work and socialize. However, the number of condoms received by NGOs has been sharply reduced in recent years. For example, up to two years ago NEP received 100 condoms/woman /month, but now this quota has been reduced to 30. In addition, it should be taken into account that NGO prevention work, even at its best, will hardly reach the total population involved in sex work.

In Rio de Janeiro, the situation is even more problematic as prevention activities carried out by prostitutes' organizations and other NGOs are weaker and more limited. The existing organizations have not received funds allocated to them in municipal and state health departments prevention plans due to problems resulting from decentralization. In addition, as seen in the interviews, prostitutes and call girls very often did not have any knowledge about public services that distributed condoms for free. On the other hand, since condom use and healthcare were incorporated into the routines of the sex market, women or their clients systematically purchase condoms at drugstores, supermarkets, and other commercial outlets.

These finding indicate that the broad awareness about the importance of prevention was an extremely positive effect of public policies implemented since the 1980s. But the study also suggests that the population engaged in sex work has access to prevention mainly through the more or less visible hands of the market. In Porto Alegre, popular stores specializing in selling condoms visit the prostitution areas. Their clients are mainly

sex workers working indoors or in *privês* (private places), who buy condoms for prices varying from 10 to 20 cents of real. In Rio de Janeiro, in the “Praça Mauá” area, which is mainly frequented by sailors, the “gringos” pay one dollar for a condom at bars or hotels. In saunas, condoms are supplied by the establishment.

4.1.4 Quality of care and discrimination

The majority of women interviewed in both cities perceived that there are no public health services and programs geared to the needs of sex workers (Rio de Janeiro); and that existing services are precarious and do not offer quality care (Porto Alegre). Two interviewees in Porto Alegre considered that the agreement between NEP and the Getúlio Vargas Hospital provided a “specialized” and good service. Another woman interviewed in the same city mentioned the Fêmina Hospital as a service where the problems found throughout the public system do not occur. According to her, this is possibly due to the fact this hospital is only for women. In Rio de Janeiro, two women interviewed in Praça Mauá said that the survey *Corrente da Saúde* (Health Chain) had facilitated their access to a specialized health service for sex workers at the Praça Onze Hospital. These exceptions, in any case, demonstrate that no broad and qualified response by the public health system as a whole exists to respond to the needs and demands for prevention, treatment, and healthcare posed by women working in the sex market. Despite this void, it is also true that “some” health units or even “some” individual health workers are especially motivated to respond well to prostitutes’ demands and needs.

The study also raised questions to explore the experience of discrimination in health services. Although interviewees generally criticize the quality of the public health system, only four women declared to have been explicitly subjected to discrimination in public clinics or hospitals (three in Porto Alegre and one in Rio de Janeiro). In the case of two women in Porto Alegre, the experiences of discrimination occurred in very specific circumstances as they were trying to donate blood (Brazilian blood banks are public). When answering the screening questions they declared their profession to be “call girls” and were automatically excluded. This exclusion was not the result of personal prejudice on the part of the health professional, but derives from official protocol for screening blood donors that automatically exclude sex workers, MSM, tattooed persons, and persons who use drugs (especially injected drugs), among others. Although some years ago the Bahia Gay Group and other Gay movement NGOs opened a discussion on the discriminatory character of this protocol, these rules remain in force.

Two other women, one in Porto Alegre and another in Rio de Janeiro, mentioned that they observed an obvious change in the behavior of doctors once they informed them they were prostitutes. In one case, according to the interviewee, the doctor gave

her a weird look, moved away from her, and was very embarrassed. In another case, by contrast, the doctor became very talkative and at the end of the consultation tried to kiss the client. A fifth interviewee, from Porto Alegre, mentioned that when she was filling out her registration form at the Getúlio Vargas Hospital, where she had gone after being referred by NEP, and stated that her profession was “call girl”, the clerk at the booth returned the form telling her to change her occupation.

Although few, these experiences amount to more than 10 percent of our sample and, most principally, they may explain why many sex workers seeking health services (public or private) prefer to hide their occupation. Most interviewees never reveal their real occupation to health professionals, except when the doctor is a “good friend”. In general, they create strategies to avoid exposure and prejudice. One of them is to claim other occupations, such as “hairstylist” or “teacher in a daycare center”. Many prostitutes prefer “non-specialized” health services as a manner to prevent discrimination. In Porto Alegre, a young woman interviewed, who had moved from the interior of the state and worked in a “house”, said that even if specialized services for sex workers were available, she would avoid them because if she goes there everybody would know she was a prostitute.

This does not mean that all women involved in commercial sex hide their profession. Many directly challenge discrimination, through personal exposure and confrontation. In Porto Alegre, “activist” prostitutes always seek to persuade their colleagues of the importance of “assuming their activity,” especially to ensure that they get proper care at health services. In Rio de Janeiro, an “old prostitute” working in Praça Mauá told us she always reacts aggressively when facing discrimination. Another one in the same place, who is younger and currently married to an Italian, said she always acknowledges being a “call girl” when going to a health service because it is important for the doctor to know what she does in order to deal with professional risks.

4.2 Health programming and service delivery: field observation and perceptions of health managers and service personnel

Throughout the study, nine health delivery sites of different levels of complexity were visited. In Porto Alegre, five establishments were observed: CTA- Caio Fernando Abreu (Testing and Counseling Center), Dermatology Outpatient Unit (ADS) CTA, Vila dos Comerciantes Health Post Counseling and Serological Advice Center (COAS/CTA), Vila dos Comerciantes Specialized AIDS Assistance Service (SAE), and Getúlio Vargas Hospital STD Outpatient Unit. In Rio de Janeiro, the following services were visited: Lapa Family Health Program (PSF), Rocha Maia Hospital CTA, and São Francisco Hospital CTA (also known as Praça XI Hospital). In the case of Rio de

Janeiro, we had also planned to observe the May 13th Medical Assistance Post (PAM), but could not happen because we were unable to secure managerial permission³⁴. The analysis also includes, in the case of Porto Alegre, description of prevention projects developed by NGOs, especially by NEP.

4.2.1 Porto Alegre

None of the services observed in Porto Alegre formally develop specific HIV/AIDS healthcare or outreach prevention activities specifically focusing on people engaged in sex work. However, in Porto Alegre, the Getúlio Vargas Hospital STD Outpatient Unit offers a sort of specialized care because of the agreement established with NEP. In the focus group discussions, it became evident that women engaged in prostitution do not visit CTAs looking for STD/AIDS specialized services. In the case of prostitutes interviewed in Porto Alegre, access to HIV/AIDS information and prevention is mainly offered by NEP itself. Testing and counseling, when they occur, happen during regular medical appointments. In the case of some women, these appointments take place in public health services (SUS), but most of them resort to private services, paid for with their own money or by the owners of “houses” and “bars”.

