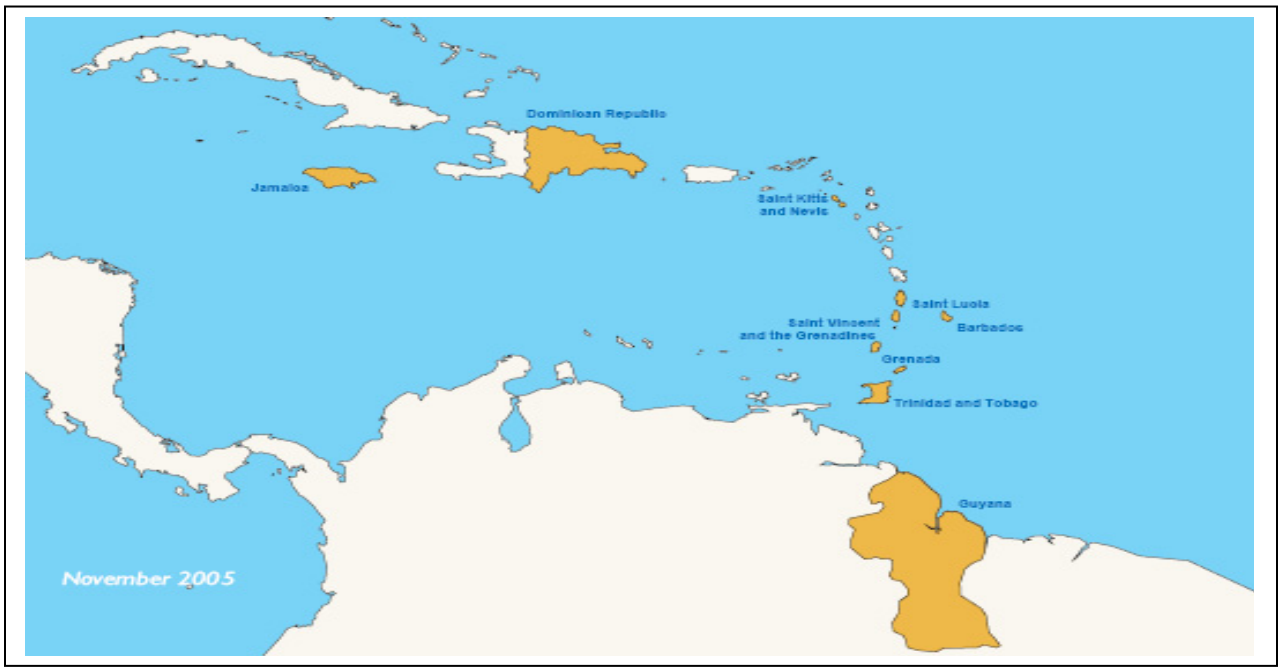
FINAL REPORT

Horizontal Technical Cooperation Group (HTCG)

A Caribbean Sub-regional Situation Analysis on Sex work and HIV February, 2007



Presented by
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A Caribbean Sub-regional Situation Analysis on Sex work and HIV

[1] This was the slogan of the first International Sex Workers' Millenium Mela, an important sex workers' conference that took place in March 2001, in Kolkota (Calcutta), India.

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Acknowledgment

Special thanks is given to the entire AIDInc team for their commitment to teamwork in pulling this analysis together, in particular Maisha Emtage and Susan Lewis. The authors are indebted to the participation and provision of information by key researchers, planners and advocates who all provided valuable information and insight into this analysis. Thanks especially to Marlene Taylor and Juanita Altenberg. In addition we are extremely grateful to the sex workers themselves. Where possible, it is a collection of their viewpoints that has been expressed in the paper through various recent regional studies, through their advocates and through consultation by the author. Not least, Thanks is extended to the DFID team Jane Armstrong, Malcolm McNeil and Miranda Munro for their support and feedback.

