Sexuality and Development:
Brazilian National Response to HIV/AIDS amongst Sex Workers

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

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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 sex workers. The analysis of the data collected is organized as follows:

1) A brief historical recapturing of how STD/HIV/AIDS prevention policies and programs directed at sex workers evolved in the last two decades;

2) The increase in 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) 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.
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” Program. 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 was 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.
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 focal group discussions and short surveys; and d) limited participant observation in public health services and focal groups with sex workers. 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 movements, (or at least it’s more visible and organized sector) has defined prostitutes their term of choice. The reason behind this choice is that in their view the terms sex work or sex workers aim at sanitizing prostitution. However since prostitute is a term that apply exclusively to women engaged in the sex market, in the Brazilian political and policy 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 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, focal 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.
Contextual analysis

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%. 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 have 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, implying increased numbers of AIDS cases among the female population and reflecting directly in the male to female ratio of AIDS cases in the last decade, which went from a ratio of 15 males: 1 female in 1986 to 1.5 male to 1 female in 2007. In the case of populations in very vulnerable contexts such as men who have sex with men, commercial sex workers, and injecting drug users, the HIV prevalence rate is above 5%. 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 aged over 50. A total of 506,499 AIDS cases had been identified by the Health Ministry up to June 2008, with 65.8% of cases among men and 34.2% among women. Two hundred thousand people are presently under 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 rates of HIV infections in Brazil have stabilized around 20,000 new AIDS cases per year, greater vulnerability to HIV infection still persists in the case of specific groups such as MSM (men who have sex with men), injected drug users (IDUs) and sex workers (SW). 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 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).

Historical perspectives of policies and programs

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), 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.

On the other hand, as analyzed by Rago (1985), Kushner (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 19th century. Rago and Kushner have also 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.

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).

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,

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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.”


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.
negative and stigmatizing views and discourses related to gays, sex workers and their clients were swiftly and sharply contested. The emergence of public discourses 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 affirm 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 work 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.\(^{12}\)

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\(^9\) 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.


\(^{11}\) 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, forecoming).
Building Brazilian response to HIV among sex workers (1989-2007)

In Brazil, the historical coincidence of the beginning of the HIV/AIDS epidemic and the “redemocratization” process favored the communication between civil society actors engaged in constructing a response and the Ministry of Health. As time evolved this early dialogues would build up as 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 the pressure of 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 group 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 and 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 in that the National Program recognized 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 non-governmental organizations (NGOs) because both the Health Ministry and the World Bank were convinced that NGOs had more capillarity 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 public bidding process that included a call for applications and project proposal submission and, the establishment of external committees to evaluate the 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, having as its main goal to identify, sensitize, and empower 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 to 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 North 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 was very clear that, although it continued to be necessary, it was not sufficient to intervene just in regard to HIV prevention, but 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 results 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 Congressmen Fernando Gabeira to regulate prostitution as labor, inspired by the German law of January 2002, which made payment of sexual services a demand, and deleted the crime of inducing 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 to 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 “anti-prostitution clause” added to PEPFAR in 2004, required that all recipients of US funding to HIV prevention projects sign a formal statement condemning prostitution and complying to not support the legalization of sex works or sex workers’ rights (Girard, 200513). 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.

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

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14 At the time, Dr. Pedro Chequer, MD.
supported the National Program decision to reject funding associated to that clause imposed by USAID. As a consequence, USAID decided to discontinue funding to Brazilian projects in 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 in view of the fact that 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 as to include health promotion at large, education to ensure the protection of 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 fully 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 enlarged this guideline in terms of directly strengthening existing organizations and leaderships as a strategy to attain 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 documentation 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. The largest number of projects was funded in the Southeast region and the North region was the least attended. 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.

Recent policy shifts (2007-2009)

From 2007 onwards policy design at the national level underwent some significant changes. Until then the HIV/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 populations. 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.

But, in the late 1990s, when a growth of infection among women was identified, a discussion was set in motion on the need to have a specific HIV containment policy for the female population that should be closely articulated to 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 man/woman), violence, and HIV, achieved new contours at the international level and started mobilizing speci-

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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.
pecific international cooperation funds for this area of work. 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, as to 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. On the occasion of its launching 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.”

Since 2007, state plans to address the feminization of the HIV/AIDS epidemic were initiated. While 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 implied focalization for other groups. In 2008, in the context of the National Conference of Policies for the LGBT Population, the National Plan 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, overcoming 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 conditions of vulnerability to HIV, as well as the prevention needs of travestis and MSM, who often are involved in sex work.