4.2.1.1 Description of services visited

Health unit	Location	Services & functioning	Comments
Cairo Fernando Abreu CTA (Porto Alegre)	It is part of the Partenon Sanatorium hospital complex (Partenon neighborhood). Close by there are some areas of prostitution. Access by bus for those coming from other neighborhoods.	It offers basic testing and counseling. There is also an AIDS hotline.	The CTA functions in a house separated from the hospital complex. It is very clean and has good ventilation. The coordinator invested in physical renovations to protect counseling privacy. On the day of the visit, during a holiday period, there were no users.
Vila dos Comerciantes COAS/CTA (Porto Alegre)	The COAS/CTA is better known as “Former PAM3,” this post is one of the largest municipal health units and a reference for AIDS. It	COAS was the former name of what is now known as CTAs. This Center functions in the same way as a CTA. In this case referrals by the health post itself are prioritized. It operates on the	COAS functions in a room in the health unit. Access is well marked with prevention posters and the red ribbon symbol. The room is spacious, comfortable, and well-lit. Counseling privacy

³⁴ PAM is a municipal health unit which is important for the care of HIV-positive persons. It receives prostitutes and MSM involved in sex work. We made several attempts to schedule visits and interviews, but never received permission to observe PAM and talk to its users.

continued

Health unit	Location	Services & functioning	Comments
Vila dos Comerciaários COAS/CTA (Porto Alegre)	is located far away from any prostitution area. However, it is close to low-income neighborhoods and row houses where women involved in sex work might live.	basis of spontaneous demand, providing talks and individualized counseling given mainly by psychology interns.	conditions are excellent and there are plenty of materials on HIV/AIDS. On the days of observation, the number of users was very small and, perhaps for this reason, the doctor who coordinates the service arrived more than half an hour late.
Vila dos Comerciaários SAE (Porto Alegre)	The SAE is located in the same unit where the Vila dos Comerciaários CTA functions.	SAE is not a testing center but does the medical follow-up of people living with HIV.	SAE physical space provides less privacy than COAS. Unlike at COAS, reception is confusing. The pace of appointments is slower. In one of the visits, there was only one doctor, who arrived late, while several people waited. The coordinating doctor did not want to be interviewed for this study.
Dermatology Outpatient Unit CTA (Porto Alegre)	This CTA is located in the Cidade Baixa neighborhood, in the downtown area of Porto Alegre. It is next to nightclubs and streets where nighttime prostitution takes place. It is at a walking distance for people living in those areas. It is located across from the “Model Clinic,” a large municipal health unit.	It offers services that are typical of a CTA. Users do not have to take a number and get in line; they just approach the reception desk and inform they are going to the CTA. There the user receives a form and proceeds to the individual interview, talk, or test. Individual interviews are short (10 minutes). Afterwards, health workers discuss the information collected and one of them gives the talk or collective counseling (30 and 60 minutes). After the talk, individual tests are done in a nearby room. Users remain at the center between one and a half to two hours. Test results are ready in 10 days. Most users are referred by ADS or other SUS services, but there is also spontaneous demand (walk-ins).	The CTA is located on the second and third floors of ADS. Physical maintenance is precarious. However, privacy conditions are adequate. There are some references to HIV/AIDS in circulation areas. During the three days of the visit, there were many users (more men than women) and we noticed that people were received and treated with much cordiality. There is also a large availability of health workers. In this period, no person presented herself/himself as a sex worker and prostitution was never discussed.

continued

Health unit	Location	Services & functioning	Comments
Getúlio Vargas Hospital STD/AIDS Outpatient Unit (Porto Alegre)	Located in Independência neighborhood, downtown Porto Alegre. It is close to areas of prostitution and access is easy for people coming from other neighborhoods.	This is a regular SUS outpatient unit. To be seen you need to take a number or schedule an appointment. According to the nurse, the differential for sex workers referred by NEP is that they use the periodical consultation for STD checks and request also a general medical checkup. This is done because both the service and NEP consider that prostitutes are not in the habit of having general medical checkups.	The outpatient unit is located on a well-lit, spacious, and comfortable floor. However, because services on this floor are not just for HIV/AIDS, information and educational materials refer mostly to pregnant women. At the floor reception, there is a poster informing that no condoms are given out at the booth. Some interviewees in focus groups stated that the service is quite good, although slow.

4.2.1.2 NGO prevention work: the NEP experience

As already mentioned, a notable characteristic of the Brazilian response to the HIV epidemic since the 1990s has been the partnership with NGOs and the transfer of funds to enable these organizations to implement prevention activities. This strategy has been even more emphasized in the case of more vulnerable groups, such as sex workers and MSM. In Porto Alegre this model has been built for many years and, due to crises in the public health system-SUS functioning in recent years, it continues functioning but poorly structured.

Concerning prevention actions geared to persons involved in commercial sex in Porto Alegre, the following organizations are still active: GAPA/RS, NUANCES, SOMOS, Equality, and NEP. GAPA/RS, NUANCES, and SOMOS develop prevention projects for homosexual men and other MSM, distributing condoms in areas of male and travesti prostitution or in cruising areas (transactional sex that may or may not involve payment). SOMOS also works with young MSM and does sex education. The Equality group works specifically with HIV/AIDS prevention among travestis. NEP, in turn, carries out specialized prevention actions focused on prostitutes, monitors women prostitutes living with HIV/AIDS and promotes treatment adherence services.

For many years, NEP has had a partnership with the Porto Alegre municipality. One of the rooms where the organization functions is owned by the municipal government. Since the late 1990s, NEP has received national AIDS policy funds for prevention work through the municipal and state health departments. Currently, NEP

prevention activities include: one-hour workshops on a variety of issues, outreach work with street and indoor prostitution, medical follow-ups, and individual and collective follow-up of women prostitutes. Any woman prostitute registered with NEP, who pays a small fee and attends at least one workshop a month, is entitled to the other services and may receive a monthly quota of condoms. The number of condoms varies according to the amount received from the Municipal Health Department (in 2009, 30 condoms/woman/month). Workshops discuss STDs but also other issues that might interest women, such as human rights and healthcare.

Street interventions are made by “activist” prostitutes, accompanied by monitors or volunteers. “Activist” prostitutes are very experienced in the sex market, involved in political work, and command a lot of respect. During these interventions, contacts are made with the “owners of the area”, managers, and prostitutes. Sex workers’ rights are discussed, as well as the importance of self-esteem and care. NEP was funded by the PACT-USAID Program up to 2005 and, in that period, interventions were carried out not only in Porto Alegre but also in the interior of the state.

4.2.2 Rio de Janeiro

Neither Rio de Janeiro municipal or state health units offer services specifically targeted at sex workers. However, in specific health units, there are initiatives aimed at creating a more favorable atmosphere and implementing more efficient responses regarding that group, especially in relation to HIV/AIDS. This situation ends up projecting the image that these are “specialized units”.

The best known service in Rio is the Lapa Family Health Program (PSF) unit, whose priority clientele are travestis living in the neighborhood. Because a significant part of this population is involved in sex work, the work of the health unit is directly related to prostitution (see item 4.2.2.2). For many years, the May 13th PAM unit has specialized in caring for HIV-positive clients and, since 2008 it has carried out sensitizing actions with health professionals and clients to overcome prejudice against gays and travestis. Another relevant health service is the São Francisco Hospital CTA that functioned as a reference service for prostitutes in the early 1990s, during the implementation of the *Previna* project and, more recently, as one site of *Corrente da Saúde* (RDS) research operations (see item 4.2.2.3.).

