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CENTRO DE ORIENTACION E INVESTIGACION INTEGRAL, INC.
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Caribbean Vulnerable Communities Coalition

PANCAP

The CVC/COIN Vulnerabilised Groups Project
Focus Right, Focus Rights

Real Youth:
HIV and Marginalized Youth Programmes in the Caribbean - Effective Models and Opportunities for Scale Up

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The Caribbean Vulnerabilised Groups Project is a five-year regional project which responds to HIV and AIDS among Caribbean sex workers, men who have sex with men, socially excluded youth, and people who use drugs.

The Caribbean Vulnerable Communities Coalition (CVC) and El Centro de Orientación e Investigación Integral (COIN) have come together to implement the project as sub-recipients of a Pan Caribbean Partnership against HIV and AIDS (PANCAP) Grant provided by the Global Fund to Fight AIDS, Tuberculosis and Malaria.

For more information, please visit our website at www.focusright.org

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Acronyms and abbreviations

CVC	Caribbean Vulnerable Communities Coalition
COIN	Centre for Integrated Training and Research
FGD	Focus Group Discussion
GIZ	German Agency for International Development
HIV	Human Immunodeficiency Virus
IDU	Injecting Drug User
IEC	Information Education Communication
JASL	Jamaica AIDS Support for Life
MSM	Men having sex with Men
SH	Sexual Health
SRH	Sexual and Reproductive Health
STI	Sexually transmitted infection
SW	Sex Worker
YMSM	Young men having sex with men

1. Introduction

1.1 Rationale for the Project

The Caribbean Vulnerable Communities Coalition (CVC) and the Centre for Integrated Training and Research (COIN) commissioned this study to review promising models of HIV interventions for marginalized youth and recommend programming and strategies to replicate in the Caribbean.

CVC/COIN defines marginalized youth as:

- Youth involved in gangs
- Youth using drugs
- Youth selling sex
- Youth living with HIV
- LGBT youth

Efforts to address vulnerability among these populations of young people are in fledgling stages in the Caribbean. This is due in large part to the fact that governments and policy makers were slow to recognize the reality that epidemics in the Caribbean are concentrated among populations whose work, behaviours, or lifestyles are criminalized. Because of public pressure, National AIDS Programmes in the region now, for the most part, disaggregate data by at-risk populations. However, they do not disaggregate data on the basis of youth and risk behaviour. Therefore, while we have evidence that youth account for the highest number of new infections, we have almost no evidence about which youth populations are driving the transmission of the virus.

Typically, development and health efforts in the region approach youth as a homogenous population facing issues of poverty, unemployment, early sexual debut, and risk of HIV and STIs. Programmes are not tailored to the specific needs of the sub-populations of youth listed above.

CVC/COIN's efforts to address the HIV-related needs of marginalized youth, and to pressure governments and regional bodies to recognize the human rights-related barriers that fuel the epidemic in youth, is in keeping with its mission to empower community-based organisations to challenge structural drivers of the HIV such as gender inequality, homophobia, transphobia, and the criminalisation of vulnerable populations. It also complements other projects currently underway by CVC/COIN to scale up health and rights programming for men who have sex with men (MSM), transgender people, migrants, and prisoners using models and innovations developed by members of these communities in partnership with government, the UN family, and the private sector.

1.2 Project methodology

The reviews of youth programme models that follow are meant to help CVC/COIN:

- Identify areas of greatest need in terms of prevalence, lack of awareness of HIV risk among youth, and potential for effective future programme planning.
- Identify additional local health providers and NGOs offering services to the target communities that may be interested in linkages and collaboration with their Marginalized Youth project.
- Propose appropriate programmatic strategies to scale-up programmes serving, and led by, marginalized youth.

Project activities included:

- A global literature review drawing out best practices in programming for marginalized youth.
- A review of CVC documents on regional interventions with marginalized youth including grant proposals, best practice analyses, and rapid situational and qualitative analyses conducted in 2011 and 2012.
- A limited study of the range of HIV services for youth provided by government and non-governmental entities in Jamaica.

These activities revealed glaring gaps in research on effective HIV prevention, care, and support programmes for marginalized youth in the region. These gaps, combined with lack disaggregated data on sub-populations of youth, and the limited scale of interventions, has meant that it is very difficult to measure the impact of models that attempt to reach marginalized youth. It also makes strikingly clear the need for the kind of research and programming that CVC/COIN has undertaken with support from PANCAP and the Global Fund to fight AIDS, TB, and Malaria.

1.3 Summary of Effective Models of HIV Interventions for Marginalized Youth in the Caribbean

Below is a summary of the types of HIV interventions for marginalized youth that may be considered for scale up throughout the region (discussed in-depth in Section 5):

Peer education programs: Identifying and training emerging leaders among marginalized youth to use culturally appropriate communication methods (art, music, theatre) to convey HIV information, distribute prevention commodities, and refer young people to services.

Youth-led networks: Networks comprised of marginalized youth who are affected by HIV/AIDS and are committed to being part of the response to the epidemic. This includes youth who work or volunteer with CBOs from different sub-populations (drug users, young people selling sex, LGBT youth) and HIV positive youth.

Safe spaces: Community spaces for marginalized youth to come together in regular meetings to engage in self-esteem building, discuss issues of common concern such as the effects of stigma and discrimination, and collaboratively strategise on how to improve outreach and service provision to their communities.

Targeted behaviour change communication (BCC): HIV messaging for marginalized youth who may or may not identify themselves as vulnerable to HIV infection, channelled through hotlines, web sites, social networking, and community events.

Youth engagement in policy and advocacy: Opportunities for marginalized youth to inform local, national, and regional policy developments that impact their reproductive health and human rights and share innovations in youth-led HIV programming occurring in local communities for support and scale up.

Youth-friendly services: NGO/CBO –run programmes, clinics, and mobile facilities that serve marginalized youth in a non-stigmatising manner and that include health education programmes and other efforts to maintain the engagement of young people in care and prevention services and activities.

Entrepreneurship, skills development, and employment training programmes: A range of training and skills building programmes to help marginalized youth seek alternative pathways than the ones that led them to increased HIV risk (drug use, transactional sex, unprotected sex).

Mentorship Programmes: Programmes in which caring adults mentor marginalized youth in community centres, clinics, or other safe spaces.

Psycho-social support: Programmes that address trauma associated gang violence, sexual violence, and the loss of family members to violence and HIV/AIDS.

2. HIV among Young People: A Global Snapshot

Globally, young people, 15 to 24 years old, accounted for 40% of all new HIV infections among adults in 2009 with approximately 3000 young people becoming infected with HIV each day (WHO). Of the 11.8 million HIV-infected youth worldwide, over seven million

are female and less than one-third of them know how to protect themselves from HIV (UNFPA).

