The CVC/COIN Vulnerabilised Groups Project

Focus Right, Focus Rights

From Tolerance to Rights

HIV and Sex Work Programs 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

Lead Writer: Julia Greenberg
Support Team: Waters, J.; Tillotson, L.; Martin, A.
Cover Photo: Jason Tanner

Acknowledgements

Thank you to the many people who provided input to this process including: Ashily Dior, Aurora Noguera-Ramkissoon, Cracey Fernandes, David Barr, Dona Da Costa Martinez, Geeta Sethi, Ian McKnight, Ivan Cruickshank, Jeff Hoover, Joel Simpson, John Hassell, Julia Roberts, Marion Scott, Michel de Groulard, Miriam Edwards, Sam Avrett, Sannia Sutherland, Sarah Godfree.

Thank you to the sex worker organizations that provided input into this report: COTRAVEDT, Guyana Sex Work Coalition, MODEMU, and SWAJ.

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March 2012

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Acronyms and abbreviations

CARICOM =	Caribbean Community
CBO =	community-based organization
COIN =	Centre for Integrated Training and Research
COTRAVEDT =	Comunidad de Trans Trabajadoras Sexuales Dominicana
CVC =	Caribbean Vulnerable Communities coalition
FPAT =	Family Planning Association of Trinidad and Tobago
JASL =	Jamaica AIDS Support for Life
MODEMU =	Movimiento de Mujeres Unidas
MoH =	Ministry of Health
MSM =	men who have sex with men
NGO =	non-governmental organization
PSI =	Population Services International
STI =	sexually transmitted infection
SWAJ =	Sex Work Association of Jamaica
UNAIDS =	Joint United Programme on HIV/AIDS
VCT =	voluntary counselling and testing
WHO =	World Health Organization

1. Executive Summary

1.1 Summary of goals of the project

The Caribbean Vulnerable Communities Coalition (CVC) and the Centre for Integrated Training and Research (COIN), an NGO based in the Dominican Republic, commissioned this study to review promising models of HIV interventions for sex workers in the Caribbean (with a focus on the Dominican Republic, Jamaica, and Trinidad and Tobago) and recommend programming and strategies for scale-up. This effort is consistent with CVC and COIN's mission to empower community-based organizations to challenge structural drivers of the HIV such as gender inequality, homophobia, transphobia, and the criminalization of vulnerable populations.[1] 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

Project activities included:

- A global literature review drawing out best practices in HIV programming for sex workers that are relevant, applicable, and replicable in the Caribbean context.
- A review of best practice interventions among sex worker organizations, NGOs, and government and private service providers in Jamaica, Trinidad and Tobago, and the Dominican Republic using rapid assessment tools created for sex worker organizations.
- Key stakeholder interviews with sex workers, NGO leaders, UN stakeholders, and government officials.
- A review of CVC documents related to regional sex worker interventions including meeting minutes, reports, and rapid situational analyses conducted by CVC/COIN staff in 2011.

1.3 Summary of models and strategies for scale-up of sex worker interventions in the region

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

1. **Prevention:** Community-based, peer-led prevention programmes including distribution of and education about: male and female condoms, lubricant, and contraceptives.

2. **Health education:** Community-based health education programmes that address the multitude of health issues facing sex workers.
3. **Access to and integration of primary care, HIV care, and sexual and reproductive health (SRH) care:** Efforts to strengthen relationships between sex worker communities and public and private health systems to improve access to HIV testing and treatment; STI screening and treatment; and primary and SRH care—and to integrate care services.
4. **Safe community spaces:** Safe spaces that are welcoming and safe for sex workers and can be used for support group meetings (focusing on such issues as self-esteem building, psychosocial care, building community solidarity, etc.), one-on-one counselling, and dissemination of health and rights information.
5. **Structured mentorships:** Peer-led mentorship programmes in which sex workers learn from one another about effective HIV prevention, care, and treatment interventions, self-esteem building, self-organizing, monitoring and evaluation, and organizational capacity building.
6. **Social and economic support:** Strategies to link sex workers to the social and economic support they require such as substance abuse counselling, rehabilitation for the formerly incarcerated, school fees for sex workers' children, and access to alternative employment for those who wish to transition out of sex work.
7. **Advocacy to improve health services for sex workers:** Monitoring and addressing discrimination and quality of care issues for sex workers in public and private health facilities and advocacy efforts to urge national AIDS programmes and research institutions to build the body evidence about epidemiological trends among sex workers in order to improve and inform targeted evidence-based interventions.
8. **Human rights education:** Basic human rights education on local, regional, and international human rights instruments, conventions, and declarations that can be deployed to protect and promote the rights of sex workers and training on how to effectively use them in organizing and activism.
9. **Enabling environment:** Legal and advocacy efforts to challenge national laws and policies that criminalize activities associated with sex work (if not sex work itself), increase sex workers' vulnerability to HIV (such as forced or coercive HIV testing and immigration policies that exclude sex workers from services), and violate their rights.
10. **Communication campaigns:** Marches and rallies, radio, television, print-media campaigns, and press conferences designed to bring sex worker health and rights issues into the public sphere, challenge stereotypes, and build tolerance.
11. **Emergency response:** The development of rapid response mechanisms that provide emergency support, and in some cases, technical assistance, to respond to police crackdowns, raid and rescue operations, anti-human rights legislation, and flare-ups of violence.

12. **Mobile sex workers**: Programmes and strategies designed to provide continuity of care and consistent prevention outreach to mobile sex workers, including data bases or management information systems to make their health records available to providers and NGOs across the region in a confidential manner.

2. HIV and Sex Work: A Global Picture

In most countries outside of Africa, HIV prevalence is concentrated among populations which, because of a variety of social and biological factors, are at higher risk of HIV infection, including sex workers, men who have sex with men (MSM), transgender people, migrants, and prisoners. Yet, global HIV resource flows to these regions continue to support strategies that are more effective for generalized epidemics and do not reach those who most need targeted prevention interventions.

This is particularly stark in the case of sex work. UNAIDS estimates less than 1% of all global funding for HIV prevention is allocated to prevention among sex workers. Further, only a small portion of that money actually reaches community organizations of sex workers,[2] despite evidence showing that prevention interventions devised and implemented by sex workers themselves are more effective.[3]
Worse, many existing programmes imposed from outside communities, especially those that focus on "rescuing sex workers," are stigmatizing and often violate the rights of sex workers, driving them underground and out of reach of prevention, care, and support services.

As the pandemic enters its fourth decade, there is finally a growing recognition among governments and leaders in the global AIDS response that it cannot be reversed if sex workers are unable to access their right to health. For example:

- The Joint United Nations Programme on HIV/AIDS (UNAIDS) released its Guidance Note on HIV and Sex Work in 2009 which recommends interventions built upon three interdependent pillars: 1. Access to HIV prevention, treatment, care and support for all sex workers and their clients; 2. Supportive environments and partnerships that facilitate universal access to needed services, including life choices and occupational alternatives to sex work for those who want to leave it; 3. and action to address structural issues related to HIV and sex work.[4]
- In the outcome document of the 2011 UN High Level Meeting on AIDS, UN Member States finally recognized that "many national HIV prevention strategies inadequately focus on populations that epidemiological evidence shows are at higher risk, specifically men who have sex with men, people who inject drugs and sex workers".[5] This marked the first time sex workers had ever been named in a UN General Assembly declaration on AIDS.

- The UNAIDS 2011-2015 strategy, "Getting to Zero," has a goal to reduce sexual transmission in the context of sex work by half.[6]

Such developments signalling a welcome shift in the global policy response were realized to a large extent because of tireless organizing and advocacy by sex workers and their allies. As the epidemic began to decimate the lives of sex workers, grassroots organizations emerged around the world providing care and support services by and for sex workers and disseminating information about HIV prevention, care, and support. Complementing this at the international level, the Global Network of Sex Worker Projects (NSWP), founded in 1990, began to play a key role ensuring that the global response to the pandemic among sex workers served to protect, not compromise, the rights of sex workers. NSWP urged UNAIDS to reconsider its policy guidelines on HIV and sex work (resulting on the guidance note referenced above). Moreover, the network acts as an anchor organization for the UNAIDS Advisory Group on HIV and Sex Work, and together with UNFPA and WHO it is creating a comprehensive HIV intervention package for sex workers, to be released this year.