4.2.2.1 Description of visited services

In this section, a summary description of the units visited is presented, as well as additional information on the work done by the Lapa PSF and the clinical survey developed at the São Francisco Hospital, which involves a significant number of prostitutes.

continued

Health unit	Location	Functioning	Comments
Lapa PSF (Rio de Janeiro)	It is located at the Ordem Terceira do Carmo Hospital, very close to the Lapa Arches, a traditional prostitution area, especially for travestis.	The Lapa PSF, although formally linked to SUS (i.e., receiving funds from the Municipal Health Department), functions at a Catholic philanthropic institution and is administered by a private university (Estácio de Sá). PSFs across the country work basically in health prevention and promotion. The work is developed by health professionals and agents covering a specific territory, and the work is based on family, social, and household contacts and networks of people living in the area. In the case of Lapa PSF, health actions with travestis became quite important because a significant number of travestis live and work in the streets, hotels, and “houses” of this neighborhood. Although women prostitutes also work in Lapa, they often live in other areas and thus are not included in PSF action. Actions are carried out after a household visit, when people’s demands and needs are identified. If necessary, people receive information, condoms, or are referred to health services.	Lapa PSF functions inside the Carmo Hospital, occupying a whole floor. It is a long corridor with consulting rooms on both sides. It is a clean, well-lit, well-cared-for place, with lots of information on the walls. The first office, on the door side, is Dr. Valeria’s who up to July 2009 prioritized seeing travestis. When we visited this service and interviewed Dr. Valeria she was getting ready to leave the service because she had passed a public competition for the Rio de Janeiro Federal University (UFRJ). It was not clear what would happen to the specialized service for travestis after she has gone.
Rocha Maia CTA (Rio de Janeiro)	It is located in the Rocha Maia Municipal Hospital, in the Botafogo neighborhood. It is hard to identify the CTA because of the absence of signs. Potentially, it is a unit sex workers working in Copacabana and Ipanema are referred to.	As in other CTAs, the service offers educational talks, testing, individual counseling, and follow-up of HIV-positive patients. Because there is no meeting room, the talk was given in the waiting room and perhaps this explains its brevity. Initially, this CTA was part of the project <i>Corrente da Saúde</i>, as one of two testing centers supporting the survey. However, because very few women sought this service and the CTA team had issues with the survey methodology, the partnership was discontinued.	The space is comfortable and the CTA has educational materials. Consulting rooms are well ventilated and provide for confidentiality. The talk we attended had five to six people, both men and women. There was no mention of prostitution and not much room for questions or testimonies. The nurse in charge explained that they do not receive many “call girls,” a maximum of three a week. All of them from the southern area (Copacabana, Ipanema, and Botafogo). The CTA does not do any work outside the unit.

continued

Health unit	Location	Functioning	Comments
São Francisco Hospital CTA (Rio de Janeiro)	The CTA takes up a fairly large part of the São Francisco University Hospital, which is the UFRJ infectology unit.	The CTA offers basic educational talks, testing, counseling, and follow-up of HIV-positive persons. Talks are given by CTA workers or interns. As the CTA is connected to a UFRJ hospital, it has become an important center of clinical research on HIV/AIDS and other infectious diseases. It was also one of the reference centers for the project <i>Corrente da Saúde</i> in the component that researched HIV/AIDS incidence among Rio de Janeiro prostitutes.	Hospital facilities are very old and lack maintenance. The CTA is easily spotted by the large amount of information materials on HIV/AIDS displayed on walls and corridors. The coordinator correctly thinks that the CTA is located in a very privileged area in terms of easy access for female prostitutes, male prostitutes, and travestis who work downtown because it is next to Campo de Santana (Central do Brasil). It is also very close to Praça Tiradentes, Praça Mauá, and Vila Mimosa. However, the only prostitutes interviewed who knew about this service were those who had participated in the <i>Corrente da Saúde</i> research.

4.2.2.2 Lapa PSF: a special case

Prevention, promotion, and healthcare actions developed by the Lapa PSF are exceptional in several ways. First, because the Family Health Program (PSF) is still incipient in the Rio de Janeiro municipality (and better implemented than other municipalities in the State of Rio de Janeiro); this particular unit is installed in a Catholic philanthropic institution and the PSF itself is run by a non confessional private university. Thus, it cannot be described as typical unit of the regular public health system. In addition, the program, in the way it was designed and implemented, resulted mainly from the investment and commitment of one doctor³⁵ who left the service in July 2009. According to this professional, in 2002, she was requested by local community leaders to map out the area where many travestis live. This survey led to the opening of the PSF unit specifically designed for this population group who is generally ill-treated at health service centers. Although occasionally prostitutes receive care at the unit, the main clientele is made up of travestis. Initially, even some Lapa PSF interns manifested resistance and prejudices against treating this population.

³⁵ We are referring to Dr. Valéria Romano, family doctor, Lapa PSF initiator, who develops a differentiated work with travestis. Currently, she is a professor at Rio de Janeiro Federal University (UFRJ).

During the case study, we visited the PSF and had the opportunity to accompany a health agent³⁶ on two household visits. The first visit was to an old and large house on Mem de Sá Street, where we met Luciana, a well-known travesti that is considered a leader in the neighborhood. The old house that is almost in shambles has ten rooms occupied by travestis. There is also a “living room.” The health agent was welcomed and introduced to everyone. The agent visited every room, filled out an individual form for each resident, talked to them all, and made medical appointments. According to this health agent, cases of tuberculosis are common and many of the travestis are HIV-positive.

Many of the residents of the house were migrants from Brazil’s North and Northeast regions. Just one was originally from the city of Rio de Janeiro. Some of them said they often came to the PSF and were well treated. They refer to the PSF doctor with lots of affection. Some of the travestis stated that since they were also “research volunteers” in a clinical investigation project on the antiretroviral drug Truvada’s efficacy as HIV preventive medication (project IPREX) they received medical treatment in a public health unit, the Evandro Chagas Hospital. However, they also reported they did not know of any other public health service besides the PSF and Evandro Chagas. They mentioned private doctors who prescribed hormones and injected silicone. During the visit, the municipal health agent distributed condoms and insisted on their use.

Afterwards, we visited another building on Resende Street. It was recently constructed but in a fairly precarious state as it looked as if had been occupied before construction was concluded. Wiring was exposed and there were no elevators, just the shafts. On the fourth floor, we knocked on an apartment door and Elizete announced herself as the health agent. Residents took a while to open the door. It was a small apartment, with home appliances and basic furniture. Two very young travestis received us. A third one lives in the apartment but we did not meet her. One of them, who had recently implanted silicone was in pain and could not move about easily. The health agent followed her routine: filled out forms, asked questions, noted down answers, distributed condoms, and scheduled appointments.

The experience of the Lapa PSF is emblematic. On the one hand, it shows the need for the health system to recognize the “differences” among users, as well as for health providers to be sensitized to meet “different” demands. As we know, the mark of “different” is quite obvious in the case of travestis because of their bodily expressions but also because their health needs, related to corporal adjustments, openly challenge sexuality and gender norms prevailing in public health vision and interventions. In addition, their life, health, and working conditions are often very precarious. This aggravates their vulnerability to AIDS, violence, and discrimination. In this regard, the

³⁶ Referred to by first name only: Elizete.

investment made by the PSF team is extremely positive and includes ongoing efforts by health professionals to educate their colleagues on issues such as gender, sexuality, and sex work. But even so, the doctor explained that travestis and sex workers who have a little bit more money choose to pay for private medical insurance and private doctors “to soften the prejudice suffered in healthcare”.

On the other hand, however, the PSF experience is one illustration of how a good public health response to sex workers needs can be highly “personalized” by becoming totally distinct from the regular public policy. The PSF in Lapa was concretely promoted and maintained by one doctor who had a strong personal interest in working with this population. Most importantly, despite her efforts to “institutionalize” the experience, when she left in July 2009, it was not certain that this distinguished work would continue.

4.2.2.3 The *Corrente da Saúde* research project

In the 2008–2009 period, the National AIDS Program funded country-wide research (Respondent Driven Sample – RDS) on HIV/AIDS incidence among three groups that experience conditions of high vulnerability: sex workers, injecting drug users, and men who have sex with men (MSM, an epidemiological category that still includes travestis and transgenders in Brazil). In Rio de Janeiro, the RDS Study on HIV and Syphilis Prevalence among Female Sex Workers was conducted by FIOTEC–Foundation for Health, Scientific and Technological Development (FIOTEC) of the Oswaldo Cruz Foundation (FIOCRUZ)³⁷. It involved over 600 women who were tested and answered a comprehensive questionnaire on their behavior, attitudes, and practices related to their work and the epidemic³⁸.

