PEPFAR CARIBBEAN REGIONAL HIV PREVENTION SUMMIT ON MOST-AT-RISK POPULATIONS AND OTHER VULNERABLE POPULATIONS

NASSAU, BAHAMAS, MARCH 15–17, 2011

AIDSTAR-One
AIDS SUPPORT AND TECHNICAL ASSISTANCE RESOURCES

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ACRONYMS

ART	antiretroviral therapy
CBO	community-based organization
CDC	Centers for Disease Control and Prevention
CHAA	Caribbean HIV/AIDS Alliance
COIN	Centro de Orientación e Investigación Integral (The Center for Counseling and Research)
COPRESIDA	Consejo Presidencial del SIDA (Presidential Council on AIDS)
CRN+	Caribbean Regional Network of People Living with HIV/AIDS
CRSF	Caribbean Regional Strategic Framework on HIV and AIDS
FBO	faith-based organization
FOSREF	Fondation pour la Santé Reprodoctrice et l'Education Familiale (The Reproductive Health and Family Education Foundation)
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HTC	HIV testing and counseling
JFLAG	Jamaica Forum for Lesbians, All-Sexuals and Gays
M&E	monitoring and evaluation
MARP	most-at-risk population
MOH	Ministry of Health
MSM	men who have sex with men
NAP	National AIDS Programme
NASCOP	National AIDS and STI Control Programme
NEPHAK	National Empowerment Network of People Living with HIV/AIDS in Kenya
NGO	nongovernmental organization
OVP	other vulnerable population
PAHO	Pan American Health Organization
PANCAP	Pan Caribbean Partnership against HIV and AIDS
PASMO	Pan American Social Marketing Organization
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PHDP	Positive Health, Dignity and Prevention

PLHIV	people living with HIV
PMTCT	prevention of mother-to-child transmission
POL	popular opinion leader
PSI	Population Services International
PWID	people who inject drugs
PWP	Prevention with Positives
STI	sexually transmitted infection
SW	sex worker
SWOP	Sex Workers' Outreach Program
UNAIDS	Joint U.N. Programme on HIV/AIDS
UNGASS	U.N. General Assembly Special Session
UNICEF	U.N. Children's Fund
USAID	U.S. Agency for International Development
VCT	voluntary counseling and testing
WHO	World Health Organization

BACKGROUND

The Caribbean region has the world's second highest HIV prevalence. While the overall estimated adult prevalence is modest—1.1 percent—this regional average encompasses considerable variations in national infection rates, ranging from nearly 0 to 3 percent (2.5 percent in Belize and 3 percent in the Bahamas) with much higher prevalence among most-at-risk populations (MARPs): men who have sex with men (MSM), sex workers (SWs), and drug users. AIDS continues to be the leading cause of death among Caribbean men and women aged 25 to 44 years.

The Caribbean region has achieved some success in improving access to care and treatment services for persons already living with HIV. However, significant gaps remain in the coverage and quality of HIV prevention, care, and support services. It is estimated that tens of thousands of people are newly infected with HIV each year in the region. National averages for general population prevalence, however, mask startlingly higher prevalence among MSM, SWs, and drug users. The HIV/AIDS epidemic is shifting to younger populations, and certain Caribbean countries have patterns of markedly higher prevalence in either one gender or the other.

The limited data available indicate the need for prevention interventions that target MARPs and people living with HIV (PLHIV). Stigma, discrimination, and criminalization of behavior (e.g., that of MSM, SWs, and drug users) have made it challenging to reach many at-risk individuals with effective interventions. However, expansion of the availability of effective and appropriate services for both MARPs and PLHIV to protect their health and reduce the risk of HIV transmission to sex partners and children is urgently needed.

To address this challenge, the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and the Bahamas Ministry of Health (MOH) sponsored a workshop on HIV prevention in the Caribbean region. The three-day workshop, the Caribbean Regional HIV Prevention Summit, took place in the Bahamas from March 15 to 17, 2011.

The Summit provided a forum for describing the HIV epidemic in the Caribbean, sharing evidence on effective preventive interventions for MARPs and other vulnerable populations (OVPs),[1] encouraging partnerships, and identifying areas needing further attention.

SUMMIT GOALS

Goals of the summit include the following:

- To have international and regional technical experts in HIV prevention programming and research describe the context of HIV infection in the region and share evidence-based interventions and promising practices in HIV prevention programming aimed at reducing HIV acquisition and transmission among MARPs and OVPs in the Caribbean region.

- To identify areas for expansion and integration of evidence-based interventions in extant prevention programs targeting MARPs and OVPs, including PLHIV.

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[1] Generally, MARP programs target SWs, MSM, and drug users. OVPs may include mobile groups (such as migrants), prisoners, members of the military, and youth, though each country may have specific OVP categories.

- To encourage partnerships and determine priority areas where further technical assistance is needed to support the prevention goal of the Caribbean Regional Partnership Framework.[2]

SUMMIT OBJECTIVES

Objectives of the summit include the following:

1. Review current epidemiologic data on HIV in the Caribbean region, which will highlight the key drivers of the epidemic and the behavioral, social, and cultural factors that contribute to the spread of HIV. Identify data that is needed to inform programs and strategies needed to obtain data.

2. Present technical updates on key evidence-based interventions and the minimum package of services targeted toward MARPs and OVPs.

3. Present and discuss examples of best practices of HIV prevention programs for MARPs and OVPs in the Caribbean and elsewhere.

4. Present and discuss structural barriers to effective prevention and treatment interventions that create an enabling environment for MARPs and OVPs to access services in the Caribbean.

5. Identify areas for adaptation or expansion of existing prevention programs to integrate evidence-based strategies and best practices to increase the likelihood of reducing incident infections in MARPs.

OVERVIEW OF THE FORMAT OF THE SUMMIT

The Summit brought together over 90 participants and presenters representing relevant government agencies, national AIDS programs, technical and policy experts, civil society organizations, program implementers for MARP groups and OVPs, regional and international organizations, and local organizations and networks supporting MARPs and PLHIV. Participants represented the 12 Partnership Framework countries in the Caribbean Region, as well as the Dominican Republic, Guyana, Haiti, and Jamaica.

The Summit included three days of plenary presentations and facilitated discussion to identify areas of need and strategies for strengthening HIV prevention programs for MARPs and OVPs.

There were four thematic areas:

1. Know Your Epidemic—Snapshot of the HIV epidemic in the Caribbean

2. Expanding prevention interventions and services for MARPs and OVPs

3. Enabling environments and sustainability issues

4. Monitoring and evaluation (M&E).

Technical and policy experts presented evidence-based interventions to scale-up HIV prevention services and key challenges in reaching MARPs and OVPs, drawing on both international and country-specific examples. On the final day, participants worked in small country teams to identify

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[2] The prevention goal is "to contribute to achievement of the CRSF [Caribbean Regional Strategic Framework on HIV and AIDS] goal of reducing the estimated number of new HIV infections in the Caribbean by 25 percent by 2013." (PEPFAR 2010, 5)

their country's current situation and future needs for technical assistance to strengthen data-gathering, policies, and programs with the goal of improving prevention services, especially for MARPs and OVPs.

Presentations from the summit may be accessed on the PANCAP website: www.pancap.org/index.php?option=com_jdownloads&Itemid=2&view=viewcategory&catid=63.

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WELCOME AND OPENING REMARKS

The Honorable Dr. Hubert A. Minnis, Minister of Health, Bahamas

Nicole Avant, U.S. Ambassador to the Bahamas

The lead facilitator, Dr. Peter Weller, welcomed the participants and briefly reviewed the purpose and expected outcomes of the summit. He outlined the overall summit goals and added related goals—identifying a minimum package of services for vulnerable populations, specifying the data needed to inform such an activity, and outlining ways to create an enabling environment to ensure that services are sustainable.

Dr. Weller emphasized that by the end of the summit, participants should have a clear plan for expanding programs, developing new programs, and moving from talk to action.

Minister Minnis welcomed the delegates to the Bahamas and provided a Bahamian context for the work focusing on prevention among MARPs and OVPs. The overall prevalence of HIV in the Caribbean is among the world's highest, second only to sub-Saharan Africa, and AIDS is the leading cause of death among men and women aged 25 to 49.

The national HIV program of the Bahamas is based on an international model and addresses oversight, planning, training, coordination, and evaluation of the national response to HIV. Antiretrovirals are provided free of charge to all public and private sector patients; the MOH, Ministry of Education, faith-based organizations (FBOs), and private hospitals are active prime providers of services. Minister Minnis commended the Bahamian response, noting that since the first case of HIV was identified in the Bahamas, the death rate has been reduced by 70 percent.

The Bahamas joined the Caribbean Regional Partnership Framework in 2009 to strengthen the HIV response with PEPFAR, and a Bahamas-specific agreement was signed in 2010. While the focus has always been on prevention and comprehensive care of PLHIV, the Bahamas has found it challenging to reach MARPs and OVPs, who they define as youth, MSM, immigrants, SWs, and people over age 50. These groups are considered subpopulations that have reduced access to the health system because of their immigration situation or economic status. The illegal Haitian population is especially affected, even though access to health care is a tenet of the MOH regardless of immigration status. SWs comprise another underserved group, in part because prostitution is illegal; thus work is needed to identify this population and to understand its networks and behaviors. Providers also face significant challenges in serving MARPs. Minister Minnis expressed his hope that these issues will be discussed during the Summit, because the Bahamas clearly needs to expand prevention interventions for MARPs and PLHIV.

Ambassador Avant welcomed participants, noting that this is a critical time in the region, with AIDS-related illnesses now the leading cause of death among young adults. The Ambassador reaffirmed the U.S. commitment to the Bahamas as a partner in the effort to reduce the spread of

HIV and help those who are infected; the PEPFAR-sponsored summit is one example of this support.

PEPFAR represents the largest investment in history made by one nation to a single disease; the Bahamas, for example, will receive more than U.S.$5 million in PEPFAR funding over the next five years. PEPFAR helps countries tackle HIV on many fronts. This includes addressing human rights challenges, reducing stigma and discrimination, and mobilizing community-based organizations (CBOs), FBOs, and others to develop creative and sustainable approaches to prevent HIV and keep communities safe and healthy.

Ambassador Avant invited CBOs, FBOs, nongovernmental organizations (NGOs), government ministries, businesses, clubs, schools, and individuals throughout the Bahamas to submit proposals for one-time grants of up to $10,000 for projects that promote HIV awareness. The main goals of these grants include: educating communities, and especially youth, about HIV prevention; reducing stigma against PLHIV; and encouraging community members to seek HIV counseling, testing, and treatment. Ambassador Avant commended the organizers of the summit and offered support for continued collaboration in prevention of HIV among MARPs and OVPs.

THEMATIC AREA 1: KNOW YOUR EPIDEMIC—SNAPSHOT OF THE HIV EPIDEMIC IN THE CARIBBEAN

The objective of presentations and discussions within this thematic area was to review current epidemiologic data on HIV in the Caribbean region; highlight the epidemic's key drivers and the behavioral, social, and cultural factors that contribute to the spread of HIV; identify data needed to inform programs; and describe strategies for obtaining data.

THE STATUS OF HIV IN THE CARIBBEAN

Dr. Bilali Camara, Senior Regional Advisor on Monitoring and Evaluation, Joint U.N. Programme on HIV/AIDS (UNAIDS), Trinidad and Tobago

Dr. Camara's presentation provided a summary of a comprehensive review of epidemiological data, key drivers, and behaviors that contribute to high rates of HIV infection among MARPs and OVPs in the region.

Regional statistics present a worrying picture:

- There were 260,000 PLHIV in the wider Caribbean in 2009.

- A total of 18,000 new HIV infections occurred in 2009 (50 per day).

- A total of 12,000 AIDS-related deaths occurred in the Caribbean in 2009 (33 per day).

- AIDS remains the leading cause of death among adults.

- There is a significant variation in epidemiological magnitude and intensity between population groups and among countries.

Positive changes have occurred. The number of AIDS-related deaths diminished by 14 percent overall between 2001 and 2009, and four countries (Belize, the Dominican Republic, Jamaica, and Suriname) reported a 25 percent reduction in the number of new infections. Three countries (Cuba, Barbados, and Guyana) achieved universal access to treatment (approximately 90 percent coverage), and the Dominican Republic is also making good progress toward the goal of universal access. Of all the Caribbean countries, Cuba has covered MARPs quite well, keeping prevalence relatively low.

The Caribbean as a whole achieved nearly 70 percent coverage for antiretroviral therapy (ART) under the previous World Health Organization (WHO) classification system, in which PLHIV are

eligible for ART when their CD4 count is less than 200. However, under the 2010 guidance (eligibility with a CD4 count less than 350), the Caribbean is not performing as well.

Coverage for prevention of mother-to-child transmission (PMTCT) is also quite good (almost 60 percent), but this overall statistic fails to provide the whole picture. For example, Guyana has 95 percent coverage, but the regimen for 43 percent of women in PMTCT programs is single-dose nevirapine, and these women need to move to a more effective regimen.

Additional statistics from the Caribbean region include the following:

- Haiti and the Dominican Republic account for 68 percent of PLHIV in the region; if Jamaica is included, this increases to about 75 percent.

- While some countries have seen decreases in the number of PLHIV in 2001 and 2009, others have had an increase.

- Women now outnumber men as PLHIV in the region as a whole (53 percent female, 47 percent male) but this varies by country. In the Bahamas, the Dominican Republic, and Haiti, women are more affected, but this is reversed in Trinidad and Tobago and Suriname.

- There is no one regional pattern of prevalence by sex group; prevalence among young men and women varies by country.

- SWs and MSM are differently, and disproportionately, affected by HIV relative to the general population. In some countries, HIV prevalence is higher among SWs; in others, MSM are more affected.

- The prison population is a transient group, but the majority of them will go back to the general population.

These data have serious implications for funding levels and for allocating resources to ensure maximum impact.

Allocation of resources: UNAIDS has developed tools for prevention activity mapping; it is important to get the information collected from this mapping to decision makers. This tool instructs program managers on the three key steps necessary to bring people to services.

Nearly two-thirds (64 percent) of money spent on HIV in the Caribbean comes from outside sources (e.g., the Global Fund to Fight AIDS, Tuberculosis and Malaria [GFATM]); moreover, many countries in the Caribbean are considered middle income and so are not eligible for some kinds of grants. In addition, management costs (e.g., salaries and per diems) have represented a large proportion of the HIV spending, but this may not be the best way to use the limited financial resources available. For example, very little money is going to research; yet robust programs require strong data both for design and monitoring.

Disturbingly, support for prevention programs has decreased in some countries. For example, in Trinidad and Tobago, the number of HIV prevention activities reported has significantly decreased from 2004 to 2010, and although the National AIDS Coordinating Committee is trying to reach out to MARPs, there is little political support for these efforts. Although 37 percent of Trinidad and Tobago's U.S.$11 million national budget went to prevention, most of this (95 percent) supported prevention activities within the general population, and was not directed at MARPs who are most affected by HIV.

HIV prevention options include the following (as presented at the meeting by Dr. Camara, but are not necessarily PEPFAR guidance):

- Abstinence
- Condoms
- Female condoms
- Be faithful
- Voluntary counseling and testing (VCT)
- Behavior change communication.

While there are numerous approaches to prevention that address underlying and biological determinants of HIV transmission, there is no "magic bullet." The focus must be on a "combination prevention" approach that addresses all major determinants of transmission. Dr. Camara outlined a "prevention revolution" that uses six key features to implement a combination prevention approach:

1. A combination of biomedical, behavioral, and structural elements, to reduce both immediate risks and underlying vulnerabilities
2. A meaningful community engagement that promotes human rights and addresses gender issues
3. A consistent synergistic approach that operates over time and on multiple levels to include individuals, families, and society
4. Investment in decentralized and community responses, with enhanced coordination and management
5. A strategy of flexible and continuous learning to adapt to changing epidemic patterns and quickly deploy new tools and innovations
6. A tailored approach that fits interventions to national and local needs and contexts.

Specific country experiences: Program managers must take into account the unique, individual needs that must inform country-level analyses. One example of this is the catastrophic impact of the 2010 earthquake in Haiti. Antenatal care surveillance sites in Haiti report a 30 to 50 percent increase in the number of women testing positive for HIV since the earthquake. Women also face increased exposure to rape and gender-based violence in refugee camps, putting them at further risk of HIV infection.

Analyses must include examination of gender, sexuality, and sexual orientation, including the legal ramifications of the behavior of specific MARP groups—such as being caught engaging in same-sex behavior where "state-sponsored" homophobia is the norm. Gender issues include not just women, nor simply men and women, but also must include transgender people, transsexual people, and others who play a role in the epidemic (that is, HIV rates in these groups are at least twice as high as in the general population). Stigma against transgender people and transsexual people is still extremely high and so they often do not receive services. Quality of care indicators point out how stigma and discrimination affect how early and how easily people seek ART. MARPs will only seek services if they feel the providers can be trusted.

Also, throughout the Caribbean, health and family life education for young people needs to be modernized and strengthened; this education should be mandatory within school systems.

Data collection: Program managers and decision makers need to find ways to gather reliable data to inform programs and support an enabling environment for behavior change. Data needs include information on the following:

- What prevention activities are effective

- The limits of prevention information (for example, the fact that testing negative for HIV is seen as a license to not change one's behaviors)

- The size of target populations

- Behavioral interactions between vulnerable groups and the general population (for example, in the Dominican Republic, 76 percent of MSM also have sex with women, and in Trinidad, many MSM are married to women)

- Data to support reform legislation: for example, data showing that the removal of sodomy laws will affect HIV prevalence or incidence.

Last words: Dr. Camara acknowledged the difficulty of changing deeply embedded cultural beliefs and attitudes, but stressed the need to try to change them. He repeated his endorsement for combination prevention—not a simple solution, but a necessary one, because HIV is not disappearing. The disease is more than replacing itself: for every 1,000 AIDS-related deaths in the Caribbean, another 1,500 new infections occur.

WHO ARE THE MOST-AT-RISK POPULATIONS AND OTHER VULNERABLE POPULATIONS?

