Chapter 5
Abriendo Puertas: A Multi-level Intervention to Improve HIV Outcomes by Addressing Stigma and Discrimination Among Female Sex Workers in the Dominican Republic

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5.1 Introduction

While the Dominican Republic (DR) has been previously recognized for community-led, structural interventions focused on HIV prevention among female sex workers (FSW), these prior efforts did not explicitly address the needs and realities of FSW living with HIV. In 2013, based on findings from formative research, we developed and implemented the *Abriendo Puertas* (Opening Doors) intervention in Santo Domingo, initially among 250 FSW living with HIV (Donastorg et al. 2014). The multi-level model has four core components: (1) individual counseling and health education; (2) peer-led HIV service navigation; (3) sensitivity trainings for clinical care providers; and (4) community solidarity and mobilization. Additionally, we piloted efforts to create access to HIV services for the regular male partners of FSW living with HIV. The model was found to be feasible and acceptable to the

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community and other stakeholders and showed initial effectiveness in improving behavioral outcomes such as protected sex, engagement in HIV treatment and care services, and adherence to antiretroviral therapy (ART).

In this chapter, we describe the development, implementation and evaluation of the *Abriendo Puertas* model, with particular attention to how the intervention challenged both HIV and sex work-related stigma and discrimination. We examine how the intervention began to enable participants to resist and redefine stigmatized identities surrounding their HIV status and occupation by creating individual- and group-level safe spaces, which facilitated development of self-acceptance and social solidarity. Findings suggest the importance of both psychosocial support and collective action, as part of a community empowerment approach to improve the health and human rights of FSW living with HIV. We also examine challenges with the model's implementation, and ongoing gaps in HIV outcomes, highlighting the need for further research and implementation science.

5.2 Background

5.2.1 Structural Factors and HIV Vulnerability Among Female Sex Workers

Female sex workers (FSW) have a 13.5-fold higher odds of being HIV-infected compared to women overall globally (Kerrigan et al. 2013; Baral et al. 2012). Structural factors including criminalization and legal constraints surrounding sex work, stigma and discrimination, violence, substance use and financial insecurity have been linked to the heightened vulnerability of FSW to HIV acquisition (Kerrigan et al. 2015). These structural factors have been found to affect the HIV risk of FSW through their negative impact on access to primary prevention services and clinical care for sexually transmitted infections, as well as inhibiting related protective behaviors such as consistent condom use with clients and other sexual partners (Shannon et al. 2015).

Despite the fact that FSW have been known to have significantly higher risk for HIV infection since the early days of the global HIV epidemic, relatively limited attention has been paid to the specific needs of FSW living with HIV. In fact, FSW living with HIV have been largely invisible in the literature and in programming. In the last 5 years, however, with the growth of Treatment as Prevention (TasP) programs for key populations, attention to FSW living with HIV has slowly increased (Mountain et al. 2014a). Similar structural factors to those described above have now been found to be associated with negative HIV care and treatment outcomes across the care continuum among FSW living with HIV. Specifically, stigma, discrimination and violence against FSW living with HIV have been linked to reduced access to HIV care and treatment services, as well as lower rates of adherence to

antiretroviral therapy (ART), and sub-optimal rates of viral suppression (Mountain et al. 2014b).

5.2.2 Understanding and Addressing Intersecting Forms of Stigma and Discrimination

In his seminal work, *The History of Sexuality,* Foucault analyzes the cultural production of differences, providing a nuanced understanding of culturally constituted stigmatization as key to the establishment and maintenance of the social order (Foucault 1978). From a Foucauldian perspective, HIV and sex work-related stigma and discrimination can be understood as strategies to enforce oppressive social norms around gender and sexuality and to discipline those who engage in behaviors that are deemed to violate established norms and threaten the status quo of existing hierarchical social and economic power relations and inequalities within a given setting.

In addition to drawing on Foucault's work to understand the nature and role of various forms of intersecting social stigmas, we consider social cohesion and community empowerment as a strategy of collective resistance to and subversion against such oppressive social norms and existing power structures (Link and Phelan 2014; Parker and Aggleton 2003). We explore how social cohesion, or the level and type of trust, solidarity and mutual aid in a given group, may create a platform for resistance against multiple forms of stigma experienced by FSW (Carrasco and Bilal 2016). Social cohesion has been shown to be an integral component of community empowerment approaches among FSW in various contexts that bring them together to analyze, articulate, and demand their human rights, including access to quality HIV services (Kerrigan et al. 2015). Social cohesion has surfaced as a necessary first step for community mobilization and subsequent alteration of the existing power structures that constrain the right to health (Kerrigan et al. 2015; Peterson and Hughey 2004). Thus, we take a structural perspective to examine how a marginalized group may challenge stigma collectively, while recognizing the multi-level nature of the empowerment process which may involve: individual conscientization (power within), working collectively (power with others), and using these collective resources to bring about change (power to), including improvements in overall health and HIV outcomes (Rowlands 1997).

