



MEN WHO HAVE SEX WITH MEN AND HIV IN THE ANGLOPHONE CARIBBEAN: A SITUATION REVIEW

TECHNICAL BRIEF

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SUMMARY

Men who have sex with men (MSM)¹ in the Anglophone countries of the Caribbean² comprise a disproportionate share of the HIV epidemic (Baral et al. 2007; Cáceres et al. 2008a). Although only 4 of the 12 Anglophone Caribbean countries publicly collect HIV prevalence data among MSM, in 3 of these 4 countries (Jamaica, Guyana, and Trinidad and Tobago) researchers report an HIV prevalence of more than 20 percent among MSM (Joint U.N. Programme on HIV/AIDS [UNAIDS] 2008). This data clearly classifies MSM in the Anglophone Caribbean as a most-at-risk population (MARPs) for HIV.

Good clinical and public health practice in HIV epidemics recommends channeling resources toward the prevention of infections and illness among MARPs by promoting health, reducing risk, and increasing access to—and utilization of—services. Despite the known extent of HIV among MSM in the Anglophone Caribbean, however, HIV interventions geared toward MSM remain severely underfunded. Foreign assistance and international donors—particularly the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM)—provide some funding for programs for MARPs, but the programs that exist do not offer comprehensive services, only bits and pieces (e.g., providing condoms and information, education, and communication materials separately).

A notable lack of human rights protection in the Anglophone Caribbean also impedes efforts to improve the health of MSM (Waters forthcoming).

This technical brief provides basic information about HIV programming for MSM in the Anglophone Caribbean and reviews programming opportunities and resources for regional and local organizations involved

¹ MSM include all adult males who engage in male-to-male sex, including those self-identifying as gay, bisexual, or heterosexual.

² The Anglophone Caribbean is defined in this document as the following 12 countries: Antigua and Barbuda, Bahamas, Barbados, Belize, Dominica, Grenada, Guyana, Jamaica, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, and Trinidad and Tobago. The Anglophone Caribbean covers over 30 islands and 2 continental entities (Guyana and Belize), with a total population of approximately 6.5 million and an average annual per capita GDP of U.S.\$12,000. The largest countries in the Anglophone Caribbean are Jamaica (with 2.8 million people) and Trinidad and Tobago (with 1.3 million people). In terms of per capita GDP, the wealthiest countries of the Anglophone Caribbean are Trinidad and Tobago, Bahamas, and Barbados; the poorest are Jamaica, Guyana, and Belize. The overall GDP per capita, however, masks major inequality in income distribution throughout the Caribbean.

in the response to HIV, nongovernmental organizations, U.S. Agency for International Development Mission staff, U.S. Government-funded health program planners and implementers, and other stakeholders including governments and other international donors and agencies.

INTRODUCTION

HIV Epidemiology

According to 2008 U.N. General Assembly Special Session (UNGASS) Country Reports, three of the largest Anglophone Caribbean countries (Jamaica, Trinidad and Tobago, and Guyana) report an HIV prevalence of 20 percent or more among MSM; in other words, at least one in five MSM tested for HIV is found to be infected (UNAIDS 2008). This startlingly high percentage rivals the highest HIV prevalence found in any population around the world. Further calculations of odds ratios indicate that Caribbean MSM are between 6 and 30 times more likely to be infected with HIV than members of the general population (Baral et al. 2007; Waters 2010). The elevated HIV prevalence among MSM (above 5 percent) is especially striking when compared to the consistently low HIV prevalence (below 1 percent) among the general population in most of the region. This discrepancy suggests that HIV epidemics in the Anglophone Caribbean may be concentrated in specific subsets of the population (see Figures 1 and 2).

This hypothesis is reinforced by 25 years of epidemiologic surveys and rapid assessments documenting the multiple and interdependent subepidemics engendered by sex between men, sex work, and drug use. Several researchers propose that the epidemic in the Caribbean may be driven jointly by two practices: multiple concurrent sexual partnerships and sex with both men and women (“bisexual concurrency”). Other factors—such as the already high HIV prevalence among MSM, migration, poverty, sex work, drug use, gender identity, and incarceration—amplify the epidemic (Asociación para la Salud Integral y la Ciudadanía de América Latina y el Caribe 2005; Wagner and Camara 1997; Waters 2010). One HIV expert in the region has recently combined available evidence about male sexual behavior and MSM-related HIV prevalence to calculate that male-to-male sex may account for 89 percent of all annual HIV infections (6,750 of 7,500) among men in Trinidad and Tobago

(Waters 2010). Averaged data from the Caribbean Epidemiology Centre (CAREC) and evidence from many Caribbean countries reinforce this conclusion, suggesting that unreported male-to-male sexual transmission may cause the majority of new HIV cases in the Caribbean at large (de Groulard et al. 2000; see Figure 3).

In all 12 Anglophone Caribbean countries, research points to the following consistent patterns:

- MSM are disproportionately infected with HIV; three major countries report an HIV prevalence of 20 percent or more among MSM.
- MSM may not self-identify, may identify as heterosexual or bisexual, and may have sex with both men and women. Lack of condom use and the high HIV prevalence among MSM probably exacerbate the role of bisexual concurrency as a driver of many HIV epidemics.
- Caribbean culture tends to reject homosexuality via extreme and frequently violent social disapproval. Local communities are generally homophobic, threatening MSM with social and economic marginalization, and sometimes violence or even death. In addition, MSM behavior is illegal in most of the Anglophone Caribbean. Some supportive social environments for MSM do exist on every island, however, especially as facilitated by the internet, and gay social networks exist in the largest cities (e.g., Kingston, Georgetown, and Port of Spain/Chaguanas).
- MSM's vulnerability to HIV is likely due not only to unprotected anal sex but also to other contextual health and rights issues such as poverty, youth, migration, sex work, drug use, gender identity, homelessness, incarceration, and the threat—or reality—of violence or marginalization.
- Most national health systems still have only weak quantified data for potential use in program design or funding allocations. Most countries have no certain calculation of the number of MSM who might be at risk for HIV infection or in need of HIV-related health services. A recent literature review of published and unpublished surveillance and research data on adult male-to-male sexual activity found that almost nothing had been published on MSM in the Anglophone Caribbean;

what little that does exist focuses on male sexual identity rather than male sexual practice (Cáceres et al. 2006).