Clancy Broxton, Most at Risk Populations Advisor, U.S. Agency for International Development (USAID)/Washington

This presentation defined MARPs and OVPs and described the variations within these categories, including their ethnographic profiles, HIV risk and burden, and human rights issues. The presentation also described the need for appropriate prevention responses, outlined implications for programming, and explained why distinctions among MARP and OVP categories are important.

Who are the MARPs and OVPs? UNAIDS defines MARPs as including MSM, SWs, drug users (the 2007 UNAIDS definition includes non-injecting drug users), and clients of SWs. In the Caribbean, as in other regions of the world, MARPs have higher levels of HIV in both concentrated and generalized epidemics. For several reasons, it may be programmatically useful to keep the strict definition of MARPs to the four groups when developing prevention programs.

MARPs tend to be more at risk, relative to the general public, because of the types of risk behaviors they engage in and where these behaviors take place. They may also engage in multiple high-risk behaviors. MARPs experience greater levels of stigma and discrimination, which sets them apart from OVPs. The illegality of their behavior may also drive MARPs underground and prevent them from seeking services.

Addressing prevention for MARPs is complex because they can move between risk behaviors and are part of the general population. Thus, programmers need to think about subpopulations within each overall category and design targeted services for them.

SWs: Sex work in the Caribbean is varied—it includes street- and brothel-based, nightclubs, and tourist-based or tourist-driven sex work. It is critical to distinguish between formal and informal sex work, because this will inform the "who, what, where, and how" of reaching these target populations. Program managers must understand the patterns of different kinds of sex work and the resultant risk. Also, factors such as economic need, gender (for all identities), and addiction mean that there are push-and-pull issues to be addressed.

Data on this group are limited in the Caribbean countries. For example, only five countries reported on the indicator of HIV prevalence among SWs in the 2008 U.N. General Assembly Special Session (UNGASS), and some of the data were old.

Prevention programs must recognize ways to reduce HIV risk among SWs; not all SWs do in fact face a high HIV risk. Programs working with SWs must also address human rights, because these individuals are affected both by the criminalization of sex work and the social stigma against sex work. This is especially the case for male and transgender SWs.

MSM: "MSM" is perhaps an overly reductionist term. It may be more useful to delineate among "gay- or bisexual-identified," "non gay-identified MSM," and "transgender," which differentiates between different groups, their vulnerabilities, and how to reach them. Only five countries reported on HIV prevalence among MSM in the 2008 UNGASS, so once again there is a dearth of data.

Due to biological and structural factors, MSM are at particularly high risk for HIV. HIV prevalence is higher among MSM than among the general population, and MSM tend to have higher rates of HIV than female SWs. The effect of criminalization of MSM behavior on vulnerability to HIV, and the effect of legal and social sanctions on treatment-seeking behavior, are particularly relevant in the Caribbean region.

Drug Users: Sexual behavior can be associated with or exacerbated by drug use. Where there are few data on SW and MSM, there is even less information on drug users in the Caribbean, and available information is old. Non-injecting drug use can lead to injecting drug use, but this depends on the local drug market and social context. Nevertheless, once HIV enters a population of people who inject drugs (PWID), it can spread very rapidly, so it is important to monitor populations of PWID.

Programs to address HIV among PWID must take the social context into account. For example, alcohol-associated risk behaviors (among OVPs) are not stigmatized the way MARP behaviors are.

OVPs: OVPs lie somewhere on the continuum between the general population and MARPs. Their behaviors are not as stigmatized as those of MARPs, so the approaches for reaching them are different. For example, OVPs may be more likely to use services accessed by the general population. MARP and OVP categories were created to help think about programs and to facilitate targeted interventions, but were not intended to limit the integration of interventions.

Last words: MARPs are more highly stigmatized than OVPs and therefore need more targeted services. Services for MARPs must be accessible, affordable, and acceptable to the target communities.

STRATEGIC RESPONSE TO MOST-AT-RISK POPULATIONS AND OTHER VULNERABLE POPULATIONS

Karina Rapposelli, Behavioral Scientist, Center for Global Health/Division of Global HIV/AIDS, Centers for Disease Control and Prevention (CDC)/Atlanta

Karina Rapposelli's presentation reviewed existing and upcoming PEPFAR guidance for implementing MARPs programming and examined the core components of a strategic response for MARPs (measurement approaches, enabling environment, capacity building, minimum package of services, scale-up, and M&E).

The future directions for the development of the core components of a strategic response to MARPs are summarized as follows:

- *Measurement approaches:* implement strategic data collection and use data more effectively to identify populations at risk and target interventions appropriately.

- *Enabling environment:* address stigma and discrimination; advocate for a legal and human rights framework developed in consensus among international partners; and mobilize the host government and civil society to define and implement prevention programs for MARPs.

- *Capacity building:* leverage existing organizations working with MARPs while training other organizations that may be able to reach these groups. Training should focus on developing skills within countries to implement, evaluate, and improve prevention programs.

- *Scaling up:* increase the availability of resources to support the systematic scale-up of effective, high-quality programs so as to achieve the coverage, intensity, and scale needed to reach MARPs.

- *M&E:* streamline MARPs indicators with PEPFAR, international agencies, and between partners.

Headquarters support for field teams: PEPFAR supports service provision, surveillance, and policy work to address HIV transmission related to high-risk behaviors. PEPFAR funds can be used in a variety of ways:

- Implementing programs including needle and syringe programs, medication-assisted therapy, ART, HIV testing and counseling (HTC), and prevention and treatment of sexually transmitted infections (STIs)

- Providing services including condom distribution; vaccination and diagnosis of viral hepatitis; prevention, diagnosis, and treatment of tuberculosis

- Conducting assessments and training

- Procuring commodities

- Conducting outreach through information, education, and communication campaigns.

PEPFAR recommends that countries implement a strategic response based on data and resources. A combination of programming is needed; MARP programming does not necessarily follow a linear

evolution, and not all programs must be in place at the same time. Governments should look to other country experiences for best practices and resolutions to barriers.

Critical issues to be addressed include accessibility, acceptability, coverage, intensity, linkages, and quality. MARPs already feel marginalized, so programs must be careful when collecting information to not overburden them with questions or make them feel pressured. Asking too many questions may make members of vulnerable communities feel uncomfortable coming in for services, and they may spread messages to their social network that others should avoid prying service providers as well. Providers must be able to address individuals respectfully, without judging their behavior, while giving appropriate messages. Interventions must be appropriate for the population: for example, there is no evidence yet for circumcision as protective among MSM.

Last words:

- *Move to scale-up:* programs need to think about how to be innovative and move pilot projects to scale, leveraging funds as necessary to scale-up those programs that are effective and of high quality.

- *Monitoring progress:* M&E can help to identify the right interventions for MARPs, their most critical needs, and the effects of interventions.

- *Facilitate access:* select services based on developing an enabling environment that meets the needs of the target population.

QUESTION AND ANSWER: SUMMARY OF DISCUSSION POINTS

Using new data: The summit is timely, because new research and data have come out over the past year in particular, and evidence presented during the summit can inform future plans for the region. Identifying and targeting MARPs using evidence-based interventions has proved successful elsewhere, and these approaches are worthy of support in the region.

Defining MARPs and OVPs: Reductionist characterizations run the risk of hiding the scope of the problem and limiting opportunities for intervention. It is necessary to accurately describe the target communities. Redefining MARPs and OVPs may be necessary, given the cultural context—for example, the stigmatization of the mentally ill could mean that they should be considered MARPs.

Data-gathering: Strategic planning should be evidence-based, but evidence on MARPs is often scarce, which makes it difficult to determine what drives epidemics in the Caribbean region. Also, data can be deceiving. While statistical percentages may look small for specific groups, the impact of high HIV prevalence within these groups may be greater in small countries or communities. Program managers and decision makers need to keep this in mind when allocating resources. Also, data collection should not only inform evidence-based programming, but also should allow comparison among countries. Time-trend analysis must be put in a national context.

Combination prevention strategies: Combination and multimodal prevention interventions are the wave of the future. The "Prevention with Positives" (PWP) approach is an important component of any multimodal response but is somewhat neglected in the region.

Strategies for prevention: Of the Caribbean countries, Guyana is the only one that has developed standards for HIV prevention, which should be shared throughout the region. However, having a standard for prevention does not guarantee adequate and appropriate programming. Looking at

intervention processes as "strategies to accomplish prevention" rather than "prevention strategies" may facilitate analysis of integrated strategies and may also affect other outcomes. Capacity building must target everyone from clinicians to community volunteers who need to be trained to be able to talk to MARPs and address their health issues and needs—everyone needs a training or sensitization process.

Locations for providing services to MARPs: Clinical services are not always the best place to provide services for MARPs because of stigma and discrimination; sometimes, the community is best suited to provide these services. Clinic services such as testing may be limited due to the lack of cheap easy screening tools, such as tests for STIs, in general populations, so it might be better to target MARPs. However, the lack of syndromic management guides for some MARPs (MSM) is another limitation.

RESPONDING TO THE NEEDS OF OVPS

Jaevian Nelson, Jamaica Forum for Lesbians, All-Sexuals and Gays(JFLAG)/Director of Advocacy, Policy, and International Affairs, Jamaica Youth Advocacy Network

The presentation focused on OVPs, especially youth, and the variations within the different categories of OVPs, and gave examples of appropriate prevention responses.

In the Caribbean, there is limited information on the knowledge, behaviors, motivations, and attitudes of OVPs; also, there is limited funding available to develop prevention programs for this group. Too often, OVPs get lost within traditional groups of MARPs. As a result, prevention programs do not consider cross-cutting issues, such as peer pressure, that drive the epidemic. Addressing the underexamined overlap between OVPs and MARPs (for example, MSM youth, some of whom engage in sex work) requires unique interventions. Gender dynamics also may make it more difficult to work with women and girls, who are not readily found at the more accessible spots that OVPs frequent. Finally, program managers need to be aware of social obstacles—for example, the influence of conservative religious groups, which is one of the factors keeping youth from receiving accurate information on HIV prevention.

HIV prevention efforts in the majority of organized community establishments seldom address sexual orientation. Too often, those interventions that do take place are not innovative, or are unattractively packaged, and thus ineffective.

Focusing on youth: A particular challenge is the difficulty of monitoring at-risk youth, who can be very mobile (and invisible), especially in instances where crime and violence escalate. More consideration should be given to where we go to look for vulnerable populations, especially women and children. National AIDS programs and larger NGOs should work more with CBOs, helping them to understand the role they can play in reducing OVPs' vulnerability to HIV. Also, outreach campaigns should make more use of social media to reach youth.

Youth should be more actively involved in lobbying for policies and participating in decision making on issues that affect them. This is vital to ensure that programs for young people represent their true needs and priorities. For example, youth organizations in Jamaica have participated in high-level meetings with PEPFAR and GFATM. Lobbying efforts in the U.S. Congress and the U.S. Office of the Global AIDS Coordinator must continue to promote reproductive health funding for youth and policy change regarding HIV prevention in the Caribbean.

Focusing on rights and evidence: Human rights should become integrated into education systems, led by local governments. There are many complaints from OVPs and MARPs that programs are operating and providing services because funds are available, when they should be doing so because human rights and evidence support the need for these services. To ensure that programs assume a rights-based approach, systems should be in place to hold providers accountable to program objectives and goals.

Recommendations include the following:

- Involve OVPs in policy and program design, implementation, and M&E

- Provide human rights education in the response to HIV

- Make more (and effective) use of music and media

- Use cross-cutting data to drive development of multifaceted programs

- Conduct more research on OVPs

- Invest in training for program designers and implementers.

The Bashy Bus program—an innovative youth intervention: The Bashy Bus program is a collaboration between the U.N. Children's Fund (UNICEF), the Jamaican MOH, GFATM, and Johnson & Johnson. The program seeks to change the way adolescents act by changing the way they think—for example, changing norms that encourage early sexual debut or multiple partners for men. The Jamaican NGO Children First runs the Bashy Bus program, where buses travel throughout Jamaica giving information to young people (high school dropouts, teenaged mothers, and others who are not in other community institutions or schools) in communities with low literacy and high rates of crime and STI and HIV incidence.

The Bashy Bus program started in 2005 because young people were having sex while on public transportation. Focus groups obtained information about issues that limited use of reproductive health and HIV services (providers talk too much, no privacy or confidentiality) and to assess whether providing services to youth outside clinics would be a better option. The Bashy Bus uses edutainment[3] and social media to reach and teach youth, and also features peer educators—high-risk youth who are empowered by the program to bring prevention messages to communities. The program is constantly evolving to address emerging issues and needs. Currently, three Bashy Buses are operating in Jamaica.

A recent evaluation found the following changes between 2006 and 2008:

- The proportion of adolescents who could correct "myths" about HIV increased (33 percent to 44 percent).

- The proportion of young people who correctly identified safer sex practices increased (32 percent to 49 percent).

- The proportion of adolescent girls who reported contraceptive use increased (52 percent to 76 percent).

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[3] "Edutainment" (educational entertainment) is media content that is intended to both educate and entertain (CDC 2009).[4] The window period is the time period between HIV exposure and when the body has produced enough HIV antibodies to be detected by an HIV antibody test, on average 25 days, and usually between two and eight weeks (CDC 2010).

- The proportion young men who reported giving gifts for sex diminished (56 percent to 38 percent).

QUESTION AND ANSWER: SUMMARY OF DISCUSSION POINTS

Focusing on OVP issues: Programs need to keep in mind what leads young people to have sex, including gender and power dynamics between young people and older partners. They also need to find ways to fund and sustain collaborations for innovative and creative prevention activities.

Prevention beyond HIV: People with STIs could be considered OVPs. Although STI clinics have low staff-to-patient ratios, having providers spend more time with clients could help avert future infections.

Take-away points OVP programs should focus on:

- *Targeted interventions, attractively packaged and innovative*—thinking outside the box

- *Evidence-based interventions*—to be sure programs are working

- *Involving OVPs in program design*—they will know what works for them

- *Confidentiality*—clients who are having sex, and especially nontraditional sex, need confidentiality in services

- *Self-help*—build the capacity of OVPs to advocate for appropriate interventions targeted to their own needs.

HOW DO WE KNOW WE GOT THERE, IF WE DON'T KNOW WHERE WE ARE GOING? KNOW YOUR RESPONSE

Irum Zaidi, Epidemiologist, Center for Global Health/Division of Global HIV/AIDS, CDC/Atlanta

This presentation described how data informs programming for MARPs, how to identify necessary data and information gaps, and methods for obtaining data. Among the topics covered were the different tools available to identify what information is needed to describe the problem. Key elements for conducting needs assessments include specifying the following:

- The target population

- Behavioral risks within the population: this could entail qualitative research such as interviews with key informants who identify a group's needs, barriers to services, priorities, and current arrangements for obtaining services; and quantitative data, to understand the magnitude of the problem, could be obtained through standardized behavioral surveys

- Factors contributing to risks (structural, community, and individual)

- Population size estimates: this could entail a census, multiplier methods, mapping, or, in smaller geographic settings, program data or service records

- HIV prevalence.

Conducting preliminary research: One does not necessarily need high-powered quantitative research to identify the appropriate intervention(s). It is possible, and sometimes better, to start with qualitative work. Such studies can pinpoint the most important issues to address, appropriate service delivery points, and ways to respond to feedback on the intervention, for example. Themes identified in qualitative studies can then be examined through quantitative studies, such as behavioral surveys, which may include HIV/STI testing. Researchers should also review data from other studies on the same themes and populations.

Program managers should consider these principles when choosing what data to obtain:

- *Assess population size:* population size is important to prioritize the right target groups.

- *Follow the data:* choose the intervention based on data from preliminary research—needs assessment; structural, community, and individual factors; and service mapping.

- *Keep it simple:* using data to inform programs need not involve complex statistics— epidemiologists should help make data more accessible to program staff and policymakers.

- *Do not stop collecting data:* it is vital to keep monitoring the program to ensure that the interventions are reaching the right people with the appropriate services.

KNOW YOUR RESPONSE—COUNTRY EXAMPLES

Complementing the previous session, presenters from Jamaica and Kenya showed how they used data to plan their programs and how the data affected the program implementation.

USING EVIDENCE IN PROGRAM PLANNING FOR MARPS: JAMAICA'S EXPERIENCE WITH MSM EMPOWERMENT WORKSHOPS

Lovette Byfield, Director—HIV Prevention, National HIV/STI Program, MOH, Jamaica

Lovette Byfield reviewed a study with MSM in Jamaica to illustrate an intervention to improve health-seeking behaviors in a highly discriminatory environment. Overall HIV prevalence is 1.7 percent in Jamaica, but it is much higher among MARPs; especially among MSM, where the prevalence is nearly one-third (32 percent, according to 2007 data; Figueroa et al. 2008).

This intervention sought to improve the health-seeking behaviors and reduce risky sex among MSM. MSM were recruited by existing peer educators to attend a series of empowerment workshops to: provide access to HTC and treatment and care for STIs and HIV; build safer sex skills (including use of condoms and lubricants and reducing the number of sex partners); and furnish grants for education or income-generating projects. Each series consisted of 15 workshops, each with 15 participants, conducted over three months with peer educators and a behavior change team working together and teaching a standardized curriculum. HIV services and one-to-one conversations about HIV or other participant concerns were available at each session. A social inclusion component entailed providing referrals or inviting agencies in charge of tax registration, national insurance, and other social services to workshops to facilitate registration by project participants.

Both workshop participants and peer educators were asked to recruit new participants, using their sexual networks, for the next workshop series. This turned out to be an important strategy.

Between 2009 and 2010, 18 workshop series took place, and 270 MSM attended the full series of workshops. A total of 230 MSM received HTC, and those who tested positive were linked to treatment sites. Two MSM support groups were formed for MSM living with HIV. Five men received educational grants. Follow-up *lymes* (visits) take place every quarter.

Successful aspects of the intervention include use of a standardized curriculum, links to services and grants, and repeated interactions, including one-on-one conversations, that built trust over the course of the series of workshops. The activities to promote social inclusion had important results: some MSM obtained remedial education, a tax registration number, or national insurance as a result. Challenges included the continuing inconsistency of properly using condoms and lubricants, as well as poor treatment by providers and the difficulty of providing services to adolescent MSM.

