CVC/COIN Vulnerabilized Groups Project: Phase One
(January 2011 - March 2013)

An Independent Evaluation

By Stuart Adams

August 2013
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# Acronyms and abbreviations

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<th>Description</th>
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<tbody>
<tr>
<td>AED</td>
<td>Academy for Educational Development</td>
</tr>
<tr>
<td>AFA</td>
<td>Aid for AIDS</td>
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<tr>
<td>AGTH</td>
<td>Alianza de Gays, Travestis y Otros Hombres que Tienen Sexo con Hombres</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>AJWS</td>
<td>American Jewish World Service</td>
</tr>
<tr>
<td>Alianza GTH</td>
<td>Alianza Nacional de Hombres Gay, Transgeneros, Transexuales, Travestis y otros Hombres que Tienen Sexo con Hombres</td>
</tr>
<tr>
<td>amfAR</td>
<td>The Foundation for AIDS Research</td>
</tr>
<tr>
<td>ART</td>
<td>Antiretroviral therapy</td>
</tr>
<tr>
<td>ASA</td>
<td>Amigos Siempre Amigos</td>
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<tr>
<td>ASHE</td>
<td>Ashe Performing Arts Company</td>
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<tr>
<td>BACKUP</td>
<td>Building Alliances, Creating Knowledge and Updating Partners</td>
</tr>
<tr>
<td>BBM</td>
<td>BlackBerry Messenger group</td>
</tr>
<tr>
<td>BCC</td>
<td>Behaviour change communications</td>
</tr>
<tr>
<td>BMZ</td>
<td>German Federal Ministry for Economic Cooperation and Development</td>
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<tr>
<td>BSS</td>
<td>Behavioural surveillance survey</td>
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<tr>
<td>CAIM</td>
<td>Proyecto Casa de Ayuda Intermedia al Menesteroso</td>
</tr>
<tr>
<td>CAISO</td>
<td>Coalition Advocating for Inclusion of Sexual Orientation (CAISO)</td>
</tr>
<tr>
<td>CARe</td>
<td>Community Action Resource, Trinidad and Tobago</td>
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<tr>
<td>CAREC</td>
<td>Caribbean Epidemiology Centre</td>
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<tr>
<td>CARICOM</td>
<td>Caribbean Community (CARICOM) Secretariat</td>
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<tr>
<td>CariFLAGS</td>
<td>Caribbean Forum for Liberation and Acceptance of Genders and Sexualities</td>
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<td>CARIFTA</td>
<td>Caribbean Free Trade Association</td>
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<tr>
<td>CARISMA</td>
<td>Caribbean Social Marketing Program for HIV and AIDS Prevention</td>
</tr>
<tr>
<td>CCM</td>
<td>Country Coordinating Mechanism</td>
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<tr>
<td>CCSS-JHU</td>
<td>Center for Civil Societies Studies at Johns Hopkins University</td>
</tr>
<tr>
<td>CEAPA</td>
<td>Correctional Education Association of Pennsylvania</td>
</tr>
<tr>
<td>CDARI</td>
<td>Caribbean Drug Abuse Research Institute</td>
</tr>
<tr>
<td>CDF</td>
<td>Community Development Fund, International Development Bank</td>
</tr>
<tr>
<td>CDC</td>
<td>Centers for Disease Control, United States</td>
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<tr>
<td>CEPROSH</td>
<td>Centro de Promoción y Solidaridad Humana</td>
</tr>
<tr>
<td>CeSaJo</td>
<td>Centro Salud Joven, Santo Domingo</td>
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<tr>
<td>CEyC</td>
<td>Clínica Esperanza y Caridad</td>
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<tr>
<td>CFLI</td>
<td>Canada Fund for Local Initiatives</td>
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<tr>
<td>CFPA</td>
<td>Caribbean Family Planning Affiliation</td>
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<tr>
<td>CHAA</td>
<td>Caribbean HIV and AIDS Alliance</td>
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<tr>
<td>CHRC</td>
<td>Caribbean Harm Reduction Coalition</td>
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<tr>
<td>CHRC</td>
<td>Caribbean Health Research Council</td>
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<tr>
<td>CIAT</td>
<td>International Treatment Activists Coalition</td>
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<tr>
<td>CICAD</td>
<td>Inter-American Drug Abuse and Control Commission</td>
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<tr>
<td>CIDA</td>
<td>Canadian International Development Agency</td>
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<td>CIDAR</td>
<td>Caribbean Drug Abuse Research Centre</td>
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<tr>
<td>Acronym</td>
<td>Full Name</td>
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<tr>
<td>CIMS</td>
<td>Centro de Acogida para Mujeres Migrantes Traficadas y Retomades</td>
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<tr>
<td>CMLF</td>
<td>Caribbean Med Labs Foundation</td>
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<tr>
<td>CND</td>
<td>National Drug Council, Dominican Republic</td>
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<tr>
<td>CODEJO</td>
<td>Comité de Jóvenes UNIDOS</td>
</tr>
<tr>
<td>CORDAID</td>
<td>Catholic Organization for Relief and Development Aid</td>
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<tr>
<td>COVIH</td>
<td>Comité de Mujeres Viviendo con VIH/SIDA</td>
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<tr>
<td>COIN</td>
<td>El Centro de Orientación e Investigación Integral</td>
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<tr>
<td>CONAVIHSDA</td>
<td>National HIV and AIDS Council, Dominican Republic (since 2009)</td>
</tr>
<tr>
<td>CONECTA</td>
<td>Alliances for public and private sectors to improve quality of prevention and care in HIV/AIDS (a Family Health International project)</td>
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<tr>
<td>COPRESIDA</td>
<td>Presidential AIDS Council, Dominican Republic (before 2009)</td>
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<tr>
<td>COTRAVETD</td>
<td>Comunidad de Trans-Trans-Travesti Trabajadoras Sexuales Dominicanas</td>
</tr>
<tr>
<td>CRN+</td>
<td>Caribbean Regional Network of People Living with HIV/AIDS</td>
</tr>
<tr>
<td>CSO</td>
<td>Civil Society Organization</td>
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<tr>
<td>CSP</td>
<td>Citizen Security Programme, Trinidad and Tobago</td>
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<tr>
<td>CTAG</td>
<td>Caribbean Treatment Action Group</td>
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<tr>
<td>CVC</td>
<td>Caribbean Vulnerable Communities Coalition</td>
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<tr>
<td>DAC</td>
<td>Development Assistance Committee</td>
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<tr>
<td>DED</td>
<td>German Development Service</td>
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<tr>
<td>DHS</td>
<td>Demographic and Health Survey</td>
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<tr>
<td>DIGECITTS</td>
<td>Division for Controlling STIs and HIV, Dominican Republic</td>
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<tr>
<td>DUs</td>
<td>Drug users</td>
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<tr>
<td>EDC</td>
<td>Education Development Centre</td>
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<tr>
<td>EOA</td>
<td>Equal Opportunities Act, Trinidad and Tobago</td>
</tr>
<tr>
<td>EOC</td>
<td>Equal Opportunities Commission, Trinidad and Tobago</td>
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<tr>
<td>EU</td>
<td>European Union</td>
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<tr>
<td>FEDOMU</td>
<td>Federación Dominicana de Municipios</td>
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<tr>
<td>FEI</td>
<td>France Expertise Internationale</td>
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<tr>
<td>FHI</td>
<td>Family Health International</td>
</tr>
<tr>
<td>FIU</td>
<td>Florida International University</td>
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<tr>
<td>FPATT</td>
<td>Family Planning Association of Trinidad and Tobago (FPATT)</td>
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<tr>
<td>FSW</td>
<td>Female sex worker</td>
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<tr>
<td>FUNDOREDA</td>
<td>Fundación Dominicano de Reducción de Daños</td>
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<tr>
<td>FURJUG</td>
<td>Fundación Red de Jóvenes Unidos de Guachupita</td>
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<tr>
<td>GAATW</td>
<td>Global Alliance against Traffic in Women</td>
</tr>
<tr>
<td>GALCK</td>
<td>Gay and Lesbian Coalition of Kenya</td>
</tr>
<tr>
<td>GFATM</td>
<td>Global Fund to Fight AIDS, Tuberculosis and Malaria</td>
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<tr>
<td>GIPA</td>
<td>Greater Involvement of People Living with AIDS</td>
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<tr>
<td>GIZ</td>
<td>German International Cooperation</td>
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<tr>
<td>GTZ</td>
<td>German Technical Cooperation</td>
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<tr>
<td>GNI</td>
<td>Gross National Income</td>
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<td>GPA</td>
<td>Global Programme on AIDS</td>
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<td>HAF</td>
<td>Hispanic AIDS Forum</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>HPP</td>
<td>Health Policy Project, USAID</td>
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HST  Hombres Trabajadores Sexuales
ICAD  International Coalition on AIDS and Development
ICASO  International Council of AIDS Services Organizations
ICPD  International Conference on Population and Development
IDAHO  International Day against Homophobia and Transphobia
IDCP  Instituto Dermatológico y Cirugía de Piel
IDUs  Injecting drug users
IEC  Information, education and communications
IFRC  International Federation of Red Cross and Red Crescent Societies
ITPC  International Treatment Preparedness Coalition
IPPF  International Planned Parenthood Association
J-FLAG  Jamaica Forum for Lesbians, All-sexuals and Gays
JASL  Jamaica AIDS Support for Life
JCF  Jamaican Constabulary Force
JN+  Jamaican Network of Seropositives
JYAN  Jamaica Youth Advocacy Network
LGBT  Lesbian, gay, bisexual, and transgender
KAP  Knowledge, Attitudes and Practices
MARPs  Most at risk populations
M&E  Monitoring and Evaluation
MODEMU  Movimiento de Mujeres Unidas
MRF  Medical Research Foundation
MSM  Men who have sex with men
MSMGF  Global Forum on MSM and HIV
MSW  Male sex worker
MUD  Mesita de Usuarios de Drogas
NACC  National AIDS Coordinating Committee, Trinidad and Tobago
NADAPP  National Alcohol and Drug Abuse Prevention Programme
NASTAD  National Alliance of State and Territorial AIDS Directors
NCDA  National Council on Drug Abuse, Jamaica
NDC  National Drug Council, Trinidad and Tobago
NSWP  Global Network of Sex Work Projects
OAS  Organization of American States
OECD  Organisation for Economic Cooperation and Development
OIS  Organization of Islamic States
OECS  Organization of Eastern Caribbean States
OSI  Open Society Institute
OVPs  Other vulnerable populations
PAHO  Pan American Health Organization
PANCAP  Pan Caribbean Partnership against HIV and AIDS
PCA  Police Complaints Authority, Trinidad and Tobago
PCU  PANCAP Coordinating Unit
PEPFAR  President’s Emergency Plan for AIDS Relief
PLWH  People living with HIV
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Name</th>
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<tbody>
<tr>
<td>PNM</td>
<td>People’s National Movement, Trinidad and Tobago</td>
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<tr>
<td>PR</td>
<td>Principal Recipient</td>
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<tr>
<td>ProSuRe</td>
<td>GTZ Supra-regional Project “Youth and AIDS in the Caribbean”</td>
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<td>PSI</td>
<td>Population Services International</td>
</tr>
<tr>
<td>QPCC and C</td>
<td>Queens Park Counselling Centre and Clinic</td>
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<tr>
<td>RBC</td>
<td>Royal Bank of Canada</td>
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<tr>
<td>REDNAJCEr</td>
<td>Red Nacional de Jóvenes Viviendo Con VIH/SIDA</td>
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<tr>
<td>REDOVIH</td>
<td>Dominican Network of People Living with HIV</td>
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<tr>
<td>REDTRASEX</td>
<td>Red de Trabajadoras Sexuales de Latinoamérica y El Caribe</td>
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<td>RevASA</td>
<td>Red de Voluntarios de Amigos Siempre Amigos</td>
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<td>RJN</td>
<td>Red Nacional de Jóvenes</td>
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<td>SHRH</td>
<td>Sexual and Reproductive Health and Rights</td>
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<td>Sida</td>
<td>Swedish International Development Cooperation Agency</td>
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<tr>
<td>SR</td>
<td>Sub-Recipient</td>
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<tr>
<td>SSR</td>
<td>Sub-Sub-Recipient</td>
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<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
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<td>SWAJ</td>
<td>Sex Workers Association of Jamaica</td>
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<tr>
<td>TABS</td>
<td>Test and Talk about Your Business Safely</td>
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<td>TRANSA</td>
<td>Trans Amigas Siempre Amigas</td>
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<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme against HIV/AIDS</td>
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<td>UNDP</td>
<td>United Nations Development Programme</td>
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<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<td>UNGASS</td>
<td>United Nations General Assembly</td>
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<td>USAID</td>
<td>United States Agency for International Development</td>
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<tr>
<td>UWI</td>
<td>University of the West Indies</td>
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<tr>
<td>VCT</td>
<td>Voluntary counselling and testing</td>
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<td>WHO</td>
<td>World Health Organization</td>
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<td>YAM</td>
<td>Youth Advocacy Movement</td>
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<td>YMCA</td>
<td>Young Men’s Christian Association</td>
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<tr>
<td>YTC</td>
<td>Youth Training Centre</td>
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<tr>
<td>YurWorld</td>
<td>Youth in the Real World</td>
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Foreword

With a B.A. in sociology (University of British Columbia, 1968) and a M.Sc. in urban and regional planning (University of Toronto, 1971), I have been doing research, analysis, policy and programme development, evaluation, impact assessment, and related writing for more than thirty years. During this time, I have focussed largely on social, economic, health and cultural issues of concern to minority, marginalized and vulnerable populations.

Since 2000, I have lived in the United Kingdom while working for international development organizations. These have included the World Health Organization (WHO), Joint United Nations Programme on HIV/AIDS (UNAIDS), UN Secretary General’s Study on Violence against Children, UN Interim Force in Lebanon (UNIFIL), International Federation of Red Cross and Red Crescent Societies (IFRC), and German Technical Cooperation (GTZ) and its successor, German International Cooperation (GIZ).

In 2007 and 2011, GTZ and GIZ commissioned me to visit the Caribbean twice to research German-supported initiatives and write up my findings for publication in the German HIV Practice Collection and the German Health Practice Collection. During the 2007 mission, I learned about the GTZ Supra-regional Project “Youth and AIDS in the Caribbean” (ProSuRe-GTZ) which aimed to develop models of good practice in Dominican Republic, Jamaica and Trinidad and Tobago. During the 2011 mission, I learned about COIN’s Youth in the Real World (YurWorld) programme. YurWorld picked up where ProSuRe-GTZ left off and laid some of the groundwork for the CVC/COIN Vulnerabilized Groups Project.

In 2012, the CVC/COIN Vulnerabilized Groups Project commissioned me to visit the Caribbean twice: Dominican Republic and Jamaica from 10 to 19 June; then Dominican Republic, Jamaica, and Trinidad and Tobago from 17 November to 7 December. The purposes of these missions and surrounding work were to research, document and evaluate the Project’s Phase One and its various elements and to write a report on my findings.

This report is the result. It attempts to tell the story of the CVC/COIN Vulnerabilized Groups Project up to the end of Phase One in a straight-forward narrative that non-specialists can easily understand. It lays the foundations for future narratives that may fill in gaps in the story so far and tell the rest of the story as it unfolds. While many have contributed to its contents, I am responsible for my own interpretations of fact, expressions of opinion, errors and omissions. The report begins with an Executive Summary. After that, the main text is divided into five parts:

Part One introduces the CVC/COIN Project and explains where it fits within the larger PANCAP Round 9 Global Fund Project.

Part Two provides national, regional and global context for the CVC/COIN Project.

Part Three describes the origins of the CVC/COIN Project in earlier initiatives.

Part Four and its Annexes describe Phase One (January 2011 - March 2013) of the CVC/COIN Project, the organizations and informal groups that drove it, the challenges they faced, and the results they achieved.

Part Five contains my conclusions and recommendations.

Stuart Adams
Brighton, United Kingdom, August 2013

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1 GTZ (2008) and GIZ (2012b).
Acknowledgements

I would like to thank the CVC/COIN Vulnerabilized Groups Project Unit for retaining me and for guiding and supporting my work. The following all made significant contributions and, unless otherwise noted, are based in the Project’s headquarters in Santo Domingo, Dominican Republic:

- Dr. John Waters, Programme Manager
- Louise Tillotson, Technical and Policy Coordinator
- Hindolo Brima, Monitoring & Evaluation Officer
- John Santana, Finance and Administrative Manager
- Ivan Cruickshank, Programme and Advocacy Coordinator (Kingston, Jamaica)
- Rosa Takkula, Programme Coordinator Dominican Republic
- Cindyann Currency, Temporary Programme Coordinator Trinidad (Port of Spain)

In particular, I would like to thank Louise Tillotson. She was my main contact with the CVC/COIN Project team, coordinated all of its inputs, accompanied me on the last of my visits to Jamaica and Trinidad and Tobago (see below), and gave me the benefit of her own observations and insights.

My research required two missions to the Caribbean. This first was from 10 to 19 June and included 6 days in Dominican Republic during which Liyana Pavon served as my guide, interpreter and translator. After I left, she visited three projects on her own and provided me with audio recordings and notes on her interviews. The second visit was from 17 November to 7 December and included 9 days in Dominican Republic during which Gustavo Dion served as my guide, interpreter and translator.

During my two missions, I met managers, staff and volunteers of more than 20 organizations involved in implementing various elements of the CVC/COIN Vulnerable Groups Project, Phase One. I also met many of the beneficiaries of those various elements including men who have sex with men, transgender women, sex workers, drug users, and marginalized youth. Only a few of these individuals are mentioned by name in the report but, whether mentioned or not, I would like to thank all of them for answering my questions and for sharing information, insights and opinions based on their experiences.

I would like to acknowledge four leaders without whose inspiration and commitment the Caribbean Vulnerable Communities Coalition (CVC), El Centro de Orientación e Investigación Integral (COIN) and the CVC/COIN Vulnerabilized Groups Project would not exist. They are Dr. Robert Carr, the first Executive Director of CVC; Ian McKnight, the second and current Executive Director of CVC; Santo Rosario Ramirez, the first and continuing Executive Director of COIN; Dr. John Waters, the first and continuing Programme Manager of the CVC/COIN Vulnerabilized Groups Project. Robert Carr died of a heart attack in May 2011 and I missed having the privilege of meeting him. However, I did have meetings with Ian, John and Santo and many other communications with John via email, Skype and telephone. Their inputs to this report have been essential and invaluable.

Finally, I would like to thank GTZ and GIZ for my 2007 and 2011 missions to the Caribbean and my first acquaintance with Dr. John Waters, COIN, COIN’s Youth in the Real World (YurWorld) programme, and the CVC/COIN Vulnerabilized Groups Project.
Executive summary

In November 2009, the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) approved a grant of US$34.5 million to finance the five-year (2011-2015) PANCAP Round 9 Global Fund Project. The Caribbean Community (CARICOM) Secretariat acts as Principle Recipient on behalf of the Pan Caribbean Partnership against HIV and AIDS (PANCAP).

The CVC/COIN Vulnerabilized Groups Project is the largest of seven components of the PANCAP Project. It aims to reduce HIV and AIDS among men who have sex with men, sex workers, drug users, and marginalized youth. Based in Santo Domingo, Dominican Republic, El Centro de Orientación e Investigación Integral (COIN) is member of the Caribbean Vulnerable Communities Coalition (CVC) and acts as Sub-Recipient on CVC’s behalf.

Based in Kingston, Jamaica, CVC is a Caribbean-wide coalition of civil society organizations (CSOs), government organizations, informal groups, and individuals that represent and serve the marginalized Caribbean subpopulations most vulnerable to HIV and AIDS.

Phase One of the CVC/COIN Project was meant to last two years, from 1 January 2011 to 31 December 2012, but was extended to 31 March 2013 due to unforeseen budget cuts and delays. It focussed on three countries (Dominican Republic, Jamaica and Trinidad and Tobago) and developed and tested methods, tools and models of practice. Now underway, Phase Two is meant to last three years. It focuses on the same three countries plus three others (Guyana, Haiti and Suriname) and aims to establish rights-based, effective and sustainable programmes to prevent HIV and AIDS.

In November 2012, the Global Fund gave Phase One of the PANCAP Round 9 Global Fund Project its highest grant performance rating: A1 or excellent. This rating followed a diagnostic review by the Global Fund’s Office of the Inspector General (OIG) that commended the CVC/COIN Project for its “exemplary work” to identify and characterize groups highly vulnerable to HIV and to develop tailored and innovative programmes to reduce their vulnerability. The OIG also commended the CVC/COIN Project for its rights-based approach to its work with adolescents of all sexual orientations and described this work as “a promising step towards creating awareness and tolerance of sexual diversity in Caribbean society.”

In May 2012, the consultant agreed to the first of two contracts under which he visited the Caribbean twice and met with the staff, volunteers and beneficiaries of all CSOs and government organizations that had primary responsibility for implementing some 20 different elements of the CVC/COIN Project. In addition, he did a thorough review of all project documentation and particular attention to monitoring and evaluation reports and other evidence as to whether or not these elements were achieving their intended results and as to what challenges or opportunities were making them more or less effective.

This report on the consultant’s findings provides a fairly comprehensive overview of the CVC/COIN Project, its origins in earlier initiatives and its national, regional and global contexts. It takes a more detailed and critical look at the project’s different elements and, also, at the organizations and informal groups primarily responsible for implementing those elements. It identifies strengths, weaknesses, challenges, and opportunities and then draws conclusions and highlights key lessons. It ends with two sets of recommendations: one for the CVC/COIN Project; one for governments and donors.

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2 http://portfolio.theglobalfund.org/en/Grant/List/MAC

The report, including its annexes (which are an integral part of the report) runs to more than 200 pages. Here we attempt to summarize only some of the key conclusions and recommendations found in Part Five of the report.

The report concludes that Phase One of the CVC/COIN Vulnerabilized Groups Project was an outstanding success and that it:

1. Accelerated progress towards the empowerment of civil society. This is important because civil society has played central roles in establishing effective, sustainable and rights-based approaches to HIV and AIDS in most countries that have successfully curtailed the spread of HIV and AIDS.

2. Accelerated progress towards “knowing your epidemic”. Caribbean countries are, at last, doing serological and behavioural surveys and other research into the marginalized sub-populations that are most vulnerable to HIV and AIDS.

3. Accelerated progress towards a sexual and reproductive health and rights (SRHR) approach to HIV and AIDS within primary health care. This approach promises to reduce stigma and discrimination by making it possible for everyone, regardless of their personal characteristics, to receive confidential and user-friendly preventive and treatment services within the context of primary health care services.

4. Did an exemplary job of monitoring and evaluation. This included asking an independent consultant to carefully examine all Phase One elements and implementers and provide a frank assessment.

Among the report’s recommendations are that, during Phase Two, the CVC/COIN Project:

1. Give high priority to establishing systems that deliver packages of preventive supplies (male condoms, female condoms, lubricants, needles and syringes, hygiene products) and services tailored to fit the unique needs of each different sub-population. This will require timely delivery and sufficient quantities of all supplies; mobile clinics (e.g., vans or portable stations) that take services to some of the sub-populations most in need of those services; quality improvement exercises involving collaboration between service providers and beneficiaries.

2. Give high priority to human rights campaigns that can be scaled up through mass media and that put a human face on human rights violations, on hatred and discrimination and on bullying and other forms of verbal and physical abuse.

3. Work closely with national health ministries and national AIDS authorities on identifying and supporting SRHR and HIV and AIDS interventions that have good potential to be scaled up and sustained beyond 2015, when Round 9 Global Fund financing expires.

4. Establish the CVC/COIN Project Unit as CVC’s permanent technical support facility and build its capacity to provide such support. This will require expanding the donor base so the Unit itself and CVC and its member CSOs do not depend on the Global Fund for their survival.

Among the consultant’s recommendations to governments and international donors are that they: recognize the vital role CSOs play in responding to HIV and AIDS among the most vulnerable populations; make up for past neglect and increase the civil society portion of total spending on HIV and AIDS.
Part One: Introduction to the CVC/COIN Vulnerabilized Groups Project

A component of the PANCAP Round 9 Global Fund Project

In early 2008, the Pan Caribbean Partnership against HIV and AIDS (PANCAP) consulted with 50 stakeholder groups around the Caribbean and gave them an October deadline for submitting proposals for two-phase projects that PANCAP might include in its overall proposal for a Round 9 grant from the Global Fund to Fight AIDS, Tuberculosis and Malaria.

In response, the Caribbean Vulnerable Communities Coalition (CVC) — based in Kingston, Jamaica — and El Centro de Orientación e Investigación Integral (COIN) — based in Santo Domingo, Dominican Republic — proposed what eventually became known as the CVC/COIN Vulnerabilized Groups Project. During two-year (2011-2012) Phase One, this project would focus on three countries: Dominican Republic, Jamaica, and Trinidad and Tobago. During three-year (2013-2015) Phase Two, it would continue to focus on those three countries plus three others. (Chosen towards the end of Phase One, the three others are Guyana, Haiti and Suriname.) Throughout, it would develop methods, tools and models of promising practice that could be adapted for use throughout the Caribbean.

In November 2009, the Global Fund approved a grant totalling US$34.5 million for PANCAP’s five-year (2011-2015) Round 9 Global Fund Project. Of the total, US$14.5 was allocated to Phase One (2011-2012) and US$20 million was allocated to Phase Two (2013-2015). Within those allocations, the CVC/COIN Vulnerabilized Groups Project was allocated US$10.2 million (30 percent) of the total five-year grant, US$3 million (21 percent) of the Phase One grant and US$7.2 million (36 percent) of the Phase Two grant.

During the 14-month gap between official approval in November 2009 and official Phase One start-up in January 2011, there were various cut-backs and other adjustments to the total grant given to Phase One of the PANCAP Round 9 Global Fund Project. Such cut-backs and other adjustments continued on through to the end of Phase One and resulted in it being extended from originally intended end-of-December-2012 completion to actual end-of-March-2013 completion. Similar cut-backs and other adjustments are now being made to the total grant given to Phase Two.

All of these cut-backs and other adjustments have been due largely to the fact that, since the September 2008 onset of the continuing global financial crisis, the Global Fund has had difficulty getting donor countries to honour their past commitments and make new commitments to replenish the Fund. The Fund, in turn, has been unable to honour all of its past commitments or to make all of the new ones it had once hoped to make. For example, it cancelled Round 11 of its grant cycle, disappointing all Caribbean government and civil society organizations that were anticipating Round 11 grants to their countries.

Negotiating and agreeing on cut-backs and other adjustments to its allocations and then absorbing these with changes at staff, consultant, programme, and activity level have been arduous, stressful and time-consuming tasks for the new, inexperienced and small CVC/COIN project team. However, by the end of Phase One, they were able to report that their total Global Fund allocation for Phase One came to just over US$2.8 million dollars and that they are being promised more than US$6 million dollars for Phase Two.
The CVC/COIN Project’s contributions to the larger project

The PANCAP Round 9 Global Fund Project has five Objectives:

1. To create an enabling environment that fosters universal access to HIV and AIDS services
2. To reduce HIV transmission in vulnerable populations
3. To lower morbidity and mortality among people living with HIV and AIDS in the Organization of Eastern Caribbean States (OECS)
4. To improve human and laboratory services for health system strengthening
5. To provide better information on the epidemic and the response.

The CVC/COIN Vulnerabilized Groups Project has principal responsibility for achieving Objective 2. It focuses on four vulnerable populations: 1. men who have sex with men (MSM), 2. sex workers (female, male and transgender), 3. marginalized youth, and 4. drug users (injecting and non-injecting). (The original plan to add a focus on prisoners in Phase Two was dropped during downward adjustments to Global Fund allocations.) In addition, the CVC/COIN Project makes significant contributions to the other four Objectives — especially to Objectives 1 and 5.

The Caribbean Vulnerable Communities Coalition (CVC) has 90 members, including civil society organizations (CSOs), government organizations, informal groups, and individuals that can legitimately claim to represent or serve MSM, sex workers, transgender women, marginalized youth, and other vulnerable sub-populations, including migrants and ethnic minorities. The members include individuals because in some of the small island nations and territories of the Caribbean there are only one or two individuals showing leadership and playing active roles in responding to HIV among some of these sub-populations.

CVC and its members, including COIN, have long been involved in activities that contribute to achievement of all of the PANCAP Round 9 Global Fund Project’s five Objectives. In fact, they are uniquely well-placed to contribute to all five for two reasons: first, achieving all five requires their active collaboration; second, they are unsurpassed in their commitment to achieving each one because the vulnerable populations they represent and serve have, for the past thirty years, paid far higher prices (in terms of injury, illness and death) than anyone else has paid for failures to accelerate progress towards each one of those objectives.

The scope of the CVC/COIN component

As discussed in more detail later in this report, the Caribbean Region embraces 30 countries (16 nations and 14 territories) with a combined population of 44 million people. The PANCAP Round 9 Global Fund Project covers only 16 of those countries with a combined population of 27 million people. It does not cover the region’s largest country, Cuba (population 11.3 million) or largest territory, Puerto Rico (population 3.7 million), or most of the smaller territories of France, Netherlands, United Kingdom, and United States.

Phase One of the CVC/COIN Vulnerabilized Groups Project focuses on only three of the countries covered by the PANCAP Round 9 Global Fund Project: Dominican Republic (population 9.9 million), Jamaica (2.7 million) and Trinidad and Tobago (1.3 million). Phase Two focuses on an additional three: Haiti (10 million), Guyana (754,000) and Suriname (525,000). That is, the CVC/COIN Project’s two Phases focus on six countries with a combined population of 25.3 million people. As already mentioned, however, it is developing methods, tools and models of promising practice that can be adapted for use throughout the Caribbean. In fact, such adaptation has been taking place from the Project’s outset, as the
Project team visits countries throughout the region and invites them to participate in various Project activities.

**The broad vision of the Caribbean Vulnerable Communities Coalition (CVC)**

Dr. Robert Carr was the inspired, committed and energetic leader who, more than anyone else, can be credited with founding CVC in 2004. Back in 1991, he became one of the founders of Jamaica AIDS Support for Life (JASL), now the oldest and largest Jamaican CSO dedicated to the AIDS response and to creating an enabling human rights environment.

Robert’s leadership skills made him the second Executive Director of JASL. He used that position to put JASL at the centre of a Jamaica-wide alliance of CSOs determined to reform the laws and change the social attitudes that make MSM, sex workers, transgender women, drug users, prisoners, migrants, and marginalized youth vulnerable to HIV and AIDS.

Robert had a Ph.D. in English literature but he was keenly aware that many Jamaican adolescents and young adults are marginalized by poverty, lack of opportunities for education and employment, histories of drug and alcohol use and sexual coercion and violence within their families, and also by ethnicity and social class. Many adolescents and young adults are marginalized further by harsh laws and harsh law enforcement and, also, by conservative and intolerant social values. These values are promoted not only by some of the country’s religious leaders but, also, by some popular singers whose lyrics celebrate “real men” and their aggressive behaviour towards women and girls as well as towards men and boys who do not conform to the “real men” stereotype.

Robert died of a heart attack when only 48 years old, on 5 May 2011. By then, Ian McKnight has succeeded him as Executive Director CVC. Ian, too, was one of the founders of JASL and its first Executive Director. In an interview on 13 June 2012, he said that Robert had always seen the Caribbean as one community of people who have much in common despite a geography that has them living on many different islands and the nearby coasts of Central and South America. This geography made it easy for colonial powers to divide the Caribbean into many different countries and to retain many as territories even today. Robert, however, was never deterred by political boundaries from looking across the region for help in understanding Jamaica’s problems and finding solutions to them.

To illustrate Robert’s vision of one Caribbean, Ian described how JASL had started out as a group of friends and relatives of people living with HIV (PLWH) and had been inspired by the non-judgemental and compassionate way in which the Government of Cuba was dealing with PLWH. Specifically, it was providing them with free housing and good health and social care and treating all PLWH equally, regardless of their sexual orientation. What Cuba was doing inspired JASL to establish the hospice (financed first by USAID and then by the Netherlands Government) that was at the core of their operations until they could no longer find the financial resources to sustain it.

More recently, CVC’s members in Jamaica, Dominican Republic and elsewhere in the Caribbean have been looking at what CSOs in Puerto Rico have been doing to respond to the high prevalence of injecting drug use in some of Puerto Rico’s poor, informal settlements on the outskirts of cities and in rural areas. Puerto Rico’s CSOs have many years of experience responding to patterns of drug use that are comparatively new elsewhere in the Caribbean.

CVC’s broad vision embraces the understanding that HIV and AIDS are by no means at the top of many vulnerable people’s lists of the problems that concern them most. Drug and alcohol abuse in their families and communities, lack of education and employment
opportunities, sexual coercion and violence, and immediate needs for food and shelter are among the many things that may be higher on their lists. In addition, all such things can contribute to vulnerable people’s feelings of being worthless and hopeless, so they simply don’t care whether or not they become infected by HIV or die from AIDS. Responding to HIV and AIDS effectively requires addressing all such issues.

Finally, CVC’s broad vision is also based on knowledge that the financial resources available to CSOs, informal groups and individuals representing and serving vulnerable populations in the Caribbean have always been severely limited. Since 2008, financial flows have been threatened by the on-going global financial crisis and consequent cut-backs in spending by Caribbean governments, territorial administrations and international donors. It all means that CVC and its members must become more adept at attracting resources from more partners and at using whatever resources they have to best advantage.

Becoming more adept will require Caribbean-wide collaboration by CVC’s members. They already receive financial and technical support from many partners. The Global Fund is just one of these, and it supports CVC’s members not only by financing the CVC/COIN Vulnerabilized Groups Project but through national and sub-regional Global Fund projects. (The cancellation of Global Fund Round 11 has been a huge disappointment to CVC’s members, because they were anticipating that they would benefit from Round 11 grants to their countries and sub-regions.) The unique contribution of the Global-Fund-financed CVC/COIN Vulnerabilized Groups Project is to promote and support Caribbean-wide collaboration, itself, and to build the capacity for effective collaboration.

Why COIN is a Sub-Recipient and CVC a Sub-Sub-Recipient

The Global Fund identified the Caribbean Community (CARICOM) Secretariat as the Principal Recipient (PR) of the PANCAP Round 9 Global Fund Project grant. It also identified seven Sub-Recipients (SRs). In ascending order, from those given the smallest shares to those given the largest shares of the originally approved total five-year budget to manage, the seven SRs are: Education Development Centre (EDC), Caribbean Med Labs Foundation (CMLF), Caribbean Health Research Council (CHRC), University of the West Indies (UWI), Organization of Eastern Caribbean States (OECS), PANCAP Coordinating Unit (PCU), and COIN. (See box for more on CARICOM and the PCU.)

COIN (founded in 1988) was named an SR while CVC (founded in 2004) was named a Sub-Sub-Recipient (SSR) under the COIN umbrella. This was because COIN is the older, better established organization; it is in the larger country and has access to more resources; and it has a longer record of effectively promoting and supporting CSOs and administering their budgets until, with COIN-supported capacity-building, they are ready to administer those budgets themselves.

It is understood, however, that COIN is just one of 90 members of CVC. From all of those members’ perspectives, CVC is the umbrella under which they are collaborating in efforts to better represent and serve vulnerable populations across the Caribbean region.

CARICOM and the PANCAP Coordinating Unit (PCU)

The Commonwealth Caribbean consists of the Caribbean’s 12 nations that were once colonies of the UK plus the Caribbean’s 6 UK territories. In 1965, some of those nations and territories established the Caribbean Free Trade Association (CARIFTA) and, in 1973, CARIFTA evolved into the Caribbean Community (CARICOM). Dutch-speaking Suriname joined CARICOM in 1995 and French-speaking Haiti joined in 2002. CARICOM now has 15 members and five associate members with a combined population of 17 million people, or 39 percent of the Caribbean’s total population.
CARICOM established the Pan Caribbean Partnership against HIV and AIDS (PANCAP) in 2001 and gave the PANCAP Coordinating Unit (PCU) a home in the CARICOM Secretariat’s offices in Georgetown, Guyana. The 15 members of CARICOM are automatically members of PANCAP. The five associate members of CARICOM can choose to become members and two have done so. All other Caribbean nations and territories can choose to become members of PANCAP and four have done so: Dominican Republic, Guadalupe, Curacao, and St. Maarten.

In all, 21 of the 30 Caribbean nations and territories are members of PANCAP. They participate through their Ministries of Health which, in general, are responsible for formulating and implementing their countries’ national strategic plans against HIV and AIDS and for aligning those plans with PANCAP’s regional strategic plan.

While the public servants who run the Ministries’ HIV programmes and participate in PANCAP may be highly committed to responding to HIV and AIDS as effectively as they can, they are not always well-supported by their countries’ elected governments and are largely dependent on international donors for financing. Eleven of the 12 Commonwealth Caribbean nations that constitute the majority of CARICOM’s members are the only nations in all of the Americas that still have laws outlawing same-sex activity and calling for harsh punishment. Their politicians have long histories of failing to commit their governments to financing strong and effective responses to HIV or to creating the environments (of human rights legislation and enforcement and of public understanding and compassion) that would make such responses possible.

Challenges posed by repeated budget adjustments

The originally approved and the continually reduced budgets were all the results of extensive discussion, negotiation and compromise involving the Global Fund, the PR and the seven SRs. The COIN and CVC representatives who participated in these processes were not always at the table when critical decisions were made and they sometimes had to argue for restoration of amounts cut from the CVC/COIN component’s budget or for redistribution of the reduced budget among its various elements. They did not always win their arguments.

Along the way the CVC/COIN component lost two of its partners — Caribbean Family Planning Affiliation (CFPA) and Caribbean Red Cross (Caribbean National Red Cross Societies belonging to the International Federation of Red Cross and Red Crescent Societies, or IFRC) — when they decided that their reduced allocations were insufficient to support their proposed activities. Other consequences were that the CVC/COIN Vulnerabilized Groups Project started with fewer human and other resources than CVC and COIN had hoped for; and CVC and COIN were unable to conclude their hiring process and have the CVC/COIN Project staff team in place before April 2011, three months after the agreed Phase One start-up date (the first working day of January 2011).

Since the CVC/COIN Project team was new, it took its staff members some time to familiarize themselves with the Project, each other, and their individual and collective responsibilities and, in short, to get them working as an efficient and effective team. Inevitably, there were a few staff re-assignments and replacements when some staff members turned out to be ill-suited to their jobs, took pregnancy leave, and so on. On the whole, however, the Project team has been achieving remarkable results with few resources. Individual staff members have often taken on tasks not anticipated in the project’s work plan and not covered by their job descriptions. (For example, they have often supported CVC member organizations and groups in other Caribbean countries besides the three Phase One focus countries.)

The CVC/COIN Vulnerabilized Groups Project has been especially short of the resources it needs to support all of the capacity-building the CVC and its members need. CVC’s newer or smaller member organizations and groups, in particular, have needed considerable help with
planning, budgeting, financial management, providing their inputs into the Project’s monitoring and evaluation system, documenting their past and on-going activities, and keeping their documents in orderly filing systems. Above all, they need help in scaling up their programmes and fulfilling their potential to stop the spread of HIV and AIDS in the Caribbean.

**This report**

This report is the first attempt to tell the story of the CVC/COIN Vulnerabilized Groups Project in a straight-forward narrative that non-experts can read and understand — even non-experts who have no knowledge of the Caribbean, its various general and concentrated HIV epidemics, the partners who have been responding to these epidemics and how they have been responding. Among its intended readers are: leaders, staff and volunteers of CVC’s member organizations and groups; representatives of government ministries and agencies and of local, national, regional and international organizations (including donors) that already partner or might be persuaded to partner with the CVC’s member organizations.

It lays the foundations for more a comprehensive narrative that fills in gaps in the story so far, tells the rest of the story as it unfolds, and responds to readers’ questions, comments and suggestions. While hundreds of people have contributed to the content of this first version of the unfolding story, the consultant evaluator and writer assumes responsibility for his own errors, omissions, interpretations of fact, and expressions of opinion.

The rest of the report is presented in three parts:

- **Part One** introduces the CVC/COIN Project and explains where it fits within the larger PANCAP Round 9 Global Fund Project.
- **Part Two** provides national, regional and global context for the CVC/COIN Project.
- **Part Three** describes the origins of the CVC/COIN Project in earlier initiatives.
- **Part Four** and its Annexes describe Phase One (January 2011 - March 2013) of the CVC/COIN Project, the organizations and informal groups that drove it, the challenges they faced, and the results they achieved.
- **Part Five** provides my observations, conclusions and recommendations.
Part Two:  
The regional and global context

The Caribbean region

The Caribbean Region embraces 30 countries (16 nations and 14 territories) with a combined population of 44 million people when defined to include:

- Thirteen island nations (Antigua and Barbuda, Bahamas, Barbados, Cuba, Dominica, Dominican Republic, Grenada, Haiti, Jamaica, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, and Trinidad and Tobago) with populations ranging from 11.3 million (Cuba) down to 52,000 (Saint Kitts and Nevis).
- Thirteen island territories: six of the United Kingdom (Anguilla, Bermuda, British Virgin Islands, Cayman Islands, Montserrat, and Turks and Caicos Islands), two of France (Guadeloupe and Martinique), three of the Netherlands (Aruba, Curaçao and St. Maarten), and two of the United States (Puerto Rico and US Virgin Islands), with populations ranging from 3.7 million (Puerto Rico) down to 6,000 (Montserrat).
- The nation of Belize which, though in Central America, is closely akin to the Caribbean’s other English-speaking countries.
- The nations of Guyana and Suriname and the territory of French Guiana which, though in South America, are closely akin to the Caribbean’s other English-, Dutch- and French-speaking countries.

The Caribbean’s main official languages are Spanish, French, English, and Dutch but, in daily life, Caribbean people speak many different dialects (some called Creole or Papiamento) that combine elements of European, African, Asian and Amerindian languages. The region’s linguistic diversity reflects the diversity of its people’s ancestry and their political, religious and cultural traditions. Despite the region’s diversity, its countries and territories have much in common including histories of imperial conquest, aboriginal suppression, colonial settlement, slavery, bonded labour, and wars that left first one imperial power and then another in possession of different countries and territories. There is much labour migration within the region and between it and North, Central and South America and Europe.

The World Bank classifies the Caribbean’s 16 independent nations as follows:

- High Income (4): Bahamas, Barbados, Saint Kitts and Nevis, Trinidad and Tobago
- Upper-Middle Income (9): Antigua and Barbuda, Cuba, Dominica, Dominican Republic, Grenada, Jamaica, Saint Lucia, Saint Vincent and the Grenadines, Suriname
- Lower-Middle Income (2): Belize, Guyana
- Low Income (1): Haiti.

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4 UN (2011).
5 [http://data.worldbank.org/about/country-classifications/country-and-lending-groups#Upper_middle_income](http://data.worldbank.org/about/country-classifications/country-and-lending-groups#Upper_middle_income)
HIV in the Caribbean: different countries, different epidemics

The Caribbean region has long had the world’s second highest HIV prevalence but, as shown in Table 1, HIV prevalence, trends and patterns vary widely from one Caribbean country to the next.

Table 1. HIV trends in the Caribbean’s ten largest independent nations, 2001-2011 (UNAIDS, 2012)

<table>
<thead>
<tr>
<th>Population in 2010 (UN est.)</th>
<th>Adult (15+) HIV prevalence</th>
<th>People (15+) Living with HIV</th>
<th>Male: Female 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bahamas</td>
<td>343,000</td>
<td>3.5</td>
<td>2.8</td>
</tr>
<tr>
<td>Barbados</td>
<td>273,000</td>
<td>0.8</td>
<td>0.9</td>
</tr>
<tr>
<td>Belize</td>
<td>312,000</td>
<td>2.3</td>
<td>2.3</td>
</tr>
<tr>
<td>Cuba</td>
<td>11,258,000</td>
<td>&lt;0.1</td>
<td>0.2</td>
</tr>
<tr>
<td>Dominican Republic</td>
<td>9,927,000</td>
<td>1.0</td>
<td>0.7</td>
</tr>
<tr>
<td>Guyana</td>
<td>754,000</td>
<td>1.9</td>
<td>1.1</td>
</tr>
<tr>
<td>Haiti</td>
<td>9,993,000</td>
<td>2.6</td>
<td>1.8</td>
</tr>
<tr>
<td>Jamaica</td>
<td>2,741,000</td>
<td>2.4</td>
<td>1.8</td>
</tr>
<tr>
<td>Suriname</td>
<td>525,000</td>
<td>2.7</td>
<td>1.0</td>
</tr>
<tr>
<td>Trinidad and Tobago</td>
<td>1,341,000</td>
<td>1.3</td>
<td>1.5</td>
</tr>
<tr>
<td><strong>All Caribbean</strong></td>
<td>1.1</td>
<td>1.0</td>
<td>240,000</td>
</tr>
</tbody>
</table>

Of particular interest is the varying male to female ratio of people living with HIV. Where high portions of all people living with HIV are male, it is more than likely that many of the men are becoming infected through male-male sex or through injecting or other drug use. (As discussed elsewhere in this report, there is evidence that inhaling crack cocaine poses a high risk of HIV infection not so much because it involves sharing equipment as because it arouses sexual desire and heightens the propensity to engage in risky sexual behaviour.) Reasons for this are that, for physiological and behavioural reasons, women are far more likely than men to become infected with HIV during any given heterosexual encounter with an HIV-positive partner. Thus, when most transmission occurs during heterosexual activity, women constitute by far the larger portion of all people infected with HIV.

Every two years, UNAIDS asks national AIDS authorities to submit progress reports on their countries’ responses to their HIV epidemics. Here are summaries of what national AIDS authorities said in the 2012 progress reports covering the three countries on which the CVC Vulnerabilized Groups Project is focused during Phase One:

**Dominican Republic.** Based on a 2007 serological and behavioural survey, HIV prevalence was an estimated 0.8 percent among the country’s entire adult population and 3.2 percent among adults living in bateyes (informal settlements associated with old sugar plantations and populated largely by ethnic Haitians). Based on a special 2008 serological and behavioural survey, HIV among vulnerable populations was an estimated: 6.1 percent among all MSM but 10.8 percent among those who self-identify as gay, 17.2 percent among those who self-identify as transgender, and 4.3 percent among those who self-identify as neither; 4.8 percent among female sex workers; 8
percent among drug users.8 The 2008 survey used the snowballing method to cover more than 1,200 each of MSM, female sex workers and drug users and, for this, it relied heavily on gay, transgender and sex worker organizations closely associated with COIN.7

Jamaica. Based on epidemic modelling, an estimated 1.7 percent of the country’s adult population was infected with HIV in 2011 but half of those did not know their HIV-status. Based on 2011 surveys, HIV prevalence was: 32.8 percent among MSM, 4.1 percent among sex workers and 12 percent among homeless people (who are often crack cocaine users). There were persistently high levels of risky behaviours such as having first sexual experiences at increasingly young ages, having multiple sex partners, and engaging in transactional sex. Contributing factors to HIV infection were poverty, gender inequality and homophobia. This survey, too, used the snowballing method to cover MSM, sex workers and homeless people. For this, it relied heavily on Jamaica AIDS Support for Life (JASL) and other civil society organizations and their daily contacts with vulnerable populations.8

Trinidad and Tobago. Based on testing in the public sector (but not the private or civil society sectors) of the health system up to the end of 2010, an estimated 1.5 percent of the country’s adult population was infected with HIV. The data was not broken down by gender or behaviours that may have contributed to infection. The country’s progress report admitted that the government had paid little attention to responding to HIV among vulnerable populations in the past but said it was changing direction and would be paying more attention in the immediate future. During 2013, it would begin collecting data from the private and civil society sectors of the health system and doing its first serological and behavioural surveys to assess HIV prevalence among MSM, sex workers and other vulnerable populations.9 Meanwhile, the only such survey ever done among the country’s MSM took place in 2006. It recruited 320 MSM using a modified snowballing technique and collected saliva samples from 235 of those men. Based on those saliva samples, it estimated that HIV prevalence was 20 percent among MSM.10

With a population of only 1.3 million people, Trinidad and Tobago ranks as the sixth most populous of the 30 nations and territories in the Caribbean. The remaining 24 have populations ranging from 754,000 (Guyana) down to 6,000 (Montserrat) and it is always difficult to collect reliable data on vulnerable populations in the small cities, towns, villages and rural areas of such small countries. The 2010 progress report from Trinidad and Tobago reported on three recent studies on the island of Tobago and noted that “respondents were wary of and reluctant to be labelled”.11 While researchers may promise confidentiality, people find it hard to trust them in places where “everyone knows everyone else” and some behaviour is not only widely disapproved but illegal.

The Dominican Republic and Jamaica surveys summarized briefly above demonstrate that surveys conducted by or in partnership with organizations and groups that represent and serve vulnerable populations can gain enough trust to collect far better data than anyone else can collect. These organizations and groups train people from vulnerable populations to conduct surveys among their peers. They do not need to be from the peers’ own

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6 COPRESIDA (2009). This survey covered all drug users. Injecting drug use is comparatively rare in Dominican Republic but in recent years there have been sharp increases in use of crack cocaine inhaled through heated and shared equipment that causes lips to blister, thus creating opportunities for transmission of HIV.

7 República Dominicana (2012).

8 National HIV/STI Programme (2012).

9 Office of the Prime Minister (2012).


11 National AIDS Coordinating Committee (2010).
communities to know how to approach people and be recognized as kindred spirits with whom it is safe to talk frankly.

**HIV prevalence among MSM in the Caribbean**

The world’s highest, according to a recent Lancet article

In July 2012, the Lancet published a series of six articles in a special issue on HIV among MSM. One of these reported the results of a meta-analysis of data from all countries where there has been surveillance of HIV among MSM and found that, across the world, MSM are many times more likely to be HIV positive than the general population of adults. The available data show that HIV prevalence among MSM in the Caribbean region is 25.4 percent, much higher than in any other region in the world — and that ranking next are Sub-Saharan Africa (17.9 percent), North America (15.4 percent) and Central and South America (14.9 percent). The available data also shows that, in many countries, HIV prevalence among MSM continues to grow even as it declines in the general population.\(^\text{12}\)

Another of the articles found that high and growing prevalence among MSM in North America was greatly distorted by the extremely high and growing prevalence among African-American MSM in particular. Among the factors accounting for this were that they tended to be poor, without health insurance and so without ready access to health services. The article suggested that, in many countries, MSM will continue to have high and growing prevalence of HIV and AIDS until all men (including those who have sex with men but do not freely admit to doing so), “can safely access care, comfortably discuss their sexual risks for HIV with health care providers, receive referrals for appropriate services, and confidentially use prevention methods and services that will reduce their risks of acquisition or transmission of HIV infection.”

The latter article also said, “Because discrimination and scarce social support are associated with HIV infection in MSM, increased attention to the importance of supportive families and educational systems for the healthy development of MSM and other sexual and gender minority youth is fundamental to the success of primary prevention.”\(^\text{13}\)

**Reasons to doubt past HIV estimates and analyses**

Daniel Halperin and Antonio de Moya were among the well-known HIV experts who co-authored a 2009 article observing that the HIV epidemic in the Dominican Republic, like HIV epidemics elsewhere in the Caribbean, has been officially characterized as being “predominantly heterosexual” in nature. This characterization is based on the fact that “only 3.5 percent of cumulative AIDS cases have been officially reported as due to homosexual transmission and another 4.3 percent as being bisexual cases.” Halperin, de Moya and their colleagues found that this was so even though, “The proportion of reported AIDS cases among men remained constant from 1989 to 2006, accounting for about two-thirds of both total cumulative and year 2006 cases.”

They also found that testing of blood at blood donor clinics indicates that HIV prevalence among the country's heterosexual population may be as low as 0.2 percent and that the much higher countrywide HIV prevalence may be due in large part to HIV prevalence among MSM and their female partners. Their article cites additional evidence to support the conclusion that, while the countrywide prevalence of HIV may be declining, the prevalence among MSM may be increasing. It says that one reason for this may be that anal sex,


\(^\text{13}\) Beyer C et al (2012b).
whether in MSM or heterosexual encounters, is a common practice but one that is largely ignored by prevention campaigns.\(^\text{14}\)

### For comparison, some estimates from the United States

The article by Halperin, de Moya and colleagues discussed in the main text says that in the Dominican Republic, “The proportion of reported AIDS cases among men remained constant from 1989 to 2006, accounting for about two-thirds of both total cumulative and year 2006 cases.” In the United States, men have long been accounting for similarly large proportions of HIV cases among Hispanic/Latino Americans and African Americans but, in the United States, there has been much more reliable reporting of modes of transmission.

In the United States in 2009, for example, men accounted for 79% (7,400) of all new HIV infections among all adult and adolescent Hispanic/Latino Americans (aged 13 and older). Gay, bisexual and other MSM represented an estimated 81% (6,000) of all new infections among Hispanic/Latino American men.\(^\text{15}\)

In the United States in 2010, men accounted for 70% (14,700) of all new HIV infections among all adult and adolescent African Americans (aged 13 and older). Gay, bisexual and other MSM represented an estimated 72% (10,600) of all new infections among all African American men.\(^\text{16}\)

As more reliable data on modes of transmission become available in the Dominican Republic and other Caribbean countries, it may become evident that gay, bisexual and other MSM account for similarly high percentages of all new cases of HIV infection among men. It may also become evident that significant percentages of all new cases among women are due to women having sex with men who also have sex with men.

### Recent estimates using UNAIDS’s Modes of Transmission (MOT) modelling tool

Pending more detailed and reliable reporting of new HIV cases (including characteristics of the individuals and modes of transmission involved) and more comprehensive and reliable behavioural and serological surveillance, UNAIDS’ has been urging developing countries to do analyses using its Modes of Transmission (MOT) modelling tool. To learn more about this tool, readers can go to these UNAIDS and WHO websites:

- [http://www.who.int/bulletin/volumes/90/11/12-102574/en/](http://www.who.int/bulletin/volumes/90/11/12-102574/en/)

In 2009, the Dominican Republic became the first Caribbean country to use the MOT modelling tool and the results included estimates that 33.3 percent of the country’s new cases of HIV in 2010 would be among MSM; 2.8 percent would be among female partners of MSM; 2.5 percent would be among sex workers; 5.6 percent would be among the clients of sex workers; 1.9 percent would be among the partners of the clients of sex workers; 0.8 percent would be among injecting drug users (IDUs); 0.15 percent would be among the partners of IDUs; 8.3 percent would be among heterosexuals who have multiple sexual partners; 1.7 percent would be among the monogamous regular partners of heterosexuals who have multiple sexual partners; 31.9 percent would be among heterosexuals who engage in low risk sexual activities (e.g., who are monogamous).\(^\text{17}\)

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15 CDC (2011).
16 CDC (2013).
In 2011, Guyana and Jamaica became the only other Caribbean countries that have used the MOT modelling tool. In Guyana the main result was the conclusion that the country’s small population size and scarcity of data made it impossible to produce meaningful estimates with the MOT tool. In Jamaica the results included estimates that 32 percent of the country’s new cases of HIV in 2012 would be among MSM; 7 percent would be among female partners of MSM; 10 percent would be among sex workers, their clients and the regular partners of their clients; a negligible percent would be among injecting drug users; 22 percent would be among homosexuals who have multiple sexual partners and their monogamous regular partners; 32 percent would be among heterosexuals who engage in low risk sexual activities.

If one-third of all new cases of HIV are among MSM in Dominican Republic and Jamaica, then it is likely that more than half of all new cases among men are among MSM and that a significant percentage of these MSM also have sex with women and transmit HIV to women.

**How many MSM are there in Caribbean countries?**

There are no reliable estimates of how many MSM there are in most countries in the Caribbean or any other region. Coming up with such estimates would require that most men be willing to answer truthfully when asked whether or not they had ever engaged in sex with other men. One well-known expert on the subject points to another difficulty when he says that researchers often begin with poor understanding of the categories people use in particular cultures and, as a result, their questions are not nuanced enough to draw out accurate information. In many cultures, for example, “having sex is something that men can only do with women. Sexual activity with other men is called something different.”

The pioneering Kinsey reports on *Sexual Behavior in the Human Male* (1948) and *Sexual Behavior in the Human Female* (1953) rejected the notion that people fit neatly into the three categories “heterosexual,” “homosexual” and “bisexual” commonly used in Europe and North America. Instead, they can be placed on a continuum from exclusively heterosexual to exclusively homosexual and may occupy different places on that continuum at different stages of their lives (e.g., when young and unmarried) or under different circumstances (e.g., when confined to same-sex institutions). The Kinsey team interviewed 12,000 people in the United States and found that, of the men, 37 percent reported some homosexual activity during their lives, 13 percent reported more homosexual than heterosexual activity and 4 percent reported exclusively homosexual activity.

In 2003, another pioneering study found that rape of male and female prisoners by other prisoners and guards is extremely common in South Africa's prisons. Up to 80 percent of prisoners are raped while in remand (detained as they await trial). Up to 65 percent of male prisoners are MSM while in prison. (Male prisoners have gangs that recruit new members by raping them and teaching them to exchange sex for protection, drugs and other favours from gang leaders.) MSM activity is one of the main reasons prisoners have much higher rates of HIV infection than in the general population. The high turn-over in prisons (with the same men rotating in and out repeatedly) means that men who are MSM while in prison but

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20 Smart T (2009).
heterosexual while outside of prison can be significant drivers of a generalized HIV epidemic.\(^23\) (Numerous other studies have found similar behaviour in other countries’ prisons and also note that dealing and possession of drugs are the most common reasons for sentencing people to prison in many countries. Injecting drugs, inhaling crack cocaine and sharing equipment are common in many prisons and when male prisoners are also engaging in MSM activity, the opportunities for HIV transmission are multiplied. Having learned to enjoy MSM activity or, at least, to see it as something they can exchange for something else it is likely that many prisoners continue to engage in it outside of prison, even if they think of themselves as heterosexual and engage mostly in heterosexual activity.)

How common is MSM behaviour in Caribbean countries? The evidence is scarce but includes:

- A 1996 article entitled “AIDS and the Enigma of Bisexuality in the Dominican Republic” observed that it is a former Spanish colony where MSM activity has not been strictly illegal for many years. However, there is widespread disapproval of men thought to be MSM, at least if they are thought be receptive partners in anal sex, to get emotionally involved with other men and to be effeminate. The article described a study done in Santo Domingo in the 1970s, before the HIV epidemic emerged. That study surveyed males 17 to 28 years old and found that 8 percent from the “upper class”, 18 percent from the “middle class” and 28 percent from the “lower class” said they had had homosexual experiences.\(^24\) (Numerous other studies have found that young people around the world are more likely to have had sexual experiences of various kinds if they are poor, living in crowded conditions, and from families and communities where alcohol and drug abuse and sexual coercion and violence are common.)

- In 2002, there was a school-based survey of students from 10 to 18 years old in 9 Caribbean countries that were former British colonies and had retained harsh colonial laws against same-sex activity and where there was widespread disapproval of such activity. The survey found that 6 percent of the male students were predominantly attracted to other males and another 4 percent were equally attracted to both males and females.\(^25\)

Important new evidence comes from the special 2008 serological and behavioural survey in the Dominican Republic mentioned in the foregoing section of this report. Using the snowballing method, it covered 1387 MSM. Only 1147 specified their sexual self-identity and, of those, 369 (32 percent) self-identified as gay, 109 (10 percent) self-identified as transgender and 669 (58 percent) indicated only that they were MSM. Those who indicated only that they were MSM had HIV prevalence of 4 percent, compared to 10.8 percent for those who self-identified as gay and 17.2 percent for those who self-identified as transgender.\(^26\)

Those findings are consistent with what self-identified gay men, transgender women and male sex workers around the world say in informal conversations. In the places they regularly meet with each other or their sex work clients, there are many men who are “closeted” or “on the down low” and don’t admit to being gay or even bisexual but who, nevertheless, seek out sex with other men. Often such men have girlfriends or wives and children and go to great lengths to hide their same-sex activity. While they may engage in less of it than do self-identified gay men, transgender women or male sex workers they

\(^{23}\) Goyer K et al (2003).
\(^{24}\) De Moya EA and Garcia R (1996).
\(^{26}\) COPRESIDA (2009). This survey covered all drug users. Injecting drug use is comparatively rare in Dominican Republic but in recent years there have been sharp increases in use of crack cocaine inhaled through heated and shared equipment that causes lips to blister, thus creating opportunities for transmission of HIV.
nevertheless have much higher rates of HIV infection than do men who engage in exclusively heterosexual sex. When a country’s population has a great many men “on the down low” engaging in sex with both men and women, they can be significant factors driving the country’s epidemic from a concentrated one to an ever-more generalized one.

As will be seen later in this report, the CVC/COIN Vulnerabilized Groups Project is placing considerable emphasis on efforts to identify and understand all MSM and the behaviours that put them and their sexual partners at risk of HIV and to reach them with HIV prevention, care and treatment tailored to their needs. It is doing the same with other vulnerable communities, reaching them through organizations, informal groups and individuals that represent and serve those communities.

Consultants note
A reviewer comments that this part of the report covers HIV among MSM extensively but lacks comparable coverage of HIV among sex workers, drug users and marginalized youth. The consultant chose to cover HIV among MSM so extensively here because the evidence suggests that national AIDS authorities in Caribbean have had little trouble acknowledging and addressing HIV among sex workers, drug users and marginalized youth but they have had a great deal of difficulty acknowledging and addressing HIV among MSM, whether or not they are also sex workers, drug users and marginalized youth. The evidence suggests that men may account for the majority of all new HIV cases in the Caribbean each year and that MSM may account for more than two-thirds of all new cases among men. For readers concerned about any imbalance in this part of the report, there is extensive discussion of HIV among sex workers, drug users and marginalized youth in Parts Three and Four of this report and in the annexes.

A colonial legacy of intolerant law, religion and public opinion

Male-male sex became legal in France in 1791, in the Netherlands in 1811 and (to some degree) in Spain in 1822, but it did not become legal in England and Wales until 1967 or in Scotland and Northern Ireland until 1982. Of the 192 member states of the United Nations, 79 still have laws that prohibit male-male sex. Of those 79 member states, 50 (63 percent) are former British colonies and 41 of the 50 are also members of the Commonwealth. The remaining 29 (37 percent) are found among the 57 member states of the Organization of the Islamic Conference (OIC).27 [Please note that many members of the OIC are also former British colonies or protectorates and some are now members the Commonwealth. To avoid double counting, such members are placed in the “former British colonies” and “Commonwealth” categories, rather than in the OIC category.]

Twelve of the 16 nations in the Caribbean are former British colonies and members of the Commonwealth and 11 of those 12 have all retained laws against male-male sex from their British colonial past. In the Caribbean and sub-Saharan Africa, most of the countries with the highest rates of HIV infection are former British colonies with laws and social attitudes against male-male sex that make it extraordinarily difficult to launch and sustain effective HIV prevention, care and treatment programmes. In such countries, Anglican (aka Episcopalian or Church of England) bishops are often prominent among religious leaders opposed to overturning laws against male-male sex.

27 Ottoson D (2008). This publication says that, in 2008, there were 86 member states of the UN that criminalize consensual same-sex acts among adults. Here we have excluded India and territories and protectorates that do not stand on their own as member states and we have included only member states whose laws are unambiguous in their prohibition of same-sex activity.
These laws can be traced back to 1534, when Henry VIII gave royal assent to the Act of Supremacy, separating the Church of England from the Church of Rome, and also to the Buggery Act. 28 It defined buggery to include both anal and oral sex with males, females or beasts but it was enforced mainly against males suspected of having sex with other males. There are those who suggest the Buggery Act was a deliberate attempt to make things uncomfortable for the Church of Rome and its same-sex institutions.

In 1817, oral sex was removed from the definition of buggery in English law but anal sex remained punishable by death until 1861, when the penalty became imprisonment for ten years to life. Anal sex then remained the only homosexual act for which men were prosecuted until 1885, when the Criminal Amendment Act of 1885 broadened the grounds for prosecution and worded them so vaguely that the police and courts had vast leeway for interpretation. The Act provided that, “Any male person who, in public or private, commits or is party to the commission of, or procures or attempts to procure the commission by any male person of any act of gross indecency with another male person, shall be guilty of a misdemeanour, and being convicted thereof shall be liable at the discrimination of the Court to be imprisoned for any term not exceeding two years, with or without hard labour.”

The Criminal Amendment Act of 1885 became known as “the blackmailers’ charter” when it was used to try and convict one of Britain’s most celebrated writers, Oscar Wilde. In England, laws against same-sex activity defined in such vague terms as “attempts to procure … any act of gross indecency” survived until 1967, when the Sexual Offences Act decriminalized same-sex activity if it was consensual, took place in private and did not involve anyone under the age of 21. 29 The age of consent for opposite-sex activity was then 16 and that eventually became the age of consent for same-sex activity too.

Alas, the Sexual Offences Act came too late for England’s former colonies, which were often left with even vaguer definitions of male-male sex and even harsher penalties for it. Where such laws exist, males are well-advised not to be so reckless as to show affection for other males in public or to dress or behave or appear in places that could lead to suspicion that they may be seeking sexual contact with other males.

While Spain abolished its law against male-male anal sex in 1822, it retained laws or, at least, official policies and practices that echoed the Catholic Church’s disapproval of any kind of sex outside of marriage or not for the purposes of procreation. Its former colonies have done the same and this has contributed to a great deal of hypocrisy but also to winking recognition that most people are sinners and a tendency to be somewhat less vehemently intolerant of MSM. Conservative Catholic values, however, inform the official policies that make condoms unavailable to sexually active adolescents and make safe medical abortion unavailable to women and girls from low-income families.

As will be seen later in this report, the CVC/COIN Vulnerabilized Groups Project is placing considerable emphasis on educating and advocating for changes in laws, official policies and practices, religious teachings, and public attitudes that make it difficult to provide effective HIV prevention, care and treatment to any and all vulnerable populations.

29 For an excellent summary of law against homosexuality in England and its former colonies see the Muralidhar S (2009).
**Two ways of being Christian, one non-judgmental and compassionate**

In *Christianity, Social Tolerance and Homosexuality*, historian John Boswell reports that his extensive research found little evidence of anti-homosexual Christian attitudes or practices before the 13th century A.D. but found considerable evidence of tolerance and some of open encouragement. Christian ceremonies sanctifying bonds between close male friends were not unknown in England and elsewhere in Christian Europe.\(^{30}\)

Some Christians believe that the Gospels and, within them, the words of Jesus Christ lie at the heart of Christian belief. The Gospels and Jesus Christ make no mention of male-male sex or people who engage in it and, in any case, urge Christians to be non-judgemental and compassionate towards the poor and otherwise marginalized and vulnerable.

Other Christians comb through the Old Testament and pick and choose among the many activities it describes as “abominations” for which people should be caste out by family and community or stoned to death. These “abominations” include most sexual activities outside marriage and not for the purposes of procreation and an array of sins that include, for example: working on the Sabbath, making and worshipping idols that represent God and other holy figures, disobeying one’s father, men cutting their hair, men shaving off their beards, failing to circumcise boys, failing to make offerings to the temple, and eating shellfish, pork, snakes, frogs, lizards, or a wide variety of birds. Sex between men is condemned only once, in the Book of Leviticus. The origins of the word “sodomy” to refer to male-male sex are found in the Book of Genesis, which does not condemn male-male sex but only male-male rape of an esteemed male guest by the men of Sodom.