Access to HIV Prevention, Treatment, and Care and Support

Sustained reductions in HIV transmission and improvements in HIV treatment outcomes require:

- A spectrum of combined HIV prevention, treatment, and care interventions at individual, network, and structural levels, at multiple access points, by multiple providers, designed to be accessible and effective for their social contexts
- Community-centered programming, whereby trusted individuals from the targeted sexual and social networks engage peers in regular, sustained education and support
- Sufficient scale to reach the entire community or network with sustained health awareness and health care access (Coates et al. 2008).

These three aspects of health programming are not yet in place for Caribbean MSM. In the 2008 UN-GASS Country Progress Reports, Anglophone Caribbean countries reported that only 50 percent of MSM indicated that they know how to protect themselves against HIV, although this data is possibly an overcalculation due to selection bias, respondent bias, and interviewer bias. A 2009 review of GFATM grants to the Government of Jamaica, the Organization of Eastern Caribbean States, and the Caribbean Regional Network of People Living with HIV/AIDS suggested that only a minimal portion of HIV funding reaches organizations serving MSM (International HIV/AIDS Alliance 2009). In addition, in its 2009 application to GFATM, the Pan Caribbean Partnership Against HIV and AIDS (PANCAP) noted:

Despite the success of a number of peer-based outreach programs for MSM and for female sex workers in the Caribbean, effective strategies to address key vulnerable populations and to change their behaviors to lower the risk of HIV transmission have not been widely disseminated in the region. In part that is because different countries have very distinct levels of prejudice and tolerance.... In some places, very little has been possible.

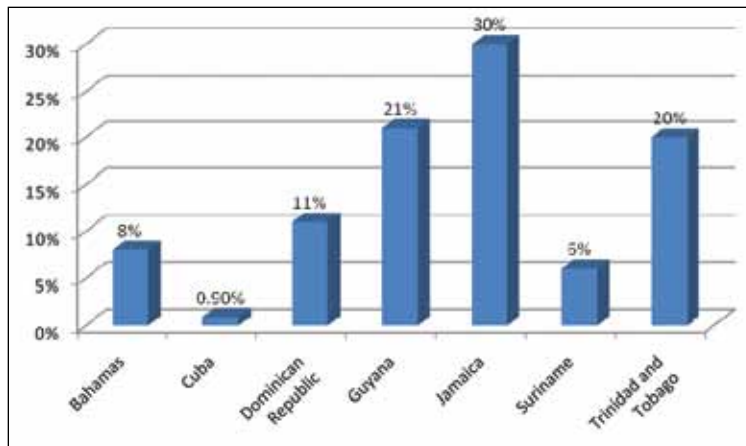


Figure 1. Reported HIV Seroprevalence among MSM, 2008 UN-GASS Country Reports

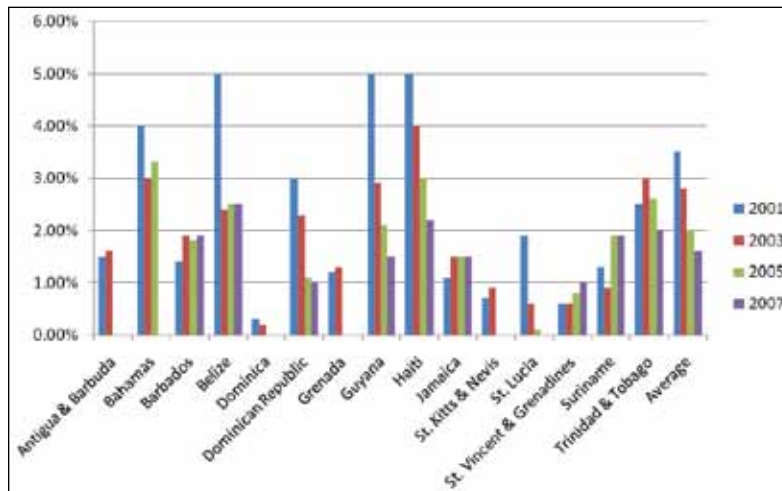


Figure 2. Reported Adult HIV Prevalence, 2008 UNGASS Country Reports

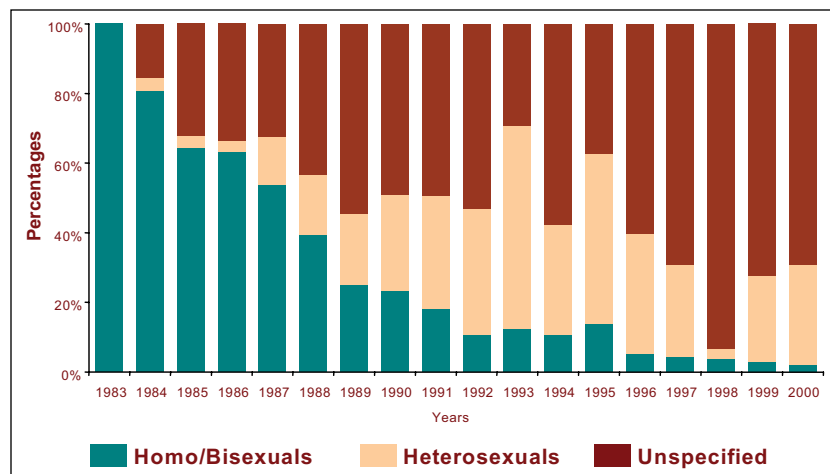


Figure 3. Male Risk for HIV by Category and Year in Trinidad and Tobago, CAREC Data

A 2009 multicountry study on access to health care, conducted in Jamaica, Trinidad and Tobago, Belize, Antigua and Barbuda, and Saint Kitts and Nevis by the Caribbean Vulnerable Communities Coalition (CVC) Healthcare Working Group, explained that gay, bisexual, and other MSM face a variety of obstacles to accessing health care: social discrimination, judgmental or moralistic attitudes, overtly hostile health care providers, concerns about privacy and confidentiality, shame, a lack of health care services specific to their needs, and the inability to pay for alternate private sector health care (Baral et al. 2008). According to the CVC, these assorted barriers to screening and treatment for HIV and sexually transmitted infections (STIs) have major consequences for the health outcomes of MSM and their partners.

