

**USAID:**

**“Preventing HIV in High-Risk  
Populations”**

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HARRIET FLESHNER [MISSPELLED?]: For those of you who don't know me, I'm Harriet Fleshner and I head the Strategic Planning, evaluation and reporting team within the Office of HIV AIDS. As you've already heard, prevention was an important part of the Barcelona conference just as primary prevention is a critical part of [unintelligible] program. It is an area where we have, one of the lessons we've learned under [unintelligible] leadership, on the work of many in this room is the prevention works and that individuals will change their behavior when given information and when supported by changes in community norms and their expectations of behavior. You'll be hearing later this day about some important prevention efforts related to you in preventing mother-to-child transmission. On this panel, we are going to focus on some very interesting discussions that went on in Barcelona about prevention among high risk populations. Unfortunately, they wouldn't give me the whole day but we're only going to focus on 2 aspects but my colleague from E and E wanted me to remind you that there were very interesting, substantive and very challenging discussion around prevention and among other high risk populations, particularly injecting drug users. As you know, injecting drug use, is still an epidemic, particularly in New York and Asia region but increasing in A&E as we see the drugs as we see the drugs flow out

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from Afghanistan. Today I have the warmest pleasure of introducing two important colleagues. Michael Sweat will lead off. He is with John Hopkins University and has been working as a partner on the Horizon's project and he will be talking about some important work with secular sex workers in the Dominican Republic. He will be followed by Jenna Delaverda [Misspelled?] from Family Health International, who will be talking again about gains and challenges in dealing with the Uniformed forces. Since I think that we are already running a little behind, I'm going to sit down right now.

MICHAEL SWEATT: Good morning and I want to thank the organizers for inviting us to come and present from these findings. You think back a while, maybe 7 years ago, NIH had a consensus conference about HIV prevention, really focussing a lot on preventing HIV infection among high-risk populations and what came out of that meeting was to look more at structural and environmental interventions. More recently the Institute of Medicine also came out with a report really saying we need to do more in this area. There's been a lot of talk about this but there hasn't often been the actions taken and what I want to present to you today is a project that we've been working on is really trying to move this agenda forward and we presented this in Barcelona and got a lot of feedback

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on that. This is a trail, looking at the efficacy and cost-effectiveness of a 100% condom intervention at the Dominican Republic. By the late 1980s in Thailand, there was a devastating epidemic emerging and early studies conducted by the Thai military showed rates of up to 25% of young 21-year-old men entering the military were infected with HIV. It really sounded an alarm in the country and one of the approaches that they took in Thailand was to do what they called 100% condom intervention and that was an intervention, in short, targeted in the sex industry and it linked the incident STD cases that women had to a feedback mechanism that put pressure on the brothel owners to try to increase condom use and increasingly what happened in that situation if a woman had an incident of STDs would send people back to the brothel to try to work with them to assure consistent condom use and eventually had sanctions in place. There was a similar article, I think that was published in the Lancet evaluating that program that showed when they implemented that intervention in different regions, almost 100% condom rate occurred and the STD rate went almost to zero. We were working in the Dominican Republic at the time at the time our colleagues a very thriving sex industry and they were very interested in this program so we did a series of formative research activities and other activities to think about adapting

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that intervention into the Dominican context and I think that it's a theme that's really important the adaptation of intervention, cross-culturally, and when we see success how we adapt them, so we spend many years really working to try to adapt that. What I am going to present to you what we presented in Barcelona on this. First of all, one thing that came out of our formative research was there really was an interest in trying to get the NDO community involved in this and to try to form coalitions with government. It was really felt from the perspective of the brothel owners, the government and the women who work in the sex industry that what was going to be most effective was a coalition of all partners and the key elements I think emphasized in the adaptation was the need to work at the level of empowerment both at the personal level, as well as the group level, that we could create a sense of collective commitment among people, and secondly that we needed that wide range of community participation. I mentioned this as a structural and environmental intervention that we were looking at and the focus of this intervention when you think about a structural intervention, some of the key components that really are focussed on looking at the environment itself, not just the individual. If you think about the classic story of John Snow and the cholera epidemic in London, John Snow went and broke the handle off the