Today a representative of the Guyana Sex Worker Coalition sits on NSWP's board, ensuring that a Caribbean perspective is included in efforts to influence global policy on HIV and sex work.[7]

3. HIV and Sex Work in the Caribbean: Regional Challenges and Assets

Until recently, largely because of stigma and discrimination against vulnerable populations, Caribbean states persisted in ignoring evidence and characterized regional epidemics as generalized, rather than concentrated among high-risk populations. As a result, an effective response to the spread of the virus among sex workers, and from sex workers to the wider population, has been lacking. The consequences are striking: for example, in Guyana, Jamaica, and the Dominican Republic, HIV prevalence among female sex workers is estimated to be 17%, 5%, and 2% respectively.[8] By comparison, overall adult prevalence is much lower in all three countries, ranging from 0.9% (Dominican Republic) to 1.7% (Jamaica).[9] According to a 2010 UNAIDS regional report on the Caribbean: "There are no comprehensive health programmes targeting sex workers in the CARICOM region, despite large and diverse sex worker communities. Traditional programming for sex workers is aimed almost exclusively at female sex workers. However, the sex worker community also includes men who sell sex to women, men who sell sex to men, and transgender sex workers."[10]

At the end of the last decade, most Caribbean governments began facing the reality that the region's epidemics are concentrated among vulnerable populations, including sex

workers. Accordingly, they began to respond to pressure from sex workers and their allies to address their HIV-related needs. The result is a progressive regional policy framework on stigma and discrimination, articulated in 2010 through the Pan Caribbean Partnership Against HIV/AIDS (PANCAP), a project of the Caribbean Community (CARICOM), that sets enabling conditions for more effective HIV interventions for sex workers:

PANCAP Regional Policy on HIV-Related Stigma and Discrimination:[11]

- Governments to decriminalize sexual-economic exchanges between consenting adults including solicitation;
- Governments to ensure that sex workers are able to access comprehensive, acceptable, quality, user-friendly HIV prevention, treatment, care and support services;
- Governments in collaboration with NGOs [non-governmental organizations] and CBOs [community-based organizations] working with sex workers and sex worker organizations to develop programmes to reduce violence, abuse, and discrimination perpetrated against sex workers;
- Governments to remove legal barriers restricting public health authorities, NGOs and CBOs from conducting education activities and supplying condoms and other sexual and reproductive healthcare products.

This policy presents an unprecedented opportunity for the region to address HIV/AIDS and sex work through evidence-based programming, especially in light of the opportunities for comprehensive programming for vulnerable populations under the Global Fund for AIDS, Tuberculosis and Malaria (Global Fund) grant awarded to PANCAP under Round 9. In order to do this, however, governments, NGOs, implementers, CBOs, and sex worker-driven networks will have to understand and confront the region-specific challenges summarized in Sections 3.1 through 3.7 below.

Of particular importance is expanding and deepening the understanding of sex worker sub-populations. The broad categories specified in the UNAIDS report only scratch the surface of what is a multivariable series of sub-populations with their own specific needs and priorities, including in regards to HIV prevention interventions. Among the important sub-populations in many Caribbean nations are non-identifying sex workers [both women and men]; MSM sex workers who do and do not identify as gay; and individuals engaged in transactional sex in prisons. Progress has been made in much of the Caribbean in reducing HIV prevalence among certain specific sex worker sub-populations—e.g., female, establishment-based, self-identifying sex workers in the Dominican Republic—but other sub-populations (e.g., transgender sex workers) have received comparatively little, if any, attention or resources. (Additional detail about sub-populations is provided in Section 3.6.)

3.1 Criminalization of sex work

The exchange of sexual services for payment or benefit itself is not a criminal offence in any CARICOM country.[12] However, particularly in English-speaking countries, a range of laws that vary by nation criminalize associated activities in many of them. As a result, in countries such as Jamaica and Trinidad and Tobago it is generally accurate to claim that sex work is effectively "criminalized" even though the specific exchange of payment for sexual services is not.

In most contexts, it is often difficult to arrest and prosecute individuals for sex work because it cannot be "proved". Thus when law enforcement personnel harass and arrest sex workers, it is usually not for soliciting *per se*, but for other criminalized activities such as vagrancy and indecent exposure. Police also often use the threat of arrest to extort bribes and sex from sex workers. In addition, laws dealing with immigration, drug use, HIV/AIDS, the possession of condoms, consensual sex between men, and immigration have severe implications on the lives of sex workers, subjecting them to conditions of violence, discrimination, and abuse.

The regional variations and unclear status were underscored by a legal analysis of sex work in the Caribbean carried out by UNIFEM in 2007. It concluded, for example, that contemporary sexual offences laws exist in half of the countries in the Commonwealth Caribbean with the following impacts (among others) on laws related to sex work:

a. The focus of the legal regime had been prostitution by women; however, the contemporary sexual offences laws now define prostitution in gender neutral terms. In these territories both men and women fall within the ambit of the definition of prostitute.
b. The activities of sex workers are now more directly criminalized by an enlarged offence of solicitation which is no longer restricted to solicitation in public places and which has heavier penalties.
c. Crimes relating to buggery and indecency include consensual sexual activities between adults, and many of these are now susceptible to heavier punishment under the contemporary laws.[13]

In regards to the third example above, for example, until less than two decades ago there was one category for the crime of buggery (which included bestiality) in Antigua and Barbuda; the maximum penalty was 10 years' imprisonment. The 1995 Sexual Offences Act made a distinction between buggery and bestiality, however, and increased the maximum prison term to 15 years for both consensual and non-consensual buggery. The maximum penalty for bestiality remained at 10 years. This has serious implications for MSM and transgender sex workers.

The sex worker-led organizations interviewed for this paper all pointed to criminal laws that restrict their work, movement, and freedom as key barriers to access to HIV services for their community. Many also highlighted a challenge linked to misperceptions and deliberate obfuscations related to actual legal regimes. Reports from some countries indicate that although sex work is not technically illegal, it is perceived as being so quite broadly—an impression often reinforced directly by police and other authorities. The inadvertent assumption or deliberate claim of illegality limits the ability to prevent and respond to human rights violations against sex workers and is used by health and other officials' to justify their refusal to provide services for sex workers (on the erroneous basis that they would be supporting individuals and communities engaged in "illegal" activities).

Such situations point to the need to support sex worker groups to better understand and know their rights and how laws actually affect them and their activities. Increased awareness would help them take more effective action to confront harassment and violations and force authorities to acknowledge and uphold legal regimes. One potential outcome would be increased access to public services that sex workers need and have a right to access.

3.2 High rates of violence against women, MSM, and transgender people

Sex workers face physical and sexual violence at the hands of clients, pimps, brothel owners, and the police.[14] Violence against sex workers is tied to extremely high rates of sexual violence in the region as well as virulent transphobia and homophobia. A 2007 World Bank study of 102 countries showed that the Caribbean region has the highest incidence of rape.[15] 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.[16] The World Health Organization (WHO) notes that violence and rape have a direct and indirect bearing on sex workers' ability to protect themselves from HIV[17] and several studies have documented the link between human rights environments and HIV prevalence for MSM, many of whom are involved in sex work.[18]

3.3 High rates of transactional sex among young women

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.[19,20] 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.

3.4 Small populations where everybody knows everybody

Confidentiality is a particular challenge in the Caribbean, where stigma against sex workers is compounded by the fact that island populations are small and "everybody knows everybody". Cited by respondents in this study and highlighted in other research, this is as a major barrier to access to care among local (as opposed to migrant) sex workers.