The domestic and foreign media pay too much attention to Caribbean Christian leaders who condemn male-male sex, argue against the removal of laws inherited from the British colonial era and fuel hatred that gives rise to verbal and physical violence and extreme discrimination against MSM. On the other hand, they pay too little attention to the many non-judgemental and compassionate Christian leaders and organizations in the Caribbean that collaborate with CVC’s members on providing health and social care to MSM, sex workers, drug users, marginalized youth and other vulnerable populations.

**International landmarks in creating enabling environments**

Around the world, countries that keep HIV prevalence low or that stop rising tides of HIV and reduce new infections significantly:

- Provide sound serological and behavioural evidence showing which populations are most vulnerable to infection and which behaviours (however private, taboo or embarrassing) make them vulnerable
- Based on that evidence, target their most vulnerable populations with explicit information (e.g., on the risk posed by anal sex or by sharing equipment for injecting or inhaling drugs) and specific services and supplies for prevention and for testing and treatment of HIV and sexually transmitted infections (STIs) — since treatment not only conserves the health of those treated but reduces the risk they will transmit their infections
- Provide secure and supportive political and social environments — guaranteed by human rights legislation and enforcement — that make it possible for vulnerable populations to organize, advocate on their own behalf, participate in all aspects of the response (research, policy development, programme planning and

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\(^{30}\) Boswell, J (1980).
implementation, and monitoring and evaluation), and feel safe and comfortable taking full advantage of the information, services and supplies on offer.

Landmarks in the worldwide movement to create secure and supportive political and social environments include:

- On 2 October 1997, member states of the European Union (EU) approved the Treaty of Amsterdam. It amended the Treaty of the European Union (1992) and contained a clause that was restated in Article 21 of The Charter of the Fundamental Rights of the European Union (2000): Any discrimination based on any ground such as sex, race, colour, ethnic or social origin, genetic features, language, religion or belief, political or any other opinion, membership of a national minority, property, birth, disability, age or sexual orientation shall be prohibited.

- On 9 October 1998, the Constitutional Court of South Africa overturned South African law that made male-male sex illegal on the grounds that it contravened the South African Constitution of 1996. South Africa thus became the first former British colony in sub-Saharan Africa to overturn laws against male-male sex it had inherited from the colonial era. In its ruling the Court cited similar rulings by the Supreme Court of Canada (another former British colony) and the European Court of Human Rights (in a case against the Government of Northern Ireland).

- On 17 May 2005, the first International Day against Homophobia and Transphobia (IDAHO) marked the fifteenth anniversary of the World Health Organization’s removal of homosexuality from its list of mental disorders. This has given the international movement against homophobia and transphobia a target date for yearly advances towards equal treatment of lesbian, gay, bisexual, and transgender (LGBT) people under the laws of all nations.

- On 17 May 2006, the second IDAHO was occasion for announcing a petition urging decriminalization of same-sex acts. It was signed by five Nobel Prize winners including South African Bishop Desmond Tutu, ten Pulitzer Prize winners and many prominent political leaders and celebrities.

- On 26 March 2007, a group of 29 distinguished experts in law and human rights from 29 countries launched the Yogyakarta Principles on the Application of Human Rights Law in Relation to Sexual Orientation and Gender Identity. Since then, the Yogyakarta Principles have often been used in advocacy for legal reform.

- On 3 June 2008, member states of the Organization of American States (OAS) — including South, Central and North America and the Caribbean — adopted the first of a series of resolutions on Human Rights, Sexual Orientation and Gender Identity.

- On 8 December 2008, Argentina read a Declaration on Sexual Orientation and Gender Identity to the UN General Assembly. Initiated by France and backed by all members of the EU and most members of the OAS, it called for all countries to decriminalize same-sex acts and to condemn all human rights violations based on sexual orientation and gender identity. Signed by 66 member states of the UN, it was read as a statement but not introduced as a motion because it was known it would be voted down by member states that included the Vatican, members of the Organization of Islamic States (OIS) and former British colonies in sub-Saharan Africa and the Caribbean.


On 2 July 2009, the High Court of Delhi ruled that Indian law making male-male sex illegal was no longer valid. India (with more people than all of Africa) is by far the most populous of the former British colonies that inherited such laws from its colonial past. In its ruling, the Court noted that such laws are not based on Indian traditions but on British and Christian traditions that conceive of sex in purely functional terms and that disapprove of all manner of sex for pleasure. Achieving the High Court’s ruling took eight years of legal argument, much of which might be used to overturn laws making male-male sex illegal in other former British colonies.

On 17 November 2011, the Human Dignity Trust was launched in the British House of Lords. “Legally challenging the illegality of homosexuality”, it is a global network that mobilizes national, regional and international lawyers and law firms in efforts to bring countries’ laws into conformity with international human rights law. Among its patrons are: Sonia Picado, President of the Inter-American Institute of Human Rights; Sir Shridath Ramphal, former Attorney General of Guyana and former Secretary General of the Commonwealth; Sir Davis Simmons, Chief Justice of Barbados (retired). Its website at [http://www.humandignitytrust.org/](http://www.humandignitytrust.org/) has an interactive map that shows the legal situation in the 11 Commonwealth Caribbean countries that have laws against homosexuality.

On 6 December 2011, US Secretary of State Hillary Clinton addressed the UN General Assembly and announced the launch of a new US Government strategy to combat human rights abuses against lesbian, gay, bisexual and transgender (LGBT) people. Part of US foreign policy, the strategy ensures that US foreign aid will promote and support the rights of LGBT people and will enlist international organizations in the fight against anti-LGBT discrimination. The strategy also establishes a Global Equality Fund to support the work of CSOs working on anti-LGBT discrimination around the world. She concluded by saying: *And finally, to LGBT men and women worldwide, let me say this: Wherever you live and whatever the circumstances of your life, whether you are connected to a network of support or feel isolated and vulnerable, please know that you are not alone. People around the globe are working hard to support you and to bring an end to the injustices and dangers you face. That is certainly true for my country. And you have an ally in the United States of America and you have millions of friends among the American people.*

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**A landmark legal case in Belize**

In September 2010, the United Belize Advocacy Movement (UNIBAM) and its Executive Director, Caleb Orosco, filed a case in the Supreme Court of Belize challenging section 53 of the country’s criminal code, which states that, “Every person who has carnal intercourse against the order of nature with any person or animal shall be liable to imprisonment for 10 years.” This law is widely interpreted to be a law against male-male sex and is echoed in section 26 of the country’s Immigration Act, which forbids entry to Belize of “any prostitute or homosexual.”

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34 Muralidhar S (2009).
On the legal team supporting UNIBAM’s case are a former Attorney General of Belize and a former Attorney General of England and Wales. Also supporting UNIBAM’s case are the International Commission of Jurists, the Commonwealth Lawyer’s Association and the Human Dignity Trust.

Opposing UNIBAM’s Case is a group calling itself Church Interested Parties that includes the Anglican and Catholic bishops of Belize and evangelical leaders. The group has issued a statement saying, “In every country that has granted a new ‘right’ to homosexual behaviour, activists have promoted and steadily expanded this ‘right’ to trump universally recognized rights to religious freedom and expression.” The group has retained their own legal team and on 30 January 2012, this team won the first round of the legal battle when the court removed UNIBAM from the case on a legal technicality. As of this writing, there has been no public announcement of when the trial will continue.

Wasted spending, austerity and the need to prioritize

The global situation

Over the past few years, it has become abundantly evident that much of the money international donors have been contributing to the global response to HIV has been misspent at all levels, from international to local. Among the reasons are:

- National and regional HIV programmes have not been based on sound serological and behavioural evidence; have not been focussing enough of their effort on the most vulnerable populations; and have not been doing enough to create secure and supportive political and social environments, with good human rights legislation and enforcement.

- Instead, those programmes have been putting far too much of their overall effort into targeting populations at little risk of becoming infected with HIV and into preaching abstinence from sex and drugs, even though it is well known that many adolescents and young adults are deaf to such preaching but can be persuaded to use harm reduction measures if given ready access to all the information, supplies and services they need.

- Very little of the money has been going to country- and community-based CSOs that actually represent and serve the most vulnerable populations on the front lines of the global HIV epidemic.

Research commissioned by Funders for Lesbian and Gay Issues found that, in 2005, the world’s LGBT organizations got grants totalling US$10.5 million dollars from all sources to spend for all purposes in developing countries. US$4.2 million of that amount went to LGBT organizations based in high-income countries to spend on programmes that aimed to serve low- and middle-income countries. That left only US$6.3 million for LGBT organizations based in low- and middle-income countries. There were around 200 of those and, because they were getting so little financial support, they often had little or no staff and were highly dependent on volunteers.

By contrast, total spending on HIV and AIDS programmes in developing countries came to around US$8.3 billion in 2005. US$6.1 billion of that amount came from international donors while US$2.2 million came from a combination of developing country governments and out-of-pocket spending by people (or the families and friends of people) living with HIV or

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35 The author of this report wrote Chapters 10 and 11 of the Report on the global AIDS epidemic (UNAIDS, 2006) and Chapter 7 of the IFRC’s World Disasters Report 2008: focus on AIDS (IFRC, 2008). These summarize the evidence about misspending then available.

vulnerable to infection. In many developing countries (as in most high-income countries), MSM are the vulnerable group most at risk of acquiring HIV and MSM constitute the majority or plurality (the largest share) of all people living with HIV. And yet, in 2005, groups representing and serving LGBT in developing countries received only US$6.3 million dollars to spend for all purposes whatsoever and this was only 0.076 percent of the US$8.3 billion dollars spent on the response to HIV and AIDS alone in developing countries.

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“An epidemic of denial, indifference and inaction”

In 2008, The Foundation for AIDS Research (amfAR) released a report on MSM, HIV and the Road to Universal Access with an opening summary saying, “[This] story is one of abject failure on the part of the institutions that have been charged with leading the response to HIV/AIDS at local, national and international levels.” The report cited epidemiological data showing “alarmingly high rates of infection among MSM” and, on the basis of reports from 126 countries, said the response has been “an epidemic of denial, indifference and inaction”.38
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Has the situation been improving? The UNAIDS World AIDS Report 2012 indicated that total spending on HIV and AIDS programmes in developing countries was US$16.8 billion in 2012. Of that amount, only US$228 million (1.36 percent) went to “key populations at higher risk.”39 In April 2013, representatives of regional networks of MSM met with representatives of the Global Forum on MSM and HIV (MSMGF) and observed that only a small fraction of that US$228 million went to MSM and only around US$5 million went to support global and regional networks of MSM.40

The Caribbean situation

Though most Caribbean countries lie comfortably within the World Bank’s High or Upper-Middle categories (Belize, Guyana and Haiti being the exceptions), they have been less generous than international donors.

In the 2008-2009 budget year, total expenditure on the HIV response in the Caribbean region came to an estimated US$497 million but only 31 percent of that total was domestic expenditure. And domestic expenditure included not only spending by governments but also out-of-pocket spending by people living with or vulnerable to HIV and their families and by local CSOs dependent on local resources. By contrast, the Global Fund and bilateral donors (including the United States, United Kingdom, Germany, France, Spain, Netherlands, and others) provided 64 percent of the Caribbean region's total spending on the HIV response in the 2008-2009 budget year. Other international donors (including organizations in the UN system and private donors such as amfAR) provided 5 percent and were the source of much of the money that went to support CVC’s member organizations.41

The on-going global financial crisis started during the 2008-2009 budget year and one of its impacts has been reduced spending on HIV by many governments and by international donors. In the Dominican Republic, for example, total spending on HIV prevention declined from an already modest US$11 million in 2007 to US$5.5 million in 2009 and will decline further if international donors continue to reduce their contributions.42 Meanwhile, Caribbean

39 UNAIDS (2012c).
40 MSMGF (2013).
41 Camara B (2011).
42 Camara B (2011).
youth continue to be sexually active. It is well known that effective prevention campaigns keep targeting adolescents and young adults with fresh messages attuned to ever-changing youth culture. It is also well known that youth culture varies from country to country and from sub-population to sub-population within countries, and that this is nowhere truer than in the culturally diverse Caribbean region.

In Latin America and Caribbean, the Global Fund has been among those in denial

In April 2009, the International HIV/AIDS Alliance published results of their analysis of 15 Global Fund grants in Latin America and Caribbean.\(^{43}\) It focused specifically on grants to Sub-Recipients since those are the grants that sometimes go to “key organizations” that represent and serve the sub-populations most vulnerable to HIV and AIDS. It found that only 4.6 percent of the total amount of grants to Sub-Recipients went to these key organizations. Of that 4.6 percent, the percentages going to organizations representing or serving people living with HIV was just over 50 percent; MSM was 27.5 percent; sex workers was 6.1 percent; transgender women was 0.0 percent.

The analysis took in only two Caribbean countries, Jamaica and Haiti. None of the Global Fund Grant to Jamaica had gone to key organizations. Of three Global Fund grants to Haiti, 3.0 percent of one went to key organizations, 1.6 percent of one went to key organizations and 0.0 percent of one went to key organizations.

The way ahead?

In April 2012, GIZ issued a new publication (researched and written by the author of this progress report) in the German Health Practice Collection.\(^{44}\) It took a look at what GIZ’s BACKUP initiative had been doing to help civil society organizations (CSOs) build their capacity to qualify for grants from the Global Fund and other donors and to put their grants to best possible use. It focussed in on three cases, one being BACKUP’s support for the rapid “learn-as-you-do” capacity-building of COIN’s Youth in the Real World (YurWorld) programme (described at great length in Part Three of this report).

The publication drew lessons from these cases and one was that, when donors cut back their contributions, they should continue to give high priority to providing financial and technical support to CSOs that can legitimately claim to represent and serve the poor and otherwise marginalized and vulnerable. Two independent peer reviewers — one from the International HIV/AIDS Alliance and one from UNAIDS — cited BACKUP’s support for YurWorld, in particular, as “a wonderful example of best practice” in strengthening the capacity of vulnerable groups to participate in the response to HIV in countries and regions with weak human rights legislation and enforcement.

A promising new beginning in Trinidad and Tobago

To provide evidence to inform development of Trinidad and Tobago’s new National HIV and AIDS Strategic Plan 2013-2018, the country’s National AIDS Coordinating Committee (NACC) commissioned spending estimates showing that, over the 2002-2009 period, the country spent an average of more than $US15 million per year on its response to HIV and AIDS but only 6 percent of that money went towards the response among MSM and other vulnerable sub-populations.\(^{45}\)

Housed in the Office of the Prime Minister, the country’s new Interim HIV/AIDS Agency will have primary responsibility for implementing the new Strategic Plan. On 29 January 2013,

\(^{43}\) International HIV/AIDS Alliance (2009).

\(^{44}\) GIZ (2012b).

Roger Samuel, Minister in the Office of the Prime Minister, spoke at the launch of the new Agency and said that the country’s official HIV figures do not give a true picture of what is really occurring since they are based entirely on actual cases reported by public hospitals, health centres and other testing facilities.\textsuperscript{46} To rectify this situation, the Ministry of Health is now working with the National Alliance of State and Territorial AIDS Directors (NASTAD) in the United States: first, to establish a system that will also collect data from private and civil society testing facilities; second, to do behavioural and serological surveys that will provide data on the concentrated epidemics among MSM and other vulnerable sub-populations.

The National HIV and AIDS Strategic Plan 2013-2018 recognizes that one consequence of past misallocation of spending is that “MSM have limited access to HIV prevention, care and support services due to the stigma and discrimination meted out to that group”.\textsuperscript{47} It establishes “advocacy, human rights and an enabling environment” as a priority — combined with better evidence from MSM-specific behavioural and serological surveillance — this gives good reason for hope that in the months and years ahead MSM will have better access to HIV-related services.

\textsuperscript{46} Guardian (2013).

\textsuperscript{47} Office of the Prime Minister (2013).
Part Three: Origins of the CVC/COIN Project

El Centro de Orientación e Investigación Integral (COIN)

Website: http://www.coin.org.do/Idioma/english/index-eng.html

Engaging vulnerable sub-populations in the response to HIV

Santo Rosario Ramirez, Executive Director of COIN, explains that the Island of Hispaniola (shared by Haiti and Dominican Republic and home to almost half of all Caribbean people) had its first known case of HIV in 1983. The Government of the Dominican Republic established its first national AIDS programme in 1987 and it eventually evolved into the Ministry of Health’s Division for Controlling STIs and HIV (DIGECITTS) and the Presidential AIDS Council (COPRESIDA). In 2009, COPRESIDA became known as the National HIV and AIDS Council (CONAVIHSIDA).

A sociologist by training, Santo was one of the national AIDS programme’s first staff. He and some of his colleagues on staff and outside the programme soon recognized that no government-run programme could be very effective at winning the trust of the people most vulnerable to HIV: MSM, transgender women, sex workers, drug users, migrants, and youth living in the poor barrios of the country’s large cities and in its poor rural communities. (The latter include the bateyes associated with former sugar plantations and home to many ethnic Haitians who have been living in the Dominican Republic for generations but still do not qualify for citizenship and the full range of public services available to everyone else.)

In November 1988, they launched El Centro de Orientación e Investigación Integral (COIN) — in English, the Center for Integrated Training and Research — and they got it legally established the following year. Thus, COIN was established shortly after the World Health Organization (WHO) established the Global Programme on AIDS (GPA) in 1987 and long before the GPA gave way to the Joint United Nations Programmes on HIV/AIDS (UNAIDS) in 1996. It was also established long before countries in the Caribbean established the Pan Caribbean Partnership against HIV and AIDS (PANCAP) in 2001.

An evidence-based and horizontal approach to capacity-building

Santo says that, from the beginning, COIN has recognized that its biggest challenge is a society that is extremely homophobic and moralistic but also deeply hypocritical. The general public and their political and religious leaders prefer not to face up to the facts of life in the Dominican Republic. One of COIN’s priorities has always been to do the research, analysis and reporting that hold up a mirror allowing society to see who is vulnerable and what makes them vulnerable and, hopefully, inspiring them to respond with compassion and respect.

Beyond holding up that mirror of sound evidence for effective action, COIN engages in three streams of action:

1. Effective communications for behaviour change
2. Access to essential health services, with emphasis on testing and treatment for HIV and other sexually transmitted infections (STIs) and other interventions that reduce opportunities for HIV transmission and infection
3. Promotion and distribution of condoms and other supplies that reduce the risk of HIV transmission and infection.
Santo describes COIN’s approach as “horizontal,” meaning that COIN aspires only to be a friend to vulnerable populations and to empower them. This approach is based on respect for their cultures and ways of life, together with recognition that they need knowledge and tools but are ultimately responsible for their own health and well-being.

COIN’s fundamental strategy is to identify and connect with natural leaders in vulnerable populations and offer to help them establish their own organizations, support them with capacity building and collaborate with them on research, advocacy, and policy and programme development and implementation. COIN also helps them network with each other at local, national, regional and international levels and helps them participate in forums where policies are set and resources are allocated. Towards those ends, COIN facilitated the formation of *El Coalitión ONG-SIDA* (Coalition of NGOs against AIDS) which now has seats on CONAVIHSIDA and the Global Fund’s Country Coordinating Mechanism (CCM).

COIN does all of the above in full recognition of the fact that HIV is by no means the only problem of concern to marginalized populations and that responding to HIV is seldom their top priority. Many of them are poor, illiterate and homeless and have major struggles just making it through each day. They are faced with extreme prejudice and what they often need, more than anything else, are safe places where they get social and psychological support.

**A few of COIN’s capacity-building initiatives**

Even while COIN itself was getting established, its founders were helping vulnerable populations find their own organizations, link with each other and launch joint programmes with COIN. Over the years, COIN’s initiatives have come to include:

- **Forward Together**, COIN’s first and oldest programme, launched in 1988. It works to bring about behaviour change by sex workers and their clients and intermediaries (e.g., bar owners and staff, taxi drivers and tour guides) in Santo Domingo and other strategic locations. The programme trains sex workers as health messengers and uses a “Reaching Equals through Equals” methodology, including “Thought Provocation Theatre”. Forward Together respects the cultures and lifestyles of sex workers and empowers them to become the main agents of change in the environments where they work.

- **Health Clinics**, starting with a mobile clinic that goes to places where vulnerable populations live, work or congregate. In addition to the mobile clinic, COIN has long had a stationery clinic in its own headquarters, located in a “red light” district where sex workers meet their clients on the streets and in bars and brothels (including guest houses, motels and parking garages that serve as such). Recently, it established another clinic, Centro Salud Joven (CeSaJo), which also serves as the headquarters of its YurWorld programme (described later in this progress report).

- **Centro de Acogida para Mujeres Migrantes Traficadas y Retomadas (CIMS)**, launched in 1994 and working with migrating, trafficked and returned women. CIMS provides them with an integrated programme of information, prevention, legal aid, medical aid, and social and psychological support. At the programme’s hub is a drop-in centre and shelter in Santo Domingo. For several years, until 2011, CIMS was supplemented by *Aura of Hope* (Trafficking in Women and Youth), a project focussing on legal and human rights issues that was a joint initiative of COIN, the Correctional Education Association of Pennsylvania (CEAPA) and MODEMU (described later in this progress report).

- **Support for establishment and on-going capacity-building of a number of organizations described at greater length later in this publication. These include:**
o **Amigos Siempre Amigos (ASA)** — “Friends Forever Friends” — founded by gay men in 1989 and now the country’s oldest and largest gay organization

o **Movimiento de Mujeres Unidas (MODEMU)** — “Movement of Women United” — founded by sex workers in 1996 and now the country's oldest and largest sex worker organization

o **Comunidad de Trans Trabajadoras Sexuales Dominicanas (COTRAVETD)** — “Community of Dominican Transgender Sex Workers” — grew out of MODEMU committee formed in 2006 and is in process of becoming legally registered so that it can receive and manage donor grants (now received and managed on their behalf by MODEMA or COIN).

o **Fundación Red de Jóvenes Unidos de Guachupita (FURJUG)** — “United Youth Network of Guachupita” — legally established in 2009 but growing out of an informal organization of youth (including gang members) who have been addressing HIV and other issues in one of Santo Domingo’s poorest barrios for the past ten years. FURJUG is now supporting similar initiatives in three other poor barrios.

**The Caribbean Vulnerable Communities Coalition (CVC)**

Website: [http://www.cvccoalition.org](http://www.cvccoalition.org)

Founded in 2004, the CVC is much newer than COIN but it grew out of Jamaica AIDS Support for Life (JASL), which was founded in 1991 and is now the oldest and largest of Jamaican CSOs representing and serving vulnerable populations in Jamaica.

Jamaica (population 2.7 million) is the most populous English-speaking country in the Caribbean but it is far less populous than the Dominican Republic (population 10 million), and also far more homophobic. With laws against male-male sex and a long history of violence against MSM, Jamaica has a reputation as one of the world’s most homophobic countries. Adding to that reputation is a 2004 Human Rights Watch report called *Hated to Death: Homophobia, Violence and Jamaica’s HIV/AIDS Epidemic*.48 By mid-June 2012, there had already been eight violent murders of MSM in Jamaica that year, far surpassing the previous record of four in one year; on 1 November 2012, a male student found in an allegedly “compromising position” with another male student was beaten by security guards while other students cheered the guards on, chanting anti-gay insults.49

Hampered by homophobia and by Jamaica’s comparatively small population (and, therefore, more limited resources), JASL has not had opportunities to do as much has COIN has done but it has taken a similar “horizontal” approach. That is, it has acted as a friend to vulnerable populations and done its best to empower them with knowledge, skills and resources — and, when they are ready, to help them establish their own organizations and then collaborate with those organizations. JASL and some of the organizations it has helped establish and continues to collaborate with are discussed at greater length later in this report.

Ian McKnight, the current Executive Director of CVC, was the first Executive Director of JASL. Robert Carr, the first Executive Director of CVC (and Ian’s immediate predecessor in that post) was the second Executive of JASL and still occupied that position when he became the leading founder of CVC. Ian confirms that, among the factors inspiring Robert to lead the drive to found CVC were: Jamaica’s comparatively small size and extreme homophobia; the even smaller sizes of many other Caribbean countries and the extreme

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49 These incidents were reported on the website of Jamaican Lesbians, All-sexuals and Gays (J-FLAG) at [http://www.jflag.org/news-events/](http://www.jflag.org/news-events/)
homophobia found in them, too. Among other things, CVC aims to achieve economies of scale through Caribbean-wide collaboration among all stakeholders representing and serving vulnerable populations.

**The Caribbean Drug Abuse Research Institute (CDARI)**

Website: [http://www.cdari.org/](http://www.cdari.org/)

Marcus Day is the founding Director the Caribbean Drug Abuse Research Institute (CDARI), launched in 2003 by a group of researchers responding to the need for an institution better prepared than more conventional institutions to work with drug-using populations.

Marcus Day and CDARI collaborated with Robert Carr on his efforts to establish the CVC, collaborated with CVC and COIN on their 2008 proposal to PANCAP, and are now key collaborators on the CVC/COIN Vulnerabilized Groups Project. Their contributions to the project include their capacity to:

- Identify and engage with drug users throughout the Caribbean, even in its smallest countries and territories
- Provide unbiased scientific research into the drug use and its consequences
- Promote a public health approach to all substance abuse and misuse
- Do assessments to identify what works in prevention, treatment and criminal justice
- Promote translation of basic and applied research into policy and practice.

**COIN’s Youth in the Real World (YurWorld) Programme**

Blog site: [http://www.jovenesdelavidareal.blogspot.co.uk/](http://www.jovenesdelavidareal.blogspot.co.uk/)

**Born out of Caribbean youth initiatives supported by Germany**

*Jóvenes de la Vida Real* — Youth in the Real World (YurWorld) — has a pre-history starting in 1995, when Germany’s GTZ (now known as GIZ) began collaborating with the Caribbean Epidemiology Centre (CAREC) on efforts to understand and address HIV and other STIs among the region’s youth. The CAREC-GTZ youth initiative was informed by evidence that adolescents and young adults (15 to 24 years old):

- Are the most sexually active and experimental age cohort, so the most likely to engage in behaviour that puts them at risk of HIV and other STIs
- May not belong to vulnerable populations (e.g., MSM, sex workers, drug users, labour migrants) for long but may join them for long enough to be exposed to high risk of HIV infection
- Constitute the age cohort least likely to believe it is vulnerable to harm or to heed warnings from health authorities, religious leaders or anyone else about the potential consequences of high-risk behaviour.

The CAREC-GTZ youth initiative gave rise to another initiative known as the GTZ Supra-regional Project “Youth and AIDS in the Caribbean” (ProSuRe-GTZ). Its aim was to develop models of good or promising practice in the Dominican Republic, Jamaica and Trinidad and Tobago during its four-year (2003-2006) first phase and then to extend its reach to other Caribbean countries in a second phase. At the end of the first phase, it was terminated for German policy reasons that in no way reflected on its achievements. One of those achievements was to plant the seeds from which YurWorld grew.

John Waters, a medical doctor who is now Programme Manager of the CVC/COIN Vulnerabilized Groups Project, was on the ProSuRe-GTZ project team for that project’s 2003-2006 duration. The project’s headquarters were in Santo Domingo and, as a practicing
medical doctor, John continued being one of the doctors who worked part-time in COIN’s mobile and stationery clinics.

John’s connections with COIN, its Executive Director and, through him, senior staff in the Ministry of Health’s Division for Controlling STIs and HIV (DIGECITTS) and the Presidential AIDS Council (COPRESIDA) served the ProSuRe-GTZ project well. In particular, Antonio de Moya, an anthropologist working for COPRESIDA, was instrumental in launching the monthly tertulias that became the project’s main mechanism for bringing together “key stakeholders” (representatives of youth and their organizations) and “key duty-bearers” (representatives of organizations with primary responsibility for driving the HIV response). Tertulias are informal social gatherings where participants are made to feel comfortable enough to engage in frank exchange of information and ideas about subjects of mutual interest to them.

Out of the tertulias grew a proposal for a café that would serve as the core of a youth centre. Among those advocating for such a café were Los Muchachos y Muchachas de la Mesa de Atras (Boys and Girls at the Back Table), an informal group of young gay, lesbian and bisexual friends who often gathered at the back of a particular café that made them feel welcome. Also, advocating for it were representatives of Jóvenes per Siempre (Youth Forever), a CSO for young people living with HIV, and Red Nacional de Jóvenes (National Network of Young People), the country’s main network of youth and youth organizations concerned with sexual and reproductive health.

The proposal was that the café/youth centre would serve as a safe place for poor and otherwise marginalized youth (including self-identifying LGBT youth. MSM that did not self-identify as LGBTI, sex workers, drug users, and gang members from Santo Domingo’s poorest barrios). It would have programmes providing them with the knowledge and skills to prevent or manage HIV and other STIs; to develop healthy and responsible sexual attitudes and behaviour; and to build self-esteem and the confidence to take control over their own lives. It would also give youth opportunities to educate and advocate for human rights and counter prejudice and discrimination; to learn arts, crafts and trades; to generate income from their products and services.

The committee of youth that developed the proposal established and ran the café/youth centre on a trial basis for several months, using the ProSuRe-GTZ offices as the venue on Thursday through Sunday evenings and Saturday and Sunday afternoons, until the ProSuRe-GTZ project came to an end in early 2006.

Two years later, in early 2008, COIN picked up where ProSuRE-GTZ left off by establishing a new COIN programme called Jóvenes de la Vida Real or Youth in the Real World (YurWorld). The programme would develop a youth centre in Santo Domingo and the centre would have outreach programmes extending into the city’s barrios and beyond, into other cities, towns and rural areas. Eventually, it might support the development of similar centres in other major cities of the Dominican Republic and also in other countries of the Caribbean.

Kick-starting YurWorld with rapid “learn-as-you-go” capacity-building

By July 2008, COIN’s YurWorld programme had won agreements for a €60,900 grant from GIZ’s BACKUP Initiative and for collaboration by UNAIDS and other partners on a ten-month (July 2008 to May 2009) process that would:

1. Build the capacity of youth and their formal and informal organizations and empower them to participate in the response to HIV in the Dominican Republic and, by example, to HIV in the whole Caribbean region
2. Build the capacity of “key stakeholders” — i.e., youth and their formal and informal organizations — to forge partnerships with “key duty-bearers” — i.e., adult-run organizations driving the HIV response — and to collaborate with them:
   a. on advocacy and proposal development and, thus, secure financing from the Global Fund and other international donors for youth-oriented programmes and projects
   b. on implementing approved proposals effectively
3. Facilitate input by youth/key stakeholders into national and regional mechanisms — e.g., national AIDS programmes and councils, Country Coordinating Mechanisms (CCMs) and PANCAP — for setting HIV policy, coordinating implementation and allocating resources
4. Advocate for and participate in research to provide the evidence-base for the response to HIV among youth — e.g., increasing knowledge of HIV among young people belonging to most at risk populations (MARPs) and other vulnerable populations (OVPs) through serological and behavioural surveillance and special studies, identifying good practices and promising innovations with a view to establishing effective and sustainable projects.

In July 2008, YurWorld launched a new round of tertulias — called Tertulias de Jovenes — at a turning point in the history of the global response to AIDS. As shown in Part Two of this progress report under the heading International landmarks in creating environments for effective responses to HIV, such landmarks reached a critical mass in 2008-2009. At long last, many international partners were beginning to take seriously the need to focus their financial and technical support on organizations working at the front lines of the epidemic and representing and serving the populations most vulnerable to HIV and AIDS.

The Tertulias de Jovenes became a key mechanism for communication and collaboration involving many partners in a rapid “learn-as-you-go” capacity-building process. This process also included training workshops for around 150 leaders from 50 youth organizations across the Dominican Republic. These workshops provided them with skills at networking, forging partnerships, advocating for action, doing research to gather evidence, developing proposals, managing projects, administering budgets, monitoring and evaluation, and reporting results.

During the ten-month (2008-2009) BACKUP-supported kick-off and the months following, COIN and its YurWorld programme established:

- **El Centro Salud Joven (CeSaJo)** providing friendly health services to marginalized and vulnerable youth. In 2010, CeSaJo was launched as an extension of COIN’s main clinic and located in Santo Domingo’s Colonial Zone, where locals and tourists congregate in the evenings in bars, restaurants, nightclubs, squares, and parks. After DIGECITTS agreed to license it as a primary health care clinic, it had to be moved to where it is now, just outside the old walls of the Colonial Zone. The actual clinic at this new location opened in January 2012, with staff, equipment and medicines financed by DIGECITTS.

- **Elements of a larger youth centre with outreach programmes.** Based in CeSaJo, these elements now receive some of their financing from the CVC/COIN Vulnerabilized Groups Project. The YurWorld staff supporting these elements also helps support the Marginalized Youth component of the Project by continuing to develop a youth centre with outreach that serves as a model of good practice and by promoting and supporting similar youth centres or, at least, youth programmes in other Caribbean countries. Among the Project-supported elements are courses to train peer educators described at great length later in this progress report. See, for example, the activities of Fundación Red de Jóvenes Unidos de Guachupita (FURJUG).
Proactividad, a programme which has received little donor support so far but which harkens back to plans for a café/youth centre providing a safe place where marginalized youth feel welcome and comfortable engaging in a range of activities, including ones providing them with job skills and opportunities to establish their own businesses. For eight months in 2009-2010, Proactividad ran a youth café during the off-hours of a commercial café until the owners closed the café and left the country. Proactividad has established a print shop (by arrangement with a commercial print shop that does the actual printing) whereby youth can learn about marketing, design, lay-out, and printing while earning money for their services. The print shop also offers a "total package" for organizations planning meeting, conferences and workshops whereby it will find appropriate venues, provide trained facilitators, design and print posters and hand-outs, and take care of catering.

A programme for drug users that began in 2009 with a grant of US$12,000 from the Caribbean Treatment Action Group (CTAG), the Caribbean affiliate of the International Treatment Preparedness Coalition (ITPC). This programme engages with drug users one evening per week at a large evangelical church that feeds the homeless. On that evening, COIN’s mobile clinic parks near the church and provides drug users with health counselling, testing for HIV and STIs and onwards referrals. The programme sensitizes staff at the care and treatment centres to which it refers drug users; trains drug users as peer educators and provides them with appropriate literature and supplies; is helping drug users establish their own legally registered organization and space.

A three-year project for drug users that began in October 2011 and that involves collaboration with the Centers for Disease Control (CDC) and has a budget of almost US$1 million. This project is: expanding peer education to cover more drug users, first in Santo Domingo and then in other cities; identifying natural leaders in their midst and training these leaders to act as role models, showing by example how to reduce risk of infection; trying new strategies for shielding drug users from harm in a country that follows the American practice of not providing safe equipment for fear of encouraging more drug use. COIN/YurWorld is principal recipient of the CDC grant and its implementing partners include the Volver Foundation (a Dominican CSO working with drug addicts) and Pangaea Global AIDS Foundation, which helps plan strategy and build capacity.

Programmes for transgender women (biological males who self-identify as females) takes into account that Trans Siempre Amigas (TRANSSA) — a group that grew out Amigos Siempre Amigos (ASA) — estimates there are 4,000 transgender women in Santo Domingo and thousands of others across the country. The most vulnerable transgender women are poor, illiterate and often involved in sex work and they have formed their own organization called Comunidad de Trans Trabajadoras Sexuales Dominicanas (COTRAVETD), which collaborates with YurWorld, the Movimiento de Mujeres Unidas (MODEMU) and others on a range initiatives described later in this publication.

A programme for MSM who do not self-identify as gay works with male sex workers, most of whom consider themselves heterosexual; with men who say they are not gay or bisexual but who come to health clinics with injuries or other symptoms of same-sex activity; and with those clients of male sex workers who do not self-identify as gay or bisexual and are sometimes married or have girlfriends. This programme is supported by a grant of US$19,000 from amfAR. In addition, a Mac Foundation grant of US$17,000 (facilitated by CVC) is paying for the production of a documentary film about men “on the down low” in Dominican Republic and Jamaica. Such men are believed to be numerous in all regions and countries and also believed to play significant roles in driving the HIV epidemic but, heretofore, there has been a lack of good evidence.
• **Programmes for self-identified gay men** consist, at this stage, largely of collaborating with well-established organizations representing and serving gay men on initiatives described later in this report. See, for example, the activities of Este Amor and Red de Voluntarios de Amigos Siempre Amigos (RevASA).

• **Projects for youth engaged in transactional sex** include a documentary film (*Buscándomela*, “Getting By”) on transactional sex along the south coast of Dominican Republic, financed with a US$14,000 grant from CTAG, and a series of radio programmes aimed primarily at female sex workers in Antigua and paid for by two grants from UNFPA. In collaboration with MODEMU, COTRAVEDT the YurWorld intends to continue giving high priority to understanding and addressing that many young Dominicans are tempted to engage in transactional sex and more overt sex work and are sometimes trafficked into this work.

**Birth of the proposal for the CVC/COIN Project**

As Programme Manager, John Waters is now head of the CVC/COIN Vulnerabilized Groups Project staff team. From 2003 to 2006, he was on the ProSuRe-GTZ project team that laid the foundations of COIN’s YurWorld Programme and, in 2008, he initiated and began spearheading the efforts to kick-start YurWorld and drive its rapid capacity-building process forward.

From 2003 onwards, John’s work often brought him into contact with Robert Carr, who became CVC’s first Executive Director in 2004, and also with Marcus Day, who became founding Director of CDARI in 2003. In addition, it brought him into contact with most of the organizations, informal groups and individuals across the Caribbean that are now members of CVC.

John consulted with Robert Carr and Marcus Day, as well as with Santo Rosario Ramirez (Executive Director of COIN), as he developed the proposal and negotiated the agreement with GIZ’s BACKUP Initiative that provided core funding for the ten-month process that would achieve the objectives outlined at the beginning of the foregoing section of this report. Even as John, Robert, Marcus, and Santo consulted with each other about those things, they consulted with each other about how CVC and its members, including COIN and CDARI, might pool resources and submit the joint proposal to PANCAP that eventually became the CVC/COIN Vulnerabilized Groups Project.

Throughout, all four leaders were aware that, to some considerable extent, COIN’s YurWorld Programme would be laying the foundations for the initiative now known as the CVC/COIN Vulnerabilized Groups Project. The latter would use many of the same methods to build the capacity of all CVC’s members to do their parts in scaling up the response to HIV among the vulnerable populations of the Caribbean. Among the features of the project that hark back to the ProSuRe-GIZ initiative are the Phase One focus on three pilot countries. As for COIN’s YurWorld programme, it has much of the responsibility for administering the CVC/COIN Project’s Marginalized Youth component.
Part Four:  
Phase One of the CVC/COIN Project

The Project Unit

Website: www.focusright.org  
Facebook: www.facebook.com/pages/CVC-COIN/227762187309403

Offices and staff

It was agreed to locate the CVC/COIN Project Unit’s main office in Santo Domingo for three reasons: 1) COIN is the Sub-Recipient overseeing the Project and it is located in Santo Domingo; 2) Dominican Republic is by far the most populous of the three Phase One focus countries; 3) Dominican Republic shares the Island of Hispaniola with Haiti, by far the most populous of the countries that were, from the outset, considered prime candidates to be added as focus countries in Phase Two. It was also agreed to have significant Project Unit presence in CVC’s headquarters in Kingston, Jamaica, and to locate country programme coordinators in each of the three Phase One focus countries.

Candidates for the Unit’s staff members were recruited and selected through a transparent process approved by the Principle Recipient and the Global Fund and described in detail in a 31 March 2011 report. The hope had been to have all staff in place before the official start of the Project’s Phase One at the beginning of January 2011 but continuing budget cutbacks and the discussions and negotiations surrounding them meant that key staff members were not in place before April 2011. The three-month delay at the beginning was one of the reasons for a three-month extension at the end. Originally planned to finish at the end of December 2012, Phase One finished at the end of March 2013.

There were a few staff replacements and re-assignments at country coordinator and support staff levels during implementation of Phase One. During the final months of Phase One, the Project Unit’s staff included:

- Dr. John Waters, Programme Manager (Santo Domingo)
- Louise Tillotson, Technical and Policy Coordinator (Santo Domingo)
- John Santana, Finance and Administrative Manager (Santo Domingo)
- Hindolo Brima, Monitoring & Evaluation Officer (Santo Domingo)
- Ivan Cruickshank, Programme and Advocacy Coordinator (Kingston)
- Arnulfo Kantun, Drug-User Programme Coordinator (Kingston)
- Rosa Takkula, Programme Coordinator Dominican Republic (Santo Domingo)
- Cindyann Currency, Temporary Programme Coordinator Trinidad (Port of Spain)

Support staff that included 2 accounting clerks, 2 auditors, 2 half-time procurement officers, and 2 ancillary staff (Santo Domingo and Kingston)

The main collaborators with the Project Unit were CVC and its member organizations. Key among these were COIN and JASL, both of which have long histories of providing technical support to civil society organizations and informal groups that represent and serve marginalized and vulnerable populations. In effect, COIN and JASL acted as technical support facilities within their respective countries, Dominican Republic and Jamaica.

The Project Unit also had a budget for consultants. The Project’s agreements with CARICOM (Principal Recipient) and the Global Fund specified ceilings for staff salaries and

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consultants’ per diem fees. These meant that the Project could not always offer competitive salaries and fees but it could, to some extent, compensate by offering very interesting, challenging and worthwhile work. The Project was particularly attractive to staff and consultants strongly committed to working with marginalized and vulnerable populations.

Overall management and capacity building

As discussed in Part Four, Dr. John Waters provided key leadership in efforts to establish COIN’s YurWorld Programme and to use it as a platform for launching the CVC/COIN Vulnerabilized Groups Project. As Programme Manager, he was head of the Project Unit throughout Phase One and he was strongly committed to making the most of Global Fund financing. This meant not only achieving all targets specified in the Project’s original agreements with CARICOM and Global Fund but going beyond those targets and also adding on, for example, 14 CVC/COIN Community Grants projects that have proven to be very fruitful in terms of lessons they teach. They have greatly added to knowledge about HIV among marginalized and vulnerable sub-populations, effective strategies for responding to it, and challenges that must be met in order to implement such strategies.

As the Project’s Technical and Policy Coordinator, Louise Tillotson has functioned to some considerable extent as the Programme Manager’s deputy and executive assistant. She has helped plan and implement the Project’s ambitious programme of activities. While her job has required considerable travel, it is has not required as much as John’s and she and John are in frequent communications via cell phone, text messaging and email.

Major challenges for the Programme Manager, Technical and Policy Coordinator, Financial and Administrative Manager, and other Project Unit staff have been posed by the fact that the Unit has no Human Resources Manager, no Office Manager and no one else with the training or experience to qualify as professionals in either of those fields. The whole approach to compensating for the absence of these professionals has been very much learn-as-you-go and sometimes the learning has only really begun after problems have become so serious that there has been urgent need for solutions. Among the past and ongoing capacity-building activities have been/are:

- Clearer job descriptions, periodic performance reviews, and timely supervision, training, re-assignment, or replacement of underperforming staff members.
- Clearer terms of reference and other measures to ensure good performance of consultants.
- Better procedures/systems for recording events and keeping comprehensive and well-organized sets of electronic (and, when appropriate, hard-copy) files, so staff and consultants can easily locate and retrieve any documents they may need.
- Better procedures/systems for monitoring in-coming and out-going communications so there is always appropriate and timely follow-up.

Whatever measures the Project Unit may take to improve its performance it will always be faced with these challenges:

- The Caribbean region has 30 nations and territories, 26 on islands and four on the coasts of Central and South America. Phase One focused on three nations and Phase Two is now focusing on six but implementing the CVC/COIN Vulnerabilized Groups Project requires considerable travel among more than those six by the Project Unit’s Programme Manager and other senior staff and also requires travel to various international events outside of the region. All of this travel — together with the fact the Project Unit staff is dispersed through two main offices and across all of the
Project’s focus countries — reduces opportunities for face-to-face communications and daily monitoring and supervision of staff and consultants.

- The Caribbean region has four languages (Spanish, French, English, and Dutch) used for the purposes of official business. It has proven very difficult to find otherwise qualified staff and consultants whose qualifications include fluency in two or more the region’s official languages. During Phase One, Dr. John Waters was the only staff member who was fluent in Spanish, French and English and he and the Unit’s bilingual Spanish-and-English-speaking staff were often called upon to act as interpreters and translators for other staff and consultants. Only in rare instances could the Unit afford the luxury of hiring temporary interpreters and translators and this is likely to remain the case.

- The Project Unit has been and will continue to be short of the resources it would need to support all of the capacity-building the CVC and its member organizations need. CVC’s newer or smaller member organizations and groups, in particular, need considerable help with planning, budgeting, financial management, providing their inputs into the Project’s monitoring and evaluation system, documenting their past and on-going activities, and keeping their documents in orderly filing systems. Above all, they will continue to need help with securing financial resources, scaling up and sustaining their projects and programmes, and fulfilling their potential to stop the spread of HIV and AIDS. To compensate for its own incapacity, the Unit will have to continue depending on the capacity of key country-level partners such as COIN and JASL to support capacity building within their respective countries. In countries that lack such obvious key partners, the Project Unit may have to consult with country-level CSOs to select one CSO per country that might function as the equivalents of COIN or JASL.

Financial and administrative management

**The Financial and Administrative Manager and support staff**

*Note that, throughout this section, “administrative management” does not imply human resources management beyond drawing up employee and consultant contracts, ensuring compliance, and attending to employee benefits and processing staff and consultant salaries, fees and expenses. Nor does it imply office management beyond procuring supplies, equipment and repairs.*

John Santana, the Project’s Finance and Administrative Manager, came to the Project after working in financial management and procurement in private industry and then serving as a procurement officer for the Dominican team supporting Haiti in its response to the January 2010 earthquake.

During Phase One, his job involved overseeing financial and administrative management at the Project’s Santo Domingo and Kingston offices and ensuring satisfactory financial and administrative performance and reporting from more than 20 CVC member organizations that participated in Phase One in various ways, including piloting the Project’s sexual health approach to peer education and implementing projects for which they had received CVC/COIN Community Grants. In all of this work, he was assisted by two accounting clerks, two auditors and two part-time procurement officers but he also had to do much hands-on work within the offices of CVC member organizations.

In effect, a considerable amount of his time was spent doing capacity-building for financial and administrative management. This involved developing tools and procedures, providing training and supervision and doing much travel. He often spent days in the offices of CVC and its member organizations going through their accounting records, bank statements,
contracts, invoices, and receipts and filling in gaps or otherwise improving the inputs he
needed to meet COIN’s requirement as a Sub-Recipient to submit complete and accurate
reports to the Principal Recipient (CARICOM) and the Global Fund.

Adding to the burden of his work were frequent changes in budget allocations to the Project
and among its various elements, long delays before the Project received instalments on its
share of the PANCAP Round 9 Global Fund grant and frequent audits of the Project’s
financial records. As the Principal Recipient, CARICOM was immediately responsible for
posing these challenges but the Global Fund was ultimately responsible. Likely reasons are
found in some of the challenges the Global Fund, itself, has been facing since the
September 2008 onset of the continuing financial crisis. (See discussion on the first page of
Part One of this report.) Another likely reason is that past experience with misspending of its
grants has caused the Global Fund to administer its grants with extreme caution and to
require similar caution on the part of its Principal recipients.

The results

The Project and most of its elements seem to have been well managed from a financial and
(narrowly defined) administrative perspective. Table 2, below, shows that it was kept well
within its budget in all but one of the major cost categories assigned by the Global Fund. The
Project’s “End of Phase I Report” to CARICOM and the Global Fund, notes that some
expenditure items (e.g., the CVC/COIN Community grants and some advocacy activities)
were not anticipated when those cost categories were assigned and had to be fit into
particular cost categories somewhat arbitrarily. That report also recommends redefining the
Global Fund’s definition of “infrastructure and equipment” so that it takes in some items now
fit into the “overheads” category.

<table>
<thead>
<tr>
<th>Category</th>
<th>Budget (US$)</th>
<th>Expenditure (US$)</th>
<th>Surplus/Deficit Amount</th>
<th>Surplus/Deficit Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Human resources</td>
<td>1,137,740</td>
<td>1,089,299</td>
<td>48,442</td>
<td>4%</td>
</tr>
<tr>
<td>Infrastructure and equipment</td>
<td>204,556</td>
<td>181,897</td>
<td>22,659</td>
<td>11%</td>
</tr>
<tr>
<td>Overheads</td>
<td>195,609</td>
<td>205,667</td>
<td>(10,058)</td>
<td>-5%</td>
</tr>
<tr>
<td>Procurement and supply management</td>
<td>9,360</td>
<td>9,053</td>
<td>307</td>
<td>3%</td>
</tr>
<tr>
<td>Communication material</td>
<td>94,588</td>
<td>82,768</td>
<td>11,820</td>
<td>12%</td>
</tr>
<tr>
<td>Planning and administration</td>
<td>54,348</td>
<td>30,499</td>
<td>23,849</td>
<td>44%</td>
</tr>
<tr>
<td>Technical assistance</td>
<td>271,180</td>
<td>256,317</td>
<td>14,863</td>
<td>5%</td>
</tr>
<tr>
<td>Training</td>
<td>557,100</td>
<td>427,228</td>
<td>129,872</td>
<td>23%</td>
</tr>
<tr>
<td>Monitoring and evaluation</td>
<td>288,408</td>
<td>229,362</td>
<td>59,046</td>
<td>20%</td>
</tr>
<tr>
<td>Total</td>
<td>2,812,889</td>
<td>2,512,090</td>
<td>300,799</td>
<td>11%</td>
</tr>
</tbody>
</table>

Monitoring & evaluation

Meeting Global Fund requirements for quantitative data

Hindolo Brima is the Project’s Monitoring and Evaluation Officer and, during much of Phase
One, he was supported by an assistant. Hindolo had primary responsibility for designing or
adapting and applying tools, mechanisms and procedures whereby the Project measured
progress against indicators and targets set in the grant agreement for Phase One of the
PANCAP Round 9 Global Fund Project. (See box.)
Global Fund indicators and targets for the CVC/COIN Project’s Phase One

The grant agreement assigns the CVC/COIN Project primary responsibility for achieving the PANCAP Projects’ Objective 2, to reduce HIV transmission in vulnerable populations. It specifies two indicators and two targets against which to measure achievement:

1) Indicator 2.1: Number of female sex workers (FSWs) reached by peer educators with a minimum package of services
   Target: 2,900 sex workers

2) Indicator 2.2: Number of men who have sex with men (MSM)* reached by peer educators with a minimum package of services; Phase One target: 4,900 MSM
   *MSM were assumed to include any biological males who have sex with men, including transgender women and male and transgender sex workers.

The agreement defines the ultimate “Minimum Package of Services” to include three elements: 1) information, education and communications (IEC) together with condoms and lubricants; 2) facilitated access to voluntary counselling and testing (VCT) for HIV and STIs; 3) facilitated access to reproductive health services that provide care and treatment for HIV and other STIs. However, it requires only one of those elements during Semesters 1 and 2 (i.e., during the first year of Phase One); only two of those elements during Semesters 3; and all four of those elements during Semester 4.

The grant agreement also assigns the CVC/COIN Project significant responsibility for achieving the PANCAP Projects’ Objective 1: to create an enabling environment that fosters universal access to HIV and AIDS services. It specifies one indicator and one target against which to measure the CVC/COIN Project’s contribution to achievement:

3) Indicator 2.3: Number of stakeholders* that participate in sensitivity training on most-at-risk-populations (MARPS) issues
   Target: 600 stakeholders
   * Stakeholders were assumed to include community leaders, religious leaders, health care professionals, police officers, immigrations officers, reporters for newspapers and other media, school principals and teachers, and anyone else in positions to promote recognition of the equal rights of everyone to essential health and social services.

In practice, around 20 CVC member organizations contributed to achievement of the targets and they included three organizations that helped pilot the CVC/COIN Project’s sexual health approach to peer education and 13 of the 14 organizations that received the Project’s Community Grants. (One of the 14 received only the first disbursement of its grant because it made no progress in implementing the project for which it had been awarded the grant.)

Hindolo worked with others in the Project Unit to develop, test and refine data collection forms that, with a little training, could be used even by illiterate peer educators. The forms had words in Spanish or English and cartoons to illustrate what the words said and told peer educators (or other responsible staff or volunteers) what information to put where. The information recorded included the nature of each one-on-one or group intervention, the characteristics of the beneficiaries (e.g., female, male or transgender; approximate age; sex worker, sex worker client, MSM, injecting drug user, marginalized youth; group of police officers, media representatives, etc.); time and location of intervention; content of intervention (e.g., one-on-one conversation, talk or presentation to group, workshop, provision of brochures and condoms and lubricants, administration of VCT, referral or accompaniment to VCT or other health services, etc.); other relevant information and comments.

Each implementing organizations collected the filled-out forms and aggregated the information they contained for inclusion in monthly reports to the Project Unit. The Project
Unit then aggregated information from all monthly reports for inclusion in Quarter Reports and the End of Phase 1 Report to CARICOM and the Global Fund.\footnote{CVC/COIN (2011 and 2012).}

All forms and procedures were specified in monitoring and evaluation plans for each of the participating organizations. The development of these plans was accompanied by training of any staff and volunteers (including peer educators) given responsibility for filling out the data-collection forms or preparing the monthly reports to the Project Unit. Hindolo established an electronic data base that makes it easy to retrieve information and prepare the Project’s Quarter Reports to CARICOM but the system is not developed to the point where all participating organizations enter their own monthly data. Instead, they submit their monthly reports by email and these reports contain both quantitative and qualitative information, including commentary on progress towards each organization’s project objectives and on challenges they have run into and lessons they have learned. These monthly reports — especially the ones submitted at the end of each project — are rich sources of both quantitative and qualitative data.

Throughout, there were efforts to avoid double-counting of individuals so that, for example, a sex worker benefiting from two one-on-one interventions would not be counted twice and a police officer attending two sensitivity training sessions would not be counted twice. Table 3, below, summarizes the CVC/COIN Project’s Phase One results as measured against the indicators and targets specified in the agreement with the Global Fund. Readers can refer to the 17 annexes to this report to get some sense of how CVC member organizations contributed to these overall results with various projects given financial and technical support by the CVC/COIN Project.

<table>
<thead>
<tr>
<th>Global Fund Indicator</th>
<th>Phase One Target</th>
<th>Phase One Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1 Number of female sex workers (FSWs) reached with the minimum package of services</td>
<td>2,900</td>
<td>5,352</td>
</tr>
<tr>
<td>2.2 Number of men who have sex with men (MSM) reached with the minimum package of services</td>
<td>4,900</td>
<td>5,156</td>
</tr>
<tr>
<td>2.3 Number of stakeholders that participate in sensitivity training on issues concerning most-at-risk populations (MARPs)</td>
<td>600</td>
<td>878</td>
</tr>
</tbody>
</table>

**Meeting the CVC/COIN Project’s requirements for additional information**

The CVC/COIN Vulnerabilized Groups Project aims to build the capacity of CVC and its member organizations to participate in and contribute to the response to HIV and AIDS in most of the Caribbean region’s nations and territories. In Phase One, it aimed to develop effective methods, practical tools and models of good or promising practice by focusing its efforts on a several of its own projects (e.g., to design, pilot and refine training methods and tools) and on a variety of projects driven by a selection of CSOs in just three countries.

Monitoring and evaluation of the Project’s Phase One has included assessing the degree to which the Project’s various components were working as they rolled out, making appropriate adjustments and then assessing end-of-Phase-One results. All of this has involved judgements based not only on quantitative information but, even more, on qualitative...
information. Responsibility for doing this kind of on-going monitoring and evaluation has been shared by all Project Unit staff, including Programme Coordinators in the three focus countries, and also by the project managers or coordinators of participating CSOs. The products of this activity include the monthly, quarterly and end-of-project reports discussed in the previous subsection. In addition, the Project’s Monitoring and Evaluation Officer has done or overseen separate evaluations of certain components including, for example, evaluations of training for peer educators and of the delivery of peer education to beneficiaries.

This report constitutes an external consultant’s additional contribution to the Project’s monitoring and evaluation activities. Due to time and budget constraints, it does little more than document some components of the project in summary form. It looks at other components in considerable detail. At the Project Unit’s request these other components include the three projects, run by three different CVC member organizations, piloting the CVC/COIN Project’s sexual health approach to peer education and the 14 projects, run by another 14 different CVC member organizations, that were financed by the CVC/COIN Project’s Community grants. The consultant’s reports on these 17 projects are contained in 17 annexes to this report.

**The Project’s strategies and activities**

**Five overall strategies**

The CVC/COIN Project’s stated strategies are:

1. Contributing to understanding of vulnerabilized populations through participatory research
2. Programming with community partners
3. Partnering with national AIDS programmes to scale up programmes for “vulnerabilized” populations
4. Advocacy
5. Building capacity and strengthening solidarity among Caribbean civil society organizations.

**The approach to HIV and AIDS prevention**

The Project’s founders coined the word “vulnerabilized” to signify that many people are made vulnerable to HIV and AIDS by the fact that they are objects of prejudice and discrimination and, often, criminalization. Being such objects, they are often denied their fundamental right to essential health and social care and have little or no access to appropriate information, supplies and services that would reduce their risks of becoming infected with HIV, of transmitting their infections to others, and of having their infections go undiagnosed and untreated. Being such objects, they are also prone to feelings of worthlessness and hopelessness that sometimes make them care so little about their own or anyone else’s health that they do not take precautions.

That conception of how people are made vulnerable to HIV and AIDS lies behind the Project’s approach to preventing those two health conditions. Specifically, the approach involves:

1. Combining a mix of behavioural and structural interventions to bring about change at the individual, organizational and societal levels; ensuring that all such interventions are mutually reinforcing.
2. Focusing on sub-populations and subcultures (e.g., MSM who are on the “down low” and self-identify as neither gay nor bisexual while also having sex with women; sex workers who do not self-identify as such even though they exchange cash for sex with multiple partners) within most-at-risk populations (MARPs).

3. Planning and implementing rights-based projects and programmes that focus on creating environments where fundamental human rights are recognized and protected; prejudice and discrimination are reduced; vulnerable people are made to feel comfortable with their gender-identities and otherwise worthy and hopeful; and vulnerable people are treated with respect and compassion and provided with information, supplies and services that fit their needs.

Six activity areas (AAs)

Phase One of CVC/COIN Project had a number of different components (e.g., the 14 projects supported by Community Grants) and, within each component, there were activities that fell into one or more of seven areas of activity:

- AA1: Research providing evidence for action
- AA 2: Development of training methods and manuals
- AA 3: Testing a range of interventions
- AA 4: Advocacy
- AA 5: Development of IEC media and tools
- AA 6: Capacity-building

The rest of this part of the report will discuss most of the Project’s key components under headings matching those six activity areas (AAs).

**AA 1: Research providing evidence for action**

Prior to launch of the CVC/COIN Project

As discussed in Part Two of this report — under the headings *HIV in the Caribbean: different countries, different epidemics and HIV prevalence among MSM in the Caribbean* — national AIDS authorities were long in the habit of characterizing their countries’ epidemics as “predominantly heterosexual” while being unable to support that characterization with evidence provided either by: complete and accurate reporting (covering sex, gender-identity and modes of transmission) of actual cases; serological and behavioural surveys of their whole populations and of the most-at-risk elements of those populations.

Not until 2006 and 2008 did national AIDS authorities in Jamaica (2006) and the Dominican Republic (2008) begin doing serological and behavioural surveys among MSM, female sex workers and drugs users and, in both cases, they did this under pressure from international donors and their countries’ CSOs, including JASL and COIN. During 2013, the national AIDS authority in Trinidad and Tobago is doing its first such surveys, again under pressure from international donors and the country's CSOs. In all three cases, the national AIDS authorities relied/are relying on partnership with CSOs that represent and/or serve these vulnerable populations to do the surveys. This is because the surveys use snowballing methods which require the collaboration of partners that know where to find members of the vulnerable populations and have already earned enough trust to get them to agree to participate as respondents.
While these recent surveys are major steps in the right direction, such surveys do not provide enough information about the many sub-populations and subcultures within the main MARPs to provide the best possible evidence on which to base effective interventions. For this reason, the CVC/COIN Project supported additional research covering selected sub-populations and subcultures in Phase One, as discussed below.

**Baseline studies of sex worker sub-populations**

In mid-2011, the CVC/COIN Project launched a series of six qualitative and quantitative studies aimed at providing a baseline evidence to inform the planning, development, monitoring, and evaluation of effective interventions among:

- Transgender and transvestite sex workers in Santo Domingo and Santiago, Dominican Republic
- Female sex workers working in the clubs and on the streets of Kingston, Jamaica
- Migrant Hispanic female sex workers in Port of Spain and Chaguanas, Trinidad.

The objectives were to:

- Provide demographic profiles of the sub-populations
- Discover their levels of knowledge about HIV and STIs and how to prevent transmission
- Discover their sexual practices, including the numbers and characteristics of their sexual partners and the extent of their condom use
- Discover anything that may be stopping them from getting essential health services
- Learn about their personal experiences in getting or not getting tested for HIV and STIs, including when they were last tested
- Learn about their personal experiences in getting or not getting care and treatment after being tested
- Learn about their personal experiences with stigmatization and discrimination in their encounters with the general public, their sexual partners, the police, and health service providers.

The methods included analyses of the findings of previous studies, development of guidelines for questions, focus group discussions, in-depth interviews, and recruitment of respondents using the snowballing method. That is, respondents were recruited by informants working with or known by CSOs that represented or served the particular sub-populations of sex workers. The results were written up in a set of reports published in Spanish in late 2011 and early 2012 and subsequently published in English. The final report in each language summarizes the findings of the other reports.52

The analyses of the findings of previous studies found that there were roughly 100,000 sex workers in the Dominican Republic, roughly 22,000 sex workers in Jamaica and not enough evidence to support even a rough estimate of the number of sex workers in Trinidad.

**The quantitative studies covered:**

- **90 transgender and transvestite sex workers in the Dominican Republic.** They turned out to be an average of 22.7 years old and they broke down into: 23 percent who had no more than a primary level of education; 68 percent who had some high school education; and 34 percent who had completed high school.

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• 70 sex workers who worked on the streets and in the clubs of Kingston, Jamaica. They turned out to be an average of 21 years old and they broke down into: 78 percent female and 22 percent male; 97 percent who were born in Jamaica; 88 percent who had a few years of schooling and 12 percent who might be said to have basic levels of education with good literacy and numeracy skills.

• 61 Hispanic female sex workers in Trinidad. They turned out to be an average of 28.5 years old and to come in roughly equal numbers from Columbia, Dominican Republic and Venezuela. They broke down into: 15 percent who had lived in Trinidad for one to three months; 45 percent who had lived there for four months to one year; and 23 percent who had lived there for one year or more; 30 percent who had no more than a primary level of education; 58 percent who had some high school education; and 21 percent who had completed high school.

Some of the findings about transgender and transvestite sex workers in Dominican Republic were:

• They have higher levels of education than is commonly assumed and are often under-employed and poor mainly because there is so much prejudice against them. This drives many of them into sex work as a way of making a living.

• Though 60 percent said they always used condoms with their regular partners, 74 percent said they had difficulty negotiating condom use and that this was most often the case with their regular partners and with their local sex work clients.

• 58 percent said they had received a talk about HIV in the past six months; 38 percent knew it was good to have at least two condoms on hand for sex; 78 believed or did not know whether or not HIV can be transmitted by oral sex; 37 believed or did not know whether or not HIV can be transmitted by sitting on toilet seats; 32 believed or did not know whether or not HIV can be transmitted by mosquito bites.

• 33 percent had been victims of physical violence by their sex work clients.

• 71 percent had been discriminated against or mistreated by the police, and 36 percent had had sex with police to avoid arrest.

• 32 percent did not know where they could go to receive HIV-related services.

Some of the findings about female and male sex workers in Jamaica were:

• Their alcohol consumption was high, with 44 percent saying they had had at least 5 drinks within the past five hours and 25 percent saying they drank every day; 63 percent used illegal drugs; 38 percent used marijuana; 19 percent used combinations of alcohol and/or several drugs, including ecstasy and crack cocaine.

• Their average age of first intercourse was 15 years and their average age upon becoming sex workers was 17. They had had an average of 8 sex partners in the past month and an average of two regular partners over the past year.

• 65 percent had had at least one regular partner over the past year; of those, only 37 percent reported the regular use of a condom with that partner and only 34 percent had used a condom on the last occasion.

• 94 percent had used a condom the last time they had sex with a client, while 78 percent said they always used condoms with partners, 18 percent said almost always and 4 percent said sometimes.

• 35 percent said they had difficulty negotiating safe sex and 65 percent said they had experienced condom breakage.

• 85 percent had received a talk about HIV in the past six months; 81 percent believed or did not know whether HIV can be transmitted through oral sex; 7 percent believed or did not know whether or not HIV can be transmitted by mosquito bites; 7 percent believed or did not know whether or not HIV can be transmitted by sharing food.
57 percent said they had had no symptoms of STIs in the past year, while 31 percent had sought help for STIs during the past year; of those, 64 percent had sought help at public clinics or hospitals and 46 percent had continued to have sex with clients while still having symptoms; of the latter, 93 percent has used a condom on the last occasion.

91 percent knew where to seek medical help but only 19 percent did so every six months; 13 percent had never been tested for HIV; of those who had been tested, 83 percent had been tested with the past year and 97 percent said they had returned to get the results; 75 percent said they were treated with respect when they got tested and the most common reason for not getting tested was that they had no time.

25 percent had experienced sexual violence and, of those, 38 percent had experienced it on the streets while 29 percent had experienced it from an intimate partner.

31 percent said fights between sex workers were frequent and 68 percent said they could not trust their colleagues and competitors.

Some of the findings about Hispanic female sex workers in Trinidad were:

- Only 30 percent believed they should have two condoms on hand for sex; 43 percent had experienced condom breakage during sex.
- Only 18 percent had received a talk about HIV in the past six months; 72 percent believed or did not know whether or not HIV can be transmitted by sitting on toilet seats; 72 percent believed or did not know whether or not HIV can be transmitted by mosquito bites; 62 percent believed or did not know whether or not HIV can be transmitted by sharing food.
- 50 percent had been victims of physical violence by their clients.
- 23 percent had had sex with police to avoid arrest.
- 88 percent did not know where they could go to receive HIV-related services; only 32 percent had ever been tested for HIV.
- 72 percent did not feel comfortable with health services they had received and 78 percent said that language barriers had made it difficult for them to communicate with health professionals.

The final report had four sets of recommendations, three for responding to HIV and AIDS among the three sub-sub-populations of sex workers and one for responding to HIV and AIDS among all sex workers in the three countries.

Baseline studies of marginalized youth sub-populations

Also in mid-2011, the CVC/COIN Project launched a parallel series of qualitative and quantitative studies among marginalized youth (15 to 24 years old) including:

- Young gang members
- Youth living with HIV
- Young drug users
- Youth who engage in transactional sex
- Young males and females who engage in same-sex activity.

The objectives, methods and resulting reports were similar to those for the series of studies focussing on sex worker sub-populations, as discussed in the previous subsection of this
report. The final report provides summaries of the findings about each of the five sub-populations of marginalized youth in each of the three countries.\(^{53}\)

The quantitative studies covered:

- **274 marginalized youth in the Dominican Republic** and, more specifically from two of the poorest barrios of Santo Domingo, Capotillo and Cristo Rey. They included 49 gang members, 46 involved in transactional sex, 69 using drugs, 72 having sex with same-sex partners, 38 living with HIV. Their average age was 20 and 37 percent were female.

