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TECHNICAL CONSULTATION ON EFFECTIVE HIV PREVENTION WITH MOST-AT-RISK POPULATIONS IN LATIN AMERICA

HOTEL-MUSEUM CASA SANTO DOMINGO, ANTIGUA,
GUATEMALA, DECEMBER 8–10, 2009



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Abstract

The Latin America and Caribbean Bureau of the U.S. Agency for International Development (USAID), together with the USAID Office of HIV/AIDS in Central America, the Centers for Disease Control and Prevention Global AIDS Program/Central America, and the AIDSTAR-One project convened experts for a technical consultation from December 8 to 10, 2009 in Antigua, Guatemala.

The participants discussed current information on the HIV epidemic in Latin America, prevention strategies and models focused on most-at-risk populations, and the importance of creating a programmatic and policy environment that supports implementation. They also had the opportunity to share experiences about the development and implementation of programs for sex workers, men who have sex with men, people living with HIV, and other most-at-risk populations.

Cover photo: Some of the participants from the technical consultation, Hotel-Museum Casa Santo Domingo, December 10, 2009. Photo taken by the Hotel-Museum Casa Santo Domingo staff.

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ACRONYMS

CDC	Centers for Disease Control and Prevention
CENSIDA	National Center for HIV/AIDS Prevention and Control, Mexico
COPRECOS	Committee of HIV/AIDS Prevention and Control of the Armed Forces and National Police of Latin America and the Caribbean
MARP	most-at-risk population
MSM	men who have sex with men
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PLHIV	people living with HIV
REDLA+	Latin American Network of People Living with HIV
STI	sexually transmitted infection
SW	sex worker
USAID	United States Agency for International Development

OBJECTIVES OF THE TECHNICAL CONSULTATION

1. Identify what is necessary to address the gaps and needs related to programming, studies, and policies pertaining to HIV prevention among most-at-risk populations (MARPs) in Latin America.
2. Identify the most up-to-date prevention programs used with MARPs including lessons learned about prevention programs that offer a minimum or comprehensive package of services for MARPs.
3. Support prevention initiatives that have been developed in the region, design and implement effective prevention programs that are appropriate and evidence-based, and advocate for better programs for the MARPs.
4. Discuss different approaches and systems that strengthen the monitoring and evaluation of the prevention programs used with MARPs.

INTRODUCTION

After more than three decades of the organized response against HIV, HIV prevention should focus on strategies that link information from epidemiology, knowledge of cultural norms, understanding of the complexities of human beings' sexual behavior (without using labels and acknowledging the differences inherent to human beings), macrostructural issues, and other factors discussed during this consultation. The HIV epidemic has led to fundamental challenges to the health of populations, highlighting elements of vulnerability in some populations more than others. That is why it is becoming increasingly urgent to devote efforts to understand how to have the largest impact when dealing with populations that are more socially and biologically vulnerable to guide the design and development of new social policies.

The technical consultation that forms the basis for this report focused on the following populations: men who have sex with men (MSM), sex workers (SWs), and people living with HIV (PLHIV), although this is not an exhaustive list of those who are vulnerable to HIV infection.

This report includes the most important themes discussed during the technical consultation about effective HIV prevention with most-at-risk groups in Latin America. The technical consultation took place on December 8, 9, and 10 in 2009 in Antigua, Guatemala, Central America.

The meeting purposefully consulted experts throughout the planning and implementation, including representatives of MARPs, to make sure their point of view was included and their ideas are in a position to affect decision making regarding HIV prevention in Latin America. Thus, consultation was a higher priority than consensus. The purpose of this report is not to build consensus, but rather to reflect the diversity and heterogeneity of the conceptual and methodological approaches represented at the technical consultation. A total of 61 experts attended, representing governmental organizations, nongovernmental organizations, and international cooperation agencies (see list in Appendix 2).

Participants had the opportunity to share experiences through plenary discussions and working groups. There were also panel presentations to share experiences. The focus was on identifying best practices and lessons learned, how to apply these to the prevention initiatives and programs targeting MARPs in Latin America, and identifying elements that should be maintained or incorporated into prevention programs. The technical consultation and this report are intended to serve as a guide for agencies, governments, and other stakeholders as they modify their prevention activities as needed.

The presentations given during the three days of the technical consultation are available on the AIDSTAR-One project website at www.aidstar-one.com/focus_areas/prevention/resources/technical_consultation_materials/latin_america_marps (presentations are in Spanish). AIDSTAR-One provided planning and implementation assistance for the event.

TECHNICAL CONSULTATION OVERVIEW

CHARACTERISTICS OF THE MOST VULNERABLE POPULATIONS THAT PREVENTION PROGRAMS SHOULD CONSIDER

The populations at greatest risk form broad and heterogeneous categories of subpopulations. It is well known that MSM, transsexuals, SWs, ethnic and indigenous groups, displaced groups, migrants, inmates, and people who inject drugs belong to populations that have high HIV risk factors. These risk factors are exacerbated by other factors such as gender, age, sexual orientation, and some disabilities. No less important are the conditions surrounding these people's lives (i.e., poverty, displacement, lack of access to services and information, unemployment, stigma, and discrimination) that strategies to reduce risk of contracting HIV must consider in their design.