5.2.3 Sex Work and HIV Prevention in the Dominican Republic

The Dominican Republic (DR) is a relatively small country of approximately ten million people (UNdata 2016) with an estimated 80,000 FSW (Kerrigan et al. 2013). Since the late 1980s, the partnerships between non-governmental organizations (NGOs), government agencies and community groups have characterized the national response to HIV among key populations including FSW. The focus on key populations reflects the historically and currently concentrated nature of the epidemic in the DR

(COPRESIDA 2008; Halperin et al. 2009), with less than 1% of the general population currently estimated to be infected with HIV (UNAIDS 2013). However, among groups such as FSW, the median national HIV prevalence stands at 4.4%, approximately six times higher than the overall HIV prevalence (CONAVIHSIDA 2012).

Sex work is not illegal in the DR, however stigma and discrimination against sex workers still exists in the media, in families and communities, and in clinical care environments (Donastorg et al. 2014; Kennedy et al. 2013; Kerrigan et al. 2016). The relatively non-restrictive legal status of sex work in the DR has facilitated community-led interventions among FSW for almost three decades (Moreno and Kerrigan 2000; Kerrigan et al. 2001). Both NGOs and community groups working on HIV prevention among FSW exist in various regions of the country, implementing peer education, condom distribution and screening and treatment services for sexually transmitted infections (STI) (Kerrigan et al. 2006). Significant variation in the type and frequency of HIV prevention interventions is known to exist among FSW across different areas of the DR, particularly outside larger cities and towns. Yet, overall, the DR has been recognized regionally and internationally for its grassroots response to HIV among FSW, which has emphasized the promotion and protection of the human rights of sex workers, including the rights to both health and work (Kerrigan et al. 2013).

HIV prevention programs such as *Avancemos* (We Shall Overcome) and *Compromiso Colectivo* (Collective Commitment) were implemented in various cities in the DR to address the multi-level factors influencing the increased risk of FSW to HIV/STI including environmental-structural factors (Kerrigan et al. 2013). Both initiatives were grounded in a rights-based approach that recognizes sex work as work and promoted FSW's ability to advocate for their labor rights, including safe working conditions. In this process, the FSW community and its partners engaged with sex establishment owners, managers and staff to create an enabling environment for HIV prevention based on the principles and practices of solidarity and collective action (Kerrigan et al. 2013). Similar to global trends, these actions and programs in the DR were largely focused on primary prevention efforts with FSW, working to reduce and limit incident HIV infections and other STIs.

5.2.4 Developing a Multi-level Intervention with FSW Living with HIV

In response to the dearth of research and programming addressing health outcomes for FSW living with HIV, in 2011 we conducted formative research in the DR including 40 in-depth interviews with FSW living with HIV and their regular male partners, four focus group discussions (FGD) among FSW, and 21 key informant interviews with policy makers and service providers working with this group. From this initial exploration, we identified challenges faced by FSW living with HIV in the DR including: stigma and discrimination associated with HIV and sex work; lack of social support and inclusion in existing interventions and services;

financial burden of transportation and medicines, beyond ART, related to HIV care and treatment; and mental health concerns such as anxiety and depression (Kennedy et al. 2013).

These challenges spoke to the structural dynamics surrounding sex work in the DR, and many other settings, where multiple forms of marginalization and exclusion produce both psychosocial and material constraints on FSW's access to care, health and human rights. In turn, these findings highlighted the need to extend prior rights-based frameworks and models of community empowerment and mobilization to FSW living with HIV. Drawing on the principles of community empowerment models among FSW (WHO et al. 2013), and findings from the formative work, in 2012 we developed a community-driven, multi-level intervention model to improve the overall health and well-being and HIV outcomes of FSW living with HIV in the DR (Donastorg et al. 2014). Our conceptual framing of this work is rooted in an understanding of the intersecting forms of stigma, discrimination and inequality experienced by FSW living with HIV related to their HIV status, occupation, socioeconomic position, and gender (Kerrigan et al. 2013). The *Abriendo Puertas* model sought to stimulate support systems to address both the psychosocial and structural dynamics of these intersecting forms of stigma, which have been documented as barriers to care and treatment among FSW in a variety of settings (Beattie et al. 2012; Beyrer et al. 2011; Ghimire and Van Teijlingen 2009; McClelland et al. 2011; Scambler and Paoli 2008).