Acronyms and Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
AED	Academy of Educational Development
ART	Antiretroviral Treatment
ARV	Antiretroviral
CAREC	Caribbean Epidemiology Centre
CARICOM	Caribbean Community and Common Market
CBO	Community Based Organisations
COIN	Centro de Orientación e Investigación Integral
CORVICOSDA	Comité de Vigilancia y Control del SIDA
CSME	Caribbean Single Market (and Economy)
CSO	Civil Society Organization
CSW	Commercial Sex Worker
DFID	Department for International Development
DR	Dominican Republic
FHI	Family Health International
FBO	Faith Based Organizations
GHESKIO	Group Haitian d'Etude du Sarcome de Kaposi et des Infections Opportunistes
GFATM/GF	Global Fund to Fight AIDS, TB, and Malaria
IOM	International Organisation for Migration
M&E	Monitoring and Evaluation
MAP	Multi-Country HIV/AIDS Program
MODEMU	Movimiento de Mujeres Unidas (Modemu)
MOH	Ministry of Health
MSM	Men who have Sex with Men
NAC	National HIV/AIDS Council or Commission
NAS/NAD	National HIV/AIDS Secretariat or Directorate
NGO	Non-Governmental Organization
NSP	National Strategic Plan
OECS	Organization of Eastern Caribbean States
PAHO	Pan American Health Organization
PANCAP	The Pan Caribbean Partnership Against HIV/AIDS
PASMO	Pan American Social Marketing Organisation
PEPFAR	US President's Emergency Plan for AIDS Relief
PLWHA	People Living with HIV/AIDS
PLHIV	People Living with HIV/AIDS
PMTCT	Prevention of mother to child transmission
PSI	Population Services International
QoL	Quality of Life
SMLA	Stitching Maxi Linder Association
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
SW	Sex workers
UNAIDS	Joint United Nations Programme on HIV/AIDS
UWI	University of West Indies
VCT	Voluntary Counselling and Testing
WB	World Bank
WHO/PAHO	World Health Organization/Pan American Health Organization

Executive Summary of key findings and recommendations

The Caribbean's largely heterosexual epidemics occur in the context of harsh gender inequalities and are being fuelled by a thriving sex industry which services both local and foreign clients, and exists against a backdrop of absolute poverty (and perceived poverty) in many countries. Despite the generalized epidemics occurring in most countries of the region, many countries still exhibit concentrated epidemics within key most at risk groups , namely sex workers and in men who have sex with men (MSM). MSM remain a hidden phenomenon in the generally homophobic social environments found in this region and unsafe sex between men is believed to account for about one tenth of reported HIV cases in the region (Caribbean Commission on Health and Development, 2005;).

This situational analysis was commissioned by the Horizontal Technical Cooperation Group (HTCG) and the analysts have attempted to highlight important aspects of the sex trade industry in the Caribbean and the importance of promoting the rights of sex workers. The analyses has been relatively brief and only highlights key issues that require urgent attention and directly related to the preservation of human rights of adult sex workers.

An area that requires more research and assessment is male sex work. Evidence from many countries (or lack of it) indicates that male sex work, in particular heterosexual contact is not viewed as sex work but rather, romance tourism occurring on a time scale of longer than a few hours and for exchange of emotions. Male sex work is "*not just about sex*". Male sex workers with identities akin to transgender, transvestites and those who engage in male to male sexual contact are in existence in most countries where sex work is reported. However, due to the policies surrounding the prohibition of homosexuality and sodomy, this group remains largely underground.

Country governments appear to be stagnating on the issue of prostitution. By remaining in a *political comfort zone*, they are failing to explicitly acknowledge the existence of a fast growing sex trade in the region, and this has left the way open for the very same governments and the tourism industry to inadvertently violate the existing laws and conventions that criminalize prostitution.

At the same time, the existence of these laws provides the basis for governments to be exonerated from failure to tackle the human rights and protection of sex workers and as such, ignoring their very basics needs in order for them to live fuller lives complete with dreams, hopes, possibilities and choices that are available to individuals of non-vulnerable populations.

Policies addressing sex tourism require careful consideration. Sound information about every day practices must be gathered to inform policy development. In addition, although sex tourism is the main route of prostitution in the region, non-tourism types of prostitution are highly prevalent especially in countries where tourism development has yet to be scaled up such as Guyana and Suriname. This form of prostitution has been in existence long before the emergence of sex tourism and is highly dangerous as it does not offer women or MSM sex workers any form of protection from their pimps or clients; and no alternatives or exit routes. In addition, as remuneration is often below decent wages, their situation prevents access to non-stigmatising, more confidential services which are often private, requiring the payment of a fee for services rendered.

Country analyses have highlighted that increasingly, sex workers and advocates are forming their own organisations with a focus on personal safety and dignity of sex workers, while other groups address issues such as abuse, empowerment, and self development. Best practices are emerging and have been documented in this paper where information has been gathered.