Related Presentations: 1) [The Nuances of Vulnerability](#); 2) [Prevention and Control of HIV: Focus on MARPs](#)

Even though there are a considerable number of populations known to be at high risk for contracting HIV, the technical consultation focused on some specific populations such as MSM, transvestites, transsexuals, SWs, inmates and PLHIV (among others).

At various times during the meeting, the need to review the concept of men having sex with men was raised because it is an analytical category, and not necessarily a term with which individuals identify. It is important to recognize there are MSM that do not consider themselves “gay.” In addition, it is important to acknowledge that men who have sex with men and women (bisexuals) have not been reached adequately because they were not identified as an at-risk population. This population is more hidden, even though a large percentage has been or is married to women, which presents a challenge when designing interventions for the prevention of HIV and other sexually transmitted infections (STIs).

Related Presentations: 1) [Preventing HIV/AIDS—The Good and Bad News](#); 2) [Differences between Subpopulations that Fall Under the MSM Categories and Programming Implications](#)

The same applies to another category known as sex workers. The term “commercial sex worker” comes from outside the population, and thus many who are a part of the population do not self-identify as such, especially those that engage in transactional sex.¹ This is a fundamental challenge

¹ Transactional sex is sex by which a person uses his or her body as an economic resource; not necessarily commercial sex, but a relationship seen in terms of reciprocity. Those involved in transactional sex usually set it apart from commercial sex, which is considered as a simple meeting between two people who do not have a relationship. Transactional sex often occurs between an older person (usually male) and a younger person (usually female), and may be desired by both or be the product of coercion by either party. Monetary incentives may include cash or gifts, and be motivated by the need for money to survive, cover school fees, buy clothes, desire to possess material goods, or to appear to belong to a higher social status. Transactional sex may be a risk factor for HIV, because by definition the relationship is characterized by an imbalance of power and economic and social disparity. Individuals involved in transactional sex have a decreased ability to protect themselves from pregnancy and disease because they are much more financially dependent for survival.

when designing strategies to reach this population. On the other hand, sex work occurs in different places, and these places have changed from their traditional locations (i.e., brothels). Currently, places such as offices, car washes, and barber shops are used. The means of communication have also changed as now the Internet, cell phones, and beepers are used to initiate contact and schedule dates. It is also necessary to incorporate all the intermediaries into the interventions, such as taxi drivers, bartenders, guides, and others who work in the tourism industry.

Related Presentation: 1) [Commercial Sex Workers and the Programming Implications for Latin America and the Caribbean](#)

People do not belong to only one single risk category or engage in only one type of risky behavior. People who are involved in sex work may be involved in other risk behaviors, and persons whose sexual orientation is homosexual or heterosexual can not only be defined by their sexual behavior. These populations can be “classified” through strategies that categorize the populations differently—for example, according to their work or their links to other social institutions. One clear consequence of classifying a person according to their sexual behavior (homosexual, heterosexual, bisexual, transvestite, transsexual, lesbian, or transgender) is that once they are classified under one category, it is more difficult to track that person under any other pertinent classifications. For example, SWs are often “hidden” under the classification of PLHIV, MSM, indigenous populations, populations belonging to different ethnic groups, displaced persons, migrant populations, prison populations, heterosexual population, women, and other populations.

People do not belong to a single risk group or have only one type of risky behavior.

Similarly, the difficulty of creating analytical categories significantly impacts transgender people because, despite being frequently and highly vulnerable and being most-at-risk, they remain “invisible” to planners and decision makers. Only people who live as transgenders can describe the subjective experience involved in feeling and being transgender.

The use of the term “homophobia” as a central theme of the fight against discrimination and HIV also contributes to the transsexual population remaining “invisible.” In addition, there is much discrimination against this population in study centers, health services, workplaces, and families.

The fundamental challenge is to build categories in consultation with specific populations, identifying them as they identify themselves. People are complex and so are their sex lives, and a person can belong to several categories at once. It is necessary to overcome the limitations posed by the construction of categories from a medical and public health perspective and instead incorporate anthropological elements of individuals’ and a population’s own identities.

While it is very important to resist the tendency to use labels, it is also essential to recognize diversity, celebrate differences, and embrace complexity. Sexual preference does not exclude love, solidarity, and camaraderie. Some experts have suggested getting rid of the MSM classification and extending the concept to lesbian, gay, bisexual, and transgender; however, it remains to be discussed

whether this represents a real leap or just expands the category and the original challenges remain.

...eroticism can be represented not only by the sexual object, but also by circumstances and what is perceived as prohibited and, in some cases, even the dangerous.

Behaviors and identities do not always go together. No one can predict the behavior of a person from his or her sexual identity and vice versa. Binary categories (man-woman, penetrated-penetrator, for example) are the norm; however, reality demonstrates that sexuality is much more complex than this. It is

important to incorporate “desire” into analysis as well as power relationships to better understand the mechanisms that drive people’s sexual behavior. For example, eroticism can be represented not only by the sexual object, but also by circumstances and what is perceived as prohibited and, in some cases, even dangerous.

The social representation of the male gender exists on a continuum from the “hypermasculine” to the “transsexual.” However, this has nothing to do with the erotic or sexualized object for this person. Many variants coexist within the binary model (male-female). This sets up gray areas where there is greater vulnerability: there are no health services and educational services offered for these populations. They are invisible.