Lessons learned include the following:

- It is important to collect both behavioral and prevalence data to inform a combination prevention response. Qualitative methods can reveal critical information in ways that quantitative research cannot.

- Issues of trust, both within and outside the community, affect the ability to reach new participants as they are referred by current or past participants.

- Conducting the interviews can happen anywhere the participant feels comfortable, so long as there is a level of confidentiality.

- Researchers must be willing to use qualitative methods and to spend time talking to the participants. The survey can only give so much data; in-depth interviews and focus group discussions will provide richer information.

- Formative work indicated the need to include questions about things like condom and lubricant use.

- Only about 25 percent of the respondents said they always used condoms; everyone else was using condoms inconsistently if at all.

- Nearly half of men had not been tested before for HIV, but of the ones who had been tested, nearly all had received their results.

- There were similar rates of unemployment among MSM who tested positive for HIV and those who tested negative, but men who tested positive were more likely to have been homeless or in jail.

- Workshop participants were referred to MSM-friendly doctors and are now being referred to other clinics where other providers have been sensitized.

- The social inclusion component was very important; MSM with low levels of education or literacy experienced high levels of discrimination when they tried to link with social agencies. MSM are a very marginalized population overall in Jamaica and many do not have social security certificates or access to state-provided services.

Findings from the workshop showed a need for a separate campaign on lubricant use—possibly starting with the general population and then moving on to the MSM communities. There needs to be more work on targeting MSM who do not live in major urban areas. Also, there is a need to focus on young MSM, who often end up homeless, as well as the parents of MSM. Parents who cannot

accept their son's sexual identity or behavior may increase their vulnerability to HIV by kicking them out of the home.

Last words: Using sexual networks has successfully opened up programming to new participants.

KENYA: SEX WORKERS

Helgar Musyoki, Program Manager, National AIDS and STI Control Programme (NASCOP), Kenya

Helgar Musyoki provided information on the HIV prevalence by province in Kenya, the sources of new HIV infections, and the importance of focusing on MARPs.

Kenya's HIV prevalence is 6.3 percent, with the largest proportion (44 percent) of new infections originating within heterosexual unions or steady partnerships; other significant sources included casual heterosexual sex, sex among MSM in prison, and sex among SWs and their clients (who have HIV prevalences of 20 percent, 15 percent, and 14 percent, respectively). The rationale for focusing on MARPs is that one-third of all new infections are attributable to these groups. HIV prevalence is between 20 and 50 percent among MARPs, and they are a bridge population to the general public.

NASCOP developed a strategy for coordinated prevention activities targeted at MARPs. The initiative entailed the following steps:

- Establishing a national MARPs program and a multi-sectoral technical working group on MARPs.

- Developing program tools including guidelines for SWs on STIs and HIV, quality standards for peer educators working with MARPs, a training curriculum for providers, and a package of minimum care for MARPs. The package included information on safer sex, demonstration and provision of condoms, HTC, family planning, and psychosocial support and referral.

- Developing an enabling policy environment, including prioritizing MARPs in the National AIDS Strategic Plan and including MARP stakeholders in policy dialogue.

- Mobilizing MARPs to demand services, engage in policy dialogue, participate in developing service guidelines, train as peer educators, and form organized groups.

- Establishing service delivery models such as drop-in centers, truckers' wellness centers, specialized MARP-friendly services, public-private partnerships and referral networks, and new interventions, such as opioid substitution therapy and needle programs.

- Providing capacity building, both online and on-site, for MARP peer educators and health workers.

- Obtaining financial support and developing goals to reach sustainability.

As a result of the program, enrollment of women in the Sex Workers' Outreach Program (SWOP) increased from under 300 in 2008 to over 5,000 in late 2010, with over 95 percent of SWs accepting HIV testing when offered the service through SWOP. A survey showed that nearly all SWs reported using condoms with casual partners—though only about two-thirds did so with regular partners. ART enrollment for both male and female SWs also increased.

A serious barrier to intervening to address the vulnerability of MARPs was the very negative political atmosphere and the taboos around discussing SWs and related issues. Research conducted to persuade the government found surprising data, including the following:

- More than 10,000 SWs operate every night—a high number that surprised stakeholders.

- MARPs are concentrated in tourist centers.

- Female SWs are more empowered to use condoms than male SWs, which speaks to the disempowerment of men in seeking health services, especially MSM.

Future directions:

- Online training to reach some hidden MARPs—facilitating training while eliminating the need to come forward

- Seeking to meet 80 percent HTC coverage for MARPs, but information on the denominator is still needed

- Behavioral surveillance in sentinel sites

- Working with the U.N. High Commission on Refugees to address HIV among migrant SWs

- Updating questions to gather some missing information (such as data on anal sex and MARPs) and target younger groups

- Focusing on referral networks to get MARPs connected to ART and other necessary services

- Seeking a feedback mechanism to see whether people use referrals

- Seeking funders to support different program components.

QUESTION AND ANSWER: SUMMARY OF DISCUSSION POINTS

Unintended consequences: Participants expressed concern that focusing on MARPs because they are a bridge population contributes to stigma and discrimination. The focus is appropriate in terms of the severity of HIV incidence among MARPs, and necessary in terms of obtaining funding, yet it may add to existing stigma and discrimination by implying that MARPs are "at fault" for bringing HIV to the rest of the population.

Political environment: Program managers must take into account the political environment and how it affects the sexual behavior of MSM.

Human rights: Programs need to be more explicit in addressing human rights and social or structural issues. Politicians should not be allowed to refuse to address human rights issues, even when they try to postpone the discussion because of elections. An important strategy in promoting rights is to let MARPs represent themselves. Attitudes start to change once people begin to interact with individuals who are most at-risk; the issues become more personal than simply discussing it within a group.

Multi-sectoral collaboration: Improving services for MARPs requires broad collaboration, with each stakeholder group providing an area of expertise or strength. For example, if the government is leading an initiative, there might be funding for civil society organizations to conduct related advocacy activities. It is important to determine how to get communities working with service providers and policymakers to design the data collection process and providers and policymakers

can share information gathered back with MARP communities for validation. Such collaborative processes and bi-directional feedback can help build social capital.

Having MARPs involved in these collaborations is vital. Organizations and communities respond very differently to a person than to the idea of a group.

Justifying research: In resource-constrained environments, it is useful to think about data collection as a prevention activity because the data-gathering allows people to share their stories, problems, and identify possible solutions.

Addressing stigma: One option for preventing stigma is to combine HIV testing with a healthy lifestyle initiative; in this approach, HIV testing is offered along with glucose monitoring, cholesterol checks, and other preventive services. This normalizes HIV testing without singling out MARPs.

Incentives: Study participants should be compensated according to their earning capacity during the time they spend responding to questions; this facilitates participation and goodwill. Incentives need not be monetary or government-financed; they could take the form of food or transportation costs. Managers should be flexible about incentives; approaches can change depending on who is participating (for example, low-income participants versus students). Involving MARPs in the design and implementation of data collection activities can be a strategy for organizations that cannot afford incentives, because if MARPs are true partners in the study, they are less likely to ask for incentives.

Also, managers developing interventions need to stay aware of the target population's need to earn. Educational and income-generating grants over time could reduce the need for incentives and encourage self-sufficiency better than one-time incentives.

Research topics: Additional interventions are needed to discuss and address phenomena affecting MARPs at the individual psychological level, such as depression and alienation. These dimensions are complex to examine, yet they are crucial to understanding at-risk populations and influencing their behavior.

THEMATIC AREA 2: EXPANDING PREVENTION INTERVENTIONS AND SERVICES FOR MARPS AND OVPS

During these sessions, presenters outlined key evidence-based interventions and the minimum package of services targeted toward MARPs and OVPs.

A series of presentations described theoretical approaches and applications:

1. How data is being used to inform and improve prevention programs for MSM, SWs, OVPs, and PLHIV.

2. What are the data and information gaps? What additional information is needed to know about MARPs and OVPs in the region to program appropriately?

3. Methods for getting information such as mapping, size estimation, rapid assessments, and behavioral surveillance surveys.

WHAT IS THE COMPREHENSIVE PACKAGE OF SERVICES FOR MARPS? DEFINITIONS, EVIDENCE, AND EXAMPLES

Clancy Broxton, Most at Risk Populations Advisor, USAID/Washington;

Karina Rapposelli, Behavioral Scientist, Center for Global Health/Division of Global HIV/AIDS, CDC/Atlanta

The presentation described a package of essential services for MARPs and outlined how this package fits within the combination prevention approach. Substantial evidence supports the effectiveness of a package of key interventions to prevent and treat HIV among those most at risk. The package should be implemented using diverse approaches including behavioral interventions, structural approaches (to reduce vulnerability arising from risky environments), and biomedical interventions (to reduce the probability of transmission).

The key components of an essential package of services for MARPs include the following elements:

- *Peer education:* Peer educators can be effective sources of information—including information provided through social media—and can also provide links to services. Studies in the Caribbean, Ghana, and Russia have shown positive outcomes.

- *Risk reduction counseling:* This approach, which entails assessing individual risks, identifying goals for safe behavior, and developing a personalized action plan, has been shown to significantly reduce incidence of unprotected anal sex.

- *Condom and lubricant promotion and distribution:* This strategy helps MARPs understand the importance of condom use and negotiate consistent use of lubricants and condoms. Studies in Cambodia and the Dominican Republic showed significant increase in condom use following interventions.

- *HTC:* Research has shown that MARPs often face barriers to obtaining services, but also shows that PLHIV who know their status will change their behavior to protect partners. Studies in Guatemala and Ukraine used several approaches (mobile HTC and MARP-friendly clinics with same-day test results) to increasing access to HTC.

- *STI screening and treatment:* Programs that provide a basic, confidential package of STI services, including screening at intervals, have been shown to reduce STIs among SWs and their clients, though the impact on HIV has been mixed. However, MARPs do have a higher risk for STIs, so STI services offer an opportunity for risk reduction counseling and condom distribution. STI programs should screen for both symptomatic and asymptomatic STIs.

- *HIV care and treatment:* It is feasible and effective to provide a package of HIV services for MARPs, though programs must ensure that the services are accessible and safe for drug users. Studies show that MARPs are capable of adhering to ART; using case managers and peer support can improve adherence. In 2010, Kenya released national guidelines on HIV prevention, care, and treatment among MARPs.

- *Access to sterile and safe disposal of injection equipment:* A safe needle disposal program reduces HIV transition among PWID, and studies show no evidence of major negative consequences. The U.S. Government has begun funding these programs in Asia, where this approach is supported.

Other components might be considered, depending on the need and context:

- *Drug dependence treatment:* Medication is being developed to help with cocaine dependence; in the meantime, providers need to use cognitive behavioral therapies, because cocaine use is higher in the Caribbean region than heroin.

- *Male circumcision:* Circumcision is effective in reducing HIV transmission through heterosexual contact; evidence does not document an impact among MSM.

- *Intervention for alcohol use and HIV-related sexual risk behavior:* This is a major risk factor in HIV transmission, yet no effective approach has been identified to date.

Key factors for successful implementation and uptake of service packages include the following:

- Accessibility (convenient locations and service hours, affordable)

- Acceptability (nonjudgmental, confidential services)

- Coverage (expanding beyond the pilot phase to a broader scale-up that can have an impact on HIV)

- Intensity (a wide range of services available)

- Links (including one-stop shopping or strong referral mechanisms)

- Quality (adherence to guidelines and standards).

Challenges for moving forward included examining implications of providing a package of services in the Caribbean context and the issues of adaptation and implementation. Going forward, programmers need to identify and address service barriers to provide appropriate services that will have a true impact on the HIV epidemic. One critical issue for consideration is whether the Caribbean should re-evaluate its status as a region with a generalized epidemic and consider a status as a region with a mixed or concentrated epidemic.

Program managers should keep in mind that combination prevention components are less effective in isolation—for example, an intervention cannot comprise only behavioral components without the biomedical and structural elements that should accompany them. Elements within each component must be developed appropriately. Also, risk reduction counseling must be client-centered, or it will not be effective.

Last words: The most important point to take away is that there is substantial evidence for the effectiveness of a core set of interventions for MARPs. A number of new biomedical interventions are providing evidence; it is important to stay current with information coming from these and other initiatives and be prepared to incorporate them as appropriate.

COUNTRY EXAMPLES

CENTRAL AMERICA PROGRAM MSM INTERVENTIONS

Giovanni Melendez, HIV/AIDS Prevention Specialist, USAID/Guatemala

The presentation examined the models or theories that serve as the basis of prevention interventions. Many professionals working in the field of prevention are "atheoretical," and this contributes to a lack of coordination of interventions and decreases efficacy. Managers can choose one model (or theory) or a mix of them, but should select at least one model and base the interventions on that model.

Each theoretical model (health belief, stage of change, and so on) is related to specific factors or characteristics, which can be linked to data or evidence. In Guatemala, there were challenges in reaching hidden populations, such as not knowing where to find MSM, or how to identify them. For many years, "alternate" sexual styles (transgender, MSM, bisexual) were all grouped under the same category, but there is a need to address the specific needs of each group.

Qualitative research showed risky behaviors were related to specific locations (bath houses, gyms, discos). Researchers also asked MSM questions about their experiences going to the places in order to understand motivations, fears, and other characteristics of this group. The Pan American Social Marketing Organization (PASMO) developed an HIV awareness campaign to share the experiences of men who do not identify openly as gay or bisexual. The campaign shared information and experiences without trying to directly influence behavior by telling the audience (men) what to do or not do. USAID/Guatemala and PASMO selected the state of change and socioecological models as

the theoretical basis for the program. Campaign videos featuring individual men's experiences are shown in movie theaters, which men might attend with their wives or lovers. The video content and format are designed to stimulate men to consider these issues and perhaps begin to discuss them. Outreach activities go beyond knowledge and address the three factors related to condom use (self-efficacy, risk perception, and social support) identified through research. Many hard-to-reach MSM use the Internet or social media, and programs need to make better use of these channels to get information out.

In implementing interventions for MARPs, it is important to listen more than talk. Facilitators and peer educators need to ask more questions and reflect back what participants have expressed. Thus, not all members of a MARP are appropriate candidates for being peer educators; the work requires aptitude, and training is needed to provide knowledge and skills.

Another challenge was ensuring that programs are effective. Comparisons are underway between those who were exposed and those who were not exposed to program interventions to identify the activities that had an effect. Researchers are also trying to identify how much exposure is enough to affect behavior. Additionally, they are trying to apply the theories to the prevention package itself, measuring the effect of receiving the whole package versus only getting a subset of services. The project uses coding to avoid double-counting and ensure an accurate count of how many people are using the services.

Last words:

- Be scientific: When planning a prevention program, develop interventions based on evidence of good practice.

- Make prevention real: People need to experience prevention in education, training, and implementation, and not just talk about prevention activities.

- Keep it changing: Prevention is a science, so be skeptical; prevention is political, so persevere; prevention is art, so be creative.

QUESTION AND ANSWER: SUMMARY OF DISCUSSION POINTS

Attribution: Programs need to develop mechanisms to identify whether changes in the target population are due to the interventions underway. In Haiti, Population Services International (PSI) has developed an M&E program that links exposure to programs with behavioral change; this is an important measure, because exposure does not necessarily translate to improved outcomes, In Guatemala and Belize, PSI uses a coding system to avoid double-counting results in pilot sites. The PASMO program can determine which activity is linked to behavioral change. Another approach is to use behavioral surveys to measure the impact of prevention activities.

Adapting proven approaches: Participants discussed ways to take lessons learned in other regions and adapt them to the local context. However, the adaptation must avoid replicating unwanted elements—for example, many services in Asia warrant replication; however, Asian countries also send PWID to detention centers, which would be an unlikely practice in the Caribbean for legal and political reasons.

Reaching all MARP groups: Program managers and advocates can generally articulate the needs of MSM and SWs, but the needs of PWID have not been clearly articulated or effectively addressed.

It is important to consult with MARP communities to reflect their needs and issues, rather than imposing activities that do not reflect the communities' priorities—something that often happens in the Caribbean. It requires careful listening to identify the factors that influence both negative and positive behaviors.

Obtaining funding: Some participants felt that funders come in already resolved about what they want to fund. As a result, countries or stakeholders have to write grant applications over and over again, responding to comments with little guidance, and by the time the activities are ready to go, all the funds have been spent on administrative costs. There seems to be a lack of transparency, with the same organizations constantly receiving the funding. Additionally, funding organizations sometimes require grantees to develop low-budget proposals and do not provide support for program design.

Last words: When working with MARPs, it is important to put the person at the center of the intervention, understand what is happening at that level, and develop skills to respond. This can address the often corrective mindset of programs, moving away from a philosophy of wanting "them" to change their behavior, and toward one of empowering individuals to take actions that lead to a positive health outcome.

SPECIFIC STRATEGIES FOR INCREASING PREVENTION SERVICES FOR MOST-AT-RISK POPULATIONS

PEER OUTREACH AND COMMUNITY-BASED PROGRAMS

Dylis L. Mc Donald, Technical Director, Caribbean HIV/AIDS Alliance (CHAA)

The presentation described the approach to prevention taken by CHAA. CHAA focuses on creating a supportive environment for HIV prevention and accessible, MARP-friendly health and social support services. To address the social and political context of the Caribbean, CHAA emphasizes community-based approaches to prevention, including behavior change interventions and HIV rapid testing. Bidirectional referral—enabling referrals between clinical and community settings—is a critical component of CHAA operations. The organization also conducts outreach and technical assistance for key stakeholders, partners, and vulnerable communities. All activities incorporate the principles of advocating for change and addressing gender concerns and discrimination.

The results of CHAA's combined approach include:

- Increased access to services for MARPs

- Increasing engagement and legitimacy of MARPs in the national response

- Acceptance of the peer-based outreach model as an effective mechanism to provide a continuum of services to MARPs

- Use of data from "nontraditional" sources at the national level in making decisions and developing interventions

- A more MARP-sensitive environment for obtaining services.

Lessons Learned

Cultivating partnerships: Developing and strengthening partnerships between stakeholders is an integral aspect of any strategy to ensure that interventions are implemented effectively and sustained over the long-term. Mobilizing peers and partners to support MARP programming in an innovative way is crucial.