Young people from vulnerable populations, especially in regions with concentrated epidemics, are disproportionately affected. For instance, evidence indicates that 95% of all new HIV infections in young people in Asia-Pacific are among young people from key affected populations; young people who buy and sell sex, young men who have sex with men, young transgender persons, and adolescent drug users (UNAIDS 2012).

Young people from marginalized populations face the same stigma and discrimination as their adult counterparts, but often lack the support of parents or caregivers who share the same negative attitudes as the wider community. Governments, many of them still reluctant to name and address the impact of HIV on vulnerable populations of adults, are even less likely to do so when it comes to young people. The UN Political Declaration on AIDS, issued by Member States in 2011, is seen to be somewhat progressive when it comes to human rights. The Declaration does mention laws and policies that exclude young people from accessing HIV services. But it fails to mention what those laws are and what populations of young people they affect, rendering it a weak advocacy tool when it comes to holding governments accountable to providing services for marginalized youth.

The UN 2011 Political Declaration on AIDS

*[Member States]*Express grave concern that young people aged 15 to 24 account for more than one third of all new HIV infections, with some 3000 young people becoming infected with HIV each day; note that most young people still have limited access to good quality education, decent employment, and recreational facilities, as well as limited access to sexual and reproductive health programmes that provide the information, skills, services and commodities they need to protect themselves; that only 34% of young people possess accurate knowledge of HIV; and that laws and policies in some instances exclude young people from accessing sexual healthcare and HIV-related services such as voluntary and confidential HIV-testing, counselling and age-appropriate sex and HIV prevention education; while also recognising the importance of reducing risk taking behaviour and encouraging responsible sexual behaviour, including abstinence, fidelity and correct and consistent use of condoms (Paragraph 25).

3. HIV and Marginalized Youth in the Caribbean: Regional Challenges and Gaps

It is known, however, that seventy percent of people living with AIDS in the Caribbean are individuals between the ages of 15 and 44, and half of these are between the ages of

25 and 34. It is estimated that most infections occur when individuals are in their teens and early twenties, underscoring the need for youth-focused education and treatment programming (One Blood: Youth & HIV in the Caribbean and Caribbean Diaspora in Canada, International Coalition on AIDS and Development, 2011).

Until recently, largely because of stigma and discrimination against vulnerable populations, Caribbean states persisted in ignoring evidence and characterised regional epidemics as generalised, rather than concentrated among high-risk populations. As a result, an effective response to the spread of the virus among these populations has been lacking, including among marginalized youth.

Girls are also especially vulnerable to HIV in the region. As UNAIDS details in its AIDS in the Caribbean report from 2010: "Existing gender and cultural norms feed into an ideology that privileges feminine abstinence, virginity and respectability and cements unequal power relations. These norms undermine resilience and safe sexual and relationship decision-making. Well established patterns include early sexual debut among both boys and girls – historically normative, but now reinforced by peer pressure and media promotion of a "bashment and bling" subculture of youth centred on sexual identity, sexual expression and sexual performance."

Regional HIV and Youth Programs are getting the Message out:
But are they reaching marginalized youth?

Red Cross Caribbean's **Together We Can** program, funded by a grant from the President's Emergency Plan for AIDS Relief (PEPFAR) uses a peer-to-peer approach "tailored to cultural sensibilities." Red Cross facilitators and Ministries of Health staff members recruit and train the youth who are between the ages of 13 and 19. Emphasis is placed on helping peer educators develop the skills necessary to conduct dynamic peer education activities-such as role-playing and practicing responses to peer pressure-with a non-judgmental approach. The programme is said to have reached tens of thousands of young people in the region (Red Cross 2012).

Population Services International has established the "**Got it? Get it."** (GIGI) brand. GIGI Is not brand of condom, but rather a brand of behaviour change messaging about youth sexuality across the Caribbean. Its website, social networking and community events are meant to speak to Caribbean youth in their own language about sex and vulnerability to HIV with a central message that HIV should never be a source of shame.

The Live Up Campaign of Caribbean Broadcast Media Partnership on HIV/AIDS (CBMP) is a coalition of more than 92 leading television and radio broadcasters representing

over 24 islands. Its celebrity-driven campaigns running on television, radio, and on-line, "seek to inspire and empower people across the region, especially youth, to help stem the spread of the disease and reduce stigma and discrimination against people living with HIV/AIDS." (CBMP website)

The imagery and language about tolerance, acceptance, and "one love" used in these campaigns may compel marginalized youth to access information about HIV. Yet linkages to concerted prevention and care programs tailored to their specific needs are not clearly defined. The low levels of knowledge about HIV prevention documented by CVC/COIN and others suggest that these massive awareness programmes are having limited impact on marginalized youth.

3.1. Lack of Knowledge about HIV

With funding from the Global Fund to Fight AIDS, TB and Malaria via PANCAP, CVC/COIN has been carrying out a series of qualitative analyses of knowledge levels about HIV/AIDS among marginalized youth. The results illustrate that there is still significant prevention work to be done among young people in the region. The examples below provide a picture of the gaps in HIV knowledge among marginalized youth in Trinidad and Tobago, Jamaica, and the Dominican Republic.

- Condom use is not consistent among marginalized youth and even young people living with HIV do not use condoms with all their partners. (Jamaica)
- Young people believe that voluntary counseling and testing is a means of prevention, relieving them of the need to use condoms post-test. (Jamaica)
- Exposure to messages about human rights and gender violence has not penetrated populations of marginalized youth. (Trinidad and Tobago)
- Mosquito bites, use of toilets and public swimming pools, kissing, and oral sex are all thought to transmit HIV. (Trinidad and Tobago)
- Young people do not think condoms are effective, especially the ones that are available cost-free. (Trinidad and Tobago)
- The use of two condoms at the same time is understood as the best protection from HIV. (Trinidad and Tobago)

A survey of "youth on the block" by PSI in 2001 in St. Vincent and the Grenadines showed that 81% of young men reported condom use with casual partners. Yet only 9% of them could put a condom on a dildo properly. (PSI 2010)

The qualitative study also shows that in Jamaica and the Dominican Republic, youth involved in gangs and transactional sex were among the groups that showed the least

knowledge about HIV. In all three countries, young people living with HIV had the highest levels of knowledge about how the disease is transmitted, but observed that their peers are largely ignorant.

3.2 Uneven Access to Services

HIV prevention must be linked to services if the region is going to play its role in the global effort to realise the promise of treatment as prevention and reach universal access goals. Qualitative data gathered by CVC/COIN shows that access to services for marginalized youth in Trinidad and Tobago range from bad to satisfactory. These populations prefer private providers to government services because the lines are shorter, the services are better, confidentiality is respected, and follow up services are easier to secure.