The *Abriendo Puertas* (Opening Doors) model and related intervention research project was formulated and implemented through a partnership between multiple sectors and actors, including: researchers and clinicians at the *Instituto Dermatológico y Cirugía de la Piel* (IDCP) in Santo Domingo; researchers from the Johns Hopkins University (JHU) and the University of North Carolina (UNC) in the United States; the Dominican sex worker rights organization, *Movimiento de Mujeres Unidas* (MODEMU); and a local NGO, *Centro de Orientación e Investigación Integral* (COIN). Strong ties and coordination with the Dominican government through its National AIDS Programs (known as DIGECITSS and COPRESIDA) and network of public HIV treatment centers was also cultivated throughout the project. The formative and intervention research were funded by the United States Agency for International Development (USAID) through the Research to Prevention (R2P) project led by the Johns Hopkins University.

To respond to the multi-level factors found to influence care and treatment outcomes among FSW living with HIV in the formative work, the following core intervention elements were included at the individual, interpersonal, institutional and community levels (Table 5.1).

Systematic efforts were also made to refer and engage the regular male partners of FSW participating in the intervention, by offering them HIV counseling and testing (via referral from their FSW partner if, and only if, she saw fit), and linkages to HIV treatment and care when appropriate. Support services for disclosure and partner communication were also provided.

Table 5.1 Multi-level intervention components of the *Abriendo Puertas (Opening Doors)* model

Level	Component	Description	Key Elements
Individual	Individual counseling and education	Six sessions of counseling, reflective exercises, and health education. Session content was developed based on formative research and three existing curricula adapted for the study population: (1) a globally-established model of peer support networks for women living with HIV in Europe and the UK (the SHE Programme); (2) a locally developed model, *Podemos* (we can), developed for people living with HIV in the DR; and (3) the HIV vaccine trials HIV testing and counseling protocol for risk reduction	Counselors follow a predetermined but flexible curriculum that includes the following topics:
			Acceptance of diagnosis and stigma
			Adherence to care and ART
			Practicing safer sex
			Reproductive and sexual health
			Disclosure of HIV status
			Other topics such as substance use, family planning and partner violence are covered when relevant
Interpersonal	Peer navigation and support	Trained FSW peer navigators accompany women as they enroll, re-engage with and/or attend HIV-related care and treatment services. Navigators maintain regular contact with study participants, which is critical to sustained retention over time. While focused on HIV services, navigators at times also offer social support and logistical assistance to make connections with other health-related services, labor and human rights services, and social services	Examples of peer navigator activities include:
			Accompanying a participant to an appointment
			Serving as a patient advocate
			Visiting study participants' homes
			Helping women with disclosure of their HIV status to friends, family members or partners
Institutional	Healthcare provider training	Sensitivity trainings were conducted with providers at government and NGO HIV clinics where women from the cohort received their clinical care to raise awareness about the experiences and needs of FSW living with HIV. The trainings responded to formative research findings that FSW often felt stigmatized or discriminated against in HIV clinics. Trainings are conducted with groups of providers including physicians, nurses, and psychologists to facilitate exchange between the clinics	Sensitivity trainings are meant to:
			Raise awareness about FSW living with HIV
			Identify and improve current clinic attitudes and practices that may be stigmatizing or discriminatory
			Improve provider communication skills on topics such as sexual behavior, violence, substance use, and barriers and strategies to treatment adherence

Community	Social solidarity and community mobilization	MODEMU facilitated a series of ‘*casas abiertas*’—or open houses—where women from the cohort came together throughout the intervention. These gatherings were instituted in response to formative research findings that FSW living with HIV felt socially isolated. At the open houses, women joined together as a group and talked about topics of interest and learned practical skills to create income-generating opportunities, such as making cleaning products and decorative sandals that they can sell	*Casas abiertas* aim to:
			Strengthen the social cohesion and solidarity among sex workers living with HIV and the larger sex worker community
			Address stigma within and beyond the sex worker community
			Help to address financial barriers to engagement in HIV care and adherence to treatment

