



**Improving Access
of Key Populations
to Comprehensive
HIV Health Services
Towards a
Caribbean Consensus**



**Pan American
Health
Organization**



*Regional Office of the
World Health Organization*



Improving Access
of Key Populations
to Comprehensive HIV
Health Services

Towards a Caribbean Consensus



PAHO HQ Library Cataloguing-in-Publication

Pan American Health Organization

Improving Access of Key Populations to Comprehensive HIV Health Services: Towards a Caribbean Consensus

Washington, D.C.: PAHO, © 2011

ISBN: 978-92-75-11653-1

I. Title

1. HIV INFECTIONS - epidemiology
2. DIAGNOSIS OF HEALTH SITUATION IN SPECIFIC GROUPS
3. Acquired Immunodeficiency Syndrome – prevention & control
4. PREJUDICE
5. HEALTH SERVICES EPIDEMIOLOGY
6. POPULATION STUDIES IN PUBLIC HEALTH
7. CARIBBEAN REGION

NLM WC 503.DC3

The Pan American Health Organization welcomes requests for permission to reproduce or translate its publications, in part or in full. Applications and inquiries should be addressed to Editorial Services, Area of Knowledge Management and Communications (KMC), Pan American Health Organization, Washington, D.C., U.S.A. The Area of Family and Community Health (FCH), HIV and STI Project, will be glad to provide the latest information on any changes made to the text, plans for new editions, and reprints and translations already available.

© Pan American Health Organization, 2011. All rights reserved.

Publications of the Pan American Health Organization enjoy copyright protection in accordance with the provisions of Protocol 2 of the Universal Copyright Convention. All rights are reserved.

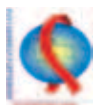
The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the Secretariat of the Pan American Health Organization concerning the status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the Pan American Health Organization in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by the Pan American Health Organization to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall the Pan American Health Organization be liable for damages arising from its use.

Improving Access of Key Populations to Comprehensive HIV Health Services

● Towards a Caribbean Consensus



Acronyms

AIDS	Acquired immunodeficiency syndrome
BAH	Bahamas
CAREC	Caribbean Epidemiology Centre
CARICOM	Caribbean Community
CBO	Community-based organization
CDARI	Caribbean Drug Abuse Research Institute
COIN	Centro de Orientación e Investigación Integral
CRSF	Caribbean Regional Strategic Framework on HIV and AIDS
CSWC	Caribbean Sex Workers Coalition
CVC	Caribbean Vulnerable Communities
CUB	Cuba
DOR	Dominican Republic
FSW	Female sex worker
GUY	Guyana
HAI	Haiti
HIV	Human immunodeficiency virus
IDU	Injecting drug use
JAM	Jamaica
MARP	Most-at-risk population
MSM	Men who have sex with men
NGO	Nongovernmental organization
PAHO	Pan American Health Organization
PANCAP	Pan Caribbean Partnership Against HIV/AIDS
PHCO	PAHO HIV Caribbean Office
SPSTI	Special Programme on Sexually Transmitted Infections (CAREC)
STI	Sexually transmitted infection
SUR	Suriname
SW	Sex worker
TG	Transgender
TNT	Trinidad and Tobago
UN	United Nations
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session (on HIV/AIDS)
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

Table of contents

Acronyms	iv
Dedication	vi
Acknowledgements	vii
Preface	1
I. BACKGROUND	2
II. FRAMING THE ISSUES	5
II.1. Risk, vulnerability, and HIV	5
II.2. The HIV/AIDS epidemic in the Caribbean	6
Men who have sex with men	6
Male and female sex workers	8
Transgender populations	10
Prison inmates	12
Drug users	12
Youth, migration and mobility	14
Discussion and recommendations regarding the nature of the HIV epidemic in the Caribbean	16
III. ISSUES AFFECTING ACCESS TO HIV HEALTH SERVICES BY KEY POPULATIONS	21
III.1. Shared issues	22
III.2. Issues affecting specific groups	23
Men who have sex with men	23
Transgender persons	24
Sex workers	25
Drug users	25
Prison inmates	26
Most-at-risk young persons	27
Migrants	27
IV. PRIORITY ACTION	29
IV.1. Recommendations for cross-cutting action	29
IV.2. Actions related to specific groups	32
V. IMPLEMENTING THE CONSENSUS MEETING RECOMMENDATIONS	37
PANCAP	37
CVC	38
UN partners	38
REFERENCES	41

● Dedication



This publication is dedicated to the memory of our dear friend and colleague, Dr. Robert Carr, who passed away in May 2011.

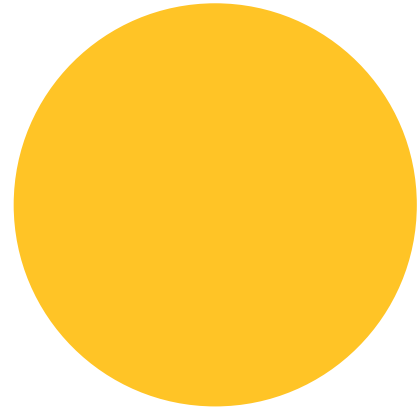
Dr. Carr's was a passionate human rights advocate and worked tirelessly to address issues facing vulnerable and marginalized groups in the Caribbean. In 2002, he joined the Jamaica AIDS Support for Life serving initially as Director of Targeted Interventions and subsequently assumed the post of Executive Director. He was also instrumental in the formation of several civil society organizations serving vulnerable populations in the Caribbean including but not limited to the Sex Worker Coalition of Jamaica; Caribbean Sex Worker Coalition; the Caribbean Forum for Lesbians, All Sexual, and Gays and the Pan Commonwealth Civil Society Network.

His commitment and the quality of his work gave him international acclaim. He contributed to human rights initiatives and advocacy efforts in collaboration with a number of international organizations including UNDP, UNAIDS and PAHO/WHO. At UNAIDS, Robert was the first Caribbean National to serve on the UNAIDS Programme Coordinating Board UNAIDS PCB; he served until his death as the Director of the International Council of AIDS Service Organizations (ICASO); and as the Co Chair of the MSM Global Forum and Global Coalition of Women and AIDS.

Dr. Carr worked closely with the PAHO/WHO Caribbean HIV Office on issues related to increased access of Most at Risk and Vulnerable Populations to HIV Health Services, and reduction of stigma and discrimination. He also served on the PAHO/WHO Technical Working Group on key populations and HIV, and was a driving force for the organization of a regional consensus meeting on access of key populations to HIV Health Services in 2009, to which this publication is a key output.

Dr. Robert Carr will be missed for his gentle personality, his passion for human rights, and for his role as champion of the regional HIV response. We hope that this publication reflects all that he has worked so hard to advance and that it will be a meaningful contribution in recognition of his efforts.

Amalia del Riego
Senior Advisor, PAHO HIV Caribbean Office
Trinidad and Tobago



Acknowledgements

Funding for the Consensus Meeting was provided by the European Commission, the World Bank PANCAP Project, the Norwegian Government, PAHO/WHO, UNICEF, UNFPA, and UNDP.

Special recognition is given to the members of the Technical Working Group, consisting of representatives of the organizations mentioned below, who coordinated the organization of the Consensus Meeting and the preparation of this document:

Sonja Caffè	PHCO
Robert Carr	CVC
Marcus Day	CDARI
Michel De Groulard	UNAIDS
Morris Edwards	PANCAP
Claudette Francis	PHCO Consultant
Ian McKnight	CVC
Salim October	UNDP
Leah-Mari Richards	UNFPA
Alex Vega	PHCO Consultant
John Waters	COIN





Preface

Thirty years into the global HIV epidemic, the Caribbean remains the sub-region with the second highest estimated adult HIV prevalence. Available data indicates that new infections in the Caribbean appear to be stabilizing, and HIV mortality is decreasing. However, some groups remain disproportionately affected by the HIV epidemic, including female sex workers, transgender persons, men who have sex with men, and young persons. Unfortunately, stigma and discrimination, social exclusion and lack of a supportive environment often limit the access to and utilization of comprehensive HIV prevention, treatment, care, and support services by these key populations. It is a public health and human rights imperative that all persons, in particular the most vulnerable, have optimal access to health services, to ensure the enjoyment of the right to the highest attainable standard of health.

In 2009, more than 80 Caribbean stakeholders representing public sector agencies, nongovernmental organizations, community-based and grassroots organizations, bilateral and multilateral agencies, activists, men who have sex with men, sex workers, transgender persons, and youth came together in a regional meeting and contributed experience, knowledge, and expertise for identification of strategic action to improve equitable access to quality HIV health services for key populations. The Meeting was held on October 7–9, 2009, in Santo Domingo, Dominican Republic, and was organized by the PAHO HIV Caribbean Office (PHCO), in collaboration with the United Nations Development Program (UNDP), the United Nations Population Fund (UNFPA), the United Nations Children’s Fund (UNICEF), the Joint United Nations Program on HIV/AIDS (UNAIDS), and the Pan Caribbean Partnership Against HIV/AIDS (PANCAP) and in partnership with Caribbean Vulnerable Communities (CVC).

The meeting results have been shared with the region through various venues, and have informed and inspired follow-up action by PAHO and other stakeholders, including the development of a training package for frontline health workers on Men’s Health, HIV and Sexual Diversity coordinated by PAHO, the PANCAP round 9 Global Fund Project focusing on most-at-risk populations, and the work of the Caribbean Vulnerable Communities (CVC) on regional and country level. The discussions and recommendations emerging from the Consensus Meeting have been summarized in this document, to enable continued dissemination and use of the meeting outcomes for strengthening and monitoring of access of key populations to HIV Health Services in the Caribbean.

PAHO remains committed to support and contribute to the development of nonjudgmental, inclusive and responsive HIV health services for all, in particular the most vulnerable.

Dr. Mirta Roses-Periago
Pan American Health Organization
Director

I

BACKGROUND

Nearly 30 years into the HIV/AIDS pandemic, the Caribbean remains one of the most highly affected sub-regions in the world, with the second highest estimated level of adult HIV prevalence. The adult prevalence rate is estimated at 1.0% (1). AIDS-related illnesses are among the leading causes of death in the 25–44-year age group. Recent data indicate that the number of new infections might be stabilizing. Nevertheless, an estimated 240,000 persons in the Caribbean are living with HIV, and the region still faces an estimated 20,000 new HIV infections annually (1).

Effective and targeted strategies are essential to prevent new HIV infections and enhance the quality and length of life of persons living with HIV. Critical conditions for achievement of the target of universal access to HIV prevention, treatment, and care services include a sound understanding of the trends of the epidemic, effective identification of vulnerable and disproportionately affected groups, and development of inclusive and nonjudgmental approaches to reach these key populations with comprehensive services.

While the Caribbean region is diverse, covering more than 30 independent and dependent countries and territories, the region has a well-established platform for collaboration on HIV through the Pan Caribbean Partnership Against HIV/AIDS (PANCAP) and the Caribbean Regional Strategic Framework on HIV/AIDS (CRSF) (2).

Evaluation of the 2002–2006 CRSF concluded that the stigma and discrimination experienced by people living with HIV and AIDS, as well as by those population groups perceived to be most at risk for infection, are major obstacles for regional efforts to provide accessible services for both prevention and treatment. Moreover, the legal frameworks in many countries hinder efforts to combat stigma and discrimination (3). Consequently, the fostering of a supportive environment for an effective HIV response was identified as one of the priority areas for the 2008–2012 CRSF. Strategic actions under this priority area include eliminating stigma and discrimination, removing legal constraints that hinder access to services, and addressing factors that contribute to HIV vulnerability in the region. The CRSF also calls for a renewed emphasis on prevention and notes that targeted prevention programs for the most-at-risk and vulnerable groups need to be scaled up.

Within this context, the PAHO HIV Caribbean Office (PHCO) organized a regional consultation, the Consensus Meeting on access of key populations to HIV prevention, treatment, and health care services in the Caribbean, in collaboration with other UN partners including UNAIDS, UNDP, UNFPA, and UNICEF and in partnership with Caribbean Vulnerable Communities (CVC). This meeting constituted a key activity in the strategic plans and 2009 work plans of both PHCO and CVC, against the background of the CRSF. It incorporated and built on initiatives and efforts from other UN partners, including UNFPA's work with sex workers and UNDP's work with MSM and transgender populations.



The vision of this meeting was to contribute to the development of nonjudgmental, inclusive, and responsive HIV/STI health services for key populations. In line with emerging evidence, the global guidance on most-at-risk and vulnerable populations, and the CRSF, the meeting focused on men who have sex with men, transgender persons, sex workers, prison inmates, and drug users, with youth, migration, and mobility as cross-cutting factors.

The meeting objectives were to:

- Review what is known about the accessibility, utilization, quality, and outcomes of HIV-related health services for men who have sex with men, transgender persons, sex workers, drug users, and prison inmates in the region.
- Jointly identify priority actions to be taken at country and regional levels to reduce barriers and enhance the quality, accessibility, utilization, and outcomes of HIV-related health services for these groups.