Human Rights Environments

The success of HIV programming depends on people's freedom to seek services and support without encountering discrimination, blackmail, violence, and criminalization. HIV programs routinely report that supporting human rights is a necessary precondition for helping people access services and negotiate health care. Several studies have documented the link between human rights environments and HIV prevalence for MSM (Baral et al. 2008; Cáceres et al. 2008b).

Unfortunately, according to 2008 data for regions around the world, the Caribbean comes in second in legal and policy environments that pose barriers to HIV programming (Gruskin and Ferguson 2008). All Anglophone Caribbean governments criminalize sex between men, with the exception of Bahamas, where these "buggery laws" were repealed in 1991 and replaced with sanctions against sex acts committed in public places. Most Caribbean legal systems are characterized in a recent UNAIDS-sponsored report as "repressive" to homosexuality (Cáceres et al. 2008b). Governmental attempts to legislate sexual behavior, sexuality, gender identity, and gender expression are usually ineffective, and are often counterproductive to their professed aims, actually contributing to people's vulnerability to HIV (Gruskin and Ferguson 2009).

A multicountry CAREC study in nine Caribbean countries documented the extreme stigmatization, discrimination, and physical violence faced by MSM a decade

ago (de Groulard et al. 2000). More recent reports from CVC have contributed the following particulars:

- In Jamaica, gay men and lesbians report verbal abuse from work colleagues; vicious beatings by police, relatives, and community members; and homelessness after being driven from their communities by angry neighbors (White and Carr 2005). Hate murder is common, especially in Jamaica but elsewhere as well (Human Rights Watch 2004).
- Also in Jamaica, men and women with same-sex partners report that homophobia and HIV-related stigma discourage them from seeking testing, treatment, and care services, and make individuals who are living with HIV less likely to reveal their seropositive status to their sexual partners (White and Carr 2005).
- In Trinidad and Tobago, business owners are reluctant to carry condoms for fear of being identified and prosecuted as prostitution establishments (Trinidadian and Tobagonian business owners 2008).
- In Belize, observational data collected by a Centers for Disease Control and Prevention research team revealed strong hatred for MSM, whose sexual practices are viewed as unnatural acts that are crimes against religious beliefs. MSM commonly experience threats of violence and verbal harassment while walking the streets of Belize City (Martin 2005).

Caribbean hostility toward MSM—and its consequences for the success of health programming—are summarized in the recent PANCAP regional Round 9 funding proposal to GFATM:

Sexuality and repression are recurrent themes in Caribbean culture. Practices exist that are taboo and thus hidden, none more so than men having sex with men. Traditional small town and island societies, highly religious and prone to gossip, tend to strongly stigmatize those openly involved in male-to-male sex and sex work. As a result, men hide these activities, often migrating temporarily or permanently to gain anonymity. Discrimination can be extreme: violence is all too frequent in some places. Many who need testing

and treatment services avoid them, since confidentiality is poorly guaranteed. Legal and regulatory systems reflect these barriers, as do the attitudes of some health service providers (as when AIDS patients are refused entry to public hospitals). Information on vulnerable populations is difficult to obtain due to their fears about lack of confidentiality. (PANCAP 2009)

CONSIDERATIONS FOR IMPROVED PROGRAMMING

Building Evidence and Subsequent Action

Research and surveillance—biological, behavioral, and social—of the HIV epidemic in the Anglophone Caribbean continues to be severely deficient. Consequently, HIV programs do not have a clear picture of which men are at highest risk for HIV infection or why. Program reporting is also lacking; for example, in the 2008 UNGASS reporting of the 12 Anglophone Caribbean countries, only Guyana and Bahamas reported on three or more of the five indicators for MSM.

This lack of data can be overcome. Surveillance methods and tools appropriate for use in Caribbean countries already exist (Gayet and Fernández-Cerdeño 2009; Heckathorn 1997; Liao, Millett, and Marks 2006; Magnani et al. 2005; Mansergh et al. 2006). The Caribbean has already undergone a massive scaling up of programs to encourage HIV testing for pregnant women (which may have skewed male-female prevalence rates because women—especially pregnant women—are much more likely to be tested than are men). In Trinidad and Tobago, a 10-year effort to promote HIV testing among pregnant women attending public antenatal facilities resulted in 95 percent coverage by 2005. These effective strategies could also be applied to programming for MSM, but most countries still cannot—or will not—report on efforts related to HIV interventions among MSM (Pan American Health Organization [PAHO] and the World Health Organization [WHO] 2006; UNAIDS 2008).

Several international organizations, however, are working to improve MSM-related research and sur-

veillance in the Anglophone Caribbean. GFATM is committed to helping overcome challenges in collecting and communicating data about HIV programming by and for MSM, transgender people, and sex workers, and has articulated a Strategy on Sexual Orientation and Gender Identities to encourage government partners to allocate funding for HIV-related research and data collection. Under this strategy, GFATM recommends financing the coordination of data collection and monitoring and evaluation (M&E) activities across health systems, which could be accomplished by funding the personnel, equipment, and space to manage and improve reach, analysis, and use of data for decision making.