Sustaining community involvement: Ongoing systematic community intervention, action, and support are critical to advocacy and engagement by MARPs. Participatory development is an essential approach. Any community-level intervention must include capacity building and engagement of community leaders, who have a significant advocacy role to play in addressing stigma and discrimination and access to "sensitive" services, especially within their own communities.

Client-centered approaches: The use of a one-on-one outreach approach is a pillar in the national response for MARPs.

Think before you integrate: Vertical service delivery is controversial, but given the legal environment in the Caribbean, it might be necessary to consider whether services for MARPs should be mainstreamed or kept separate.

Consider nontraditional data gathering: Data from projects in Antigua and Barbuda and Barbados are still being processed, but in pilot sites in Antigua, researchers are collecting new types of data that had not previously been collected. This is one of the first times a peer outreach project like this has shared detailed data with the MOH.

Last words: Prevention programs do not need to be everything to everybody. A better approach is to focus on an organization's or program's strength and to collaborate with others to reach the broader goal.

HIV TESTING AND COUNSELING (HTC)

Stephanie Behel, Epidemiologist, Center for Global Health/Division of Global HIV/AIDS, CDC/Atlanta

The presentation reviewed the evidence for the importance of HTC in the context of the Caribbean epidemic and some of the barriers and challenges to HTC. In the Caribbean, most people still do not know their HIV status, and HIV rates have not significantly diminished in the last 10 years. HIV testing is important for containing the epidemic in the Caribbean but is not sufficient in itself: linkage to and retention in services for prevention, care, and treatment are essential.

Global shifts in HTC interventions offer approaches that facilitate access to care. Countries and programs need to consider which new approaches are appropriate in their context and prioritize their implementation. Updated HTC delivery modes include the following shifts:

- Stand-alone VCT to health facility and targeted outreach

- Health care workers or professional counselors to lay counselors

- Venipuncture to finger prick or oral specimen collection

- Returning for results to point-of-care rapid testing with same-day results

- Individual HTC to HTC for partners, couples, and families

- Window period[4] testing for all to targeted risk-based retesting

- Mass scale-up of all HTC approaches to strategic HTC programming.

Recommendations:

- Implement a combination of community-based and facility-based HTC approaches.

- Support point-of-care rapid testing to reduce loss to follow-up.

- HTC programs must collaborate with providers of services for prevention, care, and treatment to strengthen linkages.

- Support national policies that address human rights issues that aim to decrease stigma and discrimination.

Key Issues:

- *Link testing to other services:* Clients who use testing services need accessible links to additional services or care. Not everyone is ready to seek additional services immediately, especially after receiving a positive test result, but the links must be available whenever the client is ready.

- *Make HTC available:* Studies conducted in several countries, including Trinidad and Tobago, have shown positive effects from HTC among PLHIV, such as reduction in the number of partners. Project Accept is an ongoing randomized controlled trial that is being conducted in Thailand and several countries in Africa. The results so far show that uptake for community-based testing (including VCT) is four times higher than for clinic-based VCT, and that post-test support clubs are effective in allaying stigma.

- *Address the structural barriers to accessible HTC:* Many countries do not have support for task shifting that allows additional providers to conduct HTC, though research shows that lower-level providers can provide HTC services safely. If HTC is considered the entry point for care, point-of-care rapid testing helps ensure the individual receives the service at that service opportunity, but there are multiple additional points where loss to follow-up can occur. Peer educators can also be used to provide HTC and to help mobilize HTC services out into the communities.

HIV PREVENTION INTERVENTIONS WITH PEOPLE LIVING WITH HIV/AIDS (PWP)

Pamela Bachanas, Team Lead, Behavioral Scientist, Center for Global Health/Division of Global HIV/AIDS, CDC/Atlanta

The Prevention with People Living with HIV (PWP) program has a new paradigm—positive health, dignity, and prevention—that was proposed by UNAIDS and the Global Network of People Living with HIV. This approach entails more than prevention, but extends to equipping PLHIV with the skills to protect their health and that of their partners and families. PWP, which engages PLHIV as equal partners in efforts to curb the spread of HIV, has been shown to reduce risk behaviors, unplanned pregnancies, and STI prevalence among participating populations. In the Caribbean, the

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[4] The window period is the time period between HIV exposure and when the body has produced enough HIV antibodies to be detected by an HIV antibody test, on average 25 days, and usually between two and eight weeks (CDC 2010).

PWP approach represents a more efficient strategy of targeting PLHIV rather than the general population.

Components of PWP include the following:

- Increasing the number of PLHIV who know their status (in the Caribbean, many PLHIV do not know their serostatus)

- Early linkage to HIV care and treatment (of about 67,000 PLHIV in the Caribbean, 12,000 are receiving ART)

- Assistance with disclosure

- Partner testing (negative partners are linked to prevention services; positive partners are linked to prevention, care, and treatment)

- Family planning and pregnancy counseling

- STI management

- Distributing condoms and water-based lubricants.

Implementing PWP entails marshaling clinicians, CBOs, and peer or lay counselors in both clinics and community settings. Peer and lay counselors who are living with HIV can be effective at delivering prevention interventions in both clinic and community settings—especially if they can serve as positive role models (e.g., as an expert client). Unfortunately, many PLHIV still report that they experience stigma and discrimination from health care workers, and many policy barriers remain in place. A PEPFAR PWP task force has developed a PWP intervention, including procedures, roles for providers and peer or lay counselors, and M&E strategies. Materials are available.

Next steps are to standardize facility- and community-based prevention and care for all PLHIV in the Caribbean region, determine key implementers of PWP and their respective roles, and address stigma and discrimination against MARPs. PWP can help make PLHIV equal partners in achieving this goal.

Last words: PWP must become part of routine care for PLHIV—more than at intake screening during the first point of contact, but part of ongoing care and services.

QUESTION AND ANSWER: SUMMARY OF DISCUSSION POINTS

Window period: There is still concern about the window period; tests being used in the Caribbean are antibody tests (immunoglobulins) that do not eliminate the window period. However, advances in rapid testing are making tests more sensitive—very few people who return have seroconverted. Therefore, providers should focus efforts on risk screening to identify persons who may have had a recent risk and who truly need to be re-tested. When to recommend re-testing is summarized in WHO's 2010 international re-testing guidance (see Resources).

Supporting PLHIV: An important component of PWP is to strengthen care, treatment, and support for those that need care but do not yet need or are not yet on ART. Networks of PLHIV

should be engaged in PWP; they are in many ways better situated to support PLHIV than the health care sector.

PWP interventions: PEPFAR has developed PWP interventions and a training manual for clinic-based health care workers, who see all individuals coming to the facility and training materials for lay counselors who can see on average about one-third of clients who access a health care facility. These training materials have been adapted for delivery in community settings including home-based care and PLHIV support groups. The same information and services should be available at multiple delivery points. It is critical to ensure that all service venues, including CBOs, follow the same standards for quality. Also, FBOs should be mobilized; they have experience in working with MARPs on addressing stigma and discrimination.

Migration: The realities of regional migration require standardized PWP packages across the islands, so that once an individual leaves one island and goes to another, he or she can receive the same services and confidentiality is maintained. Programs should consider ways of providing access to those who are not legal residents. Countries should regularly share their implementation strategies—using venues such as this meeting, for example.

Youth: PWP programs should be widely available to sexually active, HIV-positive youth.

Peer counselors: Peer or lay counselor programs require training and supervision, and the approaches, experiences, and results (positive and negative) should be documented.

INTERNATIONAL AND REGIONAL BEST PRACTICES

INTERVENTIONS FOR MEN WHO HAVE SEX WITH MEN: CONSIDERATIONS FOR THE CARIBBEAN

Rashad Burgess, Chief, Capacity Building Branch, Division of HIV/AIDS Prevention, CDC/Atlanta

This presentation introduced attendees to a number of programs targeting MSM at the community level.

Mpowerment: Mpowerment is a U.S.-based program developed to increase self-efficacy for young MSM and bisexual men of diverse backgrounds and has been shown to reduce unprotected anal intercourse by 27 percent of participants overall, with a 45 percent reduction in unprotected anal intercourse with casual partners.

Mpowerment has seven guiding principles:

1. *Social focus:* creating a community for the target group

2. *An empowerment philosophy:* helping men identify their own problems and possible solutions

3. *A peer influence:* peers may have the greatest effect on behavior change

4. *Multilevel targeting:* addresses a constellation of factors that affect HIV risk

5. *Gay-positive and sex-positive:* affirming participants' individuality and sexual choices

6. *Community building*

7. *Diffusion of innovations:* discussions affect men's behavior and spread to the wider community.

The intervention is complex but includes the following core components:

- *Core group of staff and volunteers:* carry out activities

- *Coordinators:* true (full/part time, paid) staff

- *Project space:* particularly with young MSM, the need for a safe space is critical to the intervention

- *Formal outreach:* discussions and information distribution in bars and other venues

- *Informal outreach:* discussions between volunteers and friends

- *M-groups:* discussing common questions, such as what is it like to have an older boyfriend?

- *Publicity campaign:* raising awareness in the greater community

- *Community advisory board:* guiding project implementation.

Popular opinion leader (POL): In this intervention, tested in the southern United States and subsequently internationally (in China, India, Peru, Russia, and Zimbabwe), trusted, well-liked people are recruited and trained to endorse targeted risk reduction behaviors by having casual, one-on-one conversations with their friends and acquaintances (peers) in their own social network (friendship group). Only specific peers in social networks are opinion leaders: those who are the most popular, credible, and trusted in their social network. The settings are those in which social networks can be counted or estimated and shared attitudes about HIV risk can be described. Although originally developed for MSM, the POL intervention techniques have been successfully adapted to a variety of risk populations and settings.

- *Goals:* POLs aim to spread messages about a variety of health behaviors (such as adopting safer-sex behaviors, seeking HIV antibody testing, disclosing HIV status to sex partners, and seeking prevention and medical services) throughout a community. Usually, one risk-influencing factor, or community norm, is targeted.

- *How it works:* The people in a community change the way they think about protecting themselves from HIV as a result of efforts of POL community members. During peer-to-peer conversations, opinion leaders communicate their personal approval of the targeted risk-reduction behavior, using "I" statements to emphasize personal endorsement.

- *Theoretical basis:* POL interventions are based on diffusion of innovations (sometimes called social diffusion theory). The premise is that behavior change in a population can be initiated and will then diffuse to others if enough opinion leaders within the population are known to adopt, endorse, and support the behavior. In POL interventions, the opinion leaders shape changes in safer-sex norms to make it easier for others to start and maintain risk reduction behavior changes.

d-UP! "Brothers Keeping Brothers Safe": This program was designed for black MSM and was developed in North Carolina in response to an outbreak of HIV in 2005. d-Up! incorporates social and cultural factors, and explores the notions of dual identity, internalized homophobia, and internalized racism and preparation for bias. Some results can be found in an efficacy paper published in the *American Journal of Public Health* in 2008 (see Resources).

Many Men Many Voices: This program targets MSM from a variety of backgrounds and cultures with shared risk factors, including high rates of STIs in their social networks, low awareness of HIV

serostatus, infrequent HIV testing, late diagnosis of HIV infection, and limited connections with peer communities in New York.

The issues addressed include cultural, social, and religious norms; sexual relationship dynamics ("tops" vs. "bottoms"); racism and homophobia; and church affiliation and negative views of homosexuality in churches. The program components include six weekly group sessions lasting two to three hours, along with a weekend retreat. There is an optional seventh session on community-building for MSM of color, as well as linkage to services (mental health, substance use). Sessions are facilitated by one or two peers, at least one of whom must be a black MSM. Peer leaders are skilled in leading groups and using support materials such as manuals, brochures, audiovisuals, and games.

Common challenges to these approaches include recruitment, retention, adaptation to new settings, and maintaining the program's fidelity, as well as ensuring good facilitation skills and accurate knowledge about HIV and STIs among facilitators.

Adaptation: All of these strategies can be adapted to fit the specific needs of local MARP communities. Key questions for programs considering adapting these approaches include the following:

- Does the organization have real access to the population?

- Are there members of the MARP you are serving on staff?

- Are there resources to appropriately implement the intervention?

- Is the specific targeted MARP supportive of the program?

- Will MSM feel comfortable and supported?

Last words: Access the Diffusion of Effective Behavioral Interventions website at www.effectiveinterventions.org.

A NATIONWIDE MODEL: A COMPLETE PACKAGE OF INTEGRATED HIV/AIDS PREVENTION INTERVENTIONS FOR SEX WORKERS IN HAITI

Johane Philogene-Nonez, Deputy Program Director, Fondation pour la Santé Reprodoctrice et *l'Education Familiale (FOSREF), Haiti*

FOSREF, a Haitian NGO founded in 1988, is the country's leading HIV service provider for MARPs. An MOH mandate directs FOSREF to provide nationwide coverage to SWs through its network of 32 centers. Haiti has a law against prostitution, but it is not enforced, and the number of SWs is high—an estimated 82,000 formal SWs, with perhaps three times as many in the informal sector. The SW population in Haiti is very heterogeneous, so interventions must take a number of variations into account—level of education, age, setting of services, mobility, and other factors. HIV prevalence among SWs ranges from 5 to 10 percent. SWs experience significant sexual violence and their life challenges are exacerbated by post-earthquake conditions.

Lakay (meaning "home" in Haitian Creole) is FOSREF's program for Haitian SWs. It provides integrated HIV services for female SWs and their clients through a multifaceted approach that includes a network of centers for SWs, outreach through trained SW peers and community agents, and a social rehabilitation component, "Other Choice," where over 6,000 SWs have received training in microfinance and vocational instruction. Multiple locations—there are 11 Lakay centers

in Haiti's major cities—help SWs find programs as they move around the country, and community support has been essential for the program. Focusing the centers on SW services is a way to avoid discrimination and stigma.

Peer educators have been essential to the Lakay program: providing counseling and group education, arranging logistics for clinical services, distributing condoms, and designing, testing, and distributing educational material. Additional critical factors are the support of the whole SW community—from brothel owners to street workers—and participation of SWs in every phase of the program, including choosing sites, determining work hours, and evaluating the program.

Program results include:

- Over 111,000 SWs reached

- Increased HIV testing, from 1,500 to nearly 22,000

- Decreased HIV prevalence within the network, from 25 percent to 7 percent

- Increased coverage of "hot spots" (from 10 percent to 85 percent)

- Increased condom use (from 45 percent in 2001 to 98 percent in 2009)

- 100 percent of SWs living with HIV receiving medical assistance and psychosocial support.

Major challenges have included increasing the number of male clients who use Lakay clinics (1,500 over the last two years), the potential impact of skills building in a context of widespread unemployment, and increased teenage prostitution and violence in the post-earthquake months. FOSREF has sought to address these challenges through education, partnerships with the public and private sectors, and peer training.

Programs interested in replicating this project need to remember the critical importance of trained SW peers, the need to locate SW services where SWs are, and the need to tailor interventions to the reality of SWs' lives.

Last words: Keeping SWs at the center of the program means involving them in all steps of program implementation from design through evaluation and adaptation.

POSITIVE HEALTH, DIGNITY, AND PREVENTION

Christoforos Mallouris, Director of Programmes, Global Network of People Living with HIV

Positive Health, Dignity and Prevention (PHDP) is a PLHIV-led human rights program with a "prevention with people living with HIV" framework. Its primary goal is to help PLHIV to achieve health and well-being; its secondary goal is to benefit public health.

PHDP addresses the psychosocial, economic, educational, and sociocultural vulnerabilities of PLHIV, as well as issues of gender and sexuality. The program is based on mutual respect and is tailored to specific contexts within the diverse population of PLHIV. PHDP challenges policies that promote stigma and discrimination, including laws that criminalize nondisclosure or laws that allow convictions regarding nondisclosure based on regulations that are not related to HIV.

Components of PHDP include empowerment, gender equality, human rights, prevention of new infections, sexual and reproductive health rights, social and economic support, and M&E. The program promotes leadership by PLHIV in all phases of HIV interventions and in evaluation of policies and programs that affect PLHIV, and views prevention of HIV transmission as the

responsibility of all individuals, regardless of HIV status. It takes a "people, not patients" approach to rights promotion, including sexual and reproductive health rights. Program results are measured according to goals set through the lens of the impact on the lives of PLHIV, using a variety of tools including the PLHIV Stigma Index and Human Rights Count! consultations.

The activities of the National Empowerment Network of People Living with HIV/AIDS in Kenya (NEPHAK) provide an example of good practice. NEPHAK promotes community-owned and -led programs; literacy in health, treatment, and prevention; informed, evidence-based treatment options that also benefit public health; and policy change through the leadership of PLHIV.

In Jamaica, the Community Voices on PMTCT has reached 83 percent of women and 95 percent of children in the target community. However, gaps in the implementation included limited knowledge of available services and rights among respondents, continuing discrimination by health workers, and limited involvement of men. The Jamaica Community of Positive Women is working with women living with HIV and their partners to increase understanding about PMTCT programs and what they can demand, and is sharing data with the national HIV and STI program to see how these women can support the delivery of PMTCT services.

Key considerations for replication:

- Support a response that is based on the experiences and perspectives of the person living with HIV

- Promote leadership and partnership to create linkages between programs and components (avoid new structures)

- Promote an environment that enables and supports individuals to make informed choices.

Key Positive Health, Dignity and Prevention issues: First and foremost, programs should focus on the individual living with HIV with a secondary focus on preventing transmission to others—putting the needs of the individual first will have a public health benefit. Programmers should remember that PLHIV may experience a variety of health issues, including other infections such as hepatitis C. Too often, sexual and reproductive health rights are ignored; this includes the right to have sex, shared sexual responsibility, the desire to have children, and to not be forcibly sterilized. All of these have implications for leading a healthy sexual life.

Last words: Do not look at PLHIV first for prevention—the PLHIV is not the only person in a relationship who can work to prevent HIV transmission.