The meeting was held on October 7–9, 2009, in Santo Domingo, Dominican Republic. More than 80 stakeholders representing the key populations, public sector agencies, NGOs, and bilateral and multilateral agencies participated in the event and contributed experience, knowledge, and expertise in the formulation of recommendations for strategic actions to improve equitable access to quality HIV health services for key populations.

Prior to the meeting, two consultants were contracted to develop background documents based on desk review of published and grey literature, and stakeholder interviews. Based on the information presented in these documents and additional context presented by UN partners, active dialogue took place in plenary and small group settings.

This document summarizes the key recommendations emerging from the Consensus Meeting. Section II describes what is known about the HIV/AIDS epidemic in the Caribbean, how this evidence has generally been interpreted, and the implications of this evidence for the HIV response in the region. Section III summarizes the key issues affecting access to HIV health services by key populations, including shared issues affecting all of the groups and issues affecting specific groups. Section IV presents the priority actions proposed by the Consensus Meeting participants. Recommendations include cross-cutting actions that will contribute to the fostering of nonjudgmental, inclusive, and responsive health services for all, especially key populations, and recommendations to address specific issues and challenges affecting men who have sex with men, transgender persons, sex workers, drug users, and prison inmates, with special attention to young persons and migrants in these groups. Finally, section V presents recommendations regarding the roles and responsibilities of key entities in the region for implementation of the recommended actions.





FRAMING THE ISSUES

II

Risk, vulnerability, and HIV ● II.1.

The human immunodeficiency virus (HIV) is a biological agent that has the capacity to infect persons exposed through vertical transmission from mother to child, use of contaminated needles, or exchange of infected bodily fluids through unprotected sexual intercourse with an HIV-infected partner. Globally it is evident that certain groups have been and continue to be disproportionately affected by the HIV epidemic and that risk and vulnerability are not equally distributed among population groups. An understanding of the dynamics of risk and the vulnerability of specific population groups is critical to advancing a supportive environment and developing responsive services for the most affected key populations.

UNAIDS defines “HIV risk” as the probability or likelihood of a person becoming infected with the virus (3). Certain behaviors create, increase, and perpetuate that risk, including unprotected sex with multiple partners or with a partner whose HIV status is unknown and use of syringes contaminated with HIV.

Vulnerability can be defined as a reduced ability or complete lack of control to protect oneself and avoid HIV risk. Vulnerability can result from a range of factors outside the control of the individual, including:

1. Lack of knowledge, skills, or power required to protect oneself;
2. Lack of access to essential services and commodities such as condoms; and
3. Societal factors such as:
 - a. Gender-based expectations, norms, and standards
 - b. Social and cultural norms and values regarding sexual identity and sexual behaviors
 - c. Poverty
 - d. Violence
 - e. Other human rights violations

There is also a biological dimension of vulnerability closely associated with susceptibility to contracting the infection if exposure occurs. For example, young women whose vaginal mucosae are thin and can easily tear during intercourse are biologically vulnerable. Individuals with other STIs are at increased vulnerability as well because they are more susceptible to contracting the infection should an exposure occur. Biological vulnerability is also present in persons who have lesions in the anus and rectum and have anal intercourse, men who are not circumcised and have unprotected sex, and women with ectopic cervical tissue. In addition, research suggests that use of immunodepressive substances such as crack cocaine can lead to a higher risk of viral uptake.

Vulnerability factors can be generally classified as proximate or immediate (drug use, lack of knowledge, low self-esteem) or as underlying (sexual taboos, poverty, migration, social exclusion). Such factors increase risk and undermine people's capacity to adopt or negotiate less risky behaviors. These vulnerability factors connect the epidemic to its broader socioeconomic context in ways that are not easily understood, addressed, or remedied.

HIV risk and vulnerability factors are related in complex ways and can be mutually reinforcing. People are complex beings with multiple lifestyle issues and behaviors, and as such they may simultaneously be grouped in two or more categories with overlapping risks and vulnerabilities (e.g., sex workers or prisoners who use crack cocaine). The risk of HIV infection is greatly increased when these multiple factors combine. For instance, a sex worker who is an undocumented migrant with no support system or access to health services may be more at risk of contracting the infection, as would be a man who engages in transactional sex with other men in order to support his drug use.

At the global level, certain groups such as men who have sex with men, sex workers, male-to-female transgender persons, people who use drugs, and persons who are incarcerated have been identified as groups at elevated risk of HIV infection, while women, young people, mobile populations, and specific ethnic and indigenous groups have been identified as groups at increased vulnerability to the infection.

II.2. ● The HIV/AIDS epidemic in the Caribbean

At the end of 2009 UNAIDS/WHO estimated that 240,000 persons in the Caribbean were living with HIV, with an estimated adult HIV prevalence of 1.0% (1). This regional estimate masks considerable variances between countries, ranging from a very low HIV prevalence in Cuba (<0.1%) to 3% in the Bahamas. Haiti, the Dominican Republic, Barbados, Jamaica, Trinidad and Tobago, Suriname, and Guyana are among the countries with an estimated adult HIV prevalence of 1% or higher. AIDS-related illnesses are among the five leading causes of death among Caribbean women and men (1).

Around 2007, global and regional documents began referring to the Caribbean HIV epidemic as generalized and heterosexually driven, based on the increasing numbers of women being diagnosed with HIV infection and the estimated adult HIV prevalence rate exceeding the 1% mark.

Slight but significant changes are evident in more recent characterizations of the Caribbean epidemic, including the 2008 Keeping Score II report (UNAIDS), which described the Caribbean HIV epidemic as a mosaic with a number of different epidemics within countries and across the region, and the 2009 AIDS Epidemic Update, which defined the Caribbean epidemic as a mixture of generalized and concentrated epidemics. It is also increasingly recognized that the transmission occurring among MSM and between MSM and the general population might have been underestimated.

MEN WHO HAVE SEX WITH MEN

When the HIV epidemic first emerged in the Caribbean and the rest of the world, it primarily affected men who engaged in sex with men. However, male on male sex remains highly stigmatized in the Caribbean, and openly gay men may be a minority of the MSM population in the Caribbean. There are no reliable population estimates available on the size of the broader MSM community, as it is often shrouded by fear of stigmatization due to taboos and homophobia. This environment has led MSM to self-identify as heterosexuals living a double life, married with children on one hand while secretly engaging in sex with males on the other (4). The secrecy around the MSM population complicates the collection of reliable data, which is essential for the development of programs and interventions for this group. In addition, this hidden lifestyle puts their female sexual partners at risk (5).

At least seven HIV prevalence studies have been conducted in the Caribbean among MSM during the past 10 years, all of which were cross-sectional in design and involved convenience samples of between 80 and 600 respondents. The HIV prevalence rates recorded in these studies ranged from 0.9% (Cuba, 2007) to 32% (Jamaica, 2007) (6).

Seven countries provided data on HIV prevalence rates among MSM in the 2005-2007 UNGASS reports. Cuba noted the lowest prevalence of 0.86%, and the data for the other six countries are summarized in Figure 1. In each of these countries, the HIV prevalence among MSM was significantly higher than in the general population, ranging from 2.5 to 20 times higher.

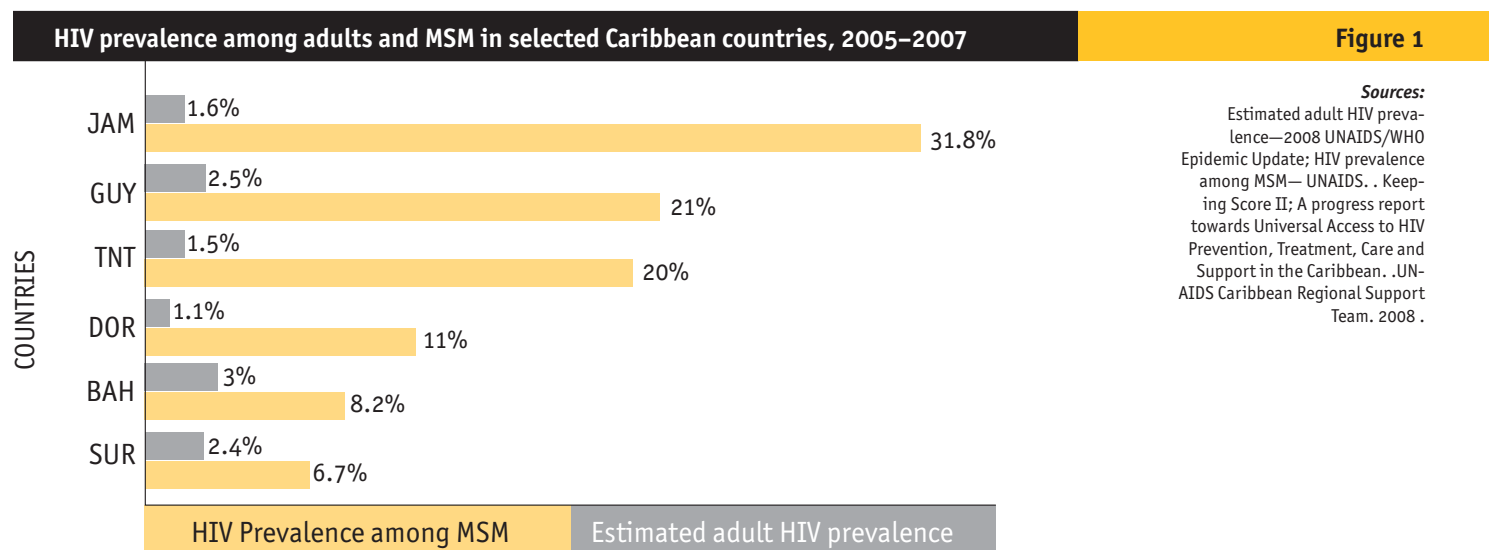


Figure 1
Sources:
 Estimated adult HIV prevalence—2008 UNAIDS/WHO Epidemic Update; HIV prevalence among MSM—UNAIDS. . Keeping Score II; A progress report towards Universal Access to HIV Prevention, Treatment, Care and Support in the Caribbean. .UNAIDS Caribbean Regional Support Team. 2008 .

A comparison between countries with anti-buggery laws and countries without such legislation indicates significantly higher HIV prevalence rates among MSM in countries with anti-buggery laws (Figure 2). This draws attention to the potential influence of environmental factors such as illegality of homosexuality and related factors (for example, elevated levels of stigma and discrimination, unsupportive social and family attitudes, and fear of exposure) on the spread of HIV among MSM. However, further research is needed to clarify the nature of the correlation and the mechanisms involved.

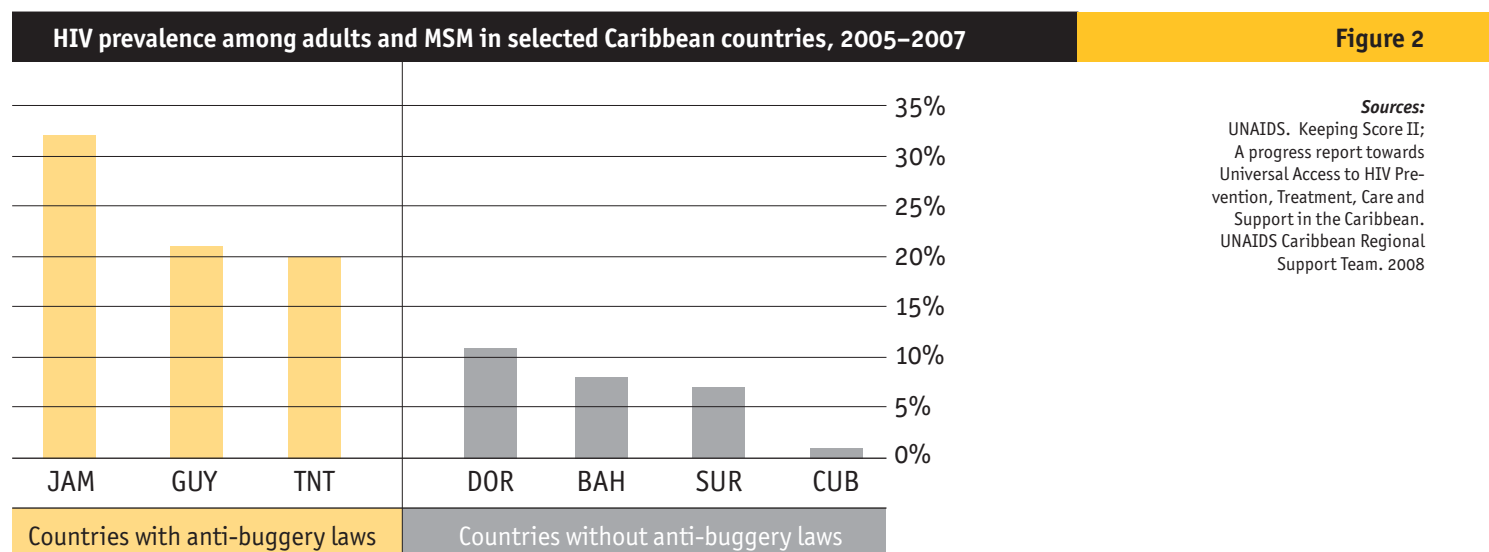


Figure 2
Sources:
 UNAIDS. Keeping Score II; A progress report towards Universal Access to HIV Prevention, Treatment, Care and Support in the Caribbean. UNAIDS Caribbean Regional Support Team. 2008