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pump where the contaminated water was located. He didn't go out and educate this people that they shouldn't use this pump, he broke the handle off that pump. That's really a structural intervention, an environmental approach to prevention and as a foundation of public health, we need to keep those approaches in mind. The other issues is if you want to have successful environmental changes, I think that lessons learned from Thailand and our own research is that we need to support those with policies and we have to reinforce those policies with both rewards and with sanctions. And so we designed a program to taking this into account. The other issue that used to come into play is recognizing the power dynamics that takes place in this situation and that was a real key component. For example, these women, they may want to have condom used in these encounters but it is the men who are often drawn into these situations who have the power and control over that and the brothel owners, need to back these women up when they insist on condoms so recognizing power dynamics is a really crucial aspect of a sort of structural intervention. These is quite a complex approach that we took, but this is a brief summary of some of the activities that took place with the intervention that we tested in the Dominican Republic. First, there were activities meant to build collective commitment, and this included interestingly

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in the Dominican Republic, sex workers are unionized. They have a union of sex workers, and a brothel owner as well. When we worked with those groups to have workshops and to talk about the need for them to work together in a collective commitment to this issue and we also engaged the government and that took place really over many years. I think that one point I was making these sorts of interventions take time to develop and get the consensus, to get the policy commitment, but I think that the payoff is you get a much more sustainable intervention. We also look at the issue of facilitating environmental cues to action and by that I mean we developed really a social marketing campaign within the brothel setting. The horizons report, I think that some of you picked up all the copies but there is a logo in there, you can see our little logo that we had. Those posters, that "this is a 100% condom" were posted on all of the participating settings. We also enhanced the STD the system. If you want to have this feedback loop where you have an incident of STD as a feedback you have to enhance the system, and we did that through several mechanisms. We paired up the NGO with the STD system so that they had peer counselors of sex workers who were located in the STD [unintelligible]. We also worked on training and making sure we had adequate drug supply. We also worked closely with the government and

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that was a challenge over time to try to get their commitment and their [unintelligible] and I think that the formative research really helped to convince the government and through a lot of collaborative efforts and discussions that they should do this and take this out of an issue and finally, monitoring and encourage intervention compliance. I think that the monitoring is going to come through. You have to get in and monitor and gets monitor and give lots and lots of feedback for these sorts of intervention. Next slide. Very briefly I will touch on the designs of the study. We did a pre-test and a post-test behavioral survey with the sex workers and we also had ongoing monthly cross-sectional assessments that we did on the brothel environment. We sent NGO workers in to do an assessment every month at each brothel to see whether they were complying with these activities. This intervention was run over a year at 34 participating sex establishments at 2 cities and the Dominican Republic and we collected both behavioral data, sexually transmitted infection data, and also had these observational data. The two models that we used, in one city on the North Coast, Puerta Plata, it was a solidarity-based model as well as policies and sanctions in place. In the south coast, in Santo Domingo, the capital city, it was only the solidarity activities so we have the sanctions in one city and we didn't have them in the other. The way to

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take a look at what role those sanctions actually played in the intervention. If you take a look at the slide, you can see this shows the compliance levels with this intervention over time. And this is whether or not the participating brothel city really met all of the required activity and what you see clearly is whether those sanctions are in place, in Pureta Plata we had much higher rates of compliance with the intervention, than we did in Santo Domingo where we did not have a sanction. So what did this do in terms of impact? Can I have the next slide, please. This slide shows a self-reported condom use by the sex workers over time. On the left you have Santo Domingo and on the right you have Puerto Plata, and then we broke it out by whether they were new clients or whether they were regular clients and that it's been a real issue in working with these populations in that once a woman gets to know a her client's [unintelligible] then condom use goes down and over and over you see this in studies so our goal is to try to raise condom use in both of these and we did see changes in condom use occurring for both regular clients and new clients. But, for example, in Puerto Plata when we had the sanctions in place, we saw more than a doubling of condom use occurring among the regular partners and you might ask yourself, these are self-report data so can we really trust them. So we also did look at STI rates