The findings of this research also show that young people across the spectrum of populations received pre-but not post-test counselling, indicating a serious flaw in health systems when it comes to retaining youth-at-risk in care. Finally, HIV positive young people had the greatest knowledge of where to access clinical care, but reported discrimination by health workers.

3.3 Violence

A 2007 World Bank study of 102 countries showed that the Caribbean region has the highest incidence of rape (Baird 2007). Further, violence against MSM and transgender people has been documented extensively in a nine-country study by the Caribbean Epidemiology Centre (CAREC) in 2000. Other recent reports from Human Rights Watch and CVC have added to the evidence base on violence against members of these two communities. Young women and LGBT youth are well represented in all of these unsettling statistics.

Youth and Violence in Jamaica

- Physical and sexual abuse affects roughly 1 in 10 Jamaican youth.
- In a 2001 study of 1,004 12-16 year olds in Clarendon, 20 percent reported carrying at least one weapon and nine percent reported being threatened or injured with a weapon at school in the 12 months prior to the survey.
- In the same study, 12 percent of boys and 10 percent of girls reported that they had been physically abused by their partners.
- Furthermore, approximately 11 percent of respondents reported having been threatened or harassed to have sex by friends (44 percent), neighbours (17 percent), relatives (16 percent), and family friends (13 percent).

- According to the Jamaica Reproductive Health Survey, approximately 20.4 percent of young women 15-19 years old report having been forced to have sexual intercourse at some point during their life. Overall, one-fifth of Jamaican women have experienced forced sexual intercourse. (Advocates for Youth: www.advocatesforyouth.org/publications/434?task=view)

Preliminary data from the CVC/COIN qualitative surveys show that relatively high numbers of youth regularly experience forced sex or threats of violence, particularly youth involved in transactional sex and LGBT youth.

3.4 Lack of enabling legal and policy environments

Laws that prohibit young people under 18 from accessing HIV testing or health services without parental consent are a major barrier to reaching marginalized youth at risk for infection. Few young people want their parents to know they are having sex or doing drugs and need an HIV test, especially if the sex was transactional or with a member of the same sex. In Jamaica, the legal age of consent for medical procedures is 16. However, the National HIV/AIDS Policy (2005) commits to expanding key services, such as voluntary counselling and testing and antiretroviral therapy, to those under 16 years (UNFPA).

Further, LGBT community are marginalized by outdated, rights-violating laws against sodomy and "gross indecency" that are still in force on most Caribbean islands. For example, in Trinidad and Tobago and St Lucia all acts of same-sex activities are illegal, while the Guyanese and Jamaica laws forbid MSM relations but are silent on same-sex relations between women. These kinds of laws drive LGBT youth underground and away from HIV prevention and care services.

The Jamaican National Youth Policy

Jamaica's National Youth Policy emphasises the participation of young people in decision-making and enhances stakeholders' capacity to increase accessible, relevant and high quality services. The policy identifies priority groups, such as girls at risk of early pregnancy and those living with HIV, and promotes gender equity and transforming norms of masculinity and femininity. It also aims to create a supportive policy environment, for example by reviewing the age of consent for sexual intercourse, marriage and accessing health services. (Ministry of Education, Government of Jamaica, June 2005)

3.5 High rates of transactional sex

Studies out of Trinidad and Tobago and Jamaica that were originally designed to explore cross generational transactional sex revealed that in the minds of young women, sex and money are inextricably linked. In fact, sex without financial gain or security is seen in some cases by this population to be non-normative. This trend has enormous implications for HIV risk since the studies document that many young women are involved in a complex web of concurrent sexual relationships and demonstrate little concern about HIV risk and inconsistent condom use. (Options Consultancy Services and PSI, 2007). The scale of this problem, the blurred boundary between transactional sex and sex work, and the fact that very little is known about HIV rates among people engaged in transactional sex collectively, present a major challenge for estimating HIV prevalence among sex workers and developing effective interventions.

CVC/COIN's qualitative study with marginalized youth in Jamaica documented young men who claim to have 100-200 sexual partners, both women and men, from whom they receive cash and gifts in kind. Aside from this research, very little is known about the impact of transactional sex among MSM on HIV transmission trends in the region.

3.6 Drug use

Injecting drug use plays a minimal role in the epidemics of most countries in the Caribbean, with the exception are Bermuda, Puerto Rico and the Dominican Republic. (Cohen 2006). However, numerous studies have documented an association between HIV risk and crack and cocaine use. Djumalieva (2002), Aceijas (2004). The relatively low impact of injecting drug users on HIV rates in the region has meant that non-injecting drug users, among them youth, have been left out of HIV interventions and have very low knowledge levels about HIV risk. For instance, 67% of the young drug users interviewed by CVC/COIN for their qualitative and quantitative analyses were unaware that HIV could be spread through sharing needles and 70% reported that they had difficulty negotiating condom use.

4. Findings of the Literature Review: Six Models of Youth Programming Employed Globally

As mentioned above, there is a paucity of literature on best practices for reaching marginalized youth in the Caribbean. This is true of all youth interventions, not just those addressing HIV.

The literature suggests six models for working with youth, several of which are inappropriate to address the situation of marginalized youth in the Caribbean:

The Treatment Model: A popular example of this model is the Public Health Prevention model. This model defines young people as deviant, mad or deficient. They present a social threat to the community. Young people must be treated or made to conform to societal norms to become productive members of society and if this is unsuccessful, action should be taken to protect society. The model assumes that all members of society agree on acceptable standards of behaviour. The values that underpin this model are social conformity, distinctions between class structures and self-improvement through competition. Social justice issues are not addressed in this model.

The Reform Model: This model defines young people as being socially disadvantaged by their environment and upbringing. This in turn may make them social outcasts and cause them to inflict violent behaviour on themselves or others. This model maintains that the values of society are acceptable and desirable but that some minor changes (reforms) may be necessary to improve conditions for disadvantaged groups. Supporters of this model believe that socio-environmental conditions affect people differently and individual coping skills will vary. Society will offer help to those who attempt to help themselves.

The Advocacy Model (Radical): The Radical Advocacy Model defines young people as being marginalized by current society through inadequate basic rights or social protection. Young people are ill informed as to their rights and how to access them. Society is viewed under this model as fundamentally unjust in its laws and bureaucracy.

The Advocacy (Non-Radical): In this model the young person is defined as having problems because they are ignorant of their rights. Furthermore, bureaucratic barriers prevent their access to knowledge and information. Society is viewed in this model as complex and bureaucratic in nature – either it cannot be changed or it is the task of others (besides the youth worker) to change it. The underpinning values of this non-radical advocacy model are based on the belief that equality is present for those who have existing equality of opportunity and access to it.