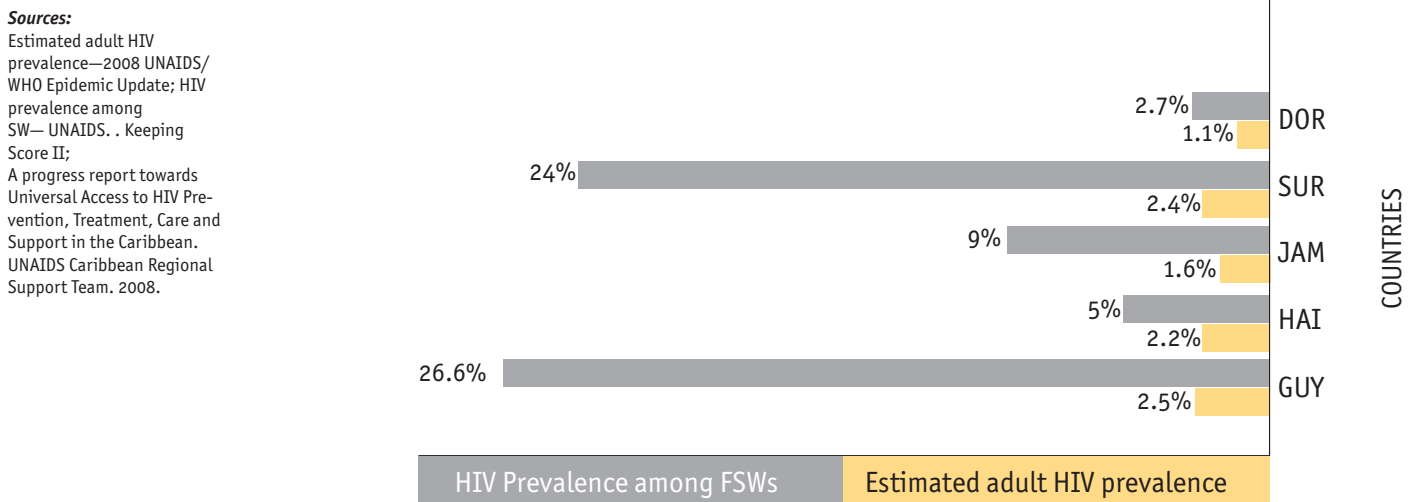
MALE AND FEMALE SEX WORKERS

Population-based data on sex workers are difficult to obtain given the legal prohibition on solicitation and some other aspects of sex work, the strong stigma and discrimination associated with sex work, the consequently clandestine nature of the activities involved, the many kinds of sex workers (masseuses, dancers, escorts, home-based sex workers, etc.), and the complexities associated with distinguishing sex work as a professional occupation and transactional sex as an activity undertaken in exchange for a benefit. As a result, data collection efforts on HIV prevalence rates among SWs have been limited, biased towards street and brothel workers, and mostly based on convenience samples.

Very few countries reported the UNGASS indicators related to SWs in their 2008 reports. Studies in five countries documented HIV prevalence rates among female sex workers, and these rates ranged from 2.7% in the Dominican Republic to 26.6% in Guyana. Only one study, in Suriname, measured the HIV prevalence rate among male sex workers, and this rate was shown to be 36% (6). The reported HIV prevalence rates among female sex workers (FSWs) were 2 to 10 times greater than those in the general adult population (Figure 3).

Figure 3

HIV prevalence among adults and female sex workers in selected Caribbean countries, 2005–2007



Kempadoo et al. summarized information on the situation of sex work and sex workers in CARICOM countries in a study commissioned by UNAIDS. The text box below summarizes some key observations from this report.

- Thriving, diverse, and ubiquitous in Caribbean countries, the sex industry offers escort, massage, and call services; exotic dancing and stripping; hotels, bars, clubs, and brothels where sex workers can be contacted and rooms rented for sexual intercourse; street-based sex work; arrangements within the tourism industry that facilitate hotel- and beach-based sex work; sex workers who work primarily at their homes or are mainly reached by phone; camp services for workers in hinterland areas; and a variety of other arrangements that include soliciting via the Internet or newspapers, telephone sex services, pornography, and drugs-based sex work.

- The dynamics of the sex industry in a given country are difficult to estimate. Most activities take place in the informal and unregulated sectors. Moreover, delineation of sex work is complicated by transactional sex—“friendships” premised upon sexual-economic negotiations that blur the boundaries of the sex industry and implicate many more people than those who would self-identify as sex workers.
- The mainstay of the sex industry is Caribbean men. They are the chief clients for both male and female sex workers and make up about 80% of sex industry owners and managers. Men also provide most additional services, such as taxis and security; police the streets, bars, and borders; craft and enforce anti-prostitution legislation; and perpetrate most of the violence against sex workers. They sometimes use physical or economic coercion to obtain sex without condoms. Sexual services are extorted by male police or Immigration officers in most countries. Men in the sex industry appear to be of all classes, nationalities, ethnicities, and sexual orientations. Many clients are involved in heterosexual marriages or steady partnerships; some of them pay for sex with men and transgender persons. The range of prices for sexual services allows men of any means to access sex workers, though the more expensive clubs and the escort services cater to the business class and wealthy men.
- HIV prevalence and knowledge of HIV prevention among the various male populations in the sex industry are little documented. The MARPS project in Guyana is one of the few initiatives to target specific male populations for HIV prevention interventions due to their known or presumed sexual activity with sex workers, namely loggers, clients, police, and security guards. Despite whatever knowledge about HIV prevention exists among the various male populations in the sex industry, many men are willing to pay for unprotected sex with sex workers.
- Male and female tourists appear to represent a small proportion of the clients, and they are virtually absent in other capacities in the sex industry. Female clients are mostly found in the tourism industries in Jamaica, Haiti, and Barbados. Foreigners are sometimes involved as owners of facets of the sex industry; they are more likely than locals to be proprietors of the hotels and resorts at which tourism-oriented and beach-based sex work takes place. Expatriate sex workers occasionally open their own establishments.
- Most sex workers are women (biologically or transgendered), although male sex workers are increasingly acknowledged everywhere. In almost every country, migrant women make up a portion of the sex worker population; women from the Dominican Republic, Jamaica, Haiti, Brazil, Colombia, Venezuela, and Guyana are regularly represented. However, it is clear that local sex workers, irrespective of gender, are in the majority in most countries, with the exception of St. Kitts and Nevis, Antigua, and Dominica. Education levels among sex workers vary from primary to tertiary. Many are not involved in sex work full time, but supplement a full-time job or other income-generating activity with earnings from sex work.
- Escorts tend to be foreign women—of Caribbean, South American, and (Eastern) European origin—mostly in their 20s; they often have a higher education degree and are employed in another job or profession. Male escorts tend to be younger than their female counterparts and unemployed otherwise. The brothels, clubs, bars, and hotels where sex work is a main activity are usually populated by female sex workers, dancers, and entertainers, although there are some specific clubs and

hotels catering to male and transgender sex work. Teenage sex workers are rarely found inside the bars, clubs, and brothels, unless forced, and the women tend generally to be in their 20s. Frequently male sex workers operate outside the clubs and bars where women work. Foreign women are heavily concentrated in clubs, bars, and brothels, where they sometimes also reside. Escort and club/bar/brothel-based sex work is generally organized and managed by a third party. In the clubs, bars, and brothels, other skilled and semiskilled workers, such as bartenders, security guards and bouncers, cashiers, cooks, cleaners or housekeepers, and administrative staff, also benefit from the arrangements. Street-based workers are predominantly local female and male-to-female transgender persons who work individually, often independently.

- In the tourism industry, young women and men who work in the resorts, hotels, bars, and beach facilities sometimes engage in sex work with the visitors on an independent basis. Others offer services to tourists on an escort or call-girl/call-boy basis and may have no other connection with the tourism industry. Both types of sex work may be facilitated by resort or hotel staff and taxi drivers. The “beach boy” or “rent-a-dread” is a well-recognized figure in the Caribbean tourism industry. Young men service both male and female tourists, and those relations are generally described as sex work or transactional sex.

Source:

Kempadoo, K, Kempadoo, O., Perkins A., Tait, A. Sex Work and the CARICOM Sex Industry; Research Report, Draft. Prepared for UNAIDS Caribbean Regional Support Team. 2010

TRANSGENDER POPULATIONS

There are no reliable estimates of the number of transgender persons in the Caribbean. The term transgender is generally used to encompass a wide variety of individuals who have in common that their gender identity, expression, or behavior does not correlate with their birth sex in a traditional sense. It includes drag queens, cross dressers, transvestites, intersex persons, and transsexuals. The terminology and, indeed, some of the definitions are not universally accepted and are evolving as the discourse continues and efforts are made to enhance understanding of the complexity of the issues. However, amidst the myriad of concepts, three are fundamental to understanding “transgenderism”:

1. Birth sex is the biological sex one is born with (natal sex, referring to the genitals and physical anatomy).
2. Gender identity refers to one’s self-identification as being a man, woman, neither, or both.
3. Gender role refers to the expressions, behaviors, and mannerisms within a particular culture that are traditionally viewed as masculine or feminine.

Transgender persons are often classified according to gender vector as male-to-female (born male, identify as female) and female-to-male (born female, identify as male).

Studies in North America and Europe have relied almost exclusively on convenience samples (i.e., self-identified participants recruited in either social service or recreational environments) to estimate the number of transgender persons in the general population. The lack of general population-based studies with transgender-inclusive data, coupled with terminology differences in defining transgenderism, has resulted in wide variations in estimates, ranging from the conservative figures derived from health science sources such as the American Psychiatric Association (1 in 30,000 male to female, and 1 in 100,000 female to male) (7) to the much higher estimates reported in the social science arena (0.2% of the general population, or 1 in every 500 persons) (8,9). According to these estimates, the Caribbean may be home to between 12,000 and 80,000 transgender persons.

II. FRAMING THE ISSUES

Visible transgender communities can be found in Cuba, the Dominican Republic, Trinidad and Tobago, Suriname, Guyana, Curaçao, Barbados, Aruba, and St. Maarten. They reside predominantly in urban areas due to the typically earlier self-identity as transgender in these areas, often migrating from smaller communities to avoid stigma and discrimination. Transgender persons also reside elsewhere in the Caribbean, but in those areas transvestite behavior is mainly restricted to private settings. There are small numbers of transsexuals who can blend in with the general population because they are very passable as women. Island hopping allows more freedom of expression (e.g., Jamaican transgender sex workers who visit Curaçao for the weekend).

Very limited data are available regarding HIV among transgender persons. Prevalence studies among transgender populations in the Dominican Republic and Puerto Rico revealed seroprevalence rates of 34% (10) and 14% (11), respectively. Studies in these countries and two other countries of Central America documented HIV prevalence rates among TG persons that were consistently higher than the estimated prevalence among MSM in these countries (Figure 4).

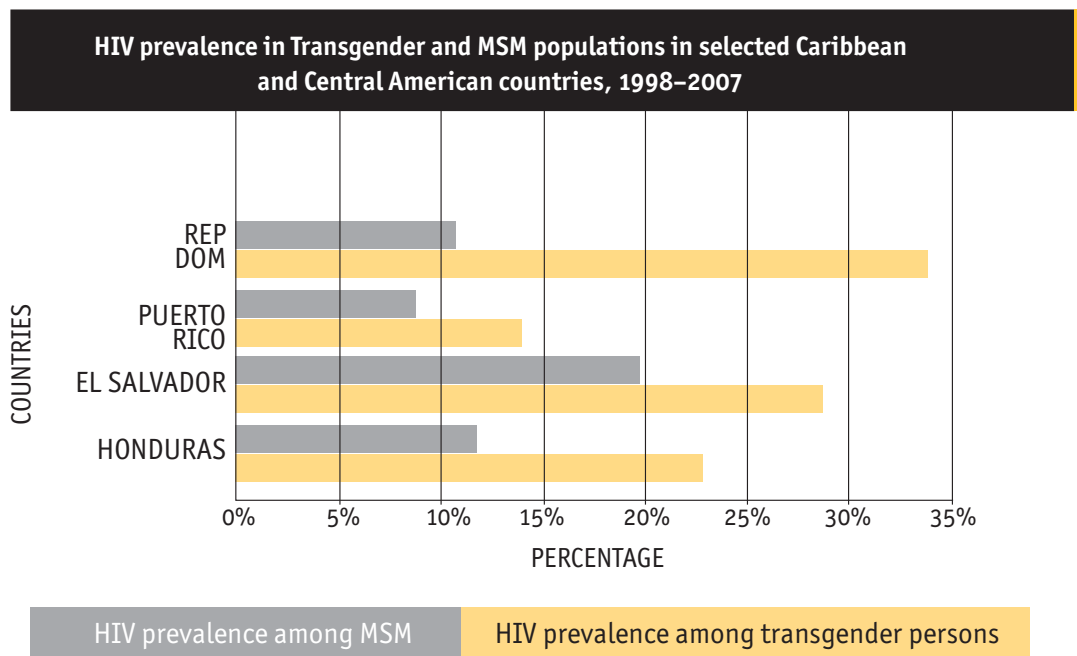


Figure 4

Sources:
Dominican Republic: Pérez Uribe, R. Cuentas Nacionales en VIH/SIDA, Estimación de Flujos de financiamiento y gasto en VIH/SIDA. República Dominicana 1998/1999.
Puerto Rico: Rodríguez-Madera, S., & Toro-Alfonso, J. (2005). Gender as an obstacle in HIV/AIDS prevention: considerations for the development of HIV/AIDS prevention efforts for male-to-female transgenders. *International Journal of Transgenderism*, 2005, 8(2/3), 113–122.
El Salvador: Estudio Multicéntrico de Prevalencia de VIH/ITS y Comportamientos en HSH, San Salvador, El Salvador, 2005.
Honduras: Estudio Multicéntrico Centroamericano de Prevalencia

Improved insight into the dynamics of the Caribbean transgender population is a major challenge, since transgender persons and groups largely move in secrecy as a result of the severe stigma and discrimination they face. There are also indications that significant numbers of TG persons engage in sex work, in part because strong social prejudice limits their access to other types of jobs. It is essential to expand efforts to generate strategic information about this group, which might well be more vulnerable than any other population in the Caribbean to HIV. In order to better understand transgender persons and to address their needs, studies must consider them as a separate population group and not solely as sex workers or as MSM.