5.2.5 *Evaluating the Feasibility and Initial Effects of Abriendo Puertas*

To evaluate the feasibility and initial effects of the *Abriendo Puertas* model, we established a cohort of 268 women between November 2012 and February 2013. The cohort was recruited using a hybrid sampling approach that relied primarily on peer navigators reaching out to the FSW community, combined with peer and key informant referrals. Of these women, 250 participated in the *Abriendo Puertas* intervention during its original implementation. Each woman participated in a pre- and post-intervention survey examining HIV-related behaviors and socio-structural factors surrounding care and treatment outcomes. Participants also provided biological samples for viral load (blood) and STI testing (urine). A subset of 24 women and 16 men participated in semi-structured in-depth interviews to explore their perceptions of and experiences with the intervention model and contextual factors that may have influenced its impact. Additionally, two focus group discussions were held, one with women who participated in community mobilization activities and one with women who did not. All participants provided informed consent and were compensated for each study visit (~$US5). The study was approved by the Institutional Review Boards of the JHU, UNC, IDCP and CONABIOS, which is the national biomedical ethical review board in the DR.

At baseline, the full cohort sample (n = 268) had a median age of 36 years. Most women (65%) had only a primary school education (range 0–8 years). The vast majority of women had at least one child (93%) and almost all women had a current regular non-paying partner (81%). Most had been sex workers for many years (median 15 years). The median number of years living with HIV was 5. On average, they charged approximately US$18 per date with clients. Alcohol use was common in the sample with 54% reporting drinking in the last week. Approximately one quarter (24%) reported having ever used illicit drugs. A minority perceived themselves to be in excellent health, while 38% reported being in fair or poor health at baseline. Almost a quarter (23%) had another STI beyond HIV at baseline. As shown in Fig. 5.1, the vast majority (92 %) of cohort participants were previously linked to HIV care and treatment services, and the majority were engaged in care in the last 6 months (85%) and currently on ART (72%) at baseline. However, only about half of the women in the cohort were virally suppressed (<50 copies/mL) (49%), indicating significant gaps in optimal engagement in the HIV care continuum at the time the *Abriendo Puertas* intervention began in 2012 among the initial 250 FSW participants.

During 10 months of follow-up with the cohort of 250 women who initiated the intervention, we achieved 91% retention (228/250). Engagement with the intervention was generally strong but varied across the different program elements. At 10 months follow-up, 86.4% of women had completed all six individual counseling sessions, 61.7 % reported having had contact with a peer navigator, and 50.4% reported having participated in at least one community mobilization activity, such as the *casas abiertas* (open houses). Only ten women (4.4%) reported having no exposure to any intervention component, while over one third (34.2%) reported

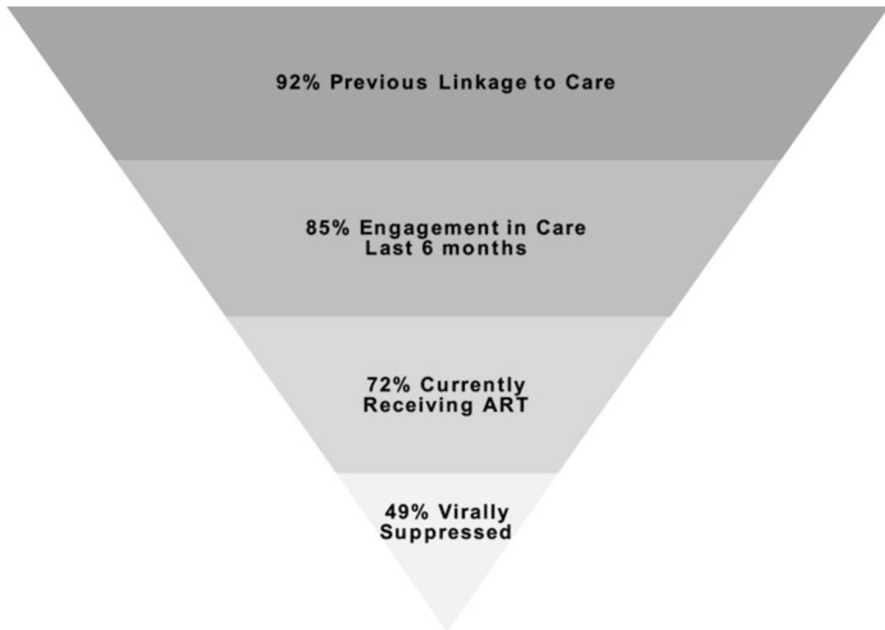

Fig. 5.1 HIV care continuum among female sex workers living with HIV in the DR (n = 268)

exposure to all three components. Over half of the women in the cohort (68.4%) were categorized as having high/moderate exposure, defined as having participated in two or three intervention components.

