

Global Best Practices

Effective Approaches to Inform SBCC Programming
and Reduce HIV Risk for Sex Workers and MSM in
Jamaica and The Bahamas

May 2011



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Table of Contents

Acronyms	ii
Executive Summary	1
Introduction	3
Method	4
Background	4
Men who have sex with men and their HIV risk	4
Sex workers and their HIV risk.....	6
The situation in the Caribbean for MSM and sex workers.....	8
Factors Influencing the Vulnerability of Men Who Have Sex with Men	9
Factors Influencing Sex-Worker Vulnerability	15
Using a Socio-Ecological Model to Find the Tipping Point for Change	20
Promising Approaches and Practices for HIV Prevention among MSM and Sex Workers	22
Interventions directed at individuals (self) — level 1	22
Interventions directed to partners, family, and peers — level 2	26
Interventions directed at local community, services, and products — level 3	31
Interventions directed at a national enabling environment — level 4	36
Combination prevention approaches.....	39
Recommendations: Filling Critical Gaps in Prevention Programming for Sex Workers and MSM	42
Conclusion	46
Works Cited	47
Annex 1: Useful Resources, Tools, and Program Descriptions	56
General Interest.....	56
Resources on MSM	57
Resources on Sex Workers	58
Annex 2: Promising Programs for Sex Workers and MSM	59

Acronyms

AIDS	Acquired immune deficiency syndrome	SBCC	Social and behavior change communication
CAFRA	Caribbean Association for Feminist Research and Action	SHIP	Sonagachi HIV/STD Intervention Project
CAREC	Caribbean Epidemiology Centre	STI	Sexually transmitted infection
CASAM	Centre for Advocacy on Stigma and Marginalization	UNAIDS	Joint United Nations Programme on HIV/AIDS
CBPR	Community-Based Participatory Research	UNDP	United Nations Development Programme
FHI	Family Health International	UNICEF	United Nations Children’s Fund
GCWA	Global Coalition on Women and AIDS	UNIFEM	United Nations Development Fund for Women
HCP	Health Communication Partnership	USAID	United States Agency for International Development
HIV	Human immunodeficiency virus	VCT	Voluntary counseling and testing
HRW	Human Rights Watch	WHO	World Health Organization
JASL	Jamaica AIDS Support for Life	STI	Sexually transmitted infection
MAP	Mobile Access Project		
MOH	Ministry of Health		
MP	Mpowerment Program		
MSM	Men who have sex with men		
NGO	Nongovernmental organization		
PAHO	Pan American Health Organization		
PANCAP	Pan Caribbean Partnership Against HIV and AIDS		
POL	Popular opinion leader		
PSI	Population Services International		
SALIN	Strategic Alliances with International NGOs		

Executive Summary

The purpose of the Global Best Practices report is to provide an overview of good and emerging social and behavior change communication (SBCC) responses to the HIV prevention needs of men who have sex with men (MSM) and sex workers from programs in the United States, sub-Saharan Africa, India, Caribbean, and Latin America. The information presented in this report is intended to support the design of programs in Jamaica and The Bahamas and to inform the global knowledge-base for the development of social and behavior change communication (SBCC) strategies addressing these populations. C-Change, specifically, will apply the findings from this report towards the provision of SBCC technical assistance to Government and civil society partners to improve the quality and reach of their response with these vulnerable populations.

Sex workers and MSM are among the populations most seriously affected by the HIV epidemic, and this has been true since its earliest days. Though these individuals are often the most difficult to reach and support with prevention programming, the value of doing so is recognized globally. Reaching most-at-risk groups with effective HIV prevention programs and services can be the key to turning the tide of a country's epidemic, because they can serve as a bridge for HIV infection to the general population, as these individuals may participate more frequently in high-risk behaviors.

The report outlines the history and development of HIV SBCC prevention programs and successful communication interventions that target MSM and sex workers. It highlights key factors that contribute to the vulnerability of these two populations, and lists and describes promising communication approaches and programs around the world that have addressed these factors, scaled up effective prevention interventions, and/or embraced a human rights perspective.

Using C-Change's Socio-Ecological Model for Change as a framework, the report ends with a discussion of HIV prevention interventions in different settings aimed at reducing risk and boosting the resilience of MSM and sex workers. The listing of promising SBCC programs concludes with examples of comprehensive programs for sex workers and MSM that combine SBCC approaches at scale and work to address the individual, interpersonal, community, and structural dimensions of HIV-related vulnerability.

The programs and approaches highlighted exemplify the vast global experience that can inform successful SBCC HIV prevention programs for MSM and sex workers in Jamaica and The Bahamas. The first step is to fill some critical gaps by:

- Developing a national SBCC strategy in each country that addresses the prevention and support needs of sex workers and MSM and provides a cohesive framework for organizations serving these populations;
- Strengthening the capacity of civil society and Ministry of Health partners implementing SBCC-related prevention programs for sex workers and MSM;
- Comprehensively addressing the deep levels of stigma these groups' experience;
- Undertaking advocacy toward the decriminalization of sex work and buggery – moving beyond

addressing individual knowledge and behaviors to creating an enabling environment for change;

- Engaging MSM and sex workers in the development of programming and messages;
- Addressing the psychosocial needs of MSM and sex workers; and
- Exploring how communication channels such as the Internet and other social media can play a role in programming for most-at-risk populations.

Jamaica and The Bahamas are at a definitive moment in their response to the HIV epidemics they face. Their governments have taken a critical step in committing to address the needs of those most-at-risk. What remains is to take bold and strategic action to meet those needs and create conditions in which individual and social change related to HIV prevention can take hold and flourish, even among the most vulnerable and hidden populations.

Introduction

The Global Best Practices Research Report reviews good and emerging social and behavior change communication (SBCC) responses from the Caribbean, as well as programs in the US, Sub-Saharan Africa, India, and Latin America to the HIV prevention needs of men who have sex with men (MSM) and sex workers¹. The information from the report is intended to be useful for organizations in Jamaica and The Bahamas, including C-Change, in developing evidence-based SBCC programs for HIV prevention among SW and MSM. It will also inform the global knowledge-base for developing SBCC strategies for work with these two populations. C-Change will use findings from this report in providing SBCC support to improve and scale up the response to the needs of these vulnerable groups by their governments and by civil society actors in Jamaica and The Bahamas

Women who sell sexual services to men have long been understood to be critical in shaping the dynamics of the global HIV epidemic (Vuylsteke, Das, Dallabetta, and Laga 2009). Approaches in this area have evolved over the years. Early on, sex workers were broadly vilified as ‘core transmitters,’ and some HIV prevention materials depicted them as vectors of certain death (fig. 1).

MSM are another critical group, and have been since the virus causing AIDS was first identified in the early 1980s. In those early days, gay and other MSM around the world responded by directly supporting and caring for partners, lovers, and friends who were sick. They also modified their sexual behavior, reducing their number of partners and practicing safer sex to reduce the risk of becoming infected or passing on the virus. Until recently, these changes resulted in dramatic reductions in HIV incidence among these populations (Rotello 1998). Many key factors affecting their vulnerability to HIV are the same or similar to those affecting sex workers.

Both groups experience stigma, discrimination, and social exclusion. Legal climates in many countries are hostile to the rights of both groups, with concomitant effects on their psychosocial health. MSM and sex workers also face similar risk factors for HIV, including violence, frequent partner change and concurrent sexual partnering, inconsistent condom use, and recurring sexually transmitted infections (STIs) that often go untreated.



¹ Most of the current research on sex work discusses female sex workers and does not specifically address male sex workers. This paper acknowledges this gap and focuses on women who define themselves as sex workers and whose primary source of income is the sex industry. This excludes women who only engage in transactional sex, a less formally defined exchange (sometimes referred to as ‘indirect’ sex work), which often takes place within the context of a ‘love’ relationship or often occurs between younger women (or men) and older men (or women).

HIV prevention programs around the world have worked to reduce these risk factors and the intense stigma that both groups often face, and to provide them with appropriate services and support. Comprehensive prevention programs now go beyond individual and community interventions, in light of the evidence that the ability to adopt preventive behaviors (such as consistent condom use) is often influenced by broader social and structural factors that may be beyond the direct control of members of vulnerable groups. These programs thus consider factors in the broader social and/or physical environment that affect the likelihood of disease transmission and seek to address them with appropriate strategies and interventions.

Method

Research for this report focused as much as possible on published program experience on male-to-male sex and sex work in the Caribbean region in order to establish the evidence-base. Because published literature of programs in the Caribbean is very limited, the review included studies in areas of the world with similar social and cultural contexts. Programs that seem particularly promising, seminal, and relevant were examined, including those in US cities among African Americans and/or Latino Americans, as well as programs in sub-Saharan Africa, India, and Latin America that respond to political and social constraints similar to those in the Caribbean. Peer-reviewed journal articles and book chapters were identified through PubMed Central. Google Scholar and Google were used to find grey literature, including reports and tools published on the Internet by organizations working with MSM and sex workers around HIV prevention.

Evaluations and program information were found initially through a Google search and on the websites of NGOs and multilateral and bilateral organizations. Additional information on HIV prevention programs that explicitly address the needs of Caribbean or African MSM and sex workers was garnered through consultations with individuals in NGO, UN, and donor communities. In a number of instances, program implementers were directly consulted through telephone interviews and via email.

Background

Men who have sex with men and their HIV risk

The term “men who have sex with men²” was developed in the context of HIV prevention and aimed to be descriptive of a sexual practice and to circumvent the use of labels such as “homosexual” or “gay,” which might not be accurate or accepted in all settings. Although the term has been useful, the term, MSM, often masks complex sexual identities, interests, and practices (Young and Meyer 2005), and its use may have led to insufficient population segmentation and inappropriate targeting of HIV prevention efforts (Dowsett nd). Indeed, the literature suggests that substantially different

² While it is recognized that the term MSM often masks complex sexual identities, interests, and practices, it is used in this report as a descriptor for men who ever engage — occasionally or regularly — in male-to-male sex, whether or not they also have sex with women.

prevention challenges are posed by men who have sex only with other men, compared to men who have sex with men and women. These two groups are unlikely to respond to the same prevention messages and advice.

Many factors influence and shape the way intimacy and sex between men are expressed, and there is no simple way to categorize the practices or identities of same-sex practicing men. Although sexual expression between men in the Caribbean is mostly clandestine, it is complex and dynamic; in many respects, it mirrors practices of African American and other black men in the United States (White and Carr 2005; Caceres 2002). Some MSM openly define themselves as gay, but many also refer to their preferred sexual position— ‘top’ or ‘bottom’—or to being bisexual, ‘versatile’, or ‘on the down low.’ Some men who have sex with men on a regular basis do not claim any label or (non-normative) sexual identity (Hanff 2006; Allen 2002). This report uses the term MSM despite its limitations, as well as ‘same-sex practicing men,’ to encompass a wide-range of sexual interests, behavior choices, and identities. It is thus used as originally intended, as a descriptor for men who ever engage (occasionally or regularly) in male-to-male sex, whether or not these men also have sex with women.

In countries where sex between men is legal, national governments (albeit reluctantly and tardily) supported HIV surveillance and provided HIV prevention, care, and support services. In countries where sex between men was or continues to be illegal, HIV surveillance data relating to MSM have been lacking; prevention, care, and support programs limited to community-driven initiatives; and only discreet support provided by ministries of health and other government departments (Baral, Sifakis, Cleghorn, and Beyrer 2007). Only in the last few years is HIV prevalence among MSM becoming better understood in much of the world through research and MSM-specific seroprevalence surveys. In addition to revealing a worrying upward trend of new infections among MSM in the United States and Europe, this research also concludes that HIV rates among MSM and transgenders in developing and middle-income countries are between nine and 45 times higher than they are within the general adult population (Baral, Sifakis, Cleghorn, and Beyrer 2007).

MSM are at risk of HIV infection through unprotected anal intercourse, which is estimated to be as much 80 times more risky than vaginal sex (Beyrer 2010). Being the receptive partner is more risky than being the insertive partner. Risk is also increased by the level of exposure to the virus, whether through multiple and concurrent sexual partnerships (Wohlfeiler and Potterat 2005), high HIV prevalence among local MSM, or both. For instance, if 45 percent of MSM are HIV-positive in a given community, the risk of exposure for a man meeting a new sexual partner is almost one in two. In Jamaica, where MSM have an estimated HIV prevalence of 32 percent or higher (Jamaica National HIV/STI Programme 2010), a young man who does not use condoms during sex with an older man could have a one-in-three chance of being exposed to the virus.

Globally, MSM have been marginalized and stigmatized. In Jamaica and many other countries, sex between two consenting adults of the same sex is illegal. Laws of this kind contribute to hostile treatment of MSM by healthcare workers and to the discrimination and violence that MSM experience, including from police and other uniformed services. Homophobic violence in Jamaica has led to murder, and more often results in terror, beatings, and intimidation. The situation is so precarious that some Jamaican MSM have sought — and obtained — political asylum in more

tolerant countries (White and Carr 2005; Hanff, 2006). The criminalization and social marginalization of MSM in Jamaica has also exacerbated delayed testing and treatment-seeking behavior, found generally among men in the region, to avoid being 'outed' as someone who has sex with other men. As a result, MSM in Jamaica commonly present late with HIV disease, and often too late for treatment (Hanff 2006).

The fact that buggery was legalized in The Bahamas in 1991 may be reflected in the lower rate of HIV infection — just over eight percent — among MSM in the country. In the absence of data before 1991 this may remain an unproven observation. The country has also adopted progressive anti-discrimination policies and legislation: a policy addresses discrimination against people living with HIV (PLHIV) in schools, and The Bahamas Employment Act of 2001 forbids discrimination in the workplace on the basis of HIV status.