3.5 Mobility

Mobility throughout the region by sex workers is common, both within individual countries and to other islands and countries, usually for a limited period. Migrant sex workers are vulnerable to HIV because the illegality of aspects of their work and their undocumented status keeps them from accessing their rights to basic education, legal services, and public health-care systems, both in their own countries and abroad. The stigmatization they face as sex workers is compounded by xenophobia and discrimination based on nationality, which further limits their ability to access even the most basic services in many places.

Subjects interviewed for this research discussed additional challenges including cultural and linguistic barriers (especially for sex workers coming to Trinidad and Tobago from South America) and abuse at the hands of corrupt officials. These challenges, compounded by the fact that their movements make it difficult to remain connected to HIV care, treatment, prevention and support activities, contribute to the vulnerability of migrant sex workers to HIV and the difficulties NGOs, CBOs, and governments face providing them with services.

3.6 Lack of research and data on sex work among the range of sub-populations in the region

Discussions with key stakeholders generated an extensive list of sub-populations of sex workers in the region and the different places they work. Some commonalities and linkages exist across many or most of the sub-populations, but differences in terms of perceptions, needs, priorities, expectations, and current ability or willingness to access services are quite significant. Effective HIV prevention programming therefore relies on recognizing and understanding the full range of sub-populations among sex workers.

In general, limited information regarding HIV prevalence and risk, among other issues, is available on the range of sub-populations. Often this is because such information is not collected at the national level, may be generalized from a bias toward street workers, and is complicated by the lack of a clear definition of sex work among researchers, HIV programmers, policymakers, medical practitioners, and sex worker groups and activists.[21] An extensive 2010 survey of 14 CARICOM member states found that some (but by no means extensive) data on HIV prevalence among sub-populations of sex workers could be found for five countries: Guyana, Haiti, Jamaica, Suriname, and Trinidad.[22] NGOs have begun to research and collect essential data on some of the sub-populations: COIN, for example, has supported recent baseline studies on transgender sex workers in the Dominican Republic, migrant Hispanic female sex workers in Trinidad, and club-based female sex workers in Jamaica. The studies will be published in 2012 but preliminary results show strikingly level low levels of knowledge about HIV and access to testing and treatment among these groups. Far too little is known about key sub-populations—many of which are listed below—and thus insufficient data are available.

Gaps have been bridged at times, however. In the Dominican Republic, for example, the relatively low HIV prevalence among sex workers is attributed in part to a particularly successful response with female sex workers who self-identify. Efforts to reach and provide services to this sub-population were spearheaded by civil society groups and sex workers themselves. Public health programmes concerned with STI prevention were also involved in a collaborative effort.

Sub-populations of Caribbean Sex Workers

Some sub-populations are associated with population-specific HIV risks in addition to stigma, violence, and lack of access to services, which are common to all.

Self-identifying female sex workers **Non-identifying female sex workers** (gender inequity and repressive cultural norms regarding gender) **Heterosexual identifying male sex workers; MSM identifying sex workers/ Gay identifying sex workers; non-identifying male sex workers** (ignorance about male sexual health, criminalization of sexual activities among men) **Sex workers who use drugs** (sex for money and alcohol)	**Transgender sex workers** (ignorance about transgender health) **Male and female sex workers who primarily serve tourists** **Migrant sex workers** (criminalization, language and cultural barriers, loss to follow-up) **Imprisoned or formerly incarcerated sex workers** (lack of prevention and condoms in prisons, sparse social services for the formerly incarcerated) **HIV-positive sex workers** (re-infection, lack of access to services} **Transactional sex, both outside and inside prisons** (concurrent multiple relationships)

Examples of unique sub-populations

The following are examples from the Dominican Republic of discrete sub-populations of sex workers that are often difficult to recognize and reach with HIV prevention information and services.

- *Calmadones* (corner stores that are also drinking spots) are gathering places where sex work involving women, men and transgenders is arranged. Most individuals involved do not self-identify as sex workers and few interventions are done in such contexts.
- Elaborate car washes are increasingly common. Many now have bars where men—as washing cars is traditionally something men are responsible for—can drink while their cars are washed. Often the buildings have rooms available where men can meet up with young women and girls from the neighbourhood for sex. The situation and context are informal and few involved identify themselves as engaged in sex work.

On our Board we have trans, MSM, and female sex workers. All populations are represented as the head so we become one body and reach these populations easily.
—Miriam Edwards, Guyana Sex Work Coalition

Where Caribbean sex workers work

Brothels ◊ Massage parlors ◊The street ◊ Clubs ◊ Rural areas ◊ Escort services ◊ Tourism industry ◊ Prison ◊ *Calmadones* ◊ Car Washes ◊ Liquor Stores ◊

Disaggregated data on the impact of HIV on sub-populations of sex workers that take into consideration overlapping risks is critically needed. The lack of clarity around the term "sex work" and ignorance about the sexual practices and particular vulnerabilities of each sub-population means that there is no consistency in data collection, research, policies, or programming. The World Bank, the United Nations Population Fund (UNFPA), WHO, UNAIDS, NSWP, and the Johns Hopkins School of Public Health are working together on a major study on the epidemiology of sex work and the cost effectiveness of interventions which will provide clear advice to guide national responses on how best to ensure value for money in the context of HIV and sex work. Findings from CVC baseline studies and other community-based research will also be useful to policymakers in the region.

3.7 Mobilizing sex workers in the region

The challenges listed above are among the many contributing to yet another challenge, that of effectively mobilizing sex workers to improve HIV awareness and access to health

services throughout the region and across sub-populations. CVC/COIN is seeking to bolster community mobilization through its sex worker project (SWP), which is being carried out in six countries in partnership with other CVC member organizations in two pilot phases. The partners are sex worker civil society organizations (CSOs) including several with strong HIV prevention programming for female sex workers, MSM sex workers and trans sex workers, such as Centro de Promoción y Solidaridad Humana (CEPROSH) in the Dominican Republic; Maxi Linder Foundation in Suriname; Fondation pour la Sante Reproductrice et l'Education Familiale (FOSREF) in Haiti; PASMO, the Population Services International (PSI) country office in Belize; and Jamaica AIDS Support for Life.

The project will provide targeted support for community mobilization as well as core support, the lack of which is a consistent concern among most organizations in the region.

4. Summary Overview of HIV and Sex Work in the Dominican Republic, Jamaica, and Trinidad and Tobago

The Dominican Republic

HIV among sex workers

The Dominican Republic has been recognized globally for its effective HIV prevention efforts among sex workers. With strong NGO-government cooperation, and interventions that stress empowerment, development, and human rights, the country has achieved a reduction in the prevalence of HIV among sex workers from 9% in 2000 to 2.7% in 2007.[23]

Environment for effective interventions

The working environment for sex workers in the Dominican Republic is generally thought to be more progressive than other Caribbean countries. Prostitution and soliciting are legal, but financial gain from sex work (i.e., ownership of brothels, pimping) is not. However, migrant sex workers, and even Dominican sex workers of Haitian descent born in the Dominican Republic, face multiple human rights abuses including lack of access to birth certificates, education, and health care. MSM and transgender sex workers experience high levels of violence and extortion from clients and from homophobic and transphobic members of the wider population.

Sex worker empowerment helps reform harmful legislation

The Dominican Republic is presently debating a proposed law to create "zones of tolerance," or red light districts, away from residential centres and places in the city

that have historical, artistic, or social significance. The law would require sex workers to carry government-issued cards certifying their health status at all times.