The Empowerment Model (Radical): This model contends that institutions, which operate to protect the privileged or powerful, systematically disempower young people. Youth are seen as only one group disempowered under this framework. The basic values of the model are that youth workers should help young people to address power imbalances in society without disempowering other disadvantaged groups. Youth workers should not act as advocates for young people but rather help them to obtain the skills to act on their own. The model also suggests that institutions, such as the media and education, are responsible for the belief that existing social hierarchical structures are natural. It focuses on oppression of marginalized groups and believes that the hierarchical structures create personal blame and apathy towards change.

The Empowerment Model (Non-Radical): This model holds that young people do not have enough control or power over their lives. Impacting on this is society's view that young people need to be protected from themselves and others. The core values framing the model are that young people need to be given more control over their lives and that they are capable of making independent decisions, providing adults allow them. It also states that empowerment can be achieved if the young person is assisted to become more powerful within whatever framework of values they individually choose. The sole motivation is to help young people gain control over their lives.

Although the literature highlights these six models for work with youth, it is important to accept that there is no single, conclusive model of youth work. In reality, different components can be taken from a range of models and incorporated into a combined model, depending on personal values, agency guidelines, or the client's issues. The literature suggests, for example, that the public health prevention model (a treatment model) may not be appropriate for addressing the HIV prevention needs of marginalized youth as defined by CVC.

Regardless of the model that is chosen, it is suggested that two conditions must be established if interventions for HIV prevention for marginalized youth are to be successful. One, the intervention should generate demand for and use of the service by the group of young people for whom the service is designed /intended, and two, there must be support for the demand.

The literature shows a range of alternatives and combinations of approaches to increase demand among youth for SRH services. These include school-based approaches, clinic-based, community-based, and peer to peer approaches. These approaches were found to be "under-developed" and the available studies do not provide strong evidence of their effectiveness. There is evidence, however, that where these approaches are part of a multi-component strategy, the outcomes may be more positive for youth. The suggestion, then, is that we move towards more large-scale, innovative, integrated, multifaceted research SRH interventions for youth (Save the Children, 2005; AYA, 2007). One of the major challenges of this recommended approach will be how to evaluate the impact of individual components on service use.

5. Promising Models and Strategies for HIV interventions among Marginalized Youth in the Region

Annex I documents a limited case study of Jamaica that was undertaken to identify government and NGO responses to HIV prevention for youth made vulnerable through incarceration, transactional sex, drug addiction (substance use), practice of same sex relations (MSM), and HIV status.

The strategies and models identified below are drawn from promising practices documented by COIN/CVC and desk research on the very limited additional documentation of HIV programmes for marginalized youth from across the region. In most cases, they are accompanied by justification of these approaches from the literature review.

One notable underlying element of all the featured models is that they employ the advocacy and empowerment strategies described in the previous section. They largely focus on community mobilisation approaches designed to empower youth to gain control over their sexuality and well being and to be knowledgeable about their rights. Most programmes and policies associated with the models were developed and implemented with the full participation of the targeted youth population.

Further, the successful youth programming featured below is informed by evidence that young adults, aged 15-24:

- Are the most sexually active and experimental age cohort, so the most likely to engage in behaviour that puts them at risk of HIV.
- May not belong to or identify as belonging to the marginalized populations named in this paper for long, but may join them for a period of time to experiment with their lifestyles.
- Are the age cohort least likely to believe they are at risk of HIV infection or to follow the advice o health authorities, adults, or anyone else about the potential consequences of high-risk behaviour. (GIZ, 2012)

This illustrates the need for flexible programming that responds to the dynamic lives of young people whose HIV risk factors are compounded by poverty, violence, stigma, and discrimination as a result of their marginalized positions in society.

Peer education programs: Identifying and training emerging leaders among marginalized youth to use culturally appropriate communication methods (art, music, theatre) to convey HIV information, distribute prevention commodities, and refer young people to services.

Model: Sexuality education through dynamic theatre productions

Ashe Performing Arts Company empowers youth to make their own decisions about living positively and playing a role in and creating a just environment within their communities through high quality musical theatre productions. Each performance engages young people to examine the issues raised in a non-threatening, entertaining manner through workshops, and other one-on-one support interventions and activities.

One example is “Safe Stupid or What!”, a musical presented in a talk show format in which high school students observe skits about young people in various scenarios related to their sexual and reproductive health and then are asked to discuss whether the protagonist in each skit had been “safe, stupid, or what?”

Youth-led networks: Networks comprised of marginalized youth who are affected by HIV/AIDS and are committed to being part of the response to the epidemic. This includes youth who work or volunteer with CBOs from different sub-populations (drug users, young people selling sex, migrants, LGBT youth) and HIV positive youth.

What the literature says: For effective results, community development interventions should promote interactions between individuals and their social networks to enhance social integration, social capital, and social inclusion. Networks of LGBT youth, youth who use drugs, youth selling sex, and youth living with HIV have the important role of empowering communities to promote an enabling environment. The network can work to address issues of human rights through alliances with public health, law and policy, and human rights communities. (Israel, 2008).

Model: Networking and service provision across youth populations to address common concerns

Youth in the Real World (YURWORLD) is a youth-led initiative to improve the participation of marginalized youth in the national HIV response in the Dominican Republic, influence funding flows for youth-focused HIV prevention, and scale up effective programming. It grew out of the Youth Ideas Café programme profiled below. Among YURWORLD programme’s are:

- A mobile unit providing services for **young drug users** including health counselling, testing for HIV and STIs, and onward referrals. YurWorld also sensitises staff at the selected care and treatment centres to which young people who use drugs are referred.

- Peer education, health and empowerment services for **young transgender women** including the social marketing of prevention commodities at lively events modelled after “tupperware parties”.

In the past the experience in the region has largely been one of CBOs working in an isolated and fragmented manner with a particular subgroup of youth. The YurWorld Model recognises and builds on the many common issues these populations share and

that can more effectively be addressed collectively. Social exclusion in effect becomes a common denominator creating solidarity and a common vision in young people who on the surface appear to share little in common (CVC/COIN 2011).

Safe spaces: Community spaces for marginalized youth to come together in regular meetings to engage in self-esteem building, discuss issues of common concern such as the effects of stigma and discrimination, and collaboratively strategise on how to improve outreach and service provision to their communities.

What the literature says: Youth centres are another intervention approach attempted and evaluated, in several places including Jamaica. The menu of services offered at Youth Centres varies. Where the Youth Centre offers sexual health education, use of life skills approaches for education is more effective than narrow didactic approaches (Pande et al. 2007; Blum, 1999). Where these youth centre programmes have been evaluated in terms of cost per output, in general, the high costs of maintaining these centres, compared to the costs of supporting outreach/peer promotion components of interventions, does not seem to be justified (Erulkar, 1997).