Policy and programme recommendations

The CEDAW Convention[2] on the Elimination of all Forms of Discrimination against Women, recognizes that the respect of human rights of vulnerable women including sex workers extends to a recognition of sex worker Health and social needs. In addition, there are other United Nations instruments that emphasize the right to health and to the socio-economic conditions that enable good health to be achieved. These are the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights, the International Covenant on Civil and Political Rights, the Convention on the Rights of the Child and the Convention on the Elimination of All Forms of Racial Discrimination.

The health and well-being of sex workers as defined by the WHO definition of health refers to the prevention of physical and mental health problems, harm reduction, equal access to treatment care and support and access to social and self development programmes that promote mental and emotional well being of sex workers and their jurisdictions.

In recognition of an holistic health and rights based approach to controlling the spread of HIV and STIs, UNAIDS recommends 4 focus areas to be addressed in the development of health and social interventions for sex workers:

1. prevention of entry or delaying entry
2. prevention of HIV transmission and harm reduction
3. treatment care and support of HIV positive sex workers and prevention of transmission
4. Beyond sex work support to sex workers who seek to exit the industry

[2] The Convention on the Elimination of all Forms of Discrimination against Women (the CEDAW Convention) is a human rights treaty for women. The UN General Assembly adopted the CEDAW Convention on 19th December 1979. It came into force as a treaty on 3rd September 1981; thirty days after the twentieth member nation became a States party to it. CEDAW is one of the most highly ratified international human rights conventions, having the support of 185 States parties. This is one of the many benefits of the CEDAW Convention; it can stand as a treaty that has achieved a global consensus and thus reflects the normative standards applicable to women's human rights. Women's health is explicitly cited as a general recommendation (GR24) area of major concern. Under GR24, the convention committee affirmed that access to health care, including reproductive health, is a basic right under the Convention on the Elimination of All Forms of Discrimination against Women, decided at its twentieth session, pursuant to article 21, to elaborate a general recommendation on article 12 of the Convention. The committee also noted that special attention should be given to the health needs and rights of women belonging to vulnerable and disadvantaged groups including, women in prostitution. Note 7 of the convention highlights that women's right to health can be achieved only when States parties fulfil their obligation to respect, protect and promote women's fundamental human right to nutritional well-being throughout their lifespan by means of a food supply that is safe, nutritious and adapted to local conditions. To this end, States parties should take steps to facilitate physical and economic access to productive resources, especially for rural women, and to otherwise ensure that the special nutritional needs of all women within their jurisdiction are met. In addition, under article 12(1) of G24 the convention Women in prostitution are also particularly vulnerable to these diseases. States parties should ensure, without prejudice or discrimination, the right to sexual health information, education and services for all women and girls, including those who have been trafficked, even if they are not legally resident in the country. In particular, States parties should ensure the rights of female and male adolescents to sexual and reproductive health education by properly trained personnel in specially designed programmes that respect their right to privacy and confidentiality.

So far, in the region HIV/AIDS prevention and care programmes for those involved in sex work have used a mix of strategies. The most effective strategies that have been identified to date are:

- promotion of safer sexual behaviour among sex workers, clients and institutions or groups associated with sex workers, such as police and sex workers' partners:
  - condom availability and correct use
  - negotiation skills
  - supportive policies
- promotion and availability of STI prevention and care services
- outreach work that includes health, social and legal services peer education among sex workers, clients and associated groups
- care of people living with HIV/AIDS (PLWHA)
- advocacy for policy and law reform at national and local levels, including respect of human rights.

Overall the following inputs and efforts are crucial for achieving success as has been observed in the Dominican Republic;

- strategic partnerships with clearly defined complimentary roles or each partner needs to be better as there are areas of duplication and wastage still in existence
- intensive resource allocation,
- development of policies for rapid responses,
- effective programming and reprogramming in responses to attained outcomes.

–This analyses has broadly revealed a number of key areas that require more analyses and subsequent programme and policy development;

1. Countries of the region should collectively devise a strategic approach to the clarification of the definition of sex work and the impact of decriminalisation of the activity. They need to focus in approaches and legislation that will avoid the promotion of power of the brothel owners, pimps and others in positions of power. Policymakers must also ensure that in addressing the legislation on criminalisation they will balance this with enforced policies that ensure that sex workers' rights as individuals with expressed and unexpressed needs, and with hopes and choices with resects to promoting their social and economic productivity are respected.