UNAIDS and PAHO support the advancement of research and surveillance in Caribbean countries in a more hands-on manner. They provide guidelines and e-training for international UNGASS reporting about HIV programming and for M&E regarding HIV prevention among MSM. These organizations also offer regional in-person trainings for country HIV program managers focused on regional M&E frameworks and global UNGASS reporting.

Expanding and Targeting HIV Interventions

Scaling up HIV interventions in specific locations and populations could significantly curtail concentrated HIV epidemics. Such interventions may not need to be expansive or expensive, but they do need to be well-targeted to people living with or at high risk for HIV.

The impact of HIV on MSM can be reduced by creating and implementing programs based on proven HIV interventions that have been appropriately targeted and brought to scale. This targeting and scale-up is the clear recommendation of PAHO/WHO and a number of other global health and HIV agencies (see Resources), but it has not yet been put into practice in any Caribbean country. The first priority for health programs should therefore be to implement and expand what is known to work. International best practice recommends that all proven HIV interventions be implemented simultaneously, at multiple levels, from multiple providers, and at sufficient scale (Coates et al. 2008; Merson et al. 2008b; Piot et al. 2008).

PILOTING NEW RESEARCH METHODS TO CHARACTERIZE HIV TRANSMISSION IN THE CARIBBEAN

High-quality data collection and reporting provide essential guidance for the development of appropriate and comprehensive interventions. Accordingly, much more can be done to improve the study of HIV risk and burden among Caribbean MSM.

Caribbean countries have the opportunity to adopt innovative research methods to better understand who is at highest risk for HIV infection or untreated illness due to HIV. Biological approaches—using reagent assays and molecular surveillance—and survey methods—such as venue-time sampling, respondent-driven sampling, and internet sampling—are all discussed in published literature as ways to engage populations that are reluctant to participate in research due to stigma, discrimination, and even the potential for arrest. Such documentation should help countries apply these methods to their own situations.

Some innovative HIV research is already being pioneered in the Caribbean. For example, a new epidemiologic modeling approach called Mode of Transmission (MoT), used successfully in Africa and Asia, has now been piloted in Jamaica and the Dominican Republic with the support of UNAIDS (Colvin, Gorgens-Albino, and Kasedde 2009). Epidemiological models are not a substitute for extensive population-wide surveillance, but results from MoT pilot studies may provide a new way to calculate the expected number of new infections per year on the basis of the currently observed distribution of infections and patterns of risk within subpopulations. If MoT is extended to neighboring countries, it may contribute to further understanding of the transmission dynamics in the region.

TURNING EVIDENCE INTO ACTION

Research and subsequent action need not be an expensive or lengthy process. Even with limited resources, a frontline program can act quickly to provide an at-risk population with a safe space to meet, hold discussion groups on HIV prevention, receive counseling, and obtain shelter (Day 2010).

For example, after a young man working with the Caribbean Harm Reduction Coalition (CHRC) conducted a small behavioral and seroprevalence study of MSM in Saint Lucia, the results motivated the creation of a shelter for young, homeless, and MSM living with HIV. The study identified a number of young MSM (aged 16 to 30 years) in need of support. CHRC now operates the shelter as both an overnight and a long-term shelter in Castries; in addition, CHRC has started a drop-in meals program in Vieux Fort and a new effort to create employment opportunities.

A range of interventions has been proven internationally to reduce the HIV incidence and prevalence among MSM. These interventions include providing access to and promoting condoms and water- or silicone-based lubricants; educating and supporting sexually active men in safer sexual and drug-use practices; and providing welcoming clinical and social services (see Table 1; The Global Forum on MSM & HIV 2010; Global HIV Prevention Working Group n.d.; Vermund, Allen, and Karim 2009; WHO 2009). The most successful programs also feature parallel support for addressing legal and institutional (such as prison) policies; poverty-related issues (such as housing and

nutrition); and the dynamics of gender, gender identity, sexuality, drug use, and race or ethnicity. Several countries and cities have already begun to scale-up HIV interventions at municipal or national levels, and thus may serve as useful examples for Caribbean programs (AIDS Projects Management Group 2009; Castel et al. 2010; South Africa National AIDS Council 2010).

Interventions for the health and rights of MSM should be implemented by both governmental health programs and community-based providers. Because the stigmatization of MSM within their communities often obstructs their access to HIV care, Caribbean health