- **244 marginalized youth in Jamaica.** They included 42 gang members, 42 involved in transactional sex, 65 using drugs, 65 having sex with same-sex partners, 30 living with HIV. Their average age was 21 and 23 percent were female.

- **199 marginalized youth in Trinidad.** They included 34 gang members, 31 involved in transactional sex, 64 using drugs, 57 having sex with same-sex partners, 12 living with HIV. Their average age was 21 and 48 percent were female.

Some of the findings about marginalized youth in the Dominican Republic were:

- 64 percent said someone had spoken to them about HIV in the past 6 months but significantly smaller percentages of drug users and youth involved in transactional sex said so.

- While 90 percent recognized condom use as a means of HIV prevention, only 59 percent said condoms were easy to find and significantly smaller percentages of gang members and youth involved in transactional sex said so.

- 56 percent said they had been taught how to use condoms correctly but many others were misinformation about how to use them correctly. Some had misinterpreted the message that they should have two condoms on hand for anal sex (in case one breaks) to mean they should wear two condoms at once (which increases the chance of breakage).

- Only 49 percent said they found it comfortable to use condoms and many said they did not trust condoms.

- Their average age of sexual initiation was 13; 51 percent had had regular sexual partners over the past year; 65 percent had had casual partners; 23 percent had had "outside partners" meaning individuals with whom they frequently had sex in addition to having sex with their main regular partners.

- 70 percent had ever been tested for HIV but, of that 70 percent, only 64 percent had been tested within the past year.

- 39 percent of all marginalized youth had been called discriminatory names but this was the case with 61 percent of those having sex with same-sex partners.

- 54 percent said they had been victims of discrimination in their own families and those most likely to have experienced such discrimination were HIV-positive.

- Asked to name the main sources of their information about HIV, marginalized youth gave the following answers in descending order from most to the least answers: mass media, school, support programmes for people living with HIV, programmes for drug users, youth networks, and CSOs supporting people having sex with same-sex partners. Those questioned more closely in focus group discussions and in-depth interviews showed an aversion to long lectures about HIV and strong preference for short talks and interactive and entertaining activities involving drama and role play.

Some of the findings about marginalized youth in Jamaica were:

• 67 percent said someone had spoken to them about HIV in the past 6 months but only 28 percent of those involved in transactional sex said so.
• 93 percent recognized condoms as effective for HIV prevention; 82 percent said obtaining condoms was easy but gang members were less likely to say so.
• 82 percent had been taught correct condom use but only 26 percent of those in gangs and 31 percent of those involved in transactional sex had been taught. More than half had experienced condom breakage and gang members, in particular, did not trust condoms because they break and they get infected anyway.
• Their average age of sexual initiation was 14; their average number of sexual partners with the past month was two and the average numbers were higher for those involved in transactional sex or having sex with same-sex partners.
• 63 percent had had casual sex (with someone other than their regular sexual partners) over the past year and 86 percent of gang member had had casual sex.
• Of those having sex with same-sex partners, only 57 percent said their casual partners were always of the same sex.
• 47 percent of said they had sex with “outside partners” meaning individuals with whom they frequently had sex in addition to having sex with their main regular partners.
• 64 percent had been tested for HIV but, of those, only two-thirds had been tested in the past year. Only one-third of gang members had been tested in the past year and the least likely to have ever been tested were drug users.
• 54 percent of all marginalized youth had been called discriminatory names. Young men who engage in transactional sex or who have sex with same sex partners are often subject not only to verbal abuse but to physical abuse by other men.

Some of the findings about marginalized youth in Trinidad were:

• 51 percent said someone had spoken to them about HIV in the past 6 months but only 23 percent of those having sex with same sex partners said so.
• 98.5 percent (i.e. all but one) said they knew where to acquire condoms but only 82 percent said it was easy to acquire them and only 68 percent of those involved in transactional sex said it was easy to acquire them.
• Only 16 percent had been taught how to use condoms correctly and those asked to demonstrate the proper use of condoms usually made mistakes (e.g., not checking the expiration date, opened packages with their teeth, not checking to make sure there was no air trapped inside, removing them recklessly).
• Their average age of sexual initiation was 15; 71 percent had had regular partners over the past year; only 21 percent used condoms regularly when having sex with these partners; only 38 percent had done so on the last occasion.
• 47 percent had ever been tested for HIV but youth in gangs and those having sex with same sex partners were less likely to have been tested and gang members were least likely to see the importance of being tested.
24 percent of all marginalized youth had been called discriminatory names but this was the case with 33 percent those who were HIV-positive, 37 percent of those having sex with same-sex partners, 53 percent of gang members.

63 percent said they knew where to go to get tested for HIV but the percentages were significantly lower among those having sex with same-sex partners and gang members.

19 percent had visited a health centre in the past year. Of those, 61 percent said they were happy with how they were treated at the health centre but 37 percent said they felt they were treated differently than other patients. Least satisfied with how they were treated were those having sex with same-sex partners, gang members and drug users.

The final report had three sets of recommendations, one for responding to HIV and AIDS among marginalized youth in each country.

**Additional sociological and behavioural evidence provided by CSOs**

Though the final reports on studies discussed above were not available in English until late summer of 2012, results of the individual quantitative and qualitative studies of sub-populations in the three countries became available in late 2011 and early 2012 and were used to inform implementation of CVC/COIN-supported programmes and projects already underway. They were also used to inform the selection, planning and implementation of 14 projects given CVC/COIN Community Grants.

Most of those programmes and projects were implemented by CSOs with long histories of representing and serving particular sub-populations of particular MARPs in particular countries. The staff, volunteers and beneficiaries of these CSOs are key but, too often, under-utilized sources of information about the characteristics of those sub-populations, their sub-cultures, the attitudes and behaviours that put them at risk of HIV and AIDS, and the barriers that prevent them from accessing the preventive information, supplies and services they need.

As part of this evaluation, the consultant took a close look at the 14 CSO-run projects given Community Grants and three additional CSO-run projects piloting CVC/COIN’s sexual health approach to peer education. These projects are discussed at greater length later in this report and the consultant’s detailed write-ups on each of them are contained in the 17 Annexes to this report. Suffice it to say here that the write-ups present much additional sociologic and behavioural evidence provided by staff, volunteers and beneficiaries of CSOs: in just the one or two short visits the consultant was able to make to each of those CSOs; also, in the CSOs’ monthly and end-of-project reports to the CVC/COIN Project Unit.

**Studies of existing practice and consultations on strategy**

In mid-2011, the Project launched a series of studies and consultations aimed at identifying models of good and promising practice and agreeing on strategic frameworks for responding to HIV among MSM, sex workers, drug users and marginalized youth.

**Addressing HIV among MSM**

In August 2011, Freemont Center (a New-York-based consulting partnership) facilitated a regional consultation that aimed to identify the core elements of effective HIV-related
Based on that consultation, the CVC/COIN Project drew up a strategic framework that included:

1. **Strategic priorities:**
   a. **Strengthening MSM communities’ capacity with:**
      i. Safe spaces including actual spaces and events (e.g., cafés, clubs, drop-in centres, movies, plays, musical performances) and virtual spaces and invents (e.g., websites, Facebook pages, Twitter accounts, YouTube videos)
      ii. Community engagement including informational and educational talks, meetings and workshops
      iii. Participatory research into, for example, the epidemiology of HIV and AIDS among MSM, different sub-populations of MSM (e.g., at various stages on the totally “out” to totally “closeted” spectrum, transgender women, male and transgender sex workers, MSM drug users), human rights laws and enforcement, the response to HIV and AIDS among different sub-populations of MSM, barriers to HIV-related services, ways of overcoming those barriers.
   b. Campaigns to improve understanding of MSM-related health and human rights, to challenge human rights violations, to counter prejudice and discrimination, to improve access to health and social services.

2. **Priorities for action:**
   a. Research and programme evaluation aimed at improving the response to HIV and AIDS among MSM
   b. Public awareness campaigns aimed at creating enabling environments where the basic human rights of MSM are recognized and MSM are treated with the same respect and compassion due to all human beings
   c. Mobilization of MSM aimed at creating safe spaces, improving the human rights environment, improving access to services, and so on
   d. Improvement of evidence-based HIV-related services including:
      i. Training of health care providers to overcome any prejudices they may have and to ensure they recognize the rights of MSM, the health-related issues that concern MSM and that they treat MSM with the respect and passion due all patients
      ii. Training of MSM staff and volunteers to support MSM access to services with social and psychological support, mentoring, counselling, treatment adherence and so on

3. **Identification of ten existing assets providing foundations on which to build** (e.g., social networks in countries, regional networks and allies).

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54 Freemont Center (2011).
55 CVC/COIN (2011b).
4. Three elements of a rights-based approach: meaningful community engagement and leadership; focus on right to protection from discrimination; focus on right to essential health services.

**Addressing HIV among sex workers, drug users and marginalized youth**

Parallel studies, consultations and strategic frameworks focusing on sex workers, drug users and marginalized youth included:

- A study of HIV interventions for sex workers in the Caribbean that identified effective models and opportunities for scale up.\(^{56}\)
- By CDARI’s Executive Director, Marcus Day, A situational assessment of responses to HIV among drug users from a harm reduction and human rights perspective.\(^{57}\)
- A strategic framework for strengthening national responses to HIV for People who use drugs\(^{58}\)
- A study of HIV interventions for marginalized youth in the Caribbean that identified models and opportunities for scale up.\(^{59}\)

**Assessing the support national AIDS programmes give to the vulnerable**

In 2012, the CVC/COIN Project commissioned a rapid assessment of how the national AIDS programmes of 13 Caribbean countries (Antigua, Barbados, Belize, Dominica, Dominican Republic, Jamaica, French Guiana, Guyana, Jamaica, St. Kitts, St. Maarten, St. Vincent, and Trinidad and Tobago) were responding to HIV among MSM, sex workers, drug users, marginalized youth, and prisoners.\(^{60}\) Based on evidence provided by the national AIDS programmes of 11 of those countries (all but Belize and Guyana), the assessment found that:

- 82 percent supported interventions for prisoners, 73 percent for sex workers, 64 percent for MSM, 55 percent for marginalized youth, and only 35 percent for drug users.
- None of the interventions for prisoners included harm reduction through provision of condoms.
- While 64 percent had written policies and strategies for prevention among MARPs, only 27 percent had specific budget allocations for actual preventive interventions.
- 47 percent said they were in the process of preparing such budget allocations and this suggested opportunities for advocacy.
- Treatment interventions focused mainly on providing antiretroviral therapy to people living with HIV and not on ensuring adherence to prescribed drug regimes.

The assessment concluded that, to ensure the development and sustainability of effective responses to HIV among vulnerable populations, two things are essential:

1. National AIDS programmes the reach out to vulnerable populations through collaboration with CSOs that represent and serve those populations
2. Capacity-building for the CSOs.

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\(^{56}\) Freemont Center (2012a).

\(^{57}\) Day M et al (2012b).

\(^{58}\) CVC/COIN (2012a)

\(^{59}\) Freemont Center (2012b).

\(^{60}\) Day M (2012a).
AA 2: Development of training methods and manuals

CVC/COIN’s “sexual health approach” to peer education

A manual for training peer educators and others

Efforts to prevent HIV and AIDS typically include behaviour change communications (BCC) combined with provision of preventive supplies (e.g., condoms, lubricants, clean needles and syringes) and services (e.g., voluntary counselling and testing for HIV, antiretroviral therapy). The BCC typically focuses largely on informing people about HIV and AIDS, how they are acquired and how they can be prevented and, also, on urging them to take up the offers of preventive supplies and services.

That simple form of BCC to prevent HIV and AIDS may work for some people but it does not work for many others — including the many intelligent and well-informed middle-class adults around the world who know they should use condoms when engaging in highly risky sexual activity but who often don’t do so. The reasons are not unlike the reasons simple BCC to prevent dangerous driving, smoking, obesity, and over-consumption of alcohol and drugs do not work for many people. People in their most sexually active years (i.e., adolescents and young adults) are especially prone to closing their ears to such BCC because they think they are more or less immune to injury, disease and death and prone, also, to not stopping to consider they could be causing the injury, disease or death of others. If they come from broken or dysfunctional families or if they are marginalized by the law, religious teachings, widespread prejudice and discrimination, poverty, or lack of education and job opportunities they may also be prone to feelings of worthlessness, hopelessness or perhaps even bitterness to the point where they just don’t care enough about their own or anyone else’s health to take precautions.

In early 2011, the CVC/COIN Project retained Alex Vega, a Caribbean-born-and-raised psychologist and social worker, to collaborate with a Caribbean-based group of experts and facilitate development of a new approach to peer education. This approach was to be based on recognition of the difficulty many people have in truly absorbing prevention messages and, also, recognition of the social, cultural, psychological, relational, sexual, and situational influences on people’s behaviour. Over the following months, Alex facilitated a process of participatory curriculum design, testing and revision and produced a manual for the training of peer educators and others (e.g., managers and staff of public, private or civil society organizations in any way involved in responding to HIV and AIDS).

The manual currently contains 14 curriculum modules — supported by hand-outs, slides presentations and other teaching tools — and suggests trainers facilitate the coverage of only one module per eight-hour day in training workshops. In practice, the manual is used as a guide for training workshops that may, for example, cover from three to five modules in one three-to-five-day training course and then, some weeks or months later, cover three to five additional modules in a second training course. Like all such manuals, it should always be considered a work-in-progress open to small improvements and radical changes.

The subjects covered in each of the current 14 modules are indicated by their titles:

1. Talking about sex, gender, and sexuality
2. Exploring sexualities: sexual orientation, sexual identity, sexual behavior and sexual diversity

3. Talking about gender roles and gender identity
4. Sexuality and the life cycle: sexuality during childhood and adolescence and the adult years
5. Identities, sexual orientations and sexual Health among “vulnerabilized” sexually marginalized populations
6. Sexual anatomy, physiology and erogenous zones: body mapping
7. Sexual health, reproductive health, sexual health care and safer sex
8. Understanding how language stigmatizes people who use drugs (PWUD) and the basic principles of harm reduction when working with PWUD
9. Sex workers and sexual health
10. Challenges to sexual health: overcoming barriers to sexual health
11. Body image
12. Masturbation and fantasy
13. Creating and maintaining intimate relationships

It has long been recognized that good peer educators are, to some considerable extent, “naturals” who empathize with their peers and can easily relate to them (one-on-one and in small groups), earn their trust, and get them to open up. They are among those few individuals in any classroom, workplace or other mid-sized-group setting to whom others turn with their personal problems. It is common practice to look for these qualities during training courses offered to potential candidates before final selection of those who will be hired.

CVC/COIN sexual health approach is based on the belief it is important that peer educators and other key people also be knowledgeable about and comfortable with their own sexualities and gender-identities and with the full range of other sexualities and gender-identities and that they understand the range of factors that can undermine efforts to change people’s behaviour.

Training and mobilizing peer educators: three pilot projects

Alex Vega and country-based experts in a variety of fields (e.g., psychology, health care, group facilitation and animation) began rolling out training of peer educators and others using early drafts of the new manual in early fall of 2011. Those receiving the training included existing peer educators and candidates for new peer educator positions and they were associated with a number of different organizations. In late 2011, CVC/COIN decided to provide financial support of roughly US$20,000 to each of three CSOs that agreed to focus specifically on piloting the training and mobilization of peer educators using the sexual health approach to peer education.

At CVC/COIN’s request, the consultant has taken a close look at these three CSOs and their pilot projects and his write-ups can be found in Annexes A1, A2 and A3. [These Annexes are integral parts of this report but are placed in Annexes because they are long and because they will be used as stand-alone documents that CVC/COIN and the CSOs implementing the pilot projects can use for their own purposes.] The three Annexes describe the following CSOs and their pilot projects:

A1: Jamaican AIDS Support for Life (JASL) has a long history of training peer educators and mobilizing them among a variety of vulnerable and marginalized sub-populations. It piloted the CVC/COIN’s sexual health approach to peer education while delivering a minimum package of services to MSM and sex workers in Kingston and nearby communities.
A2: La Comunidad de Trans- Travesti Trabajadoras Sexuales Dominicanas (COTRAVETD) is the Caribbean’s first CSO dedicated to representing and serving transgender and transvestite sex workers. It piloted CVC/COIN’s sexual health approach to peer education while delivering a minimum package of services to such sex workers in Santo Domingo.

A3: Grupo de Apoyo Este Amor (best known simply as Este Amor) is dedicated to preventing HIV and AIDS among MSM in the eastern region of the Dominican Republic. It piloted the CVC/COIN’s sexual health approach to peer education by and for young MSM (15 to 19 years old) while delivering a minimum package of services to them in towns, villages and bateys across the province of San Pedro de Macorís.

Monitoring and evaluation of the sexual health approach

While rolling out training for the sexual health approach to peer education, the Project Unit required or conducted training-specific monitoring and evaluation exercises. These included “process reports” by Alex Vega (who headed up training teams that included country-based experts) with his colleague’s observations about how well training workshops had gone and with end-of-workshop feedback from trainees. They also included evaluations by the Project Unit on the final day of workshops. Done without the trainers present, the evaluations included focus group discussions to assess what the trainees had learned and to get the trainees’ assessments of the relevance and usefulness of the training and of the training team.

In April 2012, the Project Unit also did a mid-term evaluation of the peer education delivered by JASL, COTRAVETD and Este Amor in the pilot projects mentioned above and described in Annex A1, A2 and A3. This evaluation used questionnaires, focus group discussions and interviews with peer educators, their supervisors and the peers who were meant to benefit from peer education. Its summary of results and recommendations takes up more than eight pages and is of such relevance that it serves as a highly recommended supplement to this report.

During Phase One, CVC/COIN supported additional peer education projects with its Community Grants. Included among these are the sex worker projects described in Annexes C2, C3 and C4, the drug user projects described in Annexes D1 and D3, and the marginalized youth project described in Annex E3. The coordinators and peer educators associated with some of these projects also received training in the sexual health approach to peer education.

The Annexes constitute this consultant’s evaluations of each one of the peer education projects supported by CVC/COIN during Phase One. The findings of these evaluations echo and confirm many of the findings of the Project Unit’s mid-term evaluation. These projects are all examples of good or promising practice but they also illustrate that CSOs face daunting challenges as they seek to scale up and sustain these projects so they become long-term programmes. (See box.)

As for the training manual and the validity, relevance and utility of its specific content and of the training delivered using it as a guide: this consultant would like to see more evidence. Much of the manual’s content seems to derive from the academy and not from the street and to be theoretical, jargon-ridden and open to debate. It could do with a rigorous peer review by some of the highly skilled and experienced master peer educators, trainers, facilitators, and programme coordinators associated with the CSOs that participated in Phase One of the CVC/COIN Project and that are about to participate in Phase Two. Possibilities include, for example, key people driving the projects described in Appendices A1, A2, B4, C1, C4.

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62 CVC/COIN (2012c).
D1, E2, and E3. Following that peer review might come substantial editing. Other reviewers could include clinical psychologists attached to CeSaJo, JASL and any other programmes that offer counselling by clinical psychologists.

**Challenges commonly faced by peer education initiatives**

The CVC/COIN-supported peer education projects demonstrate that:

1. **CSOs doing peer education often have inadequate and uncertain financial and human resources.** They often provide peer education on a project-by-project basis, rather than a sustained programme basis. Between projects they may lose their most skilled and experienced peer educators and have to waste their limited resources on repeated recruitment and training exercises. Annex D2 illustrates a worst-case scenario, where a CSO was unable to launch the peer education project for which it had received the first instalment of a CCV/COIN Community Grant because it lacked the necessary human resources.

2. **Low pay can mean low motivation.** Peer education is widely perceived to be a low-cost intervention that compensates for weaknesses in public education, health and social services systems. It depends on recruiting people from marginalized and vulnerable populations who are willing to work for low pay. The projects described in the Annexes to this report are generally paying their peer educators anywhere from US$100 to US$400 per month, with the latter paid only to "master peer educators" with years of training and experience and now qualified to be trainers and supervisors of other peer educators. The lower levels of pay (e.g., US$100 or US$200 per month) are generally for part-time work but that work is often a peer educator's main source of income. In addition, they may be provided with small amounts to cover their expenses and with honoraria to participate in special events. Such are their circumstances that some peer educators are more motivated by the money than by the work itself and, whatever their motivation may be, they can become quickly de-motivated by having to cover their own expenses, such as the costs of travel between their homes and intervention sites. Those who are highly motivated by the work itself often become so skilled that they are soon given more senior positions within their own organizations or else are recruited away to more senior positions in other organizations. It all means that it can be a continual struggle to build and maintain a team of highly skilled and motivated peer educators.

3. **With limited resources, CSOs often cannot provide adequate supervision** to peer educators to make sure they are showing up on-site and on-schedule to conduct their interventions, to monitor those interventions for quality and to intervene with further instruction or other support when appropriate. One result is that peer educators may provide incorrect or confusing information about HIV and AIDS and other STIs, how to prevent or treat them, or where to go for health or social services.

4. **Peers often resist peer education.** Many (perhaps most) people do not welcome uninvited intruders when going about their daily business or when out for an evening with their friends. Intruders who earnestly insist they have important life-saving, soul-saving or world-saving information, advice or counselling are perhaps least welcome of all. In fact, some people are deeply offended by such intrusions and respond with verbal or even physical abuse. No wonder that evaluations of peer education initiatives so often observe that peer educators have difficulty approaching or establishing rapport with their peers.

5. **The ability to approach strangers and get them listening and responding** comes more or less naturally to some people. The ability of such people can be considerably enhanced by training of various kinds including, for example, training to entertain and animate even the most difficult of audiences. For some other people, no amount of training will give them this ability. The ideal hiring exercise recruits many willing
candidates, puts them all through some form of inter-active training that requires them to perform and then selects those who perform best.

6. **Peers welcome any intervention that offers preventive supplies and services on the spot.** In their interventions, COTRAVETD (Annex A2), Ashe (Annex B4), CEPROSH (Annex C2), FPATT (Annex C3), MODEMU (Annex C4), FUNDOREDA (Annex D1), and NCDA (Annex D3) stand out as ones that were able to provide either essential supplies (condoms, lubricants, hygiene products, clean needs and syringes) or essential services (e.g., voluntary HIV counselling and testing) or both on the spot or nearby. In fact, COTRAVETD clearly recognizes that distributing supplies provides the best opportunities to for peer education. Otherwise:
   
a. Interventions for female sex workers often cannot offer female condoms because they have no donors willing to pay for them. Meanwhile, female condoms are rarely available in pharmacies and, if available, are prohibitively expensive.
   
b. Interventions for MSM often cannot offer water-based lubricants and these lubricants are often not available in pharmacies or, if available, are prohibitively expensive or too embarrassing for male customers to buy.
   
c. Interventions that offer male condoms often run out them.
   
d. Few interventions are able to offer any level of health services on the spot, not even voluntary HIV counselling and testing. At best, they may be able to offer access to a nearby clinic where they will not have to wait all day to be served and where staff will treat them with courtesy and respect.
   
e. CSO representatives often say they have urgent need of mobile clinics in the form of well-equipped vans with qualified counsellors and medical staff. Ashe illustrates a less costly option, a temporary space within its own building where its own performers (trained and equipped by Jamaica’s Ministry of Health) can offer voluntary counselling and testing. In sub-Saharan Africa, it is not uncommon to set up temporary health service stations in tents on a regularly scheduled basis and to staff them with paramedics in lieu of doctors or nurses.

7. Peers often need access to mental health and social services but peer educators often say they are unable to refer them to such services, either because they don’t exist or because the peer educators do not know they exist. By some combination of keen interest and natural ability and good training, some peer educators can go a considerable way towards filling the gap between need and availability of service but even those admit they can only go so far.

8. **Peers welcome accurate, interesting and appropriate IEC material.** Annex B3 describes a case where a CSO found that closeted MSM would only take away IEC material if it was small and had no conspicuous logos or other indicators that might hint that the content was gay-oriented. Many of the CSOs doing CVC/COIN-supported peer education found that they lacked good IEC material in the languages or dialects familiar to their beneficiaries. The consultant observed that lacking, in particular, was IEC that was perfectly frank and explicit about the risks of unprotected anal sex and about the precautions people who engage in it should take.

9. **Peer education interventions have significant problems with logistics.** The vulnerable sub-populations served by particular peer education programmes are often spread far and wide through urban and rural areas with poor public transportation systems. Having low incomes, few peer educators have their own cars or mopeds and have to resort to taxis unless their organizations have vans. The homes of the peer educators are also often spread far and wide. If organizations have vans, picking up peer educators at their homes and taking them to intervention
sites and then back home can consume half the drivers’ and the peer educators’ working days and cost a considerable amount in fuel and vehicle maintenance.

10. **Peers have similar problems in taking up offers of services.** Getting to and from a clinic may take hours and cost considerable money and, once at clinics, they may be left waiting for hours before they get served by over-worked staff who just don’t have time to take much interest in their cases. This can be so even of staff that is naturally inclined or trained to treat all patients with courtesy and respect and to provide them with information specific to their needs as MSM, sex workers, drug users, and so on.

11. **Scaling up peer education so that it covers large portions of vulnerable populations would require major financial commitments by governments or international donors.** The evidence suggests there are thousands of drug users whose particular drug habits (e.g., inhaling crack cocaine or injecting heroin) put them a high risk of HIV infection. There are hundreds of thousands of sex workers and even more MSM, all at high risk of HIV infection. In addition, there are millions of youth marginalized by poverty, lack of education and job opportunities and often also by broken or dysfunctional families. This leaves them prone to engaging in sexual behaviour that puts them at risk of HIV and STI infection, unwanted pregnancy and unsafe abortion. Providing peer education to a few may have a knock-on effect, so that those few educate the many and so that governments eventually see the advantages of providing meaningful sex education to youth in school and youth out of school and to introducing quantitative and qualitative improvements to education, health and social services.

**Media training**

**Training workshops for journalists**

CVC/COIN’s baseline studies of marginalized youth found that they put “mass media” at top of their sources of information about HIV and AIDS. Doing such is common across the world. Also common across the world is that many journalists rarely leave their desks or contact reliable sources before writing stories that do little more than reflect popular ignorance and prejudice. A recent survey of journalists from television, radio and newspapers in Kyrgyzstan found that they recognized that HIV was a severe threat but saw it as only one of many subjects they cover and not one for which they felt any particular responsibility. Tested for their knowledge about HIV they were found to be remarkably ill-informed about modes of transmission and how to prevent transmission.63

In the Caribbean, journalists have too often fuelled the flames of prejudice against people living with HIV or vulnerable to infection and have too often argued against rather than for efforts to create human rights environments that make it possible to respond to HIV more effectively. In 2012, for example, Jamaica’s major television stations refused to run an ad by AIDS-Free World that featured a woman telling her male friend that she did not understand why he was gay but that she loved and respected him anyway. AIDS Free World is now supporting a legal case against the television stations.64

Because the media play such vital roles in informing or misinforming the public and shaping public opinion, the CVC/COIN project launched a media training programme in the spring of 2012. In each of the Phase One focus countries (Dominican Republic, Jamaica and Trinidad and Tobago) it worked with teams consisting of AIDS activists and journalists attached to national AIDS programmes, civil society organizations or UNAIDS and developed training

63 GTZ (2009).
curricula responding to the unique epidemiological, social, political, and media realities in each country. The aim was to turn journalists and their various media outlets into well-informed allies in efforts to educate the public about HIV and AIDS, people living with HIV, the people most vulnerable to infection and related human rights issues.

Training workshops in the three focus countries generated more than 40 news items, many of them focusing on the need to create an enabling environment where the human rights of vulnerable populations are recognized and respected. (See box.)

**A two-day CVC/COIN media training workshop in Santo Domingo**

In early July 2012, the CVC/COIN Project hosted a two-day media training workshop in Santo Domingo, Dominican Republic. On the first day, a journalist noted for his fair coverage of LGBT issues reviewed how media coverage was gradually improving but had a long way to go. As recently as 2008, the editor of a prominent evening newspaper in Santo Domingo had said that he wouldn’t touch a press release that covered *maricones*, the Dominican vernacular for “fags”. And not so long ago, a local newspaper ran a headline that translates into English as, “Killed last night, 2 people and a fag.”

Speaking for COTRAVETD, Nairovi Castillo said that discrimination against transgender women reinforced by the media means that many will not visit a doctor or go for an HIV test. “We aren’t inherently vulnerable, we are made vulnerable.” Speaking for FURJUG, young people from Guachupita, one of Santo Domingo’s poorest barrios, said the media reinforce the discrimination that makes it difficult for them to get work. One said, “If five of us meet, say to do street theatre, the police think we are planning a robbery.”

Francis Taylor, Project Officer with COIN’s CDC-funded drug user project, described how discrimination against drug users puts them at greater risk of acquiring HIV and AIDS because they don’t go for testing, care and treatment. He asked if there were any drug users present who could step forward and testify. Then he stepped forward himself and said that it had been harder for him to come out as a drug user than it had been for him to come out as a gay man. That he was either of those things (gay or a drug user) surprised the journalists because Francis does not conform to popular stereotypes. Francis stands as a reminder that few gay men, drug users or members of other vulnerable or marginalized minorities conform to stereotypes.

The impact on the participants was immediate, generating a flurry of news stories carried by the media on the very first day of the training session. During a panel discussion the next day, one journalist said that before the previous day’s session he might have written a headline on the event saying, “Journalists and a bunch of fags meet.” Instead of headlines like that, newspapers over the following days ran headlines such, “The invisible speak — gang members, drug users, transgender women and sex workers”. Before the day ended, the journalists said it would be useful for them to have a permanent entity that could provide them with continuing training and to which they could turn for current information on issues and events impacting on vulnerable and marginalized populations.

**A challenge facing Caribbean AIDS and human rights activists**

Tina Brown is currently editor of *The Daily Beast/Newsweek online* and is famous as the editor who revitalized *Vanity Fair* and *The New Yorker* and rescued them from impending bankruptcy due to declining circulation. On 5 April 2013, she took part in a discussion on the *Charlie Rose* show (Bloomberg Network) on the occasion of the Women in the World Summit 2013 (held in New York) and spoke of the important role the media have played in the advancement of women. She said that readers and audiences are never much interested in issues but they are keenly interested in human stories. The main contribution of the media had been to tell the stories of individual and groups of women in their struggles for equality with men.
Much the same thing is often said by LGBT activists. They also say you have to keep feeding the media such stories until public opinion gradually comes around. They remind us of the fact that, when movie star Rock Hudson issued a statement admitting he had AIDS in 1985, private donations to AIDS causes immediately doubled in the United States and the United States Congress made its first significant commitment to the response to AIDS, voting to give US$225 million for research to find a cure. Elizabeth Taylor and Joan Rivers led a parade of celebrities who spoke with compassion of their friend and colleague in the entertainment industry and out of their efforts emerged such initiatives as The Foundation for AIDS Research (amfAR), now one of the most generous civil society donors to Caribbean CSOs representing and serving MSM. In the years following Rock Hudson’s “outing” as a gay man with AIDS, more and more ordinary and prominent gay men came out to their families, friends and colleagues and the whole country. In retrospect, gay liberation in the United States can be seen as something courageous gay men did for themselves and for all other gay men. They came out of their closets.

As hard as it may be for gay men to come out their closets in the Caribbean, the sooner they start doing so and giving their stories to the media the better. They might look to Jaqueline Montero as a role model. As discussed in Annex C4 she was a sex worker who became one of COIN’s peer educators and she is the founding Executive Director of MODEM, the preeminent CSO representing and serving sex workers in the Dominican Republic. In 2010, she made no secret of her history and her job with MODEM when she ran for election and was voted in as the Councillor representing the municipality of Haina in San Cristobal Province. Her courage in coming out as a sex worker and in seeking public office has turned her into a formidable spokesperson for sex workers in public discussion and debate. And her story is an inspiration to thousands who read about it in their newspapers or hear it told on radio or television.

As discussed later, J-FLAG launched a “We Are Jamaicans” campaign and it is a bold move it the direction of encouraging and supporting a diverse range of Jamaicans as they come out of their closets as LGBT people or as the friends and allies of same.

**Police training**

*A manual for training police*

In Caribbean countries as in most countries around the world, there are laws against at least some of male-male sex, sex work, drug possession and use, entry into countries of any non-residents who participate in such activities and there is also an absence of laws guaranteeing basic human rights protection to those categories of people, including rights to essential health and social services. Despite the existence of punitive laws or the absence of human rights protection, hundreds of thousands of Caribbean residents and migrants participate in such activities. They know full well that these activities are difficult to detect and the police and courts lack the will or resources to enforce laws and arrest and prosecute all suspects. In fact, some of the laws (e.g., those against male-male sex) are rarely if ever enforced in but their existence provides excuses for blackmail, coercion, bullying, violence, confiscation of cash and property, and all manner of discrimination and abuse against MSM, sex workers and drug users, including police demands for sexual favours in exchange for freedom from arrest or continuing detention.

CSOs such as ASA, COTRAVEDT, J-FLAG, and MODEM are doing their best to get the police on their side in efforts to counter such violations against basic human rights and to provide public safety and security to vulnerable populations. To assist in these endeavours, the CVC/COIN Project has drafted a manual to guide training workshops for police officers. The current draft\(^\text{65}\) has six training modules or sections:

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\(^{65}\) CVC/COIN (2012b).
1. Introduction to human rights
2. Stigma, discrimination and vulnerability
3. Vulnerability and risk to HIV
4. Hate Crimes
5. Human rights of sex workers
6. Human rights of LGBT people

In October 2012, the Project Unit held a validation workshop with LGBT and sex worker activists in the Dominican Republic and the validation process is continuing. The Sex Work Association of Jamaica (SWAJ) is among the CSOs participating in this process and, in so doing, applying the lessons they learned from they learned from their CVC/COIN Community Grants project, which launched the promising new police training program described in Annex C1 and mentioned in the following section of this Part of the report.

AA 3: Testing a range of interventions

Community Grants projects focusing on MSM

MSM include biological males who self-identify as gay, bisexual, transgender, or transvestite or else as heterosexual even though they sometimes have sex with other men. As discussed in Part Two of this report, evidence suggests MSM may have HIV prevalence averaging more than 25 percent across the region, higher than HIV prevalence among MSM across any other region of the world. They may account for around one-third of all new cases of HIV every year and they may account for around two-thirds of all new cases among men. In addition, bisexual or closeted MSM who have sex with both men and women may account for a significant percentage of all new cases among women across the region.

In light of such evidence, the CVC/COIN Project chose to pilot its new sexual health approach to peer education through three projects that focus on MSM. These are discussed earlier in this Part of the report and in Annexes A1, A2 and A3. In addition, when it selected the projects that would receive its 14 Community Grants, it chose four that focus primarily on MSM. Described at length in Annexes B1, B2, B3, and B4 of this report, these four projects include:

**B1, an advocacy project** whereby Trinidad and Tobago’s Coalition Advocating for Inclusion of Sexual Orientation (CAISO) documented human rights violations against LGBT, trained and mobilized advocates for human rights and launched a campaign to amend the country’s Equal Opportunities Act (EOA) so that it provide equal protection for LGBT people.

**B2, a social media project** whereby the Jamaican Youth Advocacy Network (JYAN) tested various ways of using its own “Living Out Loud” website, Facebook, Twitter, Blackberry Messenger, and the popular gay dating site Adam4Adam to create safe spaces in which LGBT and other youth and learn and talk about sexuality, gender identity, HIV and AIDS, and human rights issues.

**B3, a preventive education and community mobilization project** whereby the Dominican Republic’s el Red de Voluntarios Amigos Siempre Amigos (RevASA) reached out to a few “closeted” MSM, asked them to reach out to more and facilitated processes of preventive education and community mobilization. The latter was in the hopes that the country’s many middle class and influential but closeted MSM might join in public discussion and debate about human rights, including equal rights to essential health services.
B4, an edutainment project whereby Jamaica’s Ashe Company used interactive theatre to illustrate and provoke discussion and debate about the attitudes, behaviours and situations that put MSM at risk of HIV and STI infection. Ashe used each performance as an occasion to distribute IEC material, condoms and lubricants and to offer on-the-spot voluntary counselling and testing for HIV and referrals for other health and social services.

The latter project was particularly impressive insofar as MSM who attended the performances found them profoundly moving and transformative experiences and a large percentage of them took up the on-the-spot offer of VCT. The project supported by CVC/COIN was called “Test and Talk about Your Business Safely (TABS)” but TABS was closely associated with another Ashe Company initiative called “the Attractor Factor” and both present possibilities for inclusion in any programme to train peer educators.

Other impressive projects in terms of their impacts on MSM are the Este Amor project described in Annex A1, the REDNAJCER project described in Annex E1 and the FURJUG project described in Annex E3. Like COIN’s YurWorld programme (with which it is closely associated), the latter project demonstrates that an effective way of reaching out to all manner of young MSM, including those who are transgender or closeted, is to include them in projects for larger populations of marginalized youth.

Community Grants projects focusing on sex workers

There are an estimated 100,000 sex workers in the Dominican Republic alone. Across the Caribbean sex workers come second only to MSM as the vulnerable and marginalized population with the highest rate of HIV prevalence. Together, sex workers and their clients and their clients’ regular partners make significant contributions to the annual incidence of new HIV infections throughout the region. In light of such evidence, the CVC/COIN Project chose to pilot its new sexual health approach to peer education through two projects that focus on sex workers (and that also focus on MSM, including transgender sex workers). These are discussed earlier in this Part of the report and in Annexes A1 and A2. In addition, when it selected the projects that would receive its 14 Community Grants, it chose four that focus primarily on sex workers. Described at length in Annexes C1, C2, C3, and C4 of this report, these four projects include:

C1, a capacity-building and police training project which built the capacity of the Sex Work Association of Jamaica (SWAJ) to represent and server Jamaican sex workers. This project also launched a promising new police training programme whereby police officers and sex workers interact, learn how the attitudes and behaviours of each impact on the other, and find ways of collaborating both to increase workplace safety and security for sex workers and to make policing easier and more effective.

C2, a peer education project whereby el Centro de Promoción y Solidaridad Humana (CEPROSH) trained ethnic Haitian sex workers to reach out to migrant Haitian workers and provide them with HIV and STI prevention, care and treatment. While this project exceeded all of its targets it also highlighted the fact that the Government of the Dominican Republic is not highly committed to making male and female condoms, lubricants and essential health services available to the country’s most vulnerable populations.

C3, a peer education project whereby the Family Planning Association of Trinidad and Tobago (FPATT) trained ethnic Dominican sex workers to reach out to migrant Dominican sex workers and provide them with HIV and STI prevention, care and treatment. This project added to knowledge about Jamaica’s countrywide network of migrant sex workers from the Dominican Republic and the opportunities and barriers to reaching them with services. It highlighted, in particular, the need for mobile clinics (whether vans or temporary health stations in local venues) in any programme that
hopes to get most these sex workers to take up offers of sexual and reproductive health services.

**C4, a peer education project** whereby *el Movimiento de Mujeres Unidas* (MODEMU) trained sex workers in the Province of Barahona, Dominican Republic, to reach out to the Province’s many female, male and transgender sex workers and provide them with HIV and STI prevention, care and treatment. While the FPATT project (C3) was able to distribute almost 500 female condoms, this project was able to distribute 17,000 thanks to a generous donor. However, it highlighted the fact that neither water-based lubricants nor female condoms are readily available in the country’s pharmacies and that, even if they were available, they would be prohibitively expensive for most sex workers.

These projects demonstrate that peer education can be a highly effective way of reaching out to sex workers but only if accompanied by appropriate supplies and services. Scaling up such interventions to cover all sex workers in the region might be expensive but probably not nearly as expensive as continuing to treat all the cases of HIV and AIDS and STIs that arise from sex work.

**Community Grants projects focusing on drug users**

The report on a 2008 serological and behavioural survey estimated that HIV prevalence among drug users in the Dominican Republic was 8 percent. A 2011 serological and behavioural survey found that HIV prevalence among homeless people (who are often crack cocaine users) was 12 percent. No comparable survey has yet been completed in Trinidad and Tobago but its patterns of drug use are similar to those of Jamaica, where there are few injecting drug users but many crack cocaine users. As mentioned in Part Two of this report, evidence suggests that crack cocaine use poses a high risk of infection not so much because it involves sharing equipment as because it arouses sexual desire and lowers sexual inhibitions. In light of such evidence, when the CVC/COIN Project selected the projects that would receive its 14 Community Grants, it chose three that focus primarily on drug users and that take a harm reduction approach to preventing HIV and AIDS among all drug users, not only those who inject drugs and not only those who agree to undergo detoxification and rehabilitation of any kind. Described at length in Annexes D1, D2 and D3, these three projects are:

**D1, a capacity-building and harm reduction project** which built the capacity of *el Fundación Dominicano de Reducción de Daños* (FUNDOREDA) to represent and serve injecting drug users and other drug users in Santo Domingo. This was the Dominican Republic’s first attempt to establish a harm reduction programme that includes needle-and-syringe exchange for the country’s growing population of injecting drug users.

**D2, a proposed peer education and harm reduction project** whereby a CSO representing and serving drug users in Trinidad and Tobago was meant to establish a team of 5 peer educators who would provide street-based drug users (mainly crack cocaine users) with preventive peer education, condoms and access to VCT and other health services. The CSO received the first instalment of its grant but no further instalments when it became evident the CSO had not even started the project as its intended end approached.

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66 COPRESIDA (2009). This survey covered all drug users. Injecting drug use is comparatively rare in Dominican Republic but in recent years there have been sharp increases in use of crack cocaine inhaled through heated and shared equipment that causes lips to blister, thus creating opportunities for transmission of HIV.

D3, a peer education and harm reduction project whereby Jamaica’s National Council on Drug Abuse (NCDA) established a team of ten peer educators who provided homeless drug-users with peer education, care packages (condoms, lubricants and hygiene products) and referrals to clinics for VCT and other health services.

None of the 14 Community Grants projects surpassed the FUNDOREDA project (D1) for excellence of planning, implementation and monitoring and evaluation and for impressive results. This was due in part to FUNDOREDA’s dynamic leadership and in part to the fact that COIN (i.e., not the CVC/COIN Project Unit) felt the project sufficiently important to provide it with hands-on guidance and support from start to finish and COIN also financed additional support from Puerto Rico’s Proyecto Casa de Ayuda Intermedia al Menesteroso (CAIM). By contrast, the D2 project suffered from lack of leadership and also from lack of any support beyond the minimal support it received from the CVC/COIN Project Unit.

The NCDA project (D3) was a very good pilot project that added to knowledge about homeless drug users and the challenges involved in reaching them with preventive measures. It recognized that hygiene is a significant problem for homeless people and addressed that problem with its care packages.

Community Grants projects focusing on marginalized youth

The Caribbean region has millions of youth marginalized by poverty and lack of access to education and employment opportunities. Many are also marginalized by broken or dysfunctional families that cannot give them all the parental care they need and that may also subject them to verbal, physical and sexual abuse. Such youth often repeat those patterns of abuse and also patterns of alcohol and drug use, gang membership, petty crime, unwanted pregnancy, unsafe abortion, and transactional and commercial sex. Among them are marginalized youth made doubly vulnerable by being gay, bisexual, transgender, closeted or being females who unknowingly have sex with closeted males who are having male-male sex with other partners.

Most CVC/COIN-supported initiatives respond to HIV among marginalized youth who are also MSM, sex workers or drug users. When the CVC/COIN Project selected the projects that would receive its 14 Community Grants, it chose three that focus on marginal youth that do not necessarily fall into any of those other categories. Described at length in Annexes E1, E2 and E3, these three projects are:

E1, a treatment monitoring and advocacy project whereby La Red Nacional de Jóvenes Viviendo Con VIH/SIDA (REDNAJCER) established a Citizen’s Oversight Team of six marginalized youth living with HIV who observe interactions between health care providers and users, questioned users their experiences and then analyze and report their findings. These finding are used to inform negotiation and advocacy for improvement of HIV-and-AIDS-related health services in the Dominican Republic.

E2, a preventive education project for institutionalized youth whereby the Trinidad and Tobago YMCA and Community Action Resource (CARe) did research into the sexual culture of marginalized youth in institutional care and then designed and delivered twelve high-interactive training workshops for young offenders* (10 to 18 year old) and care-givers in St. Michael’s School for Boys. *They are called such because many of them have been tried for criminal offenses and referred to the School by the courts. However, many of them are so referred because they are deemed “hard to manage”, which sometimes comes down to their parents or other adult guardians being unfit to manage children or adolescents.

E3, a peer education and mobilization project for marginalized youth whereby el Fundación Red de Jóvenes Unidos de Guachupita (FURJUG) 90 peer educators —
10 senior “promoters” and 80 “multipliers” implemented *el Proyecto Jóvenes por el Cambia* — to spread messages promoting healthy and positive attitudes and lifestyles among youth in four of the poorest barrios of Santo Domingo. The project also aimed to unite marginalized youth to advocacy and action.

All three of these projects were innovative and highly relevant in that they addressed some of the most urgent problems facing marginalized youth across the Caribbean. The FUNDOREDA project reflected that organization’s long association with COIN and COIN’s YurWorld Programme, which also reaches out to all marginalized youth and unites them in advocacy and action regardless of whether or not they are MSM, sex workers or drug users. An important advantage of this approach is that it includes closeted MSM in its embrace and provides them with essential preventive information, supplies and services without asking questions about their sexual preferences and practices.

**A model youth centre with a clinic and outreach programmes**

**The founding of YurWorld and its Youth Health Centre (CeSaJo)**

Part Three of this report explains how COIN’s Youth in the Real World (YurWorld) Programme emerged out of *tertulias* that brought together “key stakeholders” (representatives of youth and their organizations) and “key duty-bearers” (representatives of organizations with primary responsibility for driving the HIV response) to discuss HIV and other issues of concern to both parties. These *tertulias* generated a proposal for a café that would serve as the core of a youth centre. That concept eventually led to the birth, in 2010, of El Centro Salud Joven (CeSaJo) or Youth Health Centre. CeSaJo started as a small extension of COIN’s main health clinic but, in January 2012, it moved to larger premises just outside the walls of Santo Domingo’s Colonial Zone. These new premises gave YurWorld enough space to begin realizing the original dream of a youth centre with a clinic and outreach programmes that eventually might give birth to similar youth centres elsewhere in the Dominican Republic. COIN’s YurWorld Programme and its then Manager, Dr. John Waters, were much involved in developing the proposal for the CVC/COIN Vulnerabilized Groups Project. The Project’s agreements with CARICOM and the Global Fund give YurWorld significant responsibility for supporting the Marginalized Youth component of the CVC/COIN Project. This includes responsibility for:

1. Building the YurWorld Programme and CeSaJo into models of good promising practice to which CSOs in other Caribbean countries can refer as they develop interventions tailored to their own situations and needs.

2. Supporting *tertulias* in Jamaica and Trinidad that served the same purposes as the *tertulias* in the Dominican Republic had served: to develop proposals for youth centres and/or programmes that served purposes similar to those CeSaJo and the YurWorld Programme served.

**CeSaJo’s overall objectives**

CeSaJo aims to:

1. To provide all categories of marginalized youth — lesbian, gay, bisexual, transgender, closeted MSM, people living with HIV, sex workers, those who engage in transactional sex, drug users, gang members, and youth marginalized by poverty and other factors — with youth friendly services tailored to their unique needs but within the framework of services open to all youth, so no one is branded simply for entering the centre.

2. To provide HIV-and-STI-related services within the context of sexual and reproductive health (SHR) services and to provide SHR services within the context of
primary health care, so no one is branded for taking up the offer of any particular service.

3. To provide all services to the general population of youth in CeSaJo’s neighbourhood, in order to gain good will and support from neighbourhood residents.

4. To provide all of these services within a safe space for youth that offers opportunities for leisure and for educational, cultural and recreational experiences. This will serve to draw people to the centre and to make it possible for them to slip away from other activities and take up offers of VCT and other health services.

5. To extend its health services with use of a mobile clinic that offers services to all categories of marginalized youth on their own turf.

CeSaJo’s services

CeSaJo now offers:

Medical services were established on a regular basis in early July 2012. Staffed by a medical doctor and a receptionist/archivist, the clinic is open Monday through Friday from 3 p.m. to 8 p.m. The number of patients has grown steadily and by the end of September 2012 had averaged 60 per month. The monitoring system tracks sex, age, address, nature of primary complaint and data specific to sub-populations to which the youth may belong. By the end of September, more than half of the patients were LGBT or drug users. However, during that period, a transgender organization had its temporary offices in CeSaJo and the clinic was attracting a disproportionate number of transgender people while the perception that it was mainly for LGBT people was discouraging others from using the clinic. The transgender organization has now found its own offices while the CeSaJo clinic continues to provide transgender and all other marginalized and neighbourhood youth with health services.

Clinical psychology services in an annex with sound-proofing and comfortable furniture. These services are offered on Mondays, Wednesdays and Fridays from 3 to 7 p.m. The clinical psychologist is assisted by a clinical psychology student and refers urgent cases to Moscoso Puello Hospital’s Crisis Intervention Unit, which offers psychiatric care. In recent months, an average of 20 youth per month has been taking up the offer of these services. The monitoring system tracks sex, age, address, nature of primary complaint and data specific to sub-populations to which the youth may belong. So far, the most common complaints focus on anxiety related to stress and drug use. The monitoring system allows corrective action. For example, one youth living with HIV was referred to the Crisis Intervention Centre with suspected HIV-related dementia but was lost to the system and this prompted establishment of a volunteer buddy system. These services are now offering group therapy that aims to empower youth who have low levels of self-esteem and self-confidence.

Laboratory services through its own lab, a satellite to COIN’s main lab. CeSaJo’s lab has all the equipment necessary to do basic tests (for STIs and HIV, complete blood counts (CBC), blood chemistry, urinalysis, and coprological analysis) and can send samples to the main lab for further testing when necessary.

Mobile outreach services through COIN’s mobile clinic. These were piloted from May through September 2012. The single outing in September target young males who engage in transactional sex in the Colonial Zone, the part of Santo Domingo most frequented by tourists. The mobile clinic provides rapid testing for HIV but refers people to the CeSaJo’s fixed clinic to get their results. This is to guarantee confidentiality and also to provide as a safe space and counselling for those who test
positive. To meet the challenge of getting people to go for their results, mobile clinic staff ask them to provide phone numbers so staff can follow up on no-shows.

To guarantee confidentiality, the CeSaJo clinic does not record STI and HIV test results in the records pertaining to individuals. However, in a separate system it records data that cannot be connected to individual names. To draw marginalized youth to its mobile and stationery clinics, the CeSaJo centre depends to a large extent on CSOs and their peer educators. The same is true for follow-up, to ensure that people turn up to get their test results and that they adhere to prescribed treatments. However, this is now done on an ad hoc basis and CeSaJo hopes to provide more formal system of community-based referral a follow-up.

**YurWorld’s tertulias in the Dominican Republic**

As discussed at length in Part Three of this report, CeSaJo was conceived by tertulias under the 2003-2006 ProSuRe-GTZ project. There was a two year gap after that project ended and then, in 2008, COIN picked where Germany’s GTZ left off and established the YurWorld Programme. Germany’s GTZ stepped in again with a grant from its BACKUP Initiative and this got the tertulias and the development process back on track and moving rapidly forward until, in 2010, CeSaJo had a temporary home and then, in January 2012, it moved into its current home. The whole process had intensive support from GTZ and COIN and, in both cases, Dr. John Waters played a key role in providing guidance and technical support.

Under the umbrella of the CVC/COIN Vulnerabilized Groups Project, the YurWorld Programme still hosts and facilitates tertulias in the Dominican Republic and has established a youth committee that is meant to lie at the heart of efforts to give “key stakeholders” (youth and their formal and informal organizations) a strong voice both in guiding further development of CeSaJo and its outreach programmes and engaging with “key duty-bearers” in shaping the national response to HIV and AIDS.

The CVC/COIN Project Unit’s Quarter Reports to CARICOM and the Global Fund report on the tertulias’ activities and show that in the 7th quarter (July-September 2012), for example, there were two tertulias: the first to welcome new organizations to the YurWorld Programme and the second to discuss the draft of new law on volunteer and youth participation in various national processes.

The consultant met with members of YurWorld’s youth committee at CeSaJo on 26 November 2012 and came away with the strong impression that the young people on the committee felt that, so far, they had no significant role in setting the agenda for the YurWorld Programme or CeSaJo. They agreed they had opportunities to express their opinions but they had no confidence that anyone was listening to them. When it came to specifics, however, what they said echoed what staff of the YurWorld Programme said to the consultant a year earlier, in November 2011, when he was on a mission for Germany’s GIZ (successor to GTZ) to learn about results achieved with Germany’s support under the BACKUP Initiative. Staff were worried that YurWorld’s international donors focused almost entirely on HIV and AIDS and other health related issues and the same was true of the government. All along, their vision had been of multifunctional youth centre and not of a health clinic with a few other functions tacked onto it. They said they hoped, in the years ahead, to convince some of their existing partners and, also, new partners that this vision was worthy of their support.68

**Tertulias in Jamaica and Trinidad and Tobago**

Under the Marginalized Youth component of Phase One of the CVC/COIN Project, the YurWorld Programme supported tertulias in Jamaica and in Trinidad and Tobago. They are

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68 GIZ (2012b).
continuing on through Phase Two and the hope is that they will generate proposals for youth centres and/or programmes along the lines of CeSaJo and the YurWorld Programme in the Dominican Republic.

The Jamaican Youth Advocacy Network (JYAN) has primary responsibility for the Jamaican tertulias and has been organizing, hosting and facilitating a series of meetings across Jamaica where representatives of young LGBT, people living with HIV, drug users, gang members, and so on are being asked to participate in discussion and debate surrounding three questions:

1. What can be done to empower Jamaican youth?
2. How can Jamaican youth become more involved in decision-making processes?
3. What challenges do Jamaican youth face in Jamaica?

The Trinidad and Tobago YMCA has primary responsibility for that country’s tertulias and it has been organizing, hosting and facilitating a similar series of meetings. On 20 November 2012, the consultant met with YMCA representatives and youth who had been participating in this series and got the impression that little in the way of concrete proposals had arisen from the series yet. The documentation on the Jamaican tertulias suggests the same but it is early days. Meanwhile, the CVC/COIN Project has been supporting capacity-building workshops for youth in both countries. These are discussed later, in section AA6.

**AA 4: Advocacy**

The budget allocated to Phase One of the CVC/COIN Vulnerabilized Groups Project included no specific allowance for advocacy per se but some of the capacity-building, IEC and other activities supported by the Project Unit fit best under the “Activity Area 4: Advocacy” heading. Some of these activities were initiated by CVC’s member organizations and the Project Unite did its best to support them.

**Advocating for civil society participation**

The CVC/COIN Vulnerabilized Groups Project aims to support CVC and its member organizations and informal groups in a manner consistent with:

1. The *Global Fund Strategy for Ensuring Gender Equality in the Response to HIV/AIDS* and the *Global Fund Strategy in Relation to Sexual Orientation and Gender Identities*[^69]
2. The *UNAIDS Action Framework: Addressing Women, Girls, Gender Equality and HIV* and the *UNAIDS Action Framework: Universal Access for Men who have Sex with Men and Transgender people*[^70]
3. The *Istanbul CSO Development Effectiveness Principles* and *The Siem Reap CSO Consensus on the International Framework for CSO Development Effectiveness*[^71]
4. The *Busan Partnership for Effective Development Co-operation*[^72] (See box.)

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[^70]: UNAIDS (2009a) and (2009b).
[^72]: Fourth High Level Forum on Aid Effectiveness (2011).
local to international. The Forum concluded with agreement on a declaration called the Busan Partnership for Effective Development Cooperation.

Clause 22 of the Busan declaration states:

Civil society organisations (CSOs) play a vital role in enabling people to claim their rights, in promoting rights-based approaches, in shaping development policies and partnerships, and in overseeing their implementation. They also provide services in areas that are complementary to those provided by states. Recognising this, we will:

a) Implement fully our respective commitments to enable CSOs to exercise their roles as independent development actors, with a particular focus on an enabling environment, consistent with agreed international rights, that maximises the contributions of CSOs to development.

b) Encourage CSOs to implement practices that strengthen their accountability and their contribution to development effectiveness, guided by the Istanbul Principles and the International Framework for CSO Development Effectiveness.

The CVC/COIN Vulnerabilized Groups Project itself grew out of advocacy for civil society participation in HIV-related development cooperation and is a manifestation of such participation. The CVC/COIN Project Unit’s Quart Reports and End of Phase 1 Report to CARICOM and the Global Fund provide numerous examples of the Project's continuing efforts to promote the participation in HIV-related development cooperation of CSOs, informal groups and networks representing or serving MSM, sex workers, drugs users, and marginalized youth.

In late 2011, for example, the Project Unit issued a briefing paper73 citing an International HIV/AIDS Alliance report74 which said that, in 2009, out of the US$170 million given to all Sub-recipients (SRs) of Global Fund grants in Latin American and the Caribbean, only 4.6 percent had gone to CSOs that represent and serve the populations most vulnerable to HIV and AIDS. In effect, the briefing paper urged the region’s national AIDS authorities:

- To be guided by agreed international declarations, principles, strategies and frameworks as they review and revise their national AIDS strategies and programmes
- To do what they can to create enabling environments — with good human rights legislation and enforcement — for implementation of their national AIDS strategies and programmes
- To allocate their resources in ways consistent with the evidence as to which populations are most vulnerable to HIV and AIDS and which organizations and groups are best placed to provide those populations with the services they need.

More recently, the Project Unit consulted with CSOs, informal groups and networks and then provided its feedback to a draft update of the National Strategic Plan (NSP) for Trinidad and Tobago. The Project welcomed the plan’s greater focus on vulnerable populations and its identification of advocacy for human rights as a priority, but pointed to some areas where clarification was needed. In particular, the draft NSP made no mention of resources that might be allocated to CSOs representing and serving vulnerable populations.

73 CVC/COIN (2011a).
Advocating for human rights

Helping sex workers oppose an official red light district

In fall of 2011, a Dominican Congresswoman proposed a new piece of legislation that would have created a zona rosa in Santo Domingo and prohibited sex work anywhere else. She presented her case as if it was a moral stand against sex work, but she had connections to a hotel, restaurant and bar owners’ association. Members of MODEMU and COTRAVEDT suspected the real motive was to control sex work for the owners’ own commercial gain, effectively making them madams and pimps and squeezing out all competition.

They asked Louise Tillotson, Technical and Policy Coordinator for the CVC/COIN Project, and Marianela Carvajal Díaz, Legal Advisor for COIN’s Aura of Hope project, for advice and assistance. On Wednesday, 9 November 2011, Marianela facilitated a workshop that gave sex workers a better understanding of the proposed legislation and its implications and helped them develop their arguments against it. Meanwhile, Louise helped them marshal support from sympathizers both in the Dominican Republic and abroad.

Two days later, a Congressional Committee of five (including the Congresswoman proposing the legislation) held a public hearing in a room not much larger than a school classroom. By the time the chair called the hearing to order, the room was full to overflowing with more than a hundred people taking up all seats and all standing room and spilling out into the foyer.

Among the crowd were several television crews, filming the proceedings as the Committee listened to presenters and asked them questions.

The majority were there to speak against the proposed legislation and they included not only sex workers but, also, university students taking courses in ethics and law and two nuns who forcefully confirmed much of what the sex workers were saying. Many sex workers were single mothers with children, the nuns said, and, even if not, they had low levels of education and few options for gainful employment. This new legislation would only leave them open to exploitation and squeeze out those the business owners decided were not sufficiently compliant or otherwise up to their standards.

Since the hearing, the proposed legislation has been delayed. The CVC/COIN Project Unit, COIN and UN agencies have been working on alternative legislation to regulate sex workers and meeting with Congressional representatives to exchange info and opinions.

Responding to violence against MSM in Jamaica

The Jamaica Forum for Lesbians, All-sexuals and Gays (J-FLAG) was founded in 1998 by 12 male and female business people, professionals and human rights activists. It is Jamaica’s first and oldest organization dedicated to promoting and protecting the rights of lesbians, gays and “all-sexuals”, a term the founders chose to signify that the organization was there to defend any adults’ rights to express themselves sexually so long as they do it with other consenting adults and do no harm.

J-FLAG’s website (http://www.jflag.org/) is its main vehicle for public communications, education and advocacy in part because the internet allows content providers and readers a degree of anonymity. Dane Lewis is the Executive Director of J-FLAG and he explains that his immediate predecessor was once interviewed on radio and dared to speak out in favour of LGBT rights. He gave a pseudonym but had a distinctive voice and some listeners recognized it and spread the word. He was soon inundated with a mounting flood of threats. Fearing for his life, he sought asylum in Canada, where he now lives.

During a week in mid-June 2012, when this consultant happened to be in Jamaica, the Kingston police reported six murders of MSM and those six brought the toll to eight murders.
of MSM over a three month period. The previous record had been four in one year. On the morning of 13 June 2012, Dane Lewis met with Ian McKnight, Executive Director of CVC, and Ivan Cruickshank, Programme and Advocacy Coordinator with the CVC/COIN Project. He explained that J-FLAG could not possibly let these murders pass without comment on its website. The problem was what to say without doing harm to the memory of the murdered men, without doing harm to their families and friends, and without inflaming public opinion and causing more violence against MSM.

The murdered men were known to be MSM to other MSM but some were closeted and two of the closeted ones were prominent professionals. The police reports and eye witness accounts suggested that some of them had been acting recklessly. One was last seen hanging out in a popular “cruising” area, being hailed to the window of an automobile and then climbing in beside the driver. The body of another had been found in a guest house even though he lived in Kingston. He may have brought someone to his room, possibly someone he had never met before.

After much discussion with Ian and Ivan, Dane came to the conclusion that it was best to be circumspect and put J-FLAG on the side of the police by offering to help them with their investigations. He posted a message on the website the next day that did just that and ended with these words: We call on the Prime Minister and the Ministers of National Security and Labour & Social Security to listen to the cries and needs of members of our community who continue to be subjected to discrimination and violence, have nowhere to live and no food to eat because of their sexual orientation and or gender identity. As we work collectively towards achieving Vision 2030, we invite all Jamaicans to embrace our common humanity and demonstrate respect for the lives of all people as we help make Jamaica the place of choice to live, work, raise families and do business.

The “We are Jamaicans” campaign

On 17 January 2013, J-FLAG launched its “We Are Jamaicans” campaign on YouTube at www.youtube.com/user/EqualityJA. Supported by the CVC/COIN Vulnerabilized Groups Project, this campaign carries through with recommendations made by LGBT people and their leaders and allies during consultations on how to address situations like the one described above. The campaign consists of a growing set of videos featuring a range of prominent Jamaicans that reflect the diversity of the LGBT community and the diversity of its friends.

Dane Lewis, the Executive Director of J-FLAG, is featured on one of the videos. He explains that, “Regrettably, the diversity and the complexity of Jamaica’s LGBT community are masked by media and advocacy narratives that too often focus on sex, victimhood, crime and HIV. These themes are not identity-affirming and they sometimes further entrench the marginal position of LGBT people in the society.”

Also featured on one of the videos is Javed Jaghai, an openly gay Jamaican who adds, “By diversifying the stories told about LGBT lives, the complexity of LGBT identities will be made apparent and it will be easier to evoke empathy and secure general support for tolerance.”

J-FLAG invites LGBT and straight Jamaicans to join the campaign and to share their experiences their experiences, whether or not they wish to show their faces. As of the end of April 2013, the number of hits on some of the videos was approaching 10,000 and still growing rapidly.

The Human Rights Observatory in the Dominican Republic

The journalists who attended CVC/COIN’s two day media training workshop in early July 2012 suggested a permanent entity that could provide them with additional training to which they could turn for information on issues impacting on MSM, sex workers, drugs users,
marginalized youth and other marginalized and vulnerable populations. It was agreed to form a steering committee and the CVC/COIN Project Unit has been working with that committee to establish such an entity.

The result is the Human Rights Observatory, which will promote human rights through public campaigning, media engagement and lobbying. CSOs representing or serving marginalized and vulnerable populations have been invited to participate in the Observatory, help it document human rights violations and bring the media’s attention to these violations. Three temporary and part-time consultants (a coordinator, a lawyer and journalist) have been hired to get the Observatory launched on a pilot basis. The hope is that this pilot will evolve into a permanent Observatory.

Advocating for personal responsibility

The first page of Part Three of this report describes the “horizontal approach” whereby COIN aspires only to be a friend to vulnerable populations and empower them to act in their own best interests. This approach respects their cultures and ways of life but recognizes that they need knowledge and tools that empower them to take responsibility for their own health and well-being. CVC and most of its member organizations take a similar approach and so does the CVC/COIN Project.

In the context of this approach, preventive information, education and communications (IEC) campaigns can also be considered advocacy campaigns. That is, they advocate that people take responsibility for their own health and well-being and for the impacts their attitudes and behaviour can have on the health and well-being of others.

In 2012, CVC/COIN commissioned a professional video producer, Henry Mercedes Vales, to make five “infomercials” in a series called El Placer de Protegerte (“The Pleasure of Protecting Yourself”) that emphasized both the pleasure that can be derived from all manner of sexual activity but the importance of protecting yourself and your partners from harm. These five infomercials were officially launched on 29 November 2012 on the opening night of Santo Domingo OutFest 2012, the international LGBT film festival run by RevASA. The videos can be viewed on YouTube at www.youtube.com/user/alkaflu?feature=watch but it remains to be decided exactly how they will be distributed and shown to the audiences that would most benefit from seeing them. Currently, they are available only in Spanish and the owners of some Santo Domingo bars and nightclubs have indicated their interest in showing them on their television sets. It is generally agreed that they are of a nature that they are unlikely to be broadcast by popular television stations.

AA 5: Development of IEC media and content

The Project’s website and Facebook page

As noted often in this report, the CVC/COIN Vulnerabilized Groups Project has its own website and its own Facebook page and COIN, CVC and most of CVC’s member organizations have their own websites and often their own Facebook pages, YouTube sites, blogs, and Twitter accounts. In terms of monthly hits since inception, by far the most visited of all these sites is the YouTube site of J-FLAG’s “We Are Jamaicans” campaign. Some of the other sites lack content of sufficient quantity or quality to attract many visitors, or else the content is out of date or not organized in such a way as to make it easy to find.

Netcraft issues monthly reports (available at http://news.netcraft.com/archives/category/web-server-survey/) tracking the size and growth of the Worldwide web and the April report says there are now 650 million websites and 17.6 million have been added in the past month. Other website trackers find that there are around 11 billion files (e.g., documents in PDF or Word files or video files) in the “deep web” (attached to websites). The reason for mentioning
this is that it gives some indication of just how much competition for people’s attention there is out there and how unlikely people are to visit websites that are not rich in interesting, useful and easy to locate content of good quality.

The CVC/COIN Project has not had the human resources or budget allowing it to put much effort into its website but the consultant notes that inexpensive software available from the likes of WordPress would make it comparatively easy for existing staff to make the website much more useful and user-friendly than it is now and to provide links to many of the documents, videos and other items cited in this report. (Easy to create, hotlinks can provide links through highlighted words and eliminate the need to provide website details within the text.)

It would also seem to be well worth thinking about either combining or at least closely linking the Project’s website to CVC’s website and about creating a network of linked Caribbean CSO websites, Facebook pages and YouTube sites. The CVC website might be the main window into all of them and have both links and a search function that makes it easy for site visitors to find what they are looking for.