2. In order to create regional development and economic sustainability strategies, governments must address the needs and problems of the majority of the economically under-privileged. There is an urgent need to scale up the creation of economic and job opportunities in all countries of the region with a particular focus on sex workers, single dependent young women, children of sex workers, and other youth a risk of entering the trade through forced sex and exploitation. Job training programmes linked to job creation and development programmes must be created and operate at hours that are accessible to women in various forms of employment. In addition child care services provided free of cost by government welfare departments across the region must be introduced and scaled up to recognise the needs of the underserved that cannot afford child care, otherwise. As such, the creation of an enabling environment becomes not just the reduction of stigma and discrimination, but also the provision of community based reasonable accommodation by the governments that aims to promote the inclusion and social and economic productivity of women (not only sex workers) at risk of HIV through various identified vulnerability channels.

3. Job creation and support does not necessarily enable sex workers to switch jobs altogether, as these jobs may pay two to three times less than sex work. It must be noted that job creation and training alone does not create a financial alternative to sex work and a combination of strategies are required. These include programmes focused on improving the economy and remuneration on a whole, such as creating concessions on essential goods and services (ref: Kempadoo and Melon 1998). In addition, emotional intelligence strategies in conjunction with job creation; training and social support has been shown to be successful in supporting the exit of sex workers from the industry. Times away from sex work continues to vary - some for the long term, never returning to the trade while others leave and return in spurts.

4. More tailored policies are required in order to address migration throughout the region for work and recreational purposes with a focus on CSME. The policies also need to address current practices of immigration and custom service providers that stigmatise and discriminate against "women who fit the profile of sex worker". This should involve exploring institutional policies and introducing guidance on interrogation of migrants and information to migrants on their rights to recourse. Such service delivery habits serve to promote exploitation and trafficking of sex workers who feel that they cannot turn to anyone in authority without being terrorised further.

5. The CSME envisages a Caribbean "without barriers, strengthened by its collective resources and opportunities." Free movement of persons is not yet a reality in the region, although CARICOM has approved regulations that allow for the free movement of business people, artists, sportspersons, and some categories of students; the movement of other groups has been under discussion for several years. Free trade and free movement of capital are slowly being implemented (CARICOM Secretariat 2003).The reality is that free movement of individuals means free and unchecked movement of diseases. In the absence of adequate surveillance reporting and monitoring and evaluation systems, the regions epidemic will become indistinct between countries as each shares its neighbours' HIV incidence.

6. One possible impact of open borders within a Caribbean with failure to address the laws on prostitution, access to services HIV and other health and support by migrant workers including sex workers and without control mechanism to guard against stigma and discrimination by those in authority may be the adoption of more discriminatory law - enforcement practices by police and immigration officials in order to ensure that identified sex workers are not able to work in the countries that they are visiting. This situation may further give rise to harassment and exploitation of sex workers as they are driven further underground.

7. Overall, there is an urgent need to address the 'abuse of power' by public services providers, including immigration and customs officials, the police force and health providers. Regardless of legal status of a migrants' situation in the host country, governments must produce more comprehensive guidance on service provision, client charters and policies that ensure accountability for actions taken by providers. Issues raised in addition to (4) above include the abuse and physical violence from police and protection of the rights of the clients over the sex worker's rights.

8. Decriminalisation of prostitution alone at the national level is not enough to address the breach of human rights observed through active discrimination and stigma practiced by the community at large and institutions towards sex workers. The development of institutional policies and practices that promote an enabling environment is vital. The development of

lines of accountability and other service guidelines as well as creating leadership and awareness within service providers with regards to their key role in reducing stigma and discrimination and in promoting equitable delivery of care is vital.

9. Promotion of workers rights for women in informal and unstable employment and payment conditions which forces them to extend their income through unsafe sex work and in some cases involving their teenage daughters, as observed in Suriname and Guyana.

10. While access to health care is a right contained within the international convention on Economic and social and Cultural Rights, there are problems relating to access to health and social support services by sex workers and their families. Government partnerships with civil society organisation require strengthening in order to provide a more holistic form of support to sex workers and their families;
    - ⇨ Sex worker organisations require assistance in developing and funding strategies and human resources that would promote the ongoing development of support programmes that address the emotional mental and spiritual well-being of sex workers while recognising the scope and variation of needs of the different sex worker identities
    - ⇨ Promote the access to more responsive health care for promoting their physical well being and timely access to preventative health information, materials and condoms. Prevention approaches through Behaviour change communication must be focused on the whole person and recognize the overall household situation, societal mores[3], and economic environment of the individual and also adopt a combination of emotional intelligence, health promotion and harm reduction approaches, in harmony, that promote self-empowerment, senses of self-esteem and self-worth.
    - ⇨ As in (7) above, ministries of health must become more proactive in the drive to respect of the human rights and dignity of sex workers or even those who are perceived to be sex workers , in particular young sexually active females or single mothers[4].