It is known that it is crucial to include social and emotional elements when finding more effective strategies in preventing HIV. However, there is very little documented evidence of the psychological and sociological variables.

It is crucial to include social and emotional elements when finding more effective strategies in HIV prevention. However, there is very little documented evidence of the psychological and sociological variables. Elements such as the doctor-patient relationship appear to contribute to the empowerment or disempowerment of people, and this may influence the prevention of HIV transmission or adherence to treatment.

The capacity of PLHIV to make informed decisions, the patterns of their relationships, their social support networks, and particularly the ways in which they organize social groups must also be taken into account. Variables such as love, erotic attraction, and the role of power in sexual relationships, among others, are rarely considered when designing HIV prevention models.

When characterizing the epidemic, which has remained relatively stable in Latin America, prevalence data may be hiding the fact that the incidence continues to progressively increase. However, the factors that could explain this increase are not understood sufficiently. Apparently, the increase in the incidence of HIV that is occurring in some countries in Latin America is not necessarily due to lack of access to condoms (this indicator has also risen), but also does not seem to be associated with variables such as the purchase/selling of sex.

Explanatory research is needed, preferably of a qualitative nature, to identify variables involved in this phenomenon that is characterized by the increased incidence of HIV, even while the prevalence of HIV is remaining steady. This is especially important given that the prevalence among MSM, for example, has declined much less than among other risk groups. Consistent and correct use of condoms during every sexual act, not just access to condoms, must be measured.

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Another aspect to be considered in light of this discussion is the need to retrain health staff, especially to ensure that they do not stigmatize and discriminate against their clients. Some of the experts consulted believe that health services should not be segregated for specific populations, though training for health personnel should still emphasize what is necessary when providing services to each population group. Keeping that in mind, due to the stigma and discrimination in the region, it is necessary to begin offering health services to populations most at risk while sensitizing health providers and providing services without segregation.

INNOVATIVE PREVENTION MODELS

PREVENTION MODELS BASED ON REDUCING RISKY BEHAVIORS

Experts suggest that different frameworks can be identified in the design of prevention interventions. One of these models is based on the theories of risk behavior, something considered very important when designing effective interventions for vulnerable populations.

Related Presentations: 1) [Strategies for Behavior Change](#); 2) [Preventing HIV/AIDS: Theories of Behavior Change](#)

The following are examples of these models.

Health belief model: Issues such as perceived susceptibility, severity, benefits, barriers, and self-efficacy are taken into account as predictors of how much risk a person is willing to take with their health.

Social cognitive model: This model considers that information, self-regulation skills, and skills building and social support systems are fundamental in achieving behavior change toward more healthy behaviors.

Theory of reasoned action: This model incorporates a person's beliefs, attitudes, social norms, subjective norms, motivation, intentions, and behavior change as the cofactors that must be addressed when designing interventions to change health behaviors.

MODELS BASED ON PREVENTION OUTREACH TO AT-RISK GROUPS

A different approach states that prevention should be focused on so-called at-risk groups.

The concept of an at-risk group is based on the notion that some segments of the population are more likely than others to acquire or transmit HIV. Under this approach, it is necessary to identify these groups to implement appropriate preventive strategies and to understand the interaction of STIs with HIV and their influence on the dynamics of the spread of the HIV epidemic. For example, the high prevalence of other STIs and the high number of sexual contacts among gay men/MSM and SWs make these groups especially vulnerable to HIV. Moreover, the greater transmissibility of HIV from men to women, coupled with the unspecific clinical manifestations of STIs in women and, in certain situations, not having access to health services, make these women particularly vulnerable to STIs and their complications (e.g., ectopic pregnancy and genital cancer).

Related Presentation: 1) [Combined Interventions and Prevention Challenges in Concentrated Epidemics](#)

HUMAN RIGHTS-BASED PREVENTION MODELS

A third type of framework comes from the concept that prevention is a human right. Thus, it is based on the concepts of vulnerability and risk. Risk is the probability of exposure to HIV.

Risk is the probability of being exposed to HIV. Vulnerability is the low ability to avoid HIV by being in risky situations.

Vulnerability is lowered capacity to avoid HIV by being in risky situations. This approach sees prevention as a universal right for all people.

An HIV prevention model focused on human rights includes the following:

- Involving the affected groups as part of the process of defining the problem and finding solutions
- Recognizing and not stigmatizing the sexuality of young people, women, people who have sex with same-sex partners, the elderly, and people with disabilities
- Recognizing that a transformation of gender relations is required in order to positively influence the trend of the epidemic
- Involving men in interventions that challenge the status quo, because gender roles and expectations put them at risk as well
- Recognizing that work with women and girls must also focus on their role in perpetuating negative constructions of masculinity.

STRUCTURAL CHANGE–BASED PREVENTION MODELS

The social context is the arena where prevention interventions are built, so it should be taken into account when thinking about strategies and interventions. A prerogative of prevention is to consider the social context. The political context must also be considered, because when realistically bringing about changes and transformations, it is often necessary to transform political contexts as well.

The prerogative of prevention is to consider the social context. The political context must also be considered, because when bringing changes and transformations to reality, it is often necessary to transform political contexts as well.