A ROADBLOCK TO PREVENTION: DECONSTRUCTING POPULATION SILOS—APPLYING A PUBLIC HEALTH APPROACH TO HIV AND DRUG USE AMONG SEX WORKERS AND MEN WHO HAVE SEX WITH MEN

Dr. Marcus Day, Director, Caribbean Drug and Alcohol Research Institute

The session centered on research conducted in the Caribbean on implementing effective public health measures to address drug use. The approach focuses on a street-based approach to harm prevention that looks at drug use with both an HIV lens—considering MARPs, a "silo mentality," and the multiple risks of drug users—and a drug treatment lens. The program has set up street-based centers in Port of Spain, Castries, and New Kingston.

People are complex beings with multiple issues and behaviors. Some groups, such as SWs or prisoners who use crack cocaine, may simultaneously exist in two or more "silos" or categories with overlapping risk and increased vulnerability. The chance of HIV infection is greatly increased when these multiple factors combine.

The barriers to successful intervention in multiple vulnerable groups include:

- *Drug user barriers:* feeling misunderstood or being treated differently

- *Time barriers:* lengthy waiting times, limited time to discuss problems, and restrictive hours at service delivery sites

- *Service barriers:* unwelcoming environments, high service costs, unfriendly and unskilled staff, and chaotic atmosphere

- *Interaction barriers:* discrimination, focus on abstinence, lack of trust in service, bad previous experiences, travel problems, and cultural barriers.

Respectful street-based, low-threshold services work well with any street-based or street-involved populations. The key is for services to understand that their clients engage in multiple risk behaviors. So even if a center is set up for drug users, it needs to be prepared to address sex work, MSM, and co-occurring psychiatric and criminal justice issues. Though functioning street-based services have been established, barriers remain—including resistance from the community and providers, a negative legal environment, and the silo mentality, which limits access to information. Addressing these challenges requires community sensitization, training and collaboration with providers and law enforcement, and promoting a more horizontal approach to address multiple risks.

Last words: Programs must be willing to view most at risk individuals as complex persons with multiple vulnerabilities and risk behaviors.

QUESTION AND ANSWER: SUMMARY OF DISCUSSION POINTS

SWs and unprotected anal intercourse: There are few interventions to help SWs who engage in anal sex, and SWs need to be instructed in how to use the female condom for anal sex. This is especially problematic for young female SWs and, increasingly, with adolescent girls who opt for anal, rather than vaginal, sex because they wish to remain a "virgin."

Livelihood programs: Programs to help teach SWs skills for alternate livelihoods do not address the circumstances in which they live. In Haiti, most SWs who do change their work go into the beauty business or sell products such as handicrafts, but this does not change their environment, so many women go in and out of sex work. An estimated 10 to 20 percent of women will go into other vocations, but much more work is needed in this area.

Peer educators: Peer educators can be a programmatic asset, but their retention is difficult. Programs may need to reconsider structural issues (offer peer services in a convenient space and time), peer educators' needs (food), and incentives (gift cards and other benefits). Incentives can be small, but they have an effect. Harnessing existing networks can offer a solution. In Haiti, the existing SW peer support network is used to follow up on all SWs who have received referrals and to strengthen linkages with partners.

Religion and faith: The role of religion cannot be overstated when designing prevention programs. Religion has a major effect on an individual's feelings of value as a human being. When working with MARPs, providers should discuss what it is like to be a part of a culture that can disapprove of specific behavior and explain that they can obtain support to recognize their spirituality and sexuality. Religion has a particularly negative effect on young men, perhaps leading to risky behavior.

Message overuse: Programs need a better understanding of saturation points; target groups hear the same messages and get the same services over and over.

Complexity of networking: Establishing a PLHIV network in a country is a multistage process. The first step is to ask the community what they need, then provide core support to maintain the network's advocacy role. Another key step is to provide support for governance—the Global Network of People Living with HIV/AIDS is developing an evidence-informed tool for identifying priorities. It is important to advocate for the involvement of networks in national and organizational processes. Examples of such involvement may be found through evidence-gathering methodologies (i.e., how stigma has been documented). The Global Network of People Living with HIV/AIDS can lead partnership development to direct and implement these methodologies, strengthening skills in research, monitoring and evaluation, program planning and management, advocacy, and political engagement—another way to support the network's ability to lead.

Definitions of public health: Programmers and other stakeholders may need to review the definitions of public health so that they are not narrowly defined. Programs should utilize the resources at hand (such as communities) to respond to needs, while dealing with specific populations in a way that is both realistic and evidence-based (although politicians want to ignore the realities at hand). PDHP for example, does not oppose public health, but instead offers a way for public health to look at the person first.

Terminology: PLHIV object to such terms as "Positive Prevention" or "PWP"; they are people, not positives, and they have needs beyond preventing transmission to others. Such terms ignore the situation in which PLHIV were infected and minimize the shared responsibility of community members, providers, and policymakers.

THEMATIC AREA 3: ENABLING ENVIRONMENTS—CHALLENGES AND OPPORTUNITIES FOR STRENGTHENING ACCESS TO PREVENTION AND CARE FOR MARPS AND OVPS

The objective of sessions in this thematic area was to present and discuss structural barriers to effective prevention and interventions that create an enabling environment for MARPs and OVPs to access services in the Caribbean.

ENABLING ENVIRONMENTS AND THEIR IMPACT ON HIV PREVENTION AMONG MOST-AT-RISK POPULATIONS

ECOLOGY OF ENABLING ENVIRONMENTS: STIGMA, DISCRIMINATION, AND HIV PREVENTION AMONG MARPS AND OVPS: IMPLICATIONS FOR THE CARIBBEAN

Ken Morrison, Senior Technical Advisor on HIV, The Health Policy Project

This talk described the "ecology" of an enabling environment in terms of the systems and social capital of such an environment. This viewpoint looks at the complex phenomena of stigma and discrimination as both an internal and social factor—in which social attitudes and customs generate both self-discrimination and multiple social harms including discrimination, human rights violations, and violence.

Understanding of the dynamics of HIV transmission has shifted over the past 30 years. The earlier concept was that at-risk groups engaged in risky behaviors and put themselves at risk. Today, the focus is on vulnerability: the social and structural determinants that influence a person's ability to deal with or avoid infection and stay healthy.

The Caribbean region is a diverse mixture of islands, cultures, and contexts. However, throughout the region the importance of family, community, and religion is paramount. So what happens to the isolated and marginalized people in these communities?

A qualitative study of vulnerable populations in Ecuador showed a number of recurring themes. Social exclusion led to personal discomfort at various levels (from suicidal ideation to subtle levels of self-disapproval). This discomfort in turn led individuals to a search for a means of escaping their life—from increased drug and alcohol use and constant mobility to desperation for intimacy and acceptance. Many of these behaviors simply exacerbated and reinforced levels of social exclusion. Stigma and discrimination, both internal and external, thus raise barriers to every element of combination prevention interventions.

How a society constructs its laws, policies, governance structures, and measures to ensure accountability and redress harm has enormous implications for stigma, gender, and violence. Communities often experience stigma, gender inequity, and violence together, so they need to address them together. Policy and governance structures must address universal human and social issues holistically to understand connections, document discrimination, and find ways to mitigate violence. They also need to establish linkages to other important elements in the Caribbean context—migration, laws, and education and communication on sexuality and health.

Enabling environment: An enabling environment is a set of interrelated conditions and systems—such as political, economic, administrative, informational, and sociocultural—that enhance the capacity to engage in development processes in a sustained and effective manner.

There are three key levels of intervention:

1. *Local level:* Develop an understanding of the ostracizing and abuse of MARPs and responses to deal with it.

2. *Institutional level:* Establish and enforce policies and practices to prevent denial of or provision of substandard services, including problems with confidentiality. Practices should be compulsory rather than optional.

3. *National level:* Establish minimal legal standards to reduce vulnerability and bolster HIV resilience instead of legitimizing discrimination.

A comparison of HIV prevalence among MSM according to whether homosexuality is criminalized (in Jamaica, for instance) or not (as in Cuba) shows much lower incidence in countries where the practice is not illegal. While there is no cause-and-effect relationship between law and HIV prevalence, this does show the importance of the legal environment as a factor in promoting health.

Creating a supportive or enabling environment is about systems change and also about interaction among systems:

- *Across time:* thinking strategically about long-term health outcomes and the steps to get there

- *Across levels:* from the political to the personal

- *Across sectors:* including education, faith, and private sectors (emphasize the interaction between the community and service providers).

While programs cannot undertake all promising practices, they can focus on priority issues, partnering with other organizations to implement such approaches as empowering MARPs, supporting community dialogue and education about HIV, fostering interaction among PLHIV and

the community, and promoting activism on human rights and laws. Key aspects in linking MARPs with their communities include bonding within and across communities; bridging among communities to form alliances; and establishing linkages and connections for effective interaction with policymakers.

Last words: Reducing stigma is critical to successful prevention. Strategies to reduce stigma do exist, but they are seldom evaluated and are not implemented on a large scale; it is critical to develop a strong evidence base on these strategies. Finally, policy on stigma is important, but it must constitute a systemic change that can be integrated into the lives of communities.

ENABLING ENVIRONMENT: ATTITUDES AND ACCESS TO SERVICES

Amalia Del Riego, Senior Advisor, Pan American Health Organization (PAHO) HIV Caribbean Office

The Caribbean Consensus on improving access of key populations to comprehensive HIV health services (October 2009) was a joint effort by more than 80 Caribbean stakeholders: public sector agencies (MOHs), the private sector, NGOs, CBOs, bilateral and multilateral agencies, activists, MSM, SWs, transgender persons, and youth. It was convened by the PAHO HIV Caribbean Office in collaboration with the U.N. Development Program, the U.N. Population Fund, UNICEF, the UNAIDS Regional Support Team, and the Pan Caribbean Partnership (PANCAP), in partnership with the Caribbean Vulnerable Groups Coalition.

The consensus identified the attitudes of providers and communities as a main barrier affecting access to services by MARPs. The characterization of the HIV epidemic as generalized in the recent past continues to guide response and influence attitudes, but changes in the attitudes and behaviors of providers must take place if uptake of services by key populations is to increase.

The social and legal censure of the behaviors of MARPs underlies many of the obstacles that MARPs face in maintaining their health. Providers in the Caribbean generally have a limited understanding of issues that affect key populations. They tend to be uncomfortable with sexual diversity and are unfamiliar with the practices and behaviors of MARPs and their implications for health and wellness. Their training does not prepare them to address sexual diversity or the psychosocial issues that can accompany it. Also, they often fail to conduct an appropriate sexual history and physical exam with MARPs. Thus they often overlook problems that are common among specific communities:

- *MSM:* neglected anal symptoms, violence, hepatitis and some cancers, HIV

- *Transgender persons:* depression, self-medication with hormones, substance abuse, STIs including HIV

- *SWs:* violence, abuse (sexual coercion) by police and immigration officers, unprotected sex, depression, fear of deportation or "outing"

- *Drug users:* feeling misunderstood, discrimination, mistrust of providers, inappropriate counseling

- *Prison inmates:* absence of protective systems including lack of access to condoms, disease prevention and harm reduction protocols, and follow-up

- *Migrants:* fear of authorities, language barriers, and frequent higher costs for health services

- *Youth:* lack of community support and access to information and services, violence, legal constraints, fear of being exposed.

Priority actions to enhance the health and social integration of MARPs include the following:

- Integrating health services through the primary health care approach

- Creating safe spaces for key populations

- Capacity building to help health providers understand how to address sexuality and sexual diversity in service delivery

- Fostering public-private-civil society linkages and networks

- Mobilizing the target population in self-advocacy

- Promoting men's health initiatives

- Acting to reduce stigma and discrimination in the health sector

- Increasing the availability and use of strategic information

- Increasing allocation of resources earmarked for key populations

- Decriminalizing specific behaviors

- Documenting and disseminating promising delivery models and experiences.

PAHO has developed a consensus report on MARPs, implemented a training package on men's health and sexual diversity, and disseminated a "Blueprint for MSM" outlining positive practices. There is a need for concerted and sustained efforts from all stakeholders to maintain a holistic approach for prevention, care, and treatment for MARPs and key populations. Collaborating with other organizations and harmonizing technical approaches will maximize resources and reach. One of the first steps toward these goals is to have the Technical Working Group define ways to follow up the recommendations made in the consensus report and establish relationships with a wide range of stakeholders.

POLICY AND LEGAL ISSUES IN PREVENTION OF HIV AMONG MARPS

Juliette Bynoe-Sutherland, Attorney-at-Law & Head, Policy Analysis Division, PANCAP

Dereck Springer, Strategy and Resourcing Officer (GFATM), PANCAP

Legal and policy responses are required to promote an enabling environment for scaling up prevention initiatives. Approaches should be based on human rights, gender equity, and social inclusion. This will result in the reduction of individual vulnerability and the risk environment driving the epidemic among MARPs.

The policy landscape at the beginning of the HIV pandemic contributed to stigma and discrimination against MARP groups by differentiating between the "general" and "high-risk" populations. The policy objective was to take actions to prevent the spread from the high risk to the general population. It was less important to protect populations that practice high-risk behaviors than preventing spread in the general population.

The impact of these early policies included the failure to effectively include MARPs in national HIV policies, programming, and funding. There was little understanding of the existence of barriers to assessing needs, and conceptualizing how to meet needs was very weak. Inadequate collection of data on the size, location, characteristics of populations, and coverage of MARPs, and inadequate funding for multi-sectoral services and programs for social protection, also meant that legal responses and legislative reform was limited or nonexistent on the national and regional agenda.

The drivers of policy change included the growth of strong regional and national organizations of vulnerable communities that have raised the profile of policy issues around MSM and SWs. Advocacy by PLHIV and MARPs as a result of continued human rights abuses, persecution, and civil violations, and the support of regional organizations, development partners, and U.N. agencies, have resulted in shifting funding priorities, increasing the policy focus on MARPs at the national level. Overall, however, policy change has been slow and existing policies remain weak.

There is now a growing recognition that behavior change approaches to stigma and discrimination against MARPs must be supported by laws and policies that encourage or penalize discriminatory behavior by individuals or organizations. PANCAP, USAID/PEPFAR, and other organizations are promoting policy review to complement existing initiatives to address HIV among MARPs. Legislative amendments need to address multiple needs to provide MARPs access to social services. To strengthen the impetus for change, there need to be resources to empower MARPs to advocate for themselves and petition for their own legal rights.

Numerous organizations have developed potential frameworks for prevention policy and law, including:

- Tracy Robinson of the University of the West Indies proposes a three-part framework based on rights, responsibility, and accountability (to make human rights fundamental to the rule of law).

- Susan Timberlake of UNAIDS recommends that law reform, enforcement, and access to justice be prioritized in national responses, and that legal literacy among MARPs replace generic capacity building in civil society.

- Juliette Bynoe-Sutherland of PANCAP suggests redefining preventive public health interventions and broadening the interpretation of health to include social well-being; this would facilitate funding for social and legal interventions.

- UNAIDS has identified seven key programs to improve the legal and social environment: reforming laws; training police on nondiscrimination; training health care workers on nondiscrimination, procedures, and respect for rights and confidentiality; providing legal services; building legal literacy; building gender equality and reducing violence against women; and reducing HIV-related stigma.

ENABLING ENVIRONMENTS: REGIONAL EXAMPLES

BAHAMAS: CARE IS PREVENTION

Dr. Perry Gomez, Director, National AIDS Programme (NAP)

In the Bahamas, there is legislation in support of HIV prevention. Notification of AIDS (but not of HIV) became mandatory in 1988. Homosexuality was decriminalized in1991, though this had little

effect on prevention. A 2001 law criminalized having sex if a person knows that he or she has HIV. People are still not willing to disclose their HIV status.

The Bahamas NAP, launched in 1985, is centered in the MOH and collaborates with several local NGOs. Outreach for education and prevention of stigma is conducted by the NAP's Resource Committee, a multi-sectoral entity that meets monthly. From 1985 to 1996, PLHIV received counseling and treatment. Provision of ART began in 1996, and the program was scaled up beginning in 2001.

The HIV clinic of St. Margaret's Hospital provides "one-stop shop" services, such as medical care, pharmaceutical supplies, and psychological support for men, women (including pregnant and postpartum women), and children.

ADDRESSING PROVIDER ATTITUDES

Dr. Tina Hylton-Kong, Medical Director, Caribbean HIV/AIDS Regional Training Network, Jamaica

National priorities in Jamaica include increasing the capacity of HIV prevention workers and reducing HIV transmission from PLHIV to their partners. However, discussions with MARPs and PLHIV revealed dissatisfaction related to long waiting times, lack of confidentiality and holistic treatment, and stigma and discrimination—mainly from nonmedical and ancillary staff. The discussions also revealed very limited perception of risks among MARPs—for example, inconsistent condom use among female sex workers.

The Caribbean HIV/AIDS Regional Training (CHART), Jamaica, the National HIV/STI Program, and others conduct training with attitudinal component-values clarification on VCT, stigma and discrimination, confidentiality, human rights, and gender issues. The goal is to reorient providers through training on positive prevention, motivational interviewing, and risk reduction counseling. Methodologies used include: disseminating survey findings on discrimination, testimony from MARPs, site observation and practice with mentors, and role-plays. Nearly 3,000 providers, including nurses, doctors, social workers, community workers, and other types of health workers have attended the training.

An assessment revealed a number of training needs:

- Stronger training in behavior change theories

- Incorporating attitudinal training into the curricula

- Pre-service training

- Resources and systems to support the training.

Last words: The outcome of training depends on behavior change by providers. Mentoring and modeling are just as important as the in-class training; situations occur during shadowing on the job that would not occur in the classroom.

CARIBBEAN REGIONAL NETWORK OF PEOPLE LIVING WITH HIV/AIDS

Yolanda Simon, Executive Director, Caribbean Regional Network of People Living with HIV/AIDS (CRN+)

CRN+ offers a supportive environment to help people meet their needs while allowing them to remain independent. An enabling environment puts systems in place that empower individuals to act for their own benefit or that of others—to be self-reliant. CRN+ was established in the mid-1990s with support from PAHO, WHO, and other international organizations. The network was registered as a nonprofit in 1998 and is headquartered in Port of Spain, Trinidad and Tobago; since then, networks have been established in Jamaica, St. Kitts, Antigua, Guyana, Grenada, and Haiti. Through 2008, CRN+ held annual capacity building workshops for members on advocacy, leadership, empowerment, and other topics. However, since 2008, when World Bank and GFATM support ended, most of the member groups have collapsed.