11. Sex workers and single young sexually active females who are not in the sex trade experience discrimination in their local communities and as such this promotes their lack of full participation in civil society, including the withdrawal or inability to pursue education, skills building. This cycle promotes further disadvantages and societal discrimination and greater reliance by these women on sex work, whether formally, through the sex trade or informally through more emotional connections. Therefore stigma and discrimination reduction strategies targeted towards the general population in must be scaled up. Approaches must encompass recognition of the various forms of Stigma and discrimination towards sex workers exhibited within different community settings – the local communities, educational establishments, social support service, formal workplaces and the informal employment sectors.

12. Not least, despite the separation between church and state on how best to proceed to address the issue of HIV prevention, sex work and homosexuality, it emerged clearly in some of the

[3]These are the customs and habitual practices, especially as they reflect moral standards, which a particular group of people accept and follow.

[4] Research on stigma and discrimination has demonstrated clearly that many young women who are HIV positive, received intense stigma and discrimination by health workers prior to becoming HIV positive, whether during pregnancy and delivery of their children, or when seeking treatment for a past STI. As such, many did not freely return to the services for prevention information or follow up treatments or check-ups. This placed them at greater risk of HIV regardless of their sex work status (ref: The context causes and consequences of HIV related stigma and discrimination in Barbados 2003, Adomakoh et al, Impact report from the BHIP project Ministry of Health Barbados)

country analyses that in the Caribbean the church and the perception of God in the life of many sex workers plays a key role in how they step out each day into the world of sex work. In addition, it has been well documented by governments of the region in their HIV strategic plans that their programmes must urgently find ways of working in harmony with faith based organisations given that religion and church is the cornerstone of existence in the lives of Caribbean peoples despite the confusing messages on sex and sexuality that have emerged. With such a strong reliance on spirituality by members of vulnerable groups including sex workers, their marginalisation and exclusion from their FBO is likely to have a significant impact, heightening their sense of isolation and reducing their ability to cope with stigma and discrimination as has been highlighted by the workers at Stitching Maxi Linder Association, in Suriname (SMLA). In Suriname and Dominican Republic sex workers commonly reported praying to God for protection. Best practise have emerged in Suriname, where prostitution is still a criminal offence, as to how best to involve the Christian based church in promoting community respect for the human rights of sex workers. In addition, regional initiatives such as the champions for change - stigma and discrimination reduction initiative have demonstrated that all community based organisations and groups including the FBOs can be reached to actively participate in stigma free HIV prevention among all vulnerable groups in the region including sex workers. Regardless of the legal status of sex work, these initiatives and best practices in working with FBOs need to be scaled up at country level , owned and led by civil society, including FBOs and sex workers organisations and mandated publicly by government and church leaders.

To date many programmes in the Caribbean have been limited in terms of coverage, inclusion and coordination of stakeholders, and long-term effectiveness and sustainability. When developing and implementing sex worker programmes the following partnerships and practices are recommended if the region as a whole is to improve on the good practice models that have emerged from the Dominican Republic.;

- ⇨ Active involvement of sex workers themselves in all phases of project development, implementation and evaluation;
- ⇨ Implementation of ethical and protective policies for sex workers who become increasingly visible through their involvement in HIV prevention activities;
- ⇨ Undertaking situation analyses and mapping exercises for design and subsequent monitoring and evaluation of programmes
- ⇨ Coordination of responses and resources; incorporating methods of planning and priority setting
- ⇨ Identification and inclusion of a range of project partners, including sex workers, communities, private enterprises and sectors other than health; and
- ⇨ Taking a longer-term and broader perspective on ways to decrease vulnerability of sex workers by addressing the conditions (including economic and gender issues) surrounding sex work and entry into sex work

PART ONE – REGIONAL SITUATION

1 Introduction

The Caribbean epidemic is considerably lower than the rates observed Sub Saharan Africa, however, the epidemic in terms of prevalence is second highest after Sub-Saharan Africa and therefore the absolute numbers of people infected and affected is substantial and significant within the context of the impact of social and economic development of the countries within this region (ref). Social scientists of the region have projected up to a decline in economic growth by 4 % of what it would have been in 2007.