Civil society groups both international and domestic are fighting the law on the grounds that it will breach a number of human rights protected under international law, including the right to non-discrimination and equality before the law, the right to privacy, the right to freedom of movement, as well as the right to self-determination.[24]

In November 2011, the Canadian HIV/AIDS Legal Network (CHALN) drafted an open letter to the Dominican government signed by more than 40 representatives of sex workers and organizations and individuals advocating for human rights from around the world. The engagement and interest of the international community, unexpected by legislators, helped strengthen opposition voices. Closer to home, civil society and sex worker groups (including Movimiento de Mujeres Unidas [MODEMU], a sex worker network) have spoken against the bill at public meetings.

Such empowerment efforts have been quite successful in not only halting steps toward creating a "zone of tolerance" but of potentially leading to the drafting and passage of progressive legislation with input from the sex workers rights community. The congresswoman who drafted the original bill has agreed to re-write it with a civil society coalition formed by MODEMU, COIN and UNAIDS that also includes CHALN experts and local lawyers with expertise in gender and HIV issues. That coalition will help organize a tour of legislators to two or three countries (e.g., Brazil and the Netherlands) to learn about their sex worker-related policy structures. Ideally the new bill will promote greater access by sex workers and their families to welfare, health care, and other forms of employment.

Sex worker movement and programmes

Unlike other Caribbean countries, HIV programmes for sex workers in the Dominican Republic are developed and effective, due in large part to the work of COIN. The NGO began providing HIV and prevention, education, and services related to HIV and other sexually transmitted infections (STIs) to sex workers in 1989, and over time has integrated programmes on gender, self-esteem, sexuality, sexual health and reproductive rights, human rights, comprehensive medical and laboratory services, and organizational and self management skills.[25]

COIN also developed and nurtured independent organizations such as MODEMU, the Dominican Republic's first self-organized sex worker association, and Comunidad de Trans Trabajadoras Sexuales Dominicana (COTRAVEDT), a transgender sex worker organization, both integrally involved in peer education to their own communities and able to refer clients to COIN's medical services. Further, COIN has fostered the development of CBOs

from the MSM and transgender communities such as Amigos Siempre Amigos (ASA) and Trans Siempre Amigas (TRANSSA), both of which work to address sex work-specific issues in their respective communities.

Jamaica

HIV among sex workers

HIV prevalence among female sex workers in Jamaica is estimated at 5% compared with general adult prevalence of 1.7%.[26] Sex work is seen as a key factor for the spread of HIV on the island, with 25% of reported cases of HIV indicating unprotected sex with female sex workers as a mode of acquisition of their HIV infection.[27] A recent study showed that HIV-positive sex workers tended to be older, less educated, have a history of crack/cocaine use, and were less likely to be aware of the Ministry of Health (MoH) prevention programme. More than 90% of sex workers reported having easy access to condoms and using them with local and tourist clients. However, 30% of them reported not using condoms with non-paying partners.[28]

Environment for effective interventions

Many key activities associated with sex work, such as "knowingly [living] wholly or in part on the earnings of prostitution," are criminalized under Section 23 of Jamaica's 2009 Sexual Offences Act. This legal environment drives sex workers underground and limits their ability and inclination to access essential health and other services. Members of the Sex Work Association of Jamaica (SWAJ) report that the Sexual Offences Act is often used as an excuse for harassment, extortion, and abuse of their members by police officers and private citizens. In a 2010 submission to the UN Human Rights Council, SWAJ describes a machete attack on a sex worker who chose not to go to the hospital or police for fear of discrimination, and went instead to a local NGO, Jamaica AIDS Support for Life (JASL), for services and support. Other instances of violence against sex workers have been reported to the police, but arrests are rarely made.[29]

Despite the fact that sex work is criminalized, the National HIV/AIDS Programme (NHAP) within the MoH, using its HIV prevention and care mandate, reports reaching between 3,000 and 4,000 sex workers per year through peer-led outreach and care programmes and a mobile unit that offers HIV and STI screening and condoms.[30] Further, the NHAP has developed strong relationships with JASL, the Red Cross, and other organizations serving vulnerable populations in the country. The MoH's work, while welcome, is surely hindered by the inherently obstructive characteristics of the legal regime and widespread police abuse tacitly condoned by such laws.

Sex worker movement and sex worker programmes

Similar to the situation described in the Dominican Republic, sex worker interventions in Jamaica have been fostered by a strong NGO—JASL—with a commitment to reaching vulnerable populations with services and fostering independent CBOs to take up independent rights and empowerment work. JASL has been reaching sex workers with prevention, care, and treatment since 1991 and has been supporting the autonomous sex worker association, SWAJ, since 2006.

In comparison with MODEMU in the Dominican Republic, SWAJ is a young organization that has not yet built a strong sex worker rights movement in the country. However, SWAJ has begun challenging stigma against, and stereotypes about, sex work through public actions and press work. Its members are also included in discussions about Jamaica's 2012 National HIV/AIDS response, working closely with UNFPA, the MoH, and other key partners.

■ Trinidad and Tobago

HIV among sex workers

Trinidad's most recent country progress report to the UN (its 2010 UNGASS report) did not include estimated prevalence among sex workers, indicating that it lags behind the other countries studied for this paper in measuring and responding to the HIV-related needs of this population. Trinidad's UNGASS report states that the country does not have any information on the uptake of voluntary counselling and testing (VCT) by at-risk groups such as migrant workers and sex workers due to lack of adequately disaggregated data and inconsistency in data collection. It goes on to commit to strengthening data collection methods in the course of the period of the next national HIV/AIDS Strategic Plan.[31] However, the lack of a functioning National AIDS Control Council in the country (see below) calls into question the government's ability to do this.

Environment for effective interventions

Trinidad and Tobago's Sexual Offences Act is similar to that of Jamaica's in that it criminalizes many key activities associated with sex work. For example, the first two specific sex work-related clauses state that a person who "knowingly lives wholly or in part on the earnings of prostitution" or who "in any place solicits for immoral purposes" is "guilty of an offence and is liable on conviction to imprisonment for five years". Moreover, an amendment to the act further stipulates that male or female sex workers guilty of the crime of buggery (anal sex) must undergo a mandatory HIV test, the results of which would be released

to the party bringing the charges.[32] In short, this is not an environment conducive to prevention and care for sex workers.

In August 2011, the Trinidadian government imposed a state of emergency to respond to a spike in drug and gang related violence. Some observers, including civil society groups based in the country and region, have criticized the government of using the state of emergency as an excuse to suspend constitutional guarantees and give unchecked power to law enforcement. Interview subjects working in the country reported that outreach to sex workers was significantly interrupted during the state of emergency, as law enforcement was coming down particularly hard on brothels and outreach workers feared arrest for entering the premises. Although the ban was lifted in December 2011, the climate of trust necessary for on-site health interventions for sex workers has not yet been restored. It was reported that some service providers have refused to treat sex workers for fear of attracting the attention of the police.[33]

Sex worker movement and programmes

There are no strong sex worker-led organizations in Trinidad and Tobago. Two NGOs, the Family Planning Association of Trinidad and Tobago(FPAT) and PSI, both run peer-led outreach programmes that provide (among other things) condom distribution, on-site STI and HIV testing (in brothels) and health education. The executive director of FPAT, a local organization, noted the following about one component of the group's work, with Spanish-speaking migrant workers: "We have to find a way to support migrant sex workers to leave their brothels and access services outside. Their conditions are terrible; sometimes their passports are held and they are not allowed to leave. The only way to fix this is to give them the safe spaces they need to organize and come up with their own strategies to access health."[34] PSI, on the other hand, does not consider its mandate to help form, or work with, indigenous sex worker groups. Instead, the international organization has its own outreach education field guide for peer educators, whom it "pulls from the communities to work with high-risk populations." [35]

Finally, Trinidad and Tobago's National AIDS Control Coordinating Committee was closed in 2011 to make way for the establishment of a statutory body to take up the national AIDS response. Technically, the HIV/AIDS Coordinating Unit within the MoH is responsible for national HIV programming in this interim period, but a situational analysis by CVC/COIN in 2011 showed that NGOs working on HIV report that the Unit's presence and leadership are not felt.[36]

5. Promising Models and Strategies for Scale up of Sex Worker Interventions in the Region

Our staff and board are sex workers. We know exactly what it is like to be a sex worker, what we need and what we are facing. We know about sex workers in the interior, who work in brothels, and who work on the streets. We don't have to train ourselves on these issues. Sex workers reaching sex workers should be the strategy that should be used to fight HIV around the world. If we had been doing this all along, we would have seen more progress now.