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from the study and we measured gonorrhea, trichomiasis [Misspelled?], Chlamydia and the last bar to the right shows any STIs if there was any S.T.I. whatsoever and again what we see are significant declines occur in the rates of STIs over the year of time that we had [unintelligible] intervention. And for example, Dr. Domingo, that's a 37% decline in the sexually transmitted infection rate and in Puerto Plata that's 43% decline. We also engineered into this a cost effectiveness evaluation. This was a policy-based intervention as well as the fact that we just need more data on the cost-effectiveness of these interventions. We did account for the cost and look at that. You can see that in Puerto Plata, it costs about \$125 per year to provide this intervention for a woman and about \$132 in Santo Domingo and the next slide I have the summary of the cost effectiveness analysis which showed the cost per disability is up to life-years saved. This is basically a year of lives saved and what we saw from our analysis about \$433 per life-year saves in Puerto Plata and a little over \$1000 in Santo Domingo, and the chart to the right showed sort of how that compared from other interventions, and many of these were done in Africa because that's where most of the data is available, but really I think that the point being that this falls somewhere between places of very very high prevalence and very very effective interventions such

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as the STI services in [unintelligible] trial or some of the care and support activities in Africa. I would just also like to make note that for example in the United States, we would consider intervention that cost \$10, 20, 30,000 per life-year saved to be a cost-effective intervention, so I think that this is promising at this stage. Just to conclude and summarize a bit on this. We did see significant reductions in risk behavior occurrence, especially in the presence of sanction. I think that I'd also like to add that while we did see higher rates of compliance with the sanctions, we also saw significant declines in STIs even without sanctions. I think that with the structural interventions, it is important to recognize we need a structure to work with them and some places don't have that. Folks in many industries in the sex industry, for example, may not be as highly organized. So I think that this was promising in that light too, that we could still see changes occur in places with less structure, but when you do have a structure, when you can get these policies in place, they're likely to see a stronger impact. Secondly we did have a [unintelligible] effect, in other words, the condom use is already so high with new clients, I think that we did achieve here which was a real breakthrough was to see this doubling of condom use in occurring in a one-year time frame among regular clients. Also, these

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reductions in STIs really can't be under-emphasized, both the really significant major declines in sexually-transmitted infections which we saw really showed the power of these sources of interventions, and I think that the cost-effectiveness as well; it's promising. This was a one-year implementation of this and I really think over time, we'd like to see a much more increase to occur. This sort of intervention is really based on the idea of changing the social scene, changing the norms and values, and that takes time to implement. Therefore, in one year timeframe, we felt quite good that we were able to see the changes that we had and finally I'd like to add the scale-up that this plan. The Dominican Republic now and partly based on the findings of this study, the government has agreed to go nationwide with this program and they're getting money from the World Bank for now, implement this at a nationwide level and as well, also to the World Bank, in Haiti, it's now efforted on to take the lessons learned from the Dominican Republic and work with Haiti to also implement the programs so I think that one reason this level of interest and ability to scale up has occurred is largely because we did work so closely with the government through the activities that we did over the years to get them involved and I think that the success we're seeing, they had a sense of ownership of those successes as well. Just a foreign donor

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having this as well. It's also a development's commitment and then finally, just thanks for all the people who have helped with this. Thank you.

JENNA DELAVERDA: Good morning, I'm Jenna Delaverda [Misspelled?] and I'm going to be thinking about uniformed services in a slightly different [unintelligible] I don't have very much data because not very much data exists in the he uniformed services. [unintelligible] Health International works with a group that's called Universe Services Task force which includes individuals from the Department of Defense, the Futures Group International USAID, the civilian Military Alliance to combat HIV-AIDS. The Centers for Disease Control, UN AIDS, U.S. Naval Research Hospital, militaries from central and East Africa and others to come together to combine our expertise and to get the best quality and materials out for prevention and care activities in the uniformed services. As I am going to be talking a little bit about what the issues are and what's going on with the Uniformed Services Taskforce. Uniformed Services are recognized and have been recognized for probably two decades as a higher risk group for HIV AIDS, however implementation with uniformed services have been hamper in part because uniformed services and military are often separate from civilian populations and have separate structures and approaches to activities. Most uniformed services