TABLE 1. COMPONENTS OF EFFECTIVE COMBINATION HIV INTERVENTIONS FOR MSM³

Proven HIV Interventions and Impact	Approaches from the Health Sector to Scale-up and Target HIV Interventions to Address HIV Among MSM in the Caribbean
Distribution of and education about condoms and water- or silicone-based lubricants can significantly reduce rates of HIV transmission (Weller and Davis 2002).	<ol style="list-style-type: none"> 1. Design and implement condom education, promotion, and distribution campaigns aimed at Caribbean MSM (Vittinghoff et al. 1999). 2. Distribute supplies of water- and/or silicone-based lubricant packets alongside condoms throughout the Caribbean (Silverman and Gross 1997).
Early access to HIV and STI testing, treatment, and care can significantly reduce rates of illness and transmission (WHO n.d.; Denison et al. 2008; Holtgrave and McGuire 2007; Marks et al. 2005; Pao, Pillay, and Fisher 2009; Quinn et al. 2000; Vernazza et al. 2008).	<ol style="list-style-type: none"> 3. Expand MSM-focused STI and HIV testing, including health care provider-initiated (or opt-out) testing and counseling in the public and private sector. Train and sensitize providers to avoid stigmatization, discriminatory care, and other human rights abuses (University of California, San Francisco, Center for AIDS Prevention Studies n.d.; WHO 2007). 4. Procure and distribute specific diagnostics for rectal STIs (e.g., self-administered nucleic acid amplification tests swabs and rapid point-of-care syphilis <i>Treponema pallidum</i> testing), which make testing more attractive and accessible for MSM (Lee et al. 2010; Moncada et al. 2009).
Counseling and sustained psychosocial support can significantly build motivations, skills, values, confidence, and trust to increase initiative to access HIV prevention and treatment services (UNAIDS 2003).	<ol style="list-style-type: none"> 5. Support community-based health literacy and mobilization campaigns in communities of MSM to communicate the merits of knowing one's HIV status and early diagnosis and treatment for STIs and HIV as crucial pathways to improved health (Herbst et al. 2005; Johnson et al. 2005). 6. Sensitize and train health care providers to conduct sexual health histories and counseling with the aim of identifying men who may benefit from additional STI screening (Healthy People 2020 2001; Koblin et al. 2004; Makadon et al. 2008; University of Michigan 2005).
Social and structural interventions can significantly improve access to—and the success of—HIV interventions (Gupta et al. 2008; Ehrhardt et al. 2009; Kippax 2008; Peacock et al. 2009).	<ol style="list-style-type: none"> 7. Support community-based organizations to provide MSM with certain social services: mental health services, substance abuse services, drug treatment, legal and human rights support, and case management (WHO 2010). 8. Shape policies and practices in health care settings to increase the accessibility and uptake of services for MSM. Important issues include confidentiality protocol; provider sensitivity; and non-discrimination regarding gender, gender identity, and sexual orientation.⁴ 9. Improve policies and practices in institutions beyond the health care sector (schools, prisons, the police, the media and Internet, and community-based organizations) in the same way (Diouf et al. 2004; Niang et al. 2004). 10. Support national efforts to increase MSM service accessibility and uptake such as social marketing of HIV prevention messages,⁵ the distribution of condoms and lubricant, changes in national health program eligibility guidelines to increase MSM's access, and antihomophobia campaigns (Altman 2005; Latin America and Caribbean Regional Directors Group 2009).

³ This table builds—with permission—from a similar table and data analysis constructed for a forthcoming World Bank report (Beyrer et al. 2010).

⁴ As stated 16 years ago in a University of West Indies report, "Today's medical educators are challenged not only to provide students with the factual scientific and medical information known about AIDS, but also to instill in them the professional and ethical responsibilities of being physicians who must transcend the fears and irrationalities generated by the AIDS pandemic, using their knowledge in the patient's best interests, regardless of their own visceral reactions to the patient" (Wickramasuriya 1994).

⁵ Despite widespread use of the Internet and cell phones throughout the Caribbean, interventions that use these technologies to spread prevention messages to MSM are extremely limited. Elsewhere, cell phones have been used to increase adherence to antiretrovirals, to train community outreach personnel, and in other inventive ways that should be adapted and applied to the Caribbean. There are some web-based efforts that provide information for MSM, but the Internet is used mostly for coordination and sharing ideas. By facilitating dialogue, the Internet has contributed to raising awareness and building social capital.

program planners and implementers should place special emphasis on investing in community-based HIV programs, following the principles and strategies provided in the International Association of AIDS Service Organizations (ICASO) recommendations for Community Systems Strengthening and in recommendations by researchers and community advocates (Carr 2006; ICASO 2009).⁶ In addition, given the close connections between the small island nations of the Caribbean (i.e., migration between islands; economic, political, and institutional interactions; and cultural and religious similarities), regional intervention efforts would also be valuable (PANCAP 2009).

Specific populations and HIV epidemics are not evenly distributed across the Caribbean. In order to effectively target HIV interventions for MSM, program planners and implementers should consider that the pattern of HIV infections among MSM may mirror the distribution and migration patterns of the general population. Several hypotheses may help to target HIV interventions for MSM in the Caribbean, as follows:

- An estimated half of all HIV infections among MSM are concentrated in Jamaica, Trinidad and Tobago, and Guyana.
- A high number of MSM migrate among the Caribbean countries and between the Caribbean and the United States, Canada, and the United Kingdom.
- On islands with smaller populations (i.e., Saint Lucia, Saint Vincent and the Grenadines, Grenada, Dominica, Antigua and Barbuda, and Saint Kitts and Nevis), it would be possible to implement HIV programming for MSM at a scale that could reverse or end epidemics. These islands may have severe percentages of MSM with HIV—for example, a study in Dominica found that 71 percent of all HIV cases were among MSM—but the total number of men to support may only be in the hundreds for each island.

⁶ In many populations, there is strong evidence that investment in community literacy, empowerment, and health care mobilization increases access to—and uptake of—health services and messages. For example, in the United States, research networks such as the Antiretroviral Treatment Access Study have shown that patient empowerment, health literacy, and economic rights have a measurable impact on access to and uptake of HIV services, and also that interventions such as peer navigators and case managers are effective and cost-effective means to help people follow through on health recommendations and intentions.

- The long-term sustainability of the Caribbean's HIV response may be affected by a variety of global changes that are taking place: new global health architectures, attempts to create sustainable funding streams, and the development and implementation of new health technologies (e.g., fixed dose combinations for firstline and second-line antiretroviral therapy, point-of-care STI diagnostics and HIV monitoring tools, and HIV prevention technologies such as pre- and post-exposure prophylaxis). Health program planners and implementers in the Caribbean should take advantage of these changes in order to create sustainable, universal health and rights programming.

Improving Rights Environments

All of the independent Caribbean countries are signatories to basic international agreements that set global standards for human rights, including the 1966 International Covenant on Economic, Social, and Cultural Rights and International Covenant on Civil and Political Rights, the 2001 U.N. General Assembly Declaration of Commitment on HIV/AIDS, and the 2006 Political Declaration on HIV/AIDS. These agreements endorse basic human rights for all people—freedom of expression, freedom of association and assembly, freedom against unlawful violence, and equal access to justice—and call on their signatories to champion these rights wherever they are violated. As U.S. Secretary of State Hillary Clinton stated in a 2009 speech about proposed Ugandan anti-homosexuality legislation, “When injustice anywhere is ignored, justice everywhere is denied.” Many Caribbean countries, however, still foster extensive legal and societal human rights violations.