The quality of content

Again, the Project has not had the human resources or budget to worry too much about the quality (including reader-friendliness) of its written products (including website content) but if it wants to serve CVC’s member organizations and their partners well it should do its best to pay more attention to this. As things stand, a lot of material is left in recklessly written drafts without logical structure or compelling narrative and with mystifying acronyms, invented words, meaningless jargon, and statements of “fact” for which no evidence (e.g., footnotes citing sources) is given. (See the next box.)

There are good reasons why major newspapers and magazines have their own style guides (e.g., The Economist and The Guardian style guides in the United Kingdom, The New York Times and The Washington Post style guides in the United States) and why independent writers consult those guides or other standard American and English references (e.g., The Elements of Style by Strunk and White, an American classic, or New Hart’s Rules published by Oxford University Press and applied to its own publications). As for writing about HIV and AIDS, two useful guides are The WHO Style Guide and the UNAIDS Terminology Guidelines.

The better the style of any text, the better it communicates. The better it communicates the better it informs and educates. It cannot do any of those things if readers don’t even know it exists and it is not made readily available through electronic or hard-copy media.

The importance of using standard terminology

While the consultant was producing the project write-ups provided in the Annexes to this report, the CVC/COIN Project Unit was producing a parallel set of shorter write-ups they were now publishing in what they were calling the Caribbean Civil Society Promising Practices Series. “[Please note that, after reading a draft of this section, the Project Unit renamed this series the Caribbean Civil Society Show Case Series.”

The Development Assistance Committee (DAC) of the Organisation for Economic Cooperation and Development (OECD) represents most of the developed countries (e.g., the United States, Germany, United Kingdom, and France) that donate the bulk of

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75 Available at http://colelearning.net/who/module1/page71.html.
international financing for development, whether it is channelled through their own bilateral agencies (e.g., USAID) or multilateral agencies (e.g., UNAIDS) or through developing country governments or the Global Fund or CSOs at international, regional, national, or local levels. In assessing whether or not a cooperative development programme or project is good, bad or middling, the DAC gathers and analyzes evidence against which to measure:

1. **Relevance** including, for example, the extent to which objectives are based on good serological, behavioural and sociological evidence and on evidence as to which kinds of intervention are most effective.

2. **Effectiveness** including, for example, progress towards defined targets and the extent to which the targets are likely to be achieved; any challenges which may be slowing down progress and any opportunities which could speed up progress.

3. **Efficiency** including, for example, the extent to which all available financial and other resources (including collaboration and resource-sharing with partners and volunteer contributions of labour, expertise and material) are being used to good advantage.

4. **Impact** including positive or negative and intended or unintended results, with emphasis on outputs (e.g., number of people trained as peer educators and portion of target populations reached with peer education) and outcomes (e.g., increased utilization of HIV-related services, measured changes in the behaviours that put target populations at risk).

5. **Sustainability** including the extent to which activities or benefits of activities are likely to be sustained when Global Fund and other donor support is reduced or comes to an end; any challenges which threaten sustainability and opportunities which could strengthen sustainability.77

Bilateral and multilateral donors generally apply variations on those criteria when assessing programmes or projects they support. For example, German Development Cooperation (including GIZ and KfW) determines whether or not to include write-ups of German-supported initiatives in the German Health Practice Collection based on whether the write-ups provide enough evidence to convince two independent and expert peer reviewers that the initiatives qualify as “good or promising practice” based on the degree to which they are effective, transferable, participatory and empowering, gender aware, innovative, cost-effective, sustainable, and practice monitoring and evaluation of high quality.

This consultant has researched and written many of the publications in the German Health Practice Collection and its predecessor, the German HIV Practice Collection, and can attest that it usually takes around 30 days or more of careful research (including field visits), analysis and writing to convince two independent and expert peer reviewers that even a comparatively modest programme or project qualifies as “good or promising” practice. Expert peer reviewers are especially tough in demanding evidence that an initiative is effective, transferable, cost-effective, and sustainable. If it is all of those things, it may be well worth using as a model for new initiatives elsewhere.

German Development Cooperation also requires that project write-ups serve as basic guidance manuals that show how a project was planned and implemented. That way, readers can assess whether or not it might be feasible to plan and implement a similar project in their country and can how they might get started.

The quickly written project write-ups now being published in the *Caribbean Civil Society Promising Practices Series* do not come close to providing enough evidence to convince independent and expert peer reviewers that any of the projects are examples of good or promising practice. Taken together with the evidence presented in this whole report, the more carefully researched and written Annexes to this report provide enough evidence to indicate that these projects vary. Some are very promising indeed. Some are conventional

77 OECD
examples of small-scale interventions that may be difficult to scale up and sustain until they have significant impacts. Four are weak and, of those four, one could be described as a failure because the implementing organization did not make clear that it lacked the in-house capacity to implement the project and that it needed technical support.

All of the projects described in the Annexes, however, were well worth the support the CVC Vulnerabilized Groups Project gave them insofar as they all had important lessons to teach. Why terminology matters is this: in standard practice when you characterize a project as promising, you suggest that it is worthy of continuing support and has the potential to be scaled up and sustained until it achieves significant impact. You also suggest that it is worth using as a model on which to base interventions elsewhere and that the write-up provides some basic guidance.

**Making products useful for multiple purposes**

The Project Unit has several times drawn the consultant’s attention to its PowerPoint presentation *Unseen but in the Scene None-the-less: Unravelling the Enigma of Caribbean Men who have Sex with Men*. This presentation is so carelessly written that it is useless to a reader (as opposed to workshop participant listening to a presenter explain its contents) except as a starting point for asking questions. The first two bullet-points are “DL phenomenon” and “S&D” and nowhere in the presentation is there any hint as to what those abbreviations mean.

It has a table titled “% Population Compared to % Internet use by Geographical Region” and has bars showing, for example, “37 % population” and “53% internet users” in North America. What does that mean? Are 37 percent of North Americans parakeet owners and 53 percent of parakeet owners also internet users? What are the sources of these percentages? The same table seems to indicate that only 2 percent of the population in the Caribbean are internet users but another table indicates “internet penetration” of 25.2 percent in the Caribbean. Does that mean that 25.2 percent of Caribbean people live in places where internet service providers (ISPs) offer access to the internet but only 2 percent of Caribbean people take up the offer of services? What are the sources of this information? Is the information up to date?

It has a chart showing that the popular internet dating site Adam4Adam has registered accounts for 60,737 MSM in 26 Caribbean countries, the estimated number of MSM in those 26 countries is 417,520 and, therefore, Adam4Adam users constitute 14.5 percent of all MSM in those countries. Which 26 countries are included in this calculation? What is the source of such a precise estimate of the number of MSM in those 26 countries? Is this information all up to date?

It has another table showing the percentages of MSM who are “out of the closet”, “in the closet” or “not specified” in the Dominican Republic, Jamaica and Trinidad and Tobago. These percentages may be derived from surveying a sample of the MSM who use Adam4Adam but there is nothing to indicate that such is the case, the size of the sample surveyed, who did the survey, and when. What is the definition of “in the closet”? Out to your friends but not to your wife, parents, employer, or priest?

The presentation provides much other alleged “information” unsubstantiated by convincing evidence. No doubt presenters have provided some of this evidence while talking their way through this presentation. It would have taken only a bit more work to turn it into a document that, for example, could be given to this consultant as a source of very interesting and useful information that might have been mentioned elsewhere in this report. Doing this bit of extra work would have ensured, too, that any evidence that was presented in spoken words was not lost because it was not recorded in written words.
**AA 6: Capacity-building**

A few more examples

The entire CVC/COIN Vulnerabilized Groups Project can be seen as a capacity-building exercise and this report and its Annexes provide many examples of capacity-building activities. There are many more capacity-building activities mentioned in the Project’s Quarter and End of Phase 1 Reports to CARICOM and the Global Fund.

For example, the Quarter 7 Report for July-September 2012 describes a number of CVC/COIN-supported capacity-building activities for youth in Trinidad and Tobago, including:

- **A strategic planning meeting** on 15 July 2012 with 28 representatives from “networks of youth”. The aim was to launch a process whereby youth would develop their own strategic plan for youth and use this as the basis for negotiating for the inclusion of similar strategies in the country’s National HIV and AIDS Strategic Plan 2013-2018.

- **A national stakeholders meeting** on 4 August 2012 in which 15 “key stakeholders” (youth from programmes associated with CARE, Christ Circle for Better Living, FPATT, Friends for Life, Ministry of National Security, Ministry of Youth Affairs, UNAIDS, UNFPA, Trinidad and Tobago YMCA, and youth networks) met with 5 “key duty-bearers (representatives of FPATT, Ministry of National Security, Ministry of Youth Affairs, UNAIDS, and UNFPA) to discuss strategies. Suggested strategies included, for example, ones that could: get parents or guardians and youth talking frankly about sex, improve sex education in schools, and improve guidance and counselling for sexually curious youth. At this meeting, the youth decided to hold a follow-up meeting to draft a Youth Declaration on Sexual and Reproductive Health and Rights and to share it with key duty-bearers involved in developing the new National HIV and AIDS Strategic Plan.

- **A two-day advocacy training workshop** on 16 and 17 August 2012 in which the 15 key stakeholders identified issues they would like to address in advocacy campaigns. These issues included: lack of sex education in schools, guest school speakers’ focus on abstinence-only approaches to HIV prevention, media neglect of HIV-related issues, parental neglect of need to nurture a positive and healthy approach to sex, lack of sex education in religious spaces, and lack of counselling and social support services for LGBT people.

- **A programme design and implementation workshop** on 8 September in which the 15 key stakeholders identified needs for programmes for marginalized youth and drafted the Youth Declaration on Sexual and Reproductive Health and Rights.

These activities all contributed to the “promising new beginning” discussed in the box at the end of Part Two of this report. That is, they contributed to development of Trinidad and Tobago’s new National HIV and AIDS Strategic Plan 2013-2018, which is now guiding the work of the country’s new Interim HIV/AIDS Agency. Compared to the old plan, the new one outlines a more progressive agenda. It recognizes that the country has spent too little on responding to HIV among MSM, sex workers, drug users and marginalized youth in the past. It promises to much more in the future and it establishes “advocacy, human rights and an enabling environment” as a priority.

**The way ahead**

Dr. John Waters, the Programme Manager of the CVC/COIN Vulnerabilized Groups Project, is the very definition of “a social entrepreneur”. The same can be said of Dr. Robert Carr and Ian McKnight, the first and the current Executive Directors of CVC, and of Santo Rosario Ramirez, the Executive Director of COIN. It can also be said of many of the leaders of the
CSOs participating in the CVC/COIN Project, some of them mentioned by name in the Annexes to this report. These are extraordinary individuals strongly committed to their work, ambitious in what they hope to achieve, and inspiring to the people who work with them. If there is a problem with social entrepreneurs it is that they are prone towards trying to do too much with too few resources. They sometimes evoke such metaphors as the soldier on a horse riding off in all directions or the juggler trying to keep too many balls in the air. They can also evoke thought of “The Tortoise and the Hare” from Aesop’s Fables and its lesson, “Slow and steady wins the race.”

The CVC/COIN Project’s achievements in Phase One could hardly be more impressive. However, the Project too often sacrificed quality to quantity when it added on activities that were not provided for its original budget and work plan. Going too fast and doing too much, it also wasted financial resources on certain staff members who were allowed to continue not doing what they were employed to do for too long and on consultants whose products were not up to acceptable standards. This waste was less the fault of those individuals than it was the fault of the Programme Manager, who should have been spending more time at his desk attending to his management responsibilities and less time in the field participating in so many activities.

As the CVC/COIN Project moves into Phase Two, its Programme Manager and Project Unit need to take the time to reflect on everything they did in Phase One and to draw lessons from its monitoring and evaluation activities. Among the lessons this consultant draws are:

- Effective prevention of HIV and AIDS requires, first and foremost, getting the most appropriate preventive supplies (e.g., male condoms, water-based lubricants, female condoms, clean needles and syringes, hygiene products) into the hands of those who need them. In Phase One, many CVC/COIN-supported projects were unable to do this consistently. There is obvious need to pay more attention to improving procurement and distribution systems and this is probably best done at national level.

- Effective prevention requires either getting people to the services they need or getting services to the people who need them. Clearly, getting services to the people who need them is the more effective option. There is obvious need to pay more attention to providing mobile services whether via well-equipped vans or via temporary clinics that can be set up almost anywhere.

- Effective prevention requires user-friendly services of high quality and the best way of improving the user-friendliness and quality of services is from the inside out, so that health service providers are challenged to demonstrate they know the communities they are meant to serve and are serving those communities as well as possible. The REDNAJCER project described in Annex E1 is a step in that direction. Something else to consider in Phase Two would be to advocate for and support a pilot project that undertakes a system-wide quality improvement programme in a national health care system, with particular focus on improving the quality of sexual and reproductive health services to vulnerable and marginalized populations.78

- Getting people to take up offers of preventive supplies and services requires highly effective IEC that constantly puts out engaging and fresh messages and reminders to the people who most need to receive them. There is obvious need to pay more attention as to exactly how best to get engaging and fresh messages to the culturally, linguistically and otherwise diverse marginalized and vulnerable populations typical of Caribbean countries. The CVC/COIN project’s research and the experience of a number of the CVC/COIN-supported projects described in the Annexes to this report give strong indications that music, theatre and other forms of mass entertainment or live entertainment can be very effective at engaging people’s attention. Highly

78 GIZ (2012a).
interactive interventions delivered by skilled group facilitators, animators and
performers can also be effective. By some combination of innate ability and training,
some peer educators are very effective at delivering prevention messages too.

- Although used often in this report and by the CVC/COIN Project and the CSOs that
  participate in it, the term “peer educator” might best be put to rest. COIN-supported
  projects often use terms such as “health messenger” or “health promoter” and these
  terms make room for the possibility that a person’s peers are not necessarily people
  whom a person is most likely to find it easy to listen or talk to. Of the peer educators
  who helped inform the project write-ups in the Annexes to this report, some female
  peer educators said they felt it easier to establish rapport with MSM than with anyone
  else. Some gay peer educators said they felt it easier to establish rapport with female
  sex workers than with anyone else. Young adolescents often find it difficult to be
  open and honest with their peers and prefer, instead, to talk to an older and more
  experienced person outside of their own social circles. The Este Amor project
  described in Annex A3 found that young gay men can sometimes be very effective at
  reaching out to older adults of almost any kind and might be a very effective at
  reaching closeted MSM.

- “It’s anal sex, stupid!” and “Your teenage children are doing it too, duh!” might well be
  themes of advocacy campaigns aimed at politicians, educators and religious leaders
  who refuse to face up to the realities of contemporary life and who imagine that
  adolescents and young adults really listen to abstinence-only messages or that they
  don’t do things that would shock their great grandmothers.

- In otherwise comparatively liberal and democratic societies, it is more often the case
  that oppressed people liberate themselves than that they are liberated by other
  people. If necessary, they march in the streets chanting, “We’re here! We’re queer!
  Get used to it” J-FLAG’s soft but self-liberating “We are Jamaicans” campaign is a
  breath of fresh air and so is the positive approach to self-liberation taken by the Ashe
  Company (see Annex B4). Also very positive are the approaches taken by COIN’s
  YurWorld Programme and FURJUG (see Annex E3) that encourage youth of all
  descriptions to think of themselves as one community working with common purpose.

- Approaches that encourage people to think of themselves as victims and to blame
  others for their misfortunes can easily serve to discourage them from taking
  responsibility for their own attitudes and behaviour and to defeat them before they
  even get started on improving their own circumstances and those of their peers. One
  or two of the projects described in the Annexes to this report demonstrate that a “you
  are a victim” message is also not always a very effective way of getting people to
  participate in any kind of event. In general, people would rather think of themselves
  as invincible heroes.

- If an emerging new and small CSO has no more than five or ten active members, if it
  has no record of tangible achievement, if it offers no services, and if it cannot get any
  more than a handful of people to attend its events then there is every reason to doubt
  any claims it may make to represent and serve a large category of people. If its
  founding executive director is one of the main beneficiaries of a grant given to that
  CSO and if the CSO achieves little with that grant then there is good reason to
  question the executive director’s leadership abilities and motives.

- Many of the most successful projects described in the Annexes to this report were
  implemented by CSOs that had emerged from COIN or JASL programmes and that
  still had close relations to COIN or JASL and could turn to them for technical support.
  In effect, COIN and JASL act as technical support facilities for other CSOs in their
  countries. As the CVC/COIN project moves into Phase Two it might look for CSOs
  (respected and trusted by other CSOs) in those countries that already serve as
technical support facilities or that might be able to serve that purpose, given a little capacity-building.

- There may be as many as 500,000 or more MSM in the Caribbean. There are hundreds of thousands of sex workers, thousands of drug users whose particular drug-using and sexual habits put them at high risk of HIV infection, and millions of marginalized youth who are at high risk of infection. Clearly, scaling up and sustaining responses to HIV and AIDS among these populations will require governments to play leading roles. While elected politicians may have been no friends of MSM and other vulnerable populations in the past, it will be in the best interests of those populations if CVC and its member organizations do their best to win over elected politicians as their allies and friends. Meanwhile, they should cherish and nurture any partnerships they already have with Ministers and Ministries responsible for health and social services and education. Towards that end, they should seize opportunities to offer their collaboration in government initiatives and to invite government collaboration in their own initiatives.
Part Five: Conclusions and recommendations

CVC/COIN Phase One was an outstanding success

The Global Fund’s diagnostic assessment and A1 rating

The Caribbean Community (CARICOM) Secretariat is named as the Principal Recipient (PR) of the grant for PANCAP’s five-year (2011-2015) Round 9 Global Fund Project. During Phase One, there were seven Sub-Recipients (SRs): Education Development Centre (EDC), Caribbean Med Labs Foundation (CMLF), Caribbean Health Research Council (CHRC), University of the West Indies (UWI), Organization of Eastern Caribbean States (OECS), PANCAP Coordinating Unit (PCU), and El Centro de Orientación e Investigación Integral (COIN). COIN was the SR responsible for administering the budget allocated to Phase One of the CVC/COIN Vulnerabilized Groups Project.

From 9 to 27 July 2012 — roughly three quarters of the way through Phase One of the whole PANCAP Round 9 Global Fund Project, a team from the Office of the Inspector General (OIG) of the Global Fund visited the Caribbean to do a diagnostic review. The resulting report was released on 2 October 2012 and said, “The diagnostic review observed a strong, well-managed program that responded to its objectives of supporting national capacity in the response to HIV using a regional approach, and many good practices were noted.”

It described eight good practices and attributed the following three to the CVC/COIN Project:

- “The work of COIN and CVC to identify and characterize sub-groups of people that are highly vulnerable to HIV infection, and to develop tailored and innovative programs to reduce their vulnerability is exemplary, as is the work with groups that have so far received little attention because their existence was not known or acknowledged (for instance injecting drug users, adolescent male sex workers, and homosexual adolescents).
- “The rights-based approach applied by COIN and CVC in their work with adolescents of all sexual orientations is a promising step towards creating awareness and tolerance of sexual diversity in Caribbean society.
- “The data collection form developed by COIN/CVC for outreach and peer support activities among vulnerable groups is highly appreciated by the peer activists and is a promising tool to strengthen the capacity of community-based organizations to monitor their activities.”

On 8 November 2012, the Global Fund gave Phase One of the PANCAP Round 9 Global Fund Project its highest grant performance rating: A1 or excellent. Given how often the OIG’s October 2012 report gives favourable mention to the CVC/COIN component of the overall project, there can be little doubt that its contribution to that rating was significant. While the OIG’s diagnostic review “observed a strong, well managed program” it also observed a number of “risks in the areas of program design, implementation and monitoring”. It recommended a number of “mitigating actions” to reduce these risks in Phase Two. Of particular interest, it recommended:

- “A revised performance framework … with indicators and targets that are more closely aligned with the program objectives and with the epidemiology of HIV in the Caribbean.” This recommendation would appear to have arisen, at least in part, from

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80 http://portfolio.theglobalfund.org/en/Grant/List/MAC
CVC/COIN’s complaint that the targets set in the Phase One Framework were too few and too quantitative. These targets did not reflect the need for improvements in both the quantity and quality of preventive education, supplies and services tailored to the needs of particular marginalized and vulnerable sub-populations. Nor did they reflect the need to create an enabling environment where the basic human rights of everyone are recognized and all marginalized and vulnerable people are treated with compassion and respect by health care providers and others.

- “Greater emphasis on synergies among the Sub-Recipients” so that “the individual activities of SRs fit together in to achieving the common goals and objectives of the grant.” This recommendation is consistent with this consultant’s observation that scaling up and sustaining effective responses to HIV and AIDS among MSM, sex workers, drug users, and marginalized youth will require major commitments by national governments and greater focus by all partners on evidence-based action. This consultant questions, for example, the University of the West Indies (UWI) focus on training academic “experts”. Effective responses to HIV and AIDS are driven by day-to-day practitioners working within health, welfare and education systems and by effective leaders, staff and volunteers from civil society. Training should be on-the-job and focussed on giving all of those directly-involved the knowledge and skills they need to improve their various competencies.

The consultant’s assessment

In 2007, Germany’s GTZ commissioned the consultant to visit the Caribbean and do a write-up of the GTZ Supra-regional Project “Youth and AIDS in the Caribbean” (ProSuRe-GTZ). That project aimed to develop models of good practice in the Dominican Republic, Jamaica and Trinidad and Tobago. The resulting models consisted largely of CSO programmes and projects that have continued to evolve and strengthen and that have provided key elements of the foundations on which the CVC/COIN Project continues to build. Based on ProSuRe’s capacity-building support for those CSO-driven programmes and projects, the German Peer Review Group (a network of German and international experts) found ProSuRe-GTZ to be an example of “good or promising practice” and, as a result, the write-up was included in the German HIV Practice Collection.

Out of ProSuRe-GTZ grew COIN’s YurWorld Programme, which received support for its rapid learn-as-you go approach to capacity-building from GTZ’s BACKUP Initiative. In 2011, GIZ (successor to GTZ and now home of the BACKUP Initiative) commissioned the consultant to visit the Dominican Republic again and do a write up on BACKUP’s support for YurWorld. Based on that write-up, independent peer reviewers from UNAIDS and the International HIV/AIDS Alliance found the BACKUP Initiative to be an example of “good or promising practice”. They cited BACKUP’s support for YuRWorld, in particular, as a “wonderful example --- of best practice” in strengthening the capacity of marginalized groups to qualify for and administer grants from the Global Fund and other donors.

In order to do this assessment, the consultant visited the Dominican Republic and Jamaica from 10 to 19 June 2012 and then visited the Dominican Republic, Jamaica, and Trinidad and Tobago from 17 November to 7 December 2012. During the course of those two visits, he had a chance to do site visits to most of the many programmes and projects supported by the CVC/COIN Vulnerabilized Groups Project and to talk to the leaders, staff, volunteers, and beneficiaries of most all of the CSOs involved. In addition to the two visits, he did a careful review of most of the key documentation.

The consultant strongly agrees with the assessment made by the OIG and with the rating given by the Global Fund, in so far as they apply to the CVC/COIN component of the larger

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81 GTZ (2008).
PANCAP Round 9 Global Fund project. On the whole, Phase One of the CVC/COIN Project has been an outstanding success.

**Frank criticism in preparation for Phase Two**

During Phase One of the CVC/COIN Project, its Programme Manager and Project Unit were extremely ambitious. In effect, they saw Phase One as an opportunity to continue with the rapid learn-as-you-go capacity-building process COIN’s YurWorld Programme had already started in the Dominican Republic and to extend that process to Jamaica and Trinidad and Tobago. Their reasons came down to one overarching reason: Global Fund financing had created a window of opportunity to make up for lost time and, at long last (30 years into the HIV epidemic), establish strong and lasting civil society participation in regional, national and local responses to HIV and AIDS in the Caribbean.

It could be said they were too ambitious and tried to do too much with too few resources in too little time. However, they kept within the budget, implemented the activities and surpassed the targets set out in their Phase One agreements with CARICOM and the Global Fund. In addition, they added on a number of activities that have made significant contributions to the response to HIV and AIDS in the three Phase One focus countries (Dominican Republic, Jamaica and Trinidad and Tobago) and, of equal or greater importance, have taught important lessons that can be applied in Phase Two.

In order to help the CVC/COIN Project draw such lessons from Phase One, the consultant did his best in Part Four of this report to be frank in highlighting any significant weaknesses he observed during the course of doing this evaluation. An evaluation, after all, is a coaching exercise that aims to improve performance, and no one’s performance is improved by a coach who worries overly much about tender feelings. The rest of Part Five will sometimes refer back to Phase One weaknesses and errors highlighted in Part Four, all with a view to helping the Project Unit ensure that Phase Two is even stronger than Phase One.

**It stepped up progress towards CSO empowerment**

**Why this matters**

In the high income countries that have been most successful at stopping the spread of HIV and AIDS, faith-based and other CSOs were providing health, education, social and other services that are now seen to be essential long before governments were doing so. In those countries today, CSOs partner with governments in providing those services and when governments cut back, CSOs are left trying to fill the gap.

The Center for Civil Society Studies at Johns Hopkins University (CCSS-JHU) has long been leading global efforts to change standard accounting practices (including UN accounting practices) that divide all economic activity into “public” and “private” and fail to recognize “civil society” as a third and equally important category. Working with national statistics agencies, the CCSS-JHU has published a series of analyses finding, for example, that:

- In seven high incomes countries for which data was available in 2007, CSOs accounted for an average of 22 percent of value added to GDP by the health sector. In Japan, CSOs accounted for 45 percent of value added to GDP by the health sector; in Canada, for 38 percent; and in Belgium, for 34 percent.
- The sources of CSOs' revenues were, on average: fees and charges 38 percent, private philanthropy (gifts of time and cash) 35 percent, and government payments 27 percent. Typically, private philanthropy and government payments go towards providing services to people who cannot afford the fees and charges.
On average, gifts of unpaid work (including work at lower than market wages) by staff and volunteers surpass gifts of cash and account for 60 percent of the value of private philanthropy. Unpaid work by staff and volunteers makes CSOs very cost-effective ways of delivering services.82

Governments are sometimes best able to provide the core services, but CSOs are usually best able to ensure those services are extended to the poor, illiterate, marginalized and otherwise vulnerable. They do this, in part, by advocating for human rights legislation and enforcement and by providing information, education and communications that create the social and political environments where everyone’s rights to essential services are recognized and respected. They also do it by providing supplementary services that target specific populations with services specific to their needs.

Evidence that CSOs outperform all other grant recipients

In April 2011, the Global Fund published the results of an analysis comparing the performance of all of its grants from 2005 to 2010 by category of Principal Recipient (PR): civil society, government, private, and multilateral/bilateral organization.83 Year after year, grants where CSOs were the PRs outperformed grants where other types of organization were the PRs. In 2010, for example, 52 percent of grants to CSOs met or exceeded expectations. Such was the case with only 31 percent of grants given to government organizations, 40 percent of grants given to private organizations, and 37 percent of grants given to multilateral/bilateral organizations.

A Canadian model of good practice

The early response to HIV in Vancouver, Canada, illustrates the early response typical of North American and Western European countries with comparatively strong health care systems and comparatively good human rights legislation and enforcement. When the HIV epidemic emerged in the early 1980s, the media, general public and politicians were understandably alarmed that people undergoing blood transfusion were becoming infected with HIV, so public health authorities acted swiftly to ensure safe blood supplies.

However, it was left largely to civil society organizations (CSOs) to advocate for and otherwise drive a swift and vigorous response to HIV among gay men, transgender women, sex workers, and drug users. Even in comparatively tolerant Vancouver, these were marginalized minorities and, in the minds of many people, they were “not us and not anyone we know and, anyway, didn’t they bring it upon themselves with their reckless behaviour?”

Prominent among the most active Vancouver CSOs was Providence Health Care, which describes itself as "a faith-based care provider… [offering] … compassionate care … with respect for social justice and diversity … [and taking] pride in serving people who have been marginalized for any reason." Providence Health Care runs St. Paul’s Hospital in downtown Vancouver and it serves, among others, the inner city’s large sub-populations of gay men, transgender women, sex workers, drug users, and marginalized youth (e.g., adolescents from dysfunctional families who have run away from home, live in the streets and earn what money they can by begging, petty theft and transactional sex).

St. Paul’s continued providing compassionate and respectful care to those sub-populations as they began to present with symptoms of the condition that became known as AIDS. A teaching hospital associated with the University of British Columbia, St. Paul’s soon became

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an international centre of AIDS-related research. It was the place where Dr. Julio Montaner and his team — including patients whose essential contributions they recognized by calling them “co-researchers” — did much of the pioneering work that produced Highly Active Antiretroviral Therapy (HAART).

Joining St. Paul’s in its rapid, creative, and effective response to AIDS were many existing and new community-based CSOs representing and serving Vancouver’s marginalized and vulnerable populations. They focussed on public education and advocacy, prevention (e.g., information in local gay and gay-friendly newspapers, posters, brochures, free condoms and lubricants in bars and nightclubs, needle-and-syringe exchange for injecting drug users), early diagnosis (e.g., voluntary HIV counselling and testing at convenient times and places) and health and social care (e.g., home care and hospices) for people living with HIV. They also worked alongside the city’s gay or gay-friendly doctors, nurses and social workers, many in private practice but supported by public health insurance.

Too little too late from international donors

If international donors had recognized that many developed countries had already developed models of good practice, they might have stayed focussed on supporting health ministries, hospitals and health centres on improving their services but only on condition that they take a rights-based approach and serve everyone in those communities. In the Dominican Republic and Jamaica, for example, international donors might have required that national AIDS authorities work closely with country-based CSOs, informal groups and networks that represent and serve vulnerable populations and use horizontal approaches to civil society capacity-building similar to the horizontal approaches taken by COIN and JASL.

Instead, in international forum after international and in international declaration after international declaration they paid lip services to rights-based approaches and civil society participation in national responses to HIV and AIDS but they did not follow through by attaching conditions to their support to national governments or by donating their own financial and technical support to civil society capacity-building. For more on this subject, readers can refer back to Part Two of this report and, in particular, the discussion under two headings: first, International landmarks in creating enabling environments and, second, Wasted spending, austerity and the need to prioritize.

Making up for lost time

As discussed in Part Four under the heading, Advocating for civil society participation, the Fourth High Level Forum on Aid Effectiveness adopted a declaration it called the Busan Partnership for Effective Development Co-operation on 1 December 2011. In Clause 22, that declaration makes the clearest statement yet by developed and developing countries and other international partners that they recognize, “Civil society organisations (CSOs) play a vital role in enabling people to claim their rights, in promoting rights-based approaches, in shaping development policies and partnerships, and in overseeing their implementation. They also provide services in areas that are complementary to those provided by states.”

This would seem to be a significant step forward but it remains to be seen whether this is just more lip service without follow-up. The consultant notes that this Clause is way down at number 22 on page six of the declaration. Insofar as it applies to the “vital role” played by civil society in effective responses to HIV and AIDS, it should be far up the list of Clauses and seen as a priority for urgent action.

Meanwhile, the CVC/COIN Vulnerabilized Groups Project has seized on its share of Round 9 Global Fund financing as a five-year window of opportunity in which it can do its best to make up for lost time and empower Caribbean civil society to live up to its potential to play a vital role in the response to HIV and AIDS in the Caribbean.
It stepped up progress towards “knowing your epidemic”

Why this matters

Over the past seven years, four books have radically changed the way we think about HIV and AIDS:

- Early in 2007 came The AIDS Pandemic: The Collision of Epidemiology with Political Correctness. It was written by James Chin, an epidemiologist who, from 1987 to 1992, was Chief of the Surveillance, Forecasting and Impact (SFI) Unit of the Global AIDS Programme (GPA), World Health Organization. He challenged the way UNAIDS (which replaced the GPA in 1996) produced its annual estimates and projections of HIV prevalence country-by-country and globally, using a one-size-fits-all model that assumed what was already happening in southern Africa would soon be happening everywhere else. What Chin called the “political correctness” of this model was the reluctance to admit that the populations of different countries have different patterns of risky sexual and other behaviour. Some other epidemiologists had been raising the same questions but Chin’s book brought the debate to a head and, in November 2007, UNAIDS released sharply lower estimates and projections of HIV prevalence for many countries. These included lower estimates going back through the years and recognition that, in terms of annual numbers of new infections worldwide each year, the global epidemic had peaked in the mid-1990s.

- Also in 2007 came The Invisible Cure: Africa, the West and the Fight against AIDS. It was written by Helen Epstein, a scientist and investigative journalist, and it revealed that, early on in the HIV epidemic, African villagers and the African and overseas sociologists and anthropologists who studied them had identified local patterns of sexual behaviour that put people at risk of HIV and had also found effective ways of reducing the risk. Most Western “experts” were blind to any epidemiological analyses or “cures” found by locals and imposed their own analyses and “cures”, with tragic consequences. Among the things the African locals knew long before most Western “experts” knew was that when many people in a population have two or more regular sexual partners those who engage in that kind of behaviour (which Epstein calls “multiple concurrency”) are at very high risk of HIV and other STI infection. Having two or more regular sexual partners is common in African countries where polygamy was once common but, today, it is not only men but also women who often have two or three regular sexual partners.

- The third, published in 2008, was The Wisdom of the Whores: bureaucrats, brothels, and the business of AIDS. It was written by Elizabeth Pisani, a journalist-turned-epidemiologist whose curiosity was sparked by her observation that sex workers, gay men and transgender women in Indonesia could tell her a lot more about how HIV is transmitted and how to stop transmission than could officials in the countries’ ministry of health or the visiting “experts” who were (she could not resist observing) among the primary beneficiaries of “the international AIDS industry”.

- The fourth, published in early 2012, was Tinderbox: how the West sparked the AIDS epidemic and how the world can finally overcome it. It was written by journalist Craig Timberg and epidemiologist Daniel Halperin. Their book shows how HIV entered the human population in the Congo Basin 100 or so years ago and might

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84 Chin J (2007).
87 Timberg C and Halperin D (2012).
have remained largely confined to the Congo Basin were it not for patterns of labour migration and rapid urbanization that became common during the colonial era. They also show how maps of HIV infection come close to matching maps of other sexually transmitted infections, that both types of infection are unusually common in populations where people have multiple sexual partners concurrently, and especially if the men in those populations are uncircumcised. (During the colonial era, Christian missionaries discouraged both traditional and medical male circumcision. The evidence now suggests male circumcision was especially beneficial in populations where many people had two or more regular sexual partners.)

Taken together, these four books tell us that there are many different HIV epidemics; the epidemic in one country may be very different from the epidemic in a neighbouring country; within each country there are different epidemics in different sub-populations. They also tell us that the people within sub-populations that have high rates of HIV infection are essential sources of evidence as to what patterns of behaviour and other factors may be contributing to those high rates. People within these sub-populations are also essential sources of evidence as to which interventions are most likely to reduce the incidence of HIV transmission in those same sub-populations.

**Greatly enriching knowledge of Caribbean epidemics**

One result of studies such as those described above is that “know your epidemic” has become a global slogan in campaigns urging national AIDS authorities to do their homework. As discussed in Part Two of this report, national AIDS authorities in the Caribbean were long in the habit of characterizing their epidemics as “predominantly heterosexual.” In 2006 and 2008, national AIDS authorities in Jamaica and the Dominican Republic enlisted the collaboration of JASL, COIN and other CSOs to do those country’s first official serological and behavioural surveys that reached out to MSM, sex workers and drug users. During 2013 the national AIDS authority in Trinidad and Tobago is doing the same.

As discussed in Part Four, during Phase One the CVC/COIN Project completed two series qualitative and quantitative studies of sub-populations within larger populations of sex workers (e.g., migrant Hispanic sex workers in Trinidad) and marginalized youth (e.g., youth who engage in transactional sex in Jamaica). In addition, it gathered a rich body of behavioural and sociological information about the beneficiaries of the many programmes and projects it sponsored.

All of this work has not only greatly enriched understanding of the epidemiology of the epidemic in the Dominican Republic, Jamaica and Trinidad and Tobago but has also greatly enriched the body of evidence on what works in terms of interventions. It has also identified challenges that must be met in the months and years ahead in order to ensure interventions are effective in stopping the spread of HIV and AIDS.
It stepped up progress towards holistic SHRH approaches

Why this matters

In 1994, the UN’s Cairo International Conference on Population and Development (ICPD) resolved to adopt a “Programme of Action” to promote and support comprehensive and integrated approaches to sexual and reproductive health and rights (SRHR), family planning, STIs, HIV and AIDS, and human sexuality and gender relations. It also resolved to ensure that these approaches pay particular attention to the special needs of adolescents for SRHR-related education, information and services.  

The implication was that health and education authorities should be working in unison and collaborating with civil society to promote and support such comprehensive and integrated approaches. They should also be doing their parts to create the legal, political and social environments — with basic human rights legislation and enforcement and widespread public support for human rights — where such approaches are both possible and highly effective.

Tragically, that straight-forward approach to strengthening health and education systems to address all SRHR-related issues, including HIV and AIDS, was waylaid by the United Nations Development Programme (UNDP). In 1992, UNDP established its own HIV and Development Programme running parallel to the WHO’s Global Programme on AIDS (GPA) while explaining that the programme aimed to “mainstream HIV” into many different sectors of countries’ economies. The UNDP set to work arguing for multisectoral and multi-dimensional approaches to HIV and AIDS and then for replacing the GPA with the Joint United Nations Programme on AIDS (UNAIDS) in 1996. In short order, UNAIDS was using its exaggerated estimates and projections of HIV prevalence to raise unprecedented amounts of money to combat just one health condition and much of that money was wasted on everything but strengthening health and education systems.

The abject failure of the approach driven by the UNDP and then by UNAIDS became abundantly evident in the mid-2000s, when it became clear that the epidemiology was all wrong, that billions of dollars had been wasted, that very little money had gone to the country-based CSOs that represent, serve and understand vulnerable populations on the front lines of the epidemic, and that very little had been done to address the human rights violations that were preventing these vulnerable populations from having access to HIV-related services that met their needs.

One tragic absurdity of this approach is it promoted and supported stand-alone HIV and AIDS programmes, projects and facilities right across the developing world. These were branded with words, acronyms and logos that became so well known that anyone taking up offers of the services offered by these entities was also branded as someone known or suspected to have HIV or AIDS and to belong to one of the populations known to be vulnerable to HIV and AIDS. Sexually active young adults stayed away in droves for fear that they might be branded as MSM, sex workers, clients of sex workers, drug users, people living with HIV, or sexually active before or outside marriage.

To counter the effects of their own conspicuous branding, these entities promoted and supported all manner of effort to counter “stigma and discrimination” without stopping to consider what they were doing to create the situations in which stigma and discrimination occurred.

This consultant has seen countless examples of this sort of absurdity in action. To mention just one, a UN peace-keeping operation established a clearly branded HIV and AIDS unit at one end of a corridor in its main hospital in early 2008. The unit opened with a coordinator and his assistant, added a doctor and counsellor for VCT in July and added a nurse to

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88 UN (1994).
support VCT in November. By February of 2009, this five-person unit (burning through a budget of US$1 million per year) had provided VCT to only 9 individuals, only one of whom tested positive. That one had been referred by another of the hospital’s doctors for testing because he had symptoms. This operation had 1,000 civilian and 12,000 military personnel on site at any one time and, due to rotations of military personnel, had 25,000 different individuals among its personnel each year. Interviews and focus group discussions with medical staff in the rest of the main hospital and in the operation’s satellite hospitals and with selected military and civilian personnel quickly revealed why the HIV and AIDS unit was having so little success. Most people refused to go anywhere near the unit for fear of being seen and reported as someone who might have contracted HIV and, in the case of military personnel in particular, as someone who might have participated in sexual and other activities that were not only disapproved by their officers and peers but strictly forbidden by their particular army’s regulations. (In many countries, soldiers are not protected by human rights legislation that applies to civilians. In any case, soldiers in UN peace keeping operations are often attached to army units from countries where same-sex activity is illegal.)

**Back to the future envisioned in Cairo in 1994**

In recent years, international partners in the response to HIV and AIDS have been turning their gaze back to the future envisioned in Cairo in 1994. The UN General Assembly’s 2005 World Summit resolved to add “universal access to reproductive health by 2015” as a new target under Millennium Development Goal 5 (where the main target is to have reduced maternal mortality by three-quarters from 1990 to 2015) and specified that this should be done using the comprehensive and integrated approach to SRHR recommended by the ICPD.89 The UN General Assembly’s 2006 Special Assembly on HIV/AIDS endorsed that resolution while noting that the comprehensive and integrated approaches recommended by ICPD would also greatly accelerate progress towards MDG 4 (to have reduced under-five mortality by two-thirds from 1990 to 2015) and MDG 6 (to have halted and reversed the spread of HIV and AIDS).90 The UN General Assembly’s 2010 Millennium Summit again emphasized that countries should advance towards the comprehensive and integrated approaches called for by the ICPD in 1994.91

**CVC/COIN’s support for SRHR within primary health care**

Already seen to be strong and innovative, COIN’s YurWorld Programme was charged with responsibility for overseeing the marginalized youth component of the CVC/COIN Vulnerabilized Groups during Phase One. One of its assignments was to continue developing its Youth Health Centre (CeSaJo) into a model of good practice to which partners all across the Caribbean can turn for inspiration. This work will continue into Phase Two and the whole approach is to provide HIV-and-AID-related services within the context of broader SRHR services, to provide SRHR services within the even broader context of primary health care services, and to provide all of these services within the much broader context of safe space for all youth that offers not only health services but also opportunities for recreation, entertainment, cultural experiences, and education and job training. The aim is to make all youth feel comfortable entering CeSaJo and to make them feel safe slipping away from other activities, entering the clinic and taking up offers of whichever primary health care services they need, all in such a way that other youth at the centre have no way of knowing which specific service they received.

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89 UN (2005).
90 UN (2006).
91 UN (2010).
YurWorld played an active role in supporting a number of Phase One initiatives and one of these was the FURJUG project described at length in Annex E3. That project involved all youth in poor barrios of Santo Domingo and got them working together regardless of their sexualities, gender identities, gang loyalties, and other personal characteristics. It found that HIV and AIDS were far from the only health problems facing youth and that unwanted pregnancy, unsafe abortion and temptations to participate in transactional and commercial sex were high on their own lists of concerns. All such problems might better be addressed by primary health care services that embrace SRHR services and SRHR services that embrace HIV-and-AIDS related services.

It did an exemplary job of monitoring and evaluation

The CVC/COIN Project Unit has been unusually diligent in working with CSOs to develop monitoring and evaluation tools and plans, training staff and volunteers to use the tools and implement the plans and insisting that they submit monthly reports on quantitative and qualitative results. In addition, it has conducted its own assessments of a number of the Project’s components, including the training and mobilization of peer educators and their impacts on the beneficiaries of peer education. It has aggregated, analyzed and summarized some of the results in Quarter and End of Phase 1 Reports to the CARICOM and the Global Fund. And it has asked this consultant to review the products of those exercises and do the additional documentation and evaluation of which this report is the result.

Together, all of the reports resulting from all of that monitoring and evaluation have provided the Project Unit, all CSOs participating in the Project and all national AIDS authorities and other partners of the Project with a deep and rich body of evidence on which to base future action.

Now it’s time to draw lessons and apply them

Phase One was the two-year, foundation-laying phase of the five-year (2011-2015) CVC/COIN Vulnerabilized Groups Project. Whether, at the end of the Project, independent evaluators will look back and conclude that it was a model of good or excellent practice remains to be seen. Within the constraints of time and budget, this consultant has attempted to identify the Project’s strengths and weaknesses and to describe these in considerable detail in Part Four and the Annexes of this report.

It is now up to the Project Unit to play the lead role in: first, digesting this report and the many reports produced by the Project’s other monitoring and evaluation exercises; second, drawing lessons; third, applying these lessons during Phase Two. The general aims should be to strengthen anything that is now weak and to avoid repeating errors and, in effect, “throwing good money after bad.”

The consultant suggests that, while doing those things, the Project Unit might be inspired by a vision of itself as a “lean, mean fighting machine” that will qualify for the finals and then win the cup. It might envision the cup as final judgement by two or three independent evaluators (selected jointly by CVC/COIN, CARICOM and the Global Fund) that the Project deserves to be recognized as a model of best possible practice based on seven criteria. The first five of these are the criteria used by the OECD’s Development Assistant Committee and the remaining two are additional criteria used by the German Health Practice Collection. (See the discussion in Part Four under The importance of using standard terminology.) These seven criteria are:

1. **Relevance.** To earn top marks for relevance, CVC/COIN will have to:
   a. Continue doing what it can to provide up to up-to-date and sound serological, behavioural and sociological evidence pertaining to many different sub-populations of MSM, sex workers, drug users and marginalized youth.
b. Continue doing what it can to identify, support and monitor and evaluate interventions that have credible potential to promote SRHR and stop the spread of HIV and AIDS among those sub-populations. “Credible” implies due diligence to ensure that participating CSOs have the leadership and track records making it likely they will be capable of producing results if given financial and technical support.

2. **Effectiveness.** To be given top marks for effectiveness, CVC/COIN will have to strengthen collaboration by partners in the public, civil society and private sectors in order to identify, support and monitor and evaluate a mix of small- and large-scale interventions and to demonstrate that, collectively, they can be scaled up and sustained until they substantially improve SRHR and HIV and AIDS prevention among MSM, sex workers, drug users and marginalized youth.

3. **Efficiency.** To be given top marks for efficiency, CVC/COIN will have to focus on a mix of small-scale interventions that have knock-on effects (e.g., by planting the seeds for significant change in laws, law enforcement and public attitudes) and other interventions that can be delivered at costs national governments and international donors are willing to cover.

4. **Impact.** To be given top marks for impact, CVC/COIN will have to provide evidence not only of significant outputs (e.g., number of people trained as peer educators and portion of target populations reached by peer education) but of significant outcomes (e.g., increased uptake and effective use of preventive supplies and services, measurable decreases in annual incidence of HIV and AIDS).

5. **Sustainability.** To be given top marks for sustainability, CVC/COIN will have to provide evidence that the attitudes and behaviour of the general public, elected political leaders and public health and other authorities have changed to the point where they recognize that civil society can make important contributions to SRHR and are ready to provide civil society with much of the support it needs to realize its potential.

6. **Participatory and empowering.** To be given top marks for being participatory and empowering, CVC/COIN will have to provide evidence that all of its actions are transparent; that it has developed IEC media and content of sufficient quality that it can be considered up-to-date and reliable and is provided in words (in the Caribbean’s main languages and dialects) that most literate MSM, sex workers, drug users, and marginalized youth (or, at least most staff and volunteers of the CSOs that represent and serve them) can readily understand. In addition, CVC/COIN will have to continue giving significant numbers of MSM, sex workers, drug users, and marginalized youth opportunities for involvement in research, planning, implementation, and monitoring and evaluation.

7. **Gender aware.** To be given top marks for being gender aware, CVC/COIN will have to continue doing its best: to embrace people of all sexualities and gender identities in its work; to promote and support understanding and collaboration among these people; to plan and deliver interventions that address the needs of each but do not discriminate against the others. In short, CVC/COIN will have to continue promoting and supporting the YurWorld approach.

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**Recommendations for the CVC/COIN Project**

It would be possible to restate, as recommendations, many of the observations made in Part Four and some of the conclusions given in Part Five. Here, the focus will be on just a few broad recommendations. These are all presented in full recognition of the fact that, given the limits of time and budget, the CVC/COIN Project’s Phase One achievements were extraordinary and the Project will continue to be constrained by time and budget in Phase Two. Within those constraints, the Project should do what it can to:
1. Pay careful attention to managing the Project Unit and its limited resources as efficiently and effectively as possible, ensuring that all staff and consultants are given whatever supervision, training and administrative support (e.g., good filing and communications systems) they may need to make best possible use of their time and to deliver products and services of high quality.

2. Pay careful attention to developing the internet-based systems and content necessary for effective communications between the Project Unit and all other stakeholders in the CVC/COIN Project.

3. Give high priority to supporting the CSOs implementing CVC/COIN-supported projects with:
   a. Procurement and distribution systems that deliver the ideal package of preventive supplies (male condoms, female condoms, lubricants, needles and syringes, hygiene products) to fit the needs of each different sub-population.
   b. Mobile clinics — i.e., vans or portable stations — to take services to the various sub-populations that need those services.
   c. User-friendly services of high quality, by challenging health authorities and health care providers to collaborate with the different sub-populations they serve and on service planning and delivery.
   d. Effective IEC that constantly puts out engaging and fresh prevention messages and reminders to the people who most need to receive them, so they take up offers of preventive supplies and services and used them correctly.
   e. Logistical support in recognition of the fact that getting their staff and volunteers to and from intervention sites is a major barrier preventing CSOs from realizing their potential to contribute to SRHR and HIV and AIDS prevention.

4. Give high priority to human rights campaigns that:
   a. Win over the general public and their leaders with stories that put a human face on human rights violations, on hatred and discrimination and on bullying and other forms of verbal and physical abuse.
   b. That can be scaled up through mass media, so they are not just “preaching to the converted.”

5. Continue collaborating with national AIDS authorities and other partners on the provision or more, better and continually updated serological, behavioural and sociological evidence. Recognize that the staff, volunteers and beneficiaries of organizations, informal groups and networks that represent and serve particular sub-populations are almost invariably the best sources of information about those sub-populations; also that information gathered through informal interviews, focus group discussions and casual encounters is almost invariably richer and deeper than information gathered through formal surveys. (People who design questionnaires often lack the knowledge to ask the right questions and probe for answers that might shed light, for example, on exactly why it is that crack cocaine users are so much more likely to become infected with HIV than many other categories of drug user.)

6. Work closely with national health ministries and national AIDS authorities on identifying and supporting SRHR and HIV and AIDS interventions that have good potential to be scaled up and sustained beyond 2015, when Round 9 Global Fund financing expires.

7. Establish the Project Unit as CVC’s permanent technical support facility and build its capacity to provide such support, in part by expanding the donor base so the Unit
itself and CVC and its member CSOs do not depend on the Global Fund for their survival.

8. Establish satellite technical support facilities in different countries or clusters of countries based on the models of good practice provided by JASL in Jamaica and by COIN in the Dominican Republic; that is build the capacity of one CSO to provide technical support to other CSOs with each country or cluster of countries, involving all CSOs in selection the one.

**Recommendations for governments and donors**

In 2008, The Foundation for AIDS Research (amfAR) reported the findings of its research into national HIV and AIDS programmes in 126 countries. The report spoke of the “abject failure” of those countries to address HIV among MSM even though they had “alarmingly high rates of infection”. It characterized the failure of both national governments and international donors to support evidence-based responses to HIV among MSM as “an epidemic of denial, indifference and inaction”. 92

As discussed in Part Two of this report, national governments and international donors have equally poor records when it comes to supporting responses to HIV not just among MSM but among sex workers, drug, users and marginalized youth, too. Both national governments and international donors have a lot of catching up to do and, with that in mind, the consultant recommends:

1. That Caribbean national governments and international donors be guided by Clause 22 of the *Busan Partnership for Effective Development Co-operation* and recognize, in particular, the vital role civil society organizations (CSOs) play in responding to HIV and AIDS among MSM, sex workers, drug users, and marginalized youth.

2. That Caribbean national governments and international donors be guided by resolutions adopted by the UN’s Cairo International Conference on Population and Development (ICPD) in 1994 and subsequently endorsed by the UN General Assembly’s 2006 Special Assembly on HIV/AIDS and 2010 Millennium Summit, all supporting comprehensive and integrated approaches whereby HIV and AIDS are addressed within the broader context of SRHR.

3. That Caribbean national governments and international donors collaborate with the CVC/COIN Project and its civil society partners on developing, scaling up and sustaining effective primary health care and SRHR programmes that contain within them effective responses to HIV and AIDS.

4. That Caribbean national governments and international donors collaborate with the CVC/COIN Project and its civil society partners on creating enabling environments for effective SRHR and HIV and AIDS programmes. Ultimately, this may involve the reform of laws but CSOs participating in the CVC/COIN Project are demonstrating it can also be achieved through such means as: more sensitive community policing; campaigns that put a human face on human rights violations, on hatred and discrimination and on bullying and other forms of verbal and physical abuse.

5. That international donors recognize the need to make up for past neglect and increase the civil society portion of their total spending on HIV and AIDS.

6. That international donors consider why the Development Assistance Committee (DAC) of the OECD has been strongly urging against tied aid since 1961. Bilateral donors, in particular, should not be insisting that their money go to international CSOs based in their own countries when country-based CSOs are far better placed...
to “know their epidemics” and how to respond to those epidemics effectively and efficiently.
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Annex A1 (JASL, Jamaica)

Piloting the sexual health approach to peer education among MSM and sex workers

Overview

Jamaica AIDS Support for Life was one of three Caribbean organizations chosen to pilot CVC/COIN’s new sexual health approach to peer education. In phase one (October-December 2011), 16 peer educators from across JASL’s three chapters were given five days of training guided by an early version of the new CVC/COIN training manual; then 13 of them were mobilized to deliver JASL’s basic package of services to 279 MSM and 277 sex workers. In phase two (January-December 2012), 22 peer educators were given additional training in how to engage effectively with existing and potential beneficiaries. During this phase, the peer educators’ feedback helped to refine the training manual, add to and strengthen the basic package of services and identify remaining challenges. They also delivered the enhanced package of services to 1937 MSM, 2676 sex workers and 107 clients of sex workers.

Implementer: Jamaica AIDS Support for Life (JASL)

Founded in 1991, Jamaica AIDS Support for Life (JASL) is the oldest and largest Jamaican CSO dedicated to responding to HIV and creating an enabling human rights environment. At one point, it had five chapters — in Kingston, Montego Bay, Ochos Rios, Portland, and Saint Mary — plus outreach services in Manchester and a hospice. Funding shortfalls have made it necessary to close the Portland and Saint Mary chapters, the outreach services in Manchester and the hospice.

Noelle Ingledew is Chair of JASL’s Board of Governors, Khandesi Livermore is Executive Director, Dane Richardson is Programme Development Manager, and Colette Lawrence is Administrator. Nichole Morris is Prevention Coordinator for the Kingston Chapter. In an informal meeting on 11 June 2012, the five of them discussed JASL’s history and programmes and then focussed in on its peer education efforts.

At first known simply as Jamaica AIDS Support (JAS), JASL began as a group of friends of a gay man living with HIV (PLWH). They were concerned that PLWH were not receiving the health and social care they needed due to the fear, ignorance and prejudice of health care providers and of wider Jamaican society. Jamaica had been a more tolerant country in the 1970s but it became less tolerant after 1982, when the Ministry of Health reported the country’s first case of AIDS.

AIDS was known as “gay-related immune deficiency (GRID)” until 27 July 1982, when a meeting of experts in Washington DC agreed that it was not gay-specific and should be called “acquired immune deficiency syndrome (AIDS)”. However, the mistaken belief that HIV and AIDS are confined largely to MSM has persisted in Jamaica, to the point where many men refuse to buy or use condoms or lubricants or get tested for HIV because they fear people might suspect they are gay. Also contributing to the fear, ignorance and prejudice are socially conservative leaders of Jamaica’s traditional “mainstream” churches (e.g., Anglican and Catholic) and its more popular evangelical and fundamentalist churches (e.g., Seventh Day Adventist and Pentecostal). In addition, some of the socially conservative values of the country’s church leaders — in particular the belief that males should be assertively “masculine” — are reflected in its popular music. It may seem to celebrate sexual expression but it defines acceptable sexual expression narrowly.
Ian McKnight and Robert Carr were founding members and the first and second Executive Directors of JASL. They looked abroad for examples of good practice and found one in Cuba, where the government was providing housing and health and social care for PLWH and equally good treatment of all PLWH regardless of their sexual orientation. With funding from USAID, JASL established as 12-bed hospice in 1992 and, with additional funding from the Netherlands, the hospice achieved a high standard of care. The hospice remained at the core of JASL’s operations and provided hospice care for more than 300 PLWH until it was closed in September 2000 due to lack of financing.

In addition to operating the hospice, JASL provided outreach both to PLWH and to people vulnerable to infection — including MSM, sex workers, prisoners, the hearing impaired, marginalized youth and others. Initially, JASL provided its staff and volunteers with no special training but over the years it has been providing them with an increasingly structured and sophisticated level of training. This has been made possible with the financial and technical support of partners that have included the National HIV/STI Programme (run by the Ministry of Health), PEPFAR (including USAID and World Learning, a PEPFAR-funded NGO), Global Fund, UNAIDS, UNFPA, UN Women, Caribbean HIV/AIDS Alliance, Foundation for AIDS Research (amfAR), and Population Services International (PSI).

JASL’s work has given it close connections to the populations most vulnerable to HIV infection and least able to access effective care, treatment and support. It has supported them in establishing their own informal or legally established organizations and collaborated with these and other organizations on training, programmes and advocacy, always with a view to creating an enabling environment for an effective response to HIV and other STIs.

**JASL’s programmes**

JASL’s programmes are described on its website ([www.jasforlife.org.jm](http://www.jasforlife.org.jm)) and, to a lesser extent, on its Facebook page ([www.facebook.com/Jamaicaaidssupport](http://www.facebook.com/Jamaicaaidssupport)). They are described in greater detail in “JASL Programmes” (available on request via infojasl2010@gmail.com) and they can be summarized as:

1. **HIV education and prevention including:**
   a. General population outreach through schools, churches, businesses and community groups
   b. Targeted outreach to vulnerable populations
   c. Peer education
   d. Voluntary counselling and testing (VCT) which, with rapid testing kits, can sometimes be provided by peer educators as they go about their rounds
   e. Facilitated support groups for members of vulnerable populations which sometimes result in them forming their own organizations
   f. Grants educational and income-generating projects
   g. One on one counselling by a psychologist.

2. **Treatment, care and support including:**
   a. Weekly clinics with medical doctors and nurses in each of the three chapters
   b. Care for people living with HIV (PLWH) and their families including CD4 counts, counselling (e.g., on disclosure) and support for treatment adherence
   c. STI testing and treatment and pap smears for detection of infections and early signs of cervical cancer
   d. Distribution of care packages that include nutritional items, medical supplies and toiletries
e. Positive “health and dignity” prevention through support groups and workshops aimed at helping PLWH maintain their physical and mental health and dignity
f. Twice weekly, 9 to 5 p.m. free VCT at all three chapters
g. Home and hospital care with visits by JASL members
h. A programme for orphans and vulnerable children that offers counselling, assistance with school expenses and health care, foster parenting, summer camps, and “Project Smiles” that aims to bring pleasure and joy at Christmas and year-round
i. A Life’s Work Programme that support income-generating work therapy through the production and sale of candles and cards.

3. Advocacy and education, often in partnership with CVC, J-FLAG, SWAJ and other organizations, all aimed at creating an enabling environment for an effective response to HIV

4. Special programmes including an Empowerment of HIV Positive Women Project and a Hearing Impaired Project.

**JASL’s peer educators and their beneficiaries**

JASL now has three levels of peer educator. Those with basic training given during a five-day course and with at least a minimum set of skills are paid the equivalent of US$100 per month. Those with more training (often several courses) and a higher level of skills and commitment are paid US$180 per month and those with an outstanding level of skills and commitment are called Master Peer Educators and paid US$400 per month. Master Peer Educators are qualified to train and supervise other peer educators and they often move on to senior staff positions in JASL or other AIDS service organizations. They also sometimes become founders and leaders of new CSOs. For example, Princess Brown and Marlon Taylor are Master Peer Educators who became the first and second Presidents of the Sex Workers Association of Jamaica (SWAJ).

Each of JASL’s three chapters usually has at least three or four peer educators and three senior staff (a Prevention Coordinator, a Treatment Care and Support Coordinator, and a Programme Assistant) but such is the uncertainty of funding that all are on contracts that make it clear there is no guarantee of long-term employment. Hampered by small budgets, the chapters’ peer educators are seldom able to reach out much beyond the cities and suburbs of Kingston, Montego Bay and Ocho Rios even though they know they should also be reaching out to some of the country’s poorest rural areas, where people often live in informal settlements and engage in behaviours that put them at high risk of infection by HIV and other STIs.

As a general rule, most of the beneficiaries of JASL have low levels of education, high levels of unemployment and earn what money they have in the informal economy. They often come from single parent families and from families and communities where heavy alcohol and drug use, violence, and sexual exploitation and abuse are not uncommon. Yet these families and communities often buy into some of the socially conservative values they learn from church leaders and popular entertainers — even if “buying into” those values is largely a matter of trying to keep up appearances and hide “bad” behaviour. People with higher levels of education, better jobs and more money are often somewhat more tolerant and, in any case, better able to pay for health and social care from private providers.

**Piloting the sexual health approach to peer education**

Under contracts to CVC/COIN, JASL agreed to a two-phase project. In phase one (October-December 2011), CVC/COIN and JASL gave 16 peer educators from across JASL’s three
chapters five days of training based on modules in an early version of the new CVC/COIN training manual. JASL then mobilized 13 of them to deliver JASL’s basic package of services to MSM and sex workers in Kingston and nearby areas. This package included on-the-spot distribution of condoms and lubricants and provision of information, counselling, VCT, and referrals — all enhanced by the peer educators’ new sensitivity to issues surrounding different gender identities and so on, as covered by the training modules.

In phase two (January-December 2012), 22 peer educators from across the three chapters (including the 13 already mobilized) were given additional training in how to engage effectively with existing and potential beneficiaries. During this phase, the peer educators’ feedback helped to refine the training manual, add to and strengthen the basic package of services and identify remaining challenges.

**Results achieved during the pilot project**

Phase one targets were to cover 200 MSM and 200 sex workers. The peer educators exceeded these targets by almost 40 percent and covered 279 MSM and 277 sex workers for a total of 565 individuals.

Phase two targets were to cover an additional 1200 MSM and 1200 sex workers. The peer educators exceeded the MSM target by 61 percent and covered 1937 MSM and exceeded the sex worker target by 123 percent and covered 2676 sex workers. In addition, they covered 107 clients of sex workers.

Throughout the project, JASL and its peer educators applied and expanded on lessons learned during the two training sessions. As well as helping to refine and improve the CVC/COIN training manual, the project helped JASL add to and strengthen its package of services. Enhancements included:

1. Enriching peer educator interventions with the peer-educators’ greater sensitivity to how their words and actions can either offend and alienate or befriend and earn the trust of existing and potential MSM and sex worker beneficiaries
2. Strengthening the peer educators’ capacity to provide appropriate on-the-spot advice and counselling and appropriate referrals
3. Increasing the consistent use of condoms and lubricants and the uptake of all services offered by JASL
4. More on-the-spot provision of testing and other services, since beneficiaries often do not follow up on referrals made by peer educators
5. Bi-weekly meetings of peer educators to review experiences, identify good and promising methods, and identify new sites for interventions. The latter is particularly important because law enforcement measures mean that MSM and sex workers are often obliged to vacate some sites and move to new ones.
6. Extending the reach of JASL into parishes surrounding Kingston, St. Ann (Ocho Rios) and St. James (Montego Bay); fostering new support groups such as one in the parish of St. Thomas
7. Strengthening JASL’s alliances with partners such as the NCDA, SWAJ and J-FLAG; supporting partners with their training and other capacity-building efforts
8. Increased engagement of others (besides sex workers) involved in the sex work industry in spreading prevention messages and supplies and otherwise increasing the safety and security of sex workers.
Challenges identified during the pilot project

1. Safety and security are major issues for all sex workers and especially for those working on the streets because:
   a. They are making money and closely watched by men ready to take that money away from them.
   b. They are in competition with each other and will undercut each other on the prices they charge and the services they are willing to provide (including unprotected vaginal or anal sex).
   c. Sex work often goes hand in hand with alcohol and drug use and with them come greater willingness to take risks and increased tendency for clients to become violent.
   d. They are engaging in illegal activities and subject to police harassment and arrest or simply being forced to vacate some sites and move on to others.

2. Safety and security are also issues for peer educators working among sex workers, especially after 10 p.m. when the same men who threaten sex workers with violence and theft sometimes also threaten peer educators.

3. Young MSM, who are often homeless and who exchange sex for money or favours, are especially challenging when it comes to encouraging them to practice safe sex and to take up offers of testing and treatment. Reasons include:
   a. Having been rejected by family and community, they often feel both worthless and hopeless. This makes them very short-sighted and willing to take risks because they don’t see much point in living anyway.
   b. They fear (and often internalize) stigma and discrimination and are reluctant to take up offers or supplies and services when they think that doing so will mark them as MSM.

4. Police harassment of MSM is intense and often involves their being forced to move from one site to another or to scatter about so there are no known sites where it easy to find them. The peer educators sometimes lose track of them altogether for days or weeks at a time.

5. While male condoms and lubricants are readily available through pharmacies and other retail outlets in Jamaica, it takes both money and courage to buy them and MSM are particularly reluctant to buy them. They are also abundantly available at low cost or free through various social marketing and other programmes. However, they are still often not available when and as they are most needed by sex workers and MSM. They often run out between visits by peer educators and have no immediately available places where they can replenish their supplies. In addition, JASL’s peer educators sometimes find that their own supplies are insufficient to meet the demand when they are working at particular sites.

6. Female condoms are not widely available in Jamaica though they are known to be ideal for female sex workers. Through this project, JASL’s peer educators have learned that MSM who engage in commercial or transactional sex also find them ideal but seldom have access to them.

7. While the new training has made the peer educators better able to provide constructive advice and counselling to MSM and sex workers and while they can refer them to JASL’s psychologists and others, the peer educators observe that the supply of social and psychological support services does not come close to meeting the need for those services.

8. While JASL is doing its best, with its limited resources, to provide on-site STI and HIV counselling and testing and other services to MSM and sex workers, it needs more
resources to enable it to do more. In particular, fully equipped mobile clinics would enable it to deliver its full package of services to the many MSM and sex workers who still do not follow up on referrals made by peer educators.

9. While JASL and its partners are also doing their best to engage with bar owners, police and others who can contribute to the safety, security, health, and well-being of MSM and sex works, there is much more that could be done.

**The way ahead**

In a final 12 December 2012 report on the project, in informal meetings in JASL’s Kingston offices on 11 June and 5 December 2012, and in a 4 December tour of Back Road (a busy street in a distant suburb of Kingston lined with bars, massage parlours and accommodations for sex workers and their clients), JASL staff and peer educators identified the achievements and challenges discussed above. They also discussed how they would like to see the future unfold. It would involve continuing to scale up and strengthen the sexual health approach to peer education and it would pay particular attention to:

1. Sensitizing all stakeholders to the safety, security and health and welfare issues surrounding sex work and turning them into allies in efforts to reduce the harm done to both sex workers and their clients. This would include getting owners and staff of bars and other venues to collaborate in spreading prevention messages, distributing condoms and lubricants and providing STI and HIV testing on site.

2. Reducing external and internalized stigma and discrimination against MSM, including homeless MSM who engage in sex work.

3. Doing more to address alcohol and drug use and its negative consequences among MSM and sex workers. This would involve specific training of peer educators.

4. Increasing access to services, especially by MSM, by providing those services on an outreach basis. This could be done in three ways:
   a. Training more peer educators to do on-site voluntary HIV counselling and testing
   b. Setting up clinics in different venues (e.g., bars and hotels frequented by sex workers) on a regular basis
   c. Well-equipped vans with staff that go to different sites on a regular basis.