It has been difficult to identify supportive environments for PLHIV in the Caribbean. Approaches with MARPs are similar to those recommended for PLHIV for years—involve them in planning and programming—but programs have yet to accomplish this effectively. Managers need to examine what needs to be put in place to make sure these programs are successful. There is much discussion about packages of services for MARPs, but too often—for example—service packages for PLHIV were created without consulting the community and were not appropriate or effective. This mistake should not be repeated.

Last words: In the Caribbean region, 70 percent of MARPs are PLHIV; this group must not be alienated.

POSSIBLE WORK BY FAITH-BASED ORGANIZATION LEADERS WITH NEW APPROACHES TO HIV PREVENTION IN THE RESPONSE TO HIV

Ainsley Reid, Greater Involvement of People Living with HIV/AIDS Coordinator, National HIV/STI Programme, National AIDS Committee, Jamaica

The Caribbean Conference of Churches, the development organization for 34 member churches across the Caribbean, conducted a study on whether and how FBOs have addressed HIV. Of 409 questionnaires answered, about half of respondents said that they were working on HIV issues, and another 35 percent indicated willingness to do so. Education and awareness building were the activities most often mentioned, followed by counseling and support. Nearly half (46 percent) of the initiatives were funded by donations; 31 percent of organizations did their own fundraising.

Initiatives that worked well included developing guidelines for FBOs working with HIV, including PLHIV in program management and implementation, and working across religious lines. Positive results in Jamaica included adding lessons on gender and sexuality in the Sunday school curriculum and helping to provide low-cost housing and income-generation opportunities for unemployed women on ART.

The funding environment is constricted at present, especially for the involvement of FBOs. In some instances, some stakeholders in the response to HIV seem to alienate some FBOs without providing them the requisite capacity building and help. Other challenges include the capacity to work with other sectors that hold different values, issues of program management, and sustainability.

Recommendations: National programs should continue partnering with FBO leaders who are ready to deal with less contentious issues such as reaching women with no obvious risk behaviors, who account for one-fourth of new infections in Jamaica. Programs should also seek and continue to build the capacity of leaders in FBOs to engage with other sectors. FBOs should be more involved in multi-sectoral partnerships, as they still have a significant reach. Also, FBOs should be involved in research projects that include M&E. Finally, leaders of FBOs should be involved in crafting and sharing messages of tolerance and acceptance in the context of their faith.

Last words: Some FBO leaders find it difficult to work with HIV prevention because of some of the terms used; they are still uncomfortable with a discussion of sex in public.

COORDINATING DONOR SUPPORT FOR HIV PREVENTION IN THE CARIBBEAN

Morris Edwards, Head, Strategy and Resourcing Division, PANCAP Coordinating Unit

The presentation provided a brief background on PANCAP and addressed some of the harmonization issues around the Caribbean Regional Strategic Framework on HIV and AIDS (CRSF), available prevention resources at the regional level, and lessons learned and challenges.

PANCAP is a partnership of governments; donors; civil society including PLHIV, FBOs, and the private sector; and regional agencies. Its membership extends beyond Caribbean Community states to other countries as well (outside the PEPFAR partnership framework). The European Union supports non-PEPFAR countries (including Organisation of Eastern Caribbean State countries and territories). The U.K. Department for International Development is providing funding to support stigma and discrimination reduction efforts.

PANCAP's coordination is centered on the CRSF. The organization seeks to ensure that national strategic plans and processes are aligned along the 2008–2012 CRSF. There are six priority areas in the framework: an enabling environment; a coordinated, inter-sectoral response; prevention; care, treatment, and support; capacity building; and monitoring, evaluation, and research.

PANCAP prevention goals:

- Preventing sexual transmission of HIV and reducing vulnerability to sexual transmission

- Establishing comprehensive, gender-sensitive, and targeted prevention programs for youth aged 15 to 24

- Achieving universal access to targeted prevention interventions among MARPs

- Providing PMTCT and HIV services to all pregnant women and their families

- Strengthening prevention efforts among PLHIV as part of comprehensive care

- Reducing vulnerability to HIV through early identification and treatment of other STIs.

Last words: There are many donors operating in the Caribbean, but there is insufficient information on actors, activities, and resources supporting prevention efforts. There needs to be more effort and emphasis on information sharing to improve coordination, increase the effectiveness of regional cooperation, and minimize the risk of duplication. Also, more resources need to be allocated to non-HIV conditions, such as STIs.

PANEL DISCUSSION ON COORDINATION, PARTNERSHIPS, AND SUSTAINABILITY

Elden Chamberlain, Most at Risk Populations & Networks Specialist, AIDSTAR-Two (seconded from International HIV/AIDS Alliance)

Lovette Byfield, Director—HIV Prevention, National HIV/STI Program, Jamaica

Helgar Musyoki, Program Manager, Most at Risk Populations and Vulnerable Groups, Ministry of Health and Public Sanitation – Kenya, NASCOP

Suzette Moses-Burton, HIV/AIDS Program Manager, MOH, Development, and Labor, St. Maarten

Panelists representing government agencies, NGOs, international agencies, and MARPs were asked to address the following issues:

- How can we motivate governments and other stakeholders to follow the epidemic and contribute more to prevention for MARPs and OVPs?

- How can we better coordinate and leverage funding and other resources?

- What are the specific roles of different sectors in prevention for MARPs and OVPs?

- How can we support the enhanced roles of different sectors?

- How can we build government and civil society capacity to deliver MARP- and OVP-friendly services?

Funding: A significant amount of money is coming into the Caribbean, but there is a need to know how the money is being spent and what kinds of programs are being funded. Some countries are moving into middle income status, and this has implications for future funding. In some cases, countries that cannot access regional funding build programs and develop innovative ways to mobilize resources from within. Other countries depending on external funding need to learn from this strategy and begin developing partnerships, including public-private partnerships.

Data collection: Stakeholders need to scale-up research and collect information to inform programs. Capturing information must be built into programs.

Sustainability: There is a dilemma of sustainability and how to achieve it. Governments need to have a leading role if any response is to be effective and sustainable, but there are many barriers to this leadership. One strategy is to show the cost of inaction versus action—preventive versus curative work. This approach has helped to convince governments to leverage additional funds for HIV programming.

Cross-sectoral alignment: Programs need to define the respective roles of participating stakeholders and sectors. For example, there is often conflict between the perceptions of the education sector and the health sector. Partners in HIV prevention need to align their programs to avoid duplicating efforts and wasting resources.

Emergency response: Donor funding may be available for emergencies, but over time, governments must take over and sustain activities. There need to be strategies on integrating and funding an emergency response within national planning.

Importance of self-stigma: The issue of self-stigma needs to be taken seriously. The combination of self-stigma among individuals who seek health services and the stigma they experience because of their behaviors limits program efficacy.

Focus on integration: Integration is a long-term goal for all services for MARPs, but integration is a process. Supporting that process requires building strategic relationships to expand services in a time of shrinking resources. Stand-alone services are appropriate during the pilot phase, but all services must be fully integrated to ensure sustainability.

THEMATIC AREA 4: MONITORING AND EVALUATION

The objective of presentations in this thematic area was to underscore the importance of tracking programmatic goals and effects, and highlight effective practices in M&E.

"FIT FOR PURPOSE" HEALTH SYSTEMS STRENGTHENING FOR REDUCING HIV TRANSMISSION IN MOST-AT-RISK POPULATIONS

Elden Chamberlain, Most at Risk Populations & Networks Specialist, AIDSTAR-Two (seconded from International HIV/AIDS Alliance)

AIDSTAR-Two is a USAID-funded contracting mechanism that supports capacity building on behalf of PEPFAR working groups and USAID Missions. Part of its scope of work is to document evidence-based approaches for making services more responsive to the needs of MARPs in Vietnam and Jamaica. Jamaica is a programmatic focus because it faces serious funding shortfalls—only 20 percent of the U.S.$200 million needed to implement its National Strategic Plan for HIV Prevention is available, and funding will diminish further because Jamaica is considered a middle income country. As a major donor to Jamaica's HIV response, PEPFAR wants to ensure that the funding provided will have the largest possible impact.

AIDSTAR-Two focuses on three principles: health system strengthening, a causal framework (identifying the root cause of a phenomenon to find a true solution), and the Pareto principle. The Pareto principle, also known as the 80-20 rule, provides guidance for more efficient programming. This principle assumes that 80 percent of phenomena (such as a specific cause of harm) are fueled by 20 percent of the driving forces (such as risk factors). With adequate M&E, this principle can be applied to programs to identify what is the right program, the right time, the right population, and the right location to achieve maximum results for scarce resources.

WHO identifies six building blocks, or pillars, for health systems:

1. Governance
2. Health work force, including the right mix of providers with the right training and skills
3. Service delivery: are the services provided by the right people?
4. Health information, including accurate current data and evidence to justify programs
5. Medical supplies and logistics
6. Health financing.

There are five key features of programming that are best practices which can influence the structure and function of the health system pillars:

1. Changing how resources are mobilized and allocated and how risks are pooled
2. Changing the organization of financing and the involvement of public and private sectors
3. Changing the payment and incentive structures for providers and consumers, and modifying costs of inputs
4. Using the coercive power of government through policy and regulation
5. Influencing the beliefs, preferences, and behavior of individuals, organizations, and providers.

AIDSTAR-Two recommends peer support and promotion of consistent condom use in two subpopulations: younger, less educated MSM in Kingston, Montego Bay, and Ocho Rios; and younger women who are informal SWs and drug users and their partners in Kingston, St. Catherine, St. Ann, and St. James. When determining what interventions to undertake, programmers should identify the range of cost-effective interventions; determine both the health system requirements and major bottlenecks for implementation; and identify health system strengthening interventions to remove the bottlenecks.

Last words: We are all part of the health system. Strengthening the health system is critical to the success of our work. We cannot do everything; we must prioritize. Finally, a causal analysis can help to develop:

- The right programs (for)
- The right populations (at)
- The right locations (at)
- The right time.

QUESTION AND ANSWER: SUMMARY OF DISCUSSION POINTS

Private sector: Is there a need to examine the role of the private sector and social security systems and link the private and public sectors? In many parts of the world, MSM and SWs will go to the private sector to access providers that they know, rather than using the public system. In 2010, Barbados began trying to tap into the private sector to help build the business development skills of CBOs who are serving MARPs.

Bringing citizens into decision making: How can programs do a better job ensuring the participation of populations in budget decision making and policy change?

Building governmental capacity: PAHO conducted assessments on governance in four countries in the region (the Bahamas, Belize, the Dominican Republic, and Trinidad and Tobago) and found that the governmental capacity to coordinate resources and response across players is very weak and fragmented. Governments need more support to strengthen coordination; the national action plans currently have no capacity for influence. The example from Kenya regarding SWs showed the importance of leadership by the MOH.

Categorization: Individuals who go for services do not necessarily want to be categorized into the groups that programs use (MSM, SWs) and will not tell service providers everything. For example, a man would rather tell the provider that he got a tattoo than that he injected drugs or had sex with another man. This could skew data—but people do have the right not to disclose this information. How is this accounted for when trying to find accurate data for programming? One solution is to ask the right people to collect the information—it might be better to train members of social networks rather than rely on providers. Data will always include underestimates, but there has to be a starting step.

Identifying appropriate data gathering and systems: Programs should look for best practices around information technology and health information systems in the region. It would also be critical to remove silos around health systems (government versus donor versus community sectors): all these systems need to be combined and integrated.

MONITORING AND EVALUATION FOR PROGRAM PLANNING AND QUALITY ASSURANCE

ARE WE WHERE WE WANTED TO GO? MONITORING YOUR PROGRAMS

Irum Zaidi, Epidemiologist, Surveillance Team, Center for Global Health/Division of Global HIV/AIDS, CDC/Atlanta

Program implementation is dynamic and needs to be guided with rigorous monitoring—this is an essential part of program management. Programs need to develop and track indicators to measure change according to the type of program—structural, community, normative, or individual (or all of these). Programs should expect to monitor all inputs and outputs, most processes, some outcomes, and a limited number of impacts or effects, as determined by the intervention. The monitoring can take many forms, from interviews with different stakeholders (including those who are not accessing services) to audits and observational studies.

Routine data should be reviewed to see if the program is moving toward the intended results—and if not, there should be a process evaluation to determine why.

M&E needs to start from both the grassroots level and from the program managers. Not everyone needs to do impact monitoring (this is very expensive), but every project should enhance its own internal monitoring. Input/output and process evaluation monitoring should include some quality assurance. Outcome monitoring is especially important for new interventions to show that they work.

THE CASE OF POPULATION SERVICE INTERNATIONAL CARIBBEAN AND OUR WORK WITH SPANISH-SPEAKING SEX WORKERS IN ANTIGUA

Leah-Mari Richards, Technical Advisor, PSI/Caribbean

PSI Caribbean specializes in social marketing of products and services for HIV prevention, family planning, and maternal and child health through mass media and community-based behavior change communication. The Antigua project described used behavior change communication and peer education to promote condom use among the Spanish-speaking SWs in and around St. Johns.

Monitoring focused on the effect of program exposure on correct condom use (including the female condom) and knowledge about HIV transmission, including the variables that influenced correct condom use and consistent condom use. Measurement of change is based on 16 determinants.

For each of the behavior change communication activities, there is at least one monitor who acts as a quality check to ensure that educational sessions are being conducted as designed and planned by PSI. Sales monitors ensure quality of condom distribution, working with the sales agents to provide condoms to nontraditional outlets.

Between the baseline survey in 2008 and the follow-up in 2010, participants reported significant improvements in indicators on carrying a male condom and using a female condom with a friend or client. Exposure to the intervention was high and was significantly associated with both correct and consistent condom use. Based on follow-up findings, PSI determined programmatic aspects to "tweak": ensuring the availability of condoms where the sex work occurs and continuing the one-on-one interactions with SWs, as this had proven effective in increasing women's confidence in using condoms correctly.

Programs wishing to use this approach must be sure that that their data 1) are representative and align with data on similar groups in other countries; 2) allow a seamless flow from research into programming; 3) involve a sufficiently large sample size to gather valuable information; and (4) are communicated and shared—this leads to cost savings and helps avoid mistakes.

One does not necessarily need an elaborate or electronic system; programs can use paper-based systems once they have identified the data to collect. Quality checks ensure all components of behavior change communication activities are covered. Any result is a good result—even trends that move in the opposite direction of what was planned—the point is to be able to track information and changes. In order to do this, one must continuously train and monitor staff.

Last words: Keep things simple to make sure that the research can actually be used to inform programming.

QUESTION AND ANSWER: SUMMARY OF DISCUSSION POINTS

Sharing data: Anyone can access and use PSI's data—PSI wants to contribute to the national response to HIV. However, some countries are hesitant to publish the data and put it out for public consumption.

Building research capacity: Programs need to use local researchers and build the local capacity to conduct research. To this end, PSI tries to provide additional technical assistance through site visits from staff based in Trinidad.

Harmonizing data needs: Another challenge is how to harmonize the different indicators that different donors want. Donors and programs need to make sure that field personnel have the capacity to obtain both qualitative and quantitative data. Donors should remember that not all data-gathering approaches will work everywhere, especially on the smaller islands where there may only be one person for multiple reporting systems. Data should be country-owned: remember the "Three Ones" principles (UNAIDS 2004):

- One agreed HIV/AIDS action framework that provides the basis for coordinating the work of all partners.

- One national AIDS coordinating authority, with a broad based multi-sector mandate.

- One agreed country level monitoring and evaluation system.

Stakeholders should work toward that on every level. There is also a need to reach out to civil society to see how to incorporate qualitative data at the national level.

M&E costs: Donors should examine the cost of the M&E system and the proportion of budget that should be allocated to M&E versus programs. There may be no need to create a new system if one is already in place in the country. For example, in Jamaica, PSI was able to link to an existing, strong system. Also, while there has been quite a large investment in M&E training and systems, from the regional perspective there is a need to identify each country's challenges for developing effective national data collecting systems and also for analyzing and using data for decision making. It is frustrating to get governments to appreciate the data collected, but then find that they keep information to themselves or create parallel systems. M&E is, and should be seen as, an advocacy tool, not just a report to a funder or a tool for institutions.

COUNTRY/REGIONAL GROUP WORK

Participants were grouped by country and asked to develop action steps for strengthening country-specific prevention programs for MARPs and OVPs. They were asked to incorporate key principles from the meeting and identify areas of need and strategies for adapting and expanding programs for MARPs and OVPs. They were then to identify and report to the larger group proposed actions and commitments, assigning accountability and documenting requests for support and technical assistance to implement country plans.

ANTIGUA AND BARBUDA

Where are they now?

- Collecting data from CHAA on SWs and MSM, but the CHAA office is now closed in Antigua, so services have stopped; collecting data on PLHIV, MARPs (sexual preferences, behaviors) and OVPs.

- Antigua Planned Parenthood projects focus on increasing access to reproductive health services for MARPs.

- Plans and strategies are presently outdated; there is no HIV in the workplace policy.

Where do they need to improve?

- Need to revise data collection tools to obtain data for decision making.

- NAP is the repository for collected data, however, organizations do not share their data with NAP.

- Need assistance developing private-public partnerships.

- Prevention programs for MARPs are imported and are not culturally relevant.

- Need stigma and discrimination policy.

What do they need to improve?

- Need technical assistance in developing M&E tools, basket of services for MARPs.

- Need to convene a meeting with civil society organizations and programs to conduct cost analysis, because the budget was cut by 40 percent.

- Need to eliminate laws that criminalize MSM and SWs.

BAHAMAS

Where are they now?

- Collecting data specific to MSM through the Society Against STIs & HIV, through STI clinics, and through surveys among gay men—but there is a data gap related to SWs.

- Available and affordable health care for all—nobody is denied health care who presents for care, but health care does not target MARPs. National HIV/AIDS Program prevention activities are catching up with treatment and care.

- Laws against discrimination exist, but are not enforced.

Where do they need to improve?

- Do not have a lot of epidemiological data on MARPs.