According to the 2006 AIDS Epidemic update by UNAIDS, there is an estimated 250 000 [190 000–320 000] people living with HIV in the Caribbean. Nearly three quarters are in the two countries of the island of Hispaniola: Dominican Republic and Haiti. But national adult HIV prevalence is high throughout the region: 1%–2% in Barbados, Dominican Republic and Jamaica, and 2%–4% in the Bahamas, Haiti and Trinidad and Tobago. Cuba, with prevalence below 0.1%, is the exception. Overall, an estimated 27 000 [20 000–41 000] people became infected with HIV in 2006 in the Caribbean. HIV infection levels have remained stable in the Dominican Republic and have declined in urban parts of Haiti, however, more localized trends suggest that both countries need to guard against possibly resurgent epidemics.

Although several countries are making aggressively scaling up access to antiretroviral treatment; in the **Bahamas**, **Barbados**, **Cuba** and **Jamaica** (WHO/UNAIDS, 2006), AIDS claimed 19 000 [14 000–25 000] lives in the Caribbean in 2006, making it one of the leading causes of death among adults (15–44 years).

The Caribbean's largely heterosexual epidemics occur in the context of harsh gender inequalities and are being fuelled by a thriving sex industry which services both local and foreign clients , and exists against a backdrop of absolute poverty (and perceived poverty)[5],. Despite the generalized epidemics many countries still exhibit concentrated epidemics within groups - sex workers and in men who have sex with men (MSM). MSM remains a hidden phenomenon in the generally homophobic social environments found in this region, it is a smaller, but important factor, and unsafe sex between men is believed to account for about one tenth of reported HIV cases in the region (Caribbean Commission on Health and Development, 2005; Inciardi, Syvertsen, Surratt, 2005).

There is little hard evidence as to the degrees to which various factors such as migration and sex work contribute to the spread. There is even less known with certainty about the future course of the epidemic, although credible scenarios have been drawn up. As such, the epidemic continues to remain hidden from view of the community at large, and complacency with regards to behaviour change of the general population is still observed in several countries ten years after

[5] Based on interviews with workers in the tourism industry, financial sector and the manufacturing sector and with operators of sex tours Perceived poverty is seen as need perceived by individuals, groups or communities and based on increased expectations and desire for a higher standard of living (need to pay profession feels, need to travel, need to buy a house, car) and is not necessarily characterized by need to survive that results from absolute or abject poverty. It a phenomenon observed in single young males and females and single parents living on a single income. An increase in single parent households and a breakdown of traditional family structures, including the breakdown of extended family support systems coupled with a concomitant rise in single income households appears to have resulted in decreased affordability of mortgages, travel etc for young income earning adults as revealed through detailed focus group discussion with workplace professional in the hotel sector.

the alarm was raised. In addition, also hidden are key population and vulnerable groups that are placed at risk of HIV by the very nature of their vulnerabilities. For instance, the hidden MSM populations remain untargeted for prevention efforts and in addition experience reduced access to health and social support welfare services for youth, sex workers and those most likely to enter into sex work.

Vulnerable populations of women continue to emerge over the past decade with the number of new HIV infections among women in the Caribbean now outstripping that among men. Latest estimates suggest that roughly as many women as men are now living with HIV in this region. According to a population-based survey carried out in 2002, women younger than 24 years in the Dominican Republic were almost twice as likely to be HIV infected compared with their male peers. This pattern prevails throughout the Caribbean, particularly in youth under 19 years. Several countries are also observing higher incidence rates in the 55 to 65years old age group and several country assessments attribute this trend to the 'sugar daddy' syndrome, described as exchange of sex for favors between young girls and older males.

1.1 Dimensions of the epidemic

Incidence of the disease and trajectory of the spread is linked to key factors in the Caribbean region. These include vulnerabilities arising from absolute poverty or perceived poverty, abuse, addictions, marginalization and stigmatization, socioeconomic disparities and labour Migration, Tourism and sex tourism, human trafficking, cultural and religious taboos

Understanding HIV/AIDS in the Region is hampered by underreporting. Although a number of studies at regional and national levels have been conducted with vulnerable sub groups, availability and quality of data about the beliefs and practices of sub groups in the population at country level are limited. This limits understanding of the real dimensions of the epidemic within countries. Also, ARV treatment programs are at various stages of development ranging from initiation in 2005 (St. Lucia) to programs said to be providing third, fourth or fifth generation ARV drugs (Barbados) challenging countries and donors to take extreme care in projecting the course of the epidemic in the region.