5. Providing ready access to male and female condoms and lubricants so they are always available when and as needed.

Nichole Morris, the Prevention Coordinator who oversees peer education provided by JASL’s Kingston chapter, echoed what others were saying when she gave a rating of 8.5 or 9 out of 10 to the training provided to JASL’s peer educators using the modules in the new CVC/COIN training manual. She would not give a higher rating, she said, only because there will always be room for improvement. She and the peer educators said:

1. They would like to see training as per the CVC/COIN manual become the basic training for all new peer educators and also the core of on-going training thereafter, with room left for any other kinds of training that might be appropriate.

2. They would like to see it recognized that further training after new peer educators have considerable on the job experience is essential. They had found the second session of training (in phase two) even more useful than the first (in phase one) because they came to it with a lot of on-the-ground experience in applying lessons from phase one. Thus, they were more ready to share their experiences, raise questions and engage in discussion and debate.

3. They would like to continue training of peer educators and get around to covering all the modules in the training manual in full. The training they had received had been
very intense, had covered some modules less than fully and had not got around to covering other modules at all.

The box below gives some flavour of what JASL’s peer educators do in their daily work and suggests how CVC/COIN’s sexual health approach to peer education is relevant.

**On Kingston’s streets and in its clubs and bars with JASL’s peer educators**

During an informal discussion on the afternoon of 11 June 2012, six of JASL-Kingston’s peer educators (Dwayne Green, Oneil Buchanan, Damehon Thompson, Peter-Gaye Tyrell, Renee Moulton, and Edroy Widdington) talked about who they meet and what they do as they make their rounds. Prominent among their clients are boys 14 or 15 years old who have run away or been cast out by intolerant families and communities that suspect they are gay, if only because of their “insufficiently masculine” behaviour. Some are from the poorer neighbourhoods of Kingston but many are from smaller towns and rural areas.

Unable to find jobs or to afford shelter or nutritious food, these boys often turn to petty theft and commercial or transactional sex to get by from day to day. Internalizing their families’ and communities’ prejudices, they often feel worthless. If they are not overtly suicidal, they are still inclined to engage in highly risky behaviour. They tend to hang together in groups in certain public places, where there are often many witnesses to their interactions with peer educators. This makes it necessary to approach them very discretely and to engage them in casual chat that gradually draws them into focusing on situations and behaviours that put them at risk while, perhaps, drawing them toward spaces where they can talk more freely.

The risk of infection by HIV and other STIs is not generally high on such boys’ own lists of their biggest concerns and the same is true of older MSM, sex workers and drug users. To be effective, peer educators have to be prepared to address the issues of greatest concern to anyone they engage with and this requires that they have many of the skills also required of professional psychologists or social workers. While the work can be very challenging, time-consuming and exhausting, it can also be very rewarding. One peer educator spoke of counselling a boy over many weeks while he attempted suicide repeatedly. He kept being rescued until he decided he was meant to live.

Asked if there were any messages they might wish to convey to the donors who support their work, the six peer educators were unanimous in saying that counting the number of peer educators and the number of people they reach with their interventions is far from a good way to evaluate an effective peer education programme. The most effective peer educators, like the most effective psychologists and social workers, often stick with some of the same clients for days, weeks and months on end. On a typical day, they are dealing with old cases while also taking on new ones and their effectiveness depends on personal attributes they bring to the work, the amount and quality of the training they receive, the amount of on-the-job experience they have and, most especially, their commitment to doing their best to help each client no matter how much time and energy that may take.

In other words, the numbers demanded by donors such as the Global Fund can be deceptive because the most effective peer educators may actually see fewer clients but spend more time with each one. The quality of interventions matters at least as much as the quantity.
Annex A2 (COTRAVETD, Dominican Republic)
Piloting the sexual health approach to peer education among transgender sex workers

Overview

La Comunidad de Trans- Travesti Trabajadoras Sexuales Dominicanas (COTRAVETD) was one of three Caribbean organizations chosen to pilot CVC/COIN’s new sexual health approach to peer education. In September 2011, a mix of COTRAVETD’s existing peer educators and volunteer health promoters (a total of 12 individuals) were given four days of training guided by an early version of the new CVC/COIN training manual. Over the next four months, they applied the lessons they had learned as they continued with their work among transgender and transvestite sex workers across metropolitan Santo Domingo and surrounding areas. In January 2012, they were given an additional five days of training on the wide range of ways in which different individuals perceive their own gender identities and on the most sensitive and effective ways of approaching these individuals.

CVC/COIN provided COTRAVETD with US$20,000 in financing, which covered the pay of 8 peer educators and otherwise helped build the capacity of COTRAVETD to deliver effective interventions and create a more favourable human rights environment for transgender and transvestite sex workers.

Implementer: Comunidad de Trans- Travesti Trabajadoras Sexuales Dominicanas (COTRAVETD)

Nairovi Castillo is the President of La Comunidad de Trans- Travesti Trabajadoras Sexuales Dominicanas (COTRAVETD) or “Community of Dominican Transgender and Transvestite Sex Workers”. In interviews on 15 June and 29 November 2012, she described how COTRAVETD emerged from the Movimiento de Mujeres Unidas (MODEMU) and how it had been building its capacity ever since.

In 1998, Nairovi and two other transgender sex workers, Paloma and Luna, joined MODEMU because it was Santo Domingo’s only sex worker organization and it was present on the streets and in the brothels and bars of the city’s most popular sex work districts, including La Feria and L’Avinida Maximo Gomez. At that time, MODEMU’s other members were all biological female sex workers but there were many transgender and transvestite sex workers serving the same clients in the same places and subject to the same risks, including HIV infection, client violence and police harassment and detainment. MODEMU was providing biological female sex workers with condoms and advice on their human rights, how to negotiate relations with the police and safe sex with their clients and Nairovi and her two friends wanted these same benefits for transgender and transvestite sex workers.

In 2002, MODEMU invited Nairovi, Paloma and Luna and other transgender and transvestite sex workers to a meeting and suggested they form a committee. Before joining MODEMU, most of them thought of themselves as gay men even though they knew they were not like most men who self-identified as gay. Through MODEMU, they learned they might better fit into one of three other gender categories: transvestite males (self-identified males who prefer to dress as females), transgender women (biological males who self-identify as females) or transsexual women (self-identified females born with both male and female biological characteristics and retaining those characteristics into adulthood). Accordingly, they called their committee the Comité de Trans, Travestis y Transexuales Trabajadores Sexuales.
The committee received its first funding (administered by MODEMU) from CONECTA, a five-year (2002-2007) Family Health International (FHI) programme financed by USAID. With this support, more transgender and transvestite sex workers received training as peer educators and were given supplies of condoms so they could do among transgender and transvestite sex workers as MODEMU was doing among biological female sex workers. In 2005, they were invited to join the CVC, work with COIN and attend a joint CVC/COIN workshop (financed by UNAIDS) to discuss the issues faced by all sex workers and formulate plans of action. In 2008, they attended a second CVC/COIN workshop and out of it grew their decision to establish their own organization, no longer a committee of MODEMU but still closely aligned with it as well as with CVC and COIN. Thus, COTRAVETD was born.

Since 2008, with financing from France Expertise Internationale (FEI), COTRAVETD has developed a constitution and by-laws and applied for legal registration as a charity. This was achieved in December 2012, so COTRAVETD can now receive and manage grants directly, rather than depending on MODEMU to do this on their behalf.

**COTRAVETD’s work**

COTRAVETD’s office and safe space for transgender and transvestite sex workers are currently located in the Centro Salud Joven (CeSaJo) where COIN’s YurWorld programme has its offices, safe spaces and clinic. COTRAVETD has three committees with ten members each and these focus on health, security, and education and employment. The latter committee addresses illiteracy among transgender women, many of whom dropped out of school at an early age due to intolerance and bullying by their classmates and teachers. The membership of COTRAVETD overlaps with the membership of Trans Amigas Siempre Amigas (TRANSAA) — which grew out of the gay organization Amigos Siempre Amigos (ASA) and serves all transgender women (not only sex workers) — and the two organizations collaborate on many activities.

Among COTRAVETD’s current initiatives are:

- **Kits de Batalla.** COTRAVEDT participates in a project supported by the Heartland Alliance where the strategy is to approach individuals or small groups with *Kits de Batalla* (“Battle Kits”) and then talk about their contents and how to use them as a way of delivering peer education. Each kit is a fashionable pouch (with a strap that can be slung around a neck or shoulder) containing condoms, lubricant, hand sanitizing cream and two brochures, one on primary health care and hormone therapy and the other on transmission of HIV and other STIs. This project recognizes that peer education has to be a continual process for each beneficiary, with repeated interventions to reinforce prevention messages and replenish supplies in the kits.

- **Tal Cual.** With start-up financing from FEI and the Foundation for AIDS Research (AmfAR), COTRAVETD works with COIN’s YurWorld programme to provide transgender-appropriate HIV and STI prevention, counselling, testing and treatment within the broader context of transgender-appropriate primary health. This project is known as *Tal Cual* ("As I Am") and it paid for the development of information, education and communications (IEC) material. Until recently, it gave COTRAVETD once-per-month use of COIN’s mobile clinic, taking services directly to beneficiaries, but COTRAVETD now provides referrals (and sometimes accompaniment) to the CeSaJo clinic.

- **El Encuentro con Mama.** With start-up financing from the United Nations Development Programme (UNDP), COTRAVETD established a mutual-support group called *El Encuentro con Mama*, now loosely translated as “Wednesdays with Mom”. This group brings younger transgender women together with an older and more experienced
transgender woman on a regular basis and they talk about any issues that may be on their minds. Frequent topics include social and psychological issues surrounding their self-identification as transgender women and needs for: a more friendly human rights environment; education and employment; transgender-appropriate primary health care that covers hormonal therapy and anal health (including prevention of HIV and STIs); transgender-appropriate mental health care. Among the experts invited to attend “Wednesdays with Mom” are medical doctors, psychologists and lawyers. These events attract 40 to 50 transgender women from Santo Domingo and nearby southern provinces. Providing them with refreshments is a significant but necessary expense, since it helps create informal social atmospheres conducive to open and honest exchange of information and opinion. Financial constraints mean they have had to reduce the number of these events from twice per week to once per week and then to twice per month and sometimes only once per month.

The financing agreements with FIE and AmfAR have expired. COTRAVETD hopes to get more financial and technical support from those and other sources but, currently, its main sources of financial and technical support are the Heartland Alliance, MODEMU, COIN, and the CVC/COIN “Vulnerabilized” Groups Project.

**The most vulnerable of all vulnerable groups**

When CVC/COIN did its mid-2011 studies into the characteristics, knowledge, attitudes and practices of vulnerable groups in the Caribbean,93 COTRAVETD played a central role in identifying and interviewing 90 transgender and transactional sex workers in the Dominican Republic. Discussed at greater length elsewhere in this report, findings included that these 90 were an average of 22.7 years old, 23 percent had no more than a primary level of education and only 34 percent had graduated from secondary school.

While 60 percent said they always used condoms with their regular partners, 74 percent said they had difficulty negotiating condom use and this was most often the case with their regular partners and local clients (i.e., not tourists.) One-third said they had experienced physical violence by their clients and 71 percent had experienced mistreatment by the police, while 36 percent had had sex with police to avoid arrest. Many had experienced condom breakage during rough sex and one-third did not know where they could go to receive HIV-related services.

A recent article in Lancet says that few countries are able to provide reliable estimates on HIV prevalence among transgender women, including transgender sex workers. Among the fifteen countries for which estimates are available, HIV prevalence among transgender women averages 19.1 percent and is 43 times HIV prevalence among all adults.94 Discussed at greater length elsewhere in this report, a 2008 serological and behavioural survey in Dominican Republic found that HIV prevalence among all MSM was 6.1 percent but 17.2 percent among those who self-identified as transgender women, compared to 10.8 percent among those who self-identified as gay and 4.3 percent among those who self-identified as neither transgender nor gay.95

In Dominican Republic as elsewhere, there is considerable overlap among vulnerable groups. Many poor and disenfranchised youth are MSM, many MSM are sex workers, many sex workers are drug users, and many drug users are prisoners or ex-prisoners. Found among the members of all of those groups are transgender women and transvestite men and they are subject to stigmatization and discrimination even within those groups.

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95 COPRESIDA (2009).
Nairovi says that most transgender women have intensely painful experiences: trying to understand and accept where they fit in the gender puzzle; trying to cope with intolerance and bullying within their families, schools, communities, and any other vulnerable groups to which they belong; trying to cope with the lack access to education, health, social and other services tailored to fit their needs and delivered by non-judgmental and compassionate service providers who are sensitive to those needs. All of this makes them highly susceptible to feelings of worthlessness and hopelessness and consequent failures to act in their own best interests.

Piloting the sexual health approach to peer education

In September 2012, COTRAVEDT chose 12 individuals from among its existing peer educators and volunteer health promoters to undergo four days of training guided by an early version of the CVC/COIN training manual and delivered primarily by the main author of that manual, Alex Vega.

These 12 freshly trained peer educators and volunteers then spread out to the many locations where transgender and transvestite sex workers meet their clients. These include streets, parks and other outdoor areas and also private homes, hotels, clubs, bars, grocery stores, and other indoor venues throughout metropolitan Santo Domingo and the southern part of the Dominican Republic. While many transgender and transvestite sex workers are easy to reach, others have be sought out through their friends and acquaintances so they can be given condoms and lubricants, be shown how to use them and be provided with educational material, counselling, referrals (and sometimes accompaniment) to the CeSaJo clinic or other health services and, also, be invited to become members of COTRAVETD or, at least, visit its offices and safe space at CeSaJo.

In January, after they had four months of experience applying lessons for the first round of training, the 12 peer educators and volunteers were given an additional five days of training on the wide range of ways in which individuals perceive their own gender identities and on the most sensitive and effective ways of approaching them. Again this training was guided by an early version of the CVC/COIN training manual but this time it was delivered by a team consisting mainly of Alex Vega and two experienced outreach workers and facilitators from COIN, Mariluz Martinez and Francis Taylor.

In addition to providing the training, CVC/COIN provided COTRAVETD with US$20,000 in financing. This covered the pay of 8 of COTRAVETD’s peer educators and otherwise helped build COTRAVETD’s capacity to deliver interventions and create a more favourable human rights environment for transgender and transvestite sex workers.

Results achieved during the pilot project

Attending the 29 November interview with Nairovi was Juan Gomera, who wrote COTRAVETD’s end-of-project report. It credits the project with having empowered COTRAVETD with trained peer educators and volunteers:

1. who understand that their responsibilities include promotion of justice and awareness that transgender and transvestite sex workers have basic human rights
2. who have the knowledge, skills and tools to change the risk-taking attitudes and behaviours of transgender and transvestite sex workers
3. whose interventions help transgender and transvestite sex workers avoid attracting the kind of negative attention that contributes to prejudice and discrimination against them.
The project began with two specific targets and exceeded both as follows:

1. Whereas it aimed to train only 6 peer educators, it trained 12 peer educators and volunteers. According to Nairovi, these 12 together with COTRAVETD’s additional volunteers are enough to serve the organization’s purposes until such time as it is ready to reach much beyond metropolitan Santo Domingo and surrounding areas.

2. Whereas it aimed to reach 1000 transgender and transvestite sex workers with peer education and other interventions, it had reached 1281 by early December 2012.

Financing for the project and additional support from COIN and its YurWorld programme contributed to the following actions:

1. An unspecified number of transgender and transvestite sex worker took up offers of primary health care and HIV and STI testing, care and treatment at the CeSaJo clinic and other clinics.

2. COTRAVETD was able to engage with more Haitian transgender and transvestite sex workers than in the past. This gave them a better sense of how many of them there are and how extreme the prejudice and discrimination against them is, in part simply because they are Haitian and in part because they are triply liable to police harassment and arrest because they are trans, they are sex workers and they are undocumented migrants.

3. COTRAVETD was able to participate in:
   a. CVC-COIN’s first national consultation on sex work, including a panel discussion where its members had opportunities to relate their experiences with client violence, police violence and harassment and so on
   b. CVC-COIN’s first national consultation on disenfranchised youth
   c. CVC-COIN’s first workshop on media awareness, where Nairovi had opportunities to highlight police violations such as stealing money and demanding sexual favours from sex workers
   d. November 2012 hearings before the Inter-American Commission of Human Rights where Nairovi spoke in favour of mechanisms to prevent institutionalized violence against all LBGT people and for better training of authorities in the human rights of transgender women in particular
   e. 12 interviews on television and radio interviews.

**Challenges identified during the pilot project**

During the course of the project, COTRAVETD identified the following challenges:

1. **Making lessons easier to understand and digest.** In her interview on 29 November 2012, Nairovi described the four-day September training workshop as superb and the five-day January workshop as very useful but highly technical and sometimes difficult for COTRAVETD’s peer educators and volunteers to follow. She said they depended on Francis Taylor to put things into less technical, more colloquial language they could more easily understand. (A native of the Dominican Republic, Francis is an LGBT activist, an expert in drug use and harm reduction, and an experienced facilitator with a background in theatre and acting.) She also said that transgender and transvestite sex workers often have low levels of formal education and are not used to sitting in classrooms and having to pay careful attention for long periods of time. It might be better to break-up the training into more digestible bits of two or three days at a time and to have trainers with backgrounds somewhat similar to those of trainees and better able to relate to trainees in their own colloquial language.
2. **Getting peer educators to the locations where transgender women and transgender men engage in sex work.** While COTRAVETD may have enough peer educators and volunteers, it has no access to vehicles or drivers that can get them to all of the locations where transgender women and transvestite men engage in sex work. Relying on taxis or public transportation can be prohibitively costly and time-consuming.

3. **Getting health services to those locations.** COTRAVETD’s number one priority for an addition to their programme is to again have regular use of a mobile clinic that allows them to take the services to sex workers, rather than bring the sex workers to services. In the past, they found that this helped them establish common ground and forge bonds of trust whereby sex workers felt comfortable enough to take the initiative and approach the clinic to ask for condoms and lubricants, seek information and advice and take advantage of the services on offer. It ensured far greater uptake of services than occurs through referrals to the CeSaJo clinic or other clinics. Just as taxis or public transportation can be prohibitively costly and time consuming for peer educators, so can they be prohibitively costly and time consuming for sex workers.

4. **Reaching out to migrant Haitian transgender and transvestite sex workers.** COTRAVETD would like to be able to step up its engagement with migrant Haitian transgender and transvestite sex workers and provide them with the peer education and other interventions it now provides to Dominicans.

5. **Advocating for and defending the human rights of transgender and transvestite sex workers.** COTRAVETD hopes to become more active in monitoring and reporting on human rights violations and advocating for human rights protections of transgender and transvestite sex workers. Nairovi says that too often there is no one at the table to represent transgender and transvestite sex workers when decisions affecting the rights of all sex workers are being made.

**The way ahead**

As of March 2013, COTRAVETD was still awaiting the Presidential decree needed to finalize its status as a legally registered organization. With this status, COTRAVETD will be better able to represent and serve transgender and transvestite sex workers and it will be qualified to apply for, receive and manage its own financial resources. Thus empowered, it hopes to retain its current complement of peer educators and volunteers while strengthening their capacity with continued training and other resources. Ideally, these resources will include renewed use of a mobile clinic so they can take basic health services to their beneficiaries rather than requiring their beneficiaries to travel long distances to receive services at inconvenient locations during inconvenient hours. Also high on COTRAVETD’s list of priorities are advocacy and other activities that gain wider recognition of the basic human rights of all transgender women and transvestite men (including sex workers) so they are given fair and equal access to education and employment opportunities as well as to health and social services that meet their basic needs.
Overview

Este Amor was one of three Caribbean organizations chosen to pilot CVC/COIN’s new sexual health approach to peer education. In October 2011, it chose 20 MSM from 15 to 19 years old to take four days of training guided by an early version of the new CVC/COIN training manual. At the end of this training, it chose eight to apply lessons from the training as they conducted individual and group interventions in towns, villages and bateys across the province of San Pedro de Macoris, in the Dominican Republic’s eastern region. In February 2012, these eight were given five more days of training and, in June 2012, another five days of training.

In addition to providing the training CVC/COIN provided Este Amor with US$20,000 in financing for this pilot project. The main aim was to deliver effective education, information and condoms to young MSM and to provide them with access to HIV testing and other services. However, the project’s group interventions raised the awareness of men and women of all ages and gender-identities.

Implementer: Grupo de Apoyo Este Amor

Grupo de Apoyo Este Amor — “This Love Support Group” — is better known simply as Este Amor. With a background in law, Marcia Alvarez is now a social worker and educator and she serves as the group’s project consultant/coordinator. In an interview on 14 July 2012, she said Este Amor can trace its short history back to August 2005 when four gay men, a nurse (Ninive) and a social worker (Gertrudis) met at the Complejo Micaeliano Religiosas Adoratrices, a family health centre in the province of La Romana, to the immediate east of the province of San Pedro de Macoris. At this meeting, they discussed their concern that few MSM were coming to the centre for voluntary counselling and testing for HIV and that most MSM who came were already at advanced stages of infection. They noted that there was no organization that represented or served MSM in the country’s eastern region, so they founded such an organization and called it Este Amor.

In November 2005, Este Amor became a member of the Dominican Network of People Living with HIV (REDOVIH). In March 2006, they joined with Amigos Siempre Amigos (ASA) in forming the Alianza de Gays, Travestis y Otros Hombres que Tienen Sexo con Hombres (AGTH) — the Alliance of Gays, Transvestites and Other Men Who Have Sex with Men. Through this new alliance they began receiving the training and tools they needed to build their capacity to function effectively. On 26 February 2008, they were officially registered as a non-profit civil society organization.

Este Amor now works with informal groups of MSM in four provinces in eastern Dominican Republic: La Altagracia, La Romana, San Pedro de Macoris, and El Seibo. Its main office is in La Romana and is sustained largely through donations its nurse secures on her frequent visits to New York. These donations come mainly from the New-York-based Aid for AIDS (AFA), Hispanic AIDS Forum (HAF) and Latino Commission on AIDS. These organizations also donate educational material, condoms and lubricants.
Este Amor’s work

In 2006 and 2007, Este Amor participated in two six-month projects to develop educational strategies and tools for HIV and STI prevention among MSM. The first project was under ASA’s umbrella. The second was under COIN’s umbrella and had the USAID-financed Academy for Educational Development (AED) [now FHI-360 under Family Health International] as a partner.

In 2008, Este Amor partnered with the Clínica Esperanza y Caridad (CEyC) in San Pedro de Macorís on an AmfAR-funded project to support peer education and distribute condoms among MSM and also provide them with referrals (and sometimes accompaniment) to the CEyC for HIV and STI testing, care and treatment.

In 2009, Este Amor partnered with COIN and AED in the design and implementation of a qualitative study of MSM in the eastern region. In the course of doing so, its MSM peer educators and volunteers learned qualitative research methods including participant observation, in-depth interviewing and mapping. The study’s purpose was to provide evidence on which to base action. Its final report was written by Clare Barrington, Assistant Professor in the Gillings School of Global Public Health at the University of North Carolina at Chapel Hill, and it concluded: Este Amor is well established and respected in the eastern region; it has drive, commitment, intimate knowledge of MSM, and good relations with MSM; it also has sufficient capacity on which to build and expand and serve MSM throughout the four provinces of the eastern region.

Since January 2011, Este Amor has received much of its financial and technical support through USAID-financed projects that have seen it partnering with COIN, ASA and other Dominican CSOs and also with John Snow/AIDSTAR-One and the CDC. One of these projects saw it working with medical anthropologist Mark Padilla — Associate Professor, Department of Global and Sociocultural Studies, School of International and Public Affairs, Florida International University (FIU) — on a study among men associated with the eastern region’s vibrant tourism industry (e.g., as hotel and bar staff and beach boys) who exchange sex for cash or gifts and who might be considered bisexual insofar as they are willing to have sex with both males and females.

Context of Este Amor’s project: young MSM in San Pedro

On 27 November 2012, Marcia Alvarez and the pilot project’s supervisor and eight peer educators met at the project’s training centre in San Pedro de Macorís to talk about the project, including the rationale for it. Known as Amarantha, the supervisor calls himself a transvestite man. The eight peer educators range from 16 to 19 years old and include seven who self-identify as gay men and one who self-identifies as a transgender woman.

“Out” and “closeted” MSM

The group agrees that only a very few adolescent males in San Pedro de Macorís will admit to being gay or transgender but a great many more engage in male-male sex, whether or not they also engage in male-female sex. The peer educators relate typical “coming out” stories where, for example, their mothers were not surprised when their sons confessed they were gay and — although they were not very happy about it and were concerned for their sons’ health and welfare — continued loving their sons and sometimes became closer to them due to new levels of honesty. Fathers tend to be much less accepting and sometimes reject their sons entirely, though some eventually come around to accepting their sons again and even to respecting them for their courage and admiring them for their other qualities (e.g., being intelligent and a good student).
Notwithstanding their own coming out experiences, the peer educators agree that there is extreme prejudice and discrimination against anyone suspected of being gay or transgender because of their appearance or behaviour. This means that most adolescent males who are sexually attracted to other males will never admit it because they are sufficiently masculine in appearance and behaviour to pass as “normal” heterosexual males.

Most school principals, teachers and students scorn any boy who does not conform to very narrow definitions of what is “normal”. Boys who appear in any way effeminate are isolated, bullied and sometimes thrown out of school if, for example, they dress or wear their hair in unconventional ways. If they are not thrown out they often choose to drop out, even when they are good students. Meanwhile, their schools have taught them nothing whatsoever about sexual and reproductive health or human rights and how to protect themselves against STI and HIV infection. Nor have their schools taught them anything about how to protect themselves against sexual exploitation and abuse and against the verbal and physical violence and robbery that is often inflicted on gay and transgender men by members of the general public and the police.

Asked when they became sexually active, the peer educators said at age 11, 12 or 13 until one said at age eight and all laughed and agreed that the boys they know generally become sexually active as soon as they reach adolescence and often before that. Asked vaguely how many sexual partners they had, they gave answers ranging from three to ten until one said, “Oh, do you mean in a whole year? Dozens and dozens, so many that I lose count.” The others laughed and agreed that adolescent boys are generally happy to seize any opportunity for sexual pleasure.

Whether or not they have dropped out of school, young self-identified gay and transgender males often engage in transactional and commercial sex. In San Pedro, most of the men who give them cash or gifts for sex are not tourists but locals. When they are very young and naïve they may be lured into this behaviour by older men who offer to buy them expensive gifts such as trendy running shoes or bicycles. However, it can soon become an irresistible temptation to engage in such behaviour when they come from poor families and cannot find other ways of earning money. Most employers share society’s prejudices against gay and transgender men and will not give them jobs, even if they are old enough and sufficiently well educated to qualify. In any case, there are not nearly enough jobs to go around in San Pedro or anywhere else in the eastern region of the Dominican Republic.

**Ethnic Haitian MSM in the bateys**

The unemployment situation is particularly severe in the many bateys of San Pedro de Macorís. These began as settlements for migrant Haitian labourers who came to work on the province’s many sugar plantations. All but one of those sugar plantations has ceased to operate as such and many bateys have become, in effect, neighbourhoods of the growing San Pedro urban area. The many descendents of the migrant Haitian labourers who continue to live in the bateys are mostly unemployed. Since the Haitian earthquake of January 2010 they have been joined in the bateys and in unemployment by many new migrants from Haiti.

Among the ethnic Haitians living in the bateys are many young MSM, of whom only a few self-identify as gay or transgender. Their main language is Creole and, if they are recent migrants from Haitian, they may speak little or no Spanish at all. They generally have little or no formal education and even those who have lived in Dominican Republic all of their lives do not qualify as citizens and so do not qualify for the full range of public health and other services available to citizens.
The prevalence of “closeted” MSM behaviour

Mark Padilla has done extensive research on young Dominican men who engage in transactional and commercial sex associated with the tourism industry and suggests that some men become actively bisexual because it is in their economic interests to do so.

Amarantha and the eight peer educators suggest that many men are actively bisexual for other than purely economic reasons. As self-identified gay, transgender and transvestite people, they socialize with groups of their peers and these groups are connected through social networks that extend across the province and beyond. Members of these groups and networks are well aware, through personal experience, that many supposedly heterosexual men are interested in them sexually. For example, if they go out at night such men will not only bully them but also sexually harass them (e.g., by grabbing their bums) and try to lure them into hidden places where they can have sex with them secretly. If they engage in transactional or commercial sex, they find no shortage of potential clients and these include many men with girlfriends or wives and children. They are sometimes arrested by the police and then released without being charged after they have gratified the police sexually. Most of them have had sexual experiences with supposedly heterosexual male relatives, friends and acquaintances and with supposedly heterosexual men in authority, including priests and school teachers.

Piloting the sexual health approach to peer education

At the meeting on 27 November 2012, Marcia Alvarez said that when Este Amor announced the pilot project more than enough young MSM rushed forward to present themselves as candidates to take the training CVC/COIN was offering. Because there was so much interest, they selected 20 to take the initial four-day training workshop in October 2011 and, at the end of the workshop, they chose eight of the best trainees as the project’s peer educators. At that time, these eight were from 15 to 18 years old.

Amarantha, who supervised the eight, said they worked in pairs, wore tags to identify them as peer educators with Este Amor, and did most of their interventions during the mornings or afternoons. Under law, most of the peer educators were children and, with or without the law, Este Amor had a responsibility to ensure their safety. Amaranta supervised each pair at least once per week. On one occasion, she and a pair of peer educators tried to deliver a group intervention in a public place during the evening but the two peer educators were harassed by men grabbing at them, making lewd comments and asking if they would like to come away and have sex. One of the peer educators said that, one evening, he ventured out on his own and tried to do one-on-one interventions while wearing his ID tag but he had been arrested and thrown in prison for the night by a police officer who was not interested in hearing his explanation that he was working for Este Amor.

In February 2012, after they had four months of experience applying lessons for the first round of training, the supervisor and eight peer educators were given an additional five day days of training on the wide range of ways in which individuals perceive their own gender identities and on the most sensitive and effective ways of approaching them. This second round of training helped the peer educators deal with the fact that most MSM in San Pedro de Macorís are closeted and that even those who are out to their families and friends have good reason to fear the prejudice and discrimination of others. This means the peer educators should never ask questions or deliver answers in such ways as to imply someone might be MSM before they have offered that information without prompting. The whole approach is to try to make everyone feel comfortable talking about all manner of sexual desire and activity without embarrassment or moral judgement.
Amarantha and the peer educators say that this approach meant that many men they guessed to be heterosexual participated in their group interventions and often wanted to talk to them one-on-one afterwards. The peer educators became recognized and respected for their expertise on sexual health and human rights matters and since people generally did not have access to anyone else with this kind of expertise, they were keen to participate in interventions. In fact, those who participated often urged others to participate too.

Notwithstanding the unpleasant incidents mentioned earlier, Amarantha says they usually could deal with disruptive males by drawing them aside and talking to them privately. The peer educators found their group interventions in bateys particularly rewarding. These attracted a lot of parents who were very interested in what they had to say about the risks their sons and daughters were facing as they went out into the world. Often they wanted to talk one-on-one about particular cases.

In June 2012, the supervisor and eight peer educators were given another five days of training. This was not only for their benefit, but the for the benefit of the trainers and authors of the training manual. Marcia explains that, throughout, they had to recognize that the peer educators were adolescents and they were delivering peer education among adolescents and, sometimes, their parents. They had to be very careful not to use language or get into subject areas that some might consider inappropriate for adolescents. To illustrate this she says that, as careful as they were, they were still not allowed into schools to do interventions even though they would have very much liked to do that. Anyway, the approach they were taking was sufficiently successful that the trainers wanted to help them build on that strength and also to learn from it, since it could serve as a model for interventions among MSM and other adolescents and young adults elsewhere.

**Results achieved during the pilot project**

At the 27 November meeting and in a slide presentation they prepared the 16 December 2012 CVC/COIN meeting in Jamaica, the project team reported that they had achieved the following quantifiable results:

1. **Recruitment and training of one supervisor and eight peer educators**, chosen for their active participation in the first training session, their demonstrated social skills and their active membership in groups and networks of MSM.
2. **Sensitization of staff in two health centres**, telling them about the project’s aims and preparing them to receive young MSM and other young people referred to them by the project’s peer educators.
3. **Preparation of identity tags and cards** for the supervisor and peer educators. The cards told people where they could go for more information, advice and health services. (As of 27 November, the peer educators were disappointed that COIN/CVC had not yet fulfilled a promise to provide them caps, t-shirts and backpacks that would have served as additional identification.)
4. **Preparation of a flip chart with graphic photos and brief descriptions of various STIs.** These proved to be very useful tools, generating much interest and discussion, and drawing some participants to come forward afterwards and ask what they should do if they or someone they knew had symptoms. The photos engaged more interest than the words and this was a reminder that many Dominicans, young and old, are functionally illiterate so the most effective IEC material is rich with graphic illustration.
5. **Group and one-on-one interventions covering an estimated 2500 adolescents and young adults** plus hundreds of older adults. Marcia says that, at the outset, they told each of the peer educators that they should try to cover at least 25 new individuals with interventions each month and they had exceeded that target.
6. **Distribution of 13,824 condoms.**
Challenges identified during the pilot project

During the course of the project, *Este Amor* identified the following challenges:

1. **Not enough male condoms and no lubricants.** Marcia explains that *Este Amor*’s supplies of condoms have always been unreliable. They used to get condoms from the Instituto Dermatológico (IDCP) but no longer do. For this project, they got many of their condoms from COIN but sometimes did not have enough to meet the demand at their interventions. As for lubricants, they had none at all to distribute during this project even though they knew water-based lubricants are almost essential for anal sex.

2. **No mobile clinic.** The project team did not keep track of how many young people got tested or treated for HIV and other STIs as a result of their interventions. They felt frustrated, however, by the fact there was no mobile clinic attending their interventions. They believe that a mobile clinic with be essential if they want to get many more young people to take up offers of HIV and STI testing, care and treatment.

3. **Age restriction on project participants.** *Este Amor* originally proposed to engage youth from 13 to 18 years old in the project but they were told that 13 is too young. This judgement would seem to arise from the kind of social conservatism and naivety that causes people to bury their heads in the sand and refuse to face up to the reality that many young Dominicans begin having sex as soon as they reach puberty, if not before. To protect them from serious harm, they need information about sexual and reproductive health and human rights and the knowledge and skills to protect themselves from sexual exploitation and abuse.

4. **No access to schools.** The social conservatism and naivety mentioned above prevents schools from offering courses in sexual and reproductive health and human rights, or from allowing *Este Amor*’s peer educators to fill the gap. Beyond that, Este Amor would like to be able to get into the schools and begin providing principals, teachers, students, and parents with the education and information that would stop schools from being the sources of the prejudice and discrimination that thwarts the development of so many young people.

5. **Lack of mechanisms for dealing with human rights violations.** It is not uncommon for young Dominicans to be arrested just because they look to be gay or transgender. Sometimes the police just want their money or sexual gratification and release them after getting what they want. The victims of this kind of abuse often do not know their rights and don’t try to look for or remember information that would allow anyone in authority to identify the perpetrators. In any case, there are no obvious mechanisms where they can go with their complaints and expect help with achieving justice.

The way ahead

By almost any measure, this project constitutes very promising practice and is worthy of being sustained, scaled up and continually strengthened. *Este Amor* hopes to see it evolve into a continuing programme that extends across all four provinces in the eastern region and that serves as a model for programmes in other regions. In the months and years ahead, they hope to be able to meet all of the challenges identified above. They are fully aware that their peer education model will require continual training of new peer educators that fit the requirement of being no more than 19 years old and thus are able to understand and relate to other adolescents.
Homophobia causes AIDS. Organizing can end it.

Overview

With a CVC/COIN Community Grant of US$20,000 and an AmfAR grant of US$10,000, the Coalition Advocating for Inclusion of Sexual Orientation (CAISO) worked at creating a more enabling human rights environment for the response to HIV in Trinidad and Tobago. This was a twelve month project and the CVC/COIN grant financed the first eight months, extending from April through November 2012.

The application for the CVC/COIN grant noted that CAISO is a young organization operating in a challenging social and political environment, so might fall short of achieving the ambitious objectives it had set for the project. While that turned out to be the case, the project strengthened CAISO’s capacity to represent and serve the LGBT men and women of Trinidad and Tobago and also helped it get a better measure of the challenges it faces in the months and years ahead. It also added or enhanced three components to CAISO’s work. The “Add All Three” component campaigns for amending the country’s Equal Opportunities Act (EOA) to ensure equal opportunities for everyone regardless of their sexual orientation, HIV status or age. The “I Am a Citizen” component trains and mobilizes people for advocacy for human rights. The “Tell Your Story” component documents cases of human rights violations and supports action on those cases.

Grantee: Coalition Advocating for Inclusion of Sexual Orientation (CAISO)

The Coalition Advocating for Inclusion of Sexual Orientation (CAISO) traces its short history back to Emancipation Day 2007, when its founding members met to celebrate maxi driver Kenny Mitchell’s victory in a law suit against the Trinidad and Tobago Police Service for mistreating him because he was gay. Emancipation Day occurs on the 1st of August every year and celebrates two events in the country’s colonial (pre-1962) history. On the 1st of August 1834, the UK Parliament’s Emancipation Act freed all slaves under six years old and declared that all others would be freed after an “apprenticeship” period. On the 1st of August 1838, “apprenticeship” ended and all slaves were freed. To this day, however, Trinidad and Tobago’s LGBT people have yet to be emancipated from laws that make same-sex activity illegal and do not extend the same human rights protections to LGBT people as they extend to everyone else.

On 27 June 2009, the founding members formally agreed to establish CAISO. What spurred them into action occurred two days earlier, when Gender Minister Marlene McDonald announced that the Government’s new National Gender Policy and Action Plan would not address “any issues related to … same-sex unions, homosexuality or sexual orientation.” Thus, she made it clear that the Government would not live up to the promises it made when, in June 2008, it supported an Organization of American States (OAS) resolution on Human Rights, Sexual Orientation and Gender Identity.

Founding members of CAISO included the individuals who met on Emancipation Day 2007 and also Friends for Life (serving people who live with HIV) and the Trinidad and Tobago Anti-Violence Project (opposing homophobic violence in popular culture). Early partners of CAISO included the University of the West Indies (UWI), the Family Planning Association of Trinidad and Tobago (FPATT), the Rape Crisis Society, and the YMCA.
By April of 2010, CAISO had established a steering committee of 17 men and women (seven under the age of 25) and it had named three officers: Colin Robinson (now CAISO’s Executive Director) for communications; Kareem Griffith and David Soomarie for community mobilization. In addition, it had:

- Established its presence on the internet, which now consists of two Facebook locations (www.facebook.com/caiso and www.facebook.com/groups/caiso) and a blog site (gspottt.wordpress.com)
- Appeared repeatedly in the media (television, radio, newspapers, online newsletters and blogs) drawing attention to robberies, rapes and murders of gay men and to the fact that, often, these are not prosecuted
- Worked with Christian leaders on developing a theology of inclusion and launching church services for LGBT people
- Highlighted the roles of LGBT people in the culture and history of Trinidad and Jamaica
- Hosted movie and discussion nights focussing on LGBT people and their lives, challenges and opportunities
- Wrote to and met with Government officials to focus their attention on policies and practices that have negative impacts on LGBT people
- Raised the profile of LGBT people at the 2009 Commonwealth Heads of Government Meeting (held in Port of Spain, the capitl of Trinidad and Tobago) and helped draft the civil society statement presented at that meeting
- Began planning a coherent law reform campaign.

Over the following two years, CAISO was able to find the financial resources it needed to build its capacity to sustain and scale-up activities such as those mentioned above. Its donors have included the Astraea Lesbian Foundation for Justice and the Foundation for AIDS Research (amfAR).

**The project’s context**

According to estimates by UNAIDS, HIV prevalence across the Caribbean decreased from 1.1 percent in 2001 to 1.0 percent in 2011 but, in Trinidad and Tobago, it increased from 1.3 percent to 1.5 percent. The country’s own 2012 progress report confirms these estimates but also shows that the annual number of new cases of HIV peaked in 2003-2004 and has been decreasing ever since.

On 29 January 2013, at the launch of the country’s Interim HIV/AIDS Agency, Minister in the Office of the Prime Minister Rodger Samuel pointed out that the country’s official HIV figures do not give a true picture of what is really occurring since they are based entirely on actual cases reported by public hospitals, health centres and other testing facilities. The Ministry of Health is now working with the National Alliance of State and Territorial AIDS Directors (NASTAD) in the United States: first, to establish a system that will also collect data from private and civil society testing facilities; second, to do behavioural and serological surveys.

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96 UNAIDS (2012).
97 Office of the Prime Minister (2012).
that will provide data on the concentrated epidemics among MSM and other vulnerable subpopulations.

Meanwhile, the only such survey ever done among the country's MSM took place in 2006. It recruited 320 MSM using a modified snowballing technique and collected saliva samples from 235 of those men. Based on those saliva samples, it estimated that HIV prevalence was 20 percent among MSM. It is likely that the new MSM surveys will find that that HIV prevalence among MSM has increased since 2006.

Why? The reasons are found in a series of six articles published in the Lancet's special July 2012 issue on HIV among MSM. One of these articles did a meta-analysis of data from all countries where there has been surveillance of HIV among MSM and found that, across the world, MSM are many times more likely to be HIV positive than the general population of adults. The available data show that HIV prevalence among MSM in the Caribbean region is 25.4 percent, much higher than in any other region in the world — and that ranking next are Sub-Saharan Africa (17.9 percent), North America (15.4 percent) and Central and South America (14.9 percent). The available data also shows that, in many countries, HIV prevalence among MSM continues to grow even as it declines in the general population.

Another of the articles found that high and growing prevalence among MSM in North America was greatly distorted by the extremely high and growing prevalence among African-American MSM in particular. Among the factors accounting for this were that they tended to be poor, without health insurance and so without ready access to health services. The article suggested that, in many countries, MSM will continue to have high and growing prevalence of HIV and AIDS until all men (including those who have sex with men but do not freely admit to doing so), “can safely access care, comfortably discuss their sexual risks for HIV with health care providers, receive referrals for appropriate services, and confidentially use prevention methods and services that will reduce their risks of acquisition or transmission of HIV infection.” This article also said, “Because discrimination and scarce social support are associated with HIV infection in MSM, increased attention to the importance of supportive families and educational systems for the healthy development of MSM and other sexual and gender minority youth is fundamental to the success of primary prevention.”

Fifty of the 79 countries around the world that have laws against male-male sex are former British colonies, 11 of those 50 are in the Caribbean and one of the 11 is Trinidad and Tobago. According to CAISO, the country has not only retained old colonial laws against male-male sex but, ten times since it became independent in 1962, it has adopted anti-MSM laws that have: criminalized all same-sex activity; increased penalties for anal sex; required registration for and serological testing for those convicted of buggery; excluded sexual orientation from anti-discrimination protection; and specified the heterosexuality of relationships supported by state benefits and protected against domestic violence.

Until recently, Trinidad and Tobago has done next to nothing to focus its response to HIV on MSM. To provide evidence to inform development of the National HIV and AIDS Strategic Plan 2013-2018, the country’s National AIDS Coordinating Committee (NACC) commissioned spending estimates showing that, over the 2002-2009 period, the country spent an average of more than $US 15 million per year on its response to HIV and AIDS but only 6 percent of that money went towards the response among MSM and other vulnerable subpopulations.

The new National Plan recognizes that one consequence of that misallocation of spending is that “MSM have limited access to HIV prevention, care and support services due to the stigma and discrimination meted out to that group”. It establishes “advocacy, human rights and an enabling environment” as its third priority and, as already mentioned, the Ministry of Health is now supporting MSM-specific behavioural and serological surveillance that will provide better evidence on which to base future rights-based action.

The project’s objectives and proposed methods

CAISO’s application for a CVC/COIN Community Grant outlined a two-phase project where Phase I (April through November 2012) would be financed by CVC/COIN and Phase II (December 2012 through March 2013) would be financed by amfAR. The application outlined an ambitious set of objectives and proposed methods but cautioned that CAISO was a young organization working in a challenging social and political environment and was likely to fall short of achieving all of its ambitions within the project period. Whichever of its ambitions the project might achieve or fail to achieve, it would build the capacity of CAISO to represent and serve LGBT people and help it define the challenges that might impede its progress. The objectives and proposed methods were:

1. **Recruit, train and mobilize 50 members of the LGBT community (including people living with HIV and relatives, friends or allies of LGBT) as volunteers and support two skilled leaders** to drive CAISO’s efforts to create an enabling human rights environment for the response to HIV in Trinidad and Tobago. Proposed methods were to include:
   a. Holding two three-day advocacy workshops, each with 20 demographically diverse LGBT and five of their relatives, friends or allies
   b. Mobilizing the trainees to engage in one advocacy activity per month that might include letter writing, texting, phone calls, interviews by the media or other public testimony, or participation in meetings, rallies, marches, or surveys, or recruitment of others to participate in such activities
   c. Lobbying politicians and educating the public on the need for changes in government legislation and policies
   d. In recognition of the GIPA (Greater Involvement of People Living with AIDS) principle, recruiting an LGBT person living with HIV as CAISO’s GIPA Advocate and having them join CAISO’s Executive Director on the Steering Committee overseeing the country’s first behavioural and serological survey of MSM. This Steering Committee has representatives of the Ministry of Health, the U.S. Centers for Disease Control (CDC) and the Territorial AIDS Directors.
   e. Having the Executive Director and GIPA Advocate develop training modules for CAISO’s participation in the survey mentioned above and in HIV policy and programme planning
   f. Having the Executive Director and GIPA Advocate play leadership roles in national, regional and international advocacy on behalf of LGBT people
   g. Holding monthly community meetings to educate and mobilize LGBT people.

2. **Document 25 cases of human rights violations against LGBT individuals and support them with legal counselling and advocacy.** Proposed methods were to include:

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103 Office of the Prime Minister (2013).
a. Establishing CAISO’s presence at the offices of the Human Rights Desk of Trinidad and Tobago. Established in 2006, this desk collects, analyzes and responds to the complaints of people living with HIV and of vulnerable sub-populations.

b. Assembling a panel of three lawyers willing to work as volunteers as they document cases

c. Through outreach at community forums, identifying an average of two individuals per month willing to have their cases documented

d. Developing relations with the Equal Opportunities Commission (EOC) and the Police Complaints Authority (PCA) and helping individuals present their cases to these bodies

e. If their cases are sufficiently serious or complicated, providing individuals with more intense legal counselling and possible referral to the UWI Faculty of Law’s Rights and Advocacy Project or the Caribbean Coalition for Social Justice.

3. Do research to determine the need for and feasibility of supportive housing for LGBT people. Proposed methods were to include:

a. Interviewing LGBT people who have been arrested for loitering or who are known to have histories of marginal housing or homelessness and assessing their needs for housing

b. Interviewing people (e.g., elected and appointed government officials, social workers, academics, religious leaders, business people) who have interests in supportive housing or related services and identifying possible options for providing supportive housing for LGBT people

c. Following up with additional research and analysis and formulating recommendations.

Achievements of the project’s own Phase I

As mentioned above, CAISO’s application for the CVC/COIN Community Grant cautioned that CAISO was a young organization working in a challenging social and political environment and was likely to fall short of achieving all of its ambitions within the whole project period: Phase I (April through November 2012) financed by the Grant and Phase II (December 2012 through March 2013) financed by amfAR. In an interview on 21 November 2012 and in the project’s end-of-Phase-I report submitted to CVC/COIN on 14 December 2012, CAISO’s Executive Director Colin Robinson confirmed that the project had, in fact, proven to be “too ambitious in its scale and complexity”. Colin outlined some of the main challenges that had impeded progress (discussed under the next sub-heading) but also outlined some significant achievements during Phase I, including:

1. Expansion of the “Add All Three” campaign; elevation of LGBT people’s profile in the media; enhanced participation of LGBT people in local, national, regional and international forums where policies and plans are debated and developed. Specifics included:

a. Provided critical salary support for CAISO’s Executive Director so he was able to provide sustained representation of LGBT people in the media and in local, national, regional and international forums

b. Ensured attention to LGBT people and their issues in the country’s media at least once per month. In the first two weeks of December 2012, alone, CAISO’s views on the National Gender Policy were highlighted four times in
national newspapers and its views on the immigration law against LGBT people were featured three times in national radio or television broadcasts.

c. Supported CAISO’s leadership in revitalizing the Caribbean Forum for Liberation and Acceptance of Genders and Sexualities (CariFLAGS) and in successfully applying for US$500,000 in financing from the Global Equality Fund, launched by the US Secretary of State in December 2011.

d. Staffed expansion of the “Add All Three” campaign to amend the Equal Opportunities Act (EOA) to ensure equal opportunities for everyone regardless of their sexual orientation, HIV status or age.

e. Contributed to discussion and debate on global advocacy for LGBT rights with an article called *Decolonizing Sexual Citizenship* published by the Commonwealth Advisory Bureau in April 2012.  

2. Development and implementation of the “I am a Citizen” approach to training and mobilization of LGBT people and their allies. Specifics included:

a. Developed eight modules for a training workshop that was held on 14 November 2012 and concluded with a session on strategies to mobilize the community for advocacy. Twelve people participated and agreed to focus on identifying appropriate activities for Human Rights Day on 10 December 2012. They agreed that they would collaborate on extending 350 invitations to CSOs and other stakeholders to attend planning sessions on 22 and 24 November. Only two CSOs acted on any such invitations. The Youth League of the People’s National Movement (PNM), a political party, sent representatives to the session on 22 November and the Institute for Gender and Development Studies at the University of West Indies (UWI) sent representatives to the 24 November session.

b. In light of the lack of interest shown by invited stakeholders, agreed at the 22 November session that one CAISO strategy should be to support other stakeholders in their causes. This could raise the profile of LGBT people, present CAISO as more than a single-issue organization and gain good will. It was agreed to seize an opportunity for immediate action and have CAISO representatives appear at the Highway Reroute Movement’s hunger-strike camp outside the Prime Minister’s Office the following day. CAISO representatives did this while carrying placards reading “Hungry for Human Rights”. They also posted a podcast on CAISO’s Facebook page explaining the issues that gave rise to the Highway Reroute Movement.

c. Agreed at the 24 November session to release and highlight (perhaps on a billboard) a written statement and otherwise participate in Human Rights Days events that were subsequently cancelled or changed. Instead, initiated the design and placement, in two prominent publications, of an ad with a link to a petition that was only moderately successful.

3. Development and implementation of the “Tell Your Story” approach to documenting and following up on cases of human rights violations. Specifics included:

a. Recruited three lawyers who volunteered to develop and implement a documentation process, co-located one at the Human Rights Desk of Trinidad and Tobago and publicized all of this

b. Documented a dozen cases and used these for advocacy

c. Initiated legal action in two of the cases, both involving workplace discrimination

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104 Robinson C (2012).
d. Filed one of the cases with the Equal Opportunities Commission  
e. Planned for expansion of the project to cover not only cases of human rights violations, but voices and visions.

The project’s end-of-Phase-I report indicated that research to determine the need for and feasibility of supportive housing for LGBT people would be done in the project’s Phase II, which is not covered by the CVC/COIN Community Grant.

**Challenges**

In his interview on 21 November 2012 and in his end-of-Phase-I report, Colin Robinson identified a number of challenges that he felt had impeded progress on this project. These can be summarized as:

1. **CAISO’s lack of organizational capacity**, including lack of staff and willing volunteers with the range of skills required to:
   a. Implement a project that “was much too ambitious in scale and complexity”  
   b. Meet donor requirements for monitoring and evaluation and reporting. These requirements were too onerous given the small size and limited time-scale of the project.

2. **Reluctance of LGBT people to volunteer their time and skills** and to attach their names and faces to activities (including documentation of their own experiences) that might identify them as LGBT and so subject them to prejudice and discrimination at home and in school, workplace and community.

3. **A “weak culture of human rights, governance and political accountability”** where most people, including LGBT people, are complaisant.

**The way ahead**

In July 2010, CAISO posted a brochure on its blog site ([Who & What Is CAISO?](http://gspottt.files.wordpress.com/2010/07/caiso-brochure.pdf)) that says Trinidad and Tobago’s “communities have been very active for decades, and have grown to be perhaps the most vibrant and admired in the Caribbean region. We believe the time has come to more effectively mobilize the tremendous resources within our communities and the considerable goodwill we enjoy from those outside our communities.” CAISO’s blog site and Facebook page support those statements by being comparatively lively and active and rich with news and comment about a wide variety of activities at local, national, regional and international levels.

That all stands in sharp contrast to the narrow focus of the organization’s name, Coalition Advocating for Inclusion of Sexual Orientation (CAISO), and the implication that it is interested only in amending what many LGBT people and others might see as a comparatively minor piece of legislation, the country’s Equal Opportunities Act.

Trinidad and Tobago has a population approaching 1.4 million people. In a population of that size, there are probably tens of thousands of people sexually attracted to people of their own biological sex but only a few thousand, at most, who might be active in what might be called communities of LGBT people. If those few thousand are like active LGBT elsewhere, there are probably far more of them active in the worlds of the arts, entertainment, scholarship, science, sports, business, and community service than there are in the worlds of politics and the law. It is also likely that many of them are very interested in their own health and that of other LGBT people, especially in light of the HIV epidemic and its devastating impacts on MSM.
To broaden its appeal to potential LGBT leaders and volunteers, CAISO will have to broaden its mission, programmes and projects to embrace their interests. CAISO should also note that LGBT people are as diverse in their politics and opinions as anyone else and be careful about aligning itself with particular political parties or with highly contentious opinions with which many LGBT people may disagree.
Annex B2 (JAYN, Jamaica)
Living Out Loud

Overview

With a CVC/COIN Communities Project grant of US$20,000, the Jamaican Youth Advocacy Network (JYAN) advanced development of its “I Live Out Loud” website — found at [www.iliveoutloud.org] — and also established related presence on Facebook, Twitter, BlackBerry Messenger, and the popular gay dating site Adam4Adam. The aim was to establish increasingly informative and interactive social media sites by the end of 2012 and to make these safe spaces where young Jamaicans (15 to 29 years old) can learn about sexual and reproductive health, human rights, different sexual orientations and gender identities and where they can also learn how to cope with stigma and discrimination and the verbal and physical bullying and violence LGBT people often face in home, school, workplace, and community. The hope was to attract anyone who knows or suspects they or someone else is LGBT and to provide them with information and opportunities to ask questions, to share experiences and opinions, and to benefit from online advice or referral to appropriate health and other services.

Grantee: Jamaica Youth Advocacy Network (JYAN)

Facebook: [http://www.facebook.com/groups/14966158925/]

Jaevion Nelson is the Executive Director of the Jamaica Youth Advocacy Network (JYAN). Since he was away, JYAN member Charles Barrett agreed to meet on 12 June 2012 and discuss JYAN’s history, its current activities and the project for which JYAN had received a CVC/COIN Community Projects grant.

JYAN emerged from an advocacy training programme, in the summer of 2006, coordinated by a USAID-funded project called JA-STYLE. The programme recruited and trained young leaders for advocacy, public education and capacity building in the areas of sexual and reproductive health, prevention of violence, care and protection of the ill and disabled, education, job training, employment, and entrepreneurship. At the end of the programme the young leaders decided to form their own organization, call it the Jamaica Youth Advocacy Network (JYAN) and carry on with their work.

From the outset, JYAN has been supported by Jamaica’s Ministry of Health and the National HIV/STI Programme. It was formally registered as a civil society organization in 2008 and this enabled it to receive and administer the following grants: US$105,883 (2008-2010) from Jamaica’s Global Fund grant; US$25,000 (2008-2010), US$14,000 (2011) and US$14,000 (2012) from USA-based Advocates for Youth; US$47,000 (2010) from UNICEF; US$2,295 (2010) from UK-based Global Changemakers; US$29,410 (2010) and US$35,000 (2012) and from USAID; US$ 20,000 (2011-2012) from amfAR.

Since its birth in 2006, JYAN has trained more than 1000 young leaders and it has become the foremost youth-led organization contributing to Jamaica’s response to HIV and AIDS. It has participated in a wide range of initiatives that empower young Jamaicans to take responsibility for their own sexual and reproductive health and promote and support evidence-and-rights-based approaches to HIV and AIDS. It is frequently asked to represent Jamaican youth on national decision-making boards, councils and committees and at local, national, regional and international conferences and other events.
JYAN participates in three initiatives supported by Advocates for Youth: Amplify Your Voice (www.amplifyyourvoice.org/jamaica), the International GLBT Project and, within that project, International Youth Speak Out (www.advocatesforyouth.org/topics-issues/working-with-youth/1696).

JYAN aims to represent and serve all Jamaican youth, not only the most marginalized and vulnerable. With this all-inclusive approach, it aims to be friendly and non-threatening to young Jamaicans who are not yet sure of their sexual orientation or who are not “out” to their families, friends and others.

**Context of the “Living Out Loud” project**

The project has produced four online factsheets (with three now available on its website: Focus Right, Turning the Tide and Triple Threat) and they describe a situation where openly LGBT youth are routinely subject to stigma, discrimination and violence within home, school, workplace, and community and have neither legal protection nor access to health and other services that welcome them and understand their needs. Not only does this bar them from full participation in Jamaican society, it also makes them feel worthless and hopeless about their futures. There are few physical spaces where they can meet others like themselves for mutual support, information and counselling. However, many find comparatively safe spaces online, if only for connecting with each other and arranging dates.

**The project’s objectives and intended methods**

Extending from March through November 2012, the project began with four objectives and proposed methods as follows:

1. **Provide continual training to at least 6 online peer educators who can answer young people’s questions, share information and experiences, and provide referrals to services where they can get HIV and STI information and supplies, voluntary counselling and testing and treatment.** Proposed methods were:
   a. Recruit young LGBT already trained in peer education and provide them with refresher courses and additional training in how to engage the interest of young people and interact with them on the project’s website and other spaces on the internet.
   b. Hold monthly (and, if necessary, additional) meetings of the online peer educators so they can monitor the project’s progress, share their experiences, identify challenges and opportunities, and take appropriate action.

2. **Build an interactive website with content covering sexual orientation and gender identity; healthy attitudes and lifestyles; sexual and reproductive health; HIV and STI prevention, care and treatment; human rights and how to advance them; social attitudes and how to change them.** Proposed methods were:
   a. Provide website content and continually expand, update and improve on that content.
   b. Promote the website and other social media spaces with flyers and through awareness-raising among at least ten stakeholder organizations, including JYAN’s partner organizations (JASL, J-FLAG and CVC) and other allies; where appropriate, request that they provide links from their websites to the project’s website and that they give permission for the project’s website to link to theirs.
3. **Reach for the first time (i.e., without counting subsequent occasions) an average of 50 Jamaican youth per month (for total of 450 through the duration of the project)** with the kinds of information provided above and through that information to empower them to take responsibility for their own health and well-being and for the health and well-being of their peers. Proposed methods were:
   
a. Make the web content interesting, engaging and useful while also making it and other online spaces used by the project interactive so that youth can engage with the online peer educators and with each other.
   
b. Provide four online factsheets on: LGBT youth and human rights in Jamaica; challenges and opportunities for gaining access to youth-friendly health services; how homophobia impacts on LGBT youth living with HIV; what LGBT youth can do to protect themselves and each other from HIV and also educate and advocate for change.
   
c. Incorporate online monitoring tools into the website, counting numbers of visitors and visitor interactions with peer educators and conducting a continual online survey allowing website users to rate their experiences and offer comments and suggestions.
   
d. Host a focus group discussion involving 6 to 10 website users on the impacts of the website on them.

4. **Work with the Sexual and Reproductive Health and Rights (SRHR) Advocacy Council of JYAN, J-FLAG and Pride in Action on efforts to engage with key stakeholders and increase their awareness of and support for “I Live Out Loud” and its aims.** Proposed methods were:
   
a. Develop a policy brief.
   
b. Meet with key stakeholder; share the policy brief and the four online factsheets with them; invite their inputs and secure their support.
   
c. Meet with policy-and-decision-makers and with funders and asking for their support.
   
d. Reach the general public, including through existing organizations concerned with sexual health and human rights.

**The results**

Javan Campbell has been the Project Coordinator since June 2012. On 4 December 2012, he and five of the project’s six online peer educators met with CVC/COIN’s **Technical and Policy Coordinator and the consultant evaluator** for an informal discussion of the project’s achievements and challenges. Subsequently, Javan prepared an end-of project report.

Broadly speaking, the project achieved or surpassed its four main objectives but it ran into challenges that stopped it from achieving everything it had hoped to achieve within its short duration. Specifically:

1. **At the outset, it recruited six LGBT peer educators** (five males and one female) and:
   
a. JYAN and J-FLAG provided them with three days of peer education facilitated by two experts from Eve for Life and assisted by other experts. The training focused on counselling techniques, HIV and AIDS (with specific focus LGBT-specific risks and prevention methods), LGBT-specific human rights issues, advocacy, and blogging and it introduced the use of various social media.
b. The peer educators met regularly with the project coordinator and others to share their experiences and identify challenges and opportunities. Each of them kept a written record of their activities.

c. In August, JYAN provided them with additional training to refresh their knowledge and skills and especially their skills at counselling people in crisis situations and building self-esteem. The need for this additional training grew out of challenges they had experienced in the course of doing the work, such as providing accurate answers to questions asked by their contacts and providing good advice and appropriate referrals to people in crisis situations. This additional training also addressed the needs of newly recruited peer educators for Living-Out-Loud-specific training.

2. **It enhanced the interactive website with the intended content** and:

a. Established Facebook and Twitter accounts both to promote the website and to provide alternative means of providing information to young LGBTI and interacting with them. These pages include private areas accessible by invitation only in order to prevent general access to private conversations.

b. Established a BlackBerry Messenger (BBM) group and an account with the online LGBT dating site Adam4Adam. These enable the project’s peer educators to initiate and participate in conversations with young LGBT Jamaicans.

c. With technical assistance from the USAID funded C-Change Project, the Project Coordinator surveyed LGBT people, programmers, allies and other technical experts to gather ideas for the design and content of two small flyers (or teasers) to be used in promoting the project. These were provided in multiple copies to more than 15 stakeholder groups during meetings raising their awareness of the project’s website and other social media spaces and securing their cooperation in promoting these spaces. Among the stakeholders were the Ashe Company, Children First, CVC, Eve for Life, Jamaican Network of Seropositives (JN+), Jamaican Red Cross, JASL, J-FLAG, Ministry of Labour, Ministry of Justice, National AIDS Committee, National Family Planning Board, National Health Programme, UNAIDS, and UNICEF.

3. **The project surpassed its target of reaching for the first time an average of 50 Jamaican youth per month** and identified a number of challenges in making its engagement with these youth more interactive. Specifically:

a. The Project Coordinator and the six peer educators worked with a web developer on design, original content and continual updating and enrichment of the website. They were assisted by a Peace Corps volunteer made available through CVC and also by comments by various stakeholders.

b. The project produced the four planned online factsheets of which three are now available on its website: Focus Right, Turning the Tide and Triple Threat.

c. The project’s website monitoring service found that: during June, a total of 59 different individuals visited the website and, counting repeat visits, there were a total of 157 visits during that month; during August (the peak month), a total of 334 different individuals visited a cumulative total of 562 times; during November (the last month of the project), a total of 105 different individuals visited the website a cumulative total of 330 times. Adding up the totals of different monthly visitors to the site each month provides a total of 2051 but this total includes individuals who counted as different monthly visitors month after month. The peak number of individual monthly visitors was 334 in August.
d. The project team found that it was easier to attract people to their website than it was to get them to interact once they got there. In terms of getting visitors to interact, the project’s Facebook page was the most successful of the project’s social media spaces with more than 25 LGBT youth interacting on the page each month. Also more successful at getting people to interact were the project’s BlackBerry Messenger (BBM) group, its presence on Adam4Adam and, to a lesser extent, its Twitter page. Re the advantages of Facebook, the peer educators have found more than 20 “rooms” for Jamaican LGBT on Facebook and these provide them with additional opportunities to interact with LGBT people.

e. The peer educators also often met with LGBT youth face-to-face, after connecting with them online or otherwise. Whether on-line or face to face they found that they did not always have the level of skill required to give good counselling to people in crisis and did not always know who to refer them to. When meeting face-to-face, they found they often could not provide condoms or lubricants when people asked for them.

f. The visitor survey on the website has attracted little response.

g. On 21 October 2012, the project team hosted a focus group discussion in which 12 LGBT youth talked about the content, appearance and relevance of the website. Only seven or eight of these, including one female, were youth the peer educators had contacted through the website and other social media. (The peer educators said that, in general, it is very difficult to get LGBT Jamaican youth to show up at public gatherings because they fear being exposed. Those who showed up at the focus group were provided with incentives in the form of reimbursement for their travel to and from the focus group.)

h. Issues the 21 October focus group and the 4 December meeting identified as one the website should be paying more attention to included:

   i. the strong role religion plays in encouraging homophobia
   ii. homophobic bullying and verbal and physical violence in homes, schools and communities
   iii. homophobic ejection of LGBT youth from their families’ homes
   iv. stigma and discrimination in all institutions and at all levels
   v. self-stigmatization by LGBT people who buy into the attitudes of the society around
   vi. the evidence that homophobic bullies are often struggling with their own sexual identities and diverting suspicion from themselves
   vii. temptations to be promiscuous
   viii. the roles that sexual abuse in their own families and temptations to engage in transactional sex may drive young men into becoming MSM and perhaps even into self-identifying as gay
   ix. how certain behaviour in public places is likely to attract homophobic bullying and violence
   x. the total absence of positive images of LGBT people in Jamaican media, or of any images that show LGBT people that it is possible to be both LGBT and happy
   xi. the importance of LGBT telling their “coming out” and other stories to reach other and thus learning that, for example: after they recover
from their initial shock upon learning that their son is gay, mothers often reconfirm their love and that often leads to much closer and more open and honest mother-son relationships; being a victim of homophobic bullying or violence is very much like being a victim of rape in that you are afraid and ashamed to tell other people and you may withdraw socially and collapse psychologically.

xii. focusing too much on HIV and AIDS among MSM can feed into prevailing prejudices and increase homophobia

xiii. focusing too much on HIV and AIDS can also discourage lesbians from participating in LGBTI initiatives; there has to be more of a balanced approach that focuses, for example, on the “corrective rape” of lesbian.

4. The project has successfully engaged with the Sexual and Reproductive Health and Rights (SRHR) Advocacy Council of JYAN, J-FLAG and Pride in Action and with key stakeholders, as intended. However, at the 4 December meeting, the project team identified need for more work in this area. In particular, there is need to engage with more with non-LGBT groups that are also concerned with human rights issues such as Jamaicans for Justice, the country’s most prominent human rights organization.

The challenges

Some of the challenges the project will have to meet if it is to be scaled up and sustained as an on-going programme serving Jamaica’s LGBT youth are:

1. Doing more work to understand what attracts LGBT youth to some social media spaces more than others. In the 4 December meeting, the peer educators indicated that they, personally, search the world-wide web for a wide variety of LGBT or LGBT-friendly sites including Jamaican, Caribbean and International sites and that their searches are for a wide variety of purposes. One said, for example, that he goes to a San Francisco based site for LGBT-specific information on HIV/AIDS and sexual and reproductive health.

2. Doing more to make the project’s website and its other social media spaces lively, entertaining and engaging. The Ashe Company, for example, has found that it is far easier to get people to relax, absorb information and share their experiences if they are also being entertained and being given opportunities to participate in ways that make their experiences fun rather than hard work. Point 3.b in the Results section above suggests a number of ways of engaging people by addressing a wide variety of issues that concern LGBT youth and encouraging them to share their stories.