Notwithstanding, secrecy, stigma, and discrimination continue to prevail in The Bahamas, a religiously conservative country, and many MSM relationships and activities are hidden and take place on the 'down-low.' Few HIV programs address the specific needs of MSM in The Bahamas, and MSM in need of treatment tend to access services in the late stages of infection. Mistrust of providers who lack training and exhibit discriminatory attitudes may play a role in this. The Bahamas HIV/AIDS Centre and its providers, however, have made solid inroads with the community and are working to improve client-provider relationships. Specifically with regards to work with MSM, the Centre has partnered with SASH Bahamas and the Ministry of Health to hold sexual health expos for MSM (UNGASS 2010) and they have also been working with transgendered individuals.

Sex workers and their HIV risk

"Apart from the stigma already attached to [sex workers], society has further marginalized them as core transmitters of the HIV infection. It fails to understand and recognize that they are but links in broad networks of heterosexual transmission of HIV, and that they constitute a community that bears and will continue to bear the greatest impact of the HIV epidemic."

Meena Seshu, SANGRAM India

Women who sell sexual services to men³ have long been understood to be critical in shaping the dynamics of the global HIV epidemic. HIV prevention with sex workers has considered to be a critical component of comprehensive HIV prevention programming (Vuylsteke, Das, Dallabetta, and Laga 2009), and approaches in this area have evolved over the years. Early on, sex workers were broadly vilified as 'core transmitters,' and some HIV prevention materials depicted sex workers as vectors of certain death. This stigmatizing approach has been rejected in favor of the notion of

³According to the Network of Sex Worker Projects, 'sex work' is an income-generating activity or form of employment for women and men that involves the negotiation and performance of sexual services for remuneration with or without intervention by a third party, where those services are advertised or generally recognized as available from a specific location, and where the price of services reflects the pressures of supply and demand (<http://prostitution.procon.org/view.answers.php?questionID=000849>).

vulnerability⁴, which supports the provision of appropriate, sustainable services for sex workers and other vulnerable groups at scale. It is also increasingly understood that the ability to practice HIV prevention is often influenced by broader social structural factors that may be beyond a sex worker's direct control.

The response to HIV prevention among sex workers has also adopted a human rights perspective, and incorporates the voices of sex workers, and encourages their participation in developing strategies and programs. Legitimizing sex work as work — a form of productive labor — is considered to be another critical issue by many advocates. Advancing the rights of sex workers is seen as increasing their access to HIV prevention, treatment, and care services, and their social inclusion allows them to improve their social and economic status and reduce their vulnerability to human rights abuses (PLRI, 2010).

Vuylsteke, Das, Dallabetta, and Laga state (2009:376): “Sex workers are both at risk because of having multiple sexual partners, and highly vulnerable because of environmental and structural barriers that prevent them from accessing prevention services and having control over their activities.” Critical risk factors include high levels of untreated STIs that are often asymptomatic; infrequent or inconsistent condom use; and unsafe practices such as ‘dry sex’ and use of oil-based (rather than water-based) lubricants with condoms. Sex workers are also made vulnerable to HIV through economic hardship, which is often aggravated by criminalization, violence, stigma, and unequal gender norms, among other factors. Because sex workers are at high risk of HIV and form part of broader sexual networks that bridge to lower-risk groups (such as spouses of their clients), preventing HIV transmission during sex-work interactions needs to be a high priority of HIV programs (Vuylsteke, Das, Dallabetta, and Laga 2009; Overs 2002; Rekart 2005).

High HIV incidence rates among sex workers attest to this need. In both concentrated and generalized epidemics, HIV prevalence among sex workers is estimated to be as much as 20 times higher than among the general population. Some of the statistics are astonishing: for example, in Kisumu, Kenya, in the late 1990s, an estimated 75 percent of sex workers were HIV-positive (Vuylsteke, Das, Dallabetta, and Laga 2009).

Vast global experience in HIV prevention and ample evidence indicate that it is possible to reduce HIV incidence rates among sex workers through the application of a clearly defined, evidence-based package of essential interventions (Vuylsteke et al 2009; Overs 2002; Gutierrez McPherson, Fakoya, Matheou, and Bertozzi 2010). However, such successes have not had the hoped-for impact on HIV epidemics because of challenges in taking the programs to scale.

In most countries, sex workers who need HIV prevention services do not have access to them. Other key obstacles to program scale-up include the criminalization of sex work and the failure of governments to recognize sex work as a legitimate form of labor. Such measures drive sex work underground; obstruct the provision of comprehensive prevention, treatment, and care services; and lead to exploitation and violence against sex workers by the police, other authorities, and the general population.

⁴ In this paper, vulnerability refers to factors in the broader social and/or physical environment that affect the likelihood of disease transmission.

The situation in the Caribbean for MSM and sex workers

The Caribbean region has the second highest general population HIV prevalence in the world. An estimated 230,000 people were living with HIV in the Caribbean in 2007 (UNAIDS 2008).

Approximately 60 percent of all AIDS cases reported to the Caribbean Epidemiology Centre (CAREC) are attributed to heterosexual transmission. Sex between men accounts for approximately 15 percent of these cases, injecting drug use accounts for two percent, and vertical transmission six percent (Figueroa 2008). These figures may underestimate the percentage of the overall HIV burden attributed to sex between homosexual and bisexual men due to non-disclosure of these practices (Caceres 2002).

HIV prevalence within populations engaging in high-risk sex in Jamaica, however, is much higher than that of the general population: nine percent among female sex workers and 32 percent among MSM (Jamaica National HIV/STI Programme 2010). While no firm data exist, HIV prevalence among MSM in The Bahamas is estimated to be around eight percent. According to a recent WHO/UNAIDS epidemiology fact sheet, it suggests that HIV prevalence among sex workers in urban areas in The Bahamas in 1991 was as high as 44 percent (UNAIDS/WHO/UNICEF 2008), but others have not been possible to corroborate this.

Early on, ministries of health and civil society in both countries made sincere efforts to address HIV and AIDS for their general populations, though in small-scale and in a somewhat un-standardized way. Until recently, these responses did not include a strong focus on reducing the vulnerability to HIV of MSM and sex workers due to multiple factors, such as denial, stigma, homophobia, an unhelpful legal and policy environment, and lack of political will (Figueroa 2008; Caceres 2002; White and Carr 2005).

In many ways, the response in the Caribbean reflects an overall lack of attention in middle- and low-income countries to the HIV burden among marginalized populations (Baral, Sifakis, Cleghorn, and Beyrer 2007). The response in the Caribbean also reflects the fact that sex work and buggery are criminalized, as well as the fear and denial that surround these issues in a region where national economies are heavily dependent on tourism (Brennan 2004; Kempadoo 1999). National governments, the Pan-Caribbean Partnership Against HIV/AIDS (PANCAP), UN agencies, the Red Cross, and numerous national, regional, and international NGOs are beginning to respond to the prevention and care needs of MSM and sex workers in Caribbean countries. For instance, PANCAP includes decriminalization or reduction of legal or social barriers related to sex work and MSM among its key policy initiatives and the Carisma social marketing program is a PANCAP development project that works with MSM and sex workers in several countries in the region. However, scale-up and sustainability are key challenges, given the unsupportive legal and social environments and the inadequate capacity of local organizations to take on these difficult and comprehensive tasks.

Factors Influencing the Vulnerability of Men Who Have Sex with Men

Like all social practices, sexual interests and sex between men is strongly influenced by cultural, individual, and interpersonal dynamics. Prevailing epidemic conditions determine whether and to what degree such practices expose an individual to HIV and other diseases. The next section highlights a number of critical factors in the individual, interpersonal, and social environment that influence the riskiness of male-to-male sex in the Caribbean.

HIV- and MSM-related stigma and discrimination

Stigma and discrimination related to HIV status and presumed or known sexual orientation are critical issues affecting HIV prevention in Jamaica and The Bahamas. Stigma against men who have sex with men is pronounced, with repercussions that range from verbal and physical abuse to imprisonment and homicide. Stigma also leads to low self-esteem, abuse of alcohol and drugs, and reluctance to access HIV and other health-related services. Stigma drives men who engage in same-sex practices underground, and makes them afraid to come forward for programs and needed support. MSM in Jamaica, The Bahamas, and elsewhere who are HIV-positive face a double stigma:⁵ for their sexual practices and lifestyle choices and stigma that derives from fears and misunderstandings about HIV and how it is transmitted (Ogden and Nyblade 2005).

Gender and social norms

Gender norms are the ideas and ideals in a given culture concerning appropriate behavior and social positioning of women and men and boys and girls. Gender norms also play a central role in shaping sexuality and sexual interests, prescribing what practices and behaviors are considered legitimate and for whom.⁶ In the Caribbean and elsewhere, men are socially expected to be tough, sexually dominant, risk-takers (White and Carr 2005). It is accepted that 'real' men will have sex with multiple female partners.

Homosexuality is thought to subvert these masculine ideals. To avoid stigma and social opprobrium, men may have clandestine sex with other men while maintaining a number of concurrent sexual relationships with women to assert their manliness and heterosexuality (Free Forum 2009). The strong social sanction against 'feminine' men fosters and sustains a prevalent perception of sex between men as deviant. These beliefs and sanctions drive homophobia, stigma, discrimination, and violence against same-sex practicing men (Human Rights Watch 2004), and may likewise drive risky sexual behavior.

For example, a recent study among HIV-positive African American men found that men who had sex with both men and women reported more non-injecting drug use and more sexual partners than men who had sex with only women or only men. This group was more likely to report unprotected sex with female partners than HIV-positive men who had sex only with women, and were more likely than the other two groups to have a partner that used drugs or whose HIV status was

⁵ For details on the relationships between stigma and HIV vulnerability among MSM see Agala, Beck, Lauer, Renyolds, and Sundararaj 2010.

⁶ For a thoughtful discussion of gender and its role in HIV epidemics in the LAC region, see Rao Gupta 2002.

unknown. The study concluded that bisexual African American men living with HIV needed specific support for HIV prevention, since they engaged in more sexual and drug risk-behaviors than their heterosexual and homosexual counterparts (Spikes, Purcell, Williams, Chen, Ding, and Sullivan 2009).

Religion

The fact that Jamaica and The Bahamas are religiously conservative is thought to contribute to the prevailing homophobia, stigma, and discrimination against MSM and MSM living with HIV (White and Carr 2005; McCullom 2010). Many churches in Jamaica denounce homosexuality as a sin and refer to the Bible to reinforce their messages (Human Rights Watch 2004). Similarly, the Rastafarian movement considers homosexuality an evil and unnatural abomination (Maiorana, Myers, Rebchook, Kassie, Lall, and Bombereau 2010). Robert Carr, co-chair of International Council of AIDS Service Organizations, stated at the 2010 International AIDS Conference that in Jamaica “[t]here is a clear link between religious condemnation, criminalization, stigma, and HIV infections. We see this all the time in the Caribbean... Politicians and church leaders endorse homophobic violence...”

Age and intergenerational sex

HIV prevalence among young MSM may be 20 to 30 times higher than in the general population, though few studies have explored the specific challenges and needs of these young men. The age of sexual debut in the Caribbean region is generally very low (White and Carr 2005). A survey of nine Caribbean countries conducted by the Pan American Health Organization (PAHO), for example, found that 55 percent of boys have sex by the age of 10. It also found that the difference in age between boys and their sexual partners was greater than age difference between girls and their sexual partners (Allen 2002).

At the International AIDS Conference in 2006, Nesha Haniff from Jamaica AIDS Support for Life (JASL), reported on a study of 12 young men who had unprotected sex before seeking an HIV test. Most came from extremely poor backgrounds, at least half of the small sample had sex against their will, and more than half were involved in transactional sex. Young MSM also adopted a dual identity: they were outwardly masculine, while enacting a dependent, powerless, ‘feminine’ role in their relationships with men. While they might accept being beaten by a partner in their more feminine role, their identity as a man permitted them to feel justified in having other sexual partners, both male and female (Haniff 2006). Jaevion Nelson from Jamaica Youth Advocacy Networks explained that although an older man — a ‘top’ sexually — might buy gifts for a young sexual partner/friend and expect him to look fashionable and well dressed, he would not acknowledge the person in public or be seen with them.

A study of urban MSM youth in the United States argues that there is a syndemic⁷ in this population comprising HIV, psychosocial problems, multiple sexual partnering, and unprotected anal sex

⁷ Syndemic, a term coined by medical anthropologist Merrill Singer, describes the co-occurrence and interaction of two or more diseases that exacerbate the negative health effects of any or all of the diseases. The term is particularly used to describe the interrelationships between concurrent (or co-current) diseases and the social conditions that cluster the diseases within a given population.

(Mustanski, Garofolo, Herrick, and Donenberg 2007). Given the extreme vulnerability of young Caribbean MSM, it is reasonable to expect that a similar relationship exists between psychosocial challenges, unsafe behavior, and HIV infection. More research is needed to better understand the relationships between youth and HIV risk in this population (Melles and Nelson 2010).

Class and economic status

Class and economic status also play important roles in understanding risk and vulnerability of MSM in the Caribbean. In an exploratory study in Jamaica, White and Carr (2005) found that poor HIV-positive men were less able than wealthier men living with HIV to avoid the stigma that discourages them from seeking HIV testing and other health services and obtaining prevention commodities such as condoms and lubricants. Other scholars have observed that class and ethnic segregation contribute to social and sexual vulnerability in the region (Caceres 2002; Free Forum 2009; Allen 2002; Hanff 2006).