PRISON INMATES

The available information regarding HIV among prison inmates has been generated by seroprevalence studies and routine HIV screening of inmates. The extent of HIV transmission in Caribbean prisons has not been documented through systematic studies reporting the seroconversion of inmates. Seroprevalence studies and surveillance conducted during 2004–2007 documented HIV prevalence rates among prison inmates ranging from 2% to 6% (Table 1).

Table 1

HIV prevalence among prison inmates in selected Caribbean countries, 2004–2007

Country	Year	Type of measurement	HIV prevalence	Source
Antigua and Barbuda	2005	Seroprevalence study	3%	CAREC/PAHO 2005 Annual Report
Belize	2005	Seroprevalence study	4.9%	CAREC/SPSTI report on HIV prevalence among prisoners in member countries, 2004–2005
Dominica	2005	Seroprevalence study	2.6%	CAREC/SPSTI report on HIV prevalence among prisoners in member countries, 2004–2005
Dominican Republic	2007	Surveillance of prison inmates	2.2%	2008 UNGASS report, Dominican Republic
Grenada	2005	Seroprevalence study	2.2%	CAREC/SPSTI report on HIV prevalence among prisoners in member countries, 2004–2005
Guyana	2007	Biological and behavioral surveillance survey	5.24%	2008 UNGASS report, Guyana
Jamaica	2007	2006 surveillance of prison inmates in one institution	3.3%	2008 UNGASS report, Jamaica
St. Kitts and Nevis	2004	Seroprevalence study	2.4%	CAREC/PAHO 2004 Annual Report
St. Lucia	2004	Seroprevalence study	2%	CAREC/PAHO 2004 Annual Report
St. Vincent and the Grenadines	2005	Seroprevalence study	4.1%	CAREC/SPSTI report on HIV prevalence among prisoners in member countries, 2004–2005

DRUG USERS

In general there is a lack of evidence indicating significant levels of injection drug use (IDU) in most of the Caribbean, with the exception of Puerto Rico and the Dominican Republic. A study conducted in the Dominican Republic indicated that 37% of drug users in the study were crack cocaine users, 11% used heroin, and 45% reported ever injecting (12). The blood banks of Trinidad, Guyana, and Suriname report a regular but low prevalence of hepatitis C virus in the blood supply, suggesting that some syringe sharing might be taking place (13 – 21)). The low levels or absence of IDU in the region are reflected in the available literature and in dialogue with health care professionals, who almost universally state that injectors do not present for drug treatment, health issues related to injection, or overdose treatment.

Possible explanations for the lack of IDU vary from the ease and low cost of smoking crack to the paucity of heroin trafficking routes through the Caribbean and a widely reported needle aversion among English-speaking Afro- and Indo-Caribbean people. IDU was documented in the 1980s in Bermuda, but recent inquiries of the National Drug Council, treatment professionals, and the prison authorities have found no indication of current injecting behaviors.

Evidence suggests that the primary drug-related risk of HIV in this region is due not to injection drug use but to the sexual transmission of HIV related to exchanges of sex for drugs and money to support drug habits.

In the Caribbean, drug use as an HIV risk relates primarily to the use of crack cocaine. Cannabis, possibly the most widely used illicit substance in the region, has not been associated with HIV vulnerability in studies. As early as 1994, research from Trinidad documented high HIV prevalence rates among non-injecting crack cocaine users. In that study, 3% of 27 men and 14% of 42 women with cocaine dependence tested positive for HIV (22). These results echoed studies conducted in the U.S. showing that HIV infection rates among crack smokers were similar to those among injection drug users. U.S.-based researchers hypothesized that the use of crack cocaine precipitates high-risk sexual behaviors, including having sex with multiple partners and exchanging sex for money or drugs to support an addiction (23). The interaction of alcohol and substance use and violence raises vulnerability to risky sexual behaviors and HIV transmission.

The connection between non-injection drug (cocaine) use and HIV risk is suggested by the results of several more Caribbean studies:

1. Among STD clinic attendees in Trinidad, crack cocaine use was a significant independent predictor of HIV infection among men but not women, though over three years HIV rates increased more in women (9-fold) than in men (4-fold) (24).
2. In Trinidad, data from 122 female substance users admitted to a rehabilitation center between 1996 and 2002 showed that crack use by women was associated with risky sexual behavior. Their HIV prevalence was 19.7%, eight times higher than in the general population (25).
3. Also in Trinidad, screening data from 1,227 high-risk patients admitted to a psychiatric hospital between 1991 and 1995 showed that 6.9% of these individuals were HIV positive. The highest rates were found in patients with substance use problems, especially those who used cocaine (26).
4. In the Bahamas, cocaine use among STD patients seen from 1985 to 1990 was significantly associated with HIV infection. Crack-smoking men were 10 times and women almost 6 times more likely to be HIV positive than non-crack users. A case-control analysis confirmed the association of cocaine use with HIV; HIV prevalence stabilized following declines in cocaine use. Successive, interacting cocaine, STI, and HIV epidemics were observed (27).
5. Another Bahamian study among women attending an antenatal clinic also revealed an association between crack cocaine use and HIV (28).
6. In Guyana, a significant association was found between HIV infection and a history of cocaine use among 118 street- and brothel-based FSWs, of whom 46% tested HIV positive (29).
7. In Guyana, 17% of 172 persons who used illicit drugs tested HIV positive (53% of women and 13% of men). Among this group, 97% used crack (90% daily) and 88% used cannabis; only 3.5% reported ever injecting (30).
8. In St. Lucia, 8 of 106 crack cocaine users tested (7.5%) were HIV infected, as compared with none of the 45 non-crack users in a control group. Female crack users were more likely to test HIV positive than male crack users (11% vs. 6%) (31).
9. In 2007, biological and behavioral surveillance surveys conducted in four Dominican Republic provinces revealed HIV prevalence rates among cocaine users ranging from 5.1% to 13.7% (32).
10. In Jamaica, retrospective chart extractions of 903 substance abusers hospitalized between 1991 and 2003 showed that HIV prevalence was three times higher among women than among men (11.8% vs. 3.9%); 93.3% of these women were diagnosed with crack cocaine dependence (none admitted injection drug use) (33).

11. In a St. Croix study involving 254 drug and alcohol users, women reported higher levels of crack use than men (85% vs. 49%), significantly more sexual partners in the past month (5.6 vs. 2.3), and more unprotected sex acts (11.2 vs. 6.5); they also had a higher HIV prevalence rate (8.8% vs. 1.4%). Women's precarious economic position and lesser access to other income-generating activities tended to drive them into "survival sex" to support subsistence and drug needs (34).

YOUTH, MIGRATION AND MOBILITY

Migration, mobility, and youth have been documented as factors contributing to increased risk of and vulnerability to HIV infection. In the context of the Consensus Meeting, the focus was on how migration, mobility, and youth contribute to increased risk and vulnerability among MSM, SWs, prison populations, and drug users.

- Youth

The time between childhood and adulthood is one of opportunity and exploration, giving rise to a period of first-time experiences, risk-taking, and experimentation in such areas as sexuality, relationships, and use of alcohol and other psychoactive substances. In terms of HIV, young people are less likely to be able to prevent themselves from becoming infected. They often lack the necessary knowledge and skills to consistently choose and apply safer sexual practices, including condom use. Young people are also more likely to be exploited or abused and less likely to seek or find appropriate health and support services when needed. Data regarding HIV prevalence rates among young people are limited. Using antenatal data or data from demographic and health surveys, 13 countries reported HIV prevalence rates among young persons aged 15–24 years ranging from 0.05% to 1.6% in 2006 and 2007 (Table 2). These data might not fully reflect the burden of the epidemic among vulnerable and high-risk young persons in concentrated epidemics.

Table 2

HIV prevalence among young persons aged 15–24 years in selected Caribbean countries, 2006–2007

Source:
UNAIDS. Keeping Score II: A progress report towards Universal Access to HIV Prevention, Treatment, Care and Support in the Caribbean. UNAIDS Caribbean Regional Support Team. 2008

Country	Percentage living with HIV	Year
Antigua and Barbuda	0.08% (females)	2006
Bahamas	1.26% (females)	2006
Barbados	0.6% (females)	2006
Belize	0.83% (females)	2007
Cuba	0.05% (males and females)	2007
Dominican Republic	0.30% (males and females)	2007
Guyana	1.0% (females)	2006
Haiti	1.0% (males and females)	2006
Jamaica	1.3% (females)	2007
St. Lucia	0.51% (females)	2007
St. Vincent and the Grenadines	1.36% (females)	2007
Suriname	1.10% (females)	2006
Trinidad and Tobago	1.64% (females)	2006

In most countries reported HIV prevalence rates among young persons are derived from antenatal data, and in general these rates are similar to or lower than the estimated adult prevalence. As mentioned, these data may not sufficiently capture the burden of the epidemic among young at-risk persons, particularly in the case of concentrated epidemics. Certain groups of young persons are more likely to adopt high-risk behaviors as a result of individual characteristics or environmental factors. These especially vulnerable adolescents include those who have dropped out of school, those who live in extreme poverty, those who are incarcerated in prisons or correctional facilities, and those who have been subject to or live in families where there is physical or sexual abuse. Most-at-risk adolescents and young people are those who engage in behaviors that put them at high risk for HIV infection, including young men who have sex with men, young male and female sex workers, and young injecting or non-injecting drug users.

Information regarding the specific dynamics surrounding young MSM in the Caribbean is not available, but based on global evidence it is likely that this population is disproportionately affected by mental health problems such as anxiety and depression as well as substance use, homelessness, victimization, and physical and sexual abuse.

Young sex workers are more at risk for HIV infection than their older counterparts as a result of a variety of factors, including biological and social factors. The incomplete maturation of the genital tract puts young girls at greater risk for HIV infection, and young male and female sex workers are less likely to be able to negotiate condom use with clients or protect themselves against rape or violence. While systematic data are limited, a recent assessment conducted in 14 Caribbean countries noted that girls who appeared to be as young as 13 years of age were present in several camps and brothels (35). The report also noted that young women and men are more highly prized than older sex workers.

- Migrant and mobile populations

Migration has been a constant feature of the Caribbean for at least two centuries (36). Poverty, high unemployment, and the quest for better jobs continue to foster significant population mobility in the Caribbean. Intra-regional migration has occurred mainly from lower income to higher income countries, and undocumented migration is common. Undocumented migration tends to involve those who are poor, unskilled, less educated, and economically disadvantaged. In general, undocumented migrants concentrate on the fringes of big cities in areas with high crime rates, poverty, overcrowding, social disintegration, and a lack of social and health services. Their uncertain legal status creates insecurity in everyday life and drives their political and economic marginalization (36). Because of fear of deportation, undocumented migrants tend to avoid contact with official government agencies and have little access to health and welfare information and services (37).

Gender dimensions of migration also play an important role in terms of vulnerability to HIV/AIDS. Female migrants are particularly vulnerable because they are more likely to experience sexual violence and engage in risk-associated sexual behaviors such as commercial sex.

Intra-country and inter-country mobility among sex workers, including migration from one region or country to another for work, appears to be high in the Caribbean. Significant numbers of sex workers migrate from the Dominican Republic, Colombia, and Brazil to other parts of the region (35). Often club or brothel owners arrange for these workers to be brought in, typically in groups, and they may keep their passport in custody and require them to pay for their ticket, accommodations, and food. In some venues club or brothel managers may directly collect pay from clients, leaving workers with little control over their income (35).