Structural interventions change or influence the social, political, or economic climates in a way that benefit many people at the same time, perhaps without their knowledge. Nonetheless, it is clear that structural interventions are more comprehensive but less specific than other types of interventions. Perhaps structural interventions are much more useful to address overall vulnerability rather than specific risk behaviors. Because of this, approaches that are selected should be realistically balanced for the context in which they operate.

Related Presentation: 1) [Structural Interventions for Most-at-Risk Populations](#)

It can be difficult to convince governments about the importance of structural interventions with higher risk populations (e.g., MARPs) because they are often not politically acceptable and they require devoting a great deal of staff time to benefit a limited number of people. However, it is important to keep pace with the epidemic, which means emphasizing the need to reach the MARPs in most of Latin America.

Gender-based violence, stigma, and discrimination are elements that should be incorporated into analyses of the vulnerabilities of MARPs and in the planning of programs to reach these populations.

Issues such as alcohol and drug abuse should also be integrated into HIV prevention interventions. Additionally, some groups seem to be “invisible,” such as gay adolescents, transgenders, transsexuals, SWs (especially those who engage in exchange of sex for goods or transactional sex), and heterosexual men who also have sex with other men. Their “invisibility” results in being left out of the design of prevention interventions and thus they continue to be most at risk for contracting and transmitting HIV.

BIOMEDICAL PREVENTION-BASED MODELS

This approach is based on data from randomized controlled trials. Recently, these studies have focused on the following topics:

- Diaphragm/gels
- Microbicides
- Vaccines
- Treatment of STIs
- Circumcision
- Penile hygiene.

It is clear that a single strategy is not working and that the biomedical-based interventions should be incorporated into prevention strategies that in turn give other interventions potential.

In general, the results of these studies are not positive. They show that condom use is effective in preventing HIV only when condoms are used correctly and consistently and that the diaphragm is not effective. Circumcision is effective in preventing HIV (60 percent). The vaccines offer no more than 30 percent protection, and microbicides will not protect against HIV.

It is necessary to build evidence-based policies, hence the importance of funding randomized trials. It is also necessary to continue to evaluate biomedical interventions, particularly those relating to the suppression of herpes simplex virus type 2, circumcision, microbicides, and vaccines. It is clear that a single strategy is not working and that biomedical-based interventions should be incorporated into behavioral change strategies and structural changes.

MODELS OF COMPREHENSIVE SERVICE PACKAGES

Related Presentation: 1) [Comprehensive Services Packages for Prevention in the Most-at-Risk Populations](#)

A minimum package of HIV prevention services for MARPs in concentrated epidemics includes the following:

- Outreach to promote behavior change (i.e., through peer- and community-based education)
- Access to voluntary HIV testing and counseling
- Educational and information campaigns targeting vulnerable groups
- Access to condoms and water-based lubricant
- Access to diagnosis and treatment of STIs
- Referral to comprehensive HIV care.

Interventions supporting the minimum package of HIV prevention services in concentrated epidemics include the following:

- Strategic information
 - Epidemiological information
 - Sociodemographic information

- Behavioral information (qualitative and quantitative)
- Contextual analysis
- Public policy analysis
- Mapping of actors (allies, opponents)
- Mapping of resources (financial, human)
- Capacity building: human resources
 - Advocacy
 - Building alliances
 - Technical capacity building for implementers
 - Training health care providers
- Strengthening community response
 - Community mobilizing and social auditing
 - Ownership of data and information
 - Assistance in self-management processes
 - Strengthening of social networks, community organizations, and nongovernmental organizations
 - Technical assistance in audit processes
 - Assistance in advocacy processes
- Improving the political environment and legal framework
 - Mapping of laws relating to prevention and other issues (homophobia, stigma, and discrimination); the application and regulation of legislation
 - Mapping of key players
 - Promotion and dissemination of regulatory frameworks
 - Assistance in implementation and enforcement of favorable policies, legislation, and regulations
- Actions to prevent stigma and discrimination
 - Actions geared toward decision makers
 - Actions geared toward the general population
 - Actions geared toward health care providers.

As it has been demonstrated, there are several valid models to guide the design of HIV prevention programs. However, in Latin America, there are few examples of programs that can demonstrate their HIV prevention activities are validated by a specific conceptual model. On the contrary, it

appears that interventions are predominantly based on “instincts” rather than evidence and tested models.

CONSIDERATIONS

Experts agree that each model has its strengths and weaknesses. However, regardless of the prevention model used, it is necessary to consider that any interventions that emerge from a particular model should be oriented toward greater *equity*. In this sense, it is likely that to achieve greater equity it might be necessary to focus interventions.

When designing policies, strategies, and actions to prevent HIV and other STIs, a challenge that must be addressed is rethinking the *categories of analysis* used when studying human sexuality, which is much more complex than what is captured by current analytical categories. This leaves too many gaps in the design of current interventions and can explain a great deal about the failure of some of them.

The *quality of health services* should be monitored much more efficiently, because the context of privacy in which health services are offered gives some providers the opportunity to stigmatize or discriminate against their clients or externalize their religious/moral prejudices, and evangelize or proselytize a particular religion.

One challenge identified by experts is the integration of men into the health system. One of the biggest barriers to this is health providers' attitudes. Another obstacle identified to integrating men into health services is hours of operation for provision of services (i.e., services at night might make men more likely to attend).