Class and ethnicity may also have an effect on exposure to risk. Mays and her colleagues (2004) suggest this is reflected in the multiple group memberships of African American MSM, where some are marginalized and some are not. These authors suggest that MSM sub-groups such as ‘homothugz’ can be partly explained and understood as a response to a hostile culture for MSM in the African American community, where they are a minority within a minority. Having the identity as a thug provides a degree of protection. These authors posit that these MSMs’ sense of identity and integration are linked with HIV risk-taking, and that African American men with better integrated racial, ethnic, and sexual identities are more likely than other men to engage in protective behaviors. For men whose identities are in conflict, feelings of loathing and shame are associated with alcohol and drug addiction (Mays, Cochran, and Zamudio 2004).

Violence, including sexual violence

Jamaica has come to be known as “the most homophobic place on earth” (Human Rights Watch 2004). Two of the island's most prominent gay activists, Brian Williamson and Steve Harvey, were slain in recent years, and MSM are frequently the target of gang violence. A *Time* magazine article in 2004 reported that a teen was almost killed after his father invited a group to lynch him at school, and that police encouraged another mob as they stabbed and stoned a gay man to death in Montego Bay (Padgett 2004). These sources concur that the homophobic violence witnessed in recent years is both reflected in and spurred on by a thuggish trend in the country’s music scene, which famously includes the Buju Banton song *Boom Bye Bye*, whose lyrics state that gay men “haffi dead” (have to die).

A small unpublished qualitative study of 22 focus group discussion participants in Jamaica found that MSM known as ‘thugs’ enjoy rough, physically violent sex (Anderson 2010), and that some men like to batter (beat) or be battered by their partners, although not typically during sex. A few of the young HIV-positive focus group discussants in this study reported being raped by older and typically trusted men. Respondents in the study also reported police brutality, including rape by police officers.

Legal climate

Stigma, discrimination, and violence against same-sex practicing men and women in the Caribbean are underpinned and perpetuated by laws criminalizing anal sex and other same-sex practices.⁸ While The Bahamas repealed such laws in the early 1990s, Jamaica continues to have anti-sodomy laws on the books, and homophobic ideas persist among some Parliamentarians. “Most former British colonies have not only kept these (anti-buggery) laws, but they also enforce them...Any historical analysis of the punishment for homosexual behavior in Africa, Asian or English-speaking Caribbean countries will see a clear legacy of the British Empire at play” (Dee 2010). This legal climate contributes to an extremely challenging policy environment for effective, long-term, and wide-scale HIV prevention.

Human Rights Watch (2004) reported that “legal provisions criminalizing consensual sex between adult men are used to justify the arrest of peer HIV educators and to deny HIV prevention services to prisoners, among others.” The laws directly hamper the delivery of health services to these vulnerable men and women; JASL and others who deliver services at the community level do so as quietly and clandestinely as possible to protect their workers from potential reprisals by the community and the police.

In the English-speaking Caribbean, the following countries have buggery laws that criminalize sodomy: Antigua and Barbuda, Barbados, Belize, Dominica, Grenada, Guyana, Jamaica, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, and Trinidad and Tobago (UNAIDS 2010). The Bahamas, Cuba, Dominican Republic, Haiti, and Suriname do not have such laws. The significance for HIV prevention is illustrated in table 1, which compares estimated HIV prevalence among MSM in some of these countries (UNAIDS 2010a).

Buggery criminalized		Buggery not criminalized	
Country	HIV prevalence among MSM	Country	HIV prevalence among MSM
Jamaica	25%*	Bahamas	8%
Guyana	22%	Suriname	7%
Trinidad & Tobago	~20%	Cuba	<5%

* Note: other sources have placed the MSM HIV prevalence rate at as high as 32%.

There is growing call for decriminalization among those engaged in HIV prevention, given the kind of data shown in this table and the importance of human rights for a sustained HIV prevention response (Figuera 2008; Caceres 2008; UNAIDS 2010a).

⁸ White & Carr (2005) reference the Jamaica Criminal Code's Offences against the Person Act, which contains sections that deal with male homosexual acts and non-gender-specific anal intercourse. Article 76 stipulates that anyone committing buggery with man or animal is 'liable to be imprisoned and kept to hard labor for a term not exceeding 10 years.' Under Article 79, any male convicted of “any act of gross indecency with another male person” is liable to receive a maximum sentence not exceeding 2 years, ‘with or without hard labor.’”

Low uptake of health services

The impact of negative and stigmatizing health-worker attitudes on the uptake of services is widely acknowledged. In the Caribbean region, laws criminalizing sex between men, strong social taboos, and the belief that health workers will stigmatize and disclose information contribute to the poor access to and uptake of STI and HIV testing services by MSM (Abell, Rutledge, McCann, and Padmore. 2007; Caceres 2002). When men use these services, they are unlikely to disclose that they practice oral or anal sex with other men, and some infections may be missed. More affluent MSM reportedly either seek the support of private practitioners who do not report STI and HIV rates, or travel to other islands within the region or to the United States for services and support. MSM without the necessary resources often go untreated until late in their disease.

Psychosocial health and drug use

The association between low self-esteem, depression, substance abuse, and increased risk-taking is well documented. For example, in a large telephone survey in four US cities, Stall et al. (2003) examined the association between high-risk behavior and positive HIV serostatus with psychosocial health problems, partner violence, polydrug use, childhood sexual abuse, and depression. Although these authors found partner violence and polydrug use were significantly associated with HIV seropositivity and that partner violence, poly-drug use, and childhood sexual abuse were positively associated with higher-risk sexual behavior, their main conclusion was that an additive interplay exists between risk, HIV serostatus, and psychosocial health problems. Although no causal attribution could be made from this household survey, its size gives some confidence in the validity of the findings.

Safren, Wingood, and Altice (2007) similarly conclude that more attention needs to be given to co-morbid, psychosocial problems among MSM, and that more interventions need to be based on social psychology to target HIV-associated norms, attitudes, and general behavior.

Use of the Internet

The literature generally shows higher prevalence of unprotected anal intercourse between men who meet via the Internet (Benotsch, Kalichman, and Cage 2002), though the data are inconclusive. For example, Liao, Millet, and Marks (2006) found that among the 40 percent of MSM in the United States who use the Internet to find sex partners, 49 percent are more likely to engage in unprotected sexual intercourse, while 41.2 percent are not more likely to do so. Horvath, Rosser, and Remafedi (2008) somewhat contradict these findings. They found that while men who used the Internet to meet men tended to have more sexual partners, this sex was not necessarily more likely to be unprotected. This likelihood was increased when the men were drunk or high when meeting partners through the Internet.

While there are Internet chat rooms and men seeking sexual partners on the Internet in the Caribbean, the percentage of MSM who meet sexual partners in this way is not known. Data, however scant, from other parts of the world suggest there is a growing trend in this regard in low to middle-income countries. For example, in three southern African countries, 50 percent of MSM reported meeting sexual partners over the Internet (Baral, Sifakis, Cleghorn, and Beyrer 2009).

On the other hand, researchers acknowledge the importance of the Internet as a social networking tool and a way to meet (non-sexual) friends, gain support, and limit the sense of isolation and fear that many MSM experience, particularly those living in extremely homophobic societies. It is also a useful tool for intervention. JASL in Jamaica found, for example, that the Internet was a very useful way to contact the Caribbean diaspora as a means of identifying key MSM community stakeholders in the Eastern Caribbean (Carr, McKnight, and Lewis 2004). The Internet also has immense potential for HIV prevention education and stigma reduction, as the recent US campaign “Greater Than AIDS” indicates.

Indigenous MSM responses

As in the early response to HIV, the MSM community continues to incorporate its own prevention approaches. Community-generated prevention approaches include:

- Sero-sorting: selecting partners on the basis of known or assumed HIV status;
- Strategic positioning: limiting receptive or insertive roles on the basis of known or assumed HIV status of both partners;
- Withdrawal before ejaculation; and/or
- ‘Negotiated safety’: agreeing not to use condoms within a stable relationship and either maintaining mutual fidelity or using protection in all extra-relationship sex.

Currently, no formal study of these protective practices has been undertaken. While some may reduce risk or be simply ineffective, it is possible that some may actually increase risk. More research is needed in this area.

Factors Influencing Sex-Worker Vulnerability

The purchase of sex by men is a norm in some cultures. In a number of low-income countries, 20 to 40 percent of men stated they had regular sex with sex workers (Aklilu et al. 2001; Morison et al. 2001). Sex work is often a secret, clandestine, and underground activity, though it occurs everywhere in the world and takes an almost infinite number of forms. Harcourt and Donovan (2005) list over 10 broad categories of direct sex work, where the primary purpose is to exchange sex for a fee. Not all forms of sex work take place in every country or setting, and great variation also exists in terms of the extent to which sex work is criminalized, legalized, or recognized as a legitimate form of work. Both the plurality of styles and the vagaries of policy environments have added to the challenge of providing comprehensive, sustainable, and rights-oriented HIV prevention, treatment, and care for sex workers and their clients.

In the Caribbean, sex work is associated with the tourist trade, a critically important part of the economies of the region (Kempadoo 1999). The other important backdrop is poverty. Harcourt and Donovan (2005) and Adomakoh (2007) show that most sex work is economically driven, and that sex tourism is a key element in the sex industry in the Caribbean, though sex work also takes place in Suriname, Guyana, and other countries in the region that lack highly developed tourism industries (Adomakoh 2007). Another key feature of sex work is its ties to migration and mobility, both between and within countries. Marlene Taylor, a researcher in Jamaica working with sex workers found sex workers in Jamaica travel to neighboring islands for one month or longer where “business is better and they earn US dollars” (nd).

In her sub-regional analysis of sex work in the Caribbean, Adomakoh argues that links with the tourism industry provide more than a daily wage for some sex workers. She states that sex work provides women with opportunities for “getting ahead, studying, traveling, [and] recreation” (Adomakoh 2007:24). She suggests that the sex industry — particularly high-end, escort services — is expanding in the Caribbean to include professional women and others from a range of socio-economic backgrounds who want to improve or maintain a high-status lifestyle in a challenging economic climate. She offers a long list of tourism-related forms of sex work in the region, including romance tourism, transactional sex with tourists, provision of sexual services through an agency, offers of ‘experiences’ that last from a few hours to a few days, and production of adult films on demand. While her analysis covers the whole region, the complexity of the trade indicates the importance of individual, country-specific analyses, particularly for The Bahamas and other countries where little is known about the sex industry.

Factors identified in the literature as influencing the HIV risk and vulnerability of sex workers are identified below. These can be directly addressed by behavior-change efforts to ensure that prevention technologies are used or that individuals no longer engage in behaviors that expose them to infection (aids2031 Social Drivers Working Group 2010).

High number and turnover of sexual partners

Many sexual partners is an indicator of professional success in the sex trade as well as a key factor that elevates the HIV risk of sex workers. Their high rate of partner change led to sex workers being

considered an epidemiologic core group that accounts for a disproportionate amount of STI/HIV transmission within a community (Plummer, Nagelkerke, Moses, Ndinya-Achola, Bwayo, and Ngugi 1991; Thomas and Tucker 1996; Vuylsteke et al 2009). Overs (2002) notes, that interventions to prevent transmission among those with high rates of partner change “prevents more secondary cases per primary case averted than interventions directed at those who practice low risk sex.” This applies both to sex workers and to men who acquire HIV during unprotected commercial sex and transmit it to their other partners.

The absolute number of partners is not the only issue. Having a large number is particularly risky if accompanied by low rates of condom use and/or high rates of sexual infections. The risk faced by sex workers in any given encounter is also influenced by the nature of the clientele (whether they are they violent, drunk, or using drugs) as well as the environment where the encounter takes place (whether the street, a brothel, or a five-star hotel).

Inconsistent condom use

Historically, a key focus of HIV prevention interventions with sex workers has been on increasing their knowledge of consistent and correct condom use and their access to condoms. Some successes have been achieved through the 100% condom use programs in the Dominican Republic (Kerrigan et al. 2006) and Thailand (Rojanapithayakorn and Hanenberg 1996), as well as through other, less formalized peer-outreach efforts that increase the availability of condoms at bars and entertainment venues.

According to Vuylsteke, Das, Dallabetta, and Laga (2009), researchers no longer report the low rates of condom use with paying customers that were observed early in the epidemic. In a recent study in Jamaica, for example, 90 percent of sex workers reported having easy access to condoms and to using condoms at last sex with local and tourist clients (Duncan et al. 2010). However, even where sex workers are able and willing to use condoms with paying clients, the challenge is to ensure consistent use with non-paying partners (Vuylsteke, Das, Dallabetta, and Laga 2009: 381) as well as longer-term paying partners (or regulars). Among the same sample in Jamaica, only 30% used condoms with nonpaying partners.

Condom use is also influenced by the economic standing of the sex worker and whether or not she uses drugs or alcohol. Use of alcohol has been proven to be a significant risk factor for unprotected sex (Fritz et al. 2002), and this is no less true for sex workers and their clients (Tureski and Gottert 2010). Studies have also found that poor, street-based, and/or drug-using sex workers are less likely to possess their own condoms and less likely to refuse a client who does not want to use one (Overs 2002). More recently, Shannon et al. (2009) found that charging more for sex without a condom is a strategy used by extremely poor, young, and/or drug-using sex workers.

Consistent condom use among sex workers can be achieved through effective community mobilization and outreach, including through behavior change messages delivered through edutainment and other approaches (Vuylsteke, Das, Dallabetta, and Laga 2009). Promoting consistent and correct condom use to sex workers’ clients reinforces these efforts, along with

interventions that help sex workers to develop negotiation strategies around condom use. Regular and reliable supplies of condoms and lubricants are essential for an enabling environment.⁹

Frequent STIs

Sex workers typically have higher rates of STIs than the general population. Because STIs are thought to facilitate HIV transmission, their high prevalence among sex workers are a factor that drives up their HIV rates (Vuylsteke, Das, Dallabetta, and Laga 2009). STI prevention among sex workers has been an important area of HIV prevention, and STI treatment and care should be part of a comprehensive package of services available to them, along with reproductive health services.