The RDS methodology used is based on building networks of random “seeds” that are interconnected and it proceeds in “waves” as to take into account the greatest possible diversity of a “social space”³⁹. In the network created by the research process, each person is a seed that is connected to a maximum of three other seeds or knots, and so on.

The initial strategy to recruit subjects for the study in Rio was to contact prostitutes’ organizations. But this outreach effort met resistances, difficulties in dialogue, and

³⁷ In Rio de Janeiro, the Research on Behavior and HIV and Syphilis Prevalence among Female Sex Workers was coordinated by Dr. Célia Landmann Szwarcwald.

³⁸ This account is based on interviews with four professionals who worked in this research, and with leaders of prostitutes’ organizations.

³⁹ Presentation given by the research coordinator at the IX Brazilian Congress on Collective Health (Recife, Pernambuco, November 2009).

disharmonies. The group Fio d'Alma did not respond and, in a first moment, Amocavim, denied access to Vila Mimosa. The DAVIDA NGO – albeit questioning the research objectives, approach, and methodology – decided to put their “peer to peer” volunteers at disposal of the research. The research also had two referral health units for blood collection and dissemination of information: the São Francisco Hospital CTA, was supposed to reach out to female prostitutes working in downtown, while the Rocha Maia Hospital CTA would reach out to sex workers working in the southern zone of town, including Copacabana.

However, after a few months of investment, the research team realized that the “seeds” had not multiplied and that the network had not been established. In order to overcome this difficulty, the research coordinating team met with Amocavim’s board of directors, which finally allowed researchers to have access to Vila Mimosa. To get the number of women/informants (600) within our timeframe, the methodology was changed and the original logic of seeds and dispersed networks was abandoned. Recruitment was done by three or four sex workers (seeds) who received an “incentive” of R\$ 10 for each woman they recruited. The research subjects received snacks and transportation vouchers. The Rocha Maia Hospital CTA was abandoned so the São Francisco Hospital CTA, located near Vila Mimosa, became the only health unit research site. Most women were recruited in the first two months of 2009. According to the interviewees, about 400 women (66%) were identified in Vila Mimosa.

The researchers involved justify the changes in methodology and the use of financial incentives as the only possibility to overcome the obstacles faced by prostitutes’ organizations when they tried to recruit women. But the changes in the recruitment methodology and other aspects of the research were sharply criticized by the Brazilian Prostitutes’ Network, at the national research ethics committee. According to some, these critiques have further delayed the research, in addition to having caused other methodological problems experienced in the process.

From the point of view of this case study, the research is relevant because very few prostitutes interviewed in Rio de Janeiro had information on public services for HIV/AIDS testing, counseling, and treatment. Among those women, this knowledge was acquired only because they participated in the research. It was as if the research were one of the few entry points to access the public health system – not exactly an ideal situation.

4.3 Perception and attitudes of health managers and professionals

In this section, the discourse of health professionals and program officials/managers is analyzed in relation to their perceptions and practices concerning access to healthcare by sex workers and/or women who refer to themselves as prostitutes. In interviewing

this group we sought to identify what specific programs exist in the public health system. We also aimed to further understand what kind of health care these women receive. In addition we tried to map out what are the values of health managers and professionals that may influence their view of the care provided to sex workers. We have also explored what are the critical reflections by these health workers about HIV/AIDS programming more broadly. The analysis that follows is organized according to managerial levels and it tackles issues such as service planning and organization, capacity building, interaction between health professionals and sex workers, and also views and experiences in regard to stigma and discrimination.

4.3.1 Profile of health managers and professionals

Many similarities are found among persons interviewed in terms of professional skills and trajectories. All of them are excellent professionals and most of them are specialized, having Master's or Doctoral degrees. All of them have chosen to be a public health practitioner. The majority of interviewees had a long trajectory of work in the HIV/AIDS field and many have moved a lot across health institutions at their different levels. A typical health professional in the sample may well manage healthcare in a municipality and, at the same time, carry out consulting work commissioned by international organizations. He or she may exercise a managerial or service function, even when hired to work in epidemiological surveillance. Or else, he or she may work in the public health system and simultaneously carry out HIV/AIDS related research in an academic institution.

4.3.1.1 State level Health Departments

The managers at the Rio Grande do Sul Health Department reported that the public health system has a close and comprehensive work relationship with civil society organizations, specifically with the NEP in Porto Alegre. In the 2004–2008 period they had jointly implemented six prevention projects in partnership. Prostitute activists involved with NEP have also participated in elaborating the State Plan to address the Feminization of the HIV/AIDS epidemic in the 2007–2008 periods. In addition, a NEP member is involved in the process of proposing strategies and policies for the State Health Department. She actively participates in the Health Department Campaigns' Committee. The 2009 HIV/AIDS Goals and Actions Plan (PAM) included the financing of the “First State Prostitutes' Seminar” aimed at assessing NEP interventions in 21 municipalities, which were performed in partnership with the State Health Department.

Managers and technical personnel in charge of the Rio de Janeiro State Health Department (SES) reported that there are no specific interventions designed or teams

assigned to address the health needs of prostitutes or sex workers at large. The Health Department, however, has established partnerships with NGOs and invited them to participate in the 2009 Plan of Actions and Goals (PAM), within the framework of the decentralization practiced by SUS. That is why, according to the managers, the PAM already takes into account the aspirations, desires, and needs of this specific population. Prior to decentralization, the state government funded NGO projects specifically working with HIV prevention among sex workers. But now since the state government has the responsibility to coordinate and not the obligation to implement actions of health care and outreach, the managers and technical personnel who have been interviewed consider that this “era is gone”.

Currently, partnerships between the state and NGOs are established by supporting few projects and interventions that were included in the PAM budget, such as supporting events or providing educational materials and distributing condoms to NGOs to make them available to their constituencies. However, for over four years, the State Health Department has not issued “a call for application” or opened a bidding process in the area of prevention projects involving NGOs at large and much less those involved with sex work specifically. The absence of a specific focus – for sex workers or other vulnerable populations – is justified by the managers who say that are many difficulties in fitting these groups into broad health programming.

On the other hand they consider that since all health programming in the area of HIV/AIDS is informed by the concept of vulnerability, the needs of sex workers are included in the state priorities. Thus, issues related to prostitutes/sex workers are viewed as crosscutting or belonging to other macro strategies such as the State Plan to Address the Feminization of the HIV/AIDS Epidemics. Within this broad framing, one of the responsibilities of the state government HIV/AIDS unit is to train municipal administrators in identifying the location and health needs most vulnerable populations (among them, prostitutes/sex workers should be included). However, as it will be discussed later, health professionals directly engaged in service provision lack specific training to meet the demands and needs of persons engaged in sex work.

4.3.1.2 Municipal level

In Porto Alegre, as described by HIV/AIDS managers interviewed, prevention and healthcare interventions targeted at prostitutes and/or sex workers are integrated into the overall universal logic of the public health policy, i.e., no specific focus or strategy is defined in terms of programming, health interventions or promotion or even training program. For example, one of the managers interviewed illustrated this perspective by giving the example of a 2007 health promotion campaign for primary school students that addressed issues such as drugs, STD/AIDS, and tobacco use, and

included debates on sex work. In relation to the so called specific populations, sex workers among them, the working methodology of the Municipal Health Department is the development of partnerships for prevention and incentive to actions proposed by civil society organizations.