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individuals are in the young sexually-active age group and therefore are at risk for HIV AIDS simply because of their age group. In addition, military values which contributed to the potential high risk behavior of the military. It's clear in many countries that military camps and barracks for lots of single men away from home are stationed for a long time attract services around them that put them at risk simply due to the alcohol and drugs but can be sexual group that put both the community at risk as well as the uniformed services at risk and military and peace-keeping forces are away from home for long periods of time, again, to potential high-risk behavior. Clearly, during conflict situations where social norms deteriorate, risk-taking behavior, both in civilian and military populations increases. Data on S.T.I. and HIV in uniformed services relatively scarce. Probably the largest reason I believe because military view HIV data as related to national security and don't release that data even to government sectors. In some cases, militaries don't have the money to collect the data or if they collect it they don't centralize the data. For STD., well they may offer STI services, there's also reprimands for military people seeking STI services may often seek care away from the standard military medical facilities. Recently increased attention globally for addressing HIV AIDS in the uniformed services, it's

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been increasing slighted as a security and strategic issue. UN AIDS and the UN Security Council have been HIV AIDS at peace-keeping forces and are working to set policies both regionally and nationally with the uniformed services trying to do assessments in strategic planning and helping with standard policies to approach HIV AIDS in the military. The US Government, the Department of Defense and the US AID is also supporting HIV prevention efforts and the Civilian Military Alliance to Combat HIV AIDS has been doing this work for over a decade and is continuing to do so. There were a handful of reports citing successful activities with the uniformed services. These activities successes were defined as the ability to implement education, activities within the military, that they were successfully done, expansion of peer education and prevention activities to military through the buy-in of high level military commanders and in a couple of cases actual documented behavior change in militaries as a result of prevention activities. The two that we have been able to find of recent documentation would be the police force and the Cambodian Military just to show you the overlap of prevention activities, Cambodia is a country that implemented 100% condom brothel policy, and additionally had peer education activities with the military. Military personnel were frequent users of

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sex workers in brothels and reported not a very high level of condom use. After the combined interventions, it was clear that military people were increasing using condoms with sex workers and reported visiting sex workers much less frequently. I think that the military system also offers opportunities for HIV AIDS prevention. The military has a structure, a real system and a real information flow so that if you can get buy-in from high level commanders, and policies available, then scale-up is relatively easy with the new military because there's a system to move into relatively quickly.

There's a lot to learn from civilian HIV prevention activities that can be applied to the military. It clearly needs to be adapted to the military situation. One of the things that we've realized in trying to develop peer education materials for the military is that peer education is a foreign concept for the military. It tends to be a lecture from the commander to the troops and so it takes some effort to change an approach to allow peer education to go on in the military but it is possible. I think that the constraints that we're seeing, however, in implementing uniformed services is really getting high level commitment and getting that high level commitment translated down to sort of a mid-level commander. There's clearly a lack of clear policy. People sort of

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do things that are always done but there are not clear articulated policies around certain key issues that really prevent an aggressive implementation of activities and there's not a clear commitment for monitoring and this is both behavioral monitoring as well as HIV monitoring and then funding is also cited as an issue. I think that the Uniformed Services Task Force realizes that some of the key issues that need to be addressed are really strategic planning within the militaries about how to approach HIV AIDS with the current situation, what are the strategies we're going to use to address both prevention and care and how does the military strategy dove-tail with the civilian strategy because they clearly need to complement each other since the military is within the community. There are many policy questions that military needs to address. One of the key ones is HIV testing. How is it done? Is it done as a requirement for entry into the military or military men mandatorily retested every year. If a person is found to be positive in the military, what happens to them. Do they stay and are they cared for? Are they discharged. All of these policies need to be articulated such at the HIV testing can be addressed and in addition, is an issue of surveillance. What kind of surveillance are they going to do? Is it going to be kept within the military, is it going to be reported to the civilian government. I

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think that all of these policies needs to be addressed in the military to start moving forward. And then the other issues that is part of a uniformed services issue is enlarge the mobilization of troops that are occurring throughout Africa and how do we take this opportunity to educate military about HIV AIDS prevention before they go back into the communities in the case that they might have higher HIV prevalence or going back into the communities where the HIV prevalence may be higher than in the military and also to potentially use these mobilized military people as agents of change in the community. I think that's all I wanted to say. The Uniformed Services Task force today has produced a peer education module for use in the military. It's in English, French and Portugese and has been adapted by UNA for Eastern Europe now and have our field testing in Swasiland are basic in-service training module. Thank you.