Instances of sexual exploitation and trafficking have also been documented in the region. During the past 10 years several Caribbean countries, including Belize, Guyana, the Dominican Republic, and Suriname, have been identified as transit and destination countries for women and children trafficked for the purpose of sexual exploitation. Trafficked persons have little ability to negotiate safer sex, and trafficked sex workers may be subjected to additional exploitation by police, customs officers, and other authorities, including demands for sex and demands for pay for entry or protection (35).

While tourism has always been significant in the Caribbean, the decline of the agricultural sector has further increased the economic significance of tourism for the region (38). Tourism contributes 30% to 50% of the GDP of most Caribbean countries (38). In the tourism industry, young women and men who work in the resorts, hotels, bars, and beach facilities sometimes engage in sex work with the visitors on an independent basis, but there is also a defined sex tourism industry that includes escort services and beach-based male sex work (35).

Another aspect of migration and mobility in this context is the movement of MSM. Although once again the data in this respect are anecdotal, they mirror the findings of larger studies conducted in the United States and other countries indicating that MSM tend to move within and between countries in search of anonymity and safe spaces and to escape physical and psychological stress. This type of migration can contribute to an increased sense of well-being among MSM because of their newfound anonymity, but it can also contribute to an increased risk of HIV since they may perceive more freedom to explore or experiment with their sexuality and may feel less accountable for their actions (39). The merging of migrants' sexual preferences and styles with the culture of the host environment can lead to these individuals developing more diverse ("evolving") sexualities (39).

DISCUSSION AND RECOMMENDATIONS REGARDING THE NATURE OF THE HIV EPIDEMIC IN THE CARIBBEAN

The Consensus Meeting included extensive discussions on the evolving classification of the Caribbean HIV epidemic and how this classification has influenced the regional response in general and the response towards key populations in particular.

- **Classification of the Caribbean epidemic as a generalized epidemic:** The meeting participants questioned the classification of the Caribbean epidemic as a generalized one, with HIV prevalence in the general population greater than 1%. Based on a presentation and review of different scenarios, it was argued that the Caribbean HIV epidemic might well be a concentrated epidemic, with a lower than 1% prevalence in the general population and a thus far underestimated contribution of subpopulations, in particular MSM, to the trends observed of the epidemic. The meeting participants felt more agreeable with the classification of a "mixed" epidemic, and recognized that more and better information is needed to adequately describe the HIV epidemic in the Caribbean.
- **Distraction of focus from key populations to the general population:** At different critical points in the HIV response, various documents referred to the generalized nature of the HIV epidemic, the predominantly heterosexual transmission, and the feminization of the epidemic. This characterization distracted attention and resources from the most high-risk and vulnerable groups in favor of approaches aimed at the general population. It was also noted that the idea of a generalized epidemic may have been socially and politically more acceptable and may have been useful earlier in obtaining strong, broad support for the initial HIV response efforts. However, the need for cost-effective, evidence-based prevention, testing, and treatment programs makes it urgent now to revisit this classification.

How a concentrated epidemic might appear generalized:

If a country has an adult HIV prevalence rate of 1.5%, measured by a reliable, population-based survey (e.g. DHS+), this would mean that out of each 1,000 persons, an average of 15 are HIV positive. If the ratio of males to females infected is nearly even, about 8 men and 7 women have been infected. Most or all of the women will have been infected by men; some may have been infected during the course of sex work. But since in heterosexual relations women are more vulnerable than men to becoming infected (studies show that they are 2 to 4 times more likely to become infected per unprotected coital act), at equilibrium not more than 2 to 5 of the men will have been infected by heterosexual sex, on average. Maintenance of a nearly even sex ratio among infected persons would imply that about 3 to 6 of the 8 men were infected by non-heterosexual means, principally by having sex with other men (since injection drug use is not common). That is consistent with data on MSM populations. If the frequency of MSM in the general population is 4%—a figure often used as a crude estimate—then of the roughly 500 men in a population of 1,000 persons, about 20 will be MSM. In addition, if the HIV prevalence is in the 20% to 30% range (as in some Caribbean countries), that would imply that on average 4 to 6 of these men will be HIV positive; that is, 4 to 6 of the 8 men who are HIV positive had been infected via sex with other men. Similar calculations with female sex workers would suggest that 2 or 3 (or more) of the women were infected via sex work. In all, about 40% to 60% of the infected persons would belong to MARP groups, and the rest would be part of the non-MARP population. Both MSM and SWs form part of the larger general population sampled; thus, what appeared to be a general epidemic at a 1.5% prevalence level may turn out on closer examination to consist of high-prevalence concentrated epidemics in MARP groups and an HIV prevalence of under 1% among the heterosexual, non-MARP population. And most of the new infections will be passed on by MARPs: MSM transmitting the infection to both men and women and, to a lesser extent, SWs transmitting the infection to clients and partners. Treating the population in this example as being part of a generalized epidemic could lead to suboptimal allocation of scarce resources for HIV prevention—away from the concentrated epidemics in MARP communities, where up to 30% or more are potential agents of transmission, and towards the general population, where transmitting agents are far less frequent and thus more diluted and costly to reach. To prevent HIV transmission by MSM would mean working with some 20 to 50 per 1,000 population, of whom a good number are HIV positive, while working with the general population would mean working with the remaining 950 to 980 persons per 1,000 to reach a small number of HIV-positive persons who are greatly diluted by the mass of non-infected individuals.

Source:

Waters, J. Background Paper Regarding Access to Health Services by Men Who Have Sex with Men, Transgender Persons, and Sex Workers in the Caribbean. Prepared for the PAHO HIV Caribbean Office, 2009.

The following recommendations emerged from the discussion:

- More and better information is needed to understand the complexities of the HIV epidemic in the Caribbean and its underlying sexual networks and social determinants, particularly those related to key populations, to facilitate development and implementation of appropriately targeted responses. In particular, little is known about the dynamics of the epidemic within and between different at-risk population groups. Even in a generalized epidemic where HIV becomes entrenched in the wider population, key populations could contribute disproportionately to the maintenance and spread of HIV. In particular, seroprevalence studies among key populations must be implemented to enhance insight into the dynamics of the epidemic.
- The TG population should be disaggregated in data collection and studies. Most research has either ignored transgender persons or grouped them with SW or MSM populations. Their vulnerability and potential impact on the epidemic make it urgent to develop appropriate strategic information and approaches.
- Efforts must be made to ensure the highest possible return on investments in the HIV response. Given the limited resources of the Caribbean countries, it is essential to ensure the highest possible return on what is spent on prevention, care, and treatment and the quickest possible control of the epidemic and its impact on future costs. In this context, it is urgent to reevaluate the contribution of the MARPS to the dynamics of the epidemic and to realign regional and country priorities accordingly. Monitoring and evaluation of resource flows related to HIV prevention, treatment, and care at the regional and national levels is essential, with a view to relate investments to results.
- The limited focus on key populations and their poor access to comprehensive HIV services represent a violation of their human rights and a major obstacle to achieving universal access. Urgent action is needed to rectify this situation and ensure equitable inclusion of and access to resources for these key populations.

“It is not just a paucity of data that leads to misinterpretation of the HIV epidemic. It is also a mind set, influenced by social conditioning and belief systems, related to internalized stigma and discrimination and to political pressures.”

Consensus Meeting participant





ISSUES AFFECTING ACCESS TO HIV HEALTH SERVICES BY KEY POPULATIONS

III

The meeting participants concluded that a discernible set of interrelated factors affect access to HIV health services by all key populations, in addition to issues affecting specific groups. Many HIV vulnerability factors are related to the policy and legislative environments in each country, which both reflect and influence the psychosocial context of the epidemic and of the response to it. Where stigma and discrimination are strong, for instance, or high-risk behaviors are criminalized, vulnerable populations tend to be secretive, wary, less empowered, and more difficult to work with. Government services may be limited or nonexistent, and nongovernmental organizations that work with key populations may be subject to intolerance and persecution. The sections to follow summarize the cross-cutting issues affecting all groups and the specific issues affecting each population.

III.1. ● SHARED ISSUES

- **Criminalization:** Legislation that criminalizes behaviors of key populations, including homosexuality, sex work, sex among adolescents, and substance use, contributes to secrecy, marginalization, and reduced access to services. Secrecy aimed at avoiding not only legal persecution but social stigmatization and discrimination contributes to increased risk of HIV infection, delays in diagnosis, and reduced access to services to avoid premature death. In some instances, agencies and health care workers serving these populations have been subject to accusations of aiding and abetting criminal activity.
- **Stigma and discrimination:** In addition to the legal constraints, stigma and discrimination in the general population and in the health sector constitute a major barrier to access to health services. Several studies conducted in the region in the past decade have documented significant levels of stigma and discrimination against particular sexual identities, orientations, and behaviors, including homosexuality, sex work, sex with multiple partners, and underage sex. Religious, socio-cultural, and gender-based norms, values, and stereotypes contribute to varying levels of disapproval, exclusion, and even persecution of persons and groups associated with these identities, orientations, and behaviors. In some health care settings, this stigma and discrimination translates into judgmental attitudes, hostility, and discrimination in the delivery of services. As a result, specific groups such as MSM, TG persons, and SWs have difficulty trusting that health care workers will not disclose their sexual practices and behaviors, leading them to delay or avoid seeking care for sexuality-related issues.
- **Lack of understanding of issues affecting key populations and capacity to provide appropriate services to these groups:** The meeting participants concluded that, even in the absence of prejudice or discrimination, service providers are generally uncomfortable with sexual diversity and have little understanding of the dynamics of diverse sexual identities, practices, and behaviors and their implications for health and wellness. While sexual expressions, dynamics, and behaviors are at the heart of the HIV epidemic, prevention strategies and interventions have generally ignored or underestimated the critical importance of these factors in the promotion of safer sexual practices, and in most countries prevention efforts have systematically ignored the existence of and dynamics around sexual diversity. Service providers have generally not been oriented or trained to adequately address issues related to human sexuality and sexual diversity. There appears to be little understanding of or empathy for the depression, anxiety, and other psychosocial issues members of sexual minority groups often struggle with. In addition, there are conditions and diseases of particular relevance to specific subgroups, such as anal cancer in MSM or high rates of depression and breast cancer in TG persons who use hormones. Service providers often fail to conduct appropriate sexual history interviews and physical examinations, leading to misdiagnosis and ineffective treatment. Other concerns include limited access to appropriate referrals, gaps in continuity of care, and a lack of age-appropriate services for most-at-risk adolescents and young people.
- **Lack of confidentiality:** The lack of concern for and protection of privacy and personal information, a general concern in health service delivery, is even more prominent in the case of key populations, who can suffer significant consequences, including bodily harm, if their personal information is inappropriately shared.
- **High cost for health care:** As a result of unsatisfactory experiences in public sector health services, including stigma and discrimination, judgmental attitudes, privacy and confidentiality concerns, and distrust of health workers, key populations tend to navigate to private sector health care that can come at a high cost, in particular when factoring in the cost of diagnosis, laboratory services, and medicines. There is also limited linkage with and bidirectional referral to private sector health care services.
- **Gaps in information on the size, behaviors, and health issues of key populations:** In most countries, surveillance and service delivery data are not collected or analyzed in a disaggregated manner that can make key populations visible. As a result, there is limited information available regarding the characteristics of these key populations, information that could provide a basis for improved planning and tailoring of services.

- **Lack of sustainability of services provided by nongovernmental organizations:** To date, civil society organizations have played a major role in the provision of care and support services, and in some cases basic medical services, for key populations. In many countries, these organizations and services are not recognized or structurally supported by their governments. The core funding for the majority of these organizations comes from external sources, creating an environment of external dependency and lack of sustainability. There is also limited linkage with and bidirectional referral to government services.

ISSUES AFFECTING SPECIFIC GROUPS ● III.2.

MEN WHO HAVE SEX WITH MEN

Although most major health care issues for MSM are similar to those for all men, there is growing evidence that MSM populations might experience higher rates of some medical problems and that there are unique issues to consider when providing services for MSM. It is recommended that screening for and immunization against hepatitis A and B virus, routine screening for HIV and other STIs, and routine screening for some cancers (e.g. anal neoplasia caused by the human papilloma virus) be included in care for MSM clients (40). Routine assessments of drug, alcohol, and tobacco use and screening for problems related to mental health, posttraumatic stress, stigma and discrimination, and experiences of domestic violence and hate crimes should also be incorporated (40). An assessment conducted by CVC in four countries (Guadeloupe, Suriname, Cuba, and Antigua) noted that in these countries effeminate or “identifiably gay” males were more likely to refer to stigma and discrimination as a major obstacle to health care access. They were also more likely to report disclosing sexual activity, which in some instances resulted in more relevant care, while MSM who presented as “straight” were more likely to conceal their sexual behavior from care providers, resulting in failure to detect certain conditions.

One young man on a small island reported being very concerned about developing anal sores. Not knowing whom to turn to, he simply did nothing. Much to his relief, the symptoms resolved spontaneously and he resumed sexual activity. About a month later he developed a body rash and wart-like patches in the anal area. Again, as a result of the shame and fear of being “outed,” he did nothing. To his amazement, everything cleared up again and he has remained symptom-free ever since. Following the interview and after some medical counseling, he agreed to a syphilis test, which came back positive. This case highlights a number of issues beyond simply access to care, including transmission risk to others, partner notification failure, and missed opportunities for HIV prevention and counseling.