Basic goals for human rights interventions should include the following:

- Advance positive norms about gender, diversity, pluralism, and human rights.
- Provide basic information about human rights and basic protection against violence, blackmail, arrest and incarceration, and social and economic marginalization.
- Uphold standards of non-discrimination, safety, and confidentiality, and provide training, counseling, representation, support, and social mobilization and empowerment.

Key components of human rights interventions relating to HIV among MSM are described in Table 2. With regard to MSM in the Caribbean, rights-based interventions should follow these guidelines:

- Address the negative effects of masculine gender identities and gender roles. Researchers note that

men's engagement in multiple sexual relationships and unprotected sex is often driven by the desire to prove their manhood. On the other hand, homosexuality is antithetical to the Caribbean notion of masculinity, creating a culture in which MSM are inclined to self-camouflage, having sex with—and

STRENGTHENING COMMUNITY-BASED HEALTH SERVICE REFERRAL SYSTEMS FOR MSM

Community-based health referral networks for MSM are an effective and inexpensive way to improve access to basic medical and social services. Already piloted in Antigua, Trinidad and Tobago, and the Dominican Republic, these national and international referral systems have demonstrated an ability to link MSM to a wide range of resources, including primary health care, addiction services and drug treatment, legal services, and sources of accurate health and rights information.

More can be done to build these referral systems: MSM-friendly health and social services providers should be listed in a directory, client referral and tracking procedures should be standardized, and referral registers should be kept at participating sites. Regular assessments and sensitization and technical trainings for providers should also be funded. These trainings and audits should involve MSM clients who are identified either through community-based organizations or through client advisory groups and employee resource groups.

CLIENT-CENTERED CONTINUUM OF CARE

The ability of any person to negotiate safer sex and safer drug use, and have access to HIV treatment and care is influenced by poverty, class, gender, drug and other substance use and abuse, and other factors such as stigma and discrimination, incarceration, migration, homelessness, age, and exposure to violence. Jamaica's Forum for Lesbians, All-Sexuals and Gays (J-FLAG) works with MSM by focusing services on clients' individual needs. Support for HIV testing, counseling, and assistance with medical bills and medication are combined with other vital services (such as peer-based support and case management, legal services, life skills training, and emergency housing and stipends). J-FLAG supports dozens of people each year who call when expelled from all other sources of support, including their families and local communities (J-FLAG 2010).

DESPITE STIGMA, A FOUNDATION OF CAPACITY

In Guyana, stigma and discrimination against homosexual behavior are rampant, so people tend to conceal such behavior. To provide health services and support to men who may be at high risk for HIV, a 2010 U.N. Development Programme (UNDP) situation assessment recommended that programs work with community gatekeepers while also training health providers and uniformed services to contend with the cultural antipathy toward homosexual behavior. At least six community organizations (FACTS, GRPA, GuyBow, Society Against Sexual Orientation Discrimination [SASOD], U and Me, and United Brick Layers) now provide health care and other services to homosexual, bisexual, and transgender people, despite discriminatory laws and the social and institutional rejection of people based on sexual orientation or gender identity. Stigma and discrimination have been a major barrier to HIV programming for MSM in Guyana, but these organizations have established the foundation for a significant scale-up of health outreach, peer-based counseling, targeted condom promotion, and social services to ensure access to health care (UNDP-Guyana, SASOD, and GuyBow 2010).

marrying—women while also having sex with men. The resulting multiple partnerships and clandestine sexual activity drive HIV epidemics, yet this bisexual concurrency is almost entirely hidden due to societal disapproval of homosexuality (Houston n.d.; Lee et al. 2006).

- Reduce and eliminate constraints on men's health and access to health care. The threat of social exclusion, violence, blackmail, or arrest leads many MSM to avoid health services or to deny their homosexual behavior when they do access health services. Consequently, MSM who may have been exposed to HIV are less likely to obtain testing, counseling, or ongoing treatment. Health care providers should strive to target prevention messages and interventions in order to counteract this tendency.
- Engage expert stakeholders in program design, implementation, and monitoring. Far too few Caribbean MSM are able to provide informed input into national HIV program design or implementation. National health programs therefore lack the information that MSM could offer regarding potential improvements to HIV interventions.
- Strengthen national health programming. Many national health programs are sympathetic to scientific developments and good public health practice, but may face serious setbacks when opportunistic

politics, sensationalist media, or discriminatory attitudes obstruct basic human rights.

Several regional human rights initiatives endorse the principles of human rights as foundations of HIV program effectiveness and are seeking to facilitate local action and resilience. Those initiatives are as follows:

- In April 2009, the Commonwealth Lawyers Association (CLA) called on the Secretary-General of the British Commonwealth to establish a diverse group of consultants about the potential for decriminalizing sexual orientation in Commonwealth countries. The group is to report back to the Secretary-General before the next Commonwealth Law Conference in 2011.
- In June 2009, the Organization of American States (OAS) approved a resolution on human rights, sexual orientation, and gender identity in the Americas at its 39th General Assembly session. This non-binding OAS Resolution 2504 and a preceding Resolution 2435, adopted by all Caribbean countries, called on all nations to condemn acts of violence and other crimes based on sexual orientation and gender identity, to investigate and prosecute such crimes, and to protect human rights defenders.
- In 2009, a Caribbean Regional Task Force on HIV, Homophobia, Stigma and Discrimination, and Human Rights was formed, with key participating

TABLE 2. COMPONENTS OF RIGHTS-BASED INTERVENTIONS TO ADDRESS HIV AMONG CARIBBEAN MSM

Aim	Approaches
Support individual efforts to overcome specific institutional barriers to HIV interventions	<ul style="list-style-type: none"> • Speak out about human rights standards, highlighting the principles of diversity, pluralism, non-discrimination, confidentiality, and equal access to justice. • Support legal aid networks, legal clinics, legal aid service centers, emergency hotlines, and human rights response desks.
Integrate human rights expertise into health programming	<ul style="list-style-type: none"> • Support trainings and coalitions in boosting national and regional expertise related to HIV among MSM by linking experts from all sectors: governmental health, justice, police, and social welfare agencies, as well as individuals and organizations from civil society that have expertise in gender equality, gender identity, and sexual orientation.
Enhance evidence and guidance regarding legislation and law enforcement	<ul style="list-style-type: none"> • Facilitate efforts to analyze existing legal frameworks and human rights environments as they impact access to HIV interventions. • Introduce international standards and models for human rights legislation, specifically legal reforms that could improve access to HIV interventions.