- Need to improve collaboration with policymakers and NGO officers, especially with groups like the Society Against STIs & HIV, who are very important in data collection.

- Improved enforcement of policies.

What do they need to improve?

- Use data and make data relevant.

- Sensitize health care workers on stigma and discrimination toward MARPs.

- Leverage power of the religious community to work with politics.

BARBADOS

Where are they now?

- Data on four priority groups (youth, MSM, SWs, PLHIV)—knowledge, attitudes, beliefs, and behaviors of youth surveyed every two years with one coming up this year; baseline survey in 2006 and 2007 on SWs; limited data on MSM.

- Scaling up M&E, training providers, and mobilizing communities.

- National HIV prevention plan; disconnect between policy and services (age 16 versus 18 for age of consent); draft legislation on workplace policies.

Where do they need to improve?

- Behavioral seroprevalence survey among MSM is planned, to be followed by SWs.

- Define and document programs better; train health care workers on positive prevention.

- Need to have more dialogue about repealing anti-buggery laws.

- Need to mobilize communities.

What do they need to improve?

- Refocus on groups—partner testing, follow-up.

- Use evidence from meeting on where they want to go and why.

- National program contains components for prevention with positives, need to articulate strategy and develop guidelines, and sensitize health workers to consolidate into a program.

BELIZE

Where are they now?

- Research has been done in the military; behavioral studies have been done—but there has not been a seroprevalence study on MSM or SWs.

- NAP versus civil society.

- Working to revise national operational and strategic plan, involving many stakeholders.

Where do they need to improve?

- Trying to do size estimation.

- National response includes an M&E plan, need to operationalize it.

What do they need to improve?

- Need protective policies for MARPs.

DOMINICA

Where are they now?

- Seroprevalence study conducted in 2010; in the process of conducting a size estimation study; 2006 prisoners study being repeated in 2011; knowledge, attitudes, and practices survey and behavioral surveillance survey conducted in 2005 and 2010; poverty assessment.

- Have been working on MSM sensitization and education sessions; prison officers and inmates get sensitization, education, HIV/STI testing and treatment; providing behavior change sessions for SWs; working with in- and out-of-school youth; behavior change communication and HTC.

- Assessment of ethics and human rights related to HIV conducted in 2005 but still unpublished; workplace policy for private sector, Dominica Teachers' Association, and public sector (in draft form in parliament).

Where do they need to improve?

- Need better data collection systems.

- Target interventions to address MSM needs; develop and disseminate standards.

- Review assessment from 2005 and advocate for informing national policy.

What do they need to improve?

- Additional surveys and studies, vigorous data collection.

- Technical assistance in developing targeted interventions; human and financial resources; training health care workers and peer educators.

- Technical assistance to review 2005 assessment and for policy and legal reform.

DOMINICAN REPUBLIC

Where are they now?

- Collecting services and epidemiological data on MSM and SWs through interventions being implemented; no programs for other target populations.

- Programs organized by and implemented by communities—MSM and SW programs have been evaluated and demonstrate good results; new transgender program; PLHIV programs ongoing; limited programming for drug users; some programs for youth/transactional sex.

- Involvement of the communities in developing policies with the Consejo Presidencial del SIDA (COPRESIDA [The President's Council on AIDS]), increasing the involvement of key populations—good relationship between government and civil society, but limited laws to protect MARPs.

Where do they need to improve?

- Create and implement a comprehensive, harmonized system for M&E; the NGO Centro de Orientación e Investigación Integral (COIN [The Center for Counseling and Research]) has one for MARPs separate from COPRESIDA.

- Coverage of programs is limited, no programs for emerging at-risk populations (mobile populations, drug users, youth).

- Need to continue lobbying for legislation and national commitment to provide resources for programs.

What do they need to improve?

- Build a strong, integrated M&E system.

- Support the existing programs and services instead of creating new ones; create interventions for emerging populations.

- Political support for higher national investment and strategies among partners.

GRENADA

Where are they now?

- Lack of data relevant to MARPs.

- NGOs working with MARPs and OVPs, MOH providing services to MSM and SWs.

- Laws across different areas (age of consent, voting age, marriage age) are inconsistent.

- MOH services provide some services to MSM and SWs.

- More tolerant society toward MSM and SWs.

Where do they need to improve?

- Need size estimation for MARPs and an integrated health management information system.

- Strengthen services—quality, hours of services, and follow-up.

- Need better coordination at the national level; work with two systems of church and state.

What do they need to improve?

- Access to MARPs (for size estimation).

- Target services to key populations; sensitize health care workers.

- MOH needs financial and technical support; include key populations; develop strategy to advocate with key government officials, including for workplans.

GUYANA

Where are they now?

- 2004 and 2008 behavioral surveillance surveys showed decreased prevalence among MSM and SWs as compared to other populations; 2010 qualitative assessment among MSM.

- Since 2001, package of services has included VCT, STI screening and diagnosis, condoms and (recently) lubricants, care, peer education, and home-based care.

Where do they need to improve?

- Need size estimation study; complete UNAIDS modes of transmission study.

- Need specific materials developed for MSM distributed through peer network education; expand focus on STI screening and treatment; and expand VCT referral system (especially for SWs).

- Pressure from religious community has blocked final approval from the president to abolish a law allowing the death penalty on anti-buggery laws (on books but not being implemented).

What do they need to improve?

- Develop more specific programs designed to reach variations in MSM subcategories; develop strong partnerships to reach MARPs—private sector involvement can help get condoms to remote areas; build capacity of health care workers.

- Establish a condom and lubricant distribution policy.

HAITI

Where are they now?

- Post-earthquake effects.

- Have some MSM and SW information, but data collection is not done in a coordinated or systematic way.

- Scattered, small programs centered around major towns trying to increase condom use; behavior change communication efforts based in clinics targeting MARPs and OVPs.

- Policies very scattered, NGOs moving in various directions.

Where do they need to improve?

- More information on MARPs and OVPs—research planned.

- Coordinate and standardize services and messages; refer for services.

What do they need to improve?

- See PrevSIDA plan.

- Ideally, a strong central government; realistically, better harmonization among donors.

JAMAICA

Where are they now?

- Collecting information—quite a few ongoing studies looking at HTC outreach, MARPs, and some surveys of health care attitudes.

- National strategy informed by all stakeholders, including MARPs.

Where do they need to improve?

- Some subsectors of MARPs are not represented (transgender people, male SWs, PLHIV); needs a better understanding of emerging populations (massage parlor-based SWs).

- Social services need strengthening; capacity building packages from funders are not responsive to needs, so should make them locally-relevant; respond to emerging groups (adolescent MSM).

- Develop a road map for MARPs and OVPs.

What do they need to improve?

- Gather more information.

- Move from policy papers to informed action at all levels; shift from youth focus to MARP focus.

- Partnerships with key stakeholders, including ministries and religious groups, for coordination and strategy building; integrate health and education efforts; coordinated, holistic strategy around HIV.

ST. KITTS AND NEVIS

Where are they now?

- Limited epidemiological data on MARPs and OVPs but do have some behavioral data based on the behavioral surveillance survey and CHAA work; some knowledge, attitudes, behaviors and practices information pending.

- Medical act sitting in parliament pending ratification.

Where do they need to improve?

- Mapping exercise for MARPs; making M&E framework useful (advance from draft form).

What do they need to improve?

- Form an M&E committee; revise HTC procedures to capture behavior, which also requires revising intake forms.

- Build capacity to sustain programs; look at best practices around the Caribbean to adopt locally.

- Shift to a public health approach where a person's human rights are first and foremost for health and society.

ST. LUCIA

Where are they now?

- Two studies of crack cocaine users (behavioral and seroprevalence); one seroprevalence study on prisoners in 2004; 2010 knowledge, attitudes, and practices survey.

- World Bank was funding programs but that has stopped; civil society reaching brothel- and dance hall-based SWs and work with homeless drug users; PLHIV group working on PHDP and integrating PLHIV.

- Advocacy efforts for abolition of anti-buggery law.

Where do they need to improve?

- Need data on MSM and SWs.

- Task shifting to move away from only health providers giving services; take testing to communities.

- More consistency between ministries and across ministries to brief their staff.

What do they need to improve?

- MSM and SW behavioral and seroprelavence study; move toward surveillance instead of random surveys; more collection tools, better training, and integrate data collection efforts (which has been independent of epidemiological department) for sustainability; planning research.

- Fund additional positions; recruit and train community members to provide services; establish outreach for HTC—better utilization of resources and sharing resources; make services friendlier.

- Meet with ministries of foreign affairs; vote along with policy that protects (need to inform government representatives to represent laws of the government instead of their own views); advocate for the end of prohibition, bring a public health approach, and decriminalize behaviors (would allow for SWs to plan for retirement, moving from sex work).

ST. VINCENT AND THE GRENADINES

Where are they now?

- CHAA conducted survey.

- CHAA and PSI have been working with MSM and SWs; MOH has been working with OVPs (prisoners) for outreach activities and VCT; Ministry of Education and civil society organization partners have worked with youth.

- Policy guidelines for counseling and testing; working on contact tracing guidelines and national HIV and workplace policies.

Where do they need to improve?

- Knowledge, attitudes, behaviors, and practices survey needs to be repeated among youth; prisoner seroprevalence survey needs to be improved including behavioral information; mapping of SWs, MSM seroprevalence, baseline data among prisoners needed.

- CHAA should be providing behavior change interventions among MARPs and mobilizing HTC; strengthen support groups and outreach—more work in the Grenadine islands overall.

- Repeal anti-buggery laws; gather more information on target communities regarding concerns about accessing care and impact of policies.

What do they need to improve?

- Technical and financial assistance to conduct studies (including mapping and size estimation); work with partners to strengthen quality of reporting for national indicators; need a national M&E person.

SURINAME

Where are they now?

- Two size estimation studies for MSM (2005, 2010) and for SWs; one study has been done for prisoners but is out of date; no prevalence data available on OVPs—data is being used for program planning purposes.

- Outreach and psychosocial care.

- No national-level policies for MARPs, but there is a national strategic plan.

Where do they need to improve?

- Improvement of M&E systems; more data on OVPs; more surveys to collect information, including qualitative data.

- Evidence-based planning; scaling up access to services.

- Develop policies specifically for MARPs.

What do they need to improve?

- Technical assistance for data collection; more capacity building for youth to utilize information; partnerships between MOH, donors, and private sector.

- Strengthen programs.

- Policies to address stigma and discrimination to lay actions for sanctions against human rights.

- Will report the findings of this summit to the National HIV Board, NAP, and MARP and OVP organizations to generate commitment among stakeholders.

TRINIDAD AND TOBAGO

Where are they now?

- Some qualitative studies have been conducted by individuals but are unpublished and have not been used for programming.

- Legal and policy barriers.

Where do they need to improve?

- Disaggregate data to include specific information on MARPs and OVPs; focus on value of program M&E; value data collection and focus on harmonization and data analysis.

- MARPs programs need to be monitored.

- Strengthen partnerships and policies to address MARPs and OVPs; revise these policies.

What do they need to improve?

- MARPs study being planned; standardize data collection tools, collaboration, and coordination.

- Human and financial resources; improved referral system; develop package of services appropriate to MARPs and OVPs in national programming.

- Build capacity of civil society and MARP groups; develop and distribute policies to address MARPs and provide technical guidance to develop these policies.

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APPENDIX 1:

AGENDA

CARIBBEAN REGIONAL HIV PREVENTION SUMMIT ON MOST-AT-RISK POPULATIONS AND OTHER VULNERABLE POPULATIONS

NASSAU, BAHAMAS, MARCH 15–17, 2011

GOALS:

1. To have international and regional technical experts in HIV prevention programming and research describe the context of HIV infection in the region and share evidence-based interventions and promising practices in HIV prevention programming aimed at reducing HIV acquisition and transmission among most-at-risk populations (MARPs) and other vulnerable populations (OVPs) in the Caribbean region.

2. To identify areas for expansion and integration of evidence-based interventions in extant prevention programs targeting MARPs and OVPs, including people living with HIV (PLHIV).

3. To encourage partnerships and determine priority areas where further technical assistance is needed to support the prevention goal of the Caribbean Regional Partnership Framework.

THE OBJECTIVES OF THE SUMMIT ARE TO:

1. Review current epidemiologic data on HIV in the Caribbean region, which will highlight the key drivers of the epidemic and the behavioral, social, and cultural factors that contribute to the spread of HIV. Identify data that is needed to inform programs and strategies needed to obtain data.

2. Present technical updates on key evidence-based interventions and the minimum package of services targeted toward MARPs and OVPs.

3. Present and discuss examples of best practices of HIV prevention programs for MARPs and OVPs in the Caribbean and elsewhere.

4. Present and discuss structural barriers to effective prevention and interventions that create an enabling environment for MARPs and OVPs to access services in the Caribbean.

5. Identify areas for adaptation/expansion of existing prevention programs to integrate evidence-based strategies and best practices to increase the likelihood of reducing incident infections in MARPs.

TUESDAY, MARCH 15

Time	Estimated Time	Topic	Presenter/ Facilitator	Comments/Details
Welcome and Introductions				
8:00 a.m.	30 minutes	Welcome and opening remarks	The Honorable Dr. Hubert A. Minnis, Bahamas Minister of Health Ambassador Avant, U.S. Embassy	
8:30 a.m.	10 minutes	Purpose and expected outcomes	Facilitator: Peter Weller (Trinidad and Tobago)	
Thematic Area 1: Know Your Epidemic—Snapshot of the HIV Epidemic in the Caribbean				
8:40 a.m.	40 minutes	Know Your Epidemic: Regional overview with country-specific data (where available)	Bilali Camara, UNAIDS Trinidad and Tobago	Presentation will provide a review of epidemiological data, key drivers, and behaviors that contribute to high rates of HIV infection among MARPs and OVPs.
9:20 a.m.	40 minutes	Who are the MARPs and OVPs?	Clancy Broxton, USAID Washington	Presentation will define MARPs and OVPs and the variation within the different categories and describe the need for an appropriate prevention response and other implications for programming.
10:00 a.m.	30 minutes	Q&A/Discussion on Know Your Epidemic and Who are the MARPs and OVPs	Lead Facilitator: Peter Weller Technical Lead: Billy Pick	Possible discussion questions: • What are the knowledge and information gaps related to understanding the epidemic among MARPs and OVPs? • What information do we need to know about MARPs and OVPs?
10:30 a.m.	15 minutes	**BREAK**		
10:45 a.m.	15 minutes	Q&A/Discussion continued for Know Your Epidemic and Who are the MARPs and OVPs	Lead Facilitator: Peter Weller Technical Lead: Billy Pick	Because MARPs and OVPs tend to have higher rates of HIV than other groups in the Caribbean, are we focusing our programs appropriately to work with them? If not, what do we need to do to concentrate more of our resources on prevention with MARPs and OVPs?
11:00 a.m.	30 minutes	What constitutes a strategic response for MARPs?	Karina Rapposelli, CDC Atlanta	Presentation will review existing and upcoming PEPFAR guidance for implementation of MARPs programs and introduce the following core components of a strategic response for MARPs: measurement approaches, enabling environment, capacity building, minimum package of services, scaling up, and monitoring and evaluation.

Time	Estimated Time	Topic	Presenter/ Facilitator	Comments/Details
11:30 a.m.	30 minutes	Q&A/Discussion on strategies for MARPs	Lead Facilitator: Peter Weller Technical Lead: Billy Pick	Possible discussion questions: • What experiences do you have with these strategies for MARPs in your country? • Are the strategies for each of these populations feasible to implement in your country? Why or why not?
12:00 p.m.	60 minutes	*LUNCH*		
1:00 p.m.	20 minutes	What constitutes a strategic response for OVPs?	Jaevion Nelson, JFLAG (Jamaica)	Presentation will define OVPs and the variation within the different categories, with concrete examples of each (e.g., women and girls) and describe the need for an appropriate prevention response/minimum package of services, enabling environment, capacity building, and monitoring and evaluation.
1:20 p.m.	10 minutes	Q&A/Discussion on strategies for OVPs	Lead Facilitator: Peter Weller Technical Lead: Clancy Broxton	Possible discussion questions: • How can we better target HIV prevention services to OVPs such as migrant populations and high-risk youth in the Caribbean? • Are there other examples of successful programming for vulnerable populations in the Caribbean that participants would like to share?
1:30 p.m.	30 minutes	Know Your Response: • How data informs programming for MARPs, etc. • Data and information gaps • Methods for getting data and information	Irum Zaidi, CDC Atlanta	A series of presentations will describe theoretical approaches and application: 1. How data is being used to inform and improve prevention programs for MSM, SWs, OVPs, and PLHIV. 2. What are the data and information gaps? What additional information do we need to know about MARPs and OVPs in the region to program appropriately? 3. Describe methods for getting information such as mapping, size estimation, rapid assessments, and behavioral surveillance surveys.

Time	Estimated Time	Topic	Presenter/ Facilitator	Comments/Details
2:00 p.m.	45 minutes	Know Your Response— Country examples, using data for program planning for MARPs and OVPs • Country A on MSM (25 min) • Country B on SWs (20 min)	MSM example: Lovette Byfield, MOH (Jamaica) SW example: Helgar Musyoki, NASCOP (Kenya)	Complementing the previous session, presentations will be from countries (international or regional) who can describe how they have used their data to plan their program and the impact it has had, providing concrete examples to follow. Note that international examples will need to tie in similarities with the Caribbean to ensure presentation resonates with participants.
2:45 p.m.	15 minutes	**BREAK**		
3:00 p.m.	30 minutes	Q&A/Discussion for Know Your Response session and supporting country presentations	Lead Facilitator: Peter Weller Technical Lead: Karina Rapposelli	Possible discussion questions: • How is data being used to inform and improve prevention programs for MARPs in your countries? • What other data or information (in the absence of data) is being used to inform prevention programs? • How does this data and information help your programs? • What is being done to measure your response?