Source:
Waters, J. Background Paper Regarding Access to health services by Men Who have Sex with Men, Transgender Persons, and Sex Workers in the Caribbean. Prepared for the PAHO HIV Caribbean Office, 2009

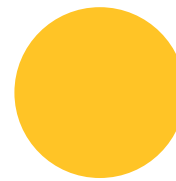
The CVC assessment identified Cuba as a model for a more holistic approach towards health care for MSM (41). Cuba has a health system that assumes fiscal and administrative responsibility for all of its citizens. Its tradition in health care excellence predates the revolution and has been upheld (42). Patients have recourse to a formal complaint procedure that is taken very seriously and can result in any member of the health care team being suspended. This applies to issues of personal conduct as well as to medical competence. A physician who treats a homosexual or transgender patient with disrespect or fails to detect a particular condition through ignorance or negligence risks being seriously reprimanded. This provides Cuban gay and TG persons with an important safeguard (43).

A related finding in all four countries was that MSM were less likely to seek medical attention for anal symptoms than for penile symptoms. Self-medicating or simply ignoring anal symptoms was more common than with penile symptoms. With the exception of Cuba, and to a lesser extent Suriname and Guadeloupe, the majority of MSM, TG persons, and sex workers in the CVC assessment accessed health care primarily through private general practitioners (especially in the smaller countries) or NGO community clinics/family planning associations (especially in the larger countries) (41). This finding has important policy and programmatic implications in the region with respect to improving access for marginalized groups, including the need to support further use of those health care sources and emulate their strong points in public sector programs.

TRANSGENDER PERSONS

Transgender persons face multiple social and institutional barriers to competent physical and mental health care. High rates of STI and HIV, an array of special health care needs, and a set of life challenges that often contribute to substance use and detrimental mental health situations make this population central to any discussion on rights-based access to health care. In the Caribbean, there are virtually no data documenting the realities that community-based service organizations witness on the ground with this population. This invisibility, along with the associated isolation and marginalization, has profound consequences for the health and well-being of the TG community. While male-to-female transgender issues are often emphasized, in the broader health care context female-to-male TG persons also face many barriers. Although some issues such as high levels of depression, suicide, substance use, violence, and discrimination are similar in male-to-female and female-to-male TG persons, many of their needs are distinct, and these differences should be considered when designing or expanding programs geared toward the TG community.

To prepare for a pilot TG health care project in the Dominican Republic, a needs assessment was carried out in 2009 (44). In this study, many TG focus group participants offered personal anecdotes of humiliating treatment from care providers and even outright refusal to provide services. They attributed this attitude to a variety of provider-related factors, including ignorance of TG-related issues, insensitivity, and an unwillingness to deal with transgender persons. The study made clear that TG persons had a deep-seated mistrust of health care professionals and seriously questioned their ability to assist with TG-related health problems. The specific knowledge and skills needed to treat transgender persons are often lacking. For example, a TG client with a long history of depression resistant to treatment with antidepressants was treated at the TG-friendly COIN clinic. A simple adjustment to a self-administered hormonal regimen was all that was required to treat her depression. Very few transgender participants reported having visited a medical doctor in the past year. The majority claimed that they managed their health among themselves, including hormone administration and STI treatment. Home remedies and natural cures were also popular. Many reported consulting with elderly neighbors knowledgeable on such matters, who were more likely to “hear them out” and treat them well.



SEX WORKERS

Local and mobile sex workers share many issues. For mobile sex workers, these issues are often heightened by socio-cultural and mobility factors that act as further barriers to accessing basic services and leave immigrant sex workers highly exposed to stigma and discrimination. Mental health is a significant issue for many migrant women. Being foreign, isolated, and away from support networks of family and friends tends to exacerbate mental health problems. Local sex workers also have mental health issues due to the anxiety and stress related to sex work generally, as well as to the cultural disenfranchisement to which they are subjected.

Some of the underlying vulnerabilities for mobile and local sex workers may stem from different sources but have similar consequences. For instance, fear of being deported as an immigrant SW and fear of being “outed” as an SW in a small community can have similar effects in driving sex work underground. There are also contextual factors that result in some local SWs having more in common with their immigrant colleagues than with local SWs in other settings. For example, street-based sex work is unusual on smaller islands such as St. Lucia and Dominica. Secrecy and fear of being identified as a sex worker are primary concerns shared by both local and immigrant SWs. Accessing sexual health services is often affected by the fear of being identified as a sex worker.

DRUG USERS

Despite evidence that crack cocaine use plays a role in HIV epidemics in the Caribbean, national drug and HIV policies and programs remain largely unlinked. Harm reduction approaches have only recently been implemented in the region. In Puerto Rico, where the majority of new HIV cases are associated with injecting drug use, needle and syringe programs as well as opioid substitution therapy are available. Abstinence-based programs and services are available in some countries. These programs and services tend to be high threshold, as they require referral and sometimes private payment or co-pays from the client.

Barriers to health services for drug users were explored in a 2005 CDARI survey conducted in St. Lucia, Trinidad, and Jamaica (45). The study documented the following barriers to services for drug users:

- General barriers: feeling that one is not understood or is treated differently
- Time barriers: lengthy waiting times, limited time to discuss problems, and restrictive opening hours of service delivery sites
- Service barriers: hostile environment, high cost (co-pay), unfriendly and unskilled staff, and chaotic atmosphere
- Respondent interaction barriers: discrimination, abstinence focus, lack of trust in service, previous bad experiences, travel problems, and cultural barriers

In this study, drug users identified the following issues as relevant in the development of rehabilitation services: job placement, friendly staff, confidentiality, counseling for substance use or referral to relevant support services, free meals, shower facilities, housing, and involvement of the beneficiary population in the design of services.

PRISON INMATES

Caribbean countries figure prominently in the global rate of incarceration, with 15 Caribbean countries and territories featuring in the world's top 30 in rates of imprisonment per capita, according to the International Centre for Prison Studies (46).

Outdated laws, lack of access to affordable or state-provided legal representation, and in general a scarcity of appropriate facilities or alternative sentencing schemes have resulted in clogged legal systems with backlogged cases and over-population. Overcrowding limits the ability of many Caribbean prison authorities to effectively segregate inmates by age, legal status (i.e., preconviction/postconviction, type of offense), and other relevant characteristics, exacerbating public health threats and increasing the risk of HIV transmission.

There are strong linkages between substance use and incarceration, as many prison inmates are also drug users. Criminalization of drug users without provision of rehabilitation services feeds a vicious circle of recidivism and re-arrest. Similarly, men who have sex with men are also present in the prison environment, ranging from openly gay prisoners to situational/circumstantial bisexual or heterosexual men who will choose same-sex partners in the absence of female partners. Sex work has been reported to be available in prison as well, and it has been documented that rape and sexual assault occur within prison settings.

Thus, the inmate population may be exposed to complex, multifactor risks, and guards and other staff may also be involved and/or exposed. Human and material links to outside populations often abound via visits, guards and staff, deliveries of foodstuffs and other goods from families, and cell phones, as well as via released inmates and repeat offenders who cycle back in. Sex and drugs continue to be available to many prisoners, more so than condoms and other means of HIV prevention.

In spite of the broad recognition of sexual activity in prison, most prisons do not have provisions for conjugal visits, and overt distribution of condoms in prison is problematic due to anti-sodomy laws and prison policies banning distribution of items that may be used to harm oneself or others. Socially, condom distribution in prisons might be perceived not only as an acknowledgment of homosexual activity but also as an endorsement of it. In the context of highly religious societies, this kind of intervention is sometimes actively resisted by both elements of civil society and the prison population itself.

HIV testing is available to prisoners in most Caribbean countries, as well as access to antiretroviral treatment. The largest challenge to HIV-positive inmates is not treatment in prison but continuity of treatment on release. For instance, crack users who return to a homeless, drug-using lifestyle will have difficulty with treatment adherence.

A critical public health issue is the flow of HIV-infected persons through the prison system. It is common when examining HIV prevalence in a prison to focus on the HIV prevalence level at a particular moment. The burden of HIV in prisons becomes much higher when taking into account the number of persons living with HIV who cycle through the prison yearly. The transient nature of the HIV-positive population in the prison system makes it urgent to coordinate prison and community interventions.

In summary, key barriers to HIV health services for prison inmates include lack of access to condoms, lack of a public health and harm reduction approach towards drug use among prisoners, lack of written HIV/infectious disease protocols for prison health programs, and lack of appropriate follow-up services for ex-convicts.

MOST-AT-RISK YOUNG PERSONS

Key issues specific to access for at-risk young persons to HIV health services are similar to the issues faced by all young persons. The societal judgment associated with homosexuality, sex among young persons, and drug use among young persons compounds these issues for sexually diverse young people, young people who sell sex, and young people who use drugs. Key challenges include:

- **Lack of political and community support:** The mix of drugs, sex, and minors creates complicated, controversial issues, difficult to address in themselves and even more difficult in the context of moral concerns, community stigma and discrimination, and exclusion of most-at-risk adolescents. Prevention and other services are often provided for the “innocent” but not for adolescents who are viewed as “lost causes” (i.e., those who seem beyond help). Situations are often made more complex by dysfunctional family structures and parental denial and disengagement, violence, and substance use. Social and religious opposition rejects solutions such as harm reduction for adolescents, condom distribution among youth, and drop-in centers for youth sex workers. Similarly, denial or lack of understanding of gender issues at the policy level, for example not taking into account factors such as forced sex, incest, gender-based violence, and lack of economic options, in particular among young women, can perpetuate or increase vulnerability.
- **Legal and policy constraints:** Provision of health services for young people in the Caribbean is limited by legal constraints, including the requirement of parental consent for medical interventions, the age of legal consent for sexual activity, and the legal prohibition to disseminate condoms among young persons. These legal constraints can be especially problematic for homosexual youth and young sex workers, since they are more likely to be in conflict with their parents or legal guardians and might even be physically or sexually victimized by their parents or guardians. There is no widespread use of legal mechanisms such as emancipation or “divorce” from legal parental oversight. The fear of being reported to authorities serves as a major barrier preventing young persons living in difficult circumstances from seeking services and divulging details of their health issues.
- **Structural barriers to service provision and uptake:** The organization of health services, including their location and opening hours, can limit the ability of young persons to access these services. Factors such as limited capacity of service providers to understand and work with young persons in difficult circumstances; requirements for identification, documentation, and registration; and need for payment limit uptake of health services by most-at-risk young persons.

MIGRANTS

In a few Caribbean countries, the public sector provides full and free health services to all in need, no questions asked. However, in most Caribbean countries immigrants, in particular undocumented migrants, have limited access to health services. Limitations can be in the form of types of services offered (for instance, some countries provide free maternal and child health services to all, but other services require payment) or required payments or co-pays. For example, in some countries those with limited access to health services face higher co-pays (including fees for diagnostic and laboratory services) than those whose access is not limited.

Health systems evaluations in several countries supported by PAHO have documented reluctance among undocumented migrants to use health services as a result of the occurrence of raids from immigration services and fear of deportation. In addition, language and cultural barriers limit migrant clients from gaining the full benefits of health services since they might be members of ethnic or language minority groups and might face specific challenges in adapting to the mainstream culture.



PRIORITY ACTION

IV

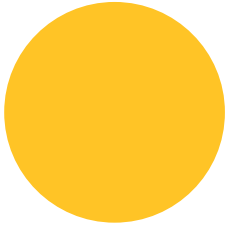
Based on extensive discussions, the Consensus Meeting participants formulated a set of recommendations for priority action in the Caribbean to improve access to comprehensive HIV health services among men who have sex with men, sex workers, prison inmates, drug users, most-at-risk young persons, and most-at-risk migrants.

RECOMMENDATIONS FOR CROSS-CUTTING ACTION

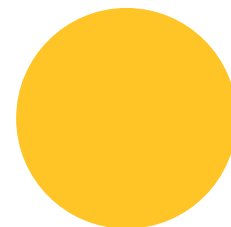
● IV.1.

These cross-cutting recommendations are based on the expectation that if they are implemented, they will significantly contribute to the fostering of nonjudgmental, inclusive, and responsive health services for all, including key populations.

- 1. Integrate health services through a primary health care approach:** Availability of a full range of health services utilizing a primary health care approach is a critical condition to ensure access for all. Integration of HIV and sexual/reproductive health services in primary care service delivery is particularly important to overcome stigma and discrimination. If STI patients are seen only in STI clinics and persons living with HIV are seen only in HIV units, then visiting these facilities marks and stigmatizes users, which compromises confidentiality. Integration of HIV with other health services will also improve the cost-effectiveness and sustainability of HIV services and will create the opportunity for leveraging of HIV resources to strengthen health systems. From the perspective of the key populations, the integrated package of health services and the delivery of those services must include availability of a continuum of medical and psychosocial services, convenient opening hours, and efficient and client-centered staff.