DISCRIMINATORY HEALTH SCREENING AND TREATMENT IN ANTIGUA AND BARBUDA

In recent interviews in Antigua and Barbuda (population 86,000) conducted by CVC, a majority of MSM interviewed said that there are few places to go for HIV-related health care, especially when sexual health or anal STI symptoms are involved. The interviewees identified only one doctor—the clinical care coordinator for HIV in Antigua—as an accessible and “safe” provider, although some men said that his strong association with HIV on the island was a deterrent. Most gay-identified interviewees recalled being treated with scorn—or ignored completely—by health care providers, and that many providers seemed uncomfortable during the medical exam. Some had been told by providers that their health problems were caused by their homosexual behavior.

One gay-identified man reported seeing four separate doctors before finding one who would provide an examination and counseling about anal STI symptoms; the first three refused to conduct rectal exams, instead writing inaccurate diagnoses and prescriptions based on the patient’s reported clinical history alone. Another man described being concerned about the anal sores he had developed. Not knowing where to turn, he simply did nothing. Much to his relief, the symptoms resolved spontaneously after a few days, and he resumed sexual activity. About a month later, he developed a body rash and wart-like patches in the anal area. Again, the shame and fear of being “outed” caused him to do nothing. To his amazement, his symptoms cleared up again, and he has remained symptom-free ever since. Following the interview with CVC, and after some medical counseling, he agreed to a syphilis test and tested positive (CVC Healthcare Working Group [forthcoming]).

ACCURATE, ACCESSIBLE HIV INFORMATION DELIVERED IN 18 COUNTRIES

The website and publication *Free FORUM* is a unique regional communication initiative that delivers HIV information throughout the Caribbean, distributing its print version at no cost to low-income populations and those without access to the Internet. In 2009, three issues of *Free FORUM* featured detailed educational articles about treatment and care, prevention, and advocacy and human rights. Produced by a not-for-profit organization (MSM: No Political Agenda [MSMNPA], based in Trinidad and Tobago), *Free FORUM* is distributed to 18 Caribbean countries (Anguilla, Antigua and Barbuda, Bahamas, Barbados, Belize, British Virgin Islands, Dominica, Dominican Republic, Grenada, Guyana, Jamaica, Puerto Rico, Saint Kitts and Nevis, Saint Lucia, Saint Maarten, Saint Vincent and the Grenadines, Suriname, and Trinidad and Tobago; MSMNPA n.d.).

organizations including PANCAP, CLA, the U.N. Special Envoy on AIDS, UNAIDS, UNDP, and the U.N. Development Fund for Women.

- The Caribbean Broadcast Media Partnership has engaged its media partners in conversations about potential antidiscrimination campaigns, with a 2009 consultation suggesting a media campaign theme of “All of us are different, but all of us have rights” (to be adapted to the vernacular).
- In keeping with the World AIDS Day 2009 theme of “Universal Access & Human Rights,” the CVC presented highlights of human rights work being conducted in Jamaica, the Dominican Republic, Belize, Suriname, Saint Lucia, and Curacao, and

recommitted to focus on human rights as a significant feature of the majority of issues that confront MSM and other vulnerable populations in the Caribbean.

Reinforcing Leadership from Governments

Caribbean heads of government bear the ultimate responsibility for scaling up action against HIV. Program directors should request that governments enlist maximum support from all sectors and ensure strong management within interventions. National governments can implement and expand national HIV programming under the existing Caribbean Regional Strategic Frame-

work and through multicountry and regional coordinating mechanisms such as PANCAP (PANCAP 2002).

Program implementers should work with national governments and regional mechanisms such as PANCAP to support intensified leadership and action in the following ways:

- Consistently champion principles of human rights, specifically the rights and equality of all people regardless of sexual orientation or gender identity. Endorse evidence-based policies and programs that respond to the documented needs of MSM in the Caribbean.
- Advocate for effective, transparent, and accountable management of HIV-related programs and resources, with the involvement of the communities who are the intended beneficiaries.
- Support regional training, capacity building, and fundraising for HIV interventions targeted to MSM.

Reinforcing Leadership from Communities

Throughout the Caribbean, community members are working with both discretion and perseverance to develop and sustain HIV programming for MSM; even in the smallest Caribbean islands, these individuals provide counseling and health services, build peer support networks, and speak out in the media on behalf of the health and rights of MSM. MSM and their allies are needed both as leaders and as technical experts for these community-level interventions. Gay men and their advocates have always been at the forefront of the global response against HIV (Merson et al. 2008a).

During the past two decades, no Caribbean country has been spared from sensationalist media and local politics threatening effective HIV programming for marginalized populations. MSM and their allies have direct experience with these undermining forces; they also have an enduring stake in both sustaining and expanding local services for HIV and addressing human rights issues. Caribbean MSM should therefore be consulted as experts in health and rights programming.

HIV prevention cannot succeed in the Caribbean without an accurate, current understanding of the complex dynamics of HIV exposure in local contexts. Scale-up of HIV testing, treatment, and care cannot succeed without accurate understanding of how these services might be accessed by target populations. For these reasons, MSM need to be involved as experts in the design and implementation of HIV-related health and human rights policies, practices, and interventions. Furthermore, despite the label of a “hard to reach” population, many Caribbean MSM are in fact easy to locate. MSM are clearly able to find each other; all Caribbean countries have networks of MSM with their own local socioeconomic contexts, identities, and patterns of behavior.