Partnership and cooperation is mostly geared to the promotion of events proposed by these organizations, as it implies occasional financial support to rent or to pay for travel expenses of participants. The work done by NEP was mentioned on several occasions during interviews with municipal and state administrators as an example of how these actions have been carried out in collaboration with the social movement. When asked if they thought a different type of service should be established for sex workers, they said they did not have an opinion and that it was up to the prostitutes' social movements to start this discussion, in case needed.

In Rio de Janeiro, partnerships with community associations were also mentioned and the main strategy adopted by the Municipal Health Department. But one main service based intervention was referred to as a sort of flagship: a pilot project that has been underway since 2008, which aims at welcoming travestis, sex workers, and MSM at health units, and includes strategies to overcome barriers in access and receptivity among health professionals. This initiative promoted workshops for health professionals with participation of different civil society actors, such as HIV-positive persons, gay men, travestis, and a leader of the prostitutes' movement. The work, carried out in a specific health unit (May 13th PAM), was led by a female health professional in partnership with NGOs. But according to information supplied by HIV/AIDS managers, the Municipal Program does not develop specific training/capacity building with health professionals to provide medical attention to sex workers.

The Program managers acknowledge that, in recent years, there has been more emphasis on HIV/AIDS prevention and healthcare work among gays and travestis than for female sex workers. They resort to different arguments as to explain this imbalance. One of these arguments is that the response of the public health system is determined to a large extent by the mobilization capacity of the target population. Since in their view gays and travestis are better organized than prostitutes, the system response mimics that gap. But some people interviewed also stated that there is a concrete lack of health professionals able to coordinate and implement actions specifically geared to prostitutes.

As in Porto Alegre, the work of the Rio de Janeiro Municipal Health Department implemented through partnerships with Amocavim, Fio d'Alma, and DAVIDA is limited to supplying prevention inputs (such as condoms and vaginal gel) and occasionally supporting events such as seminars and meetings. According to health managers, however, even in these cases the effectiveness of implementation and quality of outcomes is highly dependent on the operational capabilities of the NGOs

involved. The basic rule is that when organizations do not have technical competence, interventions do not happen and projects are discontinued. This comment contains a veiled critique in respect to the capacity of prostitutes' organizations in relation to HIV/AIDS prevention and other health related interventions.

4.3.2 SUS universality versus specific needs

Neither in Porto Alegre nor in Rio de Janeiro do existing CTAs offer information or care that is specifically designed for sex workers. In addition, most interviewees, at the counseling and testing centers and other health units, are convinced that no specific services should be established because they would create differences among people and reinforce stigma. In Rio Grande do Sul, state level managers interviewed have explicitly said that their main responsibility is to “ensure the professional capacity and quality of care” across the public health system and not to create “specific services”.

Even though there are no specific protocols or services for persons involved in sex work in Rio de Janeiro CTAs, a “Praça Onze” health unit professional reported that twenty years ago a project called *Corpos Juntos* (Bodies Together) was implemented in the former Vila Mimosa (prior to the existence of the CTA). More recently, approximately three years ago, health interventions were also implemented in Vila Mimosa in partnership with Amocavim. However, according to the same professional, healthcare today is provided on the basis of spontaneous demand: *“Here we receive the girls as we receive any other citizen...and then we offer them the same we offer to everybody else.”*

According to Rio de Janeiro health managers, the perspective for the future is that CTAs will not be the only places where people can get HIV/AIDS testing and treatment; rather, HIV- testing access to the entire population would be expanded through the basic health system (health posts, centers, and PSFs). In turn, some Porto Alegre managers and technical personnel consider that the Family Health Program (PSF) is the adequate strategic option to provide care to prostitutes because, according to one of them, it can provide better care to persons “excluded” from services.

Although health managers and professionals interviewed emphasized universal strategies – persons involved in sex work should be given the same care as the rest of the population – contradictorily, they also value concrete health service experiences that focuses on specificities and particular vulnerabilities. For example, in Porto Alegre, the partnership between NEP and the Getúlio Vargas Hospital, which implied a change in hospital routine to ensure differentiated care for female prostitutes, is considered by many as a very positive development. Similarly, in Rio, the experiences of May 13th PAM and PSF are cited as positive examples of health professionals' sensitization and adequacy of SUS to respond to “differences.”

4.3.2.1 Service functioning, healthcare quality, and education of professionals

While the observation of services performed by the study was not exhaustive it shows that both in Porto Alegre and Rio de Janeiro the quality of the public health response to the needs of sex workers' prevention and healthcare remains limited and poor, even when conditions are better, as in the case of Porto Alegre. When asked about scope and quality of services provided to prostitutes, health managers say that by and large, it is restricted to health promotion. Few mentioned the need to emphasize preventive examinations or access to treatment in the case of this particular group of people. And those who did, especially in Rio de Janeiro, drew attention to the fact that available services are precarious. For example, some Rio de Janeiro professionals noted with concerns that many sex workers who resort to CTAs, which by definition offer prevention services, are already sick.

Several people interviewed also mentioned that the hours a CTA is open to provide services are inadequate for workers in general and also for persons engaged in sex work. The idea of special opening hours was deemed a good alternative by a Rio de Janeiro State Health Department technical staff, although there is no concrete proposal to this effect.

As mentioned before, issues and themes related to prostitution have not been included in training/capacity building. Health workers reported that they developed their skills based on demand and experience. Regarding doctors, in particular, the issue is perceived by other health professionals, as a theme that will not raise their interest. Although, in Rio de Janeiro and Porto Alegre, everybody agrees that the theme of prostitution should be included in HIV/AIDS training, they consider it unsatisfactory to offer regular STD/AIDS training, capacity building, and refreshment training carried out by both state and municipal health departments.

4.3.3 Prejudice, stigma, and discrimination

Prejudice, stigma, and discrimination are recurrent themes in the interviews with health professionals in Porto Alegre and Rio de Janeiro, which emerge in a paradoxical way. On the one hand, both health managers and professionals acknowledge that sex workers and travestis encounter discrimination, and that this is a problem. For instance in two CTAs in Rio de Janeiro (one municipal and the other state level), two health professionals, in separate interviews, reported that women almost never identified themselves as prostitutes. One of them said that women do not disclose their profession because they do not want to be victims of prejudice. She also said they often witness people being discriminated against and ill-treated after receiving an HIV-positive test result. Another health professional interviewed made constant reference to providing services to women who “don't look like prostitutes,” who “look like mothers,” “who

seem to work for a multinational corporation,” or “who seem to be domestic workers”. She was in fact expressing her own prejudice that a whore should look like a whore. This overall climate also explains why some health professionals systematically change the occupation from “prostitute” to “domestic worker” on registration forms, even when the sex worker defines herself as such.

However, on the other hand, according to several persons interviewed, if the women do not disclose that they are prostitutes, this secrecy may impair the diagnosis, compromise the quality of care, and make epidemiological surveillance more difficult. Because of that some health managers and professionals interviewed in Rio de Janeiro do think that it is necessary to have a different approach to HIV prevention among sex workers. This approach would include a more detailed investigation of specific issues, such as higher exposure to STDs, violence, alcohol and drug use, as well as aspects directly related to sex work (for example, sex without a condom pays more).

Moreover some experiences suggest that barriers of silence and prejudice can in fact be overcome. Lapa PSF, in Rio is one illustration. Nevertheless, a nurse working at a municipal CTA in Rio de Janeiro also told us that, based on some questions from the testing or counseling interviews, she can find out whether or not a woman is a prostitute without having to force any disclosure. Another CTA professional (also in Rio de Janeiro) has also said that women will be more frank about their work or identity “*when they start trusting the service.*”

Although health managers and professionals interviewed demonstrated great sensitivity about issues of stigma, prejudice, and discrimination, biases can also be identified in the ways they portray prostitution. The most frequent sign of these biases is revealed by references to working conditions in prostitution that are systematically very violent and exploitative, involve drug use, and result in recurrent health problems. There is no room in the discourse of these professionals for less dramatic descriptions of prostitution, nor for recognizing that sex workers take care and invest in their health as part of their professional life.