MODEL: Safe and sociable spaces to talk, learn, and strategise

The Ideas Youth Café in the Dominican Republic was conceived during a series of *tertulias* convened by GIZ, a community tradition of engaging the community in discussion and debate on an issue of common concern. The *tertulia*s attracted various youth networks including those representing young people living with HIV and young LGBT people. In response to their assertion that the place they felt most comfortable to discuss personal and sensitive issues was a back table at a café, these young people were supported to recreate that environment in a youth Centre/Café. Sessions at the café included discussions of issues such as: management of their HIV and STIs; positive and healthy sexual behaviours; self-esteem building; opportunities to participate in public actions to counter prejudice and discrimination; opportunities to learn skills to enhance employment opportunities.

Youth engagement in policy and advocacy: Opportunities for marginalized youth to inform local, national, and regional policy developments that impact their reproductive health and human rights and share innovations in youth-led HIV programming occurring in local communities for support and scale up.

MODEL: Youth campaigns for sexual and reproductive health and rights

The Jamaica Youth Advocacy Network (JYAN) is a youth-led initiative that works to develop leaders in the areas of advocacy, public education, and capacity building in relation to sexual and reproductive health, violence prevention, care and protection, employment and entrepreneurship, and education and training.

With the support of US-based advocacy organisation, Advocates for Youth, JYAN has launched the Jamaicans Safely Tackling Adolescent and Reproductive health Campaign (J-STAR.) The Campaign focuses on: 1) Educating policy makers on the importance of increasing family planning dollars to improve the reproductive health right of young people; 2) institutionalisation of youth participation in policy decision-making bodies relevant to SRH programme design, implementation and evaluation; 3) ensuring that Health and Family Life Education forms a comprehensive, integral part of the curricula in all Jamaican secondary schools; 4)Educating the media on the issues of HIV/AIDS and family planning; partnering with the media to raise awareness of the impact of stigma and discrimination on persons living with and affected by HIV/AIDS; 5) Calling for a referral system that would allow students attending universities to access referrals for sexual and reproductive health services off campuses.

Targeted behaviour change communication (BCC): HIV messaging for marginalized youth who may or may not identify themselves as vulnerable to HIV infection, channelled through hotlines, web sites, social networking, and community events.

What the literature says: Behaviour Change Communication (BCC) messages for socially vulnerable groups who may not identify themselves as vulnerable to HIV infection are better channelled anonymously. Hotlines, web sites, and large awareness-raising events, such as International AIDS Day are possible media. Besides the potential to reach the individual, some of these media will be effective ways to raise awareness and "desensitise" the larger society to behaviours that are not usually accepted (Israel et al, 2008). However, large awareness raising events are rarely to shown to have measurable outcomes when it comes to linking those sensitised to care. Therefore smaller interventions that are tailored to a particular marginalized youth community are preferable.

Model: Young people involved with gangs spread HIV prevention messages

Fondacion Red de Jovenes de Guatchupita was founded by gang members and other youth in one of Santo Domingo's poorest barrios. Its members use traditional and contemporary music, graffiti, and other creative ways of getting prevention messages

through to peers who would be less inclined to listen to any such messages coming from official sources. One of the associated groups, Los Pandemicos, created "Mr Super Condom", a super-hero cartoon character promoting safe sex and used in national prevention campaigns.

Youth-friendly services: NGO/CBO –run programmes, clinics, and mobile facilities that serve marginalized youth in a non-stigmatising manner and that include health education programmes and other efforts to maintain the engagement of young people in care and prevention services.

What the literature says: Ketterson & Cabral de Mello (2010) observe that the provision of youth-friendly services alone is not sufficient to meet the needs of the severely underserved population. These "supply side interventions" need to be combined with demand side activities to create a more supportive environment for adolescent care seeking and increased uptake of services, and governments need to work in partnership with civil society and community organisations to reach young people effectively. The evidence suggests that effectiveness is highly specific to the context and to particular details of intervention implementation and that interventions need to be carefully tailored to the needs and social and cultural circumstances (Askew, et al, 2003; Bhuiya et al, 2004; Diop et al, 2004; Vernon et al, 2004).

MODEL: Creative peer-led HIV education on drives demand for services in Trinidad and Tobago

Trinidad and Tobago's Rap Port Information and Outreach centres use music, dance and drama to impart concrete information about sexuality and sexual health to marginalized youth. The staff and volunteers, aged 19-30, are chosen as peer educators because of their HIV status and demonstrated leadership on HIV issues. They are trained in communications, counselling and HIV.

MODEL: Youth -friendly health care created by communities and supported by the Dominican government

Centro Salud Joven (CeSaJo), the youth health centre that grew out of the YurWorld Program (profiled above) provides friendly health services to marginalized and vulnerable youth. Originally housed and staffed by COIN, it has recently been licensed by DIGECITTS (a branch of the Ministry of Health as a primary health care clinic, and provided with staff, equipment and medicines. In addition to clinical services, the Centre refers patients to peer-led trainings for marginalized youth such as Haitian immigrants.

Entrepreneurship, skills development, and employment training programmes: A range of training and skills building programmes to help marginalized youth seek alternative pathways than the ones that led them to increased HIV risk (drug use, transactional sex, unprotected sex).

What the literature says: Three types of youth employment programming for at-risk youth have been highlighted in the literature: 1) entrepreneurship; 2) skills development & training programmes; and 3) employment services for youth. The promotion of youth entrepreneurship is seen as an important strategy of youth employment promotion as, especially for marginalized youth, business creation offers a chance to participate in income generating activities. It is suggested that there are three important elements that must be taken into account when implementing youth entrepreneurship programmes: 1)financing and access to credit that is made available through loans to youth based on the quality and sustainability of their entrepreneurial initiatives and not on their financial assets; 2) business skills training to assist youth to develop and implement business plans; and 3) development of entrepreneurial spirit to pursue long-term goals.

MODEL: HIV positive youth manufacturing and selling cleaning products

Alianza Solidaria Para la Lucha Contra el Sida (ALSOLSIDA), a Dominican Network of people living with HIV/AIDS responded to high rates of unemployment among youth by developing a program to make and sell cleaning products. In this programme, young HIV positive people, including those who are unable to keep, or were fired from jobs based on their HIV status, learn to make simple cleaning products out of easily accessible materials and are encouraged to sell them in their neighbourhoods and rural areas. The project has been so successful that ALSOLSIDA is considering establishing a manufacturing plant for the products in Santo Domingo.

Mentorship Programmes: Programmes in which caring adults mentor marginalized youth in community centres, clinics, or other safe spaces.