There is debate in the literature about the most appropriate, efficient, and ethical way to provide these services. Avahan in India (Steen et al. 2006) and other programs established dedicated mobile clinics and strategically located stationary clinics where sex workers could avoid the stigma and judgment of other patients and meet staff trained to support and meet their special needs, including in interventions for rape and other forms of violence.

Others argue that more sustainable and less stigmatizing approach is integrated STI and reproductive health services and additional training for providers within general primary care centers. However these services are delivered, STI services for sex workers should include regular check-ups, HIV counseling and testing, regular screening (because many treatable STIs are asymptomatic in women), and presumptive treatment for extremely prevalent STIs, even if the screening is negative (Vuylesteke, Das, Dallabetta, and Laga 2009).

Unsafe practices

The literature touches upon drug use and alcohol use that sex workers may engage in that are strongly associated with increased risk-taking among sex workers. Rekhart (2005) discusses these issues in detail in relation to the harm-reduction approach he advocates for sex workers where drug use is an important issue. In the Caribbean, injection drug use is less of an issue for sex workers than alcohol or marijuana use (Surratt 2006; Duncan et al. 2010). However, crack cocaine has been an issue in the HIV epidemic in The Bahamas since the late 1980s and early 1990s (Gomez et al. 2002; Gomez, Kimball, Orlander, Bain, Fisher, and Holmes 1996), and may be increasingly important in Jamaica (Duncan et al 2010).

Men in some cultures are thought to prefer 'dry sex' and the feeling of un-lubricated vaginas, often achieved when women apply certain herbs, douches, or chemical drying agents. This practice increases the risk of small tears in the vaginal wall that are an entry point for HIV infection during intercourse. Two studies reported preferences for dry sex in the Caribbean: in Suriname (van Andel, de Korte, Koopmans, Behari-Ramdas, and Ruyschaert 2008) and in the Dominican Republic and Guyana (Halperin 1999). This may be a more common practice in the region than previously thought, and may merit further exploration as it relates to sex worker risk in Jamaica and The Bahamas.

⁹ In Cambodia, a new anti-trafficking law is having dramatically negative effects on sex workers. Police now feel entitled to arrest women simply for possession of condoms. Those supplying condoms to sex workers may also be implicated in trafficking, arrested, and detained and/or fined (Overs 2010).

Criminalization

Prohibition or criminalization of sex work poses serious challenges for HIV prevention, as it drives sex work underground, makes sex workers difficult to reach, and does nothing to address the violence, abuse, and exploitation that often characterize their working conditions.

Stigma and discrimination

Sex work and sex workers are stigmatized nearly everywhere in the world. Until recently, policy statements in Vietnam allied sex work and sex workers directly with HIV and referred to them as ‘social evils’ (Ogden and Nyblade 2005; Ha et al. 2010). This reflects the moral opprobrium that surrounds the practice in many countries, including Jamaica and The Bahamas. Sex workers are often seen as symbols for everything that is wrong in society, from crime, disease, and drugs to the breakdown of the traditional family and the over-sexualization of the young (Parker, Caceres, Khan, and Aggleton 2001; Vuylesteke, Das, Dallabetta, and Laga 2009).

Where stigma prevails, prevention efforts and general wellbeing suffer. The stigma surrounding sex work and sex workers in the Caribbean creates issues and HIV prevention challenges that are similar to those for MSM. Like MSM, sex workers have difficulty in accessing prevention services. They fear coming forward for HIV services, lest their neighbors and acquaintances become aware of their HIV status and spread rumors that lead them to be ostracized and lose their jobs, children, or homes. The use of HIV prevention commodities such as condoms can likewise single a person out as HIV-positive or at risk of being infected through ‘promiscuous’ behavior. Fear of stigma and social opprobrium can also prevent HIV-positive (or potentially HIV-positive) pregnant women from accessing prenatal and obstetric care and access to treatment that could prevent the spread of HIV infection to their babies.

Violence and exploitation

Violence against sex workers is a manifestation of the stigma and discrimination they experience, and a persistent problem globally (WHO 2005). Rekart (2005) cites over 13 studies of this issue, and it is a frequent topic of debate and discussion on blogs and websites concerned with sex workers rights and HIV.

UNIFEM (2007) reported on a study of violence and sex work in the Caribbean by the Caribbean Association for Feminist Research and Action (CAFRA) that stated that 90 percent of the sex workers interviewed in Guyana had been assaulted by clients. Most of these acts of violence went unreported, and the women often did not seek care for their injuries due to stigmatizing attitudes of healthcare providers.

Violence also contributes to HIV vulnerability: at least one study has shown a correlation between experience of intimate partner violence and HIV infection (Dunkle et al. 2004), while others have suggested that fear of violence can interfere with condom negotiation and enhance HIV risk in myriad other ways (Beattie et al. 2010).

Violence against sex workers often goes hand in hand with exploitation and/or extortion by police and other security forces, particularly where sex work is completely illegal. In India, for example, 70

percent of sex workers surveyed reported they had been beaten by police, and more than 80 percent had been arrested without evidence (WHO 2005).

Gang rape is a persistent atrocity experienced by sex workers in many African countries such as South Africa and Uganda. The public often sees such violence as justified, given the general disdain for sex workers as well as their ambiguous or criminal legal status. Even sex workers themselves see violence as just “part of the job” (WHO 2005; Rekhart 2005; Overs 2002), and the majority of the violent crimes committed against them go unreported (WHO 2005). The fact that sex workers are often unaware of the rights they do have increases their vulnerability. Programs to end violence against them sometimes try to start with sensitizing the police (UNAIDS 2000). One experiment in India even mobilized sex worker advocates as police watchdogs to ensure that sex workers were not harassed (Biradavolu, Burris, George, Jena, and Blankenship 2009).

Mobility and migration

Globally, many sex workers are migrants or mobile within a given nation state. Mobility is independently associated with HIV risk, so migrant sex workers face multiple risks and multiple vulnerabilities related to HIV. These women are difficult to reach, and many face cultural, social, legal, and linguistic obstacles that prevent them from accessing health services and information.

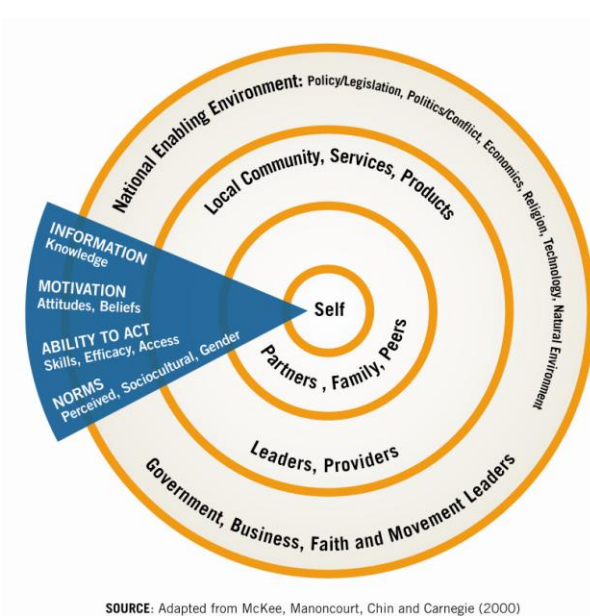
The literature suggests that many sex workers in the Caribbean are migrants from other countries in the region (Surratt 2007). Mobility within countries is also an issue for HIV transmission dynamics and risk. A recent study in Jamaica indicated that 50 percent of sex workers worked outside their home parishes (Duncan et al 2010).

Using a Socio-Ecological Model to Find the Tipping Point for Change

This chapter describes C-Change’s Socio-Ecological Model for Change and applies it as a framework for discussing HIV prevention interventions used in different settings to reduce risk and boost the resilience of MSM and sex workers. Examples are also provided of successful and/or innovative programs to promote HIV prevention with MSM and sex workers. The programs in this report are organized according to levels of analysis of the socio-ecological model; however, many of the programs have elements that apply to all levels.

The social-ecological model illustrates the important interrelationship between various levels of influence in the production of health outcomes (McKee 1992). The C-Change project adapted this model and incorporated it into a Framework for Social and Behavior Change Communication (SBCC).

Figure 2: A Socio-Ecological Model for Change



The Socio-Ecological Model for Change (fig. 2) has two parts: levels of analysis and cross-cutting factors. The levels are represented by four concentric rings, with ‘self’ at the center. Each subsequent ring represents a set of social institutions, organizations, or actors that influence each other. For programmers, the question to answer is: In which level or levels in my setting is the tipping point for change?

- Interventions directed to the individual or ‘self’ who is most affected by the issue are in the first level.

- Interventions directed to partners, family, and peers who directly influence the self are in the second level or ring.
- Interventions that target the local community (members and leaders), services and products, and providers are at the next or third level, and may directly influence the ‘self’ at local or community levels. All of these factors may shape community and gender norms, as well as access to and demand for community resources and existing services.
- The fourth level or ring is the national enabling environment, which can facilitate or hinder change. Within it are social institutions and leaders who affect ‘self’ at the national level: government policies and regulations, political forces, prevailing economic conditions, the private sector, religion, technology, and the natural environment. Actors at this level— such as national government, business, and faith and movement leaders—are often targets for advocacy and social mobilization activities.

Cross-cutting factors (represented in the triangle) are issues that need to be attended to or addressed at each level of analysis. These factors — information, motivation, and ability to act, and norms— influence each level and ultimately affect where change can occur. For programmers, the question to answer is: How are these factors addressed by programs across all levels?

Promising Approaches and Practices for HIV Prevention among MSM and Sex Workers

Interventions directed at individuals (self) — level 1

At the individual level, behavior change approaches focus on providing individuals most affected by HIV risk with the information, motivation, and technologies necessary to change sexual (and/or injection practices) from risky to safe or to maintain healthy habits and choices (Coates, Richter, and Caceres 2008).

These approaches might include delivery of accurate information about HIV and AIDS through population-appropriate media; delivery of information to guide accurate risk-perception; interventions to increase correct use of condoms and condom negotiation skills; partner communication; provision of condoms, water-based lubricants, and information regarding penile hygiene; provision of clean needles and syringes and drug therapies for opiate users; and provision of information and support to enable timely and appropriate use of health and social services.

These outcomes may be achieved through a range of strategies, such as HIV/STI counseling; peer-education; support groups and networks (including post-test clubs); skills-building; motivational approaches; and mental health support and assistance with substance misuse and abuse. Individual-level SBCC approaches include interpersonal communication, edutainment, and drama that address social norms; use of information and communications technologies, including mass media, hotlines; and, more recently, Internet-based chat rooms and social networking sites.

Interpersonal communication approach

Stand-alone peer education programs for sex workers and MSM were more frequently employed early in the epidemic. Currently, they often constitute one component of a more comprehensive program. When HIV was less well known or understood by the general public than it is today, approaches that focused on peer-to-peer delivery of information, support, and commodities were an essential mechanism for increasing condom use and STI treatment, particularly among marginalized groups that had less access to more conventional channels of information. Some of these programs had the additional effect of creating a sense of group solidarity and empowerment. With the increase of social media and accessibility to technology, interpersonal communication approaches can also access non face-to-face channels such as internet chat rooms as appropriate for the audience.

Examples of interpersonal communication for MSM

The Internet has been used by many programs to reach MSM and other difficult-to-reach groups. It has also been used to disrupt sexual networks and protect lower-risk MSM from connecting with higher-risk MSM (McFarlane Kachur, Klausner, Roland, and Cohen 2005; Wohlfeiler and Potterat 2005; Anderson 2010).

CyBER/M4M (United States): This community-based participatory research partnership is a chat-room-based prevention intervention designed to reduce HIV exposure and transmission among gay men and MSM who use chat rooms (Rhodes et al. 2010). Gay-identified men using chat rooms and community-based participatory research contributed to the development of a training manual and reference guide for lay health educators.

Participants were recruited from five chat rooms—two geared to African American MSM—that facilitate social and sexual networking among MSM in central North Carolina. The educators were online in random two-hour shifts and followed a standard protocol. They announced their purpose and availability to answer questions when they entered the chat room, then provided education about HIV and AIDS through general messages. The educator had to be mindful of chat-room culture and not overburdening participants (chatters) with health messages, as “too aggressive of an online approach was likely to alienate the chatters or even result in expulsion of the educator from the chat room” (Rhodes et al. 2008). Messages included: “In the room to answer questions about HIV and AIDS;” “I can answer questions about HIV and AIDS;” “Want to get tested for HIV? I can help;” and “Need condoms? I can tell you where to get them free.” Educators only sent instant messages directly to participants if contacted this way first.

Results: Quantitative and qualitative data informed the assessment, which documented the intervention and described the characteristics of chatters and their HIV risks and prevention needs. Of the 1,851 chatters who participated in the 18-month intervention, 210 completed the online assessment. Their mean age was 30, the majority self-identified as gay, and 25.8 percent self-identified as bisexual. More than half self-identified as white and one-third as black. A total of 8.6 percent reported being HIV-positive, and 14.8 percent reported never having been tested for HIV. Most chatters were looking for sexual partners, were not open about their sexual orientation, lacked basic information about HIV, had questions about how to be tested, and perceived a lack of general community resources to meet their needs.

Although the popularity of chat rooms among MSM in Jamaica and the rest of the Caribbean is not known, a report by Anderson in 2010 indicates chat rooms are of growing importance in this population. This intervention could thus provide a new peer-led approach that reaches hard-to-reach MSM with prevention advice and support.