One challenge identified by experts is the integration of men into the health system. One of the biggest barriers to this is health providers' *attitudes*. Another obstacle identified to integrating men into health services is the *hours of operation* for provision of services (i.e., services at night might make men more likely to attend).

Another challenge is the incorporation of knowledge from *indigenous* or *Afro-Latino* culture to the health care delivery processes that combine traditional allopathic medicine with indigenous or Afro-Latino medicine.

Similarly, *urban culture* has its own codes of communication that should be taken into account to improve the impact of HIV and STI prevention campaigns. In this sense, the issue of HIV and its prevention could be incorporated into soap operas, movies, dramas, phones, and social networking sites (such as Twitter and Facebook).

Some issues to be incorporated in a definitive way to prevent HIV are STIs and the abuse of alcohol and illegal drugs. It is also essential to incorporate the subjective dimensions of pleasure, eroticism, and desire when conceptualizing HIV prevention programs.

MEASURING THE IMPACT OF PREVENTION PROGRAMS

The method used to measure the impact of prevention programs is crucial. There are several evaluation models that could be grouped into two broad categories: quantitative and qualitative.

Related Presentation: 1) [Quantitative Evaluation and Prevention Indicators](#)

QUANTITATIVE METHODS

This type of approach measures the impact of prevention programs made from a hypothetical-deductive approach. The researcher has to strictly observe the standards of statistical methodology and maintain strict control of intervening variables. The quantitative model fits under a theoretical perspective that views prevention as a technological process. The data that emerge from a quantitative measurement are specific to a selected indicator.

There are efforts being made to measure the impact of prevention programs using quantitative methodology. This type of measurement includes systematic reviews and meta-analysis, randomized studies, quasi-experimental studies, cohort studies, case-control studies, cross-sectional surveys, epidemiological studies, and case reports. Experts say that despite the efforts in this regard, there may be discrepancies in the findings of the studies due to the methodology used or the population studied. To deal with the contradictions between studies, systematic reviews and meta-analyses have been used to reevaluate findings. However, the quality of surveys has been improving, especially with the use of computerized surveys that decrease the “social desirability” bias.

The experts consulted agree on the need for each country to generate their own indicators. This approach is important, and it represents a major challenge in terms of comparing these indicators across countries.

QUALITATIVE METHODS

The goal of a qualitative approach is to measure the impact of prevention programs by facilitating a multifaceted and contributory process through the experience sharing of program participants. Qualitative measurement requires a methodology sensitive to differences. Process evaluation is itself a process that evolves under successive discoveries and transformations of the context being studied. The purpose of the qualitative evaluation is to understand the situation being studied. The report that reflects the content of the qualitative assessment must respect both the need to know as well as the right to privacy of all participants.

Related Presentation: 1) [When to Use a Qualitative Methodology to Measure Impact](#)

In general, one could argue that what really matters is whether the expected effects are achieved in the population as a result of the intervention and if they made any difference in the lives of the participants. The qualitative methodology puts a face to numeric data and has the flexibility to bring a lot more to light than the entire research process. In addition, it can describe what happened in the early stages of intervention programs and not just the results. For example, before starting a prevention program, the qualitative approach (through focus groups and interviews) provides knowledge about the attitudes and practices of the target population so that the design of interventions will better fit the needs of that population. Similarly, after an intervention, a qualitative approach could help to explain the reasons behind outcomes and explain variations in results.

It is important to note that qualitative methods are perfectly compatible with quantitative methods. When the effectiveness of the intervention is evaluated without knowing how it was implemented, it is difficult to know how they achieved the results. It is necessary to evaluate the process, mainstream acceptability and cultural appropriateness, and find intermediate results (taking into consideration that human behavior is complex and that data does not provide all the answers).

It is important to note that qualitative methods are perfectly compatible with quantitative methods. When the effectiveness of the intervention is evaluated without knowing how it was implemented, it

is difficult to know how implementers achieved their results. It is necessary to evaluate the process, mainstream acceptability and cultural appropriateness, and find intermediate results (taking into consideration that human behavior is complex and that data alone does not provide all the answers).

CONSIDERATIONS

Experts agree that it is necessary to incorporate content related to qualitative measures in *university training programs* of health personnel. This could help to reduce low awareness of this methodology and would therefore be more likely to be used as a complement to quantitative methodology.

Measuring the impact of HIV prevention programs must include dimensions and variables such as *alcohol and drug abuse*, as they are often confounding factors that affect the impact of the interventions.

Using “mixed” methodologies would allow for the inclusion of the perceptions of the populations most affected by social exclusion, violation of civil rights, health needs, and opportunities for social participation.

Using “*mixed*” methodologies would allow for inclusion of the perceptions of the populations most affected by social exclusion, civil rights violations, health needs, and opportunities for social participation.

Similarly, it is recognized that there are gaps in *research* on the impact of HIV prevention programs on the behavior of specific groups such as gay and transgender teenagers, among others.

Again, it is important to separate the *transsexual population* from the MSM population; otherwise, the former remain “invisible” and therefore absent from studies, analysis, programming, and interventions.

FINANCING PREVENTION PROGRAMS

Data from the Resource Tracking Unit based on National AIDS Spending Assessments for 2006 was discussed during the technical consultation.