This sharply contrasts with the accounts of women investigated in this study, who talk a lot about self-care and health screening. This view prevailing among health professionals may be explained by both the dominant social imagery on prostitution and the concrete profile of clients who search for the public services that are not sought by most of the female sex workers we heard from. Thus, it is not difficult to presume that prostitutes seeking SUS services are the poorest, most vulnerable, and most subjected to violence.

Finally, it is necessary to say that many health professionals, both in Rio de Janeiro and Porto Alegre, openly questioned the representativeness of prostitutes’ organizations and their capacity to effectively identify and express sex workers’ demands. This is a

broad and complex theme that was not fully investigated. However, we thought it was important to mention this perception because it is different from the perception of AIDS policy federal program officials, and directly impacts the profile and quality of partnerships between local health institutions and the organized prostitutes' movement.

4.4 Conclusions

4.4.1 Expressive policy versus healthcare reality

Undoubtedly, national policies adopted in Brazil since the late 1980s have been very significant and positive in opening spaces for prostitutes to participate as citizens, provide visibility to their experiences, promote their human rights, thus contributing to overcoming stigma and discrimination. This conceptual framework is what explains the position of the Brazilian government in 2005, when it refused to sign the antiprostitution clause included in the Brazil-USAID agreement. The model adopted by state policies to respond to HIV/AIDS needs and demands in the realm of sex work had unequivocal and virtuous effects. In addition, systematic efforts to sensitize and educate through prevention and human rights campaigns and projects targeting specific populations had, in the case of sex workers, tangible effects regarding knowledge about HIV risks, condom use and, indirectly, the need for systematic sexual healthcare and HIV/AIDS treatment.

What is described above corresponds to the expressive dimension of Brazilian HIV/AIDS policy responses – or its ideological stances if we prefer. This dimension is critical and must be appraised when the focus of state intervention is a sexual issue, such as prostitution. However the case study clearly reveals that a big gap exists between these expressive dimensions and the effective implementation of HIV/AIDS prevention programs and access to public health services of good quality in the case of persons engaged with sex work.

This huge gap results from multiple factors. Certainly, one of these factors is the decentralization of the public health system (SUS), particularly its effects on the implementation of the HIV/AIDS policy⁴⁰. It is worth noting that the gap between policies and the reality of services resulting from the decentralization process affects SUS users as a whole. In the case of AIDS patients and people seeking information and prevention devices, this means delays to be seen by health care providers and in obtaining

⁴⁰ Alexandre Grangeiro, presentation "Acesso a serviços: novas estratégias para antigos problemas?" (Access to services: new strategies for old problems?), at the seminar *Responses to AIDS in Brazil: enhancing the debate II*. Brazilian Interdisciplinary AIDS Association. Rio de Janeiro, August 18, 2009.

HIV test results; lack of medical personnel, viral load and genotype tests, adequate follow-up to prevent opportunistic diseases, complementary exams for co-infections such as tuberculosis, hepatitis, and other STDs; and precarious health facilities. When it comes to sex workers, these gaps are aggravated by the high degree of discrimination on the part of the population as a whole and also health professionals, in addition to the lack of qualified care for this particular segment, as this study has demonstrated.

Although federal promotion and protection policies, specific programs, and plans for differentiated actions have been adopted during the period analyzed – such as the *Reference Document: STD and AIDS prevention actions for sex workers (2002)*; the *National Plan to Address the Feminization of the HIV/AIDS Epidemic (2007)*; the *National Plan to Address the AIDS/STD Epidemic among Gays, MSM, and Travestis (2008)* – there is an obvious gap between the goals and intentions spelled out in those documents and the effective implementation seen at local levels.

In addition, the interviews performed through the case study reveal that key actors (including the prostitutes) often do not consider it adequate or necessary to differentiate services, programs, or methodologies established for this group. Among other arguments, some health professionals call into question the homogeneity of the category sex worker, mainly pointing out social class issues. But other aspects relating to “collective differentials” based on vulnerabilities have also been addressed. As for some health managers and professionals the issue is not to be a sex worker, but rather the use this particular individual makes of her/his body.

Most prostitutes we have heard (and the sex worker movement itself) also reject the idea of differentiated services. This position is based on two arguments: the importance of ensuring the universality in the public health system (SUS) and the principle of non-discrimination. In their view “differentials” are required in terms of special time frames and ability of services providers to respond to their needs. But they do not support the idea of a separate program or service.

Over and above the debate on universality vs. differential treatment, several health managers and professionals interviewed do consider that the HIV/AIDS policy has been losing vigor. Today the teams working in this particular field of public health do not have the same enthusiasm and commitment they experienced in the past, among other reasons, because structural conditions of SUS and program functioning, at least in Porto Alegre and Rio de Janeiro, have much deteriorated.

The potential impacts of the discontinuation of USAID funds in 2005 should be examined against this broader backdrop. It is worth noting, for instance, that the 2005 episode was not mentioned in the interviews with municipal health managers in Rio de Janeiro or Porto Alegre. This may be explained by the high turnover of managers which would imply that people interviewed had not lived through that experience,

or perhaps this lack of attention occurs because issues related to prostitutes and sex workers are not viewed as priorities. However, it should also be taken into account that the suspension of funds did not directly affect public program budgets, but rather the sustainability of NGOs involved in prevention projects. In the NGO community the episode was certainly experienced differently. Right after the episode, some voices, mainly from groups working with homosexual populations, criticized the Brazilian government decision to suspend the agreement, which in their view had been unilateral and not based on a broad consultations with health managers, professionals, and the society itself. These critiques died away as time went by and the tensions with PACT regarding the remaining project funds were resolved.

When this topic emerged in the interviews conducted, the research people by and large positively appraised the decision to suspend the agreement. Many emphasized their support to the primacy of national sovereignty over the impositions of another country whose views contradicted our human rights principles and legislation. But, it should be said, that most people did not have enough information or clarity about the problems caused by the discontinuity of funding.

Most importantly, however, is to underline that the empirical findings of the study indicate that the scenario of disorganization in the public health system -- identified to a larger or less extent in Porto Alegre and Rio de Janeiro -- is much more relevant, than the suspension of the USAID funds, in explaining why prevention programs and public health care is not properly responding to the needs of prostitutes and sex workers at large. As we have seen, the majority of female sex workers we heard from seek health care from the private sector (health insurance or private doctors) or have their needs of HIV prevention and sexual health routine examinations met by their employers. In fact, one of the most interesting and worrying findings of the case study is this paradox: in Brazil today an permissive and positive public health policy for persons involved in sex work coexists with flagrant forms of private “sanitary regulation” that resemble the 19th century French model. Although our sample is limited, it is not unreasonable to suppose that this pattern is quite extensive in the sex industry. This is certainly an aspect that deserves further investigation.

4.4.1.1 Stigma, discrimination, and prejudice

The empirical material collected and the observations made in the course of the study show that, despite over twenty years of non-discriminatory policies and a positive official discourse on prostitution rights, health managers and professionals are scarcely prepared to deal with the cultural complexity of sex work and the experiences of people involved.