2. **Build the capacity building of health workers:** It is important to enhance health workers' understanding of sexuality and sexual diversity so that they can effectively address and integrate these issues in service delivery utilizing a human rights perspective and gender-responsive approaches. Capacity building should also increase health workers' knowledge and understanding of the physical and psychosexual health issues and concerns relevant to specific groups. Also needed are pre-service and in-service training, creation of incentives (e.g., continuing medical education credits), dialogue with medical associations, and fostering of strategic alliances.
3. **Foster linkages and networking between the public sector, private sector, and civil society:** Since many high-risk and vulnerable groups seek health services outside of the public sector, and considering the active role of civil society organizations in service provision for these key populations, it is critical that the private sector, the public sector, and civil society work closely together in the development and provision of services for key populations. Such collaborations should include bidirectional referrals, exchange of information, sharing of experience and best practices, and collective work towards a comprehensive, inclusive, and low-threshold service delivery network.
4. **Promote men's health initiatives:** The meeting participants noted that, globally and in the Caribbean, care-seeking behavior of men is low. Men tend to be reactive rather than proactive in the maintenance and promotion of their own health, and they may delay care even when they experience symptoms. However, it was also noted that health care systems tend to focus on women and children, with few initiatives aimed at protection and improvement of men's health. Interventions must acknowledge and integrate the spectrum of male sexuality in an inclusive approach based on human rights. Fostering of health services that are sensitive to the health needs of men will contribute to improvements in the health and care-seeking behaviors of all men, benefiting men of diverse sexual backgrounds as well as their female partners.
5. **Engage in concerted and sustained action to reduce HIV-related stigma and discrimination in the health sector:** Homophobia, condemnation of sexual diversity, judgment and marginalization of behaviors and persons outside the mainstream norms of sexual identity and sexual behavior, and association of HIV infection with deviant sexual behaviors are all factors noted to contribute to HIV-related stigma and discrimination. The meeting participants noted that health workers must be held to a higher standard, based on professional ethical norms governing their profession and internationally agreed-upon human rights principles. Sustained action therefore must include ongoing sensitization of health care workers as well as establishment of accountability and recourse mechanisms such as in the Cuba example described above.
6. **Increase the availability and use of strategic information:** There is a need for more information regarding HIV/STI prevalence rates, social and behavioral determinants of risk and vulnerability, and service delivery uptake and outcomes among key populations. Efforts must include strengthening of surveillance, operational research monitoring and evaluation, and collection and analysis of data disaggregated by sex, age, and other relevant variables.



- 7. Increase the allocation and monitoring of resources earmarked for key populations:** At the regional and country levels, sufficient resources must be generated and allocated to enable a sustained effort to improve access to and utilization of health services by key populations. Distribution and redistribution of available resources must take place based on a more realistic assessment of the contribution of key populations to the HIV epidemic and the actions required to reduce risks and vulnerabilities.
- 8. Decriminalize specific behaviors:** There is a general consensus that criminalization of specific behaviors, including homosexuality, sex work, and drug use, is driving marginalized groups into obscurity and complicating the effectiveness of interventions designed to reduce risks and vulnerabilities. Careful consideration must be given to assessing the feasibility of decriminalizing homosexuality, sex work, and drug use. Global discourse on the advantages and disadvantages can inform a frank dialogue in the Caribbean regarding the consequences of decriminalization and the development of appropriate policy and legislation to avoid or limit adverse results.
- 9. Create safe spaces for key populations:** While establishment of an inclusive, responsive environment throughout the service delivery network is the ultimate aim, immediate needs of key populations must be met through the establishment and strengthening of safe spaces. At a minimum, safe spaces should include stigma-free environments with friendly and qualified staff that are trained to adequately respond to the needs of key populations. These efforts can build on the experiences of Caribbean Vulnerable Communities (CVC), which was established as a coalition of community leaders and nongovernmental agencies providing services directly to and on behalf of Caribbean populations who are especially vulnerable to HIV infection or often forgotten in terms of access to treatment and health care programs, including men who have sex with men, sex workers, people who use drugs, ex-prisoners, and vulnerable young people. CVC currently has approximately 90 members from across the Caribbean.
- 10. Involve key populations:** The meeting participants emphasized the critical importance of meaningful involvement of key populations, including vulnerable young people, in the design, implementation, and monitoring of interventions. Efforts must also be made to establish intra- and inter-country peer support mechanisms for key populations, including peer support groups, peer educators and mentors, and safe houses.
- 11. Build strategic alliances:** To foster a broader movement towards inclusion, it is necessary to foster strategic alliances at the country and regional levels. These alliances must include dialogue and partnership with PANCAP; UN partners, in particular UNAIDS, PAHO/WHO, UNDP, UNICEF, and UNFPA; training and teaching institutions, including the University of the West Indies, the Caribbean HIV/AIDS Regional Training Network, and nursing schools; other international partners such as the U.S. Centers for Disease Control and Prevention, the U.S. President's Emergency Plan for AIDS Relief, and the World Bank; civil society organizations such as CVC and its member organizations; the Caribbean Regional Network of People Living with HIV/AIDS; the Caribbean Sex Workers Coalition (CSWC), and faith-based organizations.
- 12. Foster a more horizontal and inclusive approach towards key populations:** This inclusive approach should focus on risk behaviors and address complex risk and vulnerability factors rather than applying narrow, vertical approaches to specific groups.

IV.2. ● ACTIONS RELATED TO SPECIFIC GROUPS

This section presents recommendations that relate to specific groups and should be implemented in addition to and conjunction with the cross-cutting recommended actions.

Table 3

Men who have sex with men

Recommended action	Details
Develop and disseminate models and algorithms for MSM service delivery	<ul style="list-style-type: none"> • Roll out the PAHO Blueprint for the Provision of Comprehensive Care to Gay Men and Other Men Who have Sex with Men (MSM) in Latin America and the Caribbean • Document and disseminate promising and best practices for MSM services in the Caribbean
Engage in outreach to “hidden” and other hard-to-reach MSM	<ul style="list-style-type: none"> • Develop and initiate implementation of innovative approaches to reach MSM via discreet, anonymous, and confidential mechanisms (including the Internet, chat rooms, etc.) with information and services, including psychosocial support
Ensure access to supplies	<ul style="list-style-type: none"> • Develop strategies to ensure that MSM of all ages have continuous access to condoms and water-based lubricants

Table 4

Transgender persons

Recommended action	Details
Build the capacity of health workers	<ul style="list-style-type: none"> • Increase medical expertise in the area of transgender health issues through training and capacity building of Caribbean service providers
Provide information and education	<ul style="list-style-type: none"> • Develop and disseminate materials that provide information to transgender persons on issues such as surgery, hormone therapy, and safety • Provide information aimed at the general population to increase understanding of transgender issues and reduce the isolation of transgender persons • Provide information to service providers to ensure that all providers are informed, at least to some degree, of key aspects of transgender health

Transgender persons

Table 4 (Cont.)

<p>Ensure that psychosocial support mechanisms are in place</p>	<ul style="list-style-type: none"> • Train psychosocial care providers in key aspects of transgender health and build their capacity to improve the support provided to transgender persons • Support establishment of peer support mechanisms among transgender persons and groups
---	---

Sex workers

Table 5

Recommended action	Details
<p>Define and implement a minimum package of services and service delivery protocols for female, male, and transgender sex workers to meet their health needs</p>	<ul style="list-style-type: none"> • Include affordable access to Sexual and reproductive health HIV/STI screening and treatment, male and female condoms, lubricants, and cervical and breast cancer screening • Develop, implement, and disseminate models for outreach to and care of female, male, and transgender sex workers
<p>Ensure access to services and safe spaces for mobile health workers</p>	<ul style="list-style-type: none"> • Ensure that documented and undocumented persons have access to health services • Establish referral networks that cross national borders so that transiting sex workers can access STI/HIV services in safe spaces from competent providers • Strengthen and expand peer support programs and initiatives for sex workers
<p>Engage in outreach specifically aimed at male and transgender sex workers</p>	<ul style="list-style-type: none"> • Sensitize and train government and NGO service providers in outreach for male and transgender sex workers • Establish peer support programs and initiatives for male and transgender sex workers
<p>Ensure access to supplies</p>	<ul style="list-style-type: none"> • Establish networks for ongoing distribution of male and female condoms and lubricants to sex workers • Negotiate with club owners and other intermediaries to establish condom use as the norm in establishments that accommodate sex work
<p>Establish collaborations among countries that share borders and countries that transport or host significant numbers of sex workers</p>	<ul style="list-style-type: none"> • Develop collaborative plans to protect migrant sex workers from exploitation and trafficking and ensure their access to services

Table 6

Prison inmates

Recommended action	Details
Initiate harm reduction efforts in prison settings to reduce sharing of needles and syringes	<ul style="list-style-type: none"> • Provide education, including peer education • Offer counseling services • Make pharmacological treatment (methadone, buprenorphine, etc.) available to reduce dependency on heroin and other opiates • Offer needle and syringe exchange programs and provide bleach to increase the safety of injection drug use
Prevent sexual transmission of HIV in prison	<ul style="list-style-type: none"> • Provide education, including peer education • Distribute condoms and water-based lubricants • Allow conjugal visits to accommodate the sexual needs of prison inmates, reinforce their social and emotional links with their partners and families, and help with their reintegration into society after their release
Provide comprehensive health services, including tuberculosis, hepatitis, and HIV/STI screening and treatment	<ul style="list-style-type: none"> • Establish comprehensive health care programs in prisons that are equivalent to services in the community, in line with international human rights declarations • Ensure proper diet and nutrition for HIV-positive inmates who are undergoing antiretroviral therapy
Ensure continuity of care after discharge	<ul style="list-style-type: none"> • Establish protocols and referral systems to ensure that discharged inmates have continued access to antiretroviral therapy and medical care • Provide inmates with social service cards for free medical care for a defined period (e.g., 4 to 6 months), with provision for renewal should they remain unemployed
Build the capacity of prison staff	<ul style="list-style-type: none"> • Train prison staff on HIV, drug use, and other relevant issues to increase their understanding and appropriate management of issues related to sexuality, HIV transmission, and drug use
Offer inmate orientation and training	<ul style="list-style-type: none"> • Provide all new inmates with information on HIV, drug use, and other relevant issues to increase their capacity to safely navigate the prison environment • Train inmates as peer educators

IV. PRIORITY ACTION

Prison inmates

Table 6 (Cont.)

Recommended action	Details
Institute prerelease programs	<ul style="list-style-type: none"> • Develop and implement orientation and information programs for inmates who are about to be released to enable a smooth transition and reintegration into society • Allow NGOs and CBOs to work in prisons to create links between prison health services and community health services, which will facilitate transition and reintegration
Provide alternatives to prison for drug users	<ul style="list-style-type: none"> • Offer alternative sentences for persons who are in the prison system for drug use, including drug courts and community sentencing • Expand treatment and harm reduction programs for drug-dependent persons

Drug users

Table 7

Recommended action	Details
Implement harm reduction as an overarching strategy to reduce the adverse health, social, and economic consequences of the use of legal and illegal psychoactive drugs	<ul style="list-style-type: none"> • Provide education, including peer education • Offer counseling services • Make pharmacological treatment (methadone, buprenorphine, etc.) available to reduce dependency on heroin • Offer needle and syringe exchange programs and provide bleach to increase safety of injection drug use
Link/integrate harm reduction and drug dependency reduction programs with the health system and HIV/STI programs and services	<ul style="list-style-type: none"> • Design and implement harm reduction interventions through an integrated and primary health care approach • Build the capacity of service providers in case management • Deploy peer and outreach workers to reach drug users not reached through regular primary health care services
Implement drop-in and halfway centers	<ul style="list-style-type: none"> • Establish low-threshold drop-in and halfway centers for drug users, particularly drug users with long-term and short-term housing problems

Table 8

Most-at-risk young persons

Recommended action	Details
Increase access to health and support services	<ul style="list-style-type: none"> • Institute legislative and policy reform to promote and protect access of young persons to health services, including sexual/reproductive health services • Strengthen and expand targeted programs to reach vulnerable young persons with information, condoms, and skill-building programs that promote safer sexual practices
Promote and support youth participation	<ul style="list-style-type: none"> • Develop and implement strategies to engage vulnerable and at-risk young persons in the discourse around development of services and programs • Strengthen network and organizations of young persons • Train young persons as peer educators and peer counselors so that they can reach other young people
Ensure that every program or intervention targeting MARPs includes specific provisions for young persons	<ul style="list-style-type: none"> • Build the capacity of service providers and program managers to increase their understanding of the issues faced by young persons and to develop appropriate actions to provide services for this group
Provide comprehensive sexuality education for in-school and out-of-school youth	<ul style="list-style-type: none"> • Strengthen the sexuality component of health and family life education, including sexual diversity and anti-stigma education • Strengthen the sexuality component of curricula in vocational and informal educational outreach initiatives targeting vulnerable youth

Table 9

Migrants

Recommended action	Details
Increase access to services	<ul style="list-style-type: none"> • Develop regional and country-level modalities to ensure that all persons have access to affordable basic health services • Train health workers to increase their understanding of and capacity to provide adequate services for members of cultural minority groups

IV. PRIORITY ACTION

IMPLEMENTING THE CONSENSUS MEETING RECOMMENDATIONS

V

The meeting participants agreed that implementation of the consensus recommendations will require concerted and sustained efforts from all regional and country-level stakeholders. Key roles have been assigned to PANCAP, CVC, and UN partners. Prior to the Consensus Meeting, a Technical Working Group was established consisting of PAHO, UNFPA, UNDP, UNAIDS, CVC, and PANCAP. This working group coordinated the Consensus Meeting and facilitated the preparation of this report. It is anticipated that the working group will continue to serve as a coordinating and facilitating entity for the implementation of the consensus recommendations presented in this report.