Important changes were observed in terms of key HIV-related behaviors among the cohort during this 10-month period, including significant improvements in: protected sex, engagement in care, and adherence to ART. With regards to prevention outcomes, there were significantly increased odds of reporting protected sex across all partner types (aOR 2.35, 95% CI 1.30–4.43) from baseline to follow-up. Protected sex was initially defined for each type of sexual partner (new client, regular client, steady partner) and defined as 1 if the participant reported either no sex or always using condoms with that specific partner in the last 30 days, and 0 if otherwise. While reports of drug and alcohol use overall showed a non-significant declining trend, the rates of drug or alcohol use before sex dropped significantly at follow-up, with drug use before sex decreasing from 7.5 to 3.5 % ($p < 0.013$) and alcohol before sex from 47 to 40 % ($p < 0.034$). Engagement in care increased significantly from 86 to 95% ($p < 0.001$), although positive changes in retention in care were non-significant (64–69%). The percent of women on ART increased significantly from 70 to 78% ($p < 0.005$) over 10-month follow-up, as did adherence to ART in the last 4 days from 72 to 89% ($p < 0.001$). Higher intervention exposure was found to be significantly associated with changes in both ART adherence (aOR 2.42, 95% CI 1.23–4.51) and protected sex (aOR 1.76, 95% CI 1.09–2.84).

5.2.6 Challenging Intersecting Stigmas: Qualitative Experiences with Abriendo Puertas

Overall, women participating in the in-depth interviews and focus groups relayed that the intervention had a positive impact on their lives, their ability to manage living with HIV, and their overall health and wellbeing. Participants described the importance of different components of the intervention including the role of individual counseling on their sense of self-worth, peer service navigation in providing them with social and instrumental support, and community mobilization through both solidarity and the skills that they learned. Below we specifically explore how various aspects of both HIV and sex work stigma were understood and challenged by participants during the process of the *Abriendo Puertas* intervention.

Participants reported that talking to the intervention counselors and knowing that other people valued them and cared for them regardless of their HIV status or occupation provided them with a sense of relief, hope, and support. Many participants indicated that they had very low self-esteem before participating in the intervention and that this was due to the shame and discrimination that they experienced being both a person living with HIV and a sex worker. For example, when invited to participate in the *Abriendo Puertas* intervention, one participant indicated she was reluctant at first because she wondered: 'Why would they be interested in a prostitute living with HIV? I used to feel that I was insignificant.'

The women interviewed indicated that they learned coping strategies from their counselors to help them avoid internalizing stigma and discrimination related to both their HIV status and their occupation as sex workers. They also reported that they garnered strength and inspiration from the respect and kindness that they received from *Abriendo Puertas* intervention staff, which many women reported that they did not otherwise have in their lives.

Many participants highlighted that the intervention specifically helped them to change or shift their perspectives about the experience of living with HIV, which had been an ongoing struggle. They reported developing a sense that HIV was not insurmountable and was not in control of their fate. For example, one participant reported, that: 'I will die when God wants it, not when the disease decides it.' Another stated: 'This is a disease like any other disease; the main thing is that one has to take care of oneself.' A few participants indicated that before participating in the intervention they felt that HIV was a 'monster' that besieged them. Through *Abriendo Puertas*, many participants realized that a person living with HIV could lead a healthy life if she intentionally takes care of her health and adheres to treatment. The intervention helped many participants to more fully accept their HIV diagnosis, learn from their experiences and find a purpose again, and to personally and collectively empower themselves to not feel like victims, as the quote below relays.

> For me, [the intervention] was very good because I was very depressed and I thank God for coming here to Abriendo Puertas. Now, I feel great. I feel I can move forward; I have more faith in myself. All the staff members have helped me a lot. I thought that I was going to die;

> that my time was over. [At Abriendo Puertas] I got a very good psychologist. Whenever I came to see her she gave me support, she energized me, she always told me that I looked pretty. And here [at MODEMU] I participated in [casas abiertas] to learn to decorate sandals, and make hair products and candles. I thought to myself, 'But if I'm doing all of this, why can't I move forward?' I came here and they changed my life because I was so depressed, I felt dirty, I felt isolated.