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18 A noticeable moment of this inflection was the Toronto AIDS Conference (2006) in which the theme "Gender, Violence and HIV" was highly visible.
However, these recent policy inflections are not exempt of tensions and conflicts. For instance, during consultations and subsequent debates on the National Comprehensive Plan to Address the Feminization of 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 as “women.” But significantly enough there was no specific reaction against the inclusion of prostitutes.

Another relevant tension – to a large extent so far unresolved – was related to the interpretation of epidemiological data. The issue is that according to some analysts and observers, although the number of infections among women has considerably increased due to the growth of heterosexual transmission in the last decade, the high prevalence among men has continued. 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 /managers stopped prioritizing actions geared to MSM. In fact, it was not the case of prioritizing one population to the detriment of another, but to expand women’s access to services and inputs, particularly the youngest, and also to continue the actions geared to MSM.

This process of reconfiguring the public policy of response to HIV hereby described was undoubtedly determined by factors, actors, and processes that are peculiar 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.

Implementation of the two plans 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 available. 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 understanding 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 at this new stage characterize the

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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).

20 There are indications that the implementation of the Integrated Plan to Address the Feminization of the STD/AIDS Epidemic faces some important obstacles. Moreover right now an evaluation of Plan implementation is underway.
response to HIV/AIDS in Brazil. 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 identities.21 There are also concerns of whether or not this binary division may hamper implementation of actions, especially in realm of prevention.22

**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, especially after the Toronto AIDS Conference, in relation to the international arenas where policies to respond to the epidemic are discussed. 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 event counted with the participation of 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.

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.

**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

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. It 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.
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 or the national authority on HIV/AIDS continued to be 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 municipalities, particularly municipalities given that officially the role of states is mostly planning and oversight.23

The Department of STD/HIV/AIDS and Viral Hepatitis is still responsible for developing and updating all national technical guidelines and national consensuses 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 it 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.

Since the year 2000, the National AIDS Program (NAP) and now the Department of STD/HIV/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 planning basis, including funds for civil society organizations (NGOs) 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 has been a consistent setback 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. If on the one hand there is an apparent difficulty to contract, disburse, and monitor projects implemented by civil society organizations. On the other hand, there has also been lack of capacity from NGOs to properly advocate for the continuity of their effective participation and implementation of community level intervention. 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,

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23 At the ground level of 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.
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 are targeted at 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).

1. Research Findings

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

This section presents findings from the assessment and investigation of HIV/AIDS/STD 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 focal 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 (relevant actors and other health professionals) and in 2009 (women sex workers, health professionals, and service observation). The original methodology of the study included: one or two focal 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 would be 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 struggle for 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 basis. At the end of the workshops, it was requested that a group of participants stay. Those who could not or did not wish to remain left, after being invited to participate in the next activity. However, on the date of the next workshop participants did not show up and the NEP team decided to make a recruitment effort and ensured the presence of six women for a specific conversation on the research theme.

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. To carry out the research in Rio de Janeiro, we had the support and partnership of DAVIDA, which is directed by Gabriela Leite, who also coordinates the Brazilian Prostitutes’ Network. 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, it was concluded that there was no possibility of setting up focus groups, but that we could count on the help 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.

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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 Lúciias). 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 imaginary of prostitution in Brazilian society.

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24 The workshops are coordinated by NEP, by more experienced militant prostitutes or by people close to the movement.
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 by a very diverse audience. Later, there was participation in Rio de Janeiro and São Paulo fashion weeks, abroad, 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 mottoes 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.

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 might become the work space of a sex worker, even though not widely accepted by the general public, particularly around residential neighborhoods. In Porto Alegre and Rio de Janeiro, there are several areas where female prostitution is exerted, 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 Ipanema neighborhood, the sex market is also found along the Guaíba riverbank and on Oswaldo Cruz Avenue. In the central-eastern area, in Cidade Baixa neighborhood, there are 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, thus representing the so-called “low-income prostitution.”

Between the 1970s and 1990s, downtown, street prostitution – involving both women and travestis – was sharply reduced under the impact of “modernization,”. Today, the main places of female prostitution are private spaces or “public” indoor spaces: “nightclubs” or “bars,” which might have private rooms or be close to hotels or hostels. Nightclubs and bars are concentrated along Farrapos Avenue, as well as “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, entered into small partnerships, or pay a percentage of their earnings for using the room. In Porto Alegre, there are two buildings where all offices are taken by female prostitution services. For streetwalkers (low income prostitution), a trick may costs from R$ 20 to R$ 60 (1US$=R$1.7). Indoors, this amount may go up to R$ 150 and 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 Help25 – for many years considered the center of sex tourism. Others are more discreet. In these 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 large 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 historically has served the port area). In these areas, tricks vary from R$ 10 to R$100.