PANCAP

In 2004, UNAIDS highlighted PANCAP as an international best practice. PANCAP coordinates the regional HIV response through a regional strategic framework and a regional coordinating mechanism based at CARICOM. The 2008–2012 Caribbean Regional Strategic Framework on HIV and AIDS identifies a stronger focus on vulnerable and high-risk groups as a critical condition to reduce the number of new infections and achieve universal access to HIV prevention, treatment, and care.

Implementation of the consensus recommendations will require the fostering of an enabling environment and removal of legislative and political barriers to provision of services for men who have sex with men, sex workers, prison inmates, young persons, and migrants. Building on the existing PANCAP and CARICOM mechanisms, including CARICOM's Council for Human and Social Development (COHSOD), the Regional Coordinating Mechanism, and collaborations with development partners, PANCAP can contribute to increased awareness, commitment, and reform through strategic and ongoing advocacy, political leadership, and support for actions aimed at reduction of stigma and discrimination and development of policies, programs, and legislation that promote human rights.

In addition, PANCAP is strategically placed to spearhead resource mobilization efforts with the Global Fund and other donors, which will generate funds in support of regional and country-level efforts to increase the access of vulnerable and high-risk populations to HIV health services.

CVC

The primary objectives of CVC are:

- To address and promote national and regional responses to the human rights challenges involved in reducing the spread of HIV among vulnerable populations
- To provide support for members and partners of CVC in facilitating access to stigma- and discrimination-free care and treatment for people from vulnerable populations living with HIV and AIDS
- To facilitate the prevention of HIV transmission among vulnerable populations represented by CVC

CVC pursues these objectives through a variety of regional and country-level actions, guided by a strategy that aims to:

- Strengthen functional partnerships between NGOs and CBOs that provide health services for marginalized groups
- Foster partnerships between national health authorities, civil society organizations, and the private sector to improve health care delivery for marginalized groups
- Build a learning community comprising government authorities, NGOs, CBOs, the private sector, unilateral and bilateral agencies, and all other individuals and groups involved in service provision for marginalized groups

A key feature of CVC's approach is the strengthening of NGOs and CBOs involved in service delivery for marginalized groups. This civil society systems strengthening model is not aimed at removing the obligation and responsibility of the national health authorities to provide services for all, including marginalized groups; rather, it recognizes that governments may lack the expertise to work effectively with these groups. The approach includes strengthening of local organizations and fostering of community-based referral systems within and between countries. These models have been piloted in Antigua, Trinidad and Tobago, and the Dominican Republic, and the results have demonstrated that this approach constitutes a relatively inexpensive and highly effective strategy to rapidly increase access of marginalized groups to basic medical and social services. Elements of this strategy include establishment of a directory of services and development of client referral and tracking procedures. Through this strategy, CVC also seeks to safeguard the vital advocacy and rights-watch role of grassroots organizations, ensuring that this role is appropriately managed and adequately supported.

UN PARTNERS

As the regional office of the World Health Organization for the Americas, PAHO has a mandate to provide technical cooperation to the countries of the region to improve survival, health, and wellness among the populations of its member states. Within this context, the PAHO HIV Caribbean Office, based in Trinidad, took the initiative for organization of the Consensus Meeting, aimed at improving the access of most-at-risk and vulnerable populations to HIV prevention, treatment, and care services. The meeting was organized in close collaboration with UNDP, UNFPA, UNICEF, and UNAIDS, which have key assigned responsibilities related to specific populations as per the agreed-upon UN task division. Jointly, the UN partners are committed to supporting implementation of the consensus recommendations.



PUERTO RICO

Digicel

ITALIA



Knutsford

PHARMACY

Serving you better personally

Shop #14101 Centre TEL: 920-2701, Fax: 920-2000

REFERENCES

1. UNAIDS. Report on the Global AIDS Epidemic 2010. Geneva; 2010. http://www.unaids.org/globalreport/global_report.htm
2. Pan Caribbean Partnership against HIV/AIDS. Caribbean Regional Strategic Framework on HIV and AIDS 2008-2012. CARICOM; 2008. <http://www.pancap.org/docs/CRSF%20%20FINAL%20EDITED%2024%2009%2008.pdf>
3. UNAIDS. Expanding the Global Response to HIV/AIDS Through Focused Action: Reducing Risk and Vulnerability; Definitions, Rationale and Pathways. Geneva; 1998. http://data.unaids.org/Publications/IRC-pub01/jc171-expglo-bresp_en.pdf
4. De Groulard, M., et al. . Homosexual aspects of the HIV/AIDS epidemic in the Caribbean, a public health challenge for prevention and control. International AIDS Conference 2000. [Abstract Th0rD732].
5. Padilla, M. Caribbean Pleasure Industry: Tourism, Sexuality and AIDS in the Dominican Republic. Chicago: University of Chicago Press; 2007.
6. UNAIDS. Keeping Score II: A progress report towards Universal Access to HIV Prevention, Treatment, Care and Support in the Caribbean. UNAIDS Caribbean Regional Support Team; 2008. http://data.unaids.org/pub/Report/2008/20081206_keepingcoreii_en.pdf
7. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders (DSM-IC)-TR. Washington, DC; 2000. <http://www.minddisorders.com/Del-Fi/Diagnostic-and-Statistical-Manual-of-Mental-Disorders.html>
8. Kelly, D.P. Estimation of the prevalence of transsexualism in the UK; 2001. <http://ai.eecs.umich.edu/people/conway/TS/UK-TSprevalence.html>
9. Olyslager, F.,Conway, L. On the calculation of the prevalence of transsexualism. Presented at the WPATH 20th International Symposium, Chicago, Illinois; 2007.
10. Pérez Uribe, R. Cuentas Nacionales en VIH/SIDA, Estimación de Flujos de financiamiento y gasto en VIH/SIDA; 1999.
11. Rodriguez-Madera, S., Toro-Alfonso, J. Gender as an obstacle in HIV/AIDS prevention: considerations for the development of HIV/AIDS prevention efforts for male-to-female transgenders. International Journal of Transgenderism 2005,8(2/3), 113–122.
12. Calleja, J.M., et al. Status of the HIV/AIDS epidemic and methods to monitor it in the Latin American and Caribbean region. AIDS 2002, 16(3), S3–S12.
13. Caribbean Epidemiology Centre. CAREC Annual Report 2000. <http://new.paho.org/carec/dmdocuments/ar2000.pdf>.
14. Caribbean Epidemiology Centre. CAREC Annual Report 2001. <http://new.paho.org/carec/dmdocuments/annualreport2001.pdf>.
15. Caribbean Epidemiology Centre. CAREC Annual Report 2003. http://new.paho.org/carec/dmdocuments/carec_annual_report_2003.pdf.

16. Caribbean Epidemiology Centre. CAREC Annual Report 2004. <http://new.paho.org/carec/dmdocuments/2004annualreport.pdf>.
17. Caribbean Epidemiology Centre. CAREC Annual Report 2005. Rep. <http://www.carec.net/documents/2005-CAREC-Annual-Report.pdf>.
18. Caribbean Epidemiology Centre. CAREC Annual Report 2005. <http://www.carec.net/documents/2005-CAREC-Annual-Report.pdf>.
19. Caribbean Epidemiology Centre. CAREC Annual Report 2006. <http://new.paho.org/carec/dmdocuments/annualreport2006.pdf>.
20. Caribbean Epidemiology Centre. CAREC Annual Report 2007. Rep. http://new.paho.org/carec/dmdocuments/ANNUAL_REPORT_2007.pdf.
21. Caribbean Epidemiology Centre. CAREC Annual Report 2008. Rep. http://new.paho.org/carec/dmdocuments/ANNUAL_REPORT_2008.pdf.
22. Edlin, B.R., et al. Intersecting epidemics: crack cocaine use and HIV infection among inner-city young adults. *New England Journal of Medicine* 1994, 331, 1422–1427.
23. Castilla, J., et al. Drug and alcohol consumption and sexual risk behavior among young adults: results from a national survey. *Drug and Alcohol Dependence* 1999, 56, 47–53.
24. Cleghorn, F.R., et al. HIV-1 prevalence and risk factors among sexually transmitted disease clinic attendants in Trinidad. *AIDS* 1991, 9, 389–394.
25. Reid, S.D. HIV seroprevalence and risk factors in female substance abusers seeking rehabilitation in Trinidad and Tobago. *West Indian Medical Journal* 2004, 53, 155–158.
26. Hutchinson, G.A., & Simeon, D.T. HIV infection rates and associated factors in high risk patients admitted to a psychiatric hospital in Trinidad and Tobago. *West Indian Medical Journal* 1999, 48, 129–131.
27. Gomez, M.P., et al. Epidemic crack cocaine use linked with epidemics of genital ulcer disease and heterosexual HIV infection in the Bahamas: evidence of impact of prevention and control measures. *Sexually Transmitted Diseases* 2002, 29, 259–264.
28. Gomez, M.P., et al. Characteristics of HIV-infected women in the Bahamas. *Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology* 1996, 12, 400–405.
29. Persaud, N.E., et al. Drug use and syphilis: co-factors for HIV transmission among commercial sex workers in Guyana. *West Indian Medical Journal* 1999, 48, 52–56.
30. Stabroek News Guyana, February 13, 2007 (full report not available).
31. Day, M., & Norman, L. Non-injecting crack cocaine use and HIV risk in Castries, St. Lucia. Presented at the NIDA International Forum, San Juan, Puerto Rico; 2008.

REFERENCES

32. Caballero Vaillant, T. . Resultados primera Encuesta de Vigilancia de Comportamiento con Vinculacion Serologica en GTH/TRSX/UD. Santo Domingo. Presented at the COPRESIDA meeting 2009.
33. De La Haye, W., et al.. HIV sero-prevalence and pattern of substance misuse in clients admitted for substance use treatment in a general hospital in Jamaica. *West Indian Medical Journal* 2005, 53(5):35.
34. Surrat, H.L., et al.. Emerging linkages between substance abuse and HIV infection in St. Croix, United States Virgin Islands. *AIDS Care* 2005;17(1), 26–35.
35. Kempadoo, K, Kempadoo, O., Perkins A, Taitt, A. Sex Work and the CARICOM Sex Industry; Research Report, Draft. Prepared for UNAIDS Caribbean Regional Support Team; 2010.
36. Brodwin, P. Marginality and cultural intimacy in a transnational Haitian community. Occasional paper 91. Milwaukee, WI: Department of Anthropology, University of Wisconsin-Milwaukee; 2001.
37. Ferguson, J. Migration in the Caribbean: Haiti, the Dominican Republic and Beyond. London: Minority Rights Group International; 2003.
38. Economic Commission for Latin America and the Caribbean. . Latin America and the Caribbean in the World Economy 2009–2010. Santiago, Chile;2009.
39. Kalra, G., & Bhugra, D. . Migration and sexuality. *International Journal of Culture and Mental Health* 2010, 3, 117–125.
40. Makadon, H., et al. Optimizing primary care for men who have sex with men. *Journal of the American Medical Association* 2006, 296, 2362–2365.
41. Waters, J. Background Paper Regarding Access to health services by Men Who have Sex with Men, Transgender Persons, and Sex Workers in the Caribbean. Prepared for the PAHO HIV Caribbean Office; 2009.
42. Smith, K, & Lorens, H.. Renaissance and decay: a comparison of socioeconomic indicators in pre-Castro and current-day Cuba; 1998.
43. Harvard Public Health Review 2002. The Cuban paradox. [http://www.hsph.harvard.edu/review/review summer 02/txt677cuba.html](http://www.hsph.harvard.edu/review/review%20summer02/txt677cuba.html)
44. Waters, J., et al. Transgenderism and Transforming Healthcare: A Look at the Needs of the Transgender Community in Santo Domingo. Santo Domingo: COIN; 1990.
45. Day, M., et al. A Comparison of Primary Health Care Needs of Street, Out-of-Treatment Drug Using Individuals in Three Caribbean Islands. Castries: Caribbean Drug Abuse Research Institute; 2005.
46. International Centre for Prison Studies. World prison brief 2009. <http://www.kcl.ac.uk/depsta/law/research/icps/worldbrief>.





**Improving Access
of Key Populations
to Comprehensive
HIV Health Services
Towards a
Caribbean Consensus**



**Pan American
Health
Organization**



*Regional Office of the
World Health Organization*



9 789275 116531