1.2 Key Affected Groups (the most vulnerable)

The prevailing environment of stigma has enforced an environment of a lack of trust and open communication (particularly with regards to Sexuality), poor dissemination of information and unsafe sex practices. This environment has led to adverse impacts in terms promoting poor health seeking practices of young persons at risk of HIV (and includes vulnerable young children that are exposed to circumstances the promote their likelihood of entering into sex-work), commercial sex workers and MSM

Men who have sex with men

In the early days of the epidemic 2 thirds of cases could be attributed to HIV prevalence in the region (exploring country specific trends), and currently UNAIDS estimate that the overall share of reported HIV infections attributed to sex between men is approximately 10% to 12%, but homophobia and the robust socio-cultural taboos that stigmatize same sex relations mean that the actual proportion could be somewhat larger. Studies have shown that condom use is often low in MSM on the " down –low" who essentially present themselves to the public as heterosexual but are primarily homosexual and as a result of their non-disclosure, live bisexual lifestyles and expose their wives and girlfriends to HIV once infected. This group has expressed that they find it harder to access health services, including sexual health and prevention services including the

diagnosis and treatment of STIs in settings fraught with provider stigma and discrimination. Those who can afford it go elsewhere or to local private non-stigmatizing physician.

As a result of stigma against MSM, the rights of this group are often compromised. In a survey undertaken in Barbados, data showed that gay men masking as heterosexual are more likely to report seeking the services of a male sex worker (Adult sexual behaviour survey 2004). In addition, in a study on impact of HIV on PLHIV receiving care, 6 out of eight young HIV positive MSM in focus groups sessions reported being victimized - being raped and sexually abused at nights by men known to them and who present as heterosexual in the daytime. In all cases condoms were not used. Despite an obvious need, none of the men reported these incidences to the law enforcement or sought the support of health services.

Sex-workers

The ease of migration coupled with increasing travel of sex workers from within and outside of the region has contribute significantly to the increasing incidence of the epidemic. Essentially, *sharing of our neighbours' epidemic* has become a reality in the Caribbean, whereby by sex workers often reside in neighbouring countries temporarily for days or months and over a year in reported cases. Away for home, they feel free to push up their income generation capacity in high-demand areas where they and their families are relatively anonymous. As such, collectively agreed regional policies on prostitution, health care access, treatment and prevention strategies will undoubtedly provided the most efficient approach to addressing the human rights and sex workers. (See section on migrations and CSME) Sex workers are often in the countries as visitors and in several cases overstay the permitted duration allotted to them as CARICOM residents. The illegal nature of their profession makes them a distinct target of stigma and discrimination and subsequent violence - including rape, harassment and trafficking. In addition they report being subjected to stigma and discrimination in the form of inequity of service provision by health care providers, harassment by immigration officials, police force, and harassment and exploitation by taxi drivers, pimps and their clients. This issue speaks to a need to urgently address access to care of sex workers across borders and for countries on of the region to collectively agree on structure and policies of services provision to migrant populations, regional policies for addressing illegal immigrants and for addressing human trafficking and for purchases of ARVs, of as countries move to universal access.

Recent studies report that there are large centers of commercial sex workers in the Caribbean located in Curacao, the Dominican Republic and the Bahamas, Suriname, Barbados, Jamaica and Antigua (Kempadoo; sexing the Caribbean, 2004). Additionally, migration both within the Caribbean and from outside the Caribbean, is encouraging a new population of sex workers on demand.

Migrants

Migrants are the fourth major risk group in the Caribbean. The most vulnerable migrants are those men and women who cross borders as hustlers/informal commercial petty traders, mine and agriculture workers or sex workers. As irregular migrants, sex workers are often exploited and subject to violence and abuse at the hand of their pimps, clients and in certain cases there are undocumented reports of exploitation by authority figures as well.

Migrants are perceived as contributing to the spread of HIV/AIDS across borders, studies have shown that migrants are often more vulnerable than local populations in that they often face stigmatisation, are often lonely an d lack family support and resort to short term relationships. They experience greater obstacles in accessing care and support if they are living with HIV/AIDS. The circumstances of movement – e.g. whether

Voluntary or involuntary, or whether legal or "clandestine" – directly affects the potential risk of HIV- infection for migrants. A recent IOM study calls for a better understanding of the interaction between HIV/AIDS and population movements in the Caribbean in order to develop effective AIDS intervention strategies, particularly in light of the implementation of the Caribbean single market and economy (CSME).