Thematic Area 2: Expanding prevention interventions and services for most-at-risk populations and other vulnerable populations

Time	Estimated Time	Topic	Presenter/ Facilitator	Comments/Details
3:30 p.m.	60 minutes	Comprehensive package of prevention services for MARPs and OVPs	Clancy Broxton and Karina Rapposelli, USG/HQ	Presentation will detail in depth the generic comprehensive package of services for MARPs and OVPs by summarizing the evidence, providing examples of program advocacy and implementation in other countries, and mapping the package to combination prevention (e.g., framework that includes biomedical, behavioral, and structural interventions).
4:30 p.m.	15 minutes	Country examples— implementing comprehensive package of services for MARPs	MSM example: Giovanni Melendez, USAID (Guatemala)	

Time	Estimated Time	Topic	Presenter/ Facilitator	Comments/Details
4:45 p.m.	25 minutes	Q&A/Discussion	Lead Facilitator: Peter Weller Technical Lead: Kelly Wolfe	Possible discussion questions: • What challenges and successes have you encountered with implementing a comprehensive package of services for MARPs in your country? • In order for my country to provide a comprehensive package of services for MARPs in my country, we would need to: _____?

WEDNESDAY, MARCH 16

Time	Estimated Time	Topic	Presenter/ Facilitator	Comments/Details
Welcome to Day 2				
8:30 a.m.	10 minutes	Welcome back and review agenda	Peter Weller (Lead Facilitator)	
Thematic Area 2: Expanding prevention interventions and services for most-at-risk populations and other vulnerable populations (continued)				
8:40 a.m.	60 minutes	Specific strategies for increasing prevention services for MARPs: • Peer outreach and community-based programs (15 minutes) • HIV testing and counseling (e.g., mobile and venue-based, facility-based such as PITC) and linkages to care and treatment (15 minutes) • Prevention with Positives (15 minutes)	Peer outreach: Dylis McDonald, CHAA (Trinidad and Tobago) HTC: Stephanie Behel, CDC Atlanta PWP: Pam Bachanas, CDC Atlanta	Panel format: Technical experts will present on a few of the evidence-based interventions that make up the comprehensive package of prevention services. Each presentation will cover the technical aspects of the program and key considerations for increasing services for MARPs in the Caribbean region.

Time	Estimated Time	Topic	Presenter/ Facilitator	Comments/Details
9:40 a.m.	20 minutes	Q&A/Discussion	Lead Facilitator: Peter Weller Technical Lead: Julie Chitty	Possible discussion questions: • What would an HTC strategy entail for your country? What does it entail now and where would you like it to be in the next year? • What more do we need to do to reach MARPs with HTC? • Are prevention services routinely offered to PLHIV as part of their regular care and support services? If not, what can we do to encourage that it be part of their regular care and support services? • What examples do we have of governments focusing their PWP work on MARPs and OVPs? What can we do to further encourage them to focus on these groups? • Are we using peer or lay counselors in the Caribbean to work with PWP? If so, what do we know about our successes and failures (if any) in doing this?
10:00 a.m.	15 minutes	***BREAK***		
10:15 a.m.	60 minutes	International and regional best practices: • MSM and high-risk youth programs (20 minutes) • SW programs (10 minutes) • PLHIV programs (10 minutes) • Drug users (10 minutes)	Countries A & E (MSM/Youth): Rashad Burgess, CDC Division of HIV/AIDS Prevention (U.S.) Country B (SWs): Dr. Johane Philogene-Nonez (Haiti) Country C (PLHIV): Dr. Christoforos Mallouris, GNP+ (Netherlands) Country D (drug users): Marcus Day, Caribbean Drug Abuse Research Institute (St. Lucia)	Each presentation should describe a county's successful prevention program targeting one of the MARPs of interest. Presenters should focus on the process, strategy, motivators, and challenges. Presentations for this section will not necessarily be limited to regional examples and should be concrete examples of programs, not theoretical approaches.

Time	Estimated Time	Topic	Presenter/ Facilitator	Comments/Details
11:15 p.m.	45 minutes	Q&A/Discussion	Lead Facilitator: Peter Weller Technical Leads: Karina Rapposelli and Pam Bachanas	Possible discussion questions: • How do we change perceptions in the region about the role that PLHIV can play in the prevention response? • How do we encourage more PLHIV to engage in the response? • What are the programmatic linkages being made between HIV and drugs in your respective countries? • What can be done to encourage greater involvement from governments in interventions, strategies, and approaches to address the needs of MARPs? • How acceptable would these types of interventions be in the Caribbean context given the level of stigma and discrimination as well as the legal issues around homosexuality?
12:00 p.m.	60 minutes	*LUNCH*		

Thematic Area 3: Enabling environments—challenges and opportunities for strengthening access to prevention and care for most-at-risk populations and other vulnerable populations

Time	Estimated Time	Topic	Presenter/ Facilitator	Comments/Details
1:00 p.m.	60 minutes	Enabling environments and their impact on HIV prevention among MARPs and OVPs • Stigma and discrimination (20 minutes) • Attitudes and access to services (20 minutes) • Policy and legal (20 minutes)	Stigma and discrimination: Ken Morrison, Futures Group (Mexico) Attitudes and access to services: Amalia Del Regio, PAHO (Trinidad and Tobago) Policy and legal: Dereck Anthony Springer, PANCAP (Guyana)	Presenter(s) should discuss the influence of the policy and legal environment, stigma and discrimination, access to services, and attitudes on HIV prevention with MARPs and OVPs. This session provides a theoretical basis for the following panel presentations.

Time	Estimated Time	Topic	Presenter/ Facilitator	Comments/Details
2:00 p.m.	60 minutes	Regional examples—enabling environments: • Country presentation 1: Bahamas supportive law regarding MSM and impact on programs and services (15 minutes) • Country presentation 2: Addressing provider attitudes (15 minutes) • Country presentation 3: suggestion (15 minutes) • Country presentation 4: possible work by religious leaders (15 minutes)	Country 1: Perry Gomez, Bahamas NAP (Bahamas) Country 2: Tina Hylton-Kong, MOH (Jamaica) Country 3: Yolanda Simon, CRN+ (Trinidad and Tobago) Country 4: Ainsley Reid, MOH (Jamaica)	Presentations should provide concrete examples to describe how countries from the region have successfully addressed policy, stigma and discrimination, access to prevention services, and providers' attitudes toward MARPs and OVPs.
3:00 p.m.	15 minutes	***BREAK***		
3:15 p.m.	30 minutes	Q&A/Discussion (wrap-up enabling environment)	Lead Facilitator: Peter Weller Technical Lead: Lindsay Stewart	Possible discussion questions: • What are the sociocultural and legal issues related to working with MARPs and OVPs in the Caribbean and how might we better address them? • What are the practical interventions, strategies, and approaches that can be employed to address the attitudes of health care providers that perpetuate stigma and discrimination—beyond sensitization training? • What can be done to decrease stigma and discrimination and facilitate a more enabling environment?

Time	Estimated Time	Topic	Presenter/ Facilitator	Comments/Details
3:45 p.m.	50 minutes	PANCAP presentation of donor funding and prevention activities in the region (15 minutes) Panel discussion on coordination, partnerships, and sustainability	Morris Edwards, PANCAP (Guyana) Elden Chamberlain, AIDSTAR-Two (Washington, DC) Lovette Byfield, MOH (Jamaica) Helgar Musyoki, NASCOP (Kenya) Suzette Moses-Burton, NAP (St. Marteen)	Panel consists of persons from MOHs, NGOs, CBOs, UNAIDS, MARPs, U.S. Government donors, and GFATM. Example of discussion points: • How can we motivate governments and other stakeholders to follow the epidemic and contribute more to prevention for MARPs and OVPs? • How can we better coordinate and leverage funding and other resources? • What are the specific roles of different sectors in prevention for MARPs and OVPs? • How can we support the enhanced roles of different sectors? • How can we build government and civil society capacity to deliver MARP- and OVP-friendly services?
4:35 p.m.	20 minutes	Q&A/Discussion	Lead Facilitator: Peter Weller Technical Lead: Kendra Phillips	Possible discussion questions: • What system strengthening actions are most cost-effective? • What are the health system requirements for high coverage, and what are the bottlenecks that impede reaching those coverage levels? • How can we address issues and gaps in our prevention programs? What resources are needed to address issues and gaps?

THURSDAY, MARCH 17

Time	Estimated Time	Topic	Presenter/ Facilitator	Comments/Details
Welcome to Day 3				
8:30 a.m.	10 minutes	Welcome back and review agenda	Peter Weller (Lead Facilitator)	
Thematic Area 4: Monitoring and evaluation				
8:40 a.m.	20 minutes	Health systems strengthening	Elden Chamberlain, AIDSTAR-Two (Washington, DC)	

Time	Estimated Time	Topic	Presenter/ Facilitator	Comments/Details
9:00 a.m.	10 minutes	Q&A/Discussion	Lead Facilitator: Peter Weller Technical Lead: Kendra Phillips	Possible discussion questions: • What are the health system requirements for high coverage, and what are the bottlenecks that impede reaching those coverage levels? • What system strengthening actions are most effective? • How should we measure progress (indicators) that link health system strengthening to reduced incidence?
9:10 a.m.	45 minutes	Monitoring and evaluation for program planning and quality assurance: • Irum Zaidi's presentation (20 minutes) • Leah Richards' presentation (25 minutes)	Irum Zaidi, CDC Atlanta Leah-Mari Richards, PSI (Trinidad and Tobago)	Presentation(s) should describe: • How are we measuring our programs? • How should the data be used to inform programs? • What are the tools for M&E prevention programs? • How do special studies inform M&E?
9:55 a.m.	15 minutes	**BREAK**		
10:10 a.m.	20 minutes	Q&A/Discussion	Lead Facilitator: Peter Weller Technical Lead: Stephanie Behel	Possible discussion questions: • What are we doing to measure our prevention efforts? • What is being done to ensure the quality of data collected? • How can we improve our ability to measure the impact of prevention activities?
10:30 a.m.	120 minutes	Country workgroups: Develop action steps for strengthening prevention programming for MARPs and OVPs	No presenters—workgroup	Incorporate key principles from the meeting and identify areas of need and strategies for adapting and expanding programs for MARPs and OVPs. Participants will have been prompted to think about this session prior to attending the meeting.
12:30 p.m.	90 minutes	**LUNCH–Brown bag presentation by Dr. Allyson Leacock**		
2:00 p.m.	75 minutes	Report backs from program planning workgroup	Facilitated by member of the Summit Planning Committee	Making commitments, assigning accountability, and documenting requests for support and technical assistance to implement country plans.
3:15 p.m.	15 minutes	Closing remarks	Lead Facilitator: Peter Weller	

APPENDIX 2:

PARTICIPANTS

Contact Name	Country	Organization
Armour, Dr. Brian	Trinidad and Tobago	Ministry of Health
Babb, Dr. Dale	Barbados	Ministry of Health
Bachanas, Pam *(Presenter)*	United States	CDC/Prevention Branch
Baptist, Mr. Nahum Jn	St. Lucia	National AIDS Program Secretariat, Ministry of Health, Wellness, Family Affairs, National Mobilization, Human Services and Gender Relations
Barnett, Lady Camille	Bahamas	
Behel, Stephanie *(Presenter)*	United States	CDC/Prevention Branch
Bergmann, Heather	United States	AIDSTAR-One (JSI)
Bethel, Mr. Tellis		
Bowleg, Mrs. Paula	Bahamas	
Brotherson, Rev. Karen	Antigua and Barbuda	Health, Hope, HIV Network, Ministry of Health
Brown, Princess	Jamaica	Sex Worker Association of Jamaica (SWAJ)
Broxton, Clancy *(Presenter)*	United States	USAID
Burgess, Rashad *(Presenter)*	United States	CDC/OID/NCHHSTP
Byfield, Ms. Lovette *(Presenter)*	Jamaica	National HIV Program
Cabanos, Eliocedy	Belize	National AIDS Commission
Caldeira, Ellen	United States	U.S. State Department
Camara, Dr. Bilali *(Presenter)*	Trinidad and Tobago	UNAIDS
Carty-Caines, Mrs. Nadine	St. Kitts and Nevis	Ministry of Health-Nevis
Catalyn, Mr. James	Bahamas	
Chamberlain, Eldon *(Presenter)*	United States	
Charles, Mr. Terry	Grenada	National AIDS Council
Chitty, Julie	Barbados	CDC
Clarke, Fay	Barbados	DOD
Cowan, Lisa	Barbados	DOD HIV/AIDS Prevention Program
Dahl-Regis, Dr. Merceline	Bahamas	Ministry of Health
Davis, Ms. Angela	Barbados	USAID
Day, Dr. Marcus *(Presenter)*	St. Lucia	Caribbean Drug and Alcohol Research Institute
Dear, Mr. Darcy	Barbados	UGLAAB
Del Regio, Dr. Amalia *(Presenter)*	Trinidad and Tobago	PAHO/PHCO
Desabaye, Angela	Dominica	Fouche La Vie (Life Support)

Contact Name	Country	Organization
Destang-Richardson, Mrs. Gardenia	St. Kitts and Nevis	Ministry of Health-St.Kitts
Deveaux, Ms. Lynette	Bahamas	
Douglas, Ms. Muriel	Trinidad and Tobago	Tobago HIV/AIDS Coordinating Committee Secretariat
Edwards, Ms Mirriam	Guyana	Caribbean Sexworker Coalition
Edwards, Dr. Morris *(Presenter)*	Guyana	Pan Caribbean Partnership Against HIV and AIDS
Estime, Wenser MD MSc	Haiti	USAID/Haiti
Frampton, Mrs. Julie	Dominica	Ministry of Health and Social Security
Ganesh, Jennifer	Guyana	
Gayle, Jacob	United States	
George, Edris	Guyana	USAID/Guyana
Goede, Hedwig	Suriname	National AIDS Program, Ministry of Health
Gomez, Dr. Perry *(Presenter)*	Bahamas	National AIDS Program Secretariat-Ministry of Health
Gunter, Marvin	Jamaica	U.N. Population Fund
Hamilton, Dr. Del	St. Vincent and the Grenadines	National AIDS Secretariat, Ministry of Health and the Environment
Henry, Dr. Jessie	Grenada	Ministry of Health
Hylton-Kong, Dr. Tina *(Presenter)*	Jamaica	Caribbean HIV/AIDS Regional TrainingNet Work
Jervis, Ms. Marva	Bahamas	
Johnson, Ms. Camille	Bahamas	Ministry of Health
Leacock, Allyson *(Presenter)*	Barbados	Caribbean Broadcast Media Partnership on HIV/AIDS
Lewis, Yolanda	St. Lucia	CDC-CRO
Lopez, Carla	Haiti	PSI-Haiti
Lyons, Nyla	Trinidad and Tobago	CDC-CRO
Mallouris, Dr. Christoforos *(Presenter)*	United Kingdom	GN+
Mathlin, Mr. Nigel M. G.	Grenada	GrenCHAP
McDonald, Dylis *(Presenter)*	Trinidad and Tobago	Caribbean HIV/AIDS Alliance
McKnight, Mr. Ian *(Alternate Presenter)*	Jamaica	Caribbean Vulnerable Communities Coalition
Melendez , Giovanni *(Presenter)*	Guatemala	USAID
Minnis, The Honorable Dr. Hubert A.	Bahamas	Ministry of Health
Moore, Sally	Bahamas	American Red Cross Caribbean HIV/AIDS Project
Morris, Terry	St. Kitts and Nevis	St. Kitts Caribbean Healthy Lifestyles Programme
Morrison, Ken *(Presenter)*	Mexico	Futures Group

Contact Name	Country	Organization
Moses-Burton, Mrs. Suzette *(Presenter)*	St. Marteen	Caribbean Regional Network of People Living with HIV/AIDS
Mutua, Helgar *(Presenter)*	Kenya	National AIDS/STI Control Programme
Nelson, Jaevion *(Presenter)*	Jamaica	Advocates for Youth, the Jamaican Youth Advocacy Network, and JFLAG
Orozco, Caleb	Belize	United Belize Advocacy Movement
Parris, Janey	Trinidad and Tobago	CDC-CRO
Philip, Daryl	Dominica	CHAP Dominica (MSM)
Phillips, Kendra	Barbados	USAID
Philogene-Nonez MD, Johane *(Presenter)*	Haiti	FOSREF
Pick, Billy	United States	USAID
Ramirez, Santo Rosario	Dominican Republic	COIN-One Love (Centro de Orientación e Investigación Integral)
Rapposelli, Karina *(Presenter)*	United States	CDC/Prevention Branch
Reid, Ainsley *(Presenter)*	Jamaica	National HIV/STI Program
Reyes, Elfryn	Belize	DOD
Richards, Leah-Mari *(Presenter)*	Jamaica	PSI
Richardson-Pious, Claudette	Jamaica	Children First (MSM program)
Rolle, Sister Clare	Bahamas	
Rollins, Victor	Bahamas	Society Against STI/HIV
Rosseau, Mrs. Sheila	Antigua and Barbuda	Gender Affairs
Saleh-Ramírez, Aysa	United States	AIDSTAR-One (JSI)
Saunders, Dr. Francis	Bahamas	DOD
Saunders, Verlene	St. Vincent and the Grenadines	St. Vincent Planned Parenthood Association
Simon, Ms. Yolanda *(Presenter)*	Trinidad and Tobago	Caribbean Regional Network
Smith, Lara	Belize	PASMO
Smith, Sandra	Bahamas	
Springer, Dereck Anthony *(Presenter)*	Guyana	PANCAP
Stewart, Lindsay	United States	USAID/LAC/RSD
Swann, Dr. Phillip	Bahamas	CDC-CRO
Tavarez, Dr. Yira	Dominican Republic	Vice Ministry for Community Health
Thompson, Lisa	Barbados	USAID
van Emden, Kenneth	Suriname	Suriname Men United
Wilkes, Shirley	St. Kitts and Nevis	Health Promotion Unit, Ministry of Health
Weller, Peter *(Facilitator)*	Trinidad and Tobago	
Williams, Ms. Delcora	Antigua and Barbuda	National AIDS Secretariat
Wiltshire-Gay, Dr. Jacqueline	Barbados	National HIV/AIDS Commission
Wolfe, Kelly	United States	USAID/GH/OHA

Contact Name	Country	Organization
Zaidi, Irum *(Presenter)*	United States	CDC/SI Advisor
Zilber, Catherine Hastings	Jamaica	USAID

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