—Guyana Sex Worker Coalition

This section summarizes recommended programme approaches, most of which are accompanied by brief snapshots of models and strategies currently employed by sex worker organizations in the Dominican Republic, Guyana, Jamaica, and Trinidad and Tobago that provide details of innovative work that can be replicated or scaled up. In cases where an appropriate model was not identified, quotes from key stakeholder interviews are provided to demonstrate the field-level demand for the recommended approach.

One notable underlying element of all models is that they rely on community mobilization resulting in empowered communities of sex workers. Most programmes and policies associated with the models were developed and implemented with the full participation of sex workers. The capacity-building work that enables and sustains mobilization and empowerment is a critical component that must be supported to ensure that the organizations and their members can be as effective as possible—and, consequently, that the work undertaken through the programmes is successful. Community mobilization should be a priority not only for sex workers, but for all vulnerable populations affected by HIV, including MSM, injecting drug users and prisoners.

MODEL: Empowerment and Education through the Avancemos Project

One of the earliest and most successful HIV education and prevention programmes in the region, the Avancemos Project, was developed and implemented by COIN two decades ago in the Dominican Republic. Based on a peer-to-peer education methodology to reach groups marginalized by society, the project carries out STI/HIV prevent programmes targeting individuals involved in the commercial sex industry: sex workers, their clients, and the owners and tenants of facilities where sex work is performed (and thus also the establishments that serve as meeting places for this work).

The project's structure is headed by a technical group that trains and supervises a large group of peer educators, carefully selected with respect to their lifestyle and culture, to correspond with the project's target population. Those educators, known has "health

messengers" are trained in several areas: STI/HIV prevention, the use of educational techniques, and data collection and management. Among their strategies are using "provocative theatre", performed in brothels and bars, to raise clients' awareness of the dangers of having unprotected sex. The idea is that direct, face-to-face interventions spread and multiply the required healthcare knowledge among groups that are at high risk for contracting STIs/HIV, thus promoting change in risky behaviour practices.

Most project actions are aimed toward enabling sex workers to take care of their own lives. They learn about STI/HIV prevention methods as well as techniques in condom negotiation in both their personal and commercial relationships. An associated element of the project is social marketing of condoms, which are sold by the Messenger Network representatives in all businesses where the project exists.

The Avancemos Project's success was clear early on and its success has influenced interventions for vulnerable populations in the country ever since. In 1996, for example, 72% of sex workers interviewed reported that their main source of information concerning STIs/AIDS was via the project's health messengers.

5.1 Prevention: Community-based, peer-led prevention programmes including distribution of and education about: male and female condoms, lubricant, and contraceptives. *These programmes should be relevant to the specific needs of the populations listed described above and preferably reach sex workers at their places of work or in safe community spaces.*

It is worth noting as well that COIN and other groups have recognized the need to also use peer-led prevention and education methods to help drug-using sex workers to manage their drug use and reduce harms associated with it.

MODEL: Peer education based on positive sexuality and self-determination

COIN developed and piloted an innovative peer-education model in Jamaica and the Dominican Republic to address gaps in traditional peer-education programmes. Among the notable gaps are that, in COIN's view, such programmes have underestimated the difficulty people have in following risk-reduction strategies because insufficient attention has been paid to psychological, relationship, cultural, affective-arousal, and situational influences that surround and form the content of human sexual behaviour. The organization also believes that most programmes have failed to promote long-term sexual health care.

COIN's new model for transgenders, sex workers and MSM peers moves away from providing prescriptive steps to behaviour change, and instead is based on the principles of positive sexuality, self-determination, autonomy, and fairness. In the first phase of

the pilot, in 2011, a total of 20 peers were taken through a selection of 15 modules in two countries. Initial evaluations indicate that this programme is a promising rights-based intervention that is responsive to vulnerabilized populations and able to reduce HIV/STI transmission.

MODEL: Adaptation of the 100% condom programme in the Dominican Republic

A joint government-NGO adaption of Thailand's 100% Condom Programme contributed to a significant reduction of HIV prevalence among female sex workers in the Dominican Republic from an average of 9% in 2000 to 2.7% in 2007.[37] A study of this programme by the Population Council[38] determined that its success was due to a history of peer-led sex worker interventions pioneered by national NGOs (see description of Avancemos, above) in the country, the use of community solidarity and empowerment approaches to underpin the programme, and the engagement of community members in both programme and policy development. Similar findings emerged from a review of the programme published in the *American Journal of Public Health* in 2006: "Interventions that combine community solidarity and government policy show positive initial effects on HIV and STI risk reduction among female sex workers."[39] The Thai model, largely government imposed, was seen by some activists as an opportunity for state forces to criminalize sex workers by punishing those who did not comply with the policy and enforcing compulsory HIV testing to verify the programme's success. The Dominican Republic, by engaging NGOs in policy and strategy development, avoided these pitfalls.

MODEL: Reaching sex workers where they work

The Jamaican National AIDS Programme reports that it is much more difficult to carry out HIV-related outreach programmes in brothels than in clubs. In clubs, proprietors can claim that they are unaware of what their employees do on their own time in the back of the establishments, but massage parlour owners can be targeted or arrested for operating a brothel.

Such differences in responses and impressions matter greatly in terms of access to essential HIV prevention and information. The Sex Work Association of Jamaica (SWAJ) reports that one of its greatest challenges is reaching sex workers in massage parlours since they do not see themselves as sex workers and are resistant to outside intervention. This difficulty is compounded by the fact that most of these establishments in Jamaica are disguised as legitimate businesses. Owners fear exposure to the authorities and will not let outreach workers onto the premises. In order to reach this sub-population, SWAJ calls massage parlours listed in the classified ads pretending to be looking for employment. Through this approach they develop relationships with the owners so that they can bring their programmes in.

5.2 Health education: Community-based health education programmes that address the multitude of health issues facing sex workers. These could include programmes on HIV prevention, antiretroviral (ARV) treatment literacy, sexual health (including anal sex), reproductive health, and new prevention technologies such as treatment as prevention, pre-exposure prophylaxis (PrEP), microbicides, and vaccines. *Health education programmes that utilize the expertise of both sex workers and resource people from national AIDS programmes and public clinics (doctors, nurses, etc.), creating forums for sensitization and learning should be prioritized.*

MODEL: Linking health education to clinical care

In Trinidad and Tobago, PSI combines social marketing and education on how to use male and female condoms and lubricant with peer-led behaviour change communication efforts. In cooperation with the Family Planning Association of Trinidad and Tobago (FPAT), PSI is linking its health education and prevention programmes to clinical care by developing a network of private providers who offer free initial visits for any health issue a sex worker would like to address. Such issues can include HIV or STI screenings, breast exams, family planning, etc. The initiative is working particularly well with sex workers who have already been reached through the joint PSI/FPAT mobile clinic. Through on-site visits by peer educators, PSI/FPAT staff have gained the trust of sex workers—who are then able to take the next step to access care—and brothel owners, who are more likely to encourage health-seeking behaviours among their workers. [40]

MODEL: War Chest programme

COTRAVEDT, a Dominican organization working with transgender sex workers, runs the War Chest programme. The War Chest itself is a kit that contains condoms, lubricant, and educational materials that is presented by transgender peer outreach workers in social gatherings in private homes. The programme is based on Tupperware parties from decades ago in which housewives would host gatherings of peers and discuss the virtues of household wares they were trying to sell. The somewhat “campy” environment is a major part of the programme’s appeal, with the War Chest kit presented like Tupperware. Distribution of the kit is accompanied by educational presentations on sexual and primary health, the proper use of condoms, use and abuse of hormones, anal health, and STI prevention. These outreach sessions take place in private homes because transgender sex workers cannot be reached in traditional venues in the Dominican Republic (brothels, bars, clubs). Rather, transgender sex workers find clients through networks of friends and the pornography industry.[41]

MODEL: Tal Cual programme

The Tal Cual (“as I am”) programme, developed and implemented by COIN in the Dominican Republic, focuses on supporting the provision of culturally sensitive and

competent health care to transgender individuals in a safe and supportive environment. The programme works in both the public and non-governmental sectors, informing clinic staff about general and HIV-specific health needs of transgender people and developing prevention education materials that address the wide range of concerns experienced by the transgender population. Its overall goal is to increase the uptake of services by transgender individuals, which may also include activities such as mobile clinic HIV and STI testing and treatment, among other efforts.