There are also privés (private places), or “leisure spaces”, and saunas. In these places, part 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 privés might cost over R$ 1,000, while in saunas it costs from R$ 100 to R$ 150.

However, both in Porto Alegre and Rio de Janeiro, sex work networks are much more extensive and complex. They an 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

25 The nightclub Help has just been closed down. A museum will be constructed on its site.

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

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 to NEP) and 13 women who provide sex services in Rio de Janeiro, who during the period of our field study, were working in Praça Mauá and in one 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 imply any payment to them or the persons who helped in our recruitment.

### 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 prostitutes associated with the Brazilian Prostitutes’ Network. The results were recently published by DAVIDA (2010). The final report presents a framework that clusters the multiplicity of expressions of female prostitution in broader modalities as to make it possible to better analyze the correlation between the condition 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 research identified as most frequent abuses: the clients’ refusal to pay, the lack of recognition of prostitution as an occupation (on the part of police officers and other authorities), the 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: indebtedness and control over the prostitute’s income, mechanisms to charge for services, fines, and reduction of the sex transaction duration 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 also 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

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28 Maria, 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 “sauna.”

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 owners of establishments
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 funded by several state organs
that promote women’s health and rights and is one of the “cultural spots” in Rio de
Janeiro (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 reproduce the logic of confined prostitution. Both in Rio de Janeiro (where
the phenomenon is fairly widespread) and Porto Alegre, prostitutes report abusive con-
trol over their income and their time, as well as the existence of 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, police actions formally and officially
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

1.2 Sex workers’ perception

The results from the interviews with sex workers are organized in 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.


31Olivar, J. M. Guerras, trânsitos e apropriações: políticas da prostituição feminina de rua a partir das experiências
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 for their professional performance. Almost all of them recognize the risks of HIV and STDs to be 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 periodicity was related to concrete risky practices or just reflected a habit, a conventional pattern induced by the health policy or other factors. For example, in the particular case of sex workers in Rio de Janeiro saunas, this periodicity is in fact determined by the strict sanitary logic defined by the workplace, which pays for a gynecological clinic and a laboratory to make periodical examination and tests of the women they contract.

As this rule is part of the work regime, whoever refuses to be tested or to undergo periodical 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 being.32 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 suggest that SDT related sanitary controls that in the past were somehow imposed by is 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 Fêmima 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, 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.

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32 It is important to note that the manager was present at the interviews. This may have curbed somewhat sex workers’ accounts.
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 2.2.3). Two other women reported to access 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 periodical gynecological exams paid by the 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, eventually, a 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 – 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 correspond 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 struggle 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 what 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 had no sexual relations without a condom. But the experience of risk has also been mentioned in Porto Alegre as woman said 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 only recently she had become a sex worker, but she realized that from now on she needed periodical 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., 2000, and Pasini, 2000).

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 than often 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 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/month/woman, but now this quota has been reduced to 30. In addition, it should be taken into account that NGO prevention work, as good as it can be, 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 privés (private places), who buy condoms for prices varying from 10 to 20 cents of real a unit. 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.

### 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 exist 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 (specially 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 to be 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 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 inform other occupations, such as “hairdresser” 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,” including as a strategy to get better 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.
2. Health programming and service delivery: field observation and perceptions of health managers and service personnel

Throughout the study, nine health units 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 Comerciários Health Post Counseling and Serological Advice Center (COAS/CTA), Vila dos Comerciários 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, observation of the May 13th Medical Assistance Post (PAM) had also been planned, but did not happen because we were unable to secure managerial permission.34 The analysis also includes, in the case of Porto Alegre, description of prevention projects developed by NGOs, especially by NEP.

2.1 Porto Alegre

None of the services observed in Porto Alegre formally develop specific HIV/AIDS healthcare or out reach 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 focal 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 with their own money or by the owners of “houses” and “bars.”