The Pink Report and Gay Jamaica Watch (Jamaica) are two websites in Jamaica that provide information on current events and programs that impact the MSM community. The founder of Gay Jamaica Watch Blog stated “I’m concerned about the lack of free flow of information about The Jamaican Gay, Lesbian, Bisexual & Transgendered experiences, hence my Blogs & Network pages playing my part in allowing expression & cross fertilization of ideas between the various groups” (Gay Jamaica Watch nd).

An example of interpersonal communication for MSM and sex workers

Text Me! Flash Me! Watch Me! Helpline (Ghana): The Ghana (Strengthening HIV and AIDS Response Partnerships) (SHARP) project developed an initiative utilizing short messaging services

(Text Me), cell-phone based counseling (Flash Me) and video clips for cell phones (Watch Me) to support the eight key behaviors the SHARP project promoted and to increase access and uptake of HIV and AIDS information and advice, and referrals to client friendly clinics. Initially the program was aimed at MSM in 2008, but expanded to sex workers in 2009. The pilot program complemented the work of peer educators and health workers, and reinforced and diversified the sources of information, referrals and counseling already provided to MARP communities to reach those who wanted to make anonymous inquiries and receive information, referrals or counseling (Ledsky, Pyle and Clemmons 2009).

The project trained twelve counselors to provide services and were trained on phone based counseling skills, provision of MSM-friendly HIC and STI counseling and referral services, and ethical procedures for handling sensitive data and confidentiality for MSM and other MARPs (Ledsky, Pyle and Clemmons 2009). In addition, promotional flyers were circulated among networks, and prizes were offered during the pilot to encourage use of the Helpline.

Results (Ledsky, Pyle and Clemmons 2009): From September 2008 to January 2009, 1,634 Helpline call sessions were recorded. An evaluation of the pilot indicates the Helpline has had a significant **impact on STIs and counseling and testing service uptake** among MSM and sex workers. Some significant findings from the evaluation are:

- 86.9% of those surveyed shared information they received from the Helpline call session with others;
- 39.8% forwarded texts onto others to educate others or to share information;
- 43% of the users first accessed the helpline through Flashing (waiting for a call-back) and 33.6% said they texted the helpline; and
- Counseling and testing was the most frequent referral made through the Helpline and 46.6% of the clients reported that they followed up and went for the services they were referred to.

From the evaluation, the project concluded:

- Texting the Helpline and waiting for a counselor to get back to them appears to be an acceptable approach for contact;
- Clients cite the information they received as the thing they liked most and learned basic information on counseling and testing, HIV and its treatment, partner reduction, STI and condom/lubricant use;
- Helpline is a promising channel to refer clients to services.

Mass media campaigns

Mass media campaigns reach large and diverse audiences that include members of the vulnerable groups, key gatekeepers (such as health care providers, police, and other officials), and the general community. These campaigns can contribute to changing social norms and lead to greater acceptance and reductions in stigma and homophobia that constitute a barrier to HIV testing and counseling and other HIV services.

Example of a mass media campaigns for MSM

Acceptance Begins at Home (Brazil): Brazil's Ministry of Health responded to a sharp increase in HIV prevalence among MSM and terrorizing activities of anti-gay 'extermination' groups with a mass media campaign that promoted condom use and countered homophobia and discrimination, within the general population as well as among health providers (Lyra 2008). Along with the mass media campaign, the project provided direct interventions for young MSM, sensitization for health and educational professions, and interventions to manage controversy.

Eighty groups of MSM helped to distribute the campaign's materials and messages that linked condom use to self-esteem and self-care and promoted HIV testing and counseling. Information packets for educators and educational videos for students were distributed, along with materials and training for health professionals. A video and advertisements were produced for movie theatres frequented by MSM; posters, stickers, key chains, and condom dispensers were distributed or placed in bars and nightclubs; and classified advertisements were published in special-interest magazines. The mass media campaign included TV and magazine advertisements, as well as posters and leaflets. The television advertisement dramatized and modeled parental support for homosexual sons, and messages emphasized acceptance of and respect for diverse sexual orientations.

From the outset, potential counter-campaigns and increases in violence were planned for. Key opinion leaders and institutional representatives were mobilized, support was provided to journalists covering the debates, and the National AIDS Program created space on its website for sharing opinions about the campaign, both positive and negative.

Results: The project was not formally evaluated, but an assessment found that 70 percent of people who were aware of the campaign had positive feelings about it. The TV ads had the greatest reach and recall power. Two years later, the Ministry of Justice launched a campaign called Brazil without Homophobia, a program that included concrete initiatives for providing equal access to education, healthcare, and justice for MSM.

Alternative income-generating opportunities for sex workers

Sex workers often lack the education and resources to participate in other income-generating activities and insist on a safe working environment, including consistent use of condoms. If they receive education, business training, and access to credit or capital, they may be able to leave sex work or insist on condom use and be more selective about their clients. As stated by Vuylsteke Das, Dallabetta, and Laga (2009), "Sex workers who do not rely on sex work as their only source of income are in a better position to negotiate safe sex."

However, few other jobs offer poor women with limited education the level of income they can earn in sex work. While HIV and STI rates have decreased after women left sex work, one study in Thailand reports they remained high, indicating the women's continued risk of infection even after leaving the industry. Projects have offered income-generating activities and training for sex workers so they can earn extra income that enables them to reject clients who refuse to use condoms, but further research is needed to assess the effectiveness of this strategy.

Example of an alternative income-generation project for sex workers

Strengthening STD/AIDS Control Project (Kenya): In 1999, the Strengthening STD/AIDS Control Project enrolled 209 sex workers in Nairobi in a business training and loans program (Costigan et al. 2002). Prior business experience was not a criterion, but participants needed to be between ages 18 and 45, have no outstanding debts, and make a three-year commitment. Collateral was not required, and loan guarantee groups were formed of between five and 25 women. They met weekly to make fixed loan repayments, contribute compulsory savings, and receive ongoing business training.

Results: The results at mid-term were encouraging, though 90 women had left the study and six had died. The loan repayment rate was 60 percent, and 51 percent of the businesses were running. Among participants, 17 percent stopped sex work, and the average number of clients among those who continued declined by two-thirds, and STI incidence declined by 50 percent. The average weekly income from sex work declined by 50 percent, and was complemented by income from the businesses.

At 18 months, however, some problems were beginning to occur (Odek et al. 2002). There was a 90 percent forfeiture of compulsory savings to pay off debts, and many members had become ill. This generated resentment because other members bore the brunt of their dues.

Example of alternative income-generation project for MSM

Foundation SEROvie (Haiti): Since 1999, SEROvie has focused on health and rights of MSM to “break a cycle of discrimination, poverty, and HIV infection” through condom distribution, radio shows programs on anti-discrimination, and peer education (amfAR 2010). The SEROvie project realized a barrier for the community was lack of skills to obtain employment and engage in high risk behaviors. In response SEROvie developed a vocational training program that found MSM schools and assisted in paying for supplies and fees.

Results: One group of men who completed the program all found work soon after (amfAR 2010). In addition, SEROvie has responded to new rising concerns of personal safety of its clients and the needs of the community during rehabilitation following the earthquake in its programs. For example, providing information and skills on water treatment is an important part of the work with their clients.

Interventions directed to partners, family, and peers — level 2

Interventions at this level engage key stakeholders (such as friends, family members, clients, peers, and social networks) in the lives of those at risk and in the risk-reduction process. These interventions can increase the acceptability and reach of programs, particularly those that target hidden, marginalized, and difficult-to-reach populations, such as sex workers and MSM.

Peer outreach engages members of a specific group to “influence and support members of the same group to maintain healthy sexual behaviors, change risky sexual behaviors, and modify norms” (AIDSTAR-One 2010a). The approach is based on the notion that peers are more effective educators and influencers of behavior, especially among difficult-to-reach populations and/or young people.

Peers are thought to be able to deliver information in a language that is familiar and accessible. They are considered less likely to be judgmental and more supportive than non-peers or group outsiders. It is also assumed that peers will be better able to reach individuals who are otherwise hidden and/or wary of offers of help.

Examples of peer-outreach with MSM

Popular opinion leader (POL) (United States): Over the past 10 years, this program in the United States has systematically identified, recruited, trained, and engaged popular opinion leaders (POLs) within a specific population to serve as behavior change agents. A group of trusted, well-liked men who frequent gay bars endorse safer sexual behaviors in casual, one-on-one conversations with peers. During these conversations, the POL corrects misperceptions, discusses the importance of HIV prevention, describes strategies he uses to reduce his own risk (such as keeping condoms nearby, avoiding sex when intoxicated, and resisting coercion for unsafe sex), and recommends safer sex behaviors. POLs wear buttons with the project logo, which is also displayed on posters around the bars and used to start conversations. Each leader agrees to have at least 14 such conversations and to recruit another POL.

The core elements of POL include identifying and enlisting the support of well-liked leaders to take on risk-reduction advocacy roles; training cadres of POLs to disseminate risk-reduction endorsement messages within their own social networks; and supporting and reinforcing successive waves of POLs to help reshape social norms to encourage safer sex. The training package contains a manual to guide planning, implementation, maintenance, and program evaluation; a video that provides instruction in POL intervention techniques; and copies and samples of training materials.

Results: Jones et al. (2008) reported on the adaptation of POL to the specific needs of young black MSM in three cities in North Carolina. This program resulted in reported decreases in unprotected receptive anal intercourse— by 23.8 percent at four months, 24.7 percent at eight months, and 44.1 percent at 12 months. In addition, the project achieved a reported decrease in unprotected insertive anal intercourse by 35.2 percent at 12 months. The percentage of respondents who reported they always used condoms also increased, from 23 to 30.3 percent.

Improving access to HIV prevention messages and services among MSM (Togo): Population Services International (PSI) launched a small program in 2007 to reach MSM in Lomé with HIV prevention messages and products, referrals to appropriate HIV counseling and testing services, psychosocial counseling, and diagnosis and treatment of STIs (Population Services International 2009). This project, geared toward men ages 18–20, used peer-outreach for delivering safer sex messages and information to individuals otherwise difficult to reach.

The program had four components: peer education, film nights and special events, links to HIV and AIDS services, and extended outreach.

- PSI recruited and trained 17 young men to serve as peer educators and reach other MSM in their social network with HIV prevention messages. The educators provided discreet distribution channels for condoms and lubricants, led discussions, and organized film nights,

drama sketches, and events with mobile testing units. They were paid a stipend as an incentive and to compensate them for project-related costs.

- Monthly film nights and special events with MSM-themed programs complemented peer education activities and provided men with an opportunity to socialize in a safe and accepting environment. The gatherings were also used to further promote HIV prevention messages and products.
- The project linked participants to mobile HIV testing, medical treatment, counseling, pharmacy, and antiretroviral treatment —special services at lower prices.
- Over time, the project reached even deeper into MSM networks, recruiting three MSM married to women and training them to share HIV prevention messages with other married MSM. These peer educators were integrated into the larger program, but worked very discreetly to provide messages and products to a segment of the population that does not openly associate with other MSM.

Results: The PSI project in Togo has had promising results. Each month, PSI-supported peer educators reached more than 300 men and distributed over 2,000 condoms and 70 tubes of water-based lubricant. As of June 2009, over 3,000 men had been reached through peer education activities and 2,000 through other activities. The President and Minister of Health in Togo both made public statements in support of this program as a component of effective HIV prevention (Sherard 2009).

MSM-Cuba (Cuba): This is a 10-year-old HIV prevention program that relies on peer education to promote safe sex. According to a recent article, it has 1,700 volunteers in 14 provinces in Cuba and may have averted as many as 3,000 HIV infections since its founding (Acosta 2010).

The Bruthas Project (United States): This was a community-collaborative intervention to reduce HIV risk-behavior among African American men who have sex with men and women but do not form an identity around same-sex behavior (Operario, Smith, Arnold, and Kegeles 2010). The pilot intervention was based on formative qualitative research. Four individualized, risk-reduction counseling sessions were provided for the 36 African American participants. The outreach and counseling were provided by African American men with whom the participants could identify, and the counseling was designed to respond to their need for privacy and affirmation of their culture and masculine values.

During session 1, participants reviewed general risk factors for HIV and were offered HIV testing and counseling. In session 2, they discussed sexual dynamics and risk behaviors with female partners, and in session 3 they discussed sexual dynamics and risk behaviors with male partners. In the final session, the participants were supported to review motivations and situational triggers for unsafe sex and they engaged in role-play exercises that aim to define personal risk reduction goals.

Results: Baseline and three-month follow-up assessments showed significant reductions in unprotected anal sex with male partners, less unsafe sex with fewer female and male sex partners,

and decreased sex while under the influence of drugs. The men also reported reduced loneliness and significantly increased social support and self-esteem.

This may be a promising intervention for Jamaica and the rest of the Caribbean, and it is worth undertaking further research to test its applicability and impact. In The Bahamas and Jamaica, HIV prevention that specifically targets the MSM community has been delivered in the context of parties and other informal gatherings, rather than through specific programs.

Examples of peer outreach programs for sex workers

Peer-mediated education among sex workers (Kenya): One of the first peer education programs in a resource-constrained setting was among sex workers in Nairobi (Ngugi, Wilson, Sebsted, Plummer, and Moses 1996). Starting in 1989, this program trained sex workers who were selected and identified as leaders by their peers and trained as peer educators and HIV/STI counselors: in safer sex negotiations, STI and HIV and AIDS education, and condom promotion. Condom promotion was a key component, including training on condom supply sources, storage, proper use, and disposal, and on how to reject potential clients who refuse condom use. Additional educational messages targeted partner reduction, avoidance of anal sex, increased use of non-penetrative sex, and avoidance of sex during menses. Individual and group counseling provided opportunities for participants to discuss issues like condom breakage and how to handle pressure from clients who offered higher payments for sex without condoms.