Model: Cross generational support for transgender women in the Dominican Republic

"Wednesdays with Mama" is a weekly support group meeting hosted by older transgender women for younger transgender women struggling to cope with health and psycho-social challenges. During these weekly mentoring sessions, this community has the rare opportunity to share their problems and strategies to overcome them.

Psycho-social support: Programmes that address trauma associated gang violence, sexual violence and the loss of family members to violence and HIV/AIDS.

MODEL: to be added after John speaks with Leonardo Sanchez

6. Packaging HIV Interventions for Marginalized Youth: Recommendations from the Literature

The review so far has discussed the six models for working with youth, including marginalized youth, and strategies or interventions that have been shown to be successful in achieving changes in individual and community behaviours around sexual and reproductive health issues including HIV prevention. This final section of the findings focuses attention on how these strategies may be best packaged to successfully address HIV prevention for marginalized youth.

A review of 80 academic and community sector studies and reports by Bonnell and Zizys (2005) generated profiles of 12 programmes that they considered best practices in action. Three broad themes emerged from the literature: (1) an asset-based approach, promoting the strengths and skills of youth, where youth are viewed as assets in the making; (2) the importance of a caring, supportive adult in making a difference in the life of a young person; and (3) an emphasis on effective implementation, including a reliance on measurement for the sake of learning and improvement, as quality implementation often depends on organisations that embrace constant learning.

Evidence from a qualitative review of 39 HIV/STI risk reduction interventions for adolescents conducted in four settings (including schools, clinics, communities, specialised locations such as prison detention centres and drug treatment centres) in the USA by Sales, Milhausen and DiClementi (2006) indicate that, in relation to the efficacy of the interventions for addressing HIV/STI risk reduction for adolescents in these settings:

1. A tailored approach for STI/HIV risk reduction interventions is likely to be more successful than those that are not;
2. The use of theory in intervention development and implementation is associated with improved STI risk behaviour outcomes. The programmes that were most successful were ones which incorporated constructs from the Social Learning Theory and the Social Cognitive Theory. Constructs of importance were: modelling, skills building, and increasing self efficacy - with regards to safer sexual behaviours.
3. Interventions that go beyond just education to include content such as problem solving, capacity building, social skill building and enhanced gender or ethnic pride had the greatest impact on behaviour.

Generally, consistency can be found between this guidance and the successful HIV interventions among marginalized youth that are documented in section five.

The authors further suggest the following set of strategies for developing programmes that reduce the sexual risk behaviours of marginalized youth:

Strategy 1: Target those behaviours that are most amenable to change: Note that, "across numerous interventions delivered in a variety of settings, the risk behaviour most susceptible to change was condom use during vaginal sex. A few STI/HIV prevention programmes showed promising effects in terms of increasing abstinence or decreasing the number of sexual partners; however, these findings were markedly less common. Future interventions with adolescents, especially adolescents who are sexually active, should target behaviours, like condom use, that have been empirically demonstrated across a variety of adolescent subgroups and venues to be most amenable to change. Taking a focused approach that targets only those areas of behavioural change that are both reasonable and feasible for adolescents to accomplish may result in prevention efforts that not only reduce adolescents' sexual risk behaviours, but lay the foundation for more sustainable sexual risk- reduction over time. Ultimately, this approach may result in reductions in STI/HIV among adolescents" (Sales et al, 2006).

Strategy 2: Tailor programmes for the target population: Interventions with the most success decreasing high-risk sexual behaviour were those that specifically tailored and delivered their intervention to a particular subgroup of adolescents (e.g., African American females). Various researchers have supported and advocated for a tailored approach to STI/HIV risk-reduction interventions, arguing that these tailored interventions ultimately have the greatest likelihood of success. One particularly important point emerging from the review was that, regardless of the type of venue in which the intervention took place, targeted interventions are markedly more effective than general or broad-based interventions in reducing STI/HIV-associated behaviours. Targeted interventions acknowledge that adolescents are not a homogeneous group, but rather a heterogeneous mosaic of subgroups of different ethnicities/cultures, behavioural risk characteristics, developmental levels, sexual orientations, and gender differences. Because of the manifold differences between adolescent subgroups, developing interventions specifically for a particular subgroup of adolescents may produce better results in terms of reducing risk-associated behaviour. Thus, acknowledging that adolescents are not a homogeneous group is a critical first step in designing and implementing effective programmes for youth.

Strategy 3: Use theory to guide program development: The use of theory in intervention development and implementation was associated with improved STI/HIV risk behaviour

outcomes. Social learning theory and social cognitive theory were the frameworks most consistently used in successful programmes. These programmes typically:

- Incorporated modelling activities (e.g., modelling how to put on a condom correctly, or modelling how to begin a discussion about condoms with a sex partner),
- Included skill building exercises (e.g., role plays of communicating with sexual partners),
- Attempted to increase self-efficacy (their confidence to perform a specific behaviour) to communicate safer sex desires and intentions with sexual partners,
- Helped youth increase their self-efficacy to use condoms correctly.

There is evidence also that, using a strong theoretical structure helps guide the choice of intervention activities and ensures that appropriate intervention content and delivery methods are being implemented in STI/HIV programmes for youth.

Strategy 4: Address more than just sexual risk in interventions: The review highlights that interventions that go beyond STI/HIV prevention education to include an emphasis on psychological factors associated with the risk behaviours are most effective at decreasing STI/HIV risk behaviour. For example, interventions that include broader-based content, such as problem solving, decision-making skills, capacity building, social skills building, and enhancing gender and ethnic pride, had the greatest impact on reducing STI/HIV sexual behaviours. It is observed that interventions more generally targeted toward increasing resiliency and competencies are emerging as promising approaches to reducing sexual risk behaviour. Sexual decision making is a complex behaviour and is influenced by a vast array of factors; thus developing competencies in other, related domains can also strengthen adolescents' sexual decision making skills.

Additionally, programmes that help youth develop healthy alternative and traditional sources of social support, find safe and affordable housing options, and complete their education may be needed to fill gaps in the complex environmental context of HIV risk for this population.

7. Concluding observations

While CARICOM has made progress over the last several years recognising the rights and specific HIV-related needs of the populations around which the epidemic is concentrated in the Caribbean, this progress has largely not reached the youth included in those populations.

The models and strategies featured in this paper require further support and study from regional and international funding agencies and research bodies so that determinations can be made about which approaches should be scaled up in partnerships with National AIDS Programmes across the region.