In coming together to redefine stigmatizing narratives, participants were also able to describe positive aspects of their work and recognize the value of their occupation. Several women relayed how sex work gave them financial independence and the ability to provide for their children and fulfill their role as mothers, which was a source of pride rather than shame.

> I have worked, built my house, supported my children. In my household, I am man and woman… [and] we do what I say because I am the one who supports the house and provides.

Some women also indicated that the income earned from sex work helped them to avoid living in situations of domestic violence or being dependent on violent partners who threatened withdrawing financial support. A few women who reported facing ongoing violence, shared that through the intervention they learned the importance of respecting themselves and not letting other people abuse or mistreat them, and, in turn, separating from partners who abused them emotionally or verbally, while others separated from partners who refused to use condoms. Furthermore, several participants indicated that they were not using condoms consistently before participating in the intervention but that intervention counselors helped them to fully understand the importance of consistent condom use with their clients and regular partners. In the women's narratives, the importance of partner selection and consistent condom use was closely tied to and enhanced by challenging internalized stigma through the creation of solidarity with others.

While often participants' sense of personal empowerment was strengthened over the course of the intervention, many also indicated that they face a harsh socioeconomic reality in a country devoid of strong safety nets for the poor and with an HIV anti-discrimination law that is often not enforced. Many women could not follow recommended health practices due to lack of resources to attend clinic visits or not having the economic means to take medication with food as prescribed. Financial insecurity created stress related to responsibilities such as paying for rent and school fees for their children. A number of participants indicated that they were planning to or had already started making and selling some of the products that they learned to make at the *casas abiertas* implemented by MODEMU including decorative sandals, hair products, and candles. Most of the women interviewed said that one of their major hopes and dreams was to improve their financial security by starting their own business. Some were able to operationalize these dreams by continuing to produce and sell their products, or going back to school. There were examples of women who became hairdressers and one who became a nurse, each citing *Abriendo Puertas* as helping them find the motivation and strength to pursue these paths.

Through the *casas abiertas*, participants met other FSW living with HIV, some of whom were leading healthy lives and some who were struggling, which provided a rich space for exchanging experiences and support. These gatherings improved the women's sense of belonging and solidarity by creating a safe space where they could freely express themselves and connect with other women. Women who participated in the *casas abiertas* revealed in the FGD that they had developed friendships and networks with other program participants and kept in touch with them via phone or meetings after the intervention ended. These newly-formed connections enabled women to access broader networks to help themselves and other FSW and people living with HIV. The ability to help others also imbued a sense of meaning to the experience of living with HIV, coming from a sense of reciprocity and connection among FSW living with HIV, as seen in the quote from one *Abriendo Puertas* participant below.

> [Here] I met many women who are just like me. When they sent me to the casas abiertas, I did not want to go inside the room. When I sat down I wanted to run away but a lady said to me 'no [don't leave], you're just like me and if I have not left why would you leave?' I appreciated that; I stayed there. I used to think that I was the only one in this world who is living like this. At the casas abiertas I met all those women who live full of joy, that smile to life. I can smile to life too!

This sense of community, however, was not fully shared by all study participants. Women who did not participate in the *casas abiertas* revealed in the FGD that they felt it was impossible to create solidarity among FSW, many of them recounting stories of intense competition and fights among FSW at sex work establishments where they had worked. The comparison of both groups of women reveals that having the opportunity to openly interact with other FSW who were living with HIV in a safe environment helped to strengthen trust, solidarity, and reciprocity among participants. Several participants indicated the need to further strengthen the community mobilization component of the intervention by offering more opportunities for a greater number of FSW to come together in a safe space on a regular basis and to build practical financial and income-generating skills.

5.2.7 Engaging Male Partners of FSW Living with HIV

Approximately one-quarter of the women participating in the intervention referred their male regular partner for HIV counseling and testing, and participation in a brief socio-behavioral survey (n = 64 men). The majority of these men were living with the FSW partner who referred them to these services. We found that 35 of these 64 men were living with HIV; 27 were previously diagnosed and 8 were newly diagnosed during our study (Fleming et al. 2016). As a result, 45% of men were members of sero-discordant sexual partnerships. Of men with no previous HIV diagnosis (n = 37), 15 had never been tested for HIV and nine had not been tested in the past 2 years (Fleming et al. 2016). Low HIV testing was partly due to men not feeling at risk for HIV, despite having a partner who was living with HIV.