Each peer educator was responsible for a group of about 20 peers. Leaders followed up whether their peers were changing behaviors, encouraged them to seek medical attention for STI-related symptoms, and recruited new members. Communication methods included drama, songs, posters, pamphlets, and videos.

Results: The project had exciting results. The number of sex workers reporting any condom use increased from nearly nil in 1986, when the campaign started, to about 80 percent of all reported contacts by 1989. It remained at that level for the next eight years. Encouragingly, the number of men presenting to area clinics with STIs declined, and there was a reduction in the annual incidence of common STIs among men in locations where the program was implemented. In 1989, after the program scaled out to an additional four sites around Nairobi, it was found that in addition to increased condom use and decreased STI incidence, the women were charging more for sex and the proportion who rejected clients who refused to use a condom increased.

Smart Journey Program (Ethiopia): This program of the Health Communication Partnership (HCP) aimed to provide women engaged in sex work with the skills and knowledge they need to keep themselves healthy and protect themselves against violence and diseases, particularly HIV and AIDS. It had four main components: structured group peer education sessions, provision of condoms, referral to clinics, and provision of free health services.

The program trained current and former sex workers as peer educators. They visited establishments frequented by sex workers weekly, carrying out a series of activities related to safer sex and protection from violence, distributed condoms, and made referrals for free STI tests. The

intervention also targeted establishment owners due to their direct influence on the women working in their establishment.

Teams of two peer educators —a current and a former sex worker — led 12 sessions over a three-month period. Using a peer-learning guide developed by the project, the team engaged the sex workers in dialog around topics related to challenges and opportunities in their work, STIs, condom use, negotiating safe sex, and sharing and celebrating their success.

Results: The program has had a demonstrated impact (Tureski and Gottert 2010). Condom use with paying partners in the intervention community reached 98 percent, and was 92 percent among non-paying partners. The equivalent figures for sex workers who did not participate in the program were 91.5 percent with paying partners and 64.3 percent with non-paying partners. Participants also had improved attitudes towards care-seeking and went for more STI tests. In addition, the increased social support had an impact on social capital, with participants expressing a sense of collective efficacy, empowerment, and hope for the future.

Avahan (India): This program of the Bill & Melinda Gates Foundation developed a set of tools for training peers to undertake HIV prevention. These tools enabled ‘high-risk individuals’ to become leaders and managers of service provision (Bill & Melinda Gates Foundation 2009). This program is discussed more in depth in the section discussing combination approaches for sex workers.

Bali Peer Education Program (Indonesia): Peer education also forms the foundation of a program in Bali for sex workers that resulted in marked increases in knowledge about HIV and AIDS and STIs, increased condom use, and reductions in the prevalence of gonorrheal infections (Ford, Wirawan, Suastina, Reed, and Muliawan 2000).

Eastern Caribbean Community Action Project (EC-CAP) and Centro de Orientacion e Investigacion Integral (COIN) (Antigua and Barbuda, Barbados, St. Kitts and Nevis, St. Vincent and the Grenadines): These programs promote sexual and reproductive health and HIV prevention with Spanish-speaking sex workers in the Eastern Caribbean (Antigua and Barbuda, Barbados, St Kitts and Nevis, and St Vincent and the Grenadines). Funding from the Hewlett Foundation enabled further training for Spanish-speaking peer outreach workers and the development of innovative promotional tools. The peer-outreach is carried out by community animators recruited by the Caribbean HIV/AIDS Alliance from key populations identified as most at risk of HIV.

A partnership and an exchange visit with COIN, an organization in the Dominican Republic, and an intense training program built the capacity of Spanish-speaking animators, who have developed materials on behavior change communication and female condoms for use in Antigua, Barbuda, and St Kitts and Nevis. Materials include *Ana descubre sus poderes* (Ana discovers her powers), an HIV prevention comic for Spanish-speaking sex workers (International HIV/AIDS Alliance, 2009). The comic promotes female condoms and presents scenarios that include dealing with drunken clients and clients who refuse to wear a condom or offer more money for sex without a condom.

An example of outreach to sex workers

HIV-prevention interventions have been successfully conducted with clients of sex workers (Lowndes et al 2007). Mobile clinics providing STI and HIV counseling, testing and treatment, other services, and condoms have also been effective in delivering messages, information and services directly to sex workers and other individuals at risk and in need (Deering et al. 2010).

Vancouver's Mobile Access Project: the MAP van (Canada): The MAP van, a partnership between the WISH Drop-In Centre Society and the Prostitution Alternatives Counseling & Education (PACE) Society in Vancouver, Canada, is a service run mostly by women who are former sex workers (Deering et al. 2010). In operation since 2003, the MAP van was developed in response to high rates of violence, health-related harms, and murder among women in street-based sex work in Vancouver.

Each night, from 10:30 pm to 5:30 am, the van goes to locations where the women work and provides a safe space for them to rest and get refreshment and access support, information, and referrals to addiction treatment and other health and social services. Outreach staff collect and distribute reports of dangerous clients. They also provide referrals and distribute prevention resources, such as condoms, syringes, mouthpieces, and alcohol swabs. In 2009, the van made an average of 1,300 contacts and distributed 8,000 condoms and 4,800 clean syringes each month. The program is ongoing.

A recently published article explored the link between MAP van access and uptake of addiction treatment services by drug-using women who were engaged in street-based sex work between 2006 and 2008 (Deering et al. 2010). The study interviewed 242 street-based sex workers and followed them over 18 months. During this time, 42 percent reported that they used the MAP van, and this group was four times more likely to have entered a detoxification program and/or residential drug treatment, compared to women who did not access the van. This link remained, whether or not the women accessed other outpatient addiction treatment services, including alcohol and drug counseling or methadone maintenance therapy. The study also suggested that the MAP van is reaching the most marginalized women in street-based sex work, since users were significantly more likely than non-users to work in isolated outdoor spaces such as alleys or industrial settings (Science Blog 2010).

Interventions directed at local community, services, and products — level 3

This level of intervention includes a diverse range of approaches: from grassroots community mobilization efforts to public sector and/or public-private partnerships that provide health and social services and leverage support to ensure critical prevention commodities are available and accessible to those who need them.

Community mobilization

According to UNAIDS (1997), community-level action has been a force in the response to HIV and AIDS since the earliest days of the epidemic. Community mobilization by gay men in San Francisco was critical to early successes in reducing HIV prevalence in that setting in the 1980s. Community mobilization is also thought to be one of the most critical elements that contributed to the success of the Sonagachi project among sex workers in India.

For Sonagachi, at least initially, community mobilization was instigated or catalyzed by an outside organization, while it was entirely indigenous in San Francisco. This reflects a fundamental tenet of community mobilization: “the impetus for action emerges at the community level, and the catalyst formulates its agenda around community priorities, concerns, capacities, and commitments” (Donahue and Williamson 1999).

The principle behind the approach is that when communities are mobilized and organized around an issue of collective importance, they increase their power and social capital. With enhanced social capital, they may feel less stigmatized, have a stronger sense of control over their lives, and may be able to more effectively demand their rights. A mobilized community is also more likely to have access to appropriate education health and social services and insist on a safe working environment, including consistent condom use and freedom from violence and exploitation.

Examples of community mobilization with MSM

The Mpowerment Program (MP) (United States): MP was an HIV prevention program in the mid-1990s designed to address the needs of young gay and bisexual men in California through personal and community empowerment, community building, and the diffusion of new practices through social networks (Kegeles, Hays, and Coates 1996; Kegeles, Hays, Pollack, and Coates 1999).

To carry out the intervention, four young gay or bisexual men were employed part-time as project coordinators in each community. In each of these settings, the coordinators and other young gay volunteers designed and carried out all project activities, and a core group of 12 to 15 young gay men served as the decision-making body. A community advisory board made up of men and women from the local AIDS, gay and lesbian, public health, and university communities served as an informational resource, and met bimonthly with the core groups to provide advice about project activities.

The program had four components: peer outreach, peer-led small groups, an ongoing publicity campaign, and a young men’s center.

1. Peer outreach by young gay men, both formal and informal, encouraged safer sex practices.
2. During one-time, three-hour meetings of peer-led small groups of eight to ten young gay men, participants were encouraged to become agents of change by supporting their friends. Guided by the diffusion theory, the project recruited 15 percent of all young gay men in each study community for these meetings.
3. An ongoing small-scale publicity campaign designed by participants included articles and advertisements in the gay newspapers, outreach materials distributed in settings frequented by young gay men, and word-of-mouth among core group members and within their social networks.
4. A young men’s center was set up in each community that sponsored a range of events where men could meet and socialize. Safer sex posters were displayed, and safer sex materials available free of charge. Men were recruited at these social events to attend the small groups.

Results: Project results are encouraging. The proportion of men who engaged in unprotected anal intercourse decreased from 38.3 to 30.9 percent, with a reduction from 19.2 to 13.6 percent with non-primary partners and a reduction from 57.7 to 41.8 percent with stable partners. These reductions were sustained one year later with non-primary partners, but mixed results were found regarding sex with boyfriends.

A 2009 feasibility study on implementing MP in Barbados found that the program was acceptable to the community of gay-identified men on the island and could be effective in extending the reach of current HIV prevention (Maiorana et al. 2010). The study's authors argue that in Barbados: "MP would capitalize on gay social networks and existing social activities to create opportunities and spaces for men to talk about HIV prevention, empower them to protect themselves, and shift the cultural and social norms within the gay community regarding safer sex." MP is now being implemented in Barbados.

MP is promoted as an effective approach by the US Centers for Disease Control. Maiorana et al. (2010) contend that the program could serve as a model for replication in other Caribbean nations, but it needs careful adaptation to context and works best with MSM who are able to associate with other MSM. Scale up is challenging, given the program's reliance on peer-outreach and small-group interactions.

Empowerment workshops for MSM (Jamaica): The impetus for this intervention was to improve access to and use of voluntary counseling and testing (VCT) services by MSM, who typically avoid healthcare services due to stigma and discrimination. The intervention involves a series of 15 empowerment workshops hosted by the Ministry of Health's National HIV/STI Programme that offer VCT services, a safe space for MSM, and information about HIV and AIDS in the community and the benefits of knowing one's HIV status.

Pre-test counseling is provided, blood samples are tested for HIV at a public health lab, and each participant is given a distinctive identifier so his name is not linked to the sample. Results are then provided by a private doctor of his choice. Ensuring confidentiality and anonymity of test results are said to be important elements of the project's success.

Results: This intervention achieved close to 100 percent participation in the VCT services. The author of an abstract presented at the 2010 International AIDS Conference stated that it may not be necessary for MSM to staff the program, but all staff must be sensitized to the special issues of MSM (Cooper 2010).

Examples of community mobilization with sex workers

Sonagachi HIV/STD Intervention Project (SHIP) (India): The SHIP intervention started out in the early 1990s to "empower individual sex workers to practice safer sex" (Evans, Jana, and Lambert 2009: 457; UNAIDS 2000). It focused on making STI treatment more available and accessible for sex workers through free health clinics in red-light areas and by training a group of locally recruited women as health educators. Individual sex workers were given information and counseling about condom use and condom negotiation. Additional services were established, such as child care, comprehensive healthcare, and literacy education to help build trust in the community.

The emphasis and direction of the program shifted over time, however, and the main focus became supporting and sustaining behavior change through collective organization, empowerment, and collective action. The program aimed for respect for sex work as work, and contested the power relations and ideologies that make sex workers vulnerable. They did this through three main channels: creating a sense of community and political awareness; facilitating the mobilization and participation of sex workers; and working toward legal reform, social recognition, and inclusion.

1. SHIP trained and enabled local peer educators to establish networks among sex workers and between different red-light areas that created positive social identity, supported consistent and correct condom use, and helped to create a sense of community and foster political awareness. The project also created a mechanism under which individual sex worker networks could operate collectively. Now an umbrella organization — the Durbar Manhila Samanwaya Committee — runs the intervention and has expanded its scale and scope. (Durbar now has 65,000 members, and its website states that it continues to be “active in identifying and challenging the underlying socio-structural factors that help perpetuate stigma, material deprivation, and social exclusion of sex-workers.”)
2. SHIP redistributed power and resources to facilitate the mobilization and participation of sex workers. The project helped the umbrella organization to establish branches in every red-light district and conducted advocacy with local stakeholders (such as madams and brothel owners) and with power brokers, including police, mafia, and local politicians who exert control over sex workers’ lives. The goal was to build increased dignity, autonomy, and self-determination among the sex workers. SHIP also set up a sex-worker-led cooperative that provides microcredit and banking services. Though this element was hotly contested and difficult to implement, it had the effect of granting sex workers formal recognition as an occupational group by the state and provided economic resources that allowed them “to plan for the future and protect their health” (Evans, Jana, and Lambert 2009: 458).
3. To give sex workers a voice and bring about social recognition, participation, inclusion, and legal reform, SHIP engaged in extensive lobbying, networking, partnership-building, public debate, and political and legal advocacy (Evans, Jana, and Lambert 2009).

Results: An evaluation of the project found significant and sustained increases in consistent condom use by sex workers in intervention communities compared to those in a control community (Basu et al. 2004). Evans, Jana, and Lambert (2009) reported that HIV levels among sex workers in the catchment area remains low at 11 percent, and consistent condom use is around 80 percent. According to Cornish (2009), the program asserts that sex workers have rights that should be respected, helps them see that they are allied with other oppressed but politically successful groups, and provides evidence of sex workers’ positive achievements.

Mobilization of sex workers (Côte d’Ivoire): In 1990, when HIV prevalence among female sex workers in Abidjan was 69 percent, this intervention mobilized community leaders, provided health education and peer education by sex workers and former sex workers at or near worksites, and created a clinic exclusively for sex workers and their stable sex partners (Ghys et al. 2002).