One notable (and unexpected) finding early on was that dental care is a real need. Providing such care has been a major attraction for transgender sex workers to engage in the programme.

5.3 Access to and integration of primary care, HIV care, and sexual and reproductive health (SRH) care: Efforts to strengthen relationships between sex worker communities and public and private health systems to improve access to HIV testing and treatment; STI screening and treatment; and integration of HIV services into primary and SRH care. These programmes could include training healthcare workers about sex workers' health needs; developing and strengthening referral, tracking, and follow-up systems between sex worker organizations and clinics; Spanish-language services for migrant sex workers (in countries such as Trinidad and Tobago); and mobile clinics. *Access to care programmes that build the capacity of public health services to provide appropriate, non-stigmatizing services to sex workers, as well as efforts to provide sustained care for mobile sex workers who move across the region, should be prioritized.*

MODEL: Integrating a peer-based model of counselling and testing in National AIDS Programmes

The Caribbean HIV&AIDS Alliance (CHAA) uses peer educators to promote and provide HIV counselling and testing in the Eastern Caribbean. In Antigua, the educators are supporting the government in its efforts to roll out rapid HIV testing, an effort CHAA is supporting by helping train managers of the National AIDS Programme as well as representatives from the MoH and a local network of people living with HIV. To complement this, and to reduce demand on limited healthcare workers, CHAA is building parallel capacity in the community by training community and peer-based counsellors and testers according to the regionally recognised VCT standard.

CHAA bases its work on the fact that peer-based models, where outreach workers are drawn from the communities with whom they share cultural or lifestyle choices, have proved highly successful globally in responding to the epidemic. Therefore CHAA is expanding its current behaviour change communication (BCC) model to train peer educators as peer counsellors and testers. These educators are able access populations not reached by mainstream services because of their peer networks; training them in VCT fuses a peer-based model with community counselling and testing.

MODEL: Comprehensive care, support, and treatment in a safe space

Jamaica AIDS Support for Life (JASL) has a longstanding programme to provide prevention and treatment services to sex workers which includes prevention education on the street as well as in clubs, bars, and escort services. During these interventions, outreach workers provide information on HIV/AIDS, individual risk assessments, guidance on risk reduction, condom demonstrations, and condom distribution. JASL also offers voluntary HIV counselling and testing both at sex worker venues and through referral to its clinics, which offer a full range of services including counselling, meals, care packages, testing, and HIV treatment. The clinics are open at hours that are convenient for sex workers (evenings and Saturdays) and are staffed by nurses who have been sensitized to the particular needs of male, female, and transgender sex workers.

5.4 Safe community spaces: Safe spaces that are welcoming for sex workers and can be used for support group meetings (focusing on such issues as self-esteem building, psychosocial care, building community solidarity, etc.), one-on-one counselling, and dissemination of health and rights information.

MODEL: The Guyana Sex Work Coalition office

The Office of the Guyana Sex Work Coalition, funded by a women's rights donor from the Netherlands, is the only safe space for sex workers in the country. It provides a place for support groups to meet for health education, to organize for public actions, and to take part in self-esteem building activities. A staff social worker provides one-on-one counselling and refers and often accompanies sex workers to external legal or social services. Sex workers can also get a hot meal at the office and stay for 24 hours in cases of emergency.[42]

5.5 Structured mentorships: Peer-led mentorship programmes in which sex workers learn from one another about effective HIV prevention, care, and treatment interventions, self-esteem building, self-organizing, monitoring and evaluation, and organizational capacity building. *Long-term structured mentorship programmes rather than one-time trainings should be prioritized.*

The most useful and effective mentorship programmes are those that clearly emphasize learning by doing. In practice, this means a shift away from support for conventional capacity-building activities such as workshops to direct implementation involving sex workers. Evidence from around the region indicates that such strategies are more likely to engage and motivate community members, and thereby build local capacity more quickly and efficiently. They are also less likely to create dependency on external support that is not usually consistent or sustainable.

What the trans community needs is education. A three-day peer educator workshop cannot work. This is a broken and damaged community that needs to be educated about their sense of value. If CVC wants to do something, they need a team that is trained and knows trans issues that can go in and do self-esteem building over a long period of time. We need exchange programmes that should last for at least three months to help our population start doing for themselves, including getting their own funding and knowing what do with it.

—Ashily Dior, founder of Trans T&T

Also of note regarding capacity building is that external consultants are often viewed with distrust and/or suspicion in some countries of the region, such as Jamaica. In others, though—such as the Dominican Republic—external involvement is more welcome. For example, as noted previously, local civil society and sex worker groups in the country were pleased to accept support from the Canadian HIV/AIDS Legal Network (CHALN) in the effort to block passage of the proposed law establishing "zones of tolerance". CHALN and local groups subsequently created a strong civil society coalition that is working with legislators to draft progressive legislation to benefit sex workers.

MODEL: Internships for sex worker advocates

As part of a region-wide mentorship effort, PANCAP supported a mentorship programme with the goal to help build the capacity of sex worker organizations and activists and develop stronger links across the region. As part of this, a transgender activist from Belize spent three months in the Dominican Republic.

I learned how people from the Trans community can be visible, have a voice, and stop being marginalized. What gave me motivation to keep up with the activities for my community is how the Dominican trans groups do their meetings on Wednesdays and Mondays and show how an empowered community can accomplish many things, especially in the field of prevention of HIV/AIDS.

-Mia Quetzal, Intern from UNIBAM, Belize

5.6 Social and economic support: Strategies to link sex workers to the social and economic support they require such as substance abuse counselling, rehabilitation for the formerly incarcerated, school fees for sex workers' children, and access to alternative employment for those who wish to transition out of sex work. *Sex worker-led organizations are unlikely to be able to sustain social support programmes themselves. Instead, they should develop referral programmes and/or collaborative relationships with appropriate social service and economic development organizations and government agencies.*

There are sex workers who are no longer able to work or want to stop sex work and we would like to support them. They are alcoholics, substance abusers, they have children

they can't support. We couldn't give them money on a daily basis but would do home-based care for them and help them find other services.
—Guyana Sex Work Coalition

5.7 Advocacy to improve health services for sex workers: Monitoring and addressing discrimination and quality of care issues for sex workers in public and private health facilities and advocacy to urge national AIDS programmes and research institutions to build the body of evidence about epidemiological trends among sex workers in order to improve and inform targeted interventions. *Peer learning among sex workers to build capacity to engage in policy and advocacy strategy development should be prioritized.*

MODEL: Addressing stigma in healthcare settings

Peer support, and the integration of peer relationships in the provision of health care, is considered an increasingly important and valuable concept and approach among health scientists, practitioners, and community groups. Peer-based advocacy is a critical component of such overall support, particularly among individuals and populations that struggle to access quality, comprehensive care due to stigma, discrimination and lack of understanding of their specific health issues. Knowledgeable and supportive peers who have built relationships with health providers can greatly enhance the experience of others seeking effective care while at the same time holding providers accountable.