Health program planners and implementers should support intensified community leadership and action by and for MSM and their allies, following the recommended strategies of Caribbean MSM themselves (Carr 2008; ICASO 2009):

- Support the regional organization of and training for HIV programs for MSM in order to increase the capacity of—and networks available to—interventions.

FACILITATING NATIONAL ATTENTION TO A CONCENTRATED HIV EPIDEMIC

The community-based United Belize Advocacy Movement (UniBAM) provides gay men in Belize with referrals, policy analysis, research, advocacy, HIV counseling, testing, and treatment. Before 2006, the Belize national HIV effort focused largely on the general population, assuming that HIV was—or threatened to become—generalized. Subsequent data has indicated that HIV is particularly concentrated in certain subsets of the population: sex workers, MSM, and Garifunas.⁷ UniBAM has helped Belize gradually acknowledge and be more responsive to this new evidence. UniBAM is also expanding its capacity for peer-based HIV counseling, testing, and health promotion in several sites, and collaborates with the Belize Ministry of Health to enhance nurses’ understanding about issues affecting MSM. Despite a history of exclusion from national processes, UniBAM now supports national HIV planning and oversight as a member of Belize’s National AIDS Commission Policy and Legislative subcommittee, and Information, Education, and Communication Committee (Orozco 2010).

⁷ Garifunas are a people of mixed Carib and African ancestry living along the Caribbean coast of Honduras, Guatemala, Belize, and Nicaragua.

COMMUNITY LEADERSHIP IN HEALTH TRAINING AND ORGANIZING WITH TRANSGENDER PEOPLE

In September 2009, the first-ever Caribbean training and strategy consultation of transgender people was organized in Curacao. Fifteen transgender people attended from nine Caribbean countries, including Suriname, Guyana, Trinidad and Tobago, Barbados, Saint Martin, Dominica, Curacao, Jamaica, and Belize. Sponsored by CVC and the Caribbean Forum for Liberation and Acceptance of Genders and Sexualities, this gathering was a historic milestone in articulating specific transgender health issues. The meeting also brought about the creation of a ground-breaking regional resource network, resulting in the formation of the Caribbean Trans in Action Alliance and the election of a founding regional governance board (Simpson and McKnight 2010).

- Support opportunities for MSM-led community groups to have input into HIV programs, specifically to monitor how programs address their communities' health and rights needs.
- Support the core costs of community organizations, including personnel costs, space, information and communications technology, and management capacity.

REGIONAL CARIBBEAN RESOURCES AND CONTACTS

Key Regional Organizations

Asociación para la Salud Integral y la Ciudadanía de América Latina y el Caribe (ASICAL)

A regional network of organizations supporting HIV programs among MSM, with participating groups from Mexico, Guatemala, Dominican Republic, Colombia, Ecuador, Peru, Brazil, Argentina, and Chile.

Contact: asical@uio.satnet.net

Congreso de Organizaciones Gay de Centroamérica (CONGA)

A Central American coalition of organizations in seven countries focused on fighting homophobia and promoting lesbian, gay, bisexual, and transgender rights, with HIV prevention work currently underway in Honduras, Nicaragua, and Costa Rica.

Contact: Norman Guttierrez, CEPRESI, cepresi@cable.net.com.ni

Caribbean Forum for the Liberation of Genders and Sexualities (CARIFLAGS)

A non-incorporated affiliative group focused on the health and rights issues of sexual and gender minorities, comprising more than 35 advocates, allies, and organiza-

tions in 16 Caribbean countries.

Contact: Mario Kleinmoedig, Curacao, curamario@yahoo.com

Caribbean Trans in Action (CTA)

A non-incorporated affiliative group of transgender activists in more than 12 Caribbean countries advocating for the human rights and health of transgender persons in the region.

Contact: Mia Quetzal, Belize, lovejunky78@yahoo.com

Caribbean Coalition of Vulnerable Communities (CVC)

A regional network of community groups in more than eight Caribbean countries working with MSM, sex workers, drug users, prisoners, and youth.

Regional hub (Jamaica) contact: Ian McKnight, gimcknight@gmail.com

Regional hub (Dominican Republic) contact: John Waters, drjohnwaters@gmail.com

Pan Caribbean Partnership Against HIV/AIDS (PAN-CAP)

A Caribbean regional collaboration mechanism working to advance HIV/AIDS responses under the CARICOM Caribbean Regional Strategic Framework (CRSF).

Contact: Carl Browne, PANCAP Coordinating Unit Director, carlb@caricom.org

Regional HIV Contacts in Latin America and the Caribbean

UNAIDS

Latin America: Cesar Antonio Nuñez, Regional Director, nunezc@unaids.org

Caribbean: Dr. Ernest Massiah, Regional Director, massiahe@unaids.org; and Michel de Groulard, Regional Programme Adviser, degroulardm@unaids.org

UNDP

Latin America: Maria Tallarico, RST HIV Cluster Leader,
maria.tallarico@undp.org

Caribbean: Salim October, Caribbean Subregional
Focal Point, salim.october@undp.org

PAHO/WHO

Rafael Mazin, Regional Advisor on HIV/AIDS,
mazinraf@paho.org

Key UNAIDS and UNAIDS-sponsored Documents

Cáceres, C., K. Konda, and E. Segura (Cayetano Heredia University School of Public Health, Lima) with R. Lyerla (UNAIDS). 2008. *Epidemiology of Male Same-Sex Behaviour and Associated Sexual Health Indicators in Low and Middle-income Countries: 2003-2007 Estimates*. Available at www.ncbi.nlm.nih.gov/pubmed/18647866

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