The program had promising results. Reported condom use with last client increased from 63 percent in 1991 to 91 percent in 1997, and the proportion of women who visited any clinic increased from 9 percent in 1993 to 37 percent in 1997. Those attending the clinic were more likely to report having used a condom, and those attending for the first time reported dramatic increases in consistent condom use: from 20 percent in 1992 to 78 percent in 1998.

Results: There were also very clear impacts on the prevalence of STI and HIV between 1992 and 1998 among sex workers in the program: gonorrhea prevalence decreased from 33 percent to 11 percent and, astonishingly, HIV prevalence decreased from 89 percent to 32 percent.

Improved access to and delivery of local health services and supplies

Access to and delivery of health services for MSM and sex workers—HIV testing and counseling and HIV treatment, and care—is critical to HIV prevention. Both groups are at risk of HIV and in need of these services, and they are also potentially instrumental in the transition of a concentrated to a generalized epidemic.

However, both groups often face stigma and discrimination, manifested in rude behavior and/or sub-optimal treatment from providers that often drive them away from care. Identifying and finding solutions for this problem is essential, and requires working with affected populations, healthcare workers, and clinic administrators.

Advocating for reliable supplies of prevention commodities

There are many ways to make condoms and condom-compatible lubricants available and accessible to sex workers and MSM. Outreach workers can deliver these essential prevention commodities, as can mobile clinics and other health service delivery points. Some national programs have successfully introduced condom machines in bars and pubs, in locations where people meet for sex, and even in schools.

Policies on 100% condom use in brothels can reduce risk for both clients and sex workers by significantly increasing the likelihood of condoms being used during the sale of sexual services. However these policies carry risks of rights abuses and need to be implemented with care. A rights-based alternative approach was developed and advocated by the Centre for Advocacy on Stigma and Marginalization (CASAM 2008).

Creation of safe spaces

Because of the prevailing social stigma and discrimination against MSM and sex workers, it may be necessary to create safe spaces: sites, rooms, clinics, or even Internet chat rooms where they can come for information and services without fear of judgment, harassment, or arrest. In safe spaces, people from otherwise marginalized and/or criminalized groups can find a sense of community while in an environment in which they feel valued and supported.

Existing safe venues may also be used for the delivery of services. This second approach can be a form of outreach, where programs go to those at risk, rather than expecting them to be self-motivated to use existing services.

Strengthened community-based networks

Community-based groups and networks of MSM, PLHIV, sex workers, and other marginalized groups have great potential to reach into their communities with legal and advocacy help, psychosocial support, prevention guidance, and referrals to appropriate healthcare services. They can also conduct critical advocacy work to fight for legal, sexual, and reproductive rights.

However, while many of these groups are highly motivated and undertake heroic efforts on behalf of their communities, they lack skills, connections to those in power, and funding. Strengthening the organizational capacity of such groups and/or creating networks of existing groups can undergird HIV prevention efforts among populations difficult to reach.

Example of a strengthened MSM network

Investigaciones Médicas en Salud (Inmensa) (Peru): MSM community groups were doing important HIV prevention work in and around Lima, but their dispersal throughout the city weakened their potential. In 2008, Inmensa sought to redress this issue by creating an eight-group consortium and a strong network for MSM and transgenders (Amfar 2010). Among overall goals was the creation of a safe space to support community mobilization, legal registration for six groups that lacked it, and training and comprehensive capacity building for these groups.

Results: Inmensa's capacity-building activities targeted improved planning and organizational management and the completion and submission of the complex forms required for legal recognition. Two workshops covered legal responsibilities, budgeting, strategic planning, and corporate governance, among other areas, while another focused on business development and income generation. In addition, Inmensa led two advocacy workshops around human rights and health issues.

Five organizations obtained legal status as a result (two already had it), increasing their access to funding. The training provided by the project helped to develop new leaders with the skills to carry on their programs and to make a long-term impact. And, by organizing the groups into a consortium, Inmensa helped to build a stronger, more unified voice that can help sustain HIV interventions in vulnerable MSM and transgender communities.

Interventions directed at a national enabling environment — level 4

Because of social marginalization, stigma, discrimination, and social exclusion they face, MSM and sex workers in most countries often lack the social, legal, and technical support they need to adequately protect themselves from HIV and other risks. Unjust and irrational laws that criminalize sex work and same-sex sexual activities increase the vulnerability of these groups, drive them underground, and have negative repercussions for HIV prevention. Such laws make it more difficult to develop and implement effective, long-term HIV prevention, including the provision of critical prevention commodities such as condoms and lubricants, STI treatment, and other harm reduction measures.

Legal reform

Legal-judicial systems provide the formal framework for state practices, including those in the health sector (Caceres, Pecheny, Frasca, Raupp Rios, and Pocahy 2008). Experts in HIV prevention advocate the decriminalization of sexual diversity as well as the development of protective and recognition measures for MSM and sex workers. Legal reform that recognizes sex work as a legitimate form of labor would have a protective effect for sex workers and their clients.

Four main approaches to legislating sex work currently exist: prohibition, abolition, regulation, and the labor model (Wijers 2001). There is vigorous debate around which might be most supportive of HIV prevention and why.

1. **Prohibition:** In this approach, all forms of sex work are illegal, and sex workers are seen as criminals and subject to arrest. This model prevails in Jamaica and The Bahamas. In some countries, the provision and possession of prevention commodities is a crime (IRIN 2010).
2. **Abolition:** This approach, sometimes referred to as legalization, does not make sex work illegal. It sees sex workers as victims, but criminalizes the third parties involved in selling sex, such as pimps and brothel owners. This model fails to recognize the agency of sex workers, does nothing to address their often difficult and dangerous working conditions, and makes it impossible for them to organize or work together. It can drive sex work further underground and make prevention difficult.
3. **Regulation:** In this model, sex work is accepted as inevitable, but is highly regulated. Sex workers are subject to compulsory health checks, taxation, and regulation of where and how they can work. Only legal residents or citizens can practice sex work legally, so migrant sex workers are criminalized. This approach increases stigma against sex workers and disempowers them, while often increasing the power of pimps and brothel owners. Some 100% condom policies have been implemented in this type of legislative environment. While they resulted in increased condom use, the practice enhanced the ability of brothel and bar owners to exploit and harass sex workers, exacting fines or seeking arrest of those unable to comply (Overs 2002).
4. **The labor model:** This model, sometimes known as decriminalization, puts sex workers' own perspectives at the center, seeks to ensure that sex work is regarded as a legitimate form of labor, and is regulated and supported as such. This approach would ensure sex workers are entitled, like other workers, to be protected against discrimination and can access benefits and healthcare. Sex workers would be protected from abuses of power, violence, and victimization by colleagues and clients, and would not be subject to arbitrary arrest and harassment by the police and security forces. This approach would provide the richest enabling environment for HIV prevention by facilitating work-safety programs that would include condom promotion and provision, STI treatment, and other reproductive health and health services.

Examples of legal reform for MSM

Naz Foundation advocacy to decriminalize same-sex sexuality (India): Until very recently, Section 377 of India's Penal Code criminalized same-sex practices. In 2002, the Naz Foundation

filed public interest litigation in the Delhi High Court to challenge Section 377, with growing support from across the country.

Results: In October 2008, 30 Rhodes scholars of Indian descent sent a letter to Prime Minister Manmohan Singh asking him to repeal Section 377. Shortly after, he called for action to be taken to address the issue (Telegraph 2008; Sanmathi 2008). On 2 July 2009, the Indian High Court repealed the law.

Funding allocations

Creating an enabling environment to reduce vulnerability reduction and strengthening resilience through, for example, more accurate and appropriate targeting of HIV prevention spending, instead of population-wide interventions in concentrated and low-level generalized epidemics to interventions that focus on particularly vulnerable groups may be more effective.

Creating reliable supplies of prevention commodities

Ensuring continued access to condoms and condom-compatible lubricants through the creation of effective supply chains and delivery mechanisms is an important component intervention. For more discussion see section on sex workers.

Example: A campaign to promote 100% condom use for sex workers (Dominican Republic)

A program in the Dominican Republic implemented by Centro de Orientación e Investigación Integral (COIN) (Kerrigan et al 2006) combined a mandate for brothel owners to provide condoms and promote 100% condom use with its efforts to develop solidarity and supportive networks among sex workers. In addition to promoting condom use with brothel owners and clients, the program was supported by government and establishment-based policies and support systems to promote and monitor the use of condoms within sex establishments (Kerrigan et al 2006). This approach counters findings that instituting policies in brothels can increase the power and influence of their owners and police and put sex workers at risk of coercion, harassment, arrest, and job loss.

The basic program in Santo Domingo built solidarity and a collective commitment to STI/HIV prevention through workshops and meetings with sex workers and brothel owners. It made available posters and stickers in brothels that promoted 100% condom use and held meetings that included clients of sex workers. It also provided STI/HIV clinical services, HIV testing and counseling, and peer education by personnel who were trained in these areas and in ethical procedures and data collection and monitoring. The program also monitored brothels to ensure they maintained the posters and a visible supply of at condoms and that sex workers attended monthly check ups and were free of STIs.

An enhanced intervention, implemented in Puerto Plata, added a regional government policy on condom use in sex establishments and frequent monitoring by government officials. Participating establishments were informed about the government requirement and a graduated sanctioning system that included notifications, fines, and closings for non-compliance.

Results: Although condom use increased in both sites, broad-based, significant changes occurred only in Puerto Plata: significant increased condom use with regular (non-paying) partners and increased rejection by sex workers of unsafe sex. There were also stronger declines in STI prevalence, compared to Santo Domingo. Kerrigan et al (2006) conclude that an integrated approach that mobilizes communities and governments to confront HIV- and STI-related vulnerability in the context of female sex work holds promise and merits further study and application.

Combination prevention approaches

Combination prevention uses a mix of biomedical, behavioral, and structural interventions, based on epidemiologic and demographic data. These programs aim to select the optimal mix of interventions that will have the greatest impact on reducing HIV transmission, susceptibility and vulnerability to HIV, and the infectivity of the virus ¹⁰(AIDSTAR 2010b).

Combination programs cross all four levels of analysis in C-Change's socio-ecological model (individual, interpersonal, community, and structural) and all cross-cutting factors: information, motivation, ability to act, and changing norms. In addition to individually-focused health and education support, these programs aim to ensure access, scale up, and improve delivery of critical HIV services, as well as the provision of prevention supplies and commodities. SBCC programs relying on the socioecological model effect both social and individual behavior change.

Social mobilization (including community mobilization) is a central component. Implementers of combination programs do not neglect advocacy for policy change in critical areas. They involve PLHIV in program design, implementation, and advocacy at all levels, and they work to create a supportive legal and policy environment for positive prevention.

Example of a combination prevention program for MSM and sex workers

Frontiers Prevention Project (Andhra Pradesh, India): Implemented in 2002 by the International HIV/AIDS Alliance, this project conducted targeted interventions for sex workers, MSM, and injection drug users to reduce risky behaviours and STI incidence. These populations were involved in program planning, and dissemination was intended to increase community ownership and sustainability. The project also sought to improve advocacy within these groups, change policies that affect these groups, increase community awareness, and deliver a comprehensive package of prevention interventions.

Results: An evaluation by Gutierrez, McPherson, Fakoya, Matheou, and Bertozzi (2010) states that the program's combination strategy and intense implementation had a positive impact on STI incidence and condom use among MSM and sex workers who participated. "The communities are being empowered to negotiate with different bodies of control. Spaces have been created within the institutional structures (through committees), in order to bring a community perspective into the policy and decision making levels" (International HIV/AIDS Alliance India 2006). By April 2007, 8,757 sex workers, 5,597 MSM and transgender individuals, 4,730 PWH and 350 IDU were

¹⁰ In epidemiology, infectivity is to the ability of a pathogen to establish an infection

registered and were receiving health-related services regularly. These services included STI services, behavior change communication, condom programs, community mobilization, and enabling and structural interventions (Gutierrez, McPherson, Fakoya, Matheou, and Bertozzi 2010). The evaluation of the program strongly suggests that there are important benefits associated with approaches that engage communities in the design and implementation of prevention interventions for their communities. The overall results (time trends) document important changes in sexual behaviors and reductions in STI prevalence that accompany the scale-up of community-wide prevention programs that achieve high levels of coverage. These changes are also accompanied by important reductions in HIV prevalence during the same period (Gutierrez, McPherson, Fakoya, Matheou, and Bertozzi 2010).

Example of a combination prevention program for MSM

Programming for MSM (Guangxi Province, China): FHI launched in 2006 a comprehensive HIV/STI prevention intervention for MSM in Guangxi Province that included innovative forms of outreach to provide hidden MSM with information and support, including an MSM website, telephone hotline services, chat rooms, and a free instant-messaging program (FHI 2009). FHI's website states that in 2008 the United Nations Technical Working Group on MSM and HIV/AIDS in Beijing named the project as one of the best VCT models for MSM in China.

The project's drop-in center offered a safe space for MSM to discuss HIV and other important topics. It trained and employed qualified healthcare providers and a group of peer educators closely linked with the MSM community who also worked in saunas, gay bars, and other places where MSM gather. The center consolidated VCT and STI services and referred MSM to easily accessible care and treatment services.