Among the 27 men who already knew that they were living with HIV, 93% had received HIV care in the past 6 months. The large majority (78%) was currently on ART. Of those currently on ART, almost all (90%) said they followed their prescribed doses 'perfectly'. A lack of tailored care inhibited engagement in anti-retroviral treatment for those infected. The time burden for clinic appointments and acquisition of medication was also a challenge.

> Well, actually I find it to be really difficult [to get my medication] because I think that if I'm just coming to get my medication, I shouldn't have to wait a long time…I don't think they should let someone who isn't there to see a doctor but rather is just looking for his medications to wait for 4 or 5 hours, I don't think that's right…We're just poor workers and I can't be paralyzed there.

This quote highlights the challenge of navigating HIV care around work schedules, which are a critical component of men's adherence to gender norms and expectations in this setting and others.

Like the women, the male partners of FSW interviewed also reported that they had a positive experience with the intervention, interacting with study staff and the services received. They reported feeling respected and validated by the *Abriendo Puertas* study team, which differed from their experiences in other clinical care environments, as described in the following quote by a male regular partner:

> When I climbed those 4 flights of stairs, I felt good, because I felt above all like an important person…I did an interview here, I liked it a lot, they treated me not like a person, but they treated me like an important executive.

Through this pilot effort to offer HIV testing and linkage to care to men through their steady FSW partner, we found that such referrals were acceptable within the context of a substantial number of partnerships in the cohort. We also identified that structural factors, in particular gender norms and lack of accessible and tailored services for men, were important determinants of testing, engagement and retention in care among male steady partners of FSW.

5.3 Discussion

Through our mixed methods evaluation of *Abriendo Puertas,* we found that the intervention is feasible and effective in improving key behavioral outcomes related to HIV prevention, treatment and care among FSW living with HIV, including protected sex and ART adherence. Additionally, qualitative data sheds light on the process of dismantling the negative impact of both HIV and sex work-related stigma and discrimination in the lives of FSW living with HIV, including how these forces shape their health behaviors and access to HIV treatment and care.

Our findings depict the importance of both internalized and enacted stigma related to HIV and sex work in the lives of FSW living with HIV and show that through their participation in the *Abriendo Puertas* intervention, the women were able to come together to develop and put into practice new de-stigmatizing narra-

tives, opening up possibilities for both health behaviors and collective action and social change. Such a process has been documented among sex workers in other settings, including participants in the *Encontros* intervention in Brazil, which also documented the importance of having a safe shared space, enabling participants to gather and construct a positive social identity, which could be then leveraged to influence both individual behavior and broader access to resources and services (Murray et al. 2010).

The importance of employing a Foucauldian perspective to understanding stigma and discrimination in this work lies in the possibility of uncovering underlying power dynamics that fuel stigma and in identifying both psychosocial and collective strategies to address it. If stigma is indeed a tactic through which power is deployed, methods to effectively address it must subvert the norms through which stigmatizing differences are created. Such subversion entails resistance against the ways in which we are defined, categorized and classified (Rajchman 1983). The women in the *Abriendo Puertas* intervention learned to jointly challenge the negative, devaluing, constraining labels imposed on them by society. We found that this process was made possible by both the individual counseling provided and the social cohesion generated in a safe physical and social space. The solidarity created in that space through the process of the women coming together and realizing that they were not alone in facing these issues and challenges, is a critical first step to overcoming the structural stigma and marginalization they face as a group.

5.3.1 Challenges Shaping Future Research and Program Directions

Despite the positive social and behavioral changes found in our initial evaluation of the *Abriendo Puertas* intervention, there were and are ongoing challenges and gaps in HIV outcomes. For example, the rates of women with a detectable viral load remained virtually the same between baseline and follow-up (50–51%; $p = 0.715$). While there could be issues with the appropriateness of HIV treatment regimens being prescribed and possible resistance, further analysis also indicates that there may be gaps in the quality of clinical care being provided to FSW living with HIV, including sex work stigma and discrimination by HIV providers (Zulliger et al. 2015a, b). Additionally, we found that one of the most powerful predictors of a detectable viral load over time, was substance use, highlighting the importance of further research and programming for FSW living with HIV who also use drugs or alcohol (Kerrigan et al. 2016). Based on our findings to date, including both achievements and challenges, we developed (Fig. 5.2) a conceptual and operational model mapping the pathways from intervention elements through socio-structural pathways to key behavioral changes which can lead to improved viral suppression among FSW living with HIV.