Strong traces of prejudice and stigma against female prostitutes and other sex workers still prevail among health professionals working in the Brazilian Unified Health System (SUS), even when they are not fully acknowledged, or adequately elaborated. These biases may be explained by the structural difficulty to deal with “otherness” which also implies a tendency to attribute to “others” the responsibility for existing patterns of discrimination. When asked if they had been discriminatory in providing health care to sex workers, most health managers and professionals interviewed responded that they themselves do not have discriminatory attitudes, but unanimously they also declare that much prejudice and discrimination exists in the health system in relation to both HIV/AIDS and prostitution. Many discourses also tend to blame users themselves for the discrimination they experience, as it is common to hear that sex workers have internalized stigmatization, which is referred to as a problem of “self-prejudice” and “self-exclusion”. It should be noted that signs of prejudice and stigma are not only found at the service level, but are also palpable in the managerial and policy spheres. One of the female managers interviewed mentioned that she heard from a person (a man) at the highest level of institutional decision-making that “*he will not spend money buying HIV/AIDS test kits for drug addicts and whores!*”

4.4.2 Who is responsible for HIV/AIDS prevention?

A main policy advancement observed in Brazil since the 1990s was, as we have seen, the increasing participation of people directly involved in or affected by the epidemic in the elaboration of guidelines and health promotion and prevention programs. This new direction was based on the understanding that the participation of those affected would ensure that their needs would be properly responded to and that this mode of operation would make it easier to identify the circumstances of vulnerabilities and more consistently enhance rights and health promotion initiatives.

Regarding HIV/AIDS prevention in particular, the vast majority of Brazilian health services, and particularly those we looked at, are limited to the distribution of preventive devices such as male condoms (in a broader way) and female condoms (at specific health units). Affirmative educational interventions and social support to bolster safe behavior among the most vulnerable segments of the population, such as sex workers, are deemed unachievable by the state (public health sector) as STD/AIDS teams do not do outreach work. These actions are fundamentally designed and implemented as activities to be carried out by civil society organizations, given their “proximity” to those populations. However, non-governmental organizations currently receive very little funding from municipal, state, and federal governments to implement prevention projects. This is, indeed, the situation in the states of Rio de Janeiro and Rio Grande do Sul (states researched).

On the other hand, the research findings indicate that, at least in the case of the two capital cities (Rio de Janeiro and Porto Alegre), that current prevention and promotion strategies result mostly from demands raised by organized groups, instead of being a consequence of planned policies and programs based on scientific and epidemiological data. To say it differently, if a particular group is able to visibly organize and enforce requests to Health Departments, prevention initiatives will probably take place, including condom distribution and sensitization of health providers. On the other hand, if groups don't mobilize or don't have the capacity or leadership it may be the case that "nothing happens". This suggests that municipal health managers quite often disregard epidemiological realities and thus, cause dissonance between planned actions and actual needs. In addition gaps can be identified between data and epidemiological trends observed in these municipalities, as presented in official epidemiological reports issued by the Brazilian Ministry of Health, and what they devise as prevention strategies in the respective Goals and Action Plans (PAMs).



ATTACHMENTS

Attachment 1

Persons interviewed and other sources

Persons interviewed

First phase

- Ângela Donini, National STD/AIDS Program, Brasília – deputy chief of Prevention Department.
- Carmen Lúcia – from NEP/ RS (sex worker study organization in Rio Grande do Sul).
- Cleide Almeida, president of Amocavim, (sex worker organization in Rio de Janeiro).
- Denise Serafim, National STD/AIDS Program, Brasília – Prevention Department.
- Gabriela Leite, president of DAVIDA, (sex worker NGO in Rio de Janeiro).
- Ivanilda Santos, president of Fio D'alma, (sex worker NGO in Rio de Janeiro).
- Lilia Rossi, program director of Pact Brazil (USAID project) – prior National STD/AIDS Program staff in the Prevention Department.
- Magali Eleutério, National STD/AIDS Program, Brasília – Prevention Department-project monitoring and supervision.
- Roberto Chateaubriand from GAPA/MG, (Group of Life Incentive in Minas Gerais).
- Vânia Costa, National STD/AIDS Program, Brasília – Prevention Department.

Second phase

State and municipal level program officials

- Alexandre Chieppe, STD/AIDS manager in Rio de Janeiro state.
- Jane Portella, social worker, technical staff in the prevention area of the Rio de Janeiro State Health Department STD/AIDS Advisory Service (for over 10 years).

- Lilian Lauria, public health doctor and epidemiologist, and STD/AIDS manager of the Rio de Janeiro Municipal AIDS Program (5 years).
- Giselle Israel, medical doctor, specialized in Psychiatry and Public Health, and technical official at the Rio de Janeiro Municipal Health Department STD/AIDS Coordinating Organ (has worked for 16 years at the Department).
- Mônica Pinto, Nova Iguaçu Municipality STD/AIDS Coordinating Organ.
- Miriam Gizele Madeiros Weber, STD/AIDS advisor, Municipal Health Department Planning Advisory Service.
- Tânia Figueiró, coordinator of the STD/AIDS Control Section of the Rio Grande do Sul State Health Department Health Actions Division.

State and municipal level health professionals

- Carla Araújo, nurse, Master's degree and PhD in Nursing, professor at the Rio de Janeiro Federal University (UFRJ). She also works at the São Francisco de Assis Hospital and in the project *Corrente da Saúde*.
- Débora Fontenelle, general practitioner, PhD in Collective Health and former coordinator of the Rocha Maia Hospital CTA.
- Dimas Alexandre Kleimam, COAS coordinator of the Porto Alegre Municipal Health Department and infectologist at SAE and Conceição Hospital.
- Fernando Freitas, psychologist, Master's degree and PhD in Psychology, psychology professor at the Rio de Janeiro State University (UERJ), and coordinator of PRODEM (Coordinating Organ of Research on Social Demands) and of the research *Corrente da Saúde* (Health Chain) in Rio de Janeiro.
- Helena Malerba, nurse at the President Vargas Maternity and Children's Hospital STD Outpatient Unit.
- Jorge Eurico, public health doctor and member of the IPREX project.
- Ludia, coordinator of the Caio Fernando Abreu CTA, Porto Alegre, and statewide coordinator of CTAs.
- Maria Lúcia, nurse technician at the Rocha Maia Hospital CTA and pre- and post-testing counselor.
- Rosa Mayer, psychologist at the Sanitary Dermatology Outpatient Unit, Porto Alegre.

- Sonia Batista, psychologist, PhD candidate in Planning and Health at the Rio de Janeiro State University Social Medicine Institute (IMS/UERJ), founder and coordinator (up to 2008) of the São Francisco de Assis Hospital CTA, and advisor to the coordinating organ of this hospital. She is also a consultant for the Health Ministry on establishing CTAs.
- Valéria Romano, family doctor, initiator of the Lapa PSF, currently a professor at the Rio de Janeiro Federal University (UFRJ).

Other sources

Speeches given at the VII Brazilian Congress on STD and AIDS Prevention, which took place in Florianópolis, Santa Catarina, in June 2008: Keyla Simpson, Gabriela Leite, Lilia Rossi, and Magaly Eleutério.