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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.
### 2.1.1 Description of services visited

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<thead>
<tr>
<th>Health unit</th>
<th>Location</th>
<th>Services &amp; functioning</th>
<th>Comments</th>
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<tr>
<td>Cairo Fernando Abreu CTA (Porto Alegre)</td>
<td>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.</td>
<td>It offers basic testing and counseling. There is also an AIDS hotline.</td>
<td>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.</td>
</tr>
<tr>
<td>Vila dos Comerciários COAS/CTA (Porto Alegre)</td>
<td>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 is located far from any prostitution area. However, it is close to low-income neighborhoods and row houses where women involved in sex work might live.</td>
<td>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 basis of spontaneous demand, providing talks and individualized counseling given mainly by psychology interns.</td>
<td>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 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.</td>
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<tr>
<td>Vila dos Comerciários SAE (Porto Alegre)</td>
<td>The SAE is located in the same unit where the Vila dos Comerciários CTA functions.</td>
<td>SAE is not a testing center but does the medical follow-up of people living with HIV.</td>
<td>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.</td>
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<tr>
<td>Dermatology Outpatient Unit CTA (Porto Alegre)</td>
<td>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 the “Model Clinic,” a large municipal health unit.</td>
<td>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 made at a nearby room. Users remain at the center from 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).</td>
<td>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 sex worker and prostitution was never discussed.</td>
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2.1.2 NGO prevention work: the NEP experience

As already mentioned, a noticeable 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 actions. 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, monitor women prostitutes living with HIV/AIDS and promote treatment adherence services.

For many years, NEP has had a partnership with 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 who are very experienced in the sex market and political work 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.

2.2 Rio de Janeiro

Rio de Janeiro municipal and state health units do not offer either 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 an important part of this population is involved in sex work, the work of the health unit is directly related to prostitution (see item 2.2.2). For many years, the May 13 th PAM has specialized in caring for HIV-positive clients and, since 2008 it has carried out sensitizing actions with health professionals and clients to overcome prejudices 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 Prevena project and, more recently, as one site of Corrente da Saúde (RDS) research operations (see item 2.2.3.).

2.2.1 Description of visited services

In this section, a summary description of the visited units 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.
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<tr>
<th>Health unit</th>
<th>Location</th>
<th>Functioning</th>
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<tr>
<td>Lapa PSF (Rio de Janeiro)</td>
<td>It is located at the Ordem Terceira do Carmo Hospital, very close to the Lapa Arches, a traditional prostitution area, especially for travestis.</td>
<td>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.</td>
<td>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.</td>
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<tr>
<td>Rocha Maia CTA (Rio de Janeiro)</td>
<td>It is located in the Rocha Maia Municipal Hospital, in 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.</td>
<td>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 Corrente da Saúde, 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.</td>
<td>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, among 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.</td>
</tr>
<tr>
<td>São Francisco Hospital CTA (Rio de Janeiro)</td>
<td>The CTA takes up a fairly large part of the São Francisco University Hospital, which is the UFRJ infectology unit.</td>
<td>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 Corrente da Saúde in the component that researched HIV/AIDS incidence among Rio de Janeiro prostitutes.</td>
<td>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 this service were those who had participated in the Corrente da Saúde research.</td>
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2.2.2 Lapa PSF: a special case

Prevention, promotion, and healthcare actions developed by the Lapa PSF are exceptional in several ways. Firstly, because the Family Health Program (PSF) is still incipient in the Rio de Janeiro municipality (and better implemented at 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 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 doctor 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.

During the case study, we visited the PSF and had the opportunity to accompany a health agent 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 welcome 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 the 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 a modern construction 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

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).

36 Referred to by first name only: Elizete.
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 as to meet this “different” demands. As we know, the mark of “different” is quite obvious in the case of travestis because their bodily expressions but also because their health needs, related to corporal adjustments, openly challenge sexuality and gender norms prevailing 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 investment made by the PSF team is to be seen as extremely positive. They included 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 there 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 differentiated work would be continued.

2.2.3 The Corrente da Saúde research project

In the 2008-2009 period, the National AIDS Program funded a 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). It involved over 600 women who were tested and an-

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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.
answered a comprehensive questionnaire on their behavior, attitudes, and practices related to their work and the epidemic.\(^{38}\)

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 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’ voluntaries 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 outreach sex workers working in 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 per recruited woman. The research subjects received snacks and transportation vouchers. The Rocha Maia Hospital CTA was abandoned the São Francisco Hospital CTA, located near Vila Mimosa, became the only health unit research site. Most women were recruited in the two first 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.

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\(^{38}\) 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).
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.

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 at further understanding 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.

3.1 Profile of health managers and professionals

Much similarity is 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 academic institution.
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 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. Prostitutes 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 had they consider that since all health programming in the are of HIV/AIDS is informed by the concept of vulnerability, the needs of sex workers are included 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 what concerns identifying the location and health needs most vulnerable popula-
tions (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.

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 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 considered that a differential type of service should be established for services 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 overcoming 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), 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 acknowledges 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 on their view gays and travestis are better organized than prostitutes, the system response mimetizes 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 NGOs involved. The basic rule is that when organizations do not have technical competence, interventions do no 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.