Related Presentation: 1) [Financing HIV Prevention for the Most-at-Risk Populations](#)

Among the most important information, the following is highlighted:

- Total spending on HIV in the region is U.S.\$2 per capita per year (2006).
- The region allocated 15 percent of spending on HIV prevention.
- For prevention among vulnerable groups, which are also those most affected by HIV, 0.8 percent of total funding is allocated, of which 5 percent goes to prevention.
- In 8 out of 12 countries, preventive spending financing for vulnerable groups comes from international sources.

Spending on higher-risk populations is insufficient in many countries, depends on foreign (donor) funds, and is predominantly geared toward one group or another.

INTEGRATING STAKEHOLDERS INTO PREVENTION PROGRAMS

The integration of the various affected parties into the HIV prevention response through the development of common goals and coordinated strategies and activities is crucial to the success of programs. The consensus among experts is the need for a social audit at various levels, as well as the creation of a legal framework to help ensure the rights of vulnerable populations.

One of the most important results that integration of the various affected parties would bring about is a rethinking of the struggle against the HIV epidemic, incorporating human rights as a fundamental element and creating a favorable environment for public policies that can be designed around the decreasing vulnerabilities. Integration mechanisms should stimulate participation of populations that until this moment have remained invisible to health, educational, and political systems (e.g., transsexuals, gay adolescents, and transvestites).

One of the most important results that integration of the various affected parties would bring about is a rethinking of the struggle against the HIV epidemic, incorporating human rights as a fundamental element and creating a favorable environment for public policies that can be designed around decreasing vulnerabilities.

Some challenges have been identified in solidifying the integration process of affected parties into HIV prevention. Among them are the following:

- Religious fundamentalism, which sometimes promotes exclusion and separatism of any approach at odds with a particular belief system.
- International organizations' agendas, which do not always agree with each other and do not necessarily line up with each country's priorities. In some cases, governments do not feel comfortable incorporating interventions for populations at higher risk for HIV into their agendas.

Institutional weaknesses in the areas of participation of the most vulnerable populations decreases their participation in decision-making processes. This means that in many cases, the presence of MARPs would validate their participation, but it is not really active participation.

RECOMMENDATIONS FROM THE WORK GROUPS

During the last day of the meeting, the participants divided up into five work groups, each assigned to a specific topic. The following were their recommendations.

CHARACTERISTICS OF THE MOST VULNERABLE POPULATIONS THAT PREVENTION PROGRAMS SHOULD CONSIDER

Some recommendations are as follows:

1. There are identified transmission routes arising from migration (e.g., between Mexico, the United States, and Central America).
2. Incidence is rising in younger populations (under 35 years old).

3. The MSM population does not have sex exclusively with men. Approximately half of MSM have had sex at least once in their life with a woman, and a third has had sex with a woman in the last year.
4. It is important to distinguish between the categories of exposure and sexual orientation. Prevention programs must rely on information about exposure because sexual orientation per se does not imply differential or additional risks.
5. The subclassification of a population must be made in conjunction with the same population. Many of the existing classifications are rejected by the populations who are assumed would identify with these classifications, and this has implications for data collection. This may entail having specific categories for different locations. Sexual behavior is complex and under the current paradigm an individual could belong to a number of classifications at the same time. Currently, subclassifications are made from a public health perspective. It is necessary to incorporate an anthropological and sociological perspective. For example, when a woman is classified as a sex worker, the interventions would focus on her and her clients and ignore her romantic relationships. Another example is that many bisexual men do not identify themselves as such (i.e., MSM or men who have sex with men and women).
6. It is important to consider the intersection and difference between desire and sexual behavior. For example, a man's behavior may change based on a situation; he may now seek to be desired (moving from seducer to seduced).
7. It is necessary to sensitize decision makers about the vulnerabilities that exist for MARPs such as low levels of and limited access to education, low levels of community empowerment, reduced access to employment, and services unfriendly to diversity.

INNOVATIVE PREVENTION MODELS

Some recommendations are as follows:

1. Use mobile units as a strategy to detect HIV cases in places that have difficult access to testing services.
2. Establish a certification program for tour guides to include HIV in their presentations with tourists.
3. Combine traditional and indigenous medicine that has had positive results.
4. Combine integrated activities in the areas of reducing vulnerability and risk.
5. Provide awareness training in relation to homophobia and detection of alcohol and other drug abuse.
6. Use virtual networks and cellular phone technology to work with youth. For example, in Brazil a program has signed an agreement with Nokia implementing incentives for treatment compliance and exchanging them for cell phone minutes. Similarly, negotiations with Motorola are starting to address the issue of partner selection through an electronic game that is centered on a decision-making process.
7. Establish community education models that demystify pleasure and change perceptions around genital pleasure being the only way to give and receive pleasure. Methodologically, workshops about nonpenetrative sex are given.
8. Strengthen support networks, empowerment, and self-esteem for all populations.

9. Provide peer counseling in health services.
10. Promote HIV testing in MARPs, not only in pregnant women.
11. Incorporate HIV prevention campaigns into regular programming of soap operas, movies, and radio soap operas.
12. Prevention work needs to be done among people whose partners are considered “stable,” as it is a population group that shows low condom use, as opposed to those who have so-called multiple partners, to which interventions have been directed and therefore rates of condom use are higher.
13. Strengthen STI management in health care facilities. Improve the quality of prevention and service delivery to MARPs by providing diagnosis and facilitating treatment and contact tracing.
14. Implement sentinel surveillance of STIs, including counseling and the distribution of STIs and HIV as part of the surveillance system of national programs, to inform decision makers of the dynamics of the HIV epidemic in these populations.
15. Although there is some data about the role of circumcision in generalized epidemics, there is no evidence that promoting circumcision has an impact on concentrated epidemics.