We have a little bit of time for questions.

MALE VOICE: Question for Michael Sweatt.

What were the sanctions that were put in place and also was there any thought or going back to repropose the question of economic empowerment and other alternatives for the commercial test worker and also, at Barcelona were there any other studies done economic empowerment besides the [unintelligible] projects.

MICHAEL SWEATT: The sanctions were financial.

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Fines, a graduated sanction system and it leads up to closing at some point. I would just like to add to that, while we had those financial sanctions in place, they were rarely used. Actually the first step is to come in and do an education activity with warning but I think that the fear of the sanctions is what probably lead to much of the change where the actual sanctions were rarely implemented in that case. As far as other presentations on economic empowerment; there were some, I'm sorry I can't conjure up the specifics because I was overwhelmed with the meeting but somebody else in the audience.

JENNA DELAVERDA: Actually, I wasn't even in Barcelona. I downloaded it from the website. There was a study in Kenya that provided micros finance and micro enterprising training to sex workers and they looked at, kind of at the end, the results of giving them an alternative in what happened, and it was kind of a mixed bag, in terms of some women decreased the number of partners because I've got to have a business now I have to kind of focus on the business but in terms of the real economic data, as a result of this intervention, it really didn't improve it that much because they were earning more money as a result of some sex work and not as much from the business but there was some shifting. And they also have data about repayment of the loan and participation. It's still up

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on the website, I would recommend you go to it. It was done in Kenya and I can even give you copies of the presentation.

MICHAEL SWEATT: Also, if I can add to that, the Dominican Republic is actually a group of Carmelite nuns who run a program to provide training activities for women who want to leave sex work and I visited the site and I can't say I did a formal evaluation of it but my sense from talking with them is what happens is that many women go into that program for a period of time but they often go back in the sex work industry. Also, from what I've seen the activities they've learned; they've learned to make candles, it's doesn't really bring your economic viability up to a level that allows them to set with their children and stay out of the sex industry and they can make money in that environment, it's difficulty for them to move into a situation where they can't.

CONSCIOUS BROWN [Misspelled?]: Hi my name is Conscious Brown [Misspelled?] I'm from Chicago. I'm really interested in hearing what the unions were doing in Dominican and other places and Latin American. It was already unionized and what was the union doing in terms of empowerment and protection for the workers in the brothels.

JENNA DELAVERDA: Actually the union, I think that word is being translated inaccurately. It's really

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an association and they have an annual conference which is a fantastic event to attend. It's very uplifting because it focuses mostly on the issue of self-esteem, empowerment and collective support of one another. The NGO that we worked with actually helped to organize this group to get them together to work on those issues of self-esteem and empowerment and also create a voice for these women who advocate for their rights and to interact with the Association Of The Brothel Owners which is persistent in that country. It's been going for quite some time and again, I think that it points to the fact that when you have a structure to work with, it lends itself to a structural intervention and I think that Jenna's presentation pointed out that military is an organized institution, one that we can work with, lends itself to these sources of intervention.

JEFF SPIELER: Jeff Spieler [Misspelled?] for US AID. Thank you both for your presentations. I don't want to lecture on the ABCs of prevention, but I do want to mention two issues and I'd like your reaction, one is part of the Thailand success had to do with many men stopped going to massage parlors. I'd like to hear is there any experience in the he Dominican Republic and it says the number of people were going to sex workers, and 2), I want to say that we have the opportunity in all of the [unintelligible]

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type projects as well as working with the uniformed services, to actually promote the "be faithful" message. We need to be very innovative, I think in how we do that because we know from our experience that it can work, but how do we use those models to not only get the increased condom use that we want to see the most non-regular partners but to get the B in the ABC model.