What is clear from the existing evidence and the programme strategies documented above is that:

1. Empowerment and advocacy models are the most effective for addressing HIV and marginalized youth.
2. Youth involved in gangs, youth using drugs, youth selling sex, youth living with HIV, and LGBT youth must be recognised and engaged in all HIV policy and programme development.
3. HIV risk among marginalized youth in the Caribbean is exacerbated by poverty, homophobia, transphobia, gender inequality, and a culture of violence pervading the region, requiring holistic interventions where the protection and promotion of human rights are central.
4. National AIDS Plans, laws, policies, and service guidelines must recognise and respond to the marginalized youth dimension of the epidemic.
5. Changes in social norms in relation to marginalized youth are needed and can be affected through mass media and community mobilisation efforts provided that these efforts link the targeted population to non-stigmatising care.
6. Enhanced linkage of HIV/AIDS prevention with other youth activities, including education and youth development programs, job training, and other livelihoods programs are critically needed.

Annex I

Jamaica's Response to Marginalized Youth - A Limited Case Study

To respond to the lack of data on programmes for marginalized youth in the region, a limited study of the case of Jamaica was undertaken to identify Government's and Non-government agency's response to HIV prevention for marginalized youth.

Methodology:
Three data collection approaches were used to collect data for this case study. First, a review was conducted of the websites of agencies identified through knowledge of the Jamaican situation or web searches. Second, focused interviews were conducted either face-to face, by telephone or email, with a director or manager of a sample of the key government or non-government agencies. Third, focus group discussions were conducted

with a convenience sample of marginalized youth in four parishes identified with assistance from social service workers in the respective parish.

Findings: Service providers

The data collected from interviews with NGO which serve youth were supplemented with information from recent assessments conducted by Jamaica AIDS Support for Life and the C-Change Project, and posted on agency websites. Information on HIV services provided to youth by Government and Non-government entities collected from the sources described is summarised in Table 1.

Table 1: Services provided by Government and Select Non-Government Organisation to Marginalized Youth in Jamaica.

Agency	Group(s) Served	Locations	HIV-related Services Offered
Government			
Ministry of Health (MoH) / through the National HIV/ STI Programme	All groups – including PLHIV, SW, MSM	Island-wide network of health centres and hospitals	Preventive, diagnostic, treatment and curative health services, psycho-social support. Public education, risk reduction education, policy development.
Ministry of Education (MoE)	All youth	Island wide network of primary, secondary and tertiary institutions	HFLE life skills education, HIV education. Referral to health facilities for testing, condoms, etc. Policy development.
Ministry of Youth and Culture (MoYC)	All Homeless boys (Possibility Programme)	Network of 6 Youth Information Centres Kingston and St. Andrew	Education, outreach, referral, peer counselling, mentoring, remedial education
Quasi-Government			
Women's Centre of Jamaica Foundation	Pregnant teens	8 locations across the country	Prevention education, Counselling, Referral for testing, Referral for MTCT prevention, Psycho-social support, continuing education.
Non-Government Organisations			
Ashe	Inner city youth	Kingston and St. Andrew	Remedial education, dance, singing, edutainment
Caribbean HIV & AIDS Research, Education and Services (CHARES)	PLHIV	Kingston and St. Andrew (UHWI)	Treatment, psycho-social support for PLHIV and persons affected.

Agency	Group(s) Served	Locations	HIV-related Services Offered
Children First	Vulnerable youth (comprehensive programme)	Spanish Town, St. Catherine. Bashy Bus is a mobile reproductive health clinic with edutainment and counselling components.	Remedial education, job skills development, job placement, mentoring, health care (Bashy Bus).
Eve for Life	Women living with HIV, pregnant teens	Kingston and St. Andrew	Education, counselling, psycho-social support, referral for testing and treatment.
FAMPLAN		St. Ann's Bay (St. Ann) and Montego Bay (St. James).	Sexual and reproductive health services – commodities, counselling, education, outreach, testing, and referral.
Jamaica AIDS support for Life (JASL)	MSM, SW, PLHIV, OVC	Network of sites – one in each of 3 parishes (KSA, St. James and St. Ann)	Counselling (one on one and group), support groups, clinical care, HIV testing, public education.
JFLAG	MSM	Kingston and St. Andrew	
Jamaica Network of Sero-Positives (JN+)	PLHIV		Psycho-social support, referral
Jamaica Red Cross	MSM, vulnerable youth	St. Catherine (HQ), Clubs formed in schools across the country	Training education and outreach workers – peer educators. Education through peer educators. Produce educational material.
Rise Life Management	Substance users, vulnerable youth	Kingston and St. Andrew	Substance use counselling, referral, remedial education.
Young Men's Christian Association (YMCA)	Vulnerable youth (male)	Kingston and St. Andrew	Remedial education, job skills training, referral
Young Women's Christian Association (YWCA)	Vulnerable youth (female)	Kingston and St. Andrew	Remedial education, job skills training, peer education,
Youth Opportunities Unlimited (YOU)	Vulnerable youth (mentoring)	Kingston and St. Andrew	Prevention education, Mentoring, referral for testing and treatment.

Situation with Marginalized Youth in Selected Communities in Jamaica:

Five groups of vulnerable youth in the age group 15-24 years were interviewed in focus group discussions (FGD). The study focused deliberately on marginalized youth residing outside of the metropolitan area of Kingston and St. Andrew as often their voices are rarely heard partly because of difficulty accessing these youth[1]. The purpose of the FGD was to

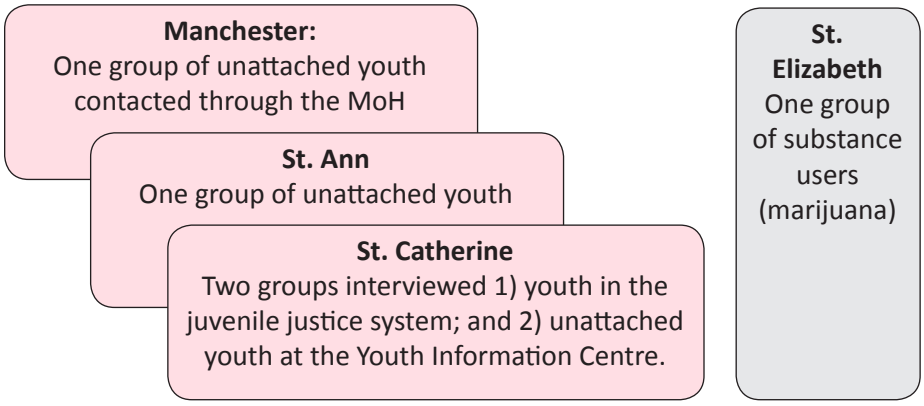
1. Difficulties experienced in getting groups of youth living with HIV and youth who are GBLT not affiliated with JASL, CVC or any of the KAS-based NGOs.

1. assist in identifying areas of greatest need in terms of prevalence, lack of awareness and access for future programme planning; and
2. Provide a basis for proposing appropriate programmatic strategies and recommendations for developing a strategy to scale-up service provision to marginalized youth.