Moving forward, further implementation science research is needed to examine how the principles, pathways and intervention elements of community empower-

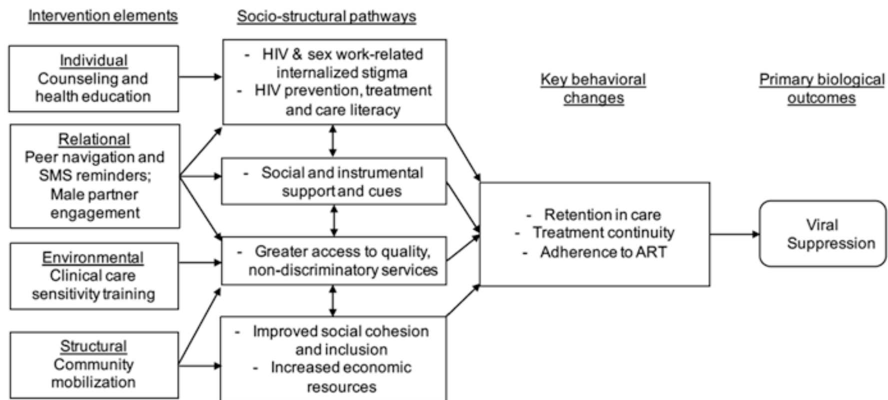

Fig. 5.2 *Abriendo Puertas* model and socio-structural pathways to improving HIV outcomes among female sex workers living with HIV

ment, including specific attention to structural factors such as intersecting stigma and discrimination, can be utilized to optimize HIV outcomes and the health and human rights of FSW living with HIV. Our findings to date highlight the importance of ensuring that interventions provide FSW living with HIV opportunities to challenge intersecting stigmas that inhibit their health, well-being and HIV outcomes through solidarity and collective action.

However, in light of the aforementioned gaps in improved biological outcomes, we continue to consider how to further strengthen the *Abriendo Puertas* intervention. Future implementation efforts may in turn consider using a screening and triaging model, which has been utilized in other settings including with people living with HIV (Broaddus et al. 2015; Reay et al. 2016), to assess the specific needs of FSW who are not virally suppressed over time in terms of counseling, navigation, social support and mobilization to tailor the intervention and increase its impact.

Since the promising findings from the initial implementation of *Abriendo Puertas* in 2014, the project received additional funding from the Advancing Partners and Communities (APC) project of John Snow International, with support from USAID, to expand the model and integrate it into three government-sponsored HIV clinics in Santo Domingo. In this second phase of the project, an additional 90 women were added to the cohort and offered the multi-level intervention package. These women were recruited directly from public clinics serving people living with HIV and the staff (social workers and psychologists) of these clinics were trained to offer the individual health education and counseling sessions in the clinic. Additionally, starting in 2015, we adapted the model for transgender women sex workers living with HIV. We piloted this adapted intervention with 30 transgender women sex workers living with HIV and conducted a mixed methods evaluation of their experiences. Evaluations of these adaptations and scale-up are still underway, but initial findings underscore the positive potential of utilizing the principles and elements of the *Abriendo Puertas* model in other populations and contexts. They have also highlighted the

challenges of integrating a model like *Abriendo Puertas* into public health clinics with limited staff, space, and resources for such activities.

In a third phase of scale up, sponsored by the USAID Linkages Project, led by FHI 360, *Abriendo Puertas* is being viewed as a tool to improve the quality of HIV care services for sex workers living with HIV by providing more holistic, comprehensive services that directly address the key psychosocial and structural factors that shape HIV care and treatment outcomes. We have developed, piloted and integrated two new sessions focused on substance use and violence into the individual counseling component as these factors were identified as critical determinants of HIV outcomes. We are also developing manuals for each intervention component to facilitate broader scale up and training. Within the DR, we are training interdisciplinary clinic teams from 11 public and NGO clinics in three cities in the *Abriendo Puertas* model. To date, the model has been well received with psychologists in particular praising the framework and tools provided by the individual counseling sessions, which allow them to do the work they were trained to do. A challenge that will be critical in this third phase of scale up is how to support community mobilization activities in smaller cities where there is not a large or strong FSW rights group. While recognizing the need for continued refinement, as one of the first models specifically developed for FSW living with HIV, *Abriendo Puertas* serves as a guide for critical future work among FSW in the DR and globally to improve their health, well-being and human rights.

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