3. Putting more research and thought into which kinds of people are best qualified to provide online information and counselling to LGBT people. It would seem likely that many troubled LGBT would look not to their peers but to older LGBT people as role models, mentors and sources of information and advice. Reasons include that older people have more experience in life and are not part of their own social circles, so are less likely to be in positions to betray confidences. It would seem likely, too, that young LGBT are prominent among the visitors to sites designed for LGBT of all ages.

4. Putting more research and thought into reaching the most marginalized of LGBT, including those in rural areas. Many marginalized youth do not have access to computers in private spaces and do not have levels of literacy required to benefit from web content written in standard English or even written in the dialects.
they speak from day to day. In addition, some parishes in mountainous Jamaica do not have access to good internet connections.

The way ahead

Social media are increasingly the means by which young people interact with each other and the larger world, so this project is on the right track in its efforts to find the most effective ways of using such media for the benefit of Jamaica’s LGBT youth. It has taught a number of significant lessons (implicit in the foregoing discussion) on which it can build in the months and years ahead.
Annex B3 (RevASA, Dominican Republic)  
Prevention and rights in the closet

Overview

With a CVC/COIN Community Grant of US$20,000 (and additional support from Spain’s Fundacion Triangulo and from USAID), el Red de Voluntarios de Amigos Siempre Amigos implemented a pilot project among “closeted” middle class gay men in Santo Domingo. Extending from April through December 2012, it aimed to increase their MSM-specific knowledge of STIs and HIV/AIDS, their correct and consistent use of male condoms and lubricants, and their uptake of testing, treatment and other services. It also aimed to increase their knowledge about the human rights issues that impact on all LGBT people and decrease their tendency to be silent bystanders in public debate surrounding those issues. The ultimate aim was to develop a model of good practice together with tools for a sustained programme that reaches out through inter-linked social networks to closeted gay men across the country, including those in smaller towns and villages.

Grantee: Red de Voluntarios de Amigos Siempre Amigos (RevASA)

Amigos Siempre Amigos (ASA) — “Friends Forever Friends” — was founded as a support group for gay men in 1989 and legally registered in 1990. Gradually, it began disseminating MSM-specific information on HIV/AIDS and STIs, how to prevent transmission, the importance of testing and where to go for counselling, testing and treatment. ASA now provides peer education, counselling, referral and social and psychological support for MSM. In addition, it advocates for MSM and facilitates their representation in national and regional processes to develop policies and programmes and to allocate resources. Its website can be found at http://www.amigossiempreamigos.com.

In an interview on 18 June 2012, Harold Alejander Jiménez explained that Red de Voluntarios de Amigos Siempre Amigos (RevASA) — “Network of Volunteers of ASA” — emerged in 2005 with the aim of expanding the focus of ASA beyond HIV and other health matters and extending its reach across the country. To become a member of RevASA, volunteers must take ASA’s training courses in health and human rights. RevASA now has around 1,500 trained member-volunteers.

The member-volunteers work at raising the visibility of LGBT people and mobilizing their support for an annual LGBT human rights forum (now in its 6th year), an annual LGBT Pride Parade (now in its 4th year), an annual LGBT film festival (now in its 3rd year) and campaigns for human rights. Currently, most of their interventions take place in Santo Domingo but they were instrumental in establishing the Alianza Nacional de Hombres Gay, Transgeneros, Transexuales, Travestis y otros Hombres que Tienen Sexo con Hombres (Alianza GTH) — “National Alliance of Gay, Transgender, Transsexual, Transvestite and other MSM” — and it has a website (http://www.alianzagth.org/) promoting and supporting many different activities.

Harold explained the challenges RevASA seeks to overcome with these activities. A 2006 opinion poll found that 58 percent of Dominicans found homosexuality unacceptable. Behind that attitude were the ultra-conservative Dominican branch of the Catholic Church and its Cardinal. He has called gay men “the scum of society” and, along with the country’s previous First Lady, has campaigned against gay marriage and called for sanctions against tourist establishments that allow celebrations of gay marriage. The country has no laws against
same-activity and its new constitution forbids discrimination based on “any human condition” but it does not specify protection for LGBT people.

While things are getting better in the country, due in no small part to work by ASA and RevASA and several other LGBT organizations, it remains true that many Dominicans have attitudes similar to those expressed by the Cardinal. The police, for example, will show up when invited to meetings with LGBT people and pay lip service to their requests for better protection but they rarely follow through.

The project’s context

Wide-spread public disapproval of male-male sex and the men who engage in it means that many middle class men who self-identify as gay do not “come out” to their families, non-gay friends, classmates, or co-workers. They often, however, have secret circles of gay friends who meet in each others’ homes or in certain venues. In Santo Domingo, these include five bars, a sauna and an adult movie theatre. Fearing exposure, these “closeted” MSM often do not take up offers of MSM-specific IEC, condoms and lubricants or counselling, testing and treatment for STIs and HIV/AIDS. They are often not well-informed about the human rights issues that impact on all LGBT people and they usually remain silent bystanders in public debate surrounding these issues. This is so even though some of them are well-placed by education, social status and skills to become opinion leaders in that debate.

Objectives and intended methods

The project was supported not only by a CVC/COIN Community Grant but also by Spain’s Fundacion Triangulo (“Triangular Foundation”) and by USAID, the latter donating condoms. It extended from April into December 2012 and had the following original objectives and intended methods:

4. **Recruit and train 30 closeted middle class gay men who are natural opinion leaders**, well able to connect with other closeted gay men and gain their trust, as follows:
   
   a. During the first two months, identify 60 potential candidates in venues and on social media sites frequented by closeted gay men.
   
   b. Hold awareness sessions with three groups of the potential candidates and hold one-on-one interviews with some of them, using these as opportunities:
      
      i. For “action research” providing information about the issues of concern to closeted MSM to be used as a basis for developing appropriate IEC material and methods;
      
      ii. To identify the 30 best candidates.
   
   c. Hold two peer education training workshops for the 30 best candidates.
   
   d. During the workshops, select 15 of the 30 for additional training in how to use Juntaderas (informal social gatherings) in their homes as opportunities for STI and HIV/AIDS and human rights education and for distribution of condoms, lubricants and IEC material.

5. **Provide peer education to an additional 450 closeted gay men** as follows:
   
   a. Have the 30 trained leaders provide peer education to other closeted gay men in bars and other venues where they often meet.
   
   b. Have the additionally trained 15 leaders hold Juntaderas in their own homes or homes of friends, aiming to establish these as regular events providing mutual support for 225 closeted gay men.
6. **Establish a system for referring closeted gay men to friendly health and social services** that offer, for example, voluntary counselling and testing for HIV and other STIs, and psychological counselling. (This might involve training the staff running these services, since research in preparation for the project indicated that it would be difficult to convince most closeted MSM that they should go to clinics that specialize in providing services to “out” gay and bisexual men.)

7. **Reach a total of 2000 closeted gay men**, providing them with IEC material, condoms and lubricants.

**Results**

At the outset, RevASA made it clear that this was truly a pilot project that would try certain strategies and methods and see whether or not they worked. Not long after the project got underway it became evident that it was more difficult than anticipated to recruit and train 30 closeted middle class gay men who are also natural opinion leaders. Only 10 were recruited and given ASA’s training in peer education and those 10 were responsible for most of the project’s activities. At a 25 November meeting, most of those 10, a few of the closeted gay men who had benefitted from their activities and representatives of RevASA and ASA gathered to evaluate the pilot project. That meeting and subsequent reports found that these were the main results:

4. Ten series of *Juntaderas* established 10 social networks of closeted gay men whose members now provide each other with mutual support in the prevention of STIs and HIV/AIDS and in addressing human rights issues and who also reach out to other closeted gay men.

5. An established system for doing peer education and distributing IEC material and condoms and lubricants in the five bars, sauna and adult movie theatre frequented by closeted gay men. An important step in the establishment of this system was a meeting with owners and staff of these venues to sensitize them to the issues and get their agreement to collaborate in taking measures appropriate for their particular venues. In bars, for example, jars of condoms on bar counters, condom dispensers in toilets, condoms handed out by bar staff with each drink, or condoms handed out by other staff (e.g., male strippers) were all possibilities. In the sauna, it was found that men did not use a condom dispenser but took condoms when they were available at the front desk.

6. An established system of referrals to psychological and social support services that included a wallet-sized card with a telephone number. (The card was redesigned when it was found that closeted gay men would not accept a card with Gay Pride rainbow colours.) By the end of November 2012, 30 closeted gay men had called the number and accessed support.

7. An estimated total of almost 1900 closeted gay men were provided with peer education and, in most cases, given IEC and condoms but not necessarily lubricants.

8. Lessons learned from the *Juntaderas* and interventions in the seven venues were used to develop and refine strategies, methods and tools as follows:
   a. *Juntaderas* work best if they remain very informal and enjoyable social occasions; only the first three in a series can focus in any formal way on the issues or else people will grow bored and stop attending.
   b. Beyond those first three in the series of *Juntaderas*, the members of these social networks continue to provide each other with mutual support by various means. They also continue to expand the networks’ reach by educating new people about the issues and remind them, for example, that they should always engage in safe sex and carry condoms and lubricants with them when going out on a date where there was potential for sexual activity.
c. Closeted gay men will not carry away printed IEC material if it is too large or too obviously gay (e.g., with Gay Pride rainbow colours), not wishing to be caught in possession of such material; pocket- or wallet-sized material is better.

d. Better still is information and reminders provided on websites, by email and by mobile phones text messages.

e. In conversation, many closeted gay men reveal that they stop using condoms after the first few dates, so prevention messages should emphasize the importance of always using condoms with trusted partners.

f. In the sauna, men have been observed penetrating partner after partner without changing their condoms, so prevention messages should also emphasize the importance of using a new condom for each sexual act with a different partner.

g. In conversation, many closeted gay men reveal that they are not very knowledgeable, experienced or skilled at using a wide range of ways of giving and receiving sexual pleasure. Prevention messages should also cover these alternatives to anal penetration.

h. In conversation, many closeted gay men reveal that they know more about HIV and AIDS than they do about other STIs and hepatitis. Prevention messages should point out the risks of any oral, anal or other sex acts and the best ways of reducing harm.

i. In conversation, many gay men reveal that they are not well-informed about the consequences of testing positive for STIs or HIV and that this sometimes increases their fear and reduces their tendency to get tested. Peer education and IEC material should emphasize that there are effective cures for many STIs and effective treatments for others and for HIV but that these are all that much more effective when there is early diagnosis of infection.

j. Group interventions in venues work best if they are brief and very entertaining. After all, people are there to have fun, not to be lectured.

k. Bars usually have televisions and bar owners said they would welcome entertaining television spots that would carry STI and HIV/AIDS-related messages.

**Challenges**

Most gay men live somewhere along a continuum that runs from total denial (even to self) that they are sexually attracted to other males, through gradual acceptance and “coming out” to others, and all the way through to bold announcement even to strangers that they are gay (i.e., by wearing items with well known gay symbols). The most extremely “closeted” gay men go to great lengths to give other people no hints of their sexual attraction to other men and may not risk going to venues where anyone they know might recognize them but, instead, may use social media or parks and other public spaces (often called “cruising” areas) for hooking up with other MSM, including male sex workers. RevASA learned through this project that it is very hard for “out” gay men to deliver interventions to extremely closeted ones. They had to learn, themselves, how to do it and ended up engaging with somewhat less closeted gay men (who at least acknowledged to themselves that they were gay, had gay friends and went to well known gay venues) and doing interventions that are also appropriate for much more “out” gay men.

This project sometimes ran out of male condoms and water-based lubricants (the latter of which are not widely available anywhere in the Dominican Republic) and confirmed that there is insufficient access to these essential preventive supplies where and when MSM
need them. They should be readily available in all bars, saunas and commercial establishments that cater largely to MSM (or, for that matter, to any other adults who go to such venues in part because they hope to meet potential sexual partners) and also readily available in all-night pharmacies and other retail outlets. This project confirmed that the owners of these establishments are often more than willing to collaborate in efforts to provide prevention information and supplies to their customers.

This project also confirmed that sexual and reproductive health services in the Dominican Republic are not, in general, MSM-friendly. All STI and HIV/AIDS clinics, in particular, should welcome anyone who comes to them with friendly staff members that give no hint of judging people for their personal appearance or any activities that may have put them at risk of infection and that provide honest guarantees of complete anonymity and confidentiality.

**The way ahead**

Project participants, RevASA and ASA deem the project a success in that it discovered what works and what does not work in the way of interventions for closeted gay men. They are in process of producing a guidance manual for countrywide use that will allow RevASA’s member-volunteers and others to build on lessons learned from the project and to promote and support similar series of *Juntaderas* and such other interventions as may be appropriate for particular communities of various sizes. Deivus Ventura was the project’s coordinator and he describes the ultimate aim to be “circles of safety” around closeted gay men so they are well-informed and always have access to condoms, water-based lubricants and any services they may need for their health and well-being.
Annex B4 (Ashe Company, Jamaica)
Test and Talk about Your Business Safely (TABS)

Overview

With a CVC/COIN Community Grant of US$20,000, the Ashe Company implemented a pilot project that, from March through November 2012, adapted and performed its highly interactive “Safe Stupid or What” musical theatre/edutainment production for audiences of young MSM in Kingston, Jamaica. Each performance illustrated and provoked thought and discussion about the attitudes, behaviours and situations that put MSM at high risk of STI and HIV infection and each was used as an opportunity to distribute IEC material, condoms and lubricants and to offer immediate, on-site confidential HIV counselling and testing and onward referrals for additional care and treatment services. The aim was to develop a model for a programme that could be scaled up and sustained and cover more and more MSM in Kingston and across the country.

Grantee: The Ashe Company

Website: http://www.theashecompany.org/
Twitter: http://twitter.com/AsheCompany
Facebook: http://www.facebook.com/AshePerforms#!/AshePerforms
Youtube: http://www.youtube.com/asheperforms

Conroy B. Wilson is the Executive Artistic Director and Michael Holgate is the Artistic Director of the Ashe Company (formerly known as the Ashe Performing Arts Company) in Kingston, Jamaica. In an informal meeting on 13 June 2012, they sat around a table with other members of the Company and talked about its history, its current activities and the project for which they had received financing from the Community Grants programme.

Ashe’s history begins in 1993 when a group of amateur, semi-professional and professional performers got together to put on musicals. Their early productions were mostly adaptations of musicals from Broadway and London’s West End but they soon became more interested in reviving and interpreting Jamaican and other Caribbean musical and cultural traditions, especially traditions that had their roots in Africa. To reflect this, they called themselves “Ashe”, a Yoruba word meaning “the strength, the power and the God within”.

Ashe was one of the few performing arts companies in the English-speaking Caribbean that based its performances on authentically Caribbean traditions, so its performances were both entertaining and educational. It became very popular with the Jamaican public and also in schools because it gave young children and adolescents rare opportunities to learn more about uniquely Jamaican and other Caribbean traditions. Its popularity soon spread to North America and Europe, where it has often performed over the 20 years since its founding.

Musical theatre is particularly demanding since it calls for good stories, music, song, and dance, sometimes of a very athletic nature. One implication is that a musical theatre company must always keep renewing itself with young talent. To feed its own needs for constant improvement, renewal and innovation the Ashe Company has a unit called the Ashe Academy that provides everything from beginner to advanced training in performing arts for people of all ages. This unit supplies Ashe and other performing arts groups with the amateur, semi-professional and professional performers they need for a wide range of productions of varying scale.
The physically demanding nature of musicals also means that many of Ashe’s performers are young and able to connect with young audiences. This fact and the naturally educational aspect of their interpretations of Jamaican and Caribbean culture, including contemporary culture, have lead to Ashe becoming a leading producer and performer of “edutainment” and, also, a leading trainer of others in the use of entertainment for educational purposes.

The Ashe Company now has three units: the Ashe Academy, the Ashe Edutainment Institute and the Ashe Performing Arts Ensemble. The Ensemble now consists of 25 professionals with expertise at writing, producing, directing and performing the kinds of professional theatrical productions Ashe performs for the general public in Jamaica and abroad. Currently, Ashe’s budget allows them to employ only three of the 25 full time.

**Ashe’s focus on HIV and other issues of concern to vulnerable populations**

The performing arts have a long-established reputation for embracing people with creative talent no matter what may be their other characteristics, for giving people from marginalized and vulnerable populations opportunities for self-expression, and for welcoming anyone and everyone who cares to join their audiences. Among Ashes members and its audiences there have always been people from the populations most vulnerable to HIV and also people living with HIV.

When Ashe first became engaged in edutainment in 1996, its aim was to do whatever it could to contribute to an effective response to HIV and to address the human rights and other issues surrounding HIV. While Ashe now addresses many other issues through edutainment, HIV and related issues remain high on its list of priorities. Its products and services now include:

- DVDs and other digital media with titles such as Vibes in a World of Sexuality, Parenting Vibes in a World of Sexuality, Safe Stupid or What, Getting to Zero, and Opening Closed Doors
- Workshops that provide training on innovative methods of teaching reproductive health and sexuality, HIV and AIDS, life skills and empowerment, parenting, violence and conflict resolution, drugs and the family
- Guidance manuals for use by people trained in the workshops
- Live performance and facilitation of live performance focussing on HIV-related themes.

During the discussion on 13 June 2012, members of Ashe talk about the power of the performing arts to reach people at the deepest levels, to change the ways they think and feel about themselves and other people and to empower them. To illustrate, they talk about how homophobia is so pervasive in Jamaica that many out gay men and other MSM feel so worthless and hopeless that they really don’t care whether or not they get HIV. You have to make them feel better about themselves and give them reasons for living before you can get across prevention messages.

Before you can get across those messages, however, you have to create safe spaces and Ashe knows only too well how hard that can be. They worked for many years to buy their own building and transform it into performance spaces, studios and offices that suited their purposes well. Their performing arts centre was in a rough neighbourhood and their policy was to employ people in the neighbourhood, one being their female security guard. At the end of one of their summer interventions, she was murdered in full view of staff, students and patrons. The motive for the murder was that she had disclosed information about a break-in the neighbourhood. The murder was the latest in a series of violent and threatening
incidents and Ashe decided it had to vacate their home and find another one. It was heartbreaking but they found a generous landlord willing to give them favourable rent on the building (in another, safer neighbourhood) where they are now and they have already done a lot to turn it into a space that works for them.

Ashe’s work serves a broad spectrum of Jamaicans, including school children. For more targeted interventions such as TABS they are now careful to be low-profile and discreet, so they don’t attract unwelcome attention. They have given the name “Youth Centre Jamaica” to their new space and this name underscores their aim to provide a safe and friendly space all Jamaican youth, not only the most marginalized and vulnerable.

Is Jamaica a particularly homophobic country? Others nod agreement as one member of Ashe says it is not so much that Jamaica is homophobic as that it is very violent. There are too many young men looking for any excuse to be violent. Factors contributing to the violence are low levels of education, unemployment and consequent anger fuelled by alcohol and drug use. Violent young men also have problems with low self-esteem and feelings of hopelessness and they could use transformative experiences, too. This is why addressing violence and teaching conflict resolution are priorities for Ashe.

**Some of Ashe’s recent projects**

From 2000 to 2005, USAID tested Ashe’s methodology in 12 Caribbean nations and territories and found it to be very effective. That has lead to USAID support for a number of Ashe projects. For example, in 2010-2011, USAID financed interventions for youth (12 to 15 years old) in schools and for youth (12 to 24 years old) out of school and from low income families; USAID financed another Ashe project to promote young people’s participation in government.

Currently, World Learning has a five-year (2010-2015) agreement with USAID to administer 9.8 million in grants to CSOs in Jamaica and the Bahamas to support HIV-related projects. With one of these grants (for US$132,000) Ashe is now implementing The Attractor Factor, a project that uses its edutainment methodology to promote healthy lifestyles among MSM and reduce the incidence of HIV.

In 2010, Ashe had financing of almost US$61,000 to create safe places for learning in partnership with Jamaica’s Ministry of Education and UNICEF. In 2009, it had financing of US$108,000 through which it partnered with the Ministry of Education, UNICEF and the Coca Cola Foundation to create Vibes Village (a safe place where young people 12 to 15 years old could learn about sexual and reproductive health) and to train teachers and provide them tools to teach sexual and reproductive health in schools.

Though they get grants from various sources, Ashe prefers to think in business terms. They have products and services to offer and they are always looking for customers who will pay for those products and services. To attract new customers, they are always expanding the range and improving the quality of their products and services. They feel they have great potential to expand their market to the wider Caribbean and even beyond. They have already done sessions in Suriname and other countries where they had to rely on translators. They also have the capacity to train groups in other countries to do many of the things they do. There is no reason, for example, that language should be a barrier to their doing work in Spanish- or Creole-speaking Caribbean and Latin America.

**Context of the TABS project**

A 2011 serological and behavioural survey found that HIV prevalence among MSM in Jamaica was 32.8 percent and national aids authorities estimate that 30 percent of all the
country’s new HIV cases each year are among MSM, while another 7 percent are among the female partners of MSM. Unprotected anal sex with multiple partners may be the biomedical explanation for this but behind that explanation are things better explained by psychology and sociology. Gay men take risks in part because they do not value themselves or look forward to bright futures and that relates to the homophobia prevalent in Jamaican families and communities. Furthermore, gay men do not take advantage of condoms and lubricants (available over the counter at pharmacies and other retail outlets) or of health services on offer and that relates to the hostility they often feel from retail and health care staff.

**The project’s objectives and methods**

Extending from March through November 2012, the TABS project had these objectives and methods:

1. **To reach 210 MSM from 16 to 30 years old with once- or twice-monthly edutainment events at Youth Centre Jamaica (Ashe’s home)** as follows:
   
a. Production of a 45-minute musical illustrating the attitudes, behaviours and situations that put MSM at high risk of HIV infection. This involved adapting the script of Ashe’s existing musical, “Safe Stupid or What”, so that it consisted of a series of scenarios illustrating such things as: discrimination against MSM and consequent fear of disclosure; trying to live up to heterosexual gender expectations; being sexually exploited and abused by relatives or other males and being too ashamed and afraid to report it to anyone; discrimination among MSM so that, for example, many middle class gay men do not want to associate with overtly effeminate gay men or with young gay men who have been rejecting by their families, live in the streets and engage in sex work and petty crime.

b. Recruitment of MSM to attend each performance using the snowballing method. Ashe’s members invited MSM they knew socially or through Ashe’s other activities and asked them to invite their friends, while also urging those friends to invite their friends, and so on. Also, at each performance, they identified “peer influencers” within their own circles (e.g., high school or university classmates, street kids) and asked them to help with recruitment.

c. Encouraging audience participation during the performance (e.g., by vocally responding to what one character is doing to another) and facilitating discussion and debate after each performance, giving people opportunities to share their own experiences and opinions.

d. Using both the performance and the following discussion to convey messages about healthy and positive attitudes and lifestyles and the specifics of HIV and how to prevent transmission. (Ashe’s performers are given specific training in the subject matter covered by their edutainment productions, so that they are prepared to engage with audiences and provide accurate information and good advice. They are guided by Ashe’s own IEC manual and its MSM module and also by CVC/COIN’s new peer education manual.)

e. Using these events to distribute IEC material, condoms and lubricants and to offer voluntary counselling immediately after each performance.

f. Aiming for up to two edutainment events per month and for an average of at least 30 MSM attending each event as audience members and participants.

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2. **To reach 160 MSM from 16 to 30 years old with voluntary counselling and testing for HIV and onward referrals.** This involves:
   
a. Providing HIV counselling and testing on site right after each post-performance. This is done in a private area separate from the performance space, to ensure anonymity and confidentiality. Some of Ashe’s performers are trained to provide pre- and post-test counselling and to do HIV testing with kits provided by the Ministry of Health.
   
b. Providing crisis counselling on site. After most performances, one or two audience members seek out the performers to talk about personal crises which sometimes require immediate attention.
   
c. Providing onward referrals for additional health or social care.
   
d. Aiming for at least 20 participants at each event to take up the offer of voluntary and confidential HIV counselling and testing.

**The results**

Jomain McKenzie and Marlon Tomlinson prepared Ashe’s final report on the TABS project and Ifidel Williams was one of the lead performers in “Safe Stupid or What”. At an informal meeting on 5 December 2012, they discussed the project’s achievements. They included:

1. **Exceeding the target of reaching 210 MSM with “Safe Stupid or What” events by 126 (or 60 percent).** Some MSM attended more than one event but, counting each individual only once, 336 MSM came to 12 performances and more than 70 attended one particular performance. Two probable reasons for the high turn-out were:
   
a. Kingston has no bars, cafes, bookstores or other safe spaces where MSM feel comfortable gathering and socializing. Each month, there may be one or two large parties in private homes but people who are not friends of the host do not always feel welcome at such parties. Thus, these edutainment events were rare opportunities for MSM to get together in a safe space.
   
b. Movies with MSM themes are rarely shown in Kingston and there are few opportunities to attend live performances with such themes. Some who attended these events said they had never before attended any kind of entertainment event that featured people like themselves and addressed the issues of greatest concern to them.
   
c. Word of mouth told MSM who had not attended that these events were very entertaining, stimulating and informative and they really should attend if they could.

2. **Exceeding the target of reaching 160 MSM with voluntary counselling and testing for HIV by 8 (or 6 percent).** That is, 168 (or 50 percent) of the 338 MSM who attended these events took up the offer. This is a better result than is usually achieved by events offering preventive education plus VCT on the side. Possible reasons for half the MSM not taking up the offer are:
   
a. They recently received VCT elsewhere and did not think they were due for their next HIV test.
   
b. They believed themselves to be at little risk of HIV because they did not engage in behaviours they believed would put them at risk or else they took precautions they believed would protect them from harm.
c. They believed that being HIV positive is not all that serious and that they would learn their status soon enough when they began presenting with symptoms.

d. They were afraid of learning their status because it could lead to exposure of their homosexuality or because they were not fully aware of how effective treatment can be.

For assessments by MSM who attended these edutainment events, see the box below.

The experience of young gay men who participated in TABS

On 5 December 2012, four young gay men who participated in the inter-active TABS events described their experiences. One said the whole production was first rate, the messages were very relevant and he thought everyone could easily relate to the characters. The others agreed, with one saying what Ashe does for gay men is far, far, far superior to what anyone else does. The members of Ashe serve as role models, provide a safe place, put on programmes that change young gay men’s lives, and even give them help with practical things like getting passports.

They said the production consisted of a series of scenarios and, depending on their own experience, each of them was more affected by some scenarios than others and each of them identified with some characters more than others. In one scenario, a father makes his young son perform oral sex on him regularly and the son is too ashamed and afraid to put a stop to it or ever tell anyone. In another, a schoolboy falls in love with one of the school’s athletes, is thrilled to notice the athlete returning his admiring glances and begins having sex with him but the athlete turns out to be rough and controlling and warns him never to tell anyone. Many — probably most — Jamaican gay men have had experiences like these but find it very hard to talk about them.

After each scenario, the audience was asked to rate the behaviour of the central gay character and decide if it was safe, stupid or what? It was like a game show as people competed to give the best answer and it got them all to relax, have fun and open up. In the discussion and debate after the performance was over they were ready to talk about their own experiences. Sometimes this awakened bad memories or focussed light on bad current situations and people were able to talk to members of Ashe afterwards and, if necessary, get referrals to someone better able to help them.

Some of them went on to participate in a related programme offered by Ashe. Called Attractor Factor, this programme consists of weekly sessions that might be described as a combination of focus group discussion and group therapy that sometimes asks participants to put on short plays that illustrate issues troubling them. These sessions teach them that there are three rules of empowerment: 1) what I think of myself is far more important than what anyone else thinks of me; 2) transform me and I transform the world I live in; 3) what I sew I also reap. These sessions also ask them to think about the five most precious stones they would like to give the man they love or they would like to receive from him. One said his five stones were respect, trust, communication, education, and independence.

They all agreed that they thought they knew a lot about HIV and AIDS and how to prevent them before they had participated in a TABS event but it had cleared up a lot of confusion and had taught them things they had not known before, such at the importance of using water-based lubricants with condoms. Beyond HIV and AIDS, both TABS and the Attractor Factor are all about learning “to love myself and to respect others.” They share a blog site at http://tabsattractorfactor.blogspot.co.uk/ and on that site you can find the phone number for a support line anyone can call if they need help.

Asked if they thought there were many MSM in Jamaica who could benefit from TABS and the Attractor Factor, they agreed that those who had participated so far were just a few of the most courageous ones. One said he guessed most Jamaican men had had sex with
other men at some time in their lives and that thousands were doing so every day. All such men could benefit from interventions such as these.

**The challenges**

While this pilot project was highly successful, some of the challenges it will have to meet as it evolves into a programme that covers ever more MSM across Jamaica are:

1. Whether or not Jamaica is near the top of the list of the world’s most homophobic countries, it is certainly near the top of the list of the world’s most violent countries and known or suspected MSM are often subject to verbal and physical violence. It has been difficult enough for Ashe to create a safe place where it can hold edutainment events for MSM in Kingston and it may be even more difficult to create such spaces in the country’s smaller cities, towns or villages.

2. These events may be successful in convincing MSM they should always use condoms and lubricants properly, whether with casual partners or their most trusted regular partners. However, there are very few places where MSM feel comfortable acquiring condoms and lubricants. They are widely available in pharmacies and other retail outlets but even heterosexual people find it embarrassing to buy them because they are not displayed on shelves open to shoppers. Instead, they are kept behind counters so that shoppers have to ask for them and risk the disapproving looks of pharmacists, shop clerks and other customers. MSM say they find it especially embarrassing to ask for water-based lubricants. These are normally purchased by women and asking for them leads to immediate suspicion that they engage in anal sex with other males.

3. Social marketing experts say that, to be effective, prevention messages must be repeated in different ways so that people continue to be reminded of them. Public HIV/AIDS prevention campaigns in Jamaica are aimed mostly at heterosexuals and do not focus on the particular behaviours that put MSM at risk. This means that MSM are not often reminded of the importance of taking appropriate precautions.

4. Because HIV/AIDS campaigns are mostly aimed at heterosexuals they do not emphasize the importance of using water-based lubricants for anal sex. In the discussions following these events it is evident that many MSM are not aware of this and, if they use any lubricants at all, they use oil-based ones that weaken condoms and make them tear.

5. Many MSM are paying less attention to HIV prevention because they believe that HIV treatment is highly effective. At the same time, some are afraid of getting tested because they believe that diagnosis is a death sentence. HIV/AIDS campaigns need to pay more attention to putting out balanced messages that make it clear that while treatments may be effective, they do not constitute cures, and that being HIV positive burdens people with the worry of having to pay very careful attention to their health for the rest of their lives and having to adhere to treatment regimes that often have unpleasant side effects and that may, at some point, cease to work very well.

6. While all health and social services should be MSM-friendly, that is far from the case in Jamaica and it will be continual challenge to arrange for access to such services for MSM across the country.

**The way ahead**

This pilot project has succeeded beyond expectations and has provided Ashe with the tools and methods it needs to sustain it and scale it up across the country. Ashe is entrepreneurial and skilled at both commercial sales and fund-raising but it will be an continual challenge for
it to achieve the financing needed to build on this pilot project and establish a long-term programme. Notwithstanding that such is the case, this project has produced a model of good practice that could be replicated across the Caribbean. There could be economies of scale if Ashe were to become the agency responsible for driving this replication.
Annex C1 (SWAJ, Jamaica)
Preventing HIV among sex workers

Overview

With a CVC/COIN Community Grant of US$20,000, the Sex Work Association of Jamaica (SWAJ) got itself better established with formal membership procedures, a strong Executive Committee, vision and mission statements, a 2013 work plan, the beginnings of a strong M&E system, a logo, and a Facebook page. SWAJ also held workshops to improve police-sex worker relations and these laid the foundations for scaled up and sustained efforts to improve sex worker relations not only with the police but with the media, health care providers and others.

Grantee: Sex Workers Association of Jamaica (SWAJ)

Established in 2009, the Sex Work Association of Jamaica (SWAJ) emerged from JASL’s work among sex workers on the streets of Kingston, Montego Bay and Ocho Rios. JASL had trained some as peer educators and was reaching out to others with peer education, condoms and lubricants and with access to voluntary and confidential STI and HIV/AIDS testing and treatment and other basic health and social services.

Princess Brown was the first President of SWAJ and Marlon Taylor was the first Secretary. At the 2012 Annual General Meeting, Marlon became President and Princess became Vice President when Members elected a new Executive Committee consisting of a President, Vice President, Secretary, Assistant Secretary, Treasurer, Assistant Treasurer, and Public Relations Officer. All are or have been sex workers with the exception of two: the Secretary works with the Jamaican Network of Seropositives (JN+), the Treasurer works with JASL and they were chosen for their expertise in procedural, legal and accounting matters and fund-raising.

In an interview on 4 December, newly elected President Marlon Taylor provided additional background. He said that SWAJ had no resources to do much before 2011, when UNFPA began providing them with significant financial and technical support. This helped them strengthen their organizational structure and operations and support a number of projects. During 2012, with additional support from their CVC Community Projects grant, they were able to carry on with this work and, for example, establish formal procedures for registering new members. By the time of the interview, 135 sex workers (116 women and 19 men) had filled out membership forms stating their names, addresses and numbers of children and identifying their next of kin (for contact in case of emergency). Of the Members, 35 (including 13 males) were in Kingston, 60 (including 2 males) were in Montego Bay and 40 (including 4 males) were in Ocho Rios.

During 2012, SWAJ formed a technical working group with nine members among which are representatives of the Ministry of Health, UNFPA, CVC, JASL, C-Change and other partner organizations. Out of this group grew vision and mission statements and a draft work plan for 2013. The plan calls for: advocacy within and outside of the sex worker community; co-hosting (with the Caribbean Sex Workers Organization) of a Caribbean regional conference of sex workers; additional training of sex workers in human rights and advocacy; and three rallies for sex workers’ rights. It also calls for strengthening the association’s M&E system and supporting the system with more training, all with the assistance of the Caribbean Health Research Council.
SWAJ is now working on getting established as a legal entity. It has its own email address and Facebook page, with a group open only to sex workers or allies who have been invited to join and then vetted by an administrator. They see no need for their own office space, since most of their work is on the streets, but they would like to have better arrangements for a room where they can hold their meetings. As for Marlon, he prefers to work on desks in the offices of CVC, JASL, J-FLAG and other partner organizations since this keeps him well informed about what they are doing and allows SWAJ to take advantage of any opportunities it may have to collaborate.

Always looking for additional financial or technical support, SWAJ is hoping various donors will support different elements of its 2013 work plan. They have applied to the Red Umbrella Fund, an international financing mechanism established by and for sex workers in 2012 and closely associated with Netherlands-based Mama Cash. In addition, they are preparing proposals for additional capacity-building support from UNFPA and project support from CVC/COIN and they are hoping they may also get some technical support from USAID’s Health Policy Project (HPP).

Focus on sex workers in the streets

Early partners of SWAJ were Eve for Life and PANOS Caribbean who played lead roles in producing "Oral Testimonies of Jamaican Sex Workers", a 48 page book published in November 2010 and containing stories told in their own words by 14 female and one male sex worker. These stories speak of poverty and verbal, physical and sexual abuse at home that drives adolescents into the streets where they often become pregnant and usually suffer further abuse by their clients, police officers and regular partners. They speak of why they tolerate such abuse: because they have next to no formal education, next to no options for employment and often have children in need of food, shelter, clothing, and education.

In July 2011, PANOS Caribbean released a video promoting the book, showing its launch and also showing sex workers soliciting clients on Kingston’s dark streets while speaking of their experiences. Available at www.youtube.com/watch?v=sTfmA1cSydl, SWAJ used this video to highlight recommendations emerging from its strategic planning exercise in 2011. The first recommendation was to launch a campaign sensitizing law enforcement officers to the human rights of sex workers and to encourage them to investigate complaints in an unbiased manner.

Marlon explains that, with its limited resources, SWAJ focuses mainly on sex workers in the streets. Among the male sex workers they have not focussed on (though they may in future) are beach boys and “rent-a-dreads”, the latter being men who cater to tourists’ fantasies of stereotypical Jamaican men and who often run stalls or shops in resort communities such as Montego Bay. Also among them are the house managers, desk clerks, bellboys, cleaning staff, and bar staff in hotels and other tourist establishments. The sex work these men do is all about opportunity, including the opportunity to emigrate to North America or Europe. They do not think of themselves as sex workers but they enter into relationships with tourists on the clear understanding that they will get gifts and cash in exchange, often including cash sent from overseas by foreigners who hope to see them again on future vacations and who know full well they will use the cash to support their Jamaican partners and children.

Among the female sex workers SWAJ has not focussed on, so far, are the female staff of tourist establishments and the many young women who come to Jamaica from other Caribbean Islands to stay in hotels during busy tourist periods, such as when American university students come during spring break. Neither has SWAJ focused on the widespread transactional sex whereby adolescents and young adults often exchange sex for goods and services they need or, at least, desire – even though SWAJ Members know from their own experiences that it is easy to transition from transactional sex to more overt commercial sex.
Responses tailored by and for sex workers

Marlon explains that SWAJ leaves peer education among sex workers to JASL and that he continues to be one of JASL’s peer educators. A significant challenge is that sex workers have been so inundated by people from various organizations informing them about HIV and how to prevent it that they no longer listen. One problem is that these messages are seldom tailored to fit their own realities. For example, when you get to know female sex workers you realize they are often single mothers who are willing to take almost any risks so long as they can get the money they need to provide their children with basic necessities and with good educations so they do not end up having to become sex workers too. Also, the 2011 Knowledge, Attitudes and Practices (KAP) study done by the Ministry of Health confirmed that sex workers have already learned to use condoms with their clients on a regular basis but they still do not use them with their “trusted” partners.

Where SWAJ can be most useful is in helping its partners reach a deeper understanding of how the world looks from the perspectives of sex workers and how best to help sex workers cope with their own realities. Here is one reality for many sex workers: they have met their regular partners on the streets or in the bars where they work. Their partners continue going to those places and connecting with other women. To avoid emotional turmoil and drama, they stop going to the places where they know their regular partners still go. SWAJ needs to do more work here, figuring out how to intervene and really drive home the message that this pattern of behaviour is even more risky than sex work itself, since it means that two people with multiple partners are having unprotected sex with each other.

Giving another example, Marlon says that the Ministry of Labour recently gave more than 50 sex workers opportunities to take courses offered by the Jamaican Foundation for Lifelong Learning and many of them only showed up once, to collect their weekly stipends for travel and lunch. Many sex workers have grade one levels of literacy, at best, and tend to operate on the basis of their own past experience or word of mouth from other sex workers. These tell them they will have to give up sex work if they want to qualify for job training, jobs or help starting up their own businesses. Again and again, they will do things like start to take advantage of offers for help with their own businesses only to see the help withdrawn when organizations making the offer find out they are continuing to engage in sex work. These organizations seem not to understand that most sex workers are poor and, again, will do anything necessary to get the money they need to support their children. If you require them to forego that money, your efforts to help them will fail.

In 2011, UNFPA collaborated with SWAJ on a project that supported sex workers in taking up offers of training, employment and business start-up opportunities while also continuing to do sex work. It was so successful that half the participating sex workers gave up sex work anyway. The project worked because it allowed them to do things at their own pace, including giving up sex work only after alternative ways of earning income had proven successful.

Context of the “Preventing HIV among sex workers” project

As mentioned earlier, the first recommendation arising out of SWAJ’s 2011 strategic planning exercise was to launch a campaign sensitizing law enforcement officers to the human rights of sex workers and to encourage them to investigate complaints in an unbiased manner. The stories told in “Oral Testimonies of Jamaican Sex Workers” are typical of the stories sex workers tell in their conversations with each other and they reveal that uppermost on their minds is safety in the very dangerous places where they do their work: on the streets, in their clients cars or homes, and in alleys, bushes and other places.
shielded from public scrutiny. Far from trusting police officers to protect them, they fear police officers because sex work is illegal in Jamaica, police officers share widespread prejudices against sex workers and often express their prejudices with acts of verbal, physical and sexual abuse and violence.

Other recommendations pertained to strengthening the capacity of SWAJ to serve as a mutual support mechanism for sex workers and to forge new alliances and strengthen existing alliances with many other partners, including the police.

**Original objectives and proposed methods**

The project extended from April through December 2012, and its original objectives and proposed methods were:

1. **To improve dialogue between sex workers and police officers** so they can put themselves in each other’s shoes, reach mutual understanding of issues related to human rights, the law, law enforcement, safety in public and private spaces, and the needs of both sex workers and police to be treated with respect and consideration. Proposed methods included:
   a. Two workshops in environments where at least 7 sex workers and 15 police officers feel comfortable in the frank exchange of information and opinion about each other’s experiences.
   b. Informing the workshop with information on the nature and scope of Jamaica’s sex work industry and on the human rights of all persons, including sex workers.

2. **To strengthen the capacity of SWAJ to serve and be accountable to its members.** Proposed methods included:
   a. Reaching agreement with cell phone service providers for special text messaging services enabling SWAJ and JASL to communicate with sex workers and send them messages about clinic operating days and hours, appointments for care and also reminders of safe sex and other harm reduction measure they should be taking. Among the aims was to increase uptake of services offered by JASL.
   b. Creating 45 new allies including police officers who might serve as the trusted persons for sex workers to contact in emergency situations or with complaints and who might serve as mediators.
   c. Developing an eight-month plan for putting a monitoring and evaluation system in place and training staff in how to implement the plan by recording their activities, submitting monthly reports and so on.

**The results**

Marlon Taylor prepared the end-of-project report and it shows that, broadly speaking, the project can be said to have achieved its original objectives but not always in the ways anticipated in the original proposal. In his 4 December 2012 interview, he explained that SWAJ is a fledgling organization that proceeds in a learn-as-you-go way and that the project ran into unforeseen challenges and opportunities that gave it a different shape at its end than the one envisioned at the beginning. Results were:

1. **Improved dialogue between sex workers and police officers** as follows:
   a. SWAJ arranged for six sex workers and three allies from JASL (one from each of its three chapters in Kingston, Montego Bay and Ocho Rios) to attend each workshop. The allies had a lot of experience working among sex workers and brought a lot of insights into the workshops. They also played a
mediating role, making sure the sex workers and police officers did not get into confrontations with each other. The facilitator was a behaviour change communications (BCC) specialist from the Ministry of Health. (Marlon explains that SWAJ enjoys good relations with the Ministry of Health in each of its four regions: north-eastern, eastern, southern, and western.)

b. The first training workshop was in July. To recruit police officers to attend, SWAJ contacted station commanders who selected the officers they thought should attend. A total of 11 police officers came.

c. The second training workshop was in September and this one was arranged after some police officers called SWAJ to say they wanted a second workshop soon because they had issues they wanted to discuss. In other words, the tide had already turned so that now it was the police officers and not the sex workers who were asking for a workshop and more dialogue. A total of 9 police officers came.

d. Both workshops were in St. Ann and it turned out to be difficult for police officers from Montego Bay to attend the second one, so SWAJ is now planning to hold a third workshop in Montego Bay.

e. The workshops were very successful from the perspectives of both SWAJ and the police officers who attended. (See box.)

2. **Strengthened the capacity of SWAJ to serve and be accountable to its members** as follows:

a. It proved too difficult to reach agreements with cell phone service providers and establish the text messaging services SWAJ and JASL had hoped to establish.

b. However, SWAJ used some of the project grant to establish a Facebook page with a closed group for its own Members.

c. While SWAJ did not keep track of how many new allies it acquired as a result of project-related activities, it continues to make good progress on expanding and strengthening its network of allies.

d. SWAJ was slow to get started on the CVC/COIN Community Grants project because it was still at an early stage of capacity development. CVC/COIN was sufficiently flexible in how the grant was used that SWAJ was able to use some of it for activities not anticipated in the proposal. These included:

   i. Developing a membership form and officially registering members
   ii. Recruiting and registering many new members
   iii. Holding more formal elections, with many members present, thus giving new strength and legitimacy to the Executive Committee
   iv. Developing a logo
   v. Developing a vision statement, mission statement and work plan and using these as the pillars for new fund-raising.

e. With technical support from JASL, CVC/COIN and the Caribbean Health Research Council, SWAJ is continuing with efforts to strengthen its capacity to do M&E so that it will be able to monitor progress on implementation of its 2013 work plan and of any new projects for which it is able to get financial or technical support.

**The challenges**

Marlon Taylor says that over the past year, SWAJ and its Members have been reaching an understanding that some of the big problems they face are more complex than they once
thought and that the immediately obvious solutions may not be the best solutions. For example, legalizing prostitution and creating red light districts might seem to be obvious ways of making sex work safer and improving relations with the police and the general public. Reports from other countries where such solutions have been applied, however, indicate that they come with rules, regulations and enforcement measures that protect a select few sex workers (e.g., very attractive young people who qualify for licenses and jobs in licensed establishments) but make life more difficult for all others. With that in mind, two key challenges for SWAJ are:

1. To reach towards better understanding of key issues and towards consensus among sex workers as to where they should stand on those issues. This can be done through research, discussion and debate within Jamaica but will also require SWAJ’s active participation in regional and international sex worker organizations.

2. To become more active in addressing factors that drive people into sex work and make them vulnerable to harm once they become sex workers. These factors include lack of education and employment opportunities and also alcohol and drug abuse and violence in homes and communities, including within the sex worker community.

The way ahead

SWAJ’s 2013 work plan indicates its direction for the immediate future. More generally, SWAJ is taking a realistic and practical harm reduction approach for the foreseeable future. This will involve scaling up and sustaining its efforts to improve relations between sex workers and law enforcement officials and extending similar efforts to health and social service providers, the media and others. During his interview Marlon said, “The state is just not interested in helping these women (i.e., female sex workers) as poor single mothers who have few options for supporting their children.” Looking further ahead, hopefully SWAJ will be able to look back and say it played a role in getting the state to care more.

SWAJ and police officer perspectives

In interviews on 4 and 5 December 2012, Marlon Taylor and three police officers from the Jamaican Constabulary Force (JCF) gave their assessments as to how well SWAJ’s July and September workshops had succeeded in improving dialogue between sex workers and the police.

Marlon says the workshops bridged a large gap between sex workers and the police and, as a result, there are already significant improvements in the way they relate to each other in the streets. For the first time, some sex workers are saying they trust the police enough that they call them in emergencies and find they can get the assistance they need. For example, one sex worker got into a situation with a client where she was beginning to fear for her life. When she had an opportunity, she called the police on her cell phone. The police soon arrived on the scene and arrested the man.

The three police officers interviewed were from three different JCF police stations and had three different areas of responsibility. One was from the JCF’s Training Branch, which provides on-the-job training to recent graduates from the training academy; one was from the Community Safety and Security Branch; one (the only male) was from the Centre for Investigation of Sexual Offences and Child Abuse. They explained that the JCF has been committed to Community Policing since 1992. It has gradually developed and refined a set of policies (available on the JCF website at www.jcf.gov.jm) to guide and reinforce this approach and these include a Diversity Policy calling for equal treatment of everyone regardless of their social status or personal characteristics and beliefs.

They said their participation in the SWAJ workshops was part of JCF’s on-going efforts to build partnerships with different elements of the Jamaican community and they described the workshops as “eye openers”. One said the workshops had helped them “stand on the other
side of the fence” and look at police officers and their attitudes and behaviours from sex workers’ perspectives. “We talked about how everyone has feelings. People are hurt when the police treat them disrespectfully, use bad words to refer to them and do not appreciate their circumstances, what they have to do just to sustain their lives.”

At the same time, the workshops had helped sex workers understand that their attitudes and behaviours in the presence of the police are not always respectful and considerate either. For example, when one gay male sex worker comes to a police station he is often accompanied by others who have no good reason for being there other to create a ruckus that alarms other members of the public who happen to be at the police station at the same time.

The workshops had given the police officers opportunities to explain the laws and the standard enforcement procedures the police are obliged to follow. It had also given them opportunities to advise the sex workers on how they can conduct themselves in the streets in ways that do not draw public complaints or police attention.

The three officers said their regular training focuses mainly on laws and enforcement procedures and covers their community policing, diversity and other policies in general ways but does not usually bring them face-to-face with different groups in the community in the way these workshops had done. As for spreading the lessons they learned in the workshops to other members of the JCF, this is not now done in any structured way. However, they are required to submit reports to their commanding officers and the commanding officers discuss these at the weekly tasking meetings attended by commanders from all stations.

They all agreed they would like to see a lot more of this kind of training, covering more police officers and with sessions that focus on particular issues including: how to prevent HIV and AIDS among sex workers and their clients; why there seem to be so many more young people going into sex work; the plight of boys rejected by their families because they are suspected of being gay and who end up homeless and earning money in sex work; the connections between the sex work, gun running and drug dealing that often take place in the same venues and involve the same people; theft and violence among sex workers and between them and their clients; human trafficking. One said that she would like to see a lot more attention paid to verbal and physical violence within families, including the violence mothers inflict on their sons and how this produces men who inflict violence on women, whether or not they are sex workers.

As for police-sex worker liaison, these three officers were all doing it an informal way but there was apparent need more to be done in conjunction with more training.
Annex C2 (CEPROSH, Dominican Republic)
Prevention of HIV/AIDS among migrant Haitian sex workers

Overview
With a CVC/COIN Community Grant of US$20,000, el Centro de Promoción y Solidaridad Humana (CEPROSH) undertook a pilot project that, from May through November 2012, provided STI and HIV/AIDS prevention, care and treatment to migrant Haitian sex workers in the Province of Puerto Plata, Dominican Republic. The project focussed on four municipalities ─ Cabarete, Montellano, San Felipe de Puerto Plata, and Sosúa ─ and within those municipalities it focussed on locations where migrant Haitian sex workers are well known to work. These included beaches and streets frequented by tourists and also bars and other establishments in Muñoz, a batey on the outskirts of San Felipe de Puerto Plata.

Grantee: Centro de Promoción y Solidaridad Humana (CEPROSH)
Website: http://www.ceprosh.org

Founded in 1987, El Centro de Promoción y Solidaridad Humana (CEPROSH) — the Centre for Human Advancement and Solidarity — achieved legal status in 1996. From its headquarters and Integrated Care Unit in Puerto Plata and an extension of the Unit in Dajabón, CEPROSH promotes and supports the development and implementation of community health policies and strategies with emphasis on sexual and reproductive health. It also delivers a range of services that include:

- Promotion of healthy lifestyles and harm reduction through education:
  - Of vulnerable communities, families and individuals including women with low incomes and little formal education, youth, undocumented migrants, batey residents, commercial and transactional sex workers, people living with HIV, plus orphans and other vulnerable children and their carers
  - Health providers, community leaders, religious leaders, and law enforcement officials including those responsible for immigration control
- Pre- and post-natal counselling and care for pregnant girls and women, new mothers and infants
- STI and HIV counselling, testing and treatment
- Nutritional counselling and support
- Home care and hospital visits
- For batey residents, referral to Muñoz Primary Care Centre where they can get free comprehensive care that includes general medicine, dentistry and immunization
- Micro-credits for people in urgent need of basic necessities.

CEPROSH’s programmes and projects sometimes focus on particular communities within one or two provinces but often reach across many provinces in the Dominican Republic’s Northern Region. This region has a thriving agricultural industry and associated with that industry are bateys ─ informal settlements that are home both to migrants from Haiti and to ethnic Haitians who have been living in the Dominican Republic for generations but still do not qualify as citizens and so do not qualify for the full range of public education, health and social services. (The Inter-American court hears many cases of alleged human rights violations against the Dominican-born-and-resident descendents of Haitian immigrants.)
These reflect the historic and continuing tensions between the Dominican Republic and Haiti and its migrants.

The coastal resorts along the Amber Coast of the Province of Puerto Plata are among the most popular in the Dominican Republic and serve as second homes or retirement homes to many Europeans and North Americans. However, in recent years, much of the up-market tourism has been migrating to Punta Cana in the country’s southeast and the Amber Coast has been attracting a lot of down-market tourism, including sex tourism by Europeans and North Americans of comparatively modest means. The province is in a free trade zone and is also temporary home to many migrant workers from elsewhere in the Dominican Republic and from other Caribbean countries. These factors all contribute to a thriving and complex sex work industry.

Dr. Bayardo Gómez is the Executive Director of CEPROSH and Alexandra Lister is the Programme Manager. In an interview on 25 June 2012, they explained that CEPROSH’s first major project was called the Avancemos Project and its first phase extended from 1993 to 1997. COIN headed up that phase which was also supported by Family Health International (FHI), with financing from USAID. The project has since been extended repeatedly and continues to target sex workers with HIV and AIDS prevention.

In 1996, the newly established Movimiento de Mujeres Unidas (MODEMU) joined CEPROSH and COIN in a three way collaboration that has continued ever since. The three organizations have developed a “health messenger” approach to peer education together with training manuals and IEC material. The content of these collaborations has varied, depending on what donors have been willing to support, but they have allowed for the continuing development and refinement of the “health messenger” approach. At first they focused on female sex workers but then they began covering male and transgender sex workers, then intermediaries in the sex work industry (e.g., guest house and bar and club owners and taxi drivers) and then clients of sex workers. Occasionally, Amigos Siempre Amigos (ASA) has joined in these collaborations — for example, supporting efforts to target male sex workers in specific areas of Puerto Plata.

Back in 1993, CEPROSH had only three people (trained by COIN) working as health messengers and they were able to cover no more than 20 to 30 bars, clubs, guest houses and other business establishments in urban areas where sex workers met their clients. By 2002, they had roughly 30 health messengers working out of CEPROSH’s headquarters and Integrated Care Unit in Puerto Plata and from 16 to 18 scattered through 8 provinces.

With the advent of the President’s Emergency Plan for AIDS Relief (PEPFAR) in 2002, it became more challenging to qualify for financing from US Government sources. Under the Bush administration, PEPFAR was bound by an anti-prostitution policy that ruled out certain activities but still made it possible to proceed with the health messenger approach. Under the Obama administration, the rules became minutely detailed and required the precise quantification of interventions with checked boxes and signatures. This made it harder to support street theatre (with HIV prevention messages) or certain interventions in bars and brothels where it would be impossible to find many bar owners or sex worker clients willing to sign forms saying they have benefited from interventions.

Which administration’s rules were easier to follow? It would be hard to say but the fact is that, when major donors change their policies, CEPROSH and its collaborating partners are obliged to change their methods and not always for the better. When the new rules are unrealistic or naïve and not based on local knowledge, they can impede progress.

Other donors — e.g., Global Fund, PAHO, UNICEF, University of California at San Francisco, Levi Strauss, Johnson and Johnson, and the Autonomous Community of Rioja
CVC/COIN Vulnerabilized Groups Project: Phase One

(Spain) — have supported various other projects and programmes. The most significant of these is the Integrated Care Unit, which provides antiretroviral therapy to more than 1,000 patients and includes a laboratory that does all of the necessary blood tests. Established eight years ago, this Unit was the first in the Northern Region and is now one of the top five in the country.

With support from the World Genesis Foundation, the Unit’s extension in Dajabón serves people in provinces bordering on Haiti. Out of that Unit CEPROSH provides HIV prevention, testing and treatment to five sub-populations: people living with HIV and their families, transport workers (e.g., truck, bus and taxi drivers), orphans and other vulnerable children, women with little education, and female sex workers and their clients.

One measure of CEPROSH’s success is the vastly increased number of condoms they now distribute in the Province of Puerto Plata alone. When they started out, they were distributing 6,000 per year and they are now distributing more than 1 million per year. Collaborating with each other on social marketing of condoms, CEPROSH and COIN now distribute around 2 million condoms per year throughout the Northern Region.

**The project’s context**

The better paid sex workers of the Province of Puerto Plata work in the bars, clubs, guest houses and other establishments that cater to tourists and comparatively well-off locals. The lower paid sex workers tend to be migrant Haitians who have little education, speak Creole but often little or no Spanish or English, and work on the beaches, in the streets or in *bateys*. CEPROSH’s health messengers have been covering the non-batey/establishment-based sex workers for years but they have not been so successful at reaching the migrant Haitian sex workers, who have much higher rates of HIV prevalence.

This situation reached crisis proportions after the Haitian earthquake in January 2010. There were suddenly many more migrant Haitian sex workers (and girls as young as 12 or less exchanging sex for cash or favours) in the province and they were charging very competitive rates. Typically, a Dominican sex worker sets her basic rate at around 800 pesos (US$ 20) and charges another 300 pesos for more time or for sex without a condom. The Haitian sex workers charge much less and there is rapidly increasing demand for them, mostly by local Dominican men. The competition has been creating tension in the whole sex work community and has lead to street fights between Dominican and Haitian sex workers. These fights threaten to undermine the work CEPROSH has done to sensitize the police so it is easier to do harm reduction among sex workers and their clients.

**The objectives**

Extending from May through November 2012, the project had three objectives:

1. **To recruit and train 18 migrant Haitian sex workers as health messengers**, with two senior ones paid to act as the leaders of eight volunteers each.

2. **To reach 240 other migrant Haitian sex workers** with health messages, supplies and referral to services.

3. **To provide all 240 with access to free health services**, including voluntary counselling and testing for HIV and STIs and, when necessary, treatment.

More generally, the aim was to establish a network of health messengers the migrant Haitian sex workers felt they could trust during the project period and, afterwards, to sustain and expand that network.
The methods

The project began with the recruitment of two former Haitian sex workers (Monica and Elizabeth) who were well settled in Puerto Plata, were already trained and experienced as health messengers and who spoke both Spanish and Creole. Acting as leaders, these two helped recruit and train sixteen volunteers who were given two days of health messenger training and were then asked to provide peer education to at least 15 other migrant Haitian sex workers each at the selected locations. (One of these 16 volunteers, Yvette, had prior training and experience that allowed her to act as a third leader, though the budget was not sufficient to pay her as such.)

As the project got underway, CEPROSH added a field coordinator (Sheila) at its own expense as it became apparent that it was a major challenge to arrange for the transportation of the health messengers from their widely scattered homes to the widely scattered locations where migrant Haitian sex workers could be found at the times of day or night when they were most likely to meet potential clients; to arrange for sex worker visits to the Integrated Care Unit or the Muñoz Primary Care Centre at times where CEPROSH's doctors, nurses and counsellors were prepared to see them. The field coordinator also acted as an observer, able to identify challenges as they emerged. (Like most of CEPROSH's regular staff, Sheila does not speak Creole and depends for translation both on the health messenger leaders and on CEPROSH's Spanish-Creole interpreter, Paul.)

Along with IEC material in Creole, the health messengers distributed and demonstrated the proper use of male condoms and provided referrals and accompaniment to the Integrated Care Unit or the Muñoz Primary Care Centre. CEPROSH arranged for its doctors, nurses and counsellors to be available exclusively to the migrant Haitian sex workers at designated times, three days per week, and asked the health messengers to bring the sex workers to them in batches.

Not long into the project, CEPROSH recognized that it had been a mistake to publicize the project as one meant exclusively for sex workers. There is too much stigma and discrimination surrounding the label “sex worker” and the reality for many Haitian girls and women is that they are desperately poor, engage in transactional sex for survival (of themselves and their children) and sometimes engage in purely commercial sex (for cash with strangers) without ever having thought of themselves as sex workers.

CEPROSH also soon recognized that unwanted pregnancy is very common among under-aged Haitian girls, whether or not they engage in transactional or commercial sex, and that this is due not only to the girls’ lack of knowledge about sexual and reproductive health but to the lack of knowledge of the boys and older men who are their sexual partners. CEPROSH also soon recognized that sexual coercion and abuse is very common among poor Haitian migrants and that Haitian males often use their female partners as sources of income, actively encourage their engagement in sex work and, also, actively discourage their engagement with anyone (e.g., health messengers) who might threaten their power over their female partners.

With additional financial support from CVC/COIN (supplementing the Community Grant), CEPROSH was able to begin addressing these issues with community education aimed at adolescents and adults of both genders, whether living in bateys or poor urban neighbourhoods.

The results

By the project’s end in November 2012, it had:
1. **Achieved the objective of recruiting 18 migrant Haitian sex workers as health messengers**, with two senior ones paid to act as leaders and a third senior one volunteering to act as a leader.

2. **Exceeded by 20 percent the objective of reaching 240 other migrant Haitian sex workers with health messages;** reached a total of 289 with messages but fell short of providing them with enough in the way of supplies because:
   a. A countrywide shortage of male condoms occurred while the project was underway, so the health messengers did not always have enough to distribute to everyone who wanted them
   b. No current donor provides or finances lubricants to go with male condoms
   c. No current donor provides or finances female condoms even though they are known to be highly effective for sex workers, freeing them of having to negotiate protected sex with their clients or their regular partners.

3. **Exceeded by 11 percent the objective of providing 240 migrant Haitian sex with health services;** of the 266 provided with services:
   a. All 266 were tested for STIs, 166 (62 percent) were found to have at least one STI, many were found to have two or more STIs, 100 percent of those with STIs were treated
   b. Only 105 (40 percent) were provided with voluntary HIV tests together with pre- and post-test counselling; the problem was not that women did not want to take up the offer but that CEPROSH was unable to extend the offer to everyone because they were unable to procure all of the chemical re-agents they needed to conduct the tests.
   c. Of the 105 tested for HIV, five (4.8 percent) tested positive and two of those were pregnant. CEPROSH gave all five comprehensive care and treatment including the recommended measures to prevent vertical transmission from mother to unborn child.

4. **Beyond its original objectives, reached a total of 1803 people with interventions that included meetings with community members and leaders of both genders and all ages to begin providing them with basic sexual and reproductive health information and education and also included additional efforts to sensitize police and other authorities about the issues that impact on migrant Haitian women whether or not they engage in transactional or commercial sex.**

**The challenges**

1. **Initial fear and suspicion of migrant Haitian sex workers**, including:
   a. Fear that their status as undocumented migrants and as sex workers could result in their deportation or imprisonment if they took the risk of engaging with any strangers (e.g., health messengers) who might report them to authorities
   b. Fear that their regular male partners would disapprove of their engagement with any such strangers
   c. Suspicion of scientific medicine and preference for religious or traditional remedies. In their initial engagement with health messengers, many Haitian women say they believe God will prevent or cure illness if they place their faith in Him and prey regularly. Others say they trust the herbal and other remedies offered by traditional healers. Some are deeply suspicious of
medical practitioners and believe, for example, that they conspire with government authorities to deceive Haitian immigrants into taking tests and treatments that, in fact, infect them with HIV and eventually kill them.

2. **Haitian sex workers' illiteracy and lack of proficiency in Spanish** together with most CEPROSH staff’s lack of proficiency in Creole and the lack of good Creole IEC material all made it difficult to make sure that health messengers were imparting accurate health messages.

3. **Logistics was major challenge** and called for significant expenditures on transportation (e.g., fuel for vehicles, payment of drivers)

4. **While recruiting volunteer health messengers, the fact that only the two lead ones would be paid proved something of a challenge.** However, all recruits are now strong advocates for the health messenger approach and for the benefits it offers to those who train and work as health messengers. (See Monica's testimony in box below.)

5. The project highlighted the fact that all efforts to mount effective responses to HIV among the sub-populations most vulnerable to HIV in the Dominican Republic are hindered by the lack of Government support for such efforts. This means that **male and female condoms and lubricants are not made readily available** to the people who need them when they need them and it also means that **basic medical supplies are not consistently available** so that HIV testing and treatment can be offered in timely manner.

**The way ahead**

On 30 November 2012, the whole project team, including the project’s 18 health messengers and a number of other migrant Haitian sex workers who had benefitted from the project assembled at CEPROSH’s headquarters to do their own end-of-project evaluation and to begin thinking about the way ahead. The foregoing discussion summarizes key conclusions of their evaluation. As for the way ahead, there was consensus that the project had been immensely beneficial for the 18 health messengers themselves and for the migrant Haitian women who had benefitted from their efforts and that the way ahead should be to continue expanding the network of health messengers, providing them with more training and improving their tools until they were able to reach out to the whole ethnic Haitian community and to health care providers, police and other authorities who interact with that community.

Alexandra Lister, CEPROSH’s Programme Manager, said the project had “opened a Pandora’s box’ and demonstrated that there is urgent need for sexual and reproductive health interventions that benefit thousands of migrant Haitians and that focus, in particular, on empowering girls and women to see to their own sexual and reproductive health needs and to provide for the health and well-being of their children.

**Monica’s testimony**

Monica was one of the leaders of the project’s health messengers and, in a private interview, she spoke of how too many migrant Haitian girls and women are silenced by their own shame. This shame is something they have learned from their own culture, which makes it taboo for women to talk about sex; about how they are controlled, exploited and abused even by boys and men in their own families; and about how they learn to blame themselves when exploitation and abuse happens.

She said that she was no exception to the rule that Haitian girls and women learn to feel ashamed and don’t share their experiences with other women, even though such sharing would be a major step in the direction of doing something about their collective situation. With that in mind, she said she wanted to tell her own story for the first time and get it down
on record so it can be repeated and so that the many other girls and women with similar stories can see they are not alone.

When Monica was only 12 years old she was raped by a man in her own family and her mother blamed her (not the man) and threw her out of the house. Out on the streets, she met other men who listened to her story and pretended to sympathize and take an interest in her welfare but they always wanted sex in exchange for any tangible support. Eventually, she met a man she really liked and who she thought liked her and she married him when she was 16 years old.

Everything seemed okay until she got pregnant. He came home one day and put two pills on the table in front her and told her she had a choice: either she could take the pills and they would cause her to abort the baby or else he would leave her and never see her again. She so much wanted to have a baby, she had been brought up to believe that abortion was a major sin and she had heard about those pills and how they could make her very sick and might even kill her as well as the baby.

She chose to keep the baby and after it was born she found herself desperate to see to its needs. Another woman who pretended to be her friend told her about how she could earn money as a sex worker and took her to a madam who agreed to take her on as one of her girls. She knew almost nothing about sex and was not good at it and the madam soon fired her, giving her only 300 pesos (US$7.50) as her final pay.

She tried very hard to find work and eventually she found a family willing to employ her as a housekeeper even though she had a child. Eventually, she met a good man and she married him. Her daughter recently graduated from elementary school and she and her current husband are so proud of her. The birth father has never provided her or her daughter with any support nor even shown any interest in even meeting their daughter. It is his loss, because she is such a beautiful child.

Monica says she is not proud of having been a sex worker but she would do it a thousand times again if it was the only way she could provide for her daughter. CEPROSH’s health messengers had helped her and then encouraged her to train as a health messenger herself. They taught her to be proud of herself and of how she had cared for her daughter without any help from the birth father.

She says the work done by CEPROSH is so important. There are many young Haitian women in situations like the one she was in and many of them have children. Those women and children don’t deserve to be shunned and punished, they deserve to be helped. Also, other women and girls need to be provided with sexual and reproductive health information and services that prevent them from getting into similar situations.
Annex C3 (FPATT, Trinidad and Tobago)
Sex Workers for Change: improving the sexual and reproductive health of migrant Hispanic sex workers

Overview

With a CVC/COIN Community Grant of US$20,000, the Family Planning Association of Trinidad and Tobago (FPATT) extended sexual and reproductive health and rights (SRHR) education, supplies and services to migrant Hispanic sex workers in Port of Spain and Chaguanas. This project grew out of research showing stigma and discrimination against migrant Hispanic sex workers for multiple reasons: the nature of their work, their low levels of education, their inability to speak English, and the fact that they are undocumented migrants competing with local sex workers and not qualified for the host country’s health and social services. The research showed they are not well-informed about HIV and AIDS, never use female condoms, and often do not use male condoms correctly or consistently with their regular or casual partners. They do not know where to get tested for HIV, do not trust promises that the results will be treated in confidence, and do not feel comfortable when visiting clinics and hospitals in part because of their inability to communicate in English.