As part of its peer-based advocacy associated with health services, the Guyana Sex Worker Coalition works to break down stigma in public health services through ongoing engagement with clinics. As noted by the Director of the Coalition, "We see part of our job as building the relationships in these clinics where stigma and discrimination are a problem. We tell the clinics: 'These persons are with the Guyana Sex Work Coalition—if they give you a problem write us and we will talk to them. And we say to the sex worker: 'if you get stigmatized, let us know and we will visit the clinic.'"[43]

5.8 Human rights education: Basic human rights education on local, regional, and international human rights instruments, conventions and declarations that can be deployed to protect and promote the rights of sex workers and training on how to effectively use them in organizing and activism. *Human rights education and training programmes run by sex workers and geared toward realizing the right to health should be prioritized.*

5.9 Enabling environment: Legal and advocacy efforts to challenge national laws and policies that criminalize activities associated with sex work (if not sex work itself), increase sex workers' vulnerability to HIV (such as forced or coercive testing and immigration policies that exclude sex workers from services), and violate their rights. This could also include

efforts to address violence against sex workers (including rape) through training police and security forces, coordinating reports of violence from individuals and organizations, and self-defence and empowerment programmes in which sex workers learn to protect themselves. *Legal and advocacy activities that further PANCAP's Regional Policy on HIV-Related Stigma and Discrimination should be prioritized.*

MODEL: Sensitizing the police

The Family Planning Association of Trinidad and Tobago (FPAT) runs workshops for police on sex worker rights. Because the country's legal regime criminalizes many aspects associated with sex work in the country, FPAT focuses its trainings on the issue of access to services and the right to protection from violence. In these workshops, its representatives specifically note their recognition that due to a range of laws criminalizing associated activities, sex work is effectively illegal and that the job of the police is to enforce the law. They have found that this approach results in acknowledgement of the basic rights of sex workers and better cooperation with police during episodes of violence.[44]

5.10 Communication campaigns: Marches and rallies, radio, television, print-media campaigns, and press conferences designed to bring sex worker health and rights issues into the public sphere, challenge stereotypes, and build tolerance. *Organizations running communication campaigns should attempt to build in security precautions and psychosocial support for sex workers who choose to be the public face of organizations and movements*.

MODELS: Walk for Tolerance in Jamaica and March to Commemorate the International Day to End Violence against Sex Workers in Guyana

In 2010 in Montego Bay, Jamaica, a coalition of vulnerable communities including lesbian, gay and transgender people, sex workers, and people living with HIV, staged a public "Walk for Tolerance", the first of its kind in the country. During a public presentation at the end of the walk, Princess Brown of the Sex Work Association of Jamaica said, "This was an important step in confronting the bigotry that has for a long while been meted out to sex workers." One of the strengths of this action, which garnered press internationally, was that it demonstrated solidarity among the most stigmatized segments of Jamaican society, thus drawing public attention to the shared human rights of people affected by HIV in the country.

For the last two years the Guyana Sex Work Coalition has held a public protest on December 17, the International Day to End Violence Against Sex Workers. These were the first public mass actions ever taken by sex workers in the country and members of the coalition report that the events took place without any incidents of violence due to the sensitization work they had undertaken with the police, who effectively restricted their response to upholding their basic responsibility to preserve public order.

5.11 Emergency response: The development of rapid response mechanisms that provide emergency support, and in some cases, technical assistance, to respond to police crackdowns, raid and rescue operations, anti-human rights legislation, and flare-ups of violence. *Sex worker organizations in-country and across the region should consider collaborative efforts to develop emergency response planning in order to strengthen the regional response to human rights violations against sex workers.*

5.12 Mobile sex workers: Programmes and strategies designed to provide continuity of care and consistent prevention outreach to mobile sex workers, including data bases or management information systems to make their health records available to providers and NGOs across the region in a confidential manner.

MODEL: Unique identifier codes to ensure continuity of care for mobile sex workers

In October 2011, the Caribbean HIV AIDS Alliance (CHAA) began asking its community-based animators to assign unique identifier codes to sex workers whom they accompany to services. This is part of an effort to track how many times sex workers are reached by their services across the region. CHAA reports that it was initially assumed that sex workers would not provide any personal information, but the code—which consists of the first two letters of the client's first name, her mother's name, her year of birth, and her gender—is increasingly accepted for use by sex workers.[45]

6. *Scaling up Sex Worker Interventions in Collaboration with National AIDS Programmes*

6.1 Barriers to NGO-government partnerships on HIV and sex work

In Guyana and Trinidad and Tobago, interview subjects indicated that legal regimes effectively criminalizing sex work are the key barrier to effective partnerships between governments and sex worker-led organizations. They stressed that this is why advocacy to create enabling environments for sex workers to access HIV treatment and care is so critical. In some cases, governments would prefer to support NGOs to provide services to sex workers, rather than providing them directly. While the financial support for services for sex workers by the government is welcomed by the NGOs, they recognize that it is not a sustainable response to the problem due to a range of extenuating concerns related to difficult legal situations that could prompt sudden changes in policies.

In some cases, the inability to access services is a result of simple neglect of the population or lack of prioritising sex worker health in clinical services. In the case of the transgender community in the Dominican Republic, the barrier to effective partnership is quite simple according to members of COTRAVEDT: services for transgender people are not included

in the priorities of the national AIDS programme. In another example, MODEMU reports that a planned programme to provide periodic health checks for their members failed because the health department refused to designate health promoters sensitized to sex worker issues.

In Jamaica, meanwhile, government officials and agencies work at cross-purposes, as the MoH directly supports the health and rights of sex workers while the police force—based partly on its members' interpretation of the legal regime—arrests, brutalizes and extorts them. To some extent a similar schizophrenic approach takes place in Guyana and Trinidad and Tobago, which share with Jamaica a relatively harsh criminal code in regards to sex work and activities associated with it. The result is that health officials' efforts on behalf of sex workers are less effective than they can or should be, and NGOs operate in more difficult environments even if they are well-capacitated and their activities approved by health authorities.

NGOs speak about barriers to effective NGO-government partnerships on HIV and sex work

The National AIDS Programme Secretariat is supportive for condom distribution and they sometimes invite us to do trainings. But because of what the laws stipulate [that sex work is criminalized], they can't do much because they get government funding. We really have to work on this.

—Guyana Sex Work Coalition

In Trinidad the government is not leading. They are not prepared to do anything that will conflict with their laws. The point of the matter is that the service providers in government won't serve these particular groups [female, transgender and MSM sex workers]. It's not explicitly stated, but I believe that the Ministries of Health and Social Development all know that the demand for sex work is universal and that criminalizing it will not make it disappear. Nonetheless they still prefer to support NGOs to provide services, rather than do it themselves.

—Family Planning Association of Trinidad and Tobago

6.2 Collaborations between NGOs and National AIDS Programmes on data collection on HIV and sex work

Rapid assessments of the work of six sex worker-led organizations showed that there is little to no opportunity for them to use the data they collect through their programmes to inform government reporting on HV prevalence, incidence, and knowledge among sex workers. Only one of the six organizations, COTRAVEDT, currently reports the results of its VCT programme to the Dominican Republic's Ministry of Public Health. The reasons for

this are a combination of low monitoring and evaluation capacity among grassroots, sex worker-led organizations and tenuous relations between sex worker organizations and National AIDS Programmes. As one respondent put it, “The distrust between government and sex workers is so strong that our members would not provide us with any information if they thought it would be going to the government, even if they were told it would be anonymous.” [46]

However, the strong links between national NGOs and sex worker led-organizations in the Dominican Republic and Jamaica create the potential for data collected at the grassroots level to inform government reporting. For instance, COIN is currently developing a Web-based platform that will allow the sex worker, MSM, and transgender-led organizations with which they partner to input data from their programmes into a database housed by the organization. COIN is working to ensure that the data captured is usable by the National HIV/AIDS Programme, ensuring not only that the government has accurate data about the various sub-populations of sex workers, but that it also has information about the scope and reach of the services provided by sex worker-led organizations.