The five group sessions were conducted in four parishes – Manchester, St. Ann, St. Catherine, and St. Elizabeth – parishes which tend to ore rural. A total of 40 youth participated in these focus group sessions. These data reflect the thoughts of youth who are:

a. Out of school, unemployed and not affiliated to any group or organisation;
b. Incarcerated
c. Involved in drug use

Time constraints to complete this assignment combined with a reluctance on the part of gatekeepers (especially of youth living with HIV, young people involved in transactional sex, and young MSM) to grant access to the youth. The case study is therefore limited to marginalized youth from three of the six groups of youth identified.



Findings of the Focus Group Discussions

1. Voices of the Youth:

What is the feedback from marginalized youth about services for them?

Sexual health needs:
Youth participating in the FGD listed a number of sexual health needs: information, testing (STI/HIV and pregnancy), counselling and guidance, *"how to protect yourself – condoms, dental dams, how to stay healthy".* These needs are being met either through the MoH

clinic services, peer educators, pharmacies and shops, and private providers (including FAMPLAN).

What are their unmet needs?

The following are some of the needs identified by marginalized youth in the four parishes that are not being met:

> *" … education on emotional stress and how to deal with issues relating to relationships, that is the only thing that is lacking"* (Manchester, unattached youth)
>
> *"Greater support for health care"* (St. Ann youth)
>
> *" … need skill centre"* (St. Catherine youth)
>
> *"YIC can inform us about career opportunities – for example when police or soldiers are recruiting, what documents, grades, tests we need and how the process work and the training available through HEART"* (St. Catherine youth).
>
> *"most of us young me bun spliff, we feel that some man could get help with the amount they bun* (St Elizabeth, substance user)
>
> *"If a man want help to stop or cut down there is nowhere that would be possible, the only rehab is jail or prison"* (St. Elizabeth, substance user).
>
> *" … also the service of a doctor in the community even once a month"* (St. Elizabeth youth)

Access to services

Except for the group of substance users from a small community where there is no access to a medical doctor, all reported the availability of a range of services. But there were a few complaints. These were that: (i) *"different services on different days"* and the implication for cost and inconvenience to the youth; (ii) staff in the facilities (clinics and health centres were not trustworthy; (iii) lack of privacy and confidentiality; (iv) dislike of the "free condoms". The youth who do not like the "free condoms" prefer to buy condoms than go to the clinic as they want anyone "*to know my business".*

Perceptions of the services available:

A range of responses were received on the question of quality services. In each group with the exception of the Manchester group, there were individuals who thought the services

were of high quality and others who reported, for example, that they were treated 'a way' (meaning with lack of respect or treated differently) and had a long wait. Those who reported long waiting time as a quality issue believe the wait is long because the service is free and they (the users of the service) are young.

The following are insights from the group of youth interviewed in Manchester.

" *… that we get good service that don't cost us anything*"; and

"Before just saying the word sex would make you laugh, now because of HIV education people can use the word"; and

"We are more knowledgeable about HIV and SRH now:".

"Very good, we have nothing bad to say about the quality of care".

The comments from the youth from some other parishes on service quality are not as positive, but unfortunately some of the opinions are based on 'hearsay'. They observe that:

" That there are good and varied services, but young people are afraid to go to the government clinics because of the lack of trust in the staff there we have heard where the wrong persons are given another person's information" (Parish A).

"There are enough places and people to deliver the services, it just that some of the people in these places can't be trusted with your private information. None of us have had that experience but people say these things so we kinda believe what we hear…" (Parish B).

"when we go to [Named NGO] we are treated with respect … when we go to the health centre it's different. Because we are young they believe like they can't see us" …."and if you have on uniform them make you feel that you should not be there".

And we had some balance:

"tell the truth the staff at the clinic doesn't treat us so bad is just that we don' trus dem. … I don' trus anybody to tell them that that bothing me".

How do youth rate the existing SH/HIV services?

Youth were asked to rate the sexual health services that are currently in place for marginalized youth. The group of substance users gave services a rating of 5 out of 10. Youth in the other groups gave an average rating of between 7 and 9 out of 10.

Best ways of reaching marginalized youth with information

The suggestions made by the youth about the best ways of reaching them with information are presented here, in their own words, by parish, in the Table 2.

Table 2: Best Ways to Reach Marginalized Youth with Information

Parish Group	Type of Group	Suggested media
Manchester	Unattached youth	*Posters, bill boards, TV, slogans*
St Ann	Unattached youth	*Through media, catchy jingle, texting service for young people, edutainment (use young people to do drama presentations, Role plays, catchy vibes.*
St. Catherine	Juvenile offenders Unattached youth	*Weekly youth meetings.* *More bill boards, TV advertisements*
St Elizabeth	Youth using drugs	*Through youth clubs, people came and talk to us, go to the street where the young people hang out, texting, training centres,* (print information on) *farm work cards, influential people who are with the youth.*

2. HIV-related Services available to Marginalized Youth

Analysis of the data from personal interviews, and agency websites indicate that the challenges common to marginalized youth in Jamaica include: the following:

- Loss of shelter/ home (homelessness) – no fixed address [drug user, MSM]
- Family rejection/ shifting
- Lack of income/ insufficient income/ sporadic income because of unemployment or under employment.
- Poorly educated – school dropout or school attendance spotty – due to family economic reasons or lack of interest in school.
- Unemployment/ self-employment (hustling)
- Food insecurity
- Lack of safety (law enforcement as well as members of the same group – rivalry)
- Poor or no access to health care
- Access to health services that is perceived to be: (i) not private or confidential; (i) non-judgmental; (iii) not safe; or (iv) of poor quality
- Access to services that are fragmented (not comprehensive) and disease specific (vertical services which require a user to visit one day for HIV testing and another day for treatment;
- Powerlessness to negotiate safe behaviours (condom use, etc.).

The limited case study indicated that, at present in Jamaica, the response from the government and NGO communities in respect of HIV-related services can be organised into six categories: HIV prevention (including education for behaviour change); self-awareness and personal development; skill development; psycho-social support; treatment; and policy development.

3. Service Models Used In Jamaica

Strategies used to achieve programme objectives include: (i) Mentorship; (ii) Peer to peer education and support; (iii) Mass media communication for behaviour modification and change; and (iv) Multi-level programmes/ integrated programmes; and (v) Others listed in Table 1. Evaluation of these programmes generally relies on qualitative feedback from service users and on service use trends tracked using monthly service statistics. Outcomes are measured at community level in two major national surveys – the National KABP survey conducted every three years by the National HIV Programme and the Reproductive Health Survey conducted by the National Family Planning Board every five years.