FINANCING PREVENTION PROGRAMS

Some recommendations are as follows:

1. A key element to consider is not only how much is invested in each country, but also how that investment is distributed. It is necessary to take MARPs into account.
2. Increase the institutional capacity of populations, in health programs and in organizations of civil society (social comptroller).
3. It is necessary to establish a management culture, including monitoring and evaluation, when conducting programs and activities undertaken with funding from government or international resources.
4. It is advisable to consider the inclusion of municipal governments to create conditions for the sustainability of actions.
5. Private sector participation is a strategy that should be considered for funding HIV prevention activities.
6. Consider cost-effectiveness studies on HIV prevention in specific populations.

PRE- AND POST-IMPLEMENTATION RESEARCH PROGRAMS

Some recommendations are as follows:

1. It is important to develop evidence-based interventions and assess their impact so that interventions are based on evidence. Additionally, the data help justify the distribution of spending on HIV.
2. Investigations should consider differences between populations, especially in the category of MSM, as this is a broad category that makes some subpopulations invisible.

3. The cause of death should be emphasized in the recording and reporting of deaths, because otherwise it is difficult to establish the relationship between incidence and prevalence, and this influences the results of epidemiological trends.
4. The research that addresses the issue of adherence to antiretroviral treatment should consider that compliance rates do not always depend on the patient, but also on other factors including the health system, health workers, and family.
5. There are populations at high risk for which there is no available research data. This limits the ability to design appropriate interventions for them.
6. It is necessary to take advantage of the studies conducted by nongovernmental organizations and universities, as well as find ways to combine research strategies.
7. There are gaps in the research on the impact of programs and the behavior of specific groups such as gay and transgender adolescents.
8. Research should be conducted to distinguish between what brings about immediate changes and what sustains these changes over time.
9. Research should be conducted with mixed methods that include the perceptions of social exclusion and the rights to citizenship, health, respect, and social participation.
10. Work must also be done to identify what the correlation is between the consumption of alcohol and drugs and what approach is suggested.
11. The use of computer surveys decreases bias, especially with MARPs (audio computer assisted self-interview allows participants to answer a computer rather than a person).

STRUCTURAL INTERVENTIONS

Some recommendations are as follows:

1. Development of a state policy of zero tolerance for homophobia or “zero homophobia.”
2. Establish a national strategic framework of integrated and multisector action plans, with results-based goals and indicators.
3. It is important to incorporate men into the health system, especially in health providers’ minds. For example, men obtain services depending on the times they are available and are more likely to attend when they are offered in the evenings.
4. Raising the awareness of military commanders as an intervention strategy to implement interventions in this field.
5. In general, training models focus on the teacher, not the learner.
6. Encourage the creation of laws to protect vulnerable populations, including their implementation and regulation.
7. HIV has been characterized as opening paths in public health. Multisector engagement has changed the paradigms in public health.

ANNEX I

AGENDA

TECHNICAL CONSULTATION ON EFFECTIVE HIV PREVENTION WITH MOST-AT-RISK POPULATIONS IN LATIN AMERICA

HOTEL-MUSEUM CASA SANTO DOMINGO, ANTIGUA, GUATEMALA, DECEMBER 8–10, 2009

Tuesday, December 8

What do we know about MARPs in Latin America and what are we doing to reach them?

- | | |
|-------------|--|
| 9:00-9:20 | Welcome
(Brad Cronk, USAID/Central American Regional Program) |
| 9:20-9:40 | Purpose and Expected Outcomes
(Cesar Castellanos) |
| 9:40-10:10 | Who are the key MARPs in Latin America and other regions? Using epidemiological information and other data for decision-making
(Gabriela Paz-Bailey, Tephinet Centers for Disease Control and Prevention [CDC], Global AIDS Program/Central America) |
| 10:10-11:00 | Discussion
How are we using this information?
How are we applying this information to implement and improve prevention programs?
Are our prevention programs evidence-based? |
| 11:00-11:20 | Break |
| 11:20-12:20 | Panel: Differences within MSM, SW, and people living with HIV populations and the implications for programming
(José Toro, University of Puerto Rico; Mark Padilla, University of Michigan; Juan Simbaqueba, Latin American Network of PLWH [REDLA+]-Colombia) |

- 12:20-1:20** **Discussion**
 What are the characteristics of the different sub-populations?
 In addition to prevalence, what other information do we have about the sub-populations?
 What information gaps exist on the sub-populations? What topics are we not appropriately covering?
 What type of prevention activities are being implemented and to which sub-populations are they directed? How are they being implemented?
 What are the most important considerations to ensure prevention programs are effective with MSM, SW, and people living with HIV?
- 1:30-2:30** **Lunch**
- 2:30-3:00** **MEASURE/Evaluation Assessment of USAID’s Central American Regional and Mexico HIV/AIDS prevention component in four countries**
 (Laura León, Capacity Project-Guatemala)
- 3:00-4:00** **Discussion**
 What issues and gaps were identified?
 Are we aware of these issues and gaps or are they new?
 How can we effectively address these issues and gaps in our prevention programs?
 What resources do we need to address these issues and gaps in our prevention programs?
- 4:00-4:20** **Break**
- 4:20-4:40** **Summary of the day**
 (Cesar Castellanos)

Wednesday, December 9

Prevention approaches, what’s new...what works?