Grantee: Family Planning Association of Trinidad and Tobago (FPATT)

The International Planned Parenthood Federation (IPPF) was founded in 1952 at the Third International Conference on Planned Parenthood in Bombay, India. It was born out of advocacy by three strong women from India, Sweden and the United States who had all spent time in their country’s prisons for daring to argue for women's right to decide if and when they would have children. Since then it has grown into a worldwide federation of national family planning associations that operate in more than 180 countries and support more than 65,000 clinics and other points for delivery of sexual and reproductive health services, including advocacy, education, counselling and medical services designed to prevent, diagnose and treat cervical cancer, STIs and HIV and AIDS.

The Family Planning Association of Trinidad and Tobago (FPATT) opened its first clinic, in Point Fortin, in September 1956 with the aim of providing medically approved and subsidized family planning services to low-income people. It joined the IPPF in 1962 and it now runs five clinics: one in San Fernando, two in Port of Spain, one in Tobago, and a mobile clinic that delivers services directly to remote or otherwise hard-to-reach populations. Opened in 2001, one of its two Port of Spain clinics is supported by the Youth Advocacy Movement (YAM) and is called De Living Room because its waiting room is comfortably furnished and has a television and small cybercafé service.

FPATT is a fully accredited Member Association of the IPPF. As such, it is required to meet the IPPF’s 10 fundamental principles and 49 standards for governance, management and services. FPATT provides:

- Family planning information and counselling
- Access to contraceptive methods, both temporary (pills, diaphragms, injectables) and permanent (tubal ligations and vasectomies).
- Access to preventative screening for breast, cervical and prostate cancer through pap smears, breast examinations and digital rectal examinations.
- Access to infertility testing and counselling.
• Access to voluntary counselling and testing for HIV.
• Sexual and reproductive health care for adolescents.
• Advocacy for legal reform in the areas of sexual rights and gender.

FPATT is a strong advocate for sexual and reproductive health and rights (SRHR) and campaigns for legal reform to protect the rights of people of all gender-identities and sexualities and to eliminate unsafe abortion. It is committed to promoting and supporting SRHR for adolescents and providing them with age-appropriate information, education and services. It is also committed to promoting and supporting SRHR for sex workers and, since 2006, has been doing outreach work that provides them with information, education, supplies, and services. Each year FPATT presents an annual Report to the Nation in which it highlights needs for government action on SRHR.

Each year, FPATT receives funding from its parent body (IPPF) to cover its core expenses and, also, a subvention from the government of Trinidad and Tobago. Other recent donors have included the Citizen Security Programme of the Ministry of National Security; Canada Fund for Local Initiatives (CFLI) and UNFPA for services to marginalized youth; Population Services International (PSI) for services to sex workers.

**Context of Sex Workers for Change**

Every year, thousands of women migrate from lower-income to higher-income Caribbean countries to earn money doing sex work and many are supporting families and children back home. In 2008, COIN published the results of its study finding that these women are stigmatized in the host countries for a number of reasons: they are not only sex workers but they are undocumented (i.e., illegal) migrants who compete with local sex workers and often do not speak the local language.106

In 2012, COIN/CVC published the results of a 2011 survey (assisted by FPATT) that covered 60 migrant Hispanic sex workers in Trinidad and Tobago and found they were mostly from Dominican Republic, Columbia and Venezuela.107 More than three-quarters had lived in the country for less than a year and many for less than four months. Their levels of education were low (with less than 30 percent having completed primary school) and they had little knowledge about HIV and how to prevent its spread. While most knew it could be transmitted sexually, three-quarters believed it could also be transmitted by mosquitoes. None had ever used a female condom; only one-quarter had been taught how to use a male condom correctly; two-thirds did not use them consistently with their regular partners; more than one-third did not use them consistently with their casual partners. Half had been verbally or physically abused by their clients, 20 percent had been forced to have sex, and 30 percent had been arrested by the police.

Nearly half had been tested for HIV within the past 12 months but less than 10 percent knew where they could get tested in Trinidad and Tobago and only 12 percent felt they could trust promises of confidentiality. Those who worked in brothels — officially operating as bars but with rooms for sex work — worried that owners and staff would learn they were HIV-positive and would spread the word. Half did not have routine health checkups and half said it was difficult to access health services. As undocumented migrants they had no access to the public health care system and more than three-quarters said they felt uncomfortable in any private clinics or hospital they had visited. They said that language was a major obstacle, since not knowing English made it difficult for them to communicate health care providers.

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106 COIN (2008).
Trinidad and Tobago has no civil society organization representing and serving sex works and advocating for their rights. Even if it had such an organization, its local members might not welcome migrant Hispanic sex workers as members because they are seen as unfair competition, offering lower prices for the same services.

**Objectives and proposed methods**

FPATT knew that its outreach to street- and brothel-based female, transgender and male sex workers had not reached many migrant Hispanic sex workers principally because they had never a specific focus or FPATT’s inventions but also because of language and cultural barriers and their undocumented status. It proposed to close the gap with a pilot project extending from April through November 2012. The project’s overall objectives were: first, to prevent HIV and STIs and reduce their harm among migrant Hispanic sex workers in Port of Spain and Chaguanas; second, to increase their knowledge about human trafficking and gender-related violence so they can better protect themselves from both practices. The specific objectives and proposed methods were as follows:

1. **To provide peer education to migrant Hispanic sex workers** by:
   a. Recruiting, training and deploying at least two bilingual Hispanic sex workers to provide outreach to their peers
   b. Using FPATT’s outreach methodology:
      i. Placing sex work in a human rights framework and addressing issues such as human trafficking, gender-based violence, and sexual and reproductive health and rights
      ii. Training sex workers as outreach workers and placing them at the centre of efforts to provide prevention and access to care and treatment
      iii. Delivering services on-site (on the streets and in the establishments where sex work takes place) and in FPATT’s clinics
      iv. Securing support and collaboration by authorities including the police and immigration officers
   c. Using FPATT’s approach to sex workers:
      i. Recruiting and training outreach workers from among them, who understand them and who can gain their trust
      ii. Approaching sex workers in their own work environments
      iii. Developing education materials specific to the sex workers and validated by them
      iv. Working not only with sex workers but also with their clients and intermediaries (e.g., business owners, taxi drivers).
   d. Taking into account that sex workers’ failure to use condoms correctly and consistently has much to do with their lack of power and inability to negotiate safe sex with their clients or safe relations the police.

2. **To facilitate the migrant Hispanic sex workers access to FPATT’s sexual and reproductive health services (including voluntary counselling and testing for HIV)** by:
   a. As part of the peer outreach workers’ training, familiarizing them with the services offered by FPATT’s stationery and mobile clinics.
   b. Having the peer outreach workers distribute vouchers for low-cost health services at the clinics.
c. Having the outreach workers accompany the sex workers to the clinics and then do follow-up (e.g., making sure they adhere to prescribed treatments).

d. Having a Spanish-speaking counsellors and health care personnel at the clinics.

3. **To establish informal mutual support groups for migrant Hispanic peer educators** by:

   a. Recognizing they are rivals on the streets and in the establishments where they work, but helping them recognize they also have common concerns and can help each other address those concerns.

   b. Providing safe environments where they can feel at ease and confident enough to talk about their individual and collective needs and aspirations.

   c. Building strong relations between the groups and FPATT so they have mutual respect and trust.

   d. Recognizing that the sex workers are concerned about a wide range of needs and helping them address needs, for example, for primary health care, nutrition and physical safety.

   e. Having access to sexual and reproductive health services available right after support group sessions.

   f. Always recognizing that it is up to the sex workers to determine the agendas of their support group sessions, including who they would like to invite as speakers.

FPATT proposed to use the findings of the 2011 survey covering 60 migrant Hispanic sex workers as a baseline against which to measure progress.\(^{108}\) Thus, the project’s results would be measured in terms of numbers of migrant Hispanic sex workers covered by its interventions and, also, the percentages of those numbers who:

- Have more knowledge about HIV, human trafficking, gender-related violence and related issues.

- Have more knowledge about how to negotiate condom use and how to use condoms correctly

- Report that their support groups have fostered better relations with FPATT and more trust of FPATT as a service provider.

The results achieved

At an informal meeting on 23 November 2012 at FPATT’s headquarters in Port of Spain, FPATT’s Executive Director Dona da Costa Martinez and the Sex Workers for Change Project Focal Person Roxanne Layne discussed the project’s challenges, achievements and hopes for the future. A few days later, Roxanne submitted the end-of-project support.

In summary, the Sex Workers for Change project:

1. **Recruited, trained and deployed three Hispanic sex workers, one as Project Assistant and two as outreach workers**, as follows:

   a. FPATT found it difficult to find suitable candidates through its network of sex workers and finally settled on three who spoke some English. Of those three, only one could be described as bilingual and she was chosen to act as Project Assistant, working under Roxanne’s supervision. They had hoped to find one with enough English, prior training and experience to qualify as Project Coordinator but that had not proven possible.

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b. FPATT provided five days of training to the Project Assistant and two outreach workers. FPATT’s trainer was highly qualified but did not speak Spanish, so the Project Assistant had acted as translator. It subsequently became apparent that the translation had been imperfect and the outreach workers had missed learning things it was important for them to know. This problem was exacerbated by the fact that there was no Spanish language training material, so the outreach workers had to commit information to memory and went away with nothing to reinforce their memory.

c. Due to difficulties in recruiting suitable candidates, the Project Assistant and outreach workers were not ready to be deployed until July.

2. **Provided migrant Hispanic sex workers with access to sexual and reproductive health education, supplies and services** over a four month period, from July through November 2012, as follows:

   a. Exceeded the target of reaching 100 and reached a total of 330 with peer education and offers of condoms and services
   b. Distributed 1758 male condoms and 493 female condoms
   c. Provided voluntary counselling and testing for HIV to 78
   d. Provided sexual and reproductive health services to 83
   e. Provided 5 with birth control methods (pills, diaphragms, injectables) other than condoms
   f. Recorded all interventions on the forms provided by CVC/COIN and reviewed these during meetings with the Project Assistant three times each week and with the outreach workers once per week

3. **Added to knowledge about the characteristics of the migrant Hispanic sex worker populations** (see box) and about the challenges in providing them with SHRH information and services.

<table>
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<tr>
<th>The project’s contribution to knowledge about migrant Hispanic sex workers</th>
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<tr>
<td>Through the Sex Workers for Change project, FPATT learned that migrant Hispanic sex workers probably constitute more than half of all female sex workers in Trinidad and Tobago. They can be found among the country’s male sex workers, too, but seldom among its transgender sex workers. While some are from Columbia and Venezuela, most are from the Dominican Republic.</td>
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The Dominican sex workers are spread throughout the country and can be found wherever there are bars and other establishments that function as brothels. These brothels can be found in or near almost every small town or village. Many of the Dominican sex workers are trafficked — i.e., tricked into believing they are coming to take up legal jobs, usually as domestic servants. Many others come with the idea of learning English and staying in the country. Many do stay, marrying local men or, at least, becoming their regular partners. A few have social insurance cards so they are able to access public health services. Many have children, either in Trinidad or Tobago or back home in the Dominican Republic, and supporting their children is often their primary motive for engaging in sex work.

The Dominican sex workers are connected through a countrywide network of relatives, friends, acquaintances and co-workers and through local branches of that network. New arrivals find themselves part of this network and it provides them with ready-made support groups. This is so despite the fact that there is also intense and sometimes violent rivalry among sex workers, as they try to knock out the competition for clients.

One thing they have in common is the need to look attractive and this means they go to beauty salons run by other Dominicans, often ones who also work part time as sex
workers. These beauty salons serve as ready-made safe places, where it is comparatively easy to deliver peer education and offer VCT.

**The challenges**

FPATT hopes there will be a phase 2 to the Sex Workers for Change project and, ultimately, to have it established as a permanent programme serving the ever changing population of migrant Hispanic sex workers in Trinidad and Tobago. It identifies the following as key challenges it will have to address:

1. **Finding bilingual trainers, counsellors and health care personnel and building and maintaining a team of bilingual outreach workers.** Its new knowledge about the countrywide network of Dominican sex workers points to the solution to the problem of finding more bilingual outreach workers and, possibly, finding likely candidates to train as master peer educators and counsellors who can train and supervise others. There are also known to be Spanish-speaking health care personnel (including local doctors who have gone to Cuba for training) but FPATT has yet to recruit any of these for its clinics. As a stop-gap, it had the Project Assistant and outreach workers provide interpretation during counselling and medical interventions but this discouraged some sex workers from taking up offers of these interventions, since it added to their worries about confidentiality.

2. **Paying bilingual outreach workers.** The project budget allowed FPATT to pay the Project Assistant US$700 and two outreach workers US$500 for their work from July through November. Without such financial incentives, it is unlikely migrant Hispanic sex workers would feel motivated enough to take the training and become active outreach workers.

3. **Finding or developing Spanish-language information, education and communications material** for use in training and for distribution to migrant Hispanic sex workers.

4. **Finding safe spaces to deliver interventions.** FPATT found that it was often difficult to draw sex workers away from the bars and other venues where they found clients but that such venues were often unsuitable. This was because owners and other staff, sex workers, and clients were there to witness interventions and there were no side rooms that might provide a degree of privacy. Some of the most successful interventions took place in beauty salons, as mentioned in the accompanying box, and this suggests one solution to this problem.

5. **Replacing FPATT’s mobile clinic.** FPATT has found that the only really effective way of getting migrant Hispanic sex workers to take up offers of sexual and reproductive health services is to take the services to them. They won’t come to FPATT’s clinic under its offices in Port of Spain because there are two immigration authority offices nearby and they fear being arrested and deported. Travel distance, fear of stigma and discrimination, and inability to communicate with staff keeps them away from FPATT’s other stationary clinics too. FPATT’s mobile clinic is the most fully equipped of all mobile clinics in the country but it was acquired in 2001 and is now approaching the end of its useful life. It sometimes won’t start and this means it is not available for some interventions where they plan to have it available.

6. **Ensuring services are free.** In the 1980s, FPATT received a USAID grant that required it to provide its services for free for seven years. When the grant ran out, it had to charge for services again but found it hard to get people used to paying for services. Most documented citizens with low incomes get their services for free. FPATT attracts citizens who are prepared to pay subsidized rates for its superior services. People with higher incomes often go to commercial clinics and hospitals and pay the full cost for their services. FPATT worries about what might happen if
migrant Hispanic sex workers get used to receiving free services from them but then, when grant money runs out, have to pay for those services. It seems likely that most will stop coming.

7. **Sensitizing police and immigration authorities.** FPATT realizes it needs to do more to sensitize police and immigration authorities to the need to provide migrant Hispanic sex workers with HIV prevention and other harm reduction measures not only for their sake but for the sake of their clients, and their clients’ regular sexual partners and children.

8. **Getting the government to take responsibility.** The World Bank places Trinidad and Tobago in its high-income category. The country has many men who can afford to pay for sexual services and it attracts many migrant sex workers from lower-income countries in Latin America and the Caribbean. As noted above, it is in everyone’s interests that the government support HIV prevention and other harm reduction measures for migrant Hispanic sex workers.

### The way ahead

To provide evidence to inform development of Trinidad and Tobago’s National HIV and AIDS Strategic Plan 2013-2018, the country’s National AIDS Coordinating Committee (NACC) commissioned spending estimates showing that, over the 2002-2009 period, the country spent an average of more than $US 15 million per year on its response to HIV and AIDS. However, only 6 percent of that money went towards the response among MSM, sex workers and the other sub-populations that are most vulnerable to HIV and AIDS. The National Plan now recognizes that the country has both a generalized epidemic and concentrated epidemics among these vulnerable sub-populations and calls for the larger share of future spending to go towards responding to those concentrated epidemics.

FPATT is now working with Community Action Resource (CARe) and other civil society organizations on efforts to establish an integrated network of government and civil society organizations that represent and/or serve vulnerable sub-populations in Trinidad and Tobago. It hopes that the new National Plan will provide the basis for scaling up and sustaining a consistent response to HIV and AIDS among all vulnerable groups, including migrant Hispanic sex workers. In the past, it has found the project-by-project approach, with long gaps between projects, to be highly unsatisfactory. Between projects, any gains they have made are soon lost. In particular, they lose their trained outreach workers and danger of this happening is particularly acute in the case of migrant Hispanic sex workers.

Again, FPATT hopes there will be a phase 2 to the Sex Workers for Change project and, ultimately, to have it established as a permanent programme serving the ever changing population of migrant Hispanic sex workers in Trinidad and Tobago. It hopes to develop and sustain a team of peer outreach workers, who acquire ever more knowledge and skills through experience and who are gradually replaced (one by one) through natural attrition. In addition, it hopes to be able to meet all of the challenges it identified during phase 1.

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109 Office of the Prime Minister (2013).
110 Fearon et al (2012). AFT
Overview

With a CVC/COIN Community Grant of US$20,000, *el Movimiento de Mujeres Unidas* (MODEMU) implemented a pilot project that, from May through November 2012, provided STI and HIV/AIDS prevention care and treatment to sex workers in the Province of Barahona, Dominican Republic. The project was the first attempt at peer education among the province’s sex workers and it introduced them to female condoms, freeing them from having to negotiate safe sex with either their clients or their “trusted partners”.

Grantee: *Movimiento de Mujeres Unidas (MODEMU)*

Jaqueline Montero is Executive Director of the Movimiento de Mujeres Unidas (MODEMU), or “Movement of Women United”. She began an interview on 18 June 2012 by outlining MODEMU’s history. From 1992 onwards, COIN had health messengers going around to the bars, clubs and other establishments where they knew they would find sex workers. The messengers found it hard to win the trust needed to engage sex workers in frank talks, so COIN recruited and trained six sex workers as health messengers. Jaqueline was one of these and so was Fatima Peña who joined in the interview with Jaqueline.

Through those six new health messengers, COIN began to get a much clearer picture of what drove women into sex work. Typically, they had little education and few job skills, had become partners of men who treated them badly, and they had children by those men. Either the men had left them or they had left the men, to escape from domestic violence, and that meant they were left with children they had to raise on their own, without any financial support from the men. With no good options for employment, they became sex workers but it was always a precarious business because sex work is illegal and not protected by labour laws and other laws that would protect them against exploitation and abuse. It is even more precarious if they undocumented migrants who might be deported if they come to the attention of the police and immigration authorities.

COIN realized the sex workers needed their own organization through which they could become empowered with knowledge and skills to look out for their own interests. In mid-1997, the sex workers had their first annual Congress, elected their first Executive Committee and asked the Committee to get them legally registered. Legal registration took place in 2000 but it was not until 2002 that they decided they had to separate from COIN and find their own premises. They loved COIN but they realized they were a women’s organization still being led by men and they needed to become independent.

Not long after moving out on its own, MODEMU joined:

- *Red de Trabajadoras Sexuales de Latinoamérica y El Caribe* (REDTRASEX) — the Latin American and Caribbean Women Sex Workers’ Network — and it now has a seat on its Executive Committee.
- The Global Network of Sex Work Projects (NSWP) — and for the past three years has attended its annual meetings in Thailand.
- The Global Alliance against Traffic in Women (GAATW) — and have participated in several of its regional and global and regional consultations and, in 2010, received support from GAATW for a Feminist Participatory Action Research project.
MODEMU’s work with male, transgender and other sex workers

The NSWP’s members include both male and female sex worker organizations. At its 2011 annual meeting, MODEMU learned that the Dominican Republic was one of the few countries involved in the NSWP that had no organization representing male sex workers. They pledged to change that before the NSWP’s 2012 meeting.

They managed to find a number of male sex workers and offered to host a meeting, on 8 September 2011, at which the male sex workers resolved to establish Organización de Hombres Trabajadores Sexuales (HTS). MODEMU is now mentoring HTS in much the same that COIN mentored MODEMU. They have secured support from AIDSTAR-One (a USAID programme) and HST now has offices in the same building and right next to MODEMU’s offices.

MODEMU is learning a lot by working alongside the male sex workers. Previously, they were barely aware of the existence of male sex workers (MSWs) because they do not work in the same places as female sex workers (FSWs) and the way the MSWs work makes them hard to recognize. They are often found in tourist areas — including the touristy parts of Santo Domingo and resorts along the coast — and they often have jobs in tourist establishments, maybe as desk clerks, doormen, bellhops, bartenders, waiters, lifeguards, or beach boys. Their employers choose them for their charm and good looks and they flirt with customers discreetly and some female customers ask if they are available for dates after work. The ones who belong to HTS say they prefer tourists as customers because they have more money and they lean especially towards European tourists because Euros are worth more than American dollars. If they have sex with Dominican women they usually don’t charge because they are doing it for pleasure and know the Dominican women cannot afford to pay much. They often go with male clients, too, and sometimes with couples.

Asked how many sex workers there are in the Dominican Republic, Jaqueline said they do not have even an approximate idea. They would love to find a donor who would support a comprehensive census that distinguished between transactional and commercial sex and discovered how many females, males and transgender people engage in either or both. Meanwhile, they are involved in discussions with REDTRASEX and the Global Fund about the possibility of doing a count of establishments where sex workers work and coming up with an approximate number of sex workers working out of all of those establishments. This would not cover sex workers who work in the streets and would miss the many female, male and transgender people who engage in transactional sex, but it would be a beginning.

Meanwhile, MODEMU’s policy is to use its strengths to reach out to as many sex workers as possible and, also, to support non-sex workers who ask for help. Other MODEMU initiatives include:

- As discussed elsewhere in this report, MODEMU gave birth to the Comunidad de Trans Trabajadoras Sexuales Dominicanas (COTRAVEDT) in much the same way it gave birth to HST.
- Work with COTRAVEDT has lead to work with Trans Amigas Siempre Amigas (TRANSAA), an organization of transgender women that grew out of Amigos Siempre Amigos (ASA).
- Also discussed elsewhere in this report is MODEMU’s work with CEPROSH.
- MODEMU has a strategy to expand its reach by forming a committee to address one new issue each year. Active Committees include:
Comité de Mujeres Viviendo con VIH/SIDA (COVIH) — “Committee of Women Living with HIV/AIDS” — supports sex workers living with HIV.

Comité de Jóvenes UNIDOS (CODEJU) — Committee of Youth United — involves young sex workers and the daughters of sex workers in taking prevention messages to young sex workers.

Las Margaritas supports sex workers who use addictive substances. (The committee’s name refers to a REDTRASEX meeting on an island called Margarita where they discussed harm reduction among drug using sex workers and also refers to Jenny Margarita, who was MODEMU’s delegate to that meeting.)

Las Tres Anas was formed by three women called Ana who had been trafficked and it works to prevent trafficking and to identify trafficked women and intervene.

Amanoche — Creole for “midnight butterfly” — works with Haitian sex workers on the streets and in establishments in bateys (See the discussion of MODEMU’s work with CEPROSH elsewhere in this report.)

Types of activity supported by MODEMU

Besides training and supporting health messengers, MODEMU’s many other activities include:

- workshops and lectures to sensitize health and social service providers, the police and others about the issues facing sex workers
- counselling and legal advice to sex workers
- campaigns such as the one described earlier in this publication where MODEMU is spearheading opposition to proposed legislation that would create a zona rosa in Santo Domingo and prohibit sex work anywhere else
- providing sex workers with vocational training (e.g., in crafts, beauty and fashion) to give them alternatives to sex work
- involving sex workers in business enterprises such as the packaging and marketing of condoms for Population Services International (PSI).

Even since it was founded in 1997, MODEMU (with support from COIN) has been using street theatre as one way of getting health messages across. They have developed mini-plays to get across messages on a range of issues including, for example, HIV and condom use, violence, human trafficking, and drug use. They have a small group that now has many years of experience putting on street theatre and they are now creating another group of adolescent girls to put on street theatre.

In 2010, Jaqueline Montero was elected as a Regidora (Councillor) representing the municipality of Haina in San Cristobal Province. Through REDTRASEX, MODEMU is encouraging other sex workers in Latin American and Caribbean countries to run for office. As the President of MODEMU, Jaqueline is encouraging sex workers to run in upcoming provincial elections in the Dominican Republic.

Jaqueline points out, too, that MODEMU has produced two books. Published in 2002, Rien Mis Labios y Llora mi Alma — published in English as “Laughing on the Outside, Crying on the Inside” — lets sex workers tell their own stories. Published in 2009, Mis Primeros Pasos — “My First Steps” — tells the story of MODEMU’s emergence as an independent organization.
MODEMU’s donors and the impact of cut-backs

The London-based charity Christian Aid provided MODEMU with its first support, initially through COIN and then directly. In fact, Christian Aid strongly encouraged and supported the process whereby they became legally registered and independent from COIN. The Catholic Organisation for Relief and Development Aid (CORDAID), based in the Netherlands, was also one of their early supporters and helped them with institutional strengthening, the development of IEC material and so on. Another early supporter was the German Development Service (DED) [now part of GIZ]. By the end of 2008, all of those organizations had withdrawn from the Dominican Republic and had stopped providing MODEMU with support.

MODEMU’s main sources of financial support now include:
- A Global Fund grant directly to the Dominican Republic and administered by the Dermatological Institute (IDCP)
- The Caribbean Social Marketing Program for HIV and AIDS Prevention (CARISMA) which, in the Dominican Republic is administered by PSI
- USAID through its FHI 360 programme
- American Jewish World Service (AJWS).

The Sex Workers United project’s context

On the southern coast, west of Santo Domingo, Barahona province is one of the poorest in the Dominican Republic. Poverty drives many women into sex work and a 2008 serological survey found that female sex workers in the province have an HIV prevalence rate of 8.4 percent, very much higher than the countrywide rate of 4.8 percent among all female sex workers. This higher rate suggests that many female sex workers in Barahona give into their clients’ demands to have sex without condoms or do not insist on the use of condoms by their trusted partners.

The sex workers, themselves, provided further context as the project proceeded. At an end-of-project meeting on 28 November 2012 a group of them agreed: Sex workers often meet new clients in two cabarets, a park and certain streets where there are many restaurants and bars but they often take their clients back to the sex workers’ homes. Once their clients know where they live, they often come directly to the sex workers’ homes. As well as private homes, these in include certain hotels and pensions.

- Lack of knowledge about sexual and reproductive health, early sexual initiation, unwanted pregnancy, domestic violence (leading to break-ups), drug use, and lack of options for earning money are the major factors driving sex work.
- Almost all of the sex workers’ clients are verbally abusive and many are physically abusive. Transgender sex workers are especially vulnerable to abuse and often experience it from passing strangers as they walk down streets.
- Among younger male clients and younger sex workers, the use of marijuana, cocaine and crack cocaine is increasingly common. Cocaine is sold in 100 peso (US$ 2.50) and 200 peso (US$ 5) bags and clients often pay for sex with just one or two of these bags, not even offering cash as an option. Young clients who use drugs are especially likely to be violent.
- From the sex workers’ perspective, Barahona is virtually lawless because most police officers are not there to protect them but, instead, to exploit and abuse them. They are quick to arrest sex workers but often release them after taking their money and

111 COPRESIDA (2009).
demanding sexual favours. Police often chase sex workers out of the park and other areas where they meet new clients and also often intervene in interactions between sex workers and tourists, warning the tourists that sex workers may rob them. For these reasons, sex workers do not see the police as people they can turn to for help when they are assaulted by their clients.

The objectives and methods
Extending from May through November 2012, the project had three objectives:

1. **To recruit, train and mobilize 15 Barahona sex workers as health messengers** as follows:
   a. Invite 30 to attend a workshop in the city of Barahona (the provincial capital), provide them with basic information about MODEMU and its health messenger programme and select 15 to send on for training
   b. In a one-day workshop train the selected 15 as health messengers
   c. Establish a committee through which the 15 agree on their messages, how to deliver them and a plan of activities
   d. Hold monthly meetings of the committee to review progress, identify challenges and find ways of overcoming them.

2. **Reach 200 sex workers with prevention messages** as follows:
   a. Provide 45 interventions per months in selected locations
   b. Provide six theatrical interventions, one per month
   c. Distribute and demonstrate the use of female and male condoms and lubrications during the above interventions and provide IEC material

3. **To increase by 20 percent the sex-workers’ take-up of monthly medical checks and of medical care and treatment for STIs and HIV** as follows:
   a. At Jaime Mota Regional University Hospital, raise management and staff awareness of sex workers and their needs for health services
   b. Negotiate an Hospital-MODEMU agreement for the provision of services
   c. Schedule special times for the sex workers to go for services
   d. Refer sex workers to the hospital and, if they request, accompany them.

The results
By the project’s end in November 2012, it had:

1. **Achieved the objective of recruiting, training and mobilizing 15 female and transgender sex workers including a 15 year-old Haitian sex worker who acted as the project’s Spanish-Creole interpreter**

2. **Achieved the objective or reaching all sex workers of whom the peer educators were aware (roughly 200 and probably considerably fewer that the total number of sex workers) in Barahona with prevention messages and supplies** and, in the course of doing so, distributed almost 17,000 female condoms and more than 50,000 male condoms to sex workers and others throughout the province (MODEMU provided the condoms, which were provided to them by donors other than CVC/COIN.)

3. **Achieved the objective of increasing the sex workers’ uptake of health services massively, by more than the 20 percent originally planned**
4. Not only achieved the objective of introducing female condoms but convinced most female sex workers that these were very much preferable to male condoms (See box.)

**Female condoms, now the Barahona sex workers’ preferred option**

At an end-of-project meeting on 28 November 2012, the project’s health messengers said that before the project, some sex workers had never even heard of female condoms and few knew how to use them. Initially, some were sceptical and reluctant to try them but they soon learned that female condoms are much stronger than male condoms, last for up to eight hours and are comfortable and unobtrusive. Best of all, female condoms free them of the need to have to negotiate safe sex with either their clients or their regular partners.

5. Beyond the original objectives, recognized and began addressing:
   a. The high prevalence of alcohol and drug abuse among both sex workers and their clients and the association of substance abuse with violence
   b. The high prevalence of congenital syphilis (passed on from mother to child) among sex workers

6. Beyond the original objectives, achieved the enthusiastic participation of many sex workers (not just the 15 health messengers) in reaching more than 3800 people with IEC material, theatrical presentations, “awareness days” and various other efforts to educate the broader community and to sensitive the owners of bars and other establishments, the police and health care providers.

**The challenges**

In their own end-of-project assessment, the project’s health messengers and beneficiaries identified these as challenges that faced them during the project:

1. **Lack of a safe space** where sex workers can go for mutual social and psychological supports, to get information and supplies and referrals to services, and to report complaints about the police, health care providers and others and get support in pursuing those complaints.

2. **Lack of a well-organized and sustained programme to sensitize and liaise with the police** and thus, for example, make it easier for sex workers to report violence by their clients and ensure there will be follow-up. Currently, MODEMU and the health messengers find that when they sensitize two or three police officers these officers are often transferred to other jurisdictions and no longer have any positive influence over their fellow officers.

3. **Need for additional work to ensure that health messengers and health care providers honour their guarantees of confidentiality** and thus allay the fear some sex workers still have of engaging with them.

4. **Lack of ready access to free or affordable supplies of female and male condoms and lubricants other than those provided by MODEMU.** The project sometimes ran out of supplies between visits of MODEMU’s representatives from Santo Domingo. Male condoms are distributed for free by hospitals and primary care units but the locations and operating hours of these facilities are not convenient. Lubricants are largely unavailable anywhere at any price. Female condoms are very rare and, if sold at all, cost around 80 to 90 pesos per condom, which amounts to most of what sex workers sometimes earn from a single encounter with a client.

5. **Lack of respect for sex workers** so that some community members do not accept them as credible educators in sexual and reproductive health matters or as credible
advocates for interventions against violence, etc. Television appearances and other events featuring Jacqueline Montero have been very beneficial in this regard but there remains need for much more interaction between sex worker representatives and communities and their leaders.

The way ahead

In their end-of-project meetings and reports MODEMU and the project’s health messengers and beneficiaries make it clear that they would very much like to see the network of health messengers sustained, expanded and strengthened so that it continues to serve sex workers throughout the Province of Barahona and so that its efforts to educate communities and sensitize police and health providers can be stepped up. They hope for financial and technical support that will enable them to continue addressing all of the challenges noted above and their priorities include:

1. Establishing a safe place
2. Extending the kind of arrangements they have with the hospital to primary care units
3. Building better relations with the police
4. Scaling up efforts to educate communities about sexual and reproductive health, drug use and violence not only as they concern sex workers but as they concern all children, adolescents and adults.
5. Long-term financing for a sustained programme rather than short-term financing for time-limited projects.
6. Establishing alliances with other organizations within Barahona
7. Extending the project’s model to other provinces.
Annex D1 (FUNDOREDA, Dominican Republic)
Open Doors: harm reduction for injecting drug users

Overview

With a CVC/COIN Community Grant of US$23,000,000, *el Fundación Dominicano de Reduccion de Daños* (FUNDOREDA) worked from May to December on planning and establishing the Dominican Republic’s first harm reduction programme among the country’s growing population of injecting drug users (IDUs). This project allowed FUNDOREDA to establish an office and safe space for IDUs in Capotillo, the barrio where most of Santo Domingo’s IDUs live.

The project supported research into the psychology of drug users and a range of harm reduction interventions including: one-on-one and group interventions to provide IDUs and other DUs with harm reduction information and supplies and, also, to collect information about IDUs and other DUs and their habits; distribution of condoms and clean needles and syringes separately and, also, in kits containing those and other supplies; confidential counselling and testing for STIs, HIV and hepatitis B and C; social and psychological support including professional counselling. It also took major steps in the direction of establishing an effective system for monitoring and reporting on human rights against DUs and for creating an environment where their human rights are recognized and they are treated with respect, courtesy and compassion.

Grantee: *Fundación Dominicano de Reduccion de Daños (FUNDOREDA)*

Federico Mercado is the President of the *Fundación Dominicano de Reduccion de Daños* (FUNDOREDA) or the Dominican Foundation for Harm Reduction. In an interview on 18 June 2012, he explained that FUNDOREDA was legally established in 2010 and grew out of his own experience as a drug user living with HIV and hepatitis C.

He was a policeman when he became a heroin user and then became infected with HIV. His drug habit got to the point where he knew he needed help but he found he could not get into the rehabilitation programme offered by *Hogar Crea Dominicano* because he was HIV-positive. That is when he became an activist and, with the help of COIN and others, managed to establish a temporary home for drug users living with HIV.

He had occasional relapses and one of those occurred when he was in Mexico City attending the 2008 International AIDS Conference. He agreed to be interviewed by a reporter while he was sick on heroin and his story attracted wide attention in the media. He accepted an offer to join a rehabilitation programme in Mexico City and it provided methadone substitution therapy that allowed him to quit heroin. He realized, for the first time, that there is an effective way of quitting and he returned to Santo Domingo determined to start a similar harm reduction programme in the Dominican Republic.

He started informally with heroin users in Capotillo, the Santo Domingo barrio where heroin use is most common. Since heroin use is strictly illegal, he worked very discreetly as he distributed clean needles and syringes and condoms and lubricants, all paid for out of his own pocket. In 2010, he began getting support from *Hogar Crea* and the Dermatological Institute (IDCP) in the form of brochures he could distribute along with the harm reduction supplies. Because *Hogar Crea* has a “zero tolerance” policy, he had to develop a two-track approach: one for people in homes for drug users (where there is zero tolerance) and one for drug users in the streets.
Injecting drug use in the Dominican Republic

During his 18 June 2012 interview, Federico says there are no accurate estimates of the numbers of IDUs in the Dominican Republic because strict illegality pushes drug use underground. However, it is well known that, after the 11 September 2001 attack on the World Trade Center, the United States stepped up its vigilance against illegal immigrants and began deporting many more for a wide range of offences. (See box below.) He thinks the majority of the IDUs in the Dominican Republic have been deported from the United States and they include people who inject heroin and "speedball", which is mixture of cocaine and heroin or, sometimes, morphine. [Six months after this interview, the Open Doors project reported the results of its interviews with its IDU beneficiaries and 41 percent said they had been deported from other countries, 28 percent said they had acquired their IDU habits within the Dominican Republic and 31 percent did not say.]

5600 Dominican drug traffickers were repatriated from 2005 to 2011

*Listin Diario* is a popular daily newspaper in the Dominican Republic. On 10 October 2011, it carried an article saying that over the past six years almost 23,000 Dominicans had been repatriated after being deported by other countries. According to data from the Dominican Directorate General of Immigration, most were from the United States. In 2010, for example, 3,918 people were repatriated and 3,211 were from the USA. Of the 23,000 repatriated from 2005 to 2011, one quarter (5,605) had been arrested and deported for drug possession or trafficking.

Federico was not deported but he got into injecting speedball while visiting the USA and he has the burns on his left arm to show it. He says that, while Capotillo has the largest concentration of IDUs in Santo Domingo, there is a much larger population of IDUs in Santiago. In general, Dominicans don’t like needles and syringes, not even to inject medicines, but those who have lived in the USA for many years or go there frequently get into American habits. The ones deported back to the Dominican Republic tend to be anywhere from 30 to 60 years old and, gradually, they are spreading the use of injecting drugs to younger people who have never been to the USA. [Six months after this interview, the Open Doors project reported that when it distributed harm reduction kits fo 563 IDUs it asked them their ages with these results: 31 percent were 15-24 years old, 28 percent were 25-34 years old, and 41 percent were 35 and more years old.]

He says that men are more visible among drug users but, if the men are using, it is likely their female partners are using too. Women’s pattern of drug use is often different though. Instead of injecting drugs, the women often inhale crack cocaine and one thing about crack cocaine is that it increases a user’s sex drive. Anal sex (whether male-female or male-male) is very common among crack cocaine users and so is transactional sex, in this case sex in exchange for drugs. Federico says that this is probably why, when he was staying in a home for drug users living with HIV, most of them were crack cocaine users.

Is there a high rate of HIV among IDUs? Federico says that few get tested for HIV and, if tested, almost none admit they are drug users. At the time of this 18 June 2012 interview, some known IDUs were just beginning to get tested under FUNDOREDA’s Community Grants project and, of the first 15 tested, 2 were found to be HIV positive. Federico says his own experience suggests there may be a higher incidence of Hepatitis C than of HIV among injecting drug. Hepatitis C treatment which is very expensive and there is no public financing for it. Many drug users he knew had already died from Hepatitis C, often in combination with HIV and lack of shelter, nutritious food and other essentials.

Why don’t more IDUs get tested for HIV? Federico says that a real challenge in providing services to IDUs is that they are ashamed and often do not admit even to themselves that
they are users. FUNDOREDA aims to help psychologists and other experts understand the full complexity of injecting drug use and develop a unified but comprehensive approach to this use and its consequences, including HIV and Hepatitis C.

A survey of IDUs in Capotillo

In April 2012, a CVC/COIN/FUNDOREDA surveyed covered 36 IDUs in Capotillo and found that more than 40 percent shared syringes with other IDUs and more than 40 percent used discarded syringes they found lying on the ground. Many used dirty water from gutters and elsewhere to dilute their shots and had abscess wounds and vein damage. Two-thirds said they exchanged sex for money or drugs and one-third said they used condoms only sometimes. Few knew their Hepatitis B or C status but nearly half had been diagnosed with one or more STIs within the past year and two were HIV-positive. Half said they were reluctant to use health services and, in two focus groups, IDUs said they had experienced stigma and discrimination from health care providers. They had also experienced verbal, physical and sexual threats, abuse and extortion by the police and military.

Of the participants in the survey, more than 80 percent rejected the suggestion that making clean syringes readily available might encourage injecting drug use. More than 95 percent wanted harm reduction interventions that included outreach with preventive education and supplies and access to opiate substitution therapy. In other words, they wanted something much more effective than what they were getting under Dominican law and law enforcement. Law 50-88 makes the possession of any quantity of drugs punishable by imprisonment, and the judicial process from arrest to conviction can leave suspects in highly stressful limbo for several years. As a consequence, drug use is pushed underground and rehabilitation programmes are obliged to use a zero-tolerance approach that discourages many drug users from entering the programmes and causes many to drop out.

A Puerto Rican harm reduction model

The 18 June 2012 interview with Federico took place over lunch during a break from a one-day workshop with Rafael (“Rafi”) Torruella, the Executive Director of el Proyecto Casa de Ayuda Intermédia al Menesteroso (CAIM). With financial and technical support from a New York-based civil society organization called Housing Works, CAIM provides clean needles, harm reduction counselling and referrals to health and drug treatment services. The beneficiaries include IDUs and other DUs who are living with or vulnerable to HIV, AIDS, Hepatitis C and other chronic health conditions in eleven communities in Puerto Rico.

Federico explained that he first became familiar with the Housing Works approach to harm reduction when learned about a project supported by Housing Works: the CitiWide Harm Reduction in the southern Bronx of New York. Recently, he met someone from Housing Works at a conference in Los Angeles and this person suggested he contact CAIM. He followed up and, as result, Housing Works agreed to finance this workshop so FUNDOREDA’s members and COIN’s staff could learn more about CAIM and how it implements the Housing Works approach to harm reduction.

CAIM serves as the basic model for the programme FUNDOREDA would like to establish in the Dominican Republic, only FUNDOREDA would like to add a residential component. This means FUNDOREDA hopes its programme will ultimately include:

- A house or some other shelter with beds, kitchen, showers, laundry, television, access to the internet, and a gym for exercise
- Support groups for IDUs and other DUs
Harm reduction training (e.g., correct use of needles, syringes, condoms, and lubricants; how to deal with overdoses)

Harm reduction kits

Access to health and social services, including counselling.

**The project’s proposed objectives and methods**

In his 18 June 2012 interview Federico said, “Right now, we are still in the egg, just breaking through the hard shell and dreaming of becoming a chick. After that, we can become a chicken or rooster.” The CVC/COIN Community Grant was the first significant funding FUNDOREDA had ever received. COIN was helping them find a suitable place in Capotillo that could serve both as their office and as a safe space for injecting drug users. (They had already found two suitable places but the landlords had refused to rent to them after they found out how they were proposing to use these places.) COIN’s CDC-funded drug user programme was providing them with technical support as they finalized their proposal and this was building their capacity to do their own planning and fund-raising. This process was finished not long after the interview and the proposed objectives and methods were:

1. **To provide access to harm reduction information and supplies for 40 IDUs and an additional 200 drug users (DUs) who are not IDUs in Capotillo and in other barrios**, with methods to include:
   a. Doing one-on-one interventions and holding workshops by trained health messengers to increase knowledge, change attitudes and practices, and prevent transmission of HIV, STIs and hepatitis B and C
   b. Distributing 5000 condoms
   c. Distributing of 4000 clean needles and syringes and collecting used needles and syringes, but not requiring one-for-one exchange since expert evidence suggests this would discourage some IDUs from getting clean equipment

2. **To improve the quality of life of 40 IDUs in Capotillo**, with methods to include:
   a. Establishing a house or other place to serve as a safe space for IDUs and also as offices for FUNDOREDA and the project
   b. Making a psychologist available to provide counselling to IDUs and to help them develop life plans, apply for subsidized health insurance and access any services they may need
   c. Providing access to showers and washing machines at low cost but not at no cost, so as to support them as they take responsibility for their own health and well-being
   d. Providing access to a kitchen where IDUs can prepare their own meals but also can get assistance to ensure the meals are nutritious
   e. Providing access to a telephone because many IDUs have no cell phones or access to other phones that allow them to send and receive calls with their families, who often live in the United States and send remittances
   f. Providing emergency first aid to deal with drug overdoses

3. **To establish a support network of IDUs in Capotillo**, with methods to include:
   a. Establishing a meeting place, as above, where IDUs and project volunteers can relax and socialize
   b. Supporting education and entertainment activities among IDUs in the barrio
4. **To establish a system for monitoring and reporting violations of the IDUs' basic human rights**, with methods to include:
   a. Establishing procedures whereby IDUs can report any violations of their rights
   b. Using information from the reports on individual cases as the basis for reports to national, regional and international bodies and for reports distributed via the web and other means

5. **To document the project** in written reports and other media for information, education, communications, advocacy and fund-raising purposes (always bearing in mind the need to preserve the anonymity of people who do not wish to be identified)

6. **To monitor, evaluate and report the results.**

**Results**

FUNDOREDA has done an exemplary job of monitoring, evaluating and reporting the results of its Open Doors project. Its end-of-project report and supporting material show that not only did the project achieve most of what it set out to achieve but it far surpassed some of its specific targets. With the help of COIN, CAIM and other partners, it was also able add elements not anticipated in the proposal. In summary, the project:

1. **Provided access to harm reduction information and supplies for 169 IDUs (i.e., 443 percent of the 40 set as its target) and an additional 945 DUs (i.e., 473 percent of the 200 set at its target) for a total of 1,114 IDUs and other DUs living in Capotillo and other barrios of Santo Domingo.** Specifics included:
   a. Providing one-on-one interventions to 622 IDUs and other DUs and group interventions (e.g., through talks) to an additional 492
   b. Distributing 10,916 condoms (i.e., 218 percent of the 5,000 target)
   c. Distributing 4,043 clean needles and syringes (i.e., 101 percent of the 4,000 target) and collecting 1,746 used needles and syringes in exchange
   d. Distributing 563 kits (with the support of City Wide) with each kit containing: 4 sets of clean needles and syringes, 4 pads to sterilize the skin at injection point, 1 cooker, water filters, 6 condoms, 2 tubes of lubricant, and educational pamphlets. The IDUs who received these kits were 79 percent male and 21 percent female; by age they were 31 percent 15-24 years old, 28 percent 25-34 years old, and 41 percent 35 and more years old.

2. **Improved the quality of life of 169 IDUs (443 percent of the 40 set as the target) and many other DUs**, with specifics including:
   a. Establishing FUNDOREDA’s and Open Doors’ offices and a safe space for IDUs and other DUs on the upper floor of a commercial building in Capotillo. This space is not the house FUNDOREDA would have preferred because, while they found suitable houses for rent, they did not find a landlord willing to rent to them. This space does not have all the amenities (e.g., showers, washing machines and a fully equipped kitchen) FUNDOREDA hopes to be able to provide in future but, as a temporary solution, it serves as an informal drop-in centre where people can socialize, play board games, make telephone calls, and receive messages and also as a space for confidential counselling and for meetings, talks, focus group discussions and workshops.
   b. Providing a range of physical and mental health and social services to IDUs and other IDUs. This included providing:
      i. 331 IDUs and other DUs with primary health care
ii. 352 with referrals for HIV tests; 24 with HIV tests; 8 who tested positive with care and treatment

iii. 400 IDUs and other DUs with one-on-one psychological counselling and other form of psycho-social support; providing an additional 294 with such support in group sessions

iv. 113 IDUs and other DUs with legal support including support for those charged with drug and other offenses and those with complaints that their basic human rights had been violated

v. Two IDUs with life-saving treatment when they overdosed on drugs. This was made possible with overdose kits donated by City Wide.

3. **Establishing a support network of IDUs and other DUs.** This network grew naturally out of the above activities, especially the provision of a safe place where they could meet. Until such time as FUNDOREDA is able to secure a more suitable safe space and secure more financial and technical support, it will not be able to provide all of the education and entertainment it hopes to provide.

4. **Taking major steps in the direction of establishing an effective system for monitoring and reporting human rights violations** and, also, in the direction of establishing an environment where the rights of IDUs and other DUs are recognized and they are treated with respect, courtesy and compassion by health and social service providers, the police and others. These steps included:
   a. Securing a seat for FUNDOREDA at *la Mesita de Usuarios de Drogas* (*MUD*) ─ Table on Drug Users ─ which is hosted by UNAIDS and has representatives from COIN, the National Drug Council (CND) and the UNDP.
   b. Making FUNDOREDA a member of the Observatory on Human Rights recently created by COIN.
   c. Conducting two focus groups for IDUs and other DUs to inform them about their basic human rights and about what they can do when their rights are violated.
   d. Through meetings and other means beginning to sensitize community members and their leaders, the police, health care providers, and the media.

5. **Building the capacity of FUNDOREDA to plan, implement, monitor, evaluate, improve and scale up and sustain Open Doors.** Specifics included:
   a. Training and support by CVC/COIN for designing and using forms for gathering data during interventions.
   b. Training in strategic planning.
   c. Training for peer educators by Ciccatelli Associates in harm reduction.
   d. Participation in number of training workshops on advocacy, interventions appropriate for marginalized youth, and so on.

6. **Documenting the project** with unusual thoroughness and thus creating a rich trove of material that can be used information, education, communications, advocacy, and fund-raising purposes. Documentation includes photos that preserve the anonymity of IDUs and other DUs and also photos of those who have agreed to be identifiable by anyone who knows them.

7. **Monitoring and evaluating and reporting the results in exemplary manner.**
Lesson learned and applied

In addition to achieving all of the above, the Open Doors project has made significant contributions to knowledge about IDUs and other DUs and about interventions that work for them. This can be seen in evidence already mentioned about the gender and age of drug users and whether or not they were deported from other countries and might have acquired their drug habits in those countries or in Dominican Republic. It can also be seen in a report on the project’s Psychological Study summarized in the box below.

Other lessons learned and applied during the course of the project were:

1. Most drug users will not follow up on referrals to health unless they are accompanied to those services or unless the services are delivered to them in mobile units.

2. Grooming, personal hygiene and nutrition are major issues for drug users. Embarrassment and shame are significant factors that stop them from venturing out into public places and taking up offers of services. They often need better clothing, access to washing machines, hygiene items, and nutritious food.

3. Requiring that IDUs turn in their used needles and syringes in order to get clean equipment will discourage many from getting that equipment, so they will continue to infect each other with used and sharing equipment. Only if clean equipment is made available in convenient and reliable ways will they be willing to turn in used equipment.

Remaining challenges

Major challenges that face FUNDOREDA and its Open Doors Project in the months and years ahead include:

1. Changing Law 50-88 so that simple possession of a small quantity of drugs is no longer cause for harsh punishment.


3. Addressing the social and psychological factors that drive drug use and stop drug users from taking up offers of health and social services, including rehabilitation services.

4. Introducing substitution therapy as an alternative to the zero-tolerance (or “cold turkey”) approach that rehabilitation programmes are now obliged to take and that discourage many drug users from taking up offers of rehabilitation.

5. Achieving FUNDOREDA’s vision of a house for IDUs that may not provide overnight accommodations but provides the amenities of a safe and comfortable day-time home that provides them with ready access to harm reduction supplies and services.

6. Scaling up information, education, communications and advocacy efforts with the aim of winning the support of key stakeholders (not least law makers and enforcers) for action to meet the above the challenges.

7. Securing the financial and technical support necessary to scale up and sustain Open Doors and replicate the Open Doors model across the country. A subsidiary challenge is to find a more suitable
The way ahead

In his 18 July interview, Felix Mercado said FUNDOREDA intended to do the best job they possibly could at documenting the Open Doors project and monitoring, evaluating and reporting the results. This was because their fervent hope is that Open Doors will evolve from a time-limited project into a sustained programme. To make that happen, they will have to convince the Dominican Government that harm reduction is far more effective than zero tolerance. This is so if the aims are not only to reduce the harm that drugs do to those that use them but, also, to solve the country’s growing drug use problem, reduce its expenditure on law enforcement and imprisonment and, perhaps, divert the savings to more constructive education, health and social services programmes.

The psychology of drug users

Junior Mendez is the Clinical Psychologist who provided counselling to DUs under FUNDOREDA’s Open Doors project. He and others had developed a tool to assess the mental state of DUs admitted to hospitals and he used this tool to assess the mental state of the DUs he counselled from October to December 2012 under Open Doors.

His report summarized its findings by saying that, in general, the DUs he counsels have tendencies to experience extreme stress before events with potential for conflict. They tend to feel helpless in the face of problems and to fear they will not be able to find solutions. Some are mistrustful, quick to misinterpret things, have difficulty in establishing good interpersonal relations, and react emotionally and inappropriately. Others, by contrast, become highly dependent on people they feel accept them. Some have feelings of insecurity, guilt, lack of energy and motivation, and general loss of interest including interest in their own health and well-being. Some have difficulty controlling their thoughts, are easily frustrated, quick to feel rejected and prone to irritable or angry responses.

His diagnostic conclusion was that he had found a number of cases of depression with thoughts of suicide and also drug-induced psychosis. He recommended a mix of psychological, pharmacological and other interventions appropriate to the needs of each individual drug user.

Among the pharmacologic interventions he recommended were replacement therapy using drugs such as methadone along with Suboxone tablets to reduce the symptoms of withdrawal from heroin. He noted that around 60 percent of the IDUs he counselled had been deported from the United States where they became aware that replacement therapy works for many drug users.
Annex D2 (Rebirth House, Trinidad and Tobago)
Outreach to street-based drug users

Overview

Rebirth House received only the first instalment (US$7,000) of its approved CVC/COIN Community Grant. The grant was meant to finance a four-month (mid-July to mid-November 2012) project to recruit and train ten peer educators, select the best five and have them reach out to street-based (including homeless) drug users in downtown Port of Spain. These peer educators were meant to take a harm-reduction approach based on evidence that few of the Trinidad and Tobago’s drug users inject their drugs but those on the streets often have multiple dependencies on alcohol and drugs (including crack cocaine) and their life styles put them at high risk of infection by HIV and other STIs. Rebirth House was unable to demonstrate enough progress to justify a second instalment but there are valuable lessons to be learned from the lack of progress.

Grantee: Rebirth House

Rebirth House was founded in 1988 by George “Tambi” Maximum, a recovering alcoholic who saw similarities between alcohol addiction and cocaine addiction and began organizing Narcotics Anonymous meetings in a borrowed garage. It was incorporated in 1991, granted charitable status 1993 and continues to promote and support the Narcotics Anonymous twelve-step approach to rehabilitation. The spiritual aspect of this approach is expressed by its motto, “But for the grace of God, ‘D’ Wounded Healers”.

Rebirth House has three residential centres that house up to 80 of its members and are usually filled to capacity. The one in Chaguaramas, in the northwest corner of Trinidad, operates as a rehabilitation centre where residents learn to farm fruit, vegetables, poultry and livestock and sometimes learn to tailor, weld or do woodwork. The one in St. Ann’s, close to downtown Port of Spain, serves as a halfway house for working members. The one in Carenage, not far from Chaguaramas, is associated with the organization’s garage and storeroom, both operated by its residents.

Rebirth House encourages its members to take responsibility for their own actions and to be self reliant. In addition to contributing their skills and labour, they are asked to make a minimal contribution equivalent to US$ 120 per month for their room and board when in residence but many do not. They live frugally and the gap between revenue and costs is partly covered by small government subsidies and contributions from donors but deficits are common.

Since 2001, Rebirth House has also operated the Oasis Drop-In Centre in the area of downtown Port of Spain where homeless and other street-based drug users are most often found. As its name suggests, this centre is meant to serve as a safe place where street-based drug users can relax, socialize, watch television, take showers, do their laundry, pick up condoms, and access information, counselling and health and social services. Oasis grew out of recognition that many drug users are not ready to take up offers of rehabilitation (and especially not when laws require it to take a zero tolerance approach and do not permit substitution therapy) but will take up offers of harm reduction.

Rebirth House has its storefront office not far from the Oasis Centre and this office, too, functions partly as a drop-in and outreach centre. The organization describes its programmes as “psycho-social” with a “spiritual aspect.” It offers its members social support, individual and group counselling, occupational therapy, and skills development. It also
reaches out to non-members with information, education and advocacy in families, communities, schools, churches, and workplaces and through the media. In doing so, it pays particular attention to highlighting danger signals that can let individuals and those who care about them know they might benefit from intervention and rehabilitation.

Rebirth House and its facilities and programmes have been endorsed and supported by the country’s National Drug Council (NDC), National Alcohol and Drug Abuse Prevention Programme (NADAPP), National AIDS Coordinating Committee (NACC), and ministries responsible for security and for health and social services. Donors have included the International Development Bank’s Community Development Fund (CDF), the European-Union-financed Regional Micro Project Fund, the European Commission’s programme for “north-south cooperation in the field of drugs and alcohol addiction”, and DOH International (part of Deutsher Orden Ordenswerke, a German faith-based charity).

The project’s context

From 2005 to 2007, the Organization of American States (OAS) and the Inter-American Drug Abuse and Control Commission (CICAD) worked with national drug and alcohol authorities to conduct surveys on alcohol drug use among secondary school students in 12 Caribbean countries. Among the findings for the students in Trinidad and Tobago were: the average age at which they had their first drink was 11 years old; 37 percent had drunk in the past month; 31 percent had engaged in binge drinking (five or more drinks per occasion) within the past two weeks; 6.7 percent had used inhalants (household products containing solvents, aerosols or gases) within the past month; 2.7 percent had used marijuana within the past month; 0.91 percent had used cocaine at least once in their lifetimes; 0.77 percent had used crack cocaine at least once; and 0.9 percent had used ecstasy at least once.

In general, patterns of alcohol and drug use among secondary school students reflect patterns of much greater alcohol and drug use among adults. Heavy use of alcohol and drugs is often associated with domestic violence, broken families, dysfunctional families, poor mental health, poor performance at school and on the job, school drop-out, unemployment, poverty, and, in extreme cases, homelessness or, at least, daily life on the streets scrambling for alcohol or drugs or the money to buy them and often resorting to sex work, shop-lifting, breaking and entry or other illegal activities.

The Caribbean, including Trinidad and Tobago, has long been a transhipment route for cocaine and heroin produced in South America and destined for North America and Europe. The carriers are often paid in drugs and they have created local markets for crack cocaine, in particular. “Crack” is an inexpensive way of getting high quickly and users often say their first high is so intense that getting high again becomes their main goal in life. Associated with the high are strong sexual desire and aggressive, highly risky sexual behaviour. Female, transgender and gay male users are often willing to exchange sex for crack or money and even some heterosexual male users will engage in male-male sex, whether for sexual release while high or in exchange for crack or money. The unique qualities of crack mean that it is often a drug of choice for low-income males and females. It drives them ever deeper into poverty, often until they find themselves living on the streets and sleeping rough. It also makes them highly vulnerable to infection by HIV and others STIs.

The project’s precedent

In February 2001, Rebirth House participated in a “training of trainers” course to build foundations for street-based harm reduction approaches to drug treatment. This course was

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held in Port of Spain and had participants from Bahamas, Barbados, Dominican Republic, Haiti, Jamaica, and Saint Lucia as well as from Trinidad and Tobago. It was initiated by DOH International and its trainers were from Bombay- and Delhi-based civil society organizations with years of experience working among India’s street-based heroin users.

In April 2001, DOH International supported a Rebirth House delegation to the International Harm Reduction Conference in New Delhi, India. In May 2001 — with support from DOH International and additional support from the European Commission’s programme for “north-south cooperation in the field of drugs and alcohol addiction” — Rebirth House mobilized five outreach workers to provide harm reduction interventions among street-based crack users in Port of Spain, Chaguana, Point Fortin, and San Fernando. In Port of Spain, it also established the Oasis Drop-In Centre and to support and supplement the outreach workers’ interventions.

This work was all done on a short-term project basis and the project came to an end in March 2002, after which Rebirth House was left to do what it could to finance and sustain its efforts to do street-based harm reduction.

**The project’s proposed but unachieved objectives**

Wishing to support at least one project responding to HIV among drug users in Trinidad and Tobago, CVC/COIN encouraged Rebirth House to apply for a CVC/COIN Community Grant. The organization then prepared a proposal for a project that closely resembled the 2001-2002 project described above. The proposed objectives were:

1. **To recruit and train 10 peer educators and select the best five to make up a team of outreach workers.** The proposal suggested that Rebirth house already had some trained and experienced peer educators and, in their case, the training would be refreshing and adding to their existing knowledge and skills.

2. **To provide peer-on-peer interventions to 150 street-based drug users in downtown Port of Spain.** adding to their knowledge and skills, providing them with IEC material and supplies and, also, providing them with access to services. Key service-providers were to include the Oasis Drop-In Centre, Queens Park Counselling Centre and Clinic (QPCC and C) and Medical Research Foundation (MRF). The QPCC and its clinic and the MRF both provide voluntary counselling, testing and treatment for HIV and other STIs are in the Port of Spain General Hospital complex, an easy walk from the Oasis Drop-In Centre and the Rebirth House office.

3. **To adopt or adapt and duplicate existing IEC material** for distribution by the peer educators to street-based drug users.

Not long after Rebirth House received approval for a CVC/COIN Community Grant to finance the project, the staff member who had written the application and who was meant to coordinate the project left the organization. Rebirth House subsequently said that it did not have the in-house capacity to write the monthly monitoring and evaluation reports that were a condition of the grant. CVC’s Programme Coordinator for Trinidad agreed to write these monthly reports and the end-of-project report submitted to CVC/COIN on 14 December 2012.

The monthly and end-of-project reports provide no evidence that Rebirth House took concrete steps to implement the project but suggest, instead, that it continued with its usual operations and absorbed the first instalment of its grant into its regular operating budget. The reports suggest two main reasons for this: 1) Rebirth House did not have staff providing it
with the in-house capacity to implement the project, 2) Rebirth House did not have partners that could provide it with the technical support it needed to implement the project.

In the Rebirth House office on 19 November 2012, all of the above was confirmed during joint discussions with the organization’s Director, Steve “LT” Richards, and Outreach Counsellor,Keith Deyalsingh. Steve referred to Keith as the leader of the project’s intended team of five peer educators. However, Keith was acting as a team of one and carrying on with the work he had been doing for some years. This work brought him into frequent contact with peer educators working for Community Action Resource (CARe). He made frequent visits to CARe’s own space within the QPCC and C, for example, and CARe’s peer educators helped him identify drug users among visitors to the clinic so he could provide them with appropriate interventions.

**Lesson learned from non-performance**

During Phase One of its Global Fund project, CVC/COIN provided Community Grants to 14 projects. The grant to Rebirth House was the only one where there there not enough evidence of performance to justify additional payments beyond the first instalment. Lessons to be learned from this experience include:

1. **The project-by-project approach to organizational capacity building, with long gaps between projects, is seriously flawed.** Like many small civil society organizations, Rebirth House has an impressive history of strong commitment and solid achievement but it depends on contributions of money and labour from its own members, modest and uncertain financial and technical support from government ministries and their agencies, and sporadic (in-one-month-and-out-the-next) financial and technical support from capricious donors.

2. **An agreement to provide an organization with a grant should be preceded by careful assessment of the organization’s capacity to use the grant effectively.** A careful look at recent annual reports (including financial reports) or their equivalents together with visits to its various sites and on-site interviews with its staff and volunteers might have revealed that Rebirth House did not have the in-house capacity to implement this project.

3. **Such an agreement might also be preceded by an attempt to engage other partners.** One potential partner, in this case, might have been the National Alcohol and Drug Abuse Prevention Programme (NADAPP). Others might have been CARe, the YMCA or the Family Planning Association of Trinidad and Tobago (FPATT), all of which have experience training and supporting peer educators to deliver HIV and STI prevention and related interventions.

4. **Trinidad and Tobago lacks one civil society organization that can act as a technical support facility to others involved in responding to HIV.** COIN in Dominican Republic and JASL in Jamaica are well recognized leaders in civil society responses to HIV and AIDS. They were born not long after the HIV epidemics emerged in their countries and they have taken horizontal approaches to building civil society’s capacity to contribute to their countries’ responses. That is, they have identified, trained and supported leaders from vulnerable sub-populations as they have established new CSOs to represent and serve those sub-populations, or as they have established new programmes within existing CSOs. If Trinidad and Tobago had a leading CSO equivalent to COIN or a JASL it would have made sense for Rebirth House to involve that CSO in this project. It is not too late, however, for the country’s CSOs to recognize one CSO as a potential leader and to promote and support efforts to build its capacity to provide technical support to other CSOs in Trinidad and Tobago.
The way ahead

Trinidad and Tobago's new National HIV and AIDS Strategic Plan 2013-2018\textsuperscript{113} recognizes that the country has both a generalized epidemic and concentrated epidemics among MSM, sex workers and drug users. It calls for the larger share of future national spending on HIV and AIDS to go towards responding to those concentrated epidemics. FPATT is now working with CARe, Rebirth House and other civil society organizations on efforts to establish an integrated network of government and civil society organizations that represent and/or serve vulnerable sub-populations in Trinidad and Tobago.

Those facts and the lessons outlined above suggest possible ways ahead. Clearly, Trinidad and Tobago needs to scale up and sustain its response to HIV and AIDS among drug users. Rebirth House is well placed to be an important partner in efforts to scale up and sustain such a response. It does not, however, currently have the capacity to do this on its own or even to be the lead partner. Until such time as it has the capacity, it should be aligned with other partners; one of those other partners should play the lead role and, among other things, be responsible for administering the budget and driving and coordinating all activities, including monitoring and evaluation.

\textsuperscript{113} Office of the Prime Minister (2013).
Annex D3 (NCDA, Jamaica)  
“Tek It to Dem 2” for homeless drug users

Overview

With a CVC/COIN Community Grant of US$20,000, Jamaica’s National Council on Drug Abuse (NCDA) trained 15 peer educators in July 2012 and then chose ten to work as a peer education team from August through November 2012. The chosen ten included three homeless drug users plus five MSM and two women with histories of sex work and, in some cases, drug abuse. Assigned to particular locations in the neighbouring parishes of Kingston and St. Andrews, they provided peer education on STIs, HIV/AIDS and drug abuse to homeless drug users and associated sub-populations, including street-based male, female and transgender sex workers. They also distributed condoms, lubricants and care packages with personal hygiene products and provided access to on-the-spot HIV testing, referrals to clinics for STI and HIV testing and treatment, and referrals to detoxification and rehabilitation services.

Grantee: National Council on Drug Abuse (NCDA)

Established in 1983, Jamaica’s National Council on Drug Abuse (NCDA) currently has representatives from 58 public, private and civil society organizations. Its Secretariat falls under the umbrella of the Ministry of Health and its responsibilities include: public education on the dangers of drug abuse; drug abuse prevention and harm reduction; examination of the medical, legal and security issues surrounding drug abuse; research into drug abuse.

In 2012, CARICOM published a report estimating that, in 2010, the economic cost of drug abuse in Jamaica was US$42 million including the costs of law enforcement, medical interventions, and lost lives and productivity. In 2010, the Organization of American States (OAS) and the Inter-American Drug Abuse and Control Commission (CICAD) published the results of a survey of secondary students (mostly 13 to 17 years old) in Caribbean countries. Among the findings for secondary students in Jamaica were: the average age at which they had had their first drink was 11.7 years old; more than one-third had drank in the past month; many engaged in binge drinking (five or more drinks per occasion) frequently; more than 7 percent had used marijuana within the past month; 3.12 percent had used cocaine at least once; 2.79 percent had used ecstasy at least once, and 1.63 percent had used crack cocaine at least once. The use of inhalants (e.g., glue and spray paint) was also common. (To learn more about these studies and the NCDA go to http://ncda.org.jm.)

Collette Browne is the NCDA’s Treatment Consultant and also Project Coordinator of the “Tek It to Dem 2” project. Kaymorie Johnson-Silviera is the Project Administrator and Marlene Rowe is the Project Case Worker. During an informal meeting on 3 December 2012, they talked about drug abuse in Jamaica, the NCDA’s work, and “Tek It to Dem 1” and “2”.