MICHAEL SWEATT: Thank you. At this point, I think Thailand was a complicated situation in my evaluation of that, and my read of the evaluation for that and having visited there much is that one thing that happens in the Thai example, when they did scaled it up, it drove a lot of those sex underground, they went from direct to indirect and it actually deinstitutionalized the sex industry and made it harder to maintain the 100% condom program and I do think the supplementative change occurred among men, where the idea is you can go into the brothel, but I think that was partially due to the 100% condom intervention because it changed the norm, it raised awareness that this was a significant risk and none of the documents and the many things that happened in Thailand, around prevention, I don't think of structural intervention in a high risk group like a sex industry is going to do it alone. I think you have to work on multiple levels and I think that is the real theme of prevention now is

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doing multi-level intervention not only is there one environment like the sex industry, but around that to focus on norms and values but to focus on "faithfulness".

HARRIET FLESHNER: I think the kind of measurement, especially in the sex work industry is probably the easiest to measure but I know that messages like are developed that cover the ABCs but clearly in the sex work relationship it's the condoms that you're promoting as part of that high risk encounter and again as I pointed out in Cambodia it was noted that military men reported less contact with sex workers as part of the fear and prevention and 100% condom brothel policy.

HODEL: HODEL From US AID. Also on condoms and commercial sex workers, I heard some anecdotal evidence from Togo that commercial sex workers said their clients either didn't know or didn't care that they were using female condoms and I was wondering if there's any other research or documentation of this.

MICHAEL SWEATT: Say it one more time.

HODEL: No, didn't care or know they were using female condoms.

FEMALE VOICE: I'm not close to the female condom research but often time clients are drunk and so female condoms may be able to be used without clients knowing that. Whether they care or not I can't answer

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that question. I know that some of the early work of female early work of female condoms in the Thai brothels of the sex workers used the female condom as a threat to get them to use the male condom. If you don't use a male condom I'm going to use this and so condoms use increased using that.

KELLY KEARNS: Hi my name is Kelly Kearns from Chicago and I have a question for Michael Sweat. First congratulations on a very interesting program in the Dominican Republic and the data honored at the STI Institute. I was wondering if you looked at HIV incidents also and how can you prevent a situation, I'm familiar with a couple of other examples in the Caribbean and Suriname where there are attempts to have 100% condom policy in brothels but the sanctions are more on the sex workers who have a positive rather than on the brothel owners and in that case, many of the sex workers are actually from other countries in the Caribbean including the Dominican Republic and they're often deported when they test positive and I'm wondering what are some ways to get around that.

MICHAEL SWEATT: First of all, we didn't look at HIV incidents. There are some human rights issues around this whole thing that I want to put on the table. You have to very very carefully, at least in a program, you have to very very carefully protect the rights of that woman because if it gets out that she's

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the one that got the STI and that lead to a sanction it's really potential for social harm so we work hard to avoid that. Interestingly in the Dominican Republic it's written into the constitution, that a sex worker has a right to work if she's HIV infected and as long as there's a condom. There's a human rights clause in there that addresses HIV. So, regarding the research, we didn't include HIV testing and that was because first of all it wouldn't have been a good indicator of our success because we wouldn't have had enough incidents over time, we didn't have the statistical power to do that, so I don't think it would have been the best measure and one other thing is we did model it, using part of the model and interestingly the rate of HIV infection among the sex workers is quite low in the Dominican Republic and most of the incidents in HIV infections, we estimated would have been the men infecting the women in that situation because they had a lot of contact with men and given that high contact rate it would have been mostly women, so it's an interesting thing, people think about sex workers and they think these women are going to infect other people, but in this context it was our intervention it was the women who were likely to get infected and of course they infect other people as well so I think that one has to be very careful about the human rights issues when you're going to do HIV testing particularly

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when you're going to link it to an intervention like this and one final point at the Barcelona meeting, we got very nervous because prior to our session, there was a demonstration on about 100% condom interventions by some advocates in other session and so I heard because I didn't attend but actually in that therapy course, said the Dominican model is a good one so we were really relieved before our presentation, but that we had taken the time to really work with the groups to have protection of the human rights and what not so I think that there's a real risk when you do these structural interventions, I think the military faces that as well because you mentioned each of the privacy and the need to protect people's rights and it's a very delicate thing that has to be looked at when you're implementing these type of intervention.

HARRIET FLEISHER: We're out of time but I encourage you to hear more about prevention as the day goes on and also the important questions.