Example of a combination prevention program for sex workers

Avahan Project (India): This project worked with partners throughout India to develop and implement comprehensive programming (Laga 2010). In 19 districts across Karnataka State, Avahan provided focused HIV prevention interventions and services for more than 60,000 sex workers and 20,000 MSM and transgenders. The following were the main elements:

- Participatory mapping and enumeration exercises to estimate the number and typologies of sex workers in the area
- Peer-mediated outreach to address difficulties reported by sex workers and promote condom use and regular STI screening
- Establishment of dedicated health services for sex workers and their regular partners
- Advocacy with police and local government officials and the establishment of 24-hour crisis-response teams
- Creation of drop-in centers that also provide welcoming safe spaces, community kitchens, and literacy classes
- Mobilization and capacity building of community-based organizations implementing prevention programs

Results: Over 13 years, the project showed dramatic impact. Ramesh et al. (2010) reported that 4,712 sex workers participated, and that more than 85 percent of them reported they had been in contact with a peer educator and had visited a project STI clinic by follow-up. Reported condom use at last sex also increased significantly for repeat clients, from 66.1 percent to 84.1 percent.

After the Avahan Project successfully scaled up services, it produced a guide that supports the implementation of its approach for hard-to-reach populations elsewhere. The premise is that highly trained individuals in a high-risk group can reach their peers effectively, and that mapping and micro-planning tools can be used to plan and track service delivery at individual levels and to position individuals as leaders and managers of service provision. Through use of these tools and techniques, Avahan and local NGOs provided services to approximately 221,000 female sex workers, 81,000 MSM and transgenders, and 18,000 injecting drug users.

There are challenges in bringing such programs to scale, especially in countries as large and culturally complex as India, but it can happen when political commitment and financial and human resources are in place.

Recommendations: Filling Critical Gaps in Prevention Programming for Sex Workers and MSM

The review finds that successful HIV prevention programs for MSM and sex workers are comprehensive and ambitious in scope, yet focused and participatory in nature. That affected communities participate in the development of programs is paramount. The UNAIDS Guidance Note on HIV and Sex Work describes three pillars for effective, evidence based responses – 1) universal access to services (prevention, treatment, care and support), 2) building supportive environments and strengthening partnerships, and 3) reduced vulnerability and access to structural issues (UNAIDS 2009). In May 2011, PEPFAR issued technical guidance on combination HIV prevention for programs for MSM; defining core elements of a comprehensive package of HIV prevention services. This package includes community-based outreach; distribution of condoms and condom-compatible lubricants; HIV counseling and testing; linkages to health care and ART; targeted information, education, and communication; and STI prevention, screening, and treatment (PEPFAR, 2011). The best practices and SBCC approach promoted in this document reinforce UNAIDS' three pillars and the combination approaches promoted by PEPFAR. Successful programs also address the layered stigma and discrimination that both MSM and sex workers face in an era of HIV and AIDS, as well as the challenges of doing so when legal frameworks criminalize their activities.

MSM and sex workers in Jamaica and The Bahamas have critical HIV prevention needs and face ongoing challenges. Gearing up for SBCC programming that meets their needs and advances HIV prevention requires a close examination of critical gaps and appropriate strategies that might fill them, as well as appropriate allocations of funding and personnel. The research and program examples provided in this document when used alongside the socio-ecological model, can help programs find the tipping point for change with these vulnerable audiences. Recommendations for Jamaica and The Bahamas include:

1. Jamaica and The Bahamas should develop national SBCC strategies that address the HIV prevention needs of MSM and sex workers.

The governments of The Bahamas and Jamaica have taken a critical first step by acknowledging the need for improved and scaled-up programming for MSM and sex workers. Each country will now need to identify and map its own strategic direction, based on knowledge of the epidemic in that setting, demographic and epidemiological data, and the social, policy, and legal context. It is important to engage sex workers, MSM, and other vulnerable populations in this process and in the development of the national SBCC strategies that address their special needs.

2. The capacity of organizations that implement the national SBCC strategies should be strengthened.

There is a critical need to foster and support sex-worker organizations, support networks for MSM, and PLHIV networks and organizations. These groups support HIV prevention and prevention programs and are source for them of peer educators, outreach workers, and local researchers. Their

involvement in program planning and implementation can ensure that activities are relevant, appropriate, and sustainable. Often, sex-worker and MSM organizations and networks, and other NGOs that indirectly influence these audiences, require capacity building to improve their operations and build advocacy and leadership skills. These organizations may also require safe spaces to meet and linkages to sources of information and funding. In Jamaica and The Bahamas, the need for strengthened capacity in SBCC has been identified.

The task of meeting the needs of the most vulnerable requires appropriate skills, support, and financial and human resources. While there is great commitment and enthusiasm among the civil society and Ministry of Health partners in Jamaica and The Bahamas providing HIV prevention information, support, and commodities for MSM and sex workers, this difficult work is often being undertaken without adequate training or support. Capacity strengthening in SBCC will enable programs to design and implement evidence-based programs that address both the individual and social change necessary to decrease HIV rates within these countries among MSM and SW.

While a full list of priority areas for capacity strengthening will be clearer as national strategies are developed, the following are recommended.

1. Support for increased coordination between government agencies and civil society actors
 2. Training and technical assistance in SBCC that strengthens the quality and scale of programming as well as the sustainability of organizations working with sex workers, MSM, and PLHIV
 3. Assistance for organizations and peer educators (both directly and indirectly supporting MARPs) in managing challenging clients and providing improved psychosocial support
 4. Assistance with outreach worker coordination, training, supervision, and provision of psychological support
 5. Support to establish drop-in centers, hotlines, and Internet-based SBCC interventions
 6. Technical assistance to improve monitoring, analysis of data, and documentation of SBCC activities
 7. Assistance with the development of SBCC materials and media for MSM and sex workers and the peer educators and health care providers who serve them
 8. Support for advocacy and social mobilization to improve the enabling environment, including decreasing stigma among service providers, within communities, and at national levels
- 3. Concerted efforts should be made to reduce stigma and discrimination against MSM and sex workers.**

The high levels of stigma and discrimination against MSM, sex workers, and PLHIV that prevail in the region present enormous challenges for prevention programs. Stigma and fear of discrimination and violence keep those in need from seeking critical health and social services, drive practices underground, and hamper their access to key messages and prevention commodities. Stigma can

lead to abuse, harassment, violence, imprisonment, and even death. It isolates individuals and can contribute to emotional trauma, mental illness, and substance misuse.

Toolkits are available that can help national programs and civil society organizations reduce stigma and discrimination, including among police and other security personnel and healthcare workers (Nyblade, Stangl, Weiss, and Ashburn 2009). Prevention programmers may also wish to consider the kind of mass media campaign launched by PAHO against homophobia in Argentina, Brazil, Columbia, and Mexico (PAHO 2008). They should also consider supporting civil society organizations to undertake advocacy for legal reform. An agenda for action for legal reform around issues affecting MSM in Asia and the Pacific was recently published by UNDP, and may have useful application in the Caribbean (Goodwin 2010).

4. Advocacy for legal reform should be undertaken.

Programmers will not be able to develop effective and sustainable HIV prevention programming for MSM and sex workers in settings where buggery and sex work are criminalized. UNAIDS and other international norm-setting institutions have listed decriminalization as a priority area because criminalization directly obstructs access to prevention, treatment, care and support. A number of resources that support this advocacy work are listed in Annex 1.

5. Affected populations should be engaged in the planning and development of SBCC messaging and HIV prevention programming.

Though the principle of involving vulnerable affected populations in all levels of the response to HIV and AIDS is often given lip-service rather than put in practice, their involvement in planning and implementation is not just the right thing to do, it is the smart thing to do. Tokenistic involvement is not the answer. These groups need to be involved at all levels of planning and implementation and supported with capacity building to enable them to become effective advocates, leaders, and spokespersons for their communities. They should be brought to the decision-making table and compensated for their contributions. They should be trained to be implementers of programs and engaged in conducting formative research and monitoring and evaluation.

6. Programs should address the psychosocial support needs of MSM and sex workers.

HIV prevention may be a relatively low priority for MSM and sex workers experiencing pressing psychosocial and financial needs. Program experience suggests that individuals in these groups are more likely to participate in HIV prevention programs if their mental health and financial needs are acknowledged and addressed (not necessarily resolved)—and when they are treated as whole people, not just recipients of HIV prevention advice.

7. The potential of the Internet and other social media for reaching MSM should be explored.

Prevention programs for MSM should explore the potential impact of using the Internet and other information and communications technologies to reach MSM who are otherwise difficult to reach. Little is known about how and how many MSM in Jamaica are using the Internet, including chat rooms and social media, but this information could be useful as programs are developed.

Conclusion

Considerable global experience is available to inform the development of high-impact, combination SBCC HIV prevention programs for MSM and sex workers (Ramesh 2010). Reaching scale with such programs is a major challenge in Jamaica and The Bahamas, given the hostile political and social environment that these groups face. Achieving scale will necessitate the development of innovative solutions that address current shortfalls in current service provision and reach difficult-to-reach populations with the information and services they need, including mobile, street-based sex workers and men who engage in same-sex activities but do not identify as MSM.

Reaching scale was identified as a major challenge in the national response in Jamaica and a priority for the Ministry of Health. Programs such as Avahan in India that have managed to achieve scale have done so in a more conducive climate and with an abundance of funding.

In light of these challenges, it may be appropriate to consider ‘scale out’ rather than scale up. Scaling out involves the adaptation and replication over time of successful smaller-scale programs in an increasing number of sites to achieve increased coverage of at-risk populations. In addition, recent research suggests that the inclusion of a strong community component in programming can have a dramatic impact in increasing condom use and reducing STI incidence among MSM and sex workers (Gutierrez et al 2010).

Attention for two critical cross-cutting areas is needed to move forward with programming for MSM and sex workers in Jamaica and The Bahamas:

1. Stigma reduction, which can be addressed through focused activities at all four levels of C-Change’s socio-ecological model for change
2. Capacity strengthening that results in meaningful, direct engagement of MSM, sex workers, and PLHIV at all levels of program and policy development and implementation

The engagement of these groups will enable programmers to be strategic, as they analyze the situation, identify the most critical tipping points for change for programs to address, and fully understand the epidemic, epidemiologically, politically, and socially and politically.

Jamaica and The Bahamas are at a definitive moment in their response to the HIV epidemics they face. They have taken a critical step by committing to addressing the needs of those most at risk of HIV infection. What remains is to take bold and strategic action to meet those needs and create the conditions in which HIV prevention can take hold and flourish, even among hidden populations.

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Annex 1: Useful Resources, Tools, and Program Descriptions

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Resources on Legal Reform

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Resources on MSM

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Annex 2: Promising Programs for Sex Workers and MSM

Level 1: Interventions directed at individuals (select)

Approach	Name of Project	URL/Contact Information
Interpersonal Communication (Internet)	The Pink Report	http://pinkreportjamaica.wordpress.com/2011/02/
	Gay Jamaica Watch Blog	http://gayjamaicawatch.blogspot.com/
	Text Me! Flash Me! Watch Me!	http://www.comminit.com/en/node/291748/347
	Brazil's 'Acceptance Begins at Home' Program	www.paho.org/english/AD/FCH/AI/homofobia.pdf
Alternative Income-generation for sex workers	Foundation SEROvie in Port-au-Prince, Haiti	http://www.amfar.org/world/msm/article.aspx?id=9288

Level 2: Interventions directed at partners, family and peers who directly influence the behavior of individuals at risk or potentially at risk (select)

Approach	Name of Project	URL/Contact Information
Peer-outreach	Popular Opinion Leader (POL)	www.cdc.gov/hiv/topics/prev_prog/rep/packages/images/POL.jpg
	Improving Access to HIV Prevention Messages and Services among Men Who Have Sex with Men in Togo	https://www.comminit.com/en/node/327998/cchange picks
	The Bruthas Project	www.bruthasproject.com/
	Ana Descubre sus Poderes	http://www.aidsalliance.org/newsdetails.aspx?id=244

Level 3: Interventions targeting community-level approaches and services(select)

Approach	Name of Project	URL/Contact Information
Social Mobilization & Empowerment	The Mpowerment	www.cdc.gov/hiv/topics/prev_prog/rep/packages/pdf/MPOWER.pdf E-mail: mpowerment@mpowerment.org
	Empowerment workshops for Jamaican men who have sex with men	http://pag.aids2010.org/Abstracts.aspx?AID=10493
	Sonagachi HIV/STD Intervention Project (SHIP), Kolkata, India	http://data.unaids.org/publications/IRC-pub05/jc438-femsexwork_en.pdf
	Mobilization of sex workers in Abidjan, Côte d'Ivoire	http://www.aidsmark.org/vct_box/Research/TargetGroups/Sex%20Workers/IncreaseCondomsandDecreaseHIVinCSWsCdi.pdf http://www.who.int/hiv/toolkit/sw
Building the Organizational Capacity of Networks	Investigaciones Médicas en Salud (Inmensa)	http://www.amfar.org/uploadedFiles/In_the_Community/Publications/Lessons%20from%20the%20Front%20Lines.pdf?n=3815

Level 4: National enabling environment (structural-level approaches)(select)

Approach	Name of Project	URL/Contact Information
Advocating for Legal Reform	Naz Foundation Advocacy for Decrim of MSM	http://www.nazindia.org/advocacy.htm

Combination HIV prevention

Name of Project	URL/Contact Information
Frontiers Prevention Project, India (MSM and Sex Workers)	Guide for NGOs: http://www.aidsalliance.org/includes/Publication/Positive_prevention.pdf Link to Gutierrez paper: http://www.biomedcentral.com/1471-2458/10/497 FPP India Baseline Report: http://www.aidsalliance.org/includes/Publication/FPP_Baseline_Report_India.pdf
Comprehensive programming for MSM in China's Guangxi Province	http://www.fhi.org/en/CountryProfiles/China/res_MSM_Prevention_Model.htm
Avahan, India (Sex Workers)	See Laga M et al (2010): http://sti.bmj.com/content/86/Suppl_1/i6.full.pdf Information about Avahan, India: http://www.gatesfoundation.org/avahan/Pages/overview.aspx