Similarly, Jamaica AIDS Support for Life, along with other NGOs in Jamaica carrying out HIV testing, are required to submit test results to the National HIV/AIDS Programme using a standardized form. Since SWAJ refers its members to JASL for services, and JASL itself is a safe space where sex workers come for testing, there is a link between SWAJ’s outreach work and the ability for the government to accurately monitor HIV prevalence and incidence among sex workers.

7. The UN Role Addressing HIV and Sex Work in the Caribbean

UNAIDS and UNFPA are the key UN agencies supporting sex work interventions in the region. To a significant extent due to the advocacy of CVC, the UN partners collaborate with sex worker-led organizations; provide technical support for behaviour change communication; and provide financial support for organizational development. UNAIDS and its co-sponsoring organizations focus on the following five elements of its strategy in the region based on them being the most relevant:

- prevention of sexual transmission, including focus on MSM and sex workers;
- prevention of vertical transmission (which UNAIDS believes can soon be eliminated in the region);
- access to treatment, a priority that emphasizes not only technical but also social issues related to stigma and discrimination to ensure sex workers can access services. A key priority is on integrating all relevant services;

- social protection and the promotion of human rights, including legal issues related to criminalization of sex work; and
- needs of women and girls.

In practice, UNAIDS work plans focus on training sex worker groups so they can take more active leadership in terms of their intervention programmes, including in regards to treatment access services. Other community mobilization and HIV prevention planning of relevance to sex workers includes supporting a wider range of civil society groups such as those working more broadly on human rights and, in some instances, church groups (which are particularly common in many Caribbean countries) that are able and willing to follow core UNAIDS principles. Much of this capacity-development work is undertaken jointly with UNFPA, the lead UN agency on sex work. Joint programmes are currently being developed in Haiti and Jamaica, and the Dominican Republic will soon follow.

In addition, as noted above, UNAIDS aims to address legal contexts. This would involve working with NGO partners and governments to address legislation that criminalizes aspects of sex work, sexual activities of minorities (e.g., MSM), as well as restrictive laws regarding mobility, immigration, and residence status. It is expected that such work, as well as work on human rights, will be undertaken in collaboration with the UN Development Programme (UNDP). Efforts already taken to date include working with government leaders in St. Kitts and Nevis encouraging political decisions that would ease restrictions and rigid policies affecting sexual minorities and sex workers.

Also in regards to policy, UNAIDS sees the election of new governments in Jamaica and Guyana as opportunities to work with their leaders on health and legal reform. In Jamaica, for example, amending the public health act to more closely associate HIV and communicable disease might open the way for improved services and reduction in criminalization related to HIV. In Guyana, meanwhile, one legal issue that could be a priority is the law forbidding cross-dressing. That law has been used to arrest and prosecute transgender individuals, including many involved in sex work.

As part of this work, UNAIDS and UNFPA have joined with CVC and its sex worker-led partners to form the HIV and Sex Work Technical Working Group. The aims of the group are:

1. Improving the coordination and coherence of a regional HIV and sex work programme which is integrated, responsive and relevant;
2. Managing and monitoring the regional mobilization around HIV and sex work;
3. Leveraging the collective strengths of regional entities to give traction, accelerate, advocate and/or support the programming decisions that have already been taken by sex workers and their organizations;

4. Facilitating and promoting networking, technical exchange and sharing among organizations responding to HIV and sex work regional and nationally.[47]

Sex workers don't readily accept HIV information so we learned from UNFPA about behaviour change communication, that you have to approach the issue from different angles. First talk about police brutality and issues with their children and then tie those issues in with HIV. Most outreach programme planners put forward what they think sex workers want but this is far from the needs of the community. For comprehensive behaviour change sex workers must be trained and empowered to buy into the programme.
—Sex Worker Association of Jamaica

8. Concluding Observations

The research undertaken for this paper informed the promising models and activities summarized in Section 5. It also led to the 11 concluding observations about HIV and sex work in the Caribbean that follow.

1. **Sex worker interventions are fledgling.** Sex worker interventions are in their nascent phase in much of the Caribbean (with the exception of the Dominican Republic) and require significant attention from donors, researchers, and the international sex worker rights movement.
2. **Community grants programmes are critical.** Virtually every interview conducted for this project stressed that effective sex worker interventions require the leadership and participation of sex workers. This leadership is essential for community mobilization and empowerment. It must be built through direct financial support to sex worker-led organizations so that they can define and implement their own programmes. The resources available for direct support to sex worker organizations, including programmes administered by CVC under the Global Fund grant, are insufficient to meet the need.
3. **Core support is essential for sex worker organizations to help them build and sustain capacity**. It is particularly important for emerging groups, including those that are already funded for HIV projects. Core support can help enable sex worker organizations to engage in advocacy and representation work including communications with other groups, both domestically and abroad, transport to meetings, and convening of sex worker meetings. Funding for such activities is often not permitted in grants for HIV projects.
4. **Sex worker-led CBOs require long-term support and mentorship.** In the Dominican Republic and Jamaica, the existing sex worker-led organizations were established, mentored, and receive ongoing technical assistance and support from national NGOS with missions to empower and reach vulnerable populations with health services (COIN and JASL). Sex worker-led efforts in Trinidad and Tobago are

fragile and lack the ongoing support of a national NGO with a history of providing safe spaces and services for sex workers.

> **The importance of safe spaces for sex workers: a global perspective**
> Drop-in centres providing health care, legal counselling, and other direct services to sex workers serve a crucial role by meeting sex workers' essential needs, and providing a safe space for them to congregate, document abuses, and mobilize for advocacy. Despite adverse circumstances, including the criminalization of sex work in many regions worldwide, drop-in centres have been successful in providing a means for sex workers to access services and organize for the recognition of their human rights. Supporting drop-in centres is an important strategy for strengthening sex worker-led activism to change the laws, policies, and practices that violate their human rights.
> —From 'Centers for Change,' a study of seven safe spaces for sex workers in six countries by the Open Society Foundations

5. **Sex worker-led HIV interventions have the most impact.** There is consensus among stakeholders ranging from CBOs, sex worker networks, private and public service providers, UN agencies, government officials, public health experts, and the staff of international NGOs that interventions that are led by, or include the substantive participation of, sex workers have the most potential to impact HIV prevalence, incidence, and mortality rates.
6. **Sex workers need "safe spaces" for self-esteem building and protection from violence.** There is consensus among the same stakeholders listed above that "safe spaces" in which the self-esteem of sex workers can be built are critical. It is in these spaces that sex workers learn the skills to protect themselves from violence, negotiate condom use, access non-stigmatizing health care, and organize to claim their rights.
7. **Effective sex worker interventions are holistic.** HIV interventions for sex workers should be holistic, combining self-esteem building, peer education provided by sex workers for sex workers, innovative strategies to link sex workers to care, efforts to combat stigma, discrimination, and violence, and advocacy for decriminalization of sex work.
8. **Sex workers seek care from private providers.** Most efforts to link sex workers to care are in the form of partnerships with private providers whose services are perceived to be more confidential and less stigmatizing than those provided by public providers.
9. **Government services are largely inaccessible to sex workers.** Significant work needs to be done to build the capacity of government health services to adequately address the needs of sex workers. A significant barrier to progress in this realm is the criminalization of sex work.
10. **Sex workers should be reached where they work.** The most effective interventions are those that begin with outreach and on-site services (such as

HIV and STI testing) in the places where sex workers work (brothels, clubs, the street, etc.).

11. **Sex worker interventions should be tailored to the specific needs of sub-populations:** The sex worker community is diverse in terms of sexual orientation and gender identity and the type of sex work performed. While CBOs and NGOs should strive to build unity among the sex worker movement for communal solidarity and more effective advocacy, interventions should be tailored to the specific needs of each sub-population.

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