- 9:00-10:00** **Panel: Models, strategies, and necessary components for effective prevention that have been proposed and implemented in recent years**
 (Diego Postigo, World Health Organization-Panama; Ivo Brito, Ministry of Health-Brazil; Elizabeth Castillo, Profamilia-Colombia)
- 10:00-11:00** **Discussion**
 How are these models conceptualized, implemented, and evaluated?
 What other models exist, or should be considered?
 What elements need to be eliminated or incorporated in our programs to develop effective prevention approaches based on these and other models?
- 11:00-11:20** **Break**

- 11:20-11:40** **Biomedical Strategies: Are they effective for prevention with MARPs?**
(José Sánchez, IMPACTA-Peru)
- 11:40-12:20** **Discussion**
What experiences exist with these strategies in Latin America?
Are these appropriate strategies for MARPs?
Is it possible to promote these strategies in the region?
What more needs to be done to promote these strategies among MARPs in Latin America?
- 12:30-1:30** **Lunch**
- 1:30-2:10** **Panel: Behavior Change Strategies: Are they effective for prevention with MARPs?**
(José Toro, University of Puerto Rico; Clancy Broxton, USAID/Washington)
- 2:10-2:50** **Discussion**
What experiences exist with these strategies in Latin America?
Are these appropriate strategies for MARPs?
Is it possible to promote these strategies in the region?
What more needs to be done to promote these behavior change strategies in an effective manner among MARPs in Latin America?
- 2:50-3:10** **Structural Interventions: Changing the political environment, reducing stigma and discrimination, and promoting human rights and citizenship**
(Mirka Negroni, Health Policy Project-Mexico)
- 3:10-3:50** **Discussion**
What interventions have been implemented and what do we know about their effectiveness?
What are the implications of including structural interventions in prevention programs targeting MARPs?
What do we need to know, do, and what resources are needed so these types of interventions are included in prevention programs?
- 3:50-4:10** **Break**
- 4:10-4:30** **Panel: What constitutes a comprehensive package of prevention services for MARPs?**
(Giovanni Meléndez, USAID/Central America Regional Program)
- 4:30-5:10** **Discussion**
Why is it important to offer a comprehensive package of services?
What experiences exist in the region?
Are we currently offering a comprehensive package of services?
How can we assure our programs are more comprehensive?

Thursday, December 10

How are we measuring the impact of prevention programs?

- 9:00-9:15** **Quantitative models and indicators**
(Carlos Magis, National Center for HIV/AIDS Prevention and Control, Mexico [CENSIDA])
- 9:15-9:30** **Qualitative models**
(Yamir Salabarría-Peña, U.S. President's Emergency Plan for AIDS Relief [PEPFAR]/CDC-Atlanta)
- 9:30-9:45** **How do we estimate population sizes to measure coverage and inform planning?**
(Sonia Morales, CDC/Central America)
- 9:45-10:45** **Discussion**
What models are being used more and why?
Do we over emphasize the importance of indicators?
Is there a tendency to ignore qualitative information?
Do PEPFAR, United Nations General Assembly Special Session on HIV/AIDS (UNGASS), and Universal Access have the most appropriate indicators for our MARPs prevention programs? Do they really demonstrate impact?
How does qualitative research complement quantitative approaches?
How should we collect and use qualitative data?
How can we improve our ability to measure the impact of prevention programs?
- 10:45-11:05** **Break**

Resources Needed and Invested in Prevention

- 11:05-11:25** **Is the level of funding designated for prevention programs in Latin America appropriate given the nature of the epidemic in the region?**
(Ricardo Valladares, Dialogue for Social Inversion Project-Guatemala)
- 11:25-12:05** **Discussion**
Given the concentrated epidemic in the majority of countries in the region, do prevention programs targeting MARPs receive adequate funding?
How is funding for prevention with MARPs defined?
Who is providing funding?
Which types of activities receive the most funding?
How can we motivate governments and others to follow the epidemic and contribute more to MARPS prevention?

Leading Prevention: Who should participate? How can we involve different stakeholders and define their roles?

- | | |
|--------------------|---|
| 12:05-12:20 | Roles of networks, nongovernmental and community-based organizations, national prevention programs, international organizations, and donor agencies in HIV/AIDS prevention
(Beto de Jesus, Pact-Brazil) |
| 12:20-12:35 | How have some governments in the region successfully integrated prevention programs targeting MARPs in a sustainable way?
(Jorge Saavedra, AIDS Healthcare Foundation-Holland) |
| 12:35-1:30 | Discussion
What mobilization strategies have been used? Which ones have been effective?
What are the specific roles of the different sectors?
Can each sector play a bigger role?
How can we support the different sectors to have larger roles? |
| 1:30-2:30 | Lunch |
| 2:30-4:30 | Group work |
| 4:30-4:45 | Break |
| 4:45-5:45 | Presentation of group work |
| 5:45-6:00 | Conclusions, recommendations, next steps |

ANNEX 2

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