Attachment 2

Summary of focal groups and survey with prostitutes

Porto Alegre

Focal Group 1	Focal Group 2	Common Trends
Number of participants: 7	Number of participants: 6	Number of participants: 13
Average payment for sexual services provided R\$ 20-50 (1 Real=1.70 dollars)	Average payment for sexual services provided R\$ 20-50	Average payment for sexual services provided R\$ 20-50
Age Groups 3: 20-25 1: 26-30 2: 46-50 1: 50-55	Age Groups 2: 26-30 1: 31-35 1: 36-40 2: 46-50	Age Groups 6: 20-30 2: 31-40 4: 41-50 1: 50-60
HIV status 2 HIV+	HIV status 1 HIV+	HIV status 3 HIV+
Working place: On the street - 2 "Houses" - 5	Working place: On the street - 3 Houses - 3	Working place and other conditions: On the street - 5 women, older, on of them HIV+ Houses - 8 younger women, two of them HIV +
Demands and access to health services All 7 search for and receive health care fairly regularly, in gynecology and other areas.	1 woman goes everyday to a health service 1 one woman have never been in a health service Average gynecological screening The previous week (1 woman) 3 months back (1 woman) 6 months back (1 woman) 8 months back (1 woman)	The women heard in Porto Alegre have relatively to health care, particularly in relation to gynecological screening and other prevention controls. They also search for specialized health care for family members, in particular children. HIV positive women have a much closer relation to the public health services. The only woman in the sample that has never visited a doctor has come to Porto Alegre from the interior of the state and just recently has engaged with sex work.

continued

Focal Group 1	Focal Group 2	Common Trends
Where have they tested for HIV? Private doctor 1 woman Public hospitals 6 women Two women did not know that they could test in public clinics	Where have they tested for HIV? Private doctor 2 women Public hospitals and clinics 3 women No test 1 woman	3 Women have tested in private services 9 have tested in the public system (hospitals and clinics) One has never tested
Test periodicity Each six month 6 women Two years 1 woman	Test periodicity Each 2 years 1 woman Each 3 months 3 women When I take risk 1 woman Never tested 1 woman	Average test periodicity The majority between 3 e 6 months Two (older women) have not tested for 2 years because they say they are not at risk One evaluates risks taken and tests when needed One has never tested
Why to test? Cases in the family Labor risks Condom broke	Why to test Regular screening Labor accidents Risk situations	Cases in the family Labor risks Regular screening Labor accidents (condom broke)
HIV/AIDS specialized health services Are well known by the 2 HIV positive women, but not by the others who were amazed to learn that testing could be done in clinics.	HIV/AIDS specialized health services Are well known by 5 of them	HIV/AIDS specialized health services Are quite well known by the group in the sample.
Health care at large: where to go? 1 goes to private hospitals and the other 6 go to public hospitals	Health care at large: where to go? 5 go to public hospitals but one complained that she is having difficulties to get a consultation. One has never gone to a medical consultation.	The majority look for the public health system One goes to private services One has never seen a doctor
HIV prevention information: Where? In the public clinics they do not talk about it There are workshops in the hospitals but I never go We get condoms at NEP	HIV prevention: Where? Nobody could respond the question. Condoms given by NEP	HIV prevention: Where? No information on preventions seems to be provided by the public health system

continued

Focal Group 1	Focal Group 2	Common Trends
Access to condoms: At NEP In Femina Hospital there are no condoms In the specialized clinics (CTAs) clinics they give between 6 to 15 condoms per month. In other regular services there are no condoms	Access to condoms: In the clinics maximum 12 per month. In one clinic is OK they give more In another clinic to get a condom you must go first to a medical consultation. Two women refer to buying condoms, but said they were expensive. The NEP activist referred to 40 condoms per month provided by the MoH.	There are multiples versions about monthly condom quotas Condoms are not available in regular public services but juts in specialized HIV/AIDS services Two women did not know they could get condoms in clinics NEP appears as the main condom provider But in both groups mentioned low costs condoms being sold in the prostitution areas where.
Experience of discrimination: 2 women could not donate blood because they ewer prostitutes The doctor completely changed his attitude when one of the woman heard said she was a sex worker.	Experience of discrimination: One woman told the story about the nurse telling her not to put in the form that she was a sex worker	Experience of discrimination: The conversation raised questions such as: What is to be discriminated? Who evaluates discrimination in the health services? Should not prostitution be openly spoken about in terms of HIV/AIDS prevention?
Quality of care in public services A 'shit' Very bad Hospital Femina is one exception because it is a women's hospital	Quality of care in public services HIV/AIDS services OK, the rest is not good	Quality of care in public services The assessment of public health services is really negative, even when HIV/AIDS services are better evaluated

Rio de Janeiro Survey

Praca Mauá	Sauna	Common Trends/Comments
Number of survey participants: 7	Number of survey participants: 11	Number of survey participants: 18
Average price of sex service provided R\$ 100 (roughly 50 US\$), but no information was collected about fees paid to establishments or pimps	Average price of sex service provided R\$ 110 (roughly 55 US\$)Saunas can charge up to 50%.	
Ages Varying between 24 and 40	Ages Varying between 24 and 33	.
Working place On the street. Women have been interviewed in Praça Mauá, but they circulate in other areas, such as Praca Tiradentes e Copacabana	Working place Sauna, that is open during day time and early night hours.	Usually women that work on the street do not work in saunas and vice-versa.
Access to health care All 7 women do a gynecological screening. The periodicity ranges between 3 and 6 months.	Access to health care Gynecological screening between 3 and 6 months	
Last HIV Test Private services 5 women Hospital São Francisco 2 women who were subjects of the RDS research	Last HIV Test Private clinic through the sauna 10 women Public clinic 1 women	Testing in private services is what prevails.
Periodicity of HIV Testing All between 3 to 6 months	Periodicity of HIV Testing All between 3 to 6 months	Regular HIV testing is the rule
Health care at large Private service 5 women Public service 2 women	Health care at large All women resort to private services, even if few of them had gone to public services in specific occasions	Private health care prevails
HIV/DST status All negative	HIV/DST status Negative 9 women Syphilis (in the past) 1 woman HIV + 1 woman	Infection rate low

continued

Praca Mauá	Sauna	Common Trends/ Comments
Use of condoms Always 5 women Not always 2 women	Use of condoms All 11 women said they always use condoms, but the fact that the sauna manager was present should be taken into account	
Access to condoms 4 women said they receive condoms from the DAVIDA prevention project 3 women said the clients pay for (1 US\$ a condom in the area that is mainly frequented by sailors)	Access to condoms The sauna provides 7 women The sauna provides and I buy 3 women I buy 1 woman	Combined access: public funded free condoms, provided by the sauna, bought in the local market
Access to information on HIV prevention Private doctor 4 women The DAVIDA outreach worker 1 woman Regular health clinic 1 woman Hospital São Francisco 1 woman	Access to information on HIV prevention Most women have never received systematic information on HIV prevention. One mentioned the lab doctor (the lab where she goes for periodical testing and is paid by the sauna). Another mention her mother and private doctor.	Information comes from various sources, but even in relation to that private providers play a major role. It should be also noted that the sauna girls, while testing and screening systematically does not receive information on prevention.
Experience of discrimination at large 5 women declared to have been discriminated because they are prostitutes One could not recall and the other one said she had never been discriminated against	Experience of discrimination at large 3 women said they had been discriminated because of the profession. The other 8 said they had not experienced discrimination because nobody knows they provide sex services. One interviewee reported that a client said to her: "You're so beautiful. What are you doing here?"	Open discrimination seems to be more frequent in the case of street walkers, who are very exposed. Sauna girls are more protected because they do not need to disclose the profession.
Experience of discrimination in health services 1 woman reported to have been discriminated by a doctor 6 said they did not have that experience, but at the same time 3 informed that they never tell doctors and other health professionals about their work. One in contrast said she always tell doctors that she is a sex worker	Experience of discrimination in health services None of the 11 women report experience of discrimination. But they also explain that they do not tell other doctors, except those paid by the sauna, or that they just disclose their professions to doctors that they really trust.	Though the dominant discourse is that discrimination has not been experienced, secrecy seems also to be the main rule in relation to health services. Non discrimination is possible because of the unwritten rule of "do not ask, do not tell"

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