They say heavy alcohol use is a cultural norm in Jamaica. Most people don’t see it as a problem until it emerges in alcohol-related health and other problems such as domestic violence, broken homes, loss of jobs, and failure at school. Since the 1960s, heavy marijuana use has also become a cultural norm. The result is a comparatively drug-friendly environment where, over the past twenty years, there has been increasing use of other drugs such as cocaine, ecstasy and crack cocaine. In other words, what is going on in secondary schools reflects what is going on in wider Jamaican society.

Of special concern is the growing use of crack cocaine. Only a small percentage of all Jamaicans use crack cocaine but it is becoming the drug of choice for increasing numbers of the country’s poor adolescents and adults because it is the cheapest and quickest way of getting high. Crack cocaine users often say they became addicted the first time they used it.
because it gave them such a rush. Thereafter, they are in constant pursuit of that same rush even though subsequent ones are never quite as good.

Part of the crack cocaine rush is an immediate surge of sexual desire, so strong that crack users will engage in sexual acts they might not otherwise engage in and they will do so without taking the precautions they might normally take. Once people become addicted, they become unable to hold down regular jobs. Desperate for money to support their crack habits, female addicts resort to sex work and are often willing to do things other sex workers will not do, such as having vaginal or anal sex without a condom. The same is true of gay and transgender crack addicts and even some heterosexual male addicts will agree to have sex with other males in exchange for crack or the money to buy it. In any case, the heterosexual male addicts often have unprotected sex with crack-addicted female sex workers and it is often rough sex, since crack brings out the violence in people who are prone to be violent anyway.

**Context of the “Tek It to Dem 2” project**

Collette Browne explains that “Tek It to Dem 1” was launched in 2008, after HIV testing of homeless people at a particular site found that 82 percent were HIV positive and all of those who tested positive were substance abusers. The NCDA proposed a pilot project to address HIV among all homeless people in two of Jamaica’s 14 parishes: Kingston and St. Andrew (a suburban parish to the immediate north of Kingston). The Ministry of Health agreed to provide financing (using money from Jamaica’s Global Fund grant) and in 2010 USAID agreed to provide additional financing. These two sources allowed them to hire two staff and acquire a van to visit homeless sites and provide preventive information, condoms, lubricants, care packages, HIV testing, counselling and referrals.

“Tek It to Dem 1” enabled them to gather more data on homeless people. Currently, there are a roughly estimated 800 or more homeless people in the two parishes but the number may be growing due to rising levels of unemployment and poverty. More than 80 percent of them are men and around 30 percent are mentally ill. The latest data show that HIV prevalence is 12 percent among all homeless people but 34 percent among homeless women and 8.7 percent among homeless men. Around 79 percent of all homeless people are substance abusers, with 74 percent of homeless women and 80 percent of homeless men being substance abusers. Around 60 percent of substance abusers are addicted to crack cocaine and many are addicted to multiple substances.

Many homeless drug abusers have been deported from the United States, United Kingdom and Canada after being charged with criminal offenses. Many others are young gay men from all over Jamaica who have come to live on the streets of Jamaica after being rejected by their families or after simply choosing to run away from less than gay-friendly families and communities. Homeless women and homeless MSM usually support their drug habits with sex work. Some heterosexual male homeless people do the same but most get their money from petty theft or washing cars and similar work for tips.

Drug abusers and sex workers often slide in and out of homelessness. When homeless they continue to mingle with non-homeless drug abusers and sex workers who visit the same sites where homeless people set up camp because they find friends there and drug dealers also visit those sites. Both homeless and non-homeless crack cocaine users visit “crack houses” (derelict buildings) where dealers sell crack cocaine and users inhale it and, while experiencing their rushes, often have sex. (For more on the context, see the box.)
Objectives of “Tek It to Dem 2”

“Tek It to Dem 2” added peer educators to “Tek It to Dem 1” with the aim of extending its reach and making it more effective. It extended from July through November 2012, and its original objectives and proposed methods were:

4. **To recruit and train 15 peer educators**, all from among homeless drug users and closely associated sub-populations in Kingston and St. Andrew parishes.

5. **To select 10 of those 15 and add them to the NCDA's core “Tek It to Dem” team.**

6. **To reach 500 homeless drug users and associated individuals (mainly street-based sex workers) with interventions tailored to their unique needs.**

The results

Collette Brown prepared the end-of-project report and it, together with information provided during the 3 December 2012 meeting with her and others on the NCDA's core “Tek It to Dem” team described these results:

1. **In July 2012, 15 peer educators were recruited and trained** as follows:
   a. They had four focus groups at locations with homeless drug users and related sub-populations were known to congregate and these had identified the most suitable candidates for training.
   b. The 15 candidates were then given three days of training provided by consultants who often do training for the Ministry of Health, by CVC/COIN and by NCDA staff.

2. **The trainers selected those 10 of the 15 they felt would be most effective** at providing peer education to homeless drug users and associated sub-populations and then mobilized and supported them as follows:
   a. The selected ten included three homeless drug abusers in their late 30s/early 40s, two still using drugs; five MSM (four gay and one transgender) and two women with histories of sex work and, in one case, a history of drug abuse.
   b. Each of the ten was assigned to do interventions among their peers at particular locations. That is, the homeless drug abusers were assigned to do interventions among homeless drug abusers at locations where they were known to congregate and sleep rough and the MSM and women were similarly assigned.
   c. When some of the ten experienced difficulty in engaging with their peers (who often distrust strangers who approach them), they were all provided with an additional day of training on how to approach people by Marlon Taylor, one of JASL’s most experienced peer educators and also President of SWAJ.
   d. There was no on-site supervision of the peer educators but there were periodic visits by members of the NCDA’s core project team to try and make sure the peer educators were where they supposed to be during their scheduled working hours.
   e. Each peer educator was asked to reach at least 20 individuals per week during a 16-week (August through November) period of work. They were each paid 5000 Jamaican dollars (just over US$50) per week and given 200 condoms per week to distribute.

3. **The peer educators reached 1592 individuals** with 2478 interventions during their 16 weeks of work, thus reaching 318 percent of the targeted 500 individuals. Not all of these individuals were homeless but most had experienced homelessness or were
vulnerable to homelessness and mingled with homeless people on the streets, in the crack houses and other locations where homeless people are commonly found. Interventions included:

a. Consistent distribution of condoms and lubricants.

b. Distribution of 500 care packages, exceeding plans to distribute just 300 care packages. The content of these care packages grew out of recommendations made by four focus groups from the sub-populations the project aimed to serve. Each package contained toothpaste, a toothbrush, a tin of sardines, bathing soap, a washcloth, roll-on deodorant, lip balm, and condoms and lubricants. The peer educators who were homeless drug users explained that a reason crack addicts are famous for their poor oral hygiene (including bleeding gums) is that they don’t invest in tooth paste or toothbrushes or take the time to brush their teeth. Personal hygiene is major problem for all homeless people because they do not have ready access to running water and they have nowhere to store bathing soap and washcloths. The packages came in bags they could easily store in their bed rolls. They were used to feeling ashamed of their bad hygiene and these products helped them clean up and work up the courage to appear in public. They explained, too, that using crack cocaine gives the body a peculiar odour that marks them as crack users to those familiar with this odour and that repels people who are not crack users. They appreciated being able to wash off this odour with the soap and washcloths provided.

c. There was little on-the-spot HIV testing that could be attributed to the project but there were many referrals to JASL’s clinic and others for STI and HIV testing.

d. Drug users were made aware of their options for detoxification and rehabilitation but none followed through with referrals because all treatment centres take the “cold turkey” approach and do not offer substitution therapy. However, both of the homeless peer educators who were still drug users said they had substantially reduced their drug use and they believed they were serving as inspiration to other homeless drug users.

For peer educators’ assessments of the project’s impacts, see the box.

The challenges

Challenges identified the NCDA’s core project team and by the peer educators include:

1. There was no on-site supervision of peer educators and many had no cell phones. As a result, there was no way of knowing whether or not they were showing up at their assigned locations at their scheduled hours. When members of the core team showed up in the project’s van, they were often unable to find the peer educators that were supposed to be there. The core team saw some of the peer educators only when they showed up at their location to collect their weekly pay cheques on Fridays.

2. Some of the peer educators had very low levels of literacy and were unable to fill out the CVC/COIN monitoring forms they were supposed to fill out during or after each of their interventions.

3. The homeless peer educators experienced numerous evictions during the course of the project and were forced by the police to move from one location to another. As for the MSM peer educators, it was often difficult to find safe places to pay them, where they would not be spotted receiving the money and subsequently robbed.

4. The peer educators, themselves, felt that they needed more training, supervision and other support. They said it would have been helpful if they had had some form of identification that ensured both police and their peers that they had legitimate
reasons for being wherever they were and that they could be trusted. Some said they could also use more psycho-social support to deal with their personal problems.

5. Under current agreements, USAID financing for “Tek It to Dem” has come to an end but there is reason for hope that it will be renewed. Financing from the Global Fund via the Ministry of Health comes to the end at the end of March 2013 and whether or not the Ministry will find other sources of financing after that remains to be seen. In Jamaica health care is free through the public system but it is chronically under-funded and under-staffed, so that it is not uncommon for people to spend their entire day in a waiting room before a doctor or nurse can see them.

The way ahead

The end-of-project report suggests practical ways of meeting all but the financial challenges mentioned above including, for example: providing all peer educators with cell phones and requiring them to carry these phones when at work; requiring them to draw up weekly work plans and schedules; working with them on making the CVC/COIN monitoring forms easier to complete. NCDA’s core “Tek It to Dem” team and the peer educators all felt that the project was successful and should be strengthened, scaled up and sustained as an on-going programme serving homeless drug users and closely related sub-populations across Jamaica. The scale-up might begin with an extension to Montego Bay, which is known to have many homeless drug users.

It is noted here that this project provided a kind of peer education that JASL provides to some of the same populations and that it might be worth considering whether or not JASL should have primary responsibility for recruiting, training and supervising peer educators while collaborating with NCDA, SWAJ and other organizations on tailoring peer education to the needs of particular sub-populations throughout Jamaica.

“Tek It to Dem 2” peer educators speak for themselves

On 3 December 2012, five of the project’s ten peer educators participated in informal discussions of their work. One of the MSM peer educators had prior training as a peer educator for JASL and said this project had given him an opportunity to focus on the MSM who often congregate in Kingston’s Emancipation Park in the evening and who also often work as sex workers on a nearby street. Not only did he find this work very worthwhile, but the pay had been enough to start his own business raising chickens.

Kevin, Michael (aka “Brinks”) and Owen (aka “Indian”) were the three homeless drug users among the peer educators and around a table in the morning and during a tour of homeless sites and crack houses during the afternoon they spoke freely of their personal experiences with homelessness and drug abuse and of their experiences as peer educators.

Kevin’s Story

Kevin had moved to Vancouver, Canada, with his mother when he was eight years old. She had married a Canadian man, they had had Canadian-born children and Kevin often felt neglected. He began getting into trouble with the police when he was a teenager. In 1988, when he was 22 years old, he has been convicted of assault and sentenced to 6 months in prison. That conviction eventually led to him being deported to Jamaica in 1991. Meanwhile, he had had a number of abusive relationships with women (where he was both victim and perpetrator of verbal abuse) and he had fathered six children. When he was on the verge of being deported he had tried crack cocaine and it immediately became his best friend, allowing him to escape from bad feelings he did not want to feel.

When he got back to Jamaica, he found that his relatives wanted nothing to do with him and to soothe his wounds he became poly-addicted to alcohol, marijuana and crack cocaine. He says there a lot of deportees, mostly from the USA and Canada, living in Jamaica and he
would guess that 47 out of 50 of them are drug abusers. Deportees are considered failures by other Jamaican’s and their North American accents and way of dressing and behaving identify them as worthless deportees.

Kevin had fathered a Jamaica-born son and, two years ago, that son had proven his salvation. One day he was down in the Gully (a homeless site) when there was a disturbance involving a well known drug trafficker when he found himself being interviewed by a reporter. His son was there and crying and pulling at his sleeve, urging him to come away. He realized then and there that there was someone in this world who loved him and needed him.

By then, Kevin was well aware of “Tek It to Dem 1” and its van, which reminded him of the needle-exchange vans he had seen in Vancouver. Next time the van came around with Collette Browne in it, he had asked her to refer him to a rehabilitation centre and since coming out of that centre he has stayed “clean.” When Collette came by again to tell him about “Tek It to Dem 2” and ask him if he would agree to be one of the 15 people to be trained as peer educators, he leapt at the opportunity.

**Michael’s Story**

Michael had moved to Toronto, Canada, to join his mother when he was 14 years old. He had graduated from high school and then gone to college to study commercial art and furniture finishing. After he earned his diploma, he got a job driving a truck and delivering furniture to people’s houses. He started supplementing his income by stealing with his friends and thinks that a reason he started getting into trouble was that he felt his mother neglected him in favour of his two Canadian born sisters. He had been caught, charged and convicting of stealing and, as a result, was deported after he had been in Canada for 20 years. He had a common law wife in Canada and they had married in the hopes that it would save him from deportation but it didn’t work and he was sent back to Jamaica two days after the wedding. Their daughter was one and a half years old then and she is now 23 and has given him a grandson.

Michael was smoking marijuana but taking no other drugs when in Canada. After landing back in Jamaica, he had soon got a job with an embassy and eventually became a surveillance specialist and then a chauffeur. Once he had driven a diplomat to and from Montego Bay. He had not been aware that there had been any problem until he was called in because the man had complained about him driving too fast and recklessly, though he was not aware of having done so. As a result he had lost his job.

Before he was fired, he was earning enough money that his “baby mother” (partner and mother of his child) did not have to work to support them and their child. After he was fired, she started “getting bun” (having affairs with other men). He still had a US visa and he used it to move to Miami for three months but came back three months later to find that his baby mother had left and taken the child and all of their furniture. He started having sex with other women and on one occasion the woman had offered to share her crack cocaine with him. That was six years ago and ever since that first time, he has been addicted to crack cocaine. Soon his addiction put him on the streets where he found himself competing with big rats for the food he was able to find in garbage cans.

When “Tek It to Dem 1” started up he saw its van and staff coming to the Gully and other places where he slept rough. They were bringing condom and lubricants, providing testing for HIV and referrals to other services and they were providing good advice. He felt himself strongly drawn towards them and they became his friends. He felt worthless and no one else cared for him until they came along and showed him a little love. Like Kevin, he had leapt at the chance to take training and become a peer educator.

Before he became a peer educator, Michael was using 50 or 60 hits of crack cocaine per day and he was doing his best to pay for it honestly by washing people’s cars or helping them when he saw them stopped by the road because they had flat tires or other troubles.
The drugs were eating up all his money, so he could not access a computer and keep in touch with his Canadian daughter through her Facebook page. He felt dirty and worthless and hated appearing in public places before he started the peer education training. Through that training and his subsequent work with the project he has learned that he is not worthless, that his situation is not hopeless and that there are practical ways he can face up to his problems rather than escaping into highs with crack cocaine. Without ever going into a rehabilitation centre, he has cut down his drug use to the point where he can go six or seven days without crack cocaine. When he has a relapse, he no longer stays down wallowing in self-pity but soon pulls himself out of it. Being a peer educator has really boosted his ego and he is now able to love people and help them in the same ways “Tek It to Dem” has helped him.

**Life on the streets**

Kevin, Michael and Owen describe the two locations where they do most of their interventions. The Gully (a drainage ditch and its banks) has around eight people sleeping rough in it every night and four of them are women. Another 100 or so people (90 men and 10 women) hang around the Gully, socialize with each other and buy drugs there. There are many more living on a particular street downtown and the ratio of men to women is about the same. Not far from that street are 15 crack houses. At any one time you might find 20 people in a crack house, with around 60 passing through each day. People come to these houses to buy and use drugs and to have sex during the rush immediately afterwards. They know enough to use condoms and lubricants but if these are not immediately available they will have unprotected sex anyway and often it is rough sex, increasing the chance of bleeding and HIV infection. They guess that nearly all female, gay and transgender crack users exchange sex for drugs or the money to buy it and that around 10 percent of heterosexual crack users will do the same.

Kevin thinks it is so easy for the female, gay and transgender crack addicts to sell sex for drugs that they are less likely to go into rehabilitation than heterosexual male crack addicts. For most heterosexual males, getting money puts them in situations where they are likely to get assaulted (e.g., for breaking and entering houses) or arrested and imprisoned so that gives them more motivation to go into rehab or simply cut down or quit drug abuse on their own.

Kevin also thinks, however, that female, gay and transgender crack addicts’ dependency on selling sex means that they are that much more in need of protection. The men they sell sex to are often addicts, too, and desperately in need of money and drugs. Once they have had sex, they often demand back whatever they have paid for it and become violent if their demand is not met. In addition, crack cocaine brings out their inherent violence.

**Working as peer educators**

All three agree that their stories inspire other homeless drug users to recognize that they can never be so far down that there is not a way up again. They look at one of them and say, “If he can do it, so can I.” As for their day to day work, they see just hanging out and giving homeless people someone to talk to is part of their job. So is bringing them food and otherwise letting them know someone cares. Their presence also makes homeless people feel safer, since they live under constant threat of verbal and physical violence from passers-by and of being moved on by the police, so they don’t even have outdoor space they can call home.

They say that most homeless people are at least averagely intelligent, though they may not be literate or well-educated. They understand the messages and they are grateful for the condoms, lubricants and care packages the peer educators give them. They also appreciate the referrals to services, even if they don’t follow up. A real challenge, however, is to make them feel their lives are worth living and to give them hope for the future. Another challenge is to convince them that a diagnosis of HIV is not a death sentence and that treatment
works. As things stand, many who think they are probably HIV-positive choose not to get tested. Instead, they take even more drugs and engage in even more risky sex saying to themselves, “Let me just die in a pleasure zone.” A few even say, “Let me get even for my infection and infect other people too.”

Looking at Jamaican society in general, the three of them agree that popular Jamaican culture (including Jamaican movies) makes young people think it is cool and even glamorous to be a “bad man” who snorts cocaine and thus becomes filled with self-confidence, invincible and untouchable by their enemies. The wild sex associated with drug-using is also cool and young men, in particular, are very attracted to the idea of becoming “bad men” themselves. Anyway, sex is an enormous and growing part of Jamaican culture. For many women, it is all about getting money for their children. It is driven by poverty and it puts many men in the position of being like pimps. They may not actively encourage their partners to sell sex for money but neither do they try to discourage them.

Those are all reasons why Kevin, Michael and Owen agree that it would be great to see “Tek It to Dem” expanded and carried into schools. They believe that trained peer educators such as they could do a lot to educate secondary school students about the perils of drug use and associated sexual activities.
Annex E1 (REDNAJCER, Dominican Republic)  
Monitoring services for youth living with HIV 

Overview 
With a CVC/COIN Community Grant of US$20,000, La Red Nacional de Jóvenes Viviendo Con VIH/SIDA (REDNAJCER) developed a system for monitoring the quality of services delivered by health care providers to marginalized youth living with HIV. This project ran from May through November 2012 and established partnerships with key stakeholders, including the Ministry of Health’s Division for Controlling STIs and HIV (DIGECITTS) and a network of public health care facilities. It also established a Citizens’ Oversight Team of six marginalized youth who observed interactions between health care providers and users, questioned users about their experiences and then analyzed and reported their findings. The aim was to lay the foundations of citizen-driven monitoring system that could be scaled up and sustained across the country's health care system. 

Grantee: Red Nacional de Jóvenes Viviendo Con VIH/SIDA (REDNAJCER) 

La Red Nacional de Jóvenes Viviendo Con VIH/SIDA (REDNAJCER) — the National Network of Youth Living with HIV/AIDS — was founded in 2004 and legally registered in 2007. It serves as a mechanism for mutual support and collective advocacy and action. Its main aim is to ensure the participation of all young Dominicans living with HIV/AIDS in the planning, delivery, monitoring and evaluation, and improvement of the HIV/AIDS-related health and social services available to them. 

Felix Reyes is the founding Director of REDNAJCER. In an interview on 13 July 2012, he said he learned he was HIV-positive in 1998 and became actively involved with el Grupo Clara, which got much of its support from the CONECTA Project run by Family Health International (FHI) and financed by USAID. He was one of the many people living with HIV who were not only young but from marginalized populations. By 2004, they were getting tired of other people claiming to speak on their behalf and trying to stop them from expressing their own honest opinions. So they decided to form their own group where they could speak for themselves and not be bound by any restrictions. 

With nowhere else to meet, they met in Juan Pablo Duarte Olympic Park. CONECTA continued to give them a bit of support and, as their network grew, then met in other venues such as the Youth Ministry, a hotel and a mechanic’s shop. Various organizations offered to contribute but there were usually strings attached that would have restricted their freedom to speak frankly about their impatience with the lack of good care and treatment offered by the country’s public health system. 

Participating in the interview with Felix, Danilda Soto said she joined REDNAJCER in 2007 as a human right advocate working for a Caribbean-wide project. She could see how hard it was for Felix and other marginalized young Dominicans to get the country’s health authorities to listen to them. She could also see how much competition and conflict there was among organizations claiming to represent or serve people living with HIV. She liked REDNAJCER’s democratic and egalitarian approach more than the more hierarchical approaches taken by the others. 

Felix explained that REDNAJCER’s approach is horizontal so all members are equal. They aim for transparency, unity and trust but also individual freedom of speech and action. They don’t try to control their members in any way. They can say whatever is on their minds and
belong to any other organizations and still be members of REDNAJCER. Why, he asked, should young people give up their freedom to express themselves just because they are HIV-positive?

In 2006, the Agua Buena Human Rights Association (based in Costa Rica) invited REDNAJCER to participate in research supported by the International Treatment Activists Coalition (CIAT) and the International Treatment Preparedness Coalition (ITPC). The methodology was to meet with people living with HIV and then with health care centres where those people went for treatment. The managers and staff of some of these centres refused to talk to them, complaining that REDNAJCER had not asked for the centres' permission before speaking to their patients.

The research findings were published in the ITPC’s 2007 annual report, which contradicted the rosy picture portrayed in official government reports and said the Dominican Republic was failing to provide antiretroviral treatment to many people living with HIV and, as a result, they were dying. Though it was published internationally, the report was suppressed in the Dominican Republic. In fact, some members of REDNAJCER received death threats and one of their American supporters was ordered to leave the country within 48 hours because he was no longer welcome.

Felix says that, in retrospect, the report has had positive impacts but, in his opinion, the government continues to be insincere and hypocritical. When they are looking for financing from donors, they say the rights things but once they have the money in hand, they do not always follow through and do the right things.

The project’s context

The public health care system in the Dominican Republic is under-funded. People often travel long distances to get to their nearest public health care centre and, once there, they often find it is over-crowded, under-staffed, ill-equipped and poorly maintained. Even if they have an appointment, they may have to wait all day to see a doctor or nurse and then only get to see them briefly and be prescribed treatments they can ill afford. These things discourage many people from seeking timely diagnosis when they have symptoms of serious infection or disease or from adhering to their prescribed treatments.

Young people living with HIV find the public health care system even more challenging than most users find it. Health care staff too often take the attitude that these young people are to blame for their HIV-infections — and also to blame for being MSM, sex-workers, drug users, or simply ill-educated and poor — and that part of their treatment should be stern disapproval accompanied by lectures on morality or religion. They have especially strong prejudices against transgender people, effeminate gay men and poor youth with tattoos suggesting they may be drug users or gang members. Felix cites the case of one urologist who denies services to anyone he knows to be HIV-positive and has been heard to say, “They deserve HIV when they behave that way.” (In fact, most kinds of infection and disease could be prevented by changes in lifestyle and environment.) Another doctor denies services while explaining that he is afraid of acquiring HIV infection from someone he treats.

The country’s government has not been an enthusiastic or generous participant in the international response to HIV/AIDS. In 2002, the Dominican Network of People Living with HIV (REDOVIH) lodged a complaint with the Inter-American Commission on Human Rights saying the public health care system was not providing antiretroviral therapy (ART) to everyone who needed it and was, therefore, in breach of international conventions specifying everyone’s rights to essential health care. Since 2004, the public health care system has been providing ART but the financing has been covered by a Global Fund grant. That grant is due to expire at the end of March 2013 and REDNAJCER is among the many

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114 ITPC (2007).
stakeholders demanding an amendment to Subsection N, Article 17 of the Social Security Act so that it requires the public health care system to continue providing ART for everyone who needs.

Even when free ART is offered to everyone, however, many marginalized youth do not take up offers of voluntary HIV counselling, testing and treatment or do not adhere to their treatment regimes. Reasons include their expectation that health care centres will not provide them with services in a respectful, courteous and compassionate manner. Reasons also include that the country’s systems of public health and social care do not provide the nutritional supplements or the social and psychological support that people living with HIV need if ART is to be as effective as it should be.

Factors contributing to those problems include: many young people living with HIV are not aware they have the right to receive essential health and social care and to be treated with courtesy, respect and compassion as they do so; many young people living with HIV internalize society’s prejudices and think they are not worthy of better care.

**The project’s proposed objectives and methods**

Among the partners helping REDNAJCER develop its proposal for a CVC/COIN Community Projects grant were COIN, DIGECITSS, Hospital el Almirante, UNAIDS, and UNFPA. The objectives and methods laid out in the proposal were as follows:

1. **To recruit and train 25 volunteers from among MSM and other marginalized youth living with HIV and then select and mobilize members of a team,** with methods to include:

   a. Holding an induction meeting and then a workshop to provide 25 volunteers with basic training in the monitoring of health and social services and to develop a six-month workplan for the project

   b. Selecting the best candidates from among the 25 volunteers; making them the members of a Citizens’ Oversight Team; developing a form for gathering the information needed to measure user satisfaction with services; developing a flyer on the rights of young people as service users

   c. Selecting two health care facilities to act as pilots and, for each centre, holding a workshop to inform the director and staff about the project and seek their collaboration

   d. Holding monthly feedback sessions in each health care facility, where members of the Action Team meet with managers and staff and review the latest monitoring results and identify ways to improve the quality of services.

2. **To develop and implement a capacity-building plan for REDNAJCER and to include plans for a mechanism for continuing collaboration between REDNAJCER and its partners**

3. **To document the whole process and communicate the results** including:

   a. Video-taping activities, then developing a script and editing to produce a good video presentation

   b. Producing a written report with recommendations.

**The results**

In an informal meeting on 29 November 2012, Felix Reyes and three members of the Citizens’ Oversight Team — Dawaldyn Villa Mendoza, Franklyn Sanchez and Geisha Collins — reviewed the project’s challenges and achievements. Based on what they and
REDNAJCER’s 14 December 2012 end-of-project report had to say, the project’s achievements can be summarized as follows:

1. **The workshop was held in July 2012.** It emphasized citizen’s rights to monitor health and social services and play significant roles in ensuring these services meet high standards of quality, based on their efficiency, effectiveness and fairness (i.e., provision of equally good services to all users). During and after the workshop, actions included:

   a. **The selection of six volunteers to constitute the Citizens’ Oversight Team.** The six included one transgender person (Geisha), two women and three MSM. They ranged in age 18 to 28 years old, were all HIV positive and some had histories of sex work or drug use.

   b. **The selection of four health centres (two more than originally intended) to act as pilots.** The four were Hospital Padre Billini, Hospital Dr. Luís E. Aybar, Hospital Francisco Moscoso Puello, and Centro Sanitario de Santo Domingo.

   c. **The development, validation and deployment of two forms for gathering data on user experiences with health and social services.** This involved a series of focus group meetings engaging the Action Team and health facility staff and users in developing, testing and refining the forms. One of the resulting forms had 18 questions pertaining to users’ experiences with HIV/AIDS-related services and the other had 12 questions pertaining to their experiences with a broader range of health and social services.

   d. **Launch and continuation through October 2012 of monitoring in the two centres.** With one exception, the launch went smoothly. The exception was when an administrator at one hospital barred entry to Geisha and Danilda was called in to mediate. The administrator said he thought Geisha was dressed inappropriately, with too much skin showing around her stomach and waist.

   e. **The monitoring of interactions between 152 youth living with HIV and their health care providers.** The results were reported on a regular basis to directors and staff of the four health care facilities and they were also aggregated, analyzed and presented in a November 2012 report.

2. **Capacity-building achievements** included:

   a. The whole process of working with key partners to develop, refine and implement the project plan was an important capacity building exercise for REDNAJCER, a comparatively new and small civil society organization with few resources.

   b. The process left them with **constructive partnerships with the Ministry of Health’s DIGECITTS** and with four health care facilities and thus laid the foundations for what could turn out to be constructive partnerships with the Ministry and a country-wide network of public health care facilities.

   c. The process also left them with **stronger partnerships with COIN, UNAIDS and UNFPA** and this could turn out to be the beginnings of a growing network of partners able to provide REDNAJCER with financial and technical support.

   d. From August into November 2012, the project supported development of REDNAJCER’s **Advocacy Plan** and helped REDNAJCER play a lead role (with support from COIN) in organizing and staging a pre-walk press conference followed by the **5 September 2012 “Walk for a Dignified Life.”** This walk advocated for an amendment to Subsection N, Article 17 of the
Social Security Act so that it requires the public health care system to continue providing free ART to everyone who needs it, even if the Global Fund ceases to provide financing for ART. Participants in the walk included representatives from 120 civil society organizations including all the country's networks of people living with HIV.

e. By mid-December 2012, REDNAJCER also organized and staged eight vigils in front of government offices arguing for the amendment, which is a matter of extreme urgency for all Dominicans living with HIV.

f. Out of efforts to organize and stage the “Walk for a Dignified Life” was born the National Front for Access to Antiretroviral Therapy. The Front unites, for the first time, all of the country’s civil society organizations supporting the response to HIV, including its networks of people living with HIV. The Executive Director of the National HIV and AIDS Council (CONAVIHSIDA) has established a Committee to support the Front within his office and, as of this writing, the President of the Dominican Republic is saying that his government will provide enough financing to the total national response to HIV/AIDS to provide for this.

3. Documentation and communication material produced by the project include:

   a. A November 2012 report on the findings of the Citizens’ Oversight Team as recorded in the two forms Team members filled out as they interviewed 152 users of the services offered by the four health care facilities

   b. Producing a written report with recommendations.

**The challenges**

In the informal meeting on 29 November 2012 and in their end-of-project support, representative of REDNAJCER and its Citizen’s Oversight Team identified the following challenges:

1. Sometimes people living with HIV and their peers in the subpopulations most vulnerable to HIV can be their own worst enemies. The members of one subpopulation often have prejudices against members of other subpopulations (e.g., gay men and against transgender people). Within each of these subpopulations there are people who internalize society’s prejudices against that whole subpopulation or against elements of it (masculine gay men against feminine ones) or who have prejudices against anyone living with HIV. Overcoming all such prejudices and uniting people in common cause remains an on-going challenge.

2. Few Dominicans are well aware of their country’s obligations, under a number of international conventions to which it is signatory, to provide everyone with access to essential health services of good quality. That is, they are not well aware of their rights to such services. Raising their awareness remains an on-going challenge.

3. In recent years, international donors have been reducing their contributions to cooperative development programmes and reducing the share of their contributions that go to middle-income countries such as the Dominican Republic. As international financing for the national response to HIV/AIDS diminishes, getting the government to fill the widening gap between the money required and the money available to respond to HIV/AIDS effectively will be an on-going challenge.

**The way ahead**

Health care providers and health care users are natural allies in any struggle to secure the resources necessary to develop and sustain a public health care system that provides
services of high quality to everyone equally. Through this project, REDNAJCER has come to a greater appreciation that this is so. It has forged new alliances with the Ministry of Health and health care facilities and many other partners — from multilateral organizations such as UNAIDS and UNFP to other networks of people living with HIV — and this bodes well for the future. It has also established a mechanism and developed some basic tools for monitoring the health care services provided to people living with HIV. These could prove to be the beginnings of a countrywide system.

There are many tried and proven approaches to improving the quality of health care services and REDNAJCER and its partners, including the Ministry of Health, may wish to explore some of these in the years ahead.\footnote{An overview of such approaches and two examples are provided in GIZ (2012a).}
Annex E2 (CARe/YMCA, Trinidad and Jamaica)
Sex fX (effects): preventing HIV among institutionalized youth

Overview

With a CVC/COIN Community Grant of US$20,000, the Trinidad and Tobago YMCA and Community Action Resource (CARe) did research into “the sexual culture of marginalized youth in institutional care” and then designed and delivered twelve training workshops for young offenders and care-givers in St. Michael’s School for Boys. When the project was launched in May 2012, St. Michael’s housed 58 boys from 10 to 18 years old and had 30 predominantly female Caretakers working in shifts. One set of six workshops focused on HIV and AIDS and the other set of six focused on issues surrounding gender-identity and associated sexual attitudes and behaviour. Each set included separate workshops for the older boys (15 to 18 years old), the younger boys (10 to 14 years old) and the Caretakers. The aim was to develop a model of good or promising practice that could be adapted for use in other institutions for marginalized youth in Trinidad and Tobago and elsewhere.

Grantees: Community Action Resource (CARe) and Trinidad & Tobago YMCA

Community Action Resource (CARe) can trace its roots back to 1983 when the first cases of AIDS were reported in Trinidad and Tobago and a small group of young people living with HIV began meeting to discuss the many challenges they faced in their personal lives and in getting access to information and services. In 1985, social worker Catherine Williams became the group’s most dynamic leader after her husband died of AIDS and she learned that she, too, was HIV positive. The group and some of its allies held the first formal meeting of CARe in April 1989. Today, CARe remains the country’s first and foremost civil society organization representing and serving people living with HIV.

David Dk Soomarie was 20 years old in 1985 when he started his first job and his employer required a medical examination. He learned he was HIV-positive but retained the job, in advertising. After months of anxiety and despair, he realized he felt fine and had no noticeable symptoms of disease. With renewed zest for life, he became active in amateur theatre. Through theatre he became involved with the Trinidad and Tobago YMCA, which had programmes that taught him about HIV/AIDS and how to prevent HIV transmission by practicing safe sex. He also joined CARe and, after he became seriously ill and learned he had a low CD4 count, he became one of the country’s most prominent advocates for better HIV and AIDS prevention, care and treatment.

David has been CARe’s Coordinator of Programmes and Services since 2010. These include weekly empowerment sessions that aim to improve the quality of life for people living with HIV and, also, outreach providing peer support to people newly diagnosed with HIV at the Queens Park Counselling Centre (QPCC) and Clinic and the Medical Research Foundation (MRF). David and other members of CARe have been trained as Community Based Volunteers by the Ministry of Health and the Trinidad and Tobago Red Cross Society. This qualifies them not only for peer support of people living with HIV but also for HIV-related education and advocacy in the wider community and its various sub-populations, not least marginalized youth.

The Young Men’s Christian Association (YMCA) of Trinidad and Tobago (commonly known as “the Y”) was founded in 1964 and is part of the World Alliance of YMCAs. The
Alliance’s motto is “Empowering Young People” so they can be healthy in “body, mind, and spirit”, as symbolized by the three points of the triangle in the YMCA’s logo. Not long after the HIV epidemic emerged in Trinidad and Tobago, the Y began responding through its Youth Outreach Services.

The primary focus of the Y’s HIV/AIDS programmes is on empowering sexually active young people from 14 to 21 years old with the knowledge, skills and condoms they need to prevent HIV and STIs. One of the strategies is to partner with 3Canal (www.3canal.com) and ISLANDPeople (http://islandpeoplemas.com) in promoting healthy attitudes and behaviour (e.g., taking responsibility for your own actions and respecting the rights of others regardless of their gender or sexual orientation) through popular music and dance. Another is to organize and support a Condom Crew as it circulates through streets, parks, bars, and clubs during Carnival.

Gleeson Job is the Y’s HIV/AIDS manager and, in addition to driving HIV prevention among youth, he plays an active role in advocating for and supporting HIV prevention, care and treatment in local, national, regional, and international forums. Like David Dk Soomarie of CARe, Gleeson is a skilled educator, speaker and facilitator and often plays a prominent role on such forums.

The Y takes a special interest in marginalized youth including impoverished, out-of-school, LGBT, and institutionalized youth. Donors supporting this work in recent years have included the government’s Citizen Security Programme (CSP), Canadian International Development Agency (CIDA), Royal Bank of Canada (RBC), JB Fernandes (a USA-based foundation), GDF Suez (a multinational energy company with operations in Trinidad and Tobago), and the United Nations Population Fund (UNFPA).

**Sex fX project context**

Trinidad and Tobago has three main institutions for young offenders referred by the courts. The Youth Training Centre (YTC) comes under the jurisdiction of the Trinidad and Tobago Prison Service. St. Michael’s School for Boys (established in 1889) is jointly financed by the government and the Anglican Church; St. Jude’s School for Girls (established in 1890) is jointly financed by the government and the Catholic Church; both come under the jurisdiction of ministries responsible for education and social services including the recently established Ministry of Gender, Youth and Child Development. In addition to those three institutions, there are a number of smaller ones run by local CSOs. For example, Ailwood Home is run by the CREDO Foundation and houses from four to seven boys.

A 2006 study covered the 300 young offenders then in the three main institutions. It found that the YTC housed 201 males and females from 11 to 23 years old, St. Michael’s housed 50 males from 9 to 18 years old, and St. Jude’s housed 49 females from 10 to 18 years old. It also found that 54 percent of young offenders less than 14 years old and 77 percent of those from 15 to 17 years old had been sent to the institutions after committing two or more offences.

Prior to being institutionalized, 15 percent had been living in both-parent families, 39 percent in mother-only families, 16 percent in father-only families, and the rest with step-parents, other relatives or non-relatives. More than 43 percent had come from families with histories of severe alcohol or drug problems and, associated with those problems, were verbal and physical violence. Prior to being institutionalized, 40 percent had belonged to gangs and the ones who had been in gangs were the ones most likely to have committed crimes of violence. Nearly half of the boys said they felt unsafe in their institutions because they feared other boys’ violence.
As for personal habits, 85 percent had drunk alcohol and 10 percent within the past 30 days; 69 percent had smoked marijuana and 24 percent within the past 30 days; 2.3 percent (7 individuals) had used crack cocaine and 0.3 percent (1 individual) within the past 30 days. Most (88 percent) said alcohol and drugs were easy to acquire and under-estimated the risks of alcohol and drug use.

The Sex fX project focused on St. Michael’s. The 2006 study found that the 50 boys then in St. Michael’s had an average age of 14.6 years and that 66 percent had entered before they turned 14 while the remaining 34 percent had entered before they turned 16. The offences for which the courts had sent them to St. Michael’s were: 28 for being “beyond control”, 11 for robbery, five for possession or sale of drugs, two for breaking and entry, and one each for violence, possessing firearms or other weapons, running away, and breaking a curfew. That is, the majority were there for what might be called “behavioural problems” rather than for serious crimes. (Staff of St. Michael’s clarify that the term “beyond control” found in the 2006 study report covers cases where boys are being abused or neglected and have no relatives willing to take them in.)

In May 2012, when the Sex fX project was launched, there were 58 boys in St. Michael’s. They ranged in age from 10 to 18 years old and had histories roughly similar to those described above. There were two Principals (one for the school and one for the residence), a Manager and 30 predominantly female Caretakers working in shifts and the Y’s staff and volunteers had been working in St. Michael’s for many years. The school’s staff and the Y’s staff and volunteers were aware that, with no girls present, the boys sometimes turned to each other for sexual gratification. They occasionally asked questions about sex but, in general, were not comfortable doing so. In any case, the school’s staff felt themselves insufficiently qualified or comfortable to have frank discussions about anal, oral and vaginal sex, the risks of HIV and STI infection, and how to reduce those risks.

It was also evident to the school’s staff and the Y’s staff and volunteers that the boys were sometimes uncertain about their own sexuality and gender-identities but bought into widespread male prejudices against both females and any males known or suspected to be gay or transgender. Of particular concern, the boys often used degrading and violent language when talking about females, effeminate males or known or suspected LGBT people. In addition, many of the boys had learning disabilities or behavioural problems that made them difficult to teach or counsel.

**Objectives and intended methods**

The Sex fX project extended from May through November 2012 and, at the outset, had the following objectives and intended methods:

1. **Reach a basic understanding of the sexual culture of marginalized youth in one institution (St. Michael’s Boys School)** as follows:
   a. Develop lists of questions to guide focus group discussions and to structure participant responses.
   b. Hold two focus group discussions involving 25 to 30 young residents and note attitudes and behaviour that put them at risk of HIV and STI infection.
   c. Hold one focus group discussion involving 5 to 10 Caretakers and note their observations about attitudes and behaviour that put the young residents at risk.

2. **Provide the marginalized youth and the Caretakers with knowledge about HIV and AIDS and about prevention methods** as follows:
a. Based on the focus group findings, design and deliver four workshops involving 25 to 30 young residents and designed to increase their knowledge of HIV and AIDS and to change attitudes and behaviour that put them at risk of infection.

b. Based on the focus group findings, design and deliver two workshops involving 5 to 10 Caretakers and giving them the knowledge and skills to provide correct information and advice to the young residents.

c. For all workshops, design and apply pre- and post-tests to measure changes in knowledge, attitudes and likely behaviour.

3. **Provide the marginalized youth and the Caretakers with awareness of different gender-identities and sexual activities and the associated risks** as follows:

a. Based on the focus group findings, design and deliver four workshops involving 25 to 30 young residents and highlight, in particular, any sexual activities that could put them at risk of HIV and STI infection and any measures that could reduce the risk.

b. Based on the focus group findings, design and deliver two workshops involving 5 to 10 Caretakers and giving them the knowledge and skills to provide correct information and sensitive advice to the young residents.

c. For all workshops, design and apply pre- and post-tests to measure changes in knowledge, attitudes and likely behaviour.

**Results achieved by the Sex fX project**

In an informal meeting at the YMCA on 20 November 2012, representatives of CARe and the Y discussed the Sex fX project and its achievements and challenges and, also, presented the project’s video documentary (which was still being edited). Among those present were Wayne Jackman and David Dk Soomarie, both from CARe and two of the three facilitators and educators who had primary responsibility for all of the project’s focus group discussions and workshops. (The third was from the Y and unable to attend this meeting.) On 14 December 2012, CARe and the Y submitted their end-of-project report. In summary, the project’s achievements can be summarized as follows.

1. During discussions leading to St. Michael’s/CARe/YMCA agreement on the project’s objectives and methods, some Caretakers expressed apprehension about the project. The two Principals and Manager provided strong support for the project but ensured the Caretaker’s concerns were taken into account during design and delivery of the workshops. The Caretakers’ main concerns were:
   a. The project might go against the school’s duty to safeguard the confidentiality and safety of the boys by, for example, exposing their sexual preferences to other boys or else identifying individual boys in the project’s documentation.
   b. The project might promote attitudes and behaviour that go against traditional Anglican teaching, which favours abstinence except within marriage and does not condone male-male sex.
   c. Most of the boys in St. Michael’s have significant behavioural problems and these would make it very difficult to conduct orderly and effective workshops.

2. During early discussions it was agree to hold two focus group discussions instead of three but to add two key informant interviews. The key informant interviews, focus group discussions, workshop pre-tests, and the actual workshops enriched understanding of the sexual culture of marginalized youth and provided specific
information on their circumstances and their knowledge, attitudes and practices. Among the findings were:

a. St. Michael’s Principals, Manager and Caretakers worry that:
   i. Most of the boys come from families that are in some way broken or dysfunctional and consequences include low self-esteem, lack of social skills, low levels of education, poor prospects for legitimate employment, and propensity to find illegal ways of compensating.
   ii. When they are released from the school, it is highly likely that the boys will go back to the same environments and the same patterns of behaviour that caused them to be sent to the school and could cause them to be imprisoned as adults.
   iii. Confined to an institution for years, the boys have little opportunity to interact with girls and there can be little doubt that this will impact on their attitudes and behaviour after they are released.
   iv. The degrading and violent language the boys use to refer to girls and women does not bode well for how they might treat girls and women in the future.
   v. All of the above suggest the boys are likely to engage in unsafe sex after they leave the school, whether or not they are engaging in unsafe sex with other boys while in the school.

b. The boys reveal that:
   i. They tend to see sex primarily in terms of release and often cite pornography as their main ways of learning about sex.
   ii. They tend to believe they should react violently to any males or females who do not live up to the standard expectations of their gender and who may seem to be LGBT. This leads them to be less than frank in admitting, even to themselves, that anything they do with other boys constitutes real sex.
   iii. While many know enough about HIV to know, for example, that you cannot tell whether or not someone is HIV positive by looking at them, most are misinformed about exactly how HIV is transmitted, how it can be prevented, how it can be treated, and its symptoms and consequences if it goes untreated.
   iv. Those who were gang members before they were institutionalized are the least knowledgeable about HIV and the most likely to believe they are invulnerable to infection.

3. From the outset, CARRe and the Y wanted to cover the younger boys (10 to 14) with workshops. Initially, the school’s staff thought they were too young but they changed their minds when, during their first workshop, the older boys made it clear that it was naïve to assume that the younger boys were not sexually active and equally in need of HIV-related education. It was then agreed there would be separate workshops for the younger boys, with methods and content appropriate for their age group.

4. Adding workshops for the younger boys but adhering to the plan to have a total of eight workshops boys (four focusing on HIV and AIDS, and four on gender-identities and sexual practices) meant that some of the workshops were over-subscribed. The project team did its best to limit the number of boys in each workshop to 15 but even that number was high. The project paid careful attention to monitoring impacts of the workshops with methods including: having a reporter record each workshop;
photographing and video-taping parts of some workshops; administering pre- and post-tests or having evaluation sessions towards the end of each workshop; asking the project team and the school’s staff to report any observations they may have made during or after the workshops; having a final evaluation session after all workshops were done. Among the findings were:

a. St. Michael’s residents were even more rambunctious than a more typical group of pre- and adolescent boys but their interest was held both by the topics under discussion and by the highly inter-active, flexible and sometimes theatrical methods used by the project’s facilitators/educators.

b. The workshops were energetic and fun-filled and enlivened by the educators’ unthreatening and entertaining ways of challenging what the boys had to say about HIV and AIDS, females, people of different gender-identities, sex, and safe or unsafe sexual practices.

c. The school’s staff often heard the boys talking about what they had learned during the weeks after the workshops.

d. By the end of the workshops, most of the younger boys (10 to 14) knew how HIV was contracted, could name three STIs and knew how to put on a condom. The older boys had shown somewhat less interest in the workshops and were now less knowledgeable than the younger boys. This suggests that, perhaps, younger boys are more open to learning from knowledgeable adults and less likely to take the defensive position that they already know everything about sex.

e. By the end of the workshops, both the boys and Caregivers felt they were better able to talk about sex, HIV and AIDS, and issues surrounding gender and different gender identities.

f. The facilitators felt that the boys were generally intelligent and eager to learn but needed male mentors to speak to them about sex and other issues of importance to their personal development.

5. It proved more challenging to involve the Caretakers in their four workshops (two focusing on HIV and AIDS, and two on gender-identities and sexual practices) not because they were not interested but because they worked in shifts and when at work had their regular duties to attend to. The monitoring methods where similar to those described above and among the findings were:

a. Some Caretakers continued to express some of the apprehensions mentioned in item 1 of this list of results but the workshops were very dynamic and informative and even those with apprehensions contributed to the observations about the boys mentioned in item 2.a of this list of results.

b. The Caretakers recognize that, like all pre- and adolescent boys, the ones in St. Michael’s are very curious and experimental when it comes to sex, are often uncertain or confused about their own gender-identities and sexual inclinations, and are often very uncomfortable talking about these matters with adults and so get their information from unreliable sources.

6. On 31 October 2012 (after all the workshops were done and evaluated), the Sex fX team hosted a Stakeholders’ Meeting at the Hyatt Regency Hotel. A spokesperson for St. Michael’s said the project’s positive impacts were such that it should be sustained as a programme providing continual education to the boys at St. Michael’s. (There is continual turn-over in residents and new renovations to the school have given it the capacity to take in up to 70 residents.) The Sex fX team explained that they were editing the project’s many hours of video footage into a short documentary and showed a ten-minute preview. A spokesperson for the
Ministry of Gender, Youth and Child Development Gender commended the project, indicated that the government would be willing to support similar efforts in other institutions for marginalized youth and recommended that the Sex fX team use the documentary to market their approach.

7. On 23 November 2012, the Sex fX team hosted a Graduation and Closing Ceremony at the Courtyard by Marriot Hotel. The team congratulated the boys, gave them tokens and certificates for participating in the project and urged them to take the lessons they had learned seriously. Afterwards, one of the boys gained the attention of the room and expressed his heartfelt appreciation for the project and his sentiments were reinforced by the other boys as they mingled with the Sex fX team and guests.

8. On 10 and 11 December 2012, the Sex fX team held a two-day training workshop for the St. Michael’s Caretakers. This was an add-on to the project not foreseen at the beginning and grew out of enthusiasm for the project by the School’s management team. The workshop went as follows:

a. During the first day, the Caretaker’s reviewed what they had observed or learned about the school’s residents during the project and then considered a set of possible guidelines for developing a programme to education the residents about sexual and reproductive health. Among themselves, the Caretakers decided on four guidelines: 1) focus on respect for the individual and their self-worth and dignity, 2) emphasize the life-enhancing aspects of human sexuality while also highlighting the risks, 3) take a whole life approach that prepares individuals for different stages of their life, 4) encourage careful thought and reflection about gender identities and stereotyping.

b. During the second day, the Caretakers brainstormed about education strategies that might work for the school’s residents. Among their suggestions were: having educational workshops every three months, covering personal hygiene and etiquette at these workshops, inviting people living with HIV and male role models to speak, creating forums for the boys to display their various talents, giving rewards to boys and caretakers who have made outstanding contributions.

c. Finally, the workshop concluded with the Caretakers establishing a committee to ensure follow-through and with the Sex fX team pledging to support this committee.

**Challenges**

The Sex fX team has identified two challenges that might face anyone wishing to launch a similar project or programme:

1. Parents and other guardians and the managers and staff of schools or other institutions for pre- and adolescent male and females often prefer not think that people so young are almost always curious about sex, are often sexually active and are often uncertain or confused about their own gender identities and other sexual matters. These same adults often resist efforts to educate young people about such things and this resistance may prove to be an insurmountable obstacle. During the early stages of planning the Sex fX project, the project team considered three possible institutions before they decided to focus on St. Michael’s because it had people at senior management level ready to give their enthusiastic support to the project. Leadership at that level was critical to the project’s success.
2. The Sex fX team had the three strongly committed, well-trained and highly experienced facilitators/educators who brought invaluable skills to the project, including the skills to animate and engage pre- and adolescent boys in interactive situations where the unexpected invariably happens and on-the-spot innovation is invariably necessary. A project team without such resources might need to find or develop more structured course material and methods.

The way ahead

The Sex fX team did an exemplary job of monitoring their project’s progress and evaluating its results. The team has achieved its aim of developing a model of good or promising practice and, beyond that, it has already launched two processes: one to extend the project into a continuing programme at St. Michael’s School for Boys; the other to sell the model to key stakeholders and get indications that they may support its extension into other settings.

The Sex fX team has already foreseen the need to enhance the project’s transferability to other settings. Possibilities include: developing a workshop guidance manual with modules for each subject area and each category of participant: younger boys, older boys, younger girls, older girls, and institutional staff; developing a standardized training manual for workshop educator/facilitators.

The Sex fX team itself suggests the possibility of expert teams of educators/facilitators who deliver workshops for marginalized youth in a variety of settings, including non-residential institutions and non-institutional venues easily accessible by, for example, out-of-school youth in poor communities. In the case of the Sex fX team, this kind of work would be a logical extension of the work long done the Y’s and CARe’s outreach programmes.
Annex E3 (FURJUG, Dominican Republic)  
Youth for Change

Overview

With a CVC/COIN Community Grant of US$24,729,000, el Fundación Red de Jóvenes Unidos de Guachupita (FURJUG) implemented el Proyecto Jóvenes por el Cambia — or Youth for Change Project. From April through November 2012, the project extended a programme already established in one barrio, Guachupita, to four other barrios: La Ciénega, Los Guandules, Villa María, and Villas Agrícolas. These are among Santo Domingo’s poorest barrios and each of them is home to hundreds of youth made vulnerable by lack of education and job opportunities, broken families, alcohol and drug abuse, and temptations to criminal activity.

Implemented from April through November 2012, the project provided training and support to 90 peer educators including: ten “Promoters” to train and support 80 “Multipliers” (20 in each of the four barrios) to spread messages promoting healthy and positive attitudes and lifestyles that include taking responsibility for oneself, acting responsibility towards others and making positive contributions to one’s family, barrio, city, and country. The project also aimed to unite youth for collective action within their barrios and to establish an inter-barrio network uniting them for collective action citywide and countrywide.

Grantee: Fundación Red de Jóvenes Unidos de Guachupita (FURJUG)

Luis (“Chi Chi”) Alberto Jimenez is the President of the Fundación Red de Jóvenes Unidos de Guachupita (FURJUG), or “United Youth of Guachupita Foundation”. During a long informal discussion on 16 June 2012, he was joined by Lino Arturo Castro and then by Linet Perez, one of FURJUG’s most experienced peer educators. They were all in Boca Chica that day to participate in a joint FURJUG/YurWorld training workshop for peer educators from Villas Agrícolas and Villa María.

Luis says that FURJUG’s story begins with Lino Castro. Lino explains that he spent three years in prison for drug possession and that gave him a lot of time to reflect on how he ended up there and what he could do to help others avoid the same fate. When he left prison, he joined Amigos Siempre Amigos (ASA) and became a peer educator. Then he approached COPRESIDA with his proposal for a pilot programme in three barrios where many of Santo Domingo’s youth gangs are concentrated: Guachupita, Los Guandules and Cristo Rey. COPRESIDA agreed and Lino set to work in 2004.

When Lino came to Guachupita, Luis was 22 and a member of a gang called the “Darks from the Bronx” and they were involved in petty crime. He was also a member of a sports club, an outstanding basketball player and making his living in a professional league. Lino could see that Luis was a natural leader and asked him to join in efforts to pull other young people together into a group they eventually decided to call Jóvenes Unidos de Guachupita.

Back then, all of Guachupita’s youth had poverty in common but often not much else. There were different gangs (or nations, as gangs call themselves) at war with each other but many youth were excluded from gangs because they were gay, lesbian, transgender or just “not cool.” With Lino’s guidance and support, they gradually pulled themselves together and they learned how to put their differences aside and put their collective skills to good use. They used graffiti, reggaetón (combining elements of reggae, bomba and other Latin music, hip-hop and rap) and bachata (a musical tradition that comes from poor rural parts of the
Dominican Republic) to get across messages about positive, healthy lifestyles. Youth who used to say they would die for their gang began saying they would die for their barrio and then “we live for our barrio”.

From 2004 to 2008, the future of Jóvenes Unidos de Guachupita was uncertain. For the first six months, they were supported by COPRESIDA and after that they got support from the Dermatological Institute (IDCP) for awhile. In 2006, Anita Navarro of UNAIDS took an active interest in them and opened a lot of doors. Lino remained interested, too, and helped them reach out to LGBT people, drug users, ex-prisoners, and even prisoners. An ex-prisoner himself, Lino helped them visit the many young people from Guachupita who end up in La Victoria and Najayo prisons.

Despite active interest from Anita Navarro and Lino Castro, their work was often stop-and-go with little activity between small grants. Then in 2008, they approached Santo Rosario and asked if COIN would take Jóvenes Unidos de Guachupita under its umbrella. This got them involved with John Waters and COIN’s YurWorld 2008-2009 rapid-capacity-building process. Since then, YurWorld has been providing their volunteers with training in peer education and Jóvenes Unidos de Guachupita has become legally registered under the name Fundación Red de Jóvenes Unidos de Guachupita (FURJUG).

Luis displays FURJUG’s new registration papers and says they will make FURJUG less dependent on COIN and better able to raise and manage its own money from donors. Luis, himself, got his first training as a peer educator from COPRESIDA in 2005. Since then, he and others in FURJUG have taken many other trainings both in Dominican Republic and abroad (e.g., in Mexico and Puerto Rico) and are now confident in their ability to operate as an independent organization and manage their own money and projects.

Luis says he loves this work so much that he now considers it his vocation. He has left professional basketball in order to devote all of his time to FURJUG. He especially loves working with young people and helping them take responsibility for their own lives and avoid some of the mistakes he and Lino made when they were younger.

**The project’s context**

Luis, Lino and Linet agree that the main problems facing marginalized youth in Santo Domingo’s poorest barrios are, in logical order:

1. **Lack of education, training and job opportunities.** Very few young people are able to find full-time jobs in the formal economy. At best, they find odd jobs in the informal economy that might last for a few hours or days. Gangs give them something to do with their time and opportunities to earn money through activities that are very often illegal. Every day, in Guachupita alone, the police arrest two or three young people and they end up in prison, usually for theft or drug possession.

2. **Alcohol and, increasingly, drug abuse.** The main drugs in most poor barrios are marijuana, cocaine and crack cocaine (known as perico or “stone”). There is some use of injected drugs such as heroin and speedball (a mixture of heroin and cocaine) but those are more common in Capotillo and too expensive for most marginalized youth. Crack is more expensive than marijuana or cocaine but, still, costs as little as 200 pesos (US$5) per dose and is far more potent and addictive. It is made by cooking a mix of cocaine and chemicals, which often make it that much more harmful. Users crush the stone to smoke it and sometimes they mix it with marijuana to produce diablito or “little devil”.

3. **Unwanted teenage pregnancy and contributing factors.** (See box.)
4. **STIs and HIV/AIDS.** While these are major problems, they follow on the heels of the other problems. Part of the larger problem of lack of education, for example, is lack of education in sexual and reproductive health and the low self-esteem and risk-taking behaviour that arise from having poor prospects in life.

At an informal meeting on 26 November 2012, youth involved in the project suggested a fifth item for the list when they often mentioned:

5. **Broken or dysfunctional families.** These let kids down by driving them into the streets and doing nothing to support them once they are there. The problem is made worse by the near absence of public social services that would help troubled families and their children and address issues such as domestic violence and sexual abuse and exploitation.

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**Unwanted teenage pregnancy is a major and growing problem**

Lino Castro and Linet Perez say that unwanted teenage pregnancy is a major and growing problem in Santo Domingo’s poor barrios and outline these dimensions of the problem:

- There is a lot of pressure on girls to start having sex as soon as they reach puberty if not even earlier, one reason being a lot of pressure on boys to do the same. Having sex is one way a boy with poor prospects in life can prove that he is, nevertheless, not only a worthwhile person but “a real man”. Twelve year old boys are having sex and putting pressure on 12 year old girls to be their partners.

- A dangerous new trend is that the word *menores* (minors) has become slang for young girls who are ready to exchange sex for cell phones, brand name shoes and clothing, and other things people in their age cohort value and treat as status symbols. Men now get other men to attend their parties by promising there will be *menores* present.

- Some unmarried teenage girls want to get pregnant. Their education and job prospects are bleak and they see having children as an option that puts pressure on their families, churches, state agencies and others to take care of them. These girls, too, engage in transactional sex but often for essentials such as milk, food and clothing for their children.

- Once girls grow accustomed to transactional sex, it is not a big step for them to become commercial sex workers where they exchange sex for cash and venture out of their barrios to Santo’s Domingo’s “red light” districts and the many establishments that function as brothels.

- While some teenage girls want to get pregnant and have children, most do not. But Dominican society is predominantly Catholic and socially conservative and that means condoms are not readily available (at least, not to under-age girls and boys) in pharmacies and other retail outlets and safe medical abortions are not available in the public health system. As a result, girls often resort to home remedies some of which prove to be extremely harmful and even fatal.

- Sexual coercion and violence are also very common. Contributing factors are heavy use of alcohol and drugs and low self-esteem of boys and men. Out of school, unemployed and with poor prospects they have few ways of proving themselves other than to join gangs, engage in risky behaviour and make sexual conquests.

Lino says that it all comes down to the absence of government policies and programmes based on the realities facing Dominican youth from poor families. Government policy is based on the conservative Catholic values of middle class Dominicans and that means the sex education in schools focuses almost entirely on abstinence before marriage and faith within it. He would like to address this whole situation systematically, starting with a survey of adolescents from age 12 on up to find out what they know and what they experience in their day-to-day lives. Based on the evidence provided by the survey, they could then develop a programme that addresses the whole issue realistically. He suggests a pilot
project that might involve organizations such as UNICEF and that might train people as young as 12 years old to be peer educators.

**Objectives**

Extending from April through November 2012, the Youth for Change Project began with these objectives:

1. **Promote behavioural change to prevent HIV and STIs among marginalized youth**
2. **Foster positive attitudes contributing to self-esteem, healthy choices and peaceful conflict**
3. **Increase by 20 percent the number of youth who take up offers of youth-friendly health services**

**Methods**

The project began with careful identification and recruitment of ten youth, all from the four barrios, who had leadership potential. By June, FURJUG was ready to give these ten three days of training to qualify them as Promoters and get them functioning as a Team Coordinating Committee. Over the following weeks, the Promoters identified and recruited 20 youth within each of the four barrios (for a total of 80 youth) and provided them with training as Multipliers.

The Promoters and Multipliers then facilitated the following activities in each of the four barrios:

1. Graffiti Days where youth were given IEC material and guidance as they used that material to create murals with positive messages
2. Film events in which films with themes and messages relevant to life in the barrios were shown and then discussed
3. Talks about sexual and reproductive health and healthy lifestyles emphasizing positive messages such as:
   a. the importance of treating your body as a temple
   b. the central role of sex in reproduction, evolution, and personal and spiritual growth
   c. the importance of making creative and constructive use of your time
   d. the importance of resolving conflicts in peaceful ways in which everyone wins
4. Visits to nearby health clinics accompanied by COIN’s psychologist, Mary Carbuccia
5. Workshops to help youth develop their own “Life and Personal Growth Projects” based on self-esteem, optimism and personal interests and ambitions together with realistic assessments of the challenges and opportunities ahead
6. Breakfast meetings to assess achievements and plan the way ahead.

The above events were all used as opportunities to distribute IEC material and male condoms. Among the additional activities were:

1. Meetings with managers and staff of barrio-based and other health facilities to agree on consistent and coordinated delivery of youth-friendly services
2. Meetings with other youth organizations and groups, including informal groups in other barrios hoping that the project might be extended to cover them
3. Development of a presentation on “Safe Spaces for Youth with Real Lives” in order to promote the creation of such spaces
4. Supporting, collaborating and participating in a Dominican-Haitian Fellowship Festival called “Trading for Living”; a national break-dance contest called Dominican Battle 2012; a YurWorld gathering on youth volunteerism.

Throughout, the project was careful to document its activities with photographs and mini-reports recording both qualitative and quantitative information.

**Results**

The original application that resulted in the CVC/COIN Community Grant called for the training and support of only ten peer educators, not the ten Promoters and 80 Multipliers who were actually trained and successfully mobilized.

In an informal meeting on 26 November, most of the Project’s Promoters and a few of its Multipliers gathered around a table to share their project experiences. Based on what they had to say and on the extensive documentation the project team have provided, **this project has surpassed its targets beyond all reasonable expectations. This owes largely to the creative leadership shown by FURJUG; the enthusiastic participation of the ten Promoters, 80 Multipliers and large numbers of youth in all of the barrios; the enthusiastic support of COIN and its YurWorld programme.**

As for creative leadership, back on 16 June 2012, when the project was just getting well established, Luis explained that, throughout, they would be encouraging the Promoters, Multipliers and barrio youth to be creative and assertive in deciding to hold events or do individual interventions in streets, bars or other venues, as they saw fit, and in deciding on the content of all such interventions. The whole idea was to empower youth in each barrio, to encourage them to set up their own equivalents of Jóvenes Unidos de Guachupita and then to support and collaborate with them thereafter through a growing network of youth groups.

At the 26 November meeting, **one of the Promoters summarized the reasons for the project’s success by saying that Promoters and Multipliers are from the barrios and are typical of other youth in the barrios in that they mostly come from dysfunctional families.** When they go out into the world they find so many realities that they are just not equipped to deal with in constructive ways. Instead, they seek quick solutions (e.g., getting money fast through theft or drug dealing, responding with verbal or physical violence whenever there is conflict) rather than long-term, one-step-at-a-time solutions that would lead to permanent jobs, their own businesses and better personal relations. Coming from this background themselves, they put a lot of thought into their interventions. They try to understand what issues may be of concern to any particular group of youth and what kinds of activity might interest them most. Then they plan activities that will draw them in. Doing this, they create environments where the youth trust them and where, while having fun, they can also talk about their problems openly and honestly and find solutions.

While all of the project’s interventions have achieved positive results, those that have worked best have often been ones with elements of creative engagement and entertainment.

**Challenges**

The project team identifies these as some the main challenges:

1. The educational system is an abysmal failure when it comes to meeting the needs of children, adolescents and young adults from low-income families. Given low salaries, school staff is often absent and, when present, use out-dated curricula and rote learning methods that fail to engage the interest of their students. Rates of student
absenteeism and drop-out are high. Projects such like this cannot hope to fully compensate for the failures of this system but they can try their best. [Over the past few years there has been public debate surrounding the government’s failure to obey a law requiring that 4 percent of the country’s GDP be spent on public education. In fact, government spending on public education has averaged around 2 percent of GDP. In his inaugural speech on 16 August 2012, President Danilo Medina committed his government to increasing its expenditure on public education until it conforms to the law.]

2. While some health care providers were enthusiastic collaborators with the project, others were less than enthusiastic and there is need for much more work to make sure health care providers are providing youth-friendly services to all youth.

3. The same can be said of the providers of psychological and social support. The Dominican Republic does not have a strong system of social services and this means that when a young person is in serious trouble (e.g., feeling suicidal or having problems with violence or sexual abuse within their family) there is often no obvious service they can be referred to.

**The way ahead**

The project team would like to see the project evolve into a sustained programme serving youth in all of the poorer barrios of Santo Domingo and in similar communities across the country. They believe there is an almost unlimited need for programmes that build self-esteem among these youth and that help them develop healthy attitudes and behaviours that, among other things, protect them against STIs and HIV/AIDS.

### What motivated youth to become Promoters and Multipliers?

At an informal meeting on 26 November 2012, Promoters and Multipliers agreed that they got involved because they did not want to remain trapped in the situations they were in and knew other youth in their barrios felt the same way. Here are some approximate quotes:

*I was a street kid and, through this project, I have freed myself from what I used to be. The project teaches us to channel our skills and interests towards making contributions to our communities. In my case, this means I have become a graffiti artist who puts positive messages on walls.*

*I was in jail for six months and, while there, I realized that there was nothing for me on the streets outside. I decided that I needed to find something for myself in my own barrio and also help my barrio develop a better self-image.*

*Most of us wish we could be productive members of society but, to become that, we need to be listened to and we need to create spaces where the listening can happen.*

*Christmas is approaching and this is a time of year when we are especially bothered by the fact that we have no money to buy gifts, nice clothes or go out and have a drink and good times with our friends. It just breaks you up. You feel a lot of pressure and the strong temptation is to go out and commit crimes to get the money. This project is helping us find better ways to achieve our goals.*

*The message we try to get across is be true to your dreams. All of us here have dreams or we would never have decided to leave the life we were living and participate in this project.*

*I have had no problems being accepted in this group. I can just be myself and it is fine with everyone else.* (Spoken by a transgender person.)

*This project is working 100 percent for us and our barrios. The only problem is people in other barrios are upset because they want the project to be working in their barrios too.*