3.2 SUS universality versus specific needs

Neither in Porto Alegre nor in Rio de Janeiro, 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 he 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 better provide 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 positives examples of health professionals’ sensitization and adequacy of SUS to respond to “differences.”

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 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 opening hours of CTA and other service are inadequate for workers in general and also 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 that 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 unsatisfactory the offer of regular STD/AIDS training, capacity building, and refresh training carried out by both state and municipal health departments.

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 that often witnesses people being discriminated and ill-treated after receiving an HIV-positive test result. Another health professional interviewed made constant references to have propvide services to women who “don’t look like prostitutes,” who “look like mothers,” “who seem to work for a multinational corporation,” “who seem domestic workers”. She was in fact expressing her own prejudice, as 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 define 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, compromises the quality of care, and make it more difficult epidemiological surveillance. Because of that some health managers and professionals interviewed in Rio de Janeiro do think that it is necessary to have a differential approach to HIV prevention among sex workers. This approach would include a more detailed investigation of specific issues, such as differentiated (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 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 and prostitutes. The most frequent sign of these biases refers to working conditions in prostitution, which are systematically to be very violent and exploitative, to involve drug use, and to imply 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 imaginary on prostitution and the concrete profile of clients who search for the public services that are not sought by most
female sex workers we have heard. 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. Conclusions

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 overcome 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. Therefore, the expressive dimension of state policies regarding prostitution has 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.

However, the study indicates that there is a huge gap between the expressive and educational dimensions of the Brazilian policy on HIV/AIDS for people involved in the sex market, and effective local implementation of those policies, especially regarding access to and quality of services, both preventive and sexual healthcare services.

This huge gap results from multiple factors. Certainly, one of these factors is the public health system (SUS) decentralization, particularly of its effects on the implementation of the HIV/AIDS policy.  

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 and in obtaining 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, during the period analyzed, federal promotion and protection policies, and specific programs and plans for differentiated actions have been adopted – 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 been also 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 to ensure 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 discontinuity 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 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 in 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 decision to suspend the agreement. Many underlined they 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.

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, that the suspension of the USAID funds, to explain why prevention programs and the public health care is not properly responding to the needs of prostitutes and sex workers at large. As we have seen the majority female sex workers we have heard seeks responses for their health needs in 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 the most interesting and worrying findings of the case study is this paradox: in Brazil today an expressive 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 unsuitable to suppose that this pattern is quite extensive in the sex industry and this is certainly one aspect that deserves further investigation.

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 tend as well to blame users themselves for the discrimination they experience, as it is common to hear that sex workers have internalized stigmatization, which is referred 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 at 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!”

Who is responsibility 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 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 a safer 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, nongovernment 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 con-
sequence 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, causing 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).
Attachment

I. Persons interviewed – First phase

1. Lília Rossi, program director of Pact Brazil (USAID project) – prior National AIDS Program staff in the Prevention Department.
5. Roberto Chateaubriand from GAPA/MG, (Group of Life Incentive in Minas Gerais).
7. Ângela Donini, National HIV/AIDS Program, Brasília – deputy chief of Prevention Department.

II. Persons interviewed – Second phase

State and municipal level program officials

1. Alexandre Chieppe, STD/AIDS manager in Rio de Janeiro state.
2. 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).
3. Lilian Lauria, public health doctor and epidemiologist, and STD/AIDS manager of the Rio de Janeiro Municipal AIDS Program (5 years).
4. 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).


7. 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

1. Débora Fontenelle, general practitioner, PhD in Collective Health and former coordinator of the Rocha Maia Hospital CTA.

2. Valéria Romano, family doctor, initiator of the Lapa PSF, currently a professor at the Rio de Janeiro Federal University (UFRJ).

3. 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.

4. Maria Lúcia, nurse technician at the Rocha Maia Hospital CTA and pre- and post-testing counselor.

5. Jorge Eurico, public health doctor and member of the IPREX project.

6. 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.

7. 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.

8. Ludia ________, coordinator of the Caio Fernando Abreu CTA, Porto Alegre, and statewide coordinator of CTAs.

9. Rosa Mayer, psychologist at the Sanitary Dermatology Outpatient Unit, Porto Alegre.
10. Helena Malerba, nurse at the President Vargas Maternity and Children’s Hospital STD Outpatient Unit.

11. Dimas Alexandre Kleimam, COAS coordinator of the Porto Alegre Municipal Health Department and infectologist at SAE and Conceição Hospital.

2. Other sources

Speeches given at the National Prevention Conference in June, 2008: Keyla Simpson, Gabriela Leite, Lília Rossi, and Magaly Eleutério.

Research study team

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