Youth and single and dependent young women - While data on gender distribution based on reported cases are available by country, the actual understanding of the gender dimension and design of an appropriate response has not been fully realized thus far. This is particularly important considering that HIV/AIDS is becoming more prevalent among young people; particularly incidence in increasing fastest in young women aged 15 to19, although data are not always reliable across all countries. Yet interventions are not directed to the self esteem, coping with peer pressure, values, mores, sexual practices, and reproductive health needs of today's youth. Similarly, interventions do not generally address the uneven power relationships between men and women.

Drug users

One study undertaken in an Ocho Rios market place in Jamaica cited that a sero-prevalence survey in 11 drug addicted sex workers revealed that 9 were positive. Other than 'hard core' drug uses such as crack-cocaine, sex workers often report that that they use Ganga to dull the painful aspects of their employment. Those who reported using it in Negril would take it before going to work. In a Barbados study, 19% of sex workers working in rooms above the bars and operated by pimps would drink alcohol between clients also as a means of dulling the sensations.

The users of hard drugs are extremely vulnerable, engaging in actions that expose them to HIV being perpetuated as a result of their dependency, as observed in the Ocho Rios Market place. This dependency on drugs results in a more heightened and desperate need for money, and hence a willingness to forget their safety and to engage in dangerous liaisons with mainly locals and the occasional tourist. This group will tend to engage in commercial sex for any amount of money that will enable then to get a quick fix.

Dawn is a forty- two year old
Go-Go dancer, who wept as she spoke about
Being raped by five men.
She was only nineteen years old
At the time of the incident.
She sold sex in all fourteen parishes.
Dawn consumes large quantities
Of alcohol and ganja to "ease the tension".
She says that she is trying to quit her years
Of smoking crack cocaine.

(Courtesy of Marlene Taylor 2006)

PLHIV

Those who already live with HIV and AIDS continue to be marginalised from the workplace and from comprehensive health and supportive services as a result of self-stigma and enacted stigma (discrimination). As a result, their sense of isolation produces a chain reaction that promotes the spread of HIV as a result of their increased and prolonged poverty situations; Where many were impoverished as a result of unemployment due to the physical debilitation of AIDS, now in the era of life prolonging ARV therapy, many PLHIV continue to be impoverished as a result

inaccessibility to jobs or retraining programmes. Where a PLHIV may not have been involved in sex work, there is a heightening of the risk for them to turn to this form of employment, formally or informally engaging in 'sexual relationships in exchange for favours' as a means of generating some economic sustainability within their household. Often the latter form of informal sex work is also a means of gaining some from emotional and romantic interlude with a temporary partner, going as far as having children for him. This was demonstrated in Barbados through the PMTCT services whereby almost 25% of previous HIV positive mothers returned to the service pregnant within 2 years, with a different father to be. Disclosure of HIV status in such situations has not been known to be a common occurrence amongst HIV positive sex workers. A study in Suriname revealed that a very small minority reported revealing their status to clients but this could not be verified.

1.3 Greatest strengths – biggest threats: Intra regional Issues that fuel the HIV/AIDS epidemic (sharing epidemics)

1.3.1 Labour migration

Migration between islands and in and out of the region is an every day norm for formal, informal workers and tourists from within the Caribbean. It is viewed as a positive phenomenon and signifies progress, change and influence as individuals are able to conduct their "business" in terms of trade, study, for family reasons and leisure throughout the region and beyond. Marshall[6] describes migration as being perceived very positively by Caribbean peoples and view as a strategy for upward mobility and betterment." As migrants including sex workers move in search of economic opportunities.

There are 3 main migrations flows in the Caribbean: Internal migration (from rural to city and vice versa); Intra regional immigration (between islands); Outward migration (between the Caribbean region and other regions)

Since the advent of research on HIV spread in regions across the world, mobility has been linked to increased risk of HIV infection, with surveys indicating that behavioural patterns of mobile workers demonstrate greater tendency to report risky sexual behaviour for a myriad of reasons, not yet fully explored within the region. Hence, the characteristic of the population movement that constitutes such an important part of Caribbean life requires increased and more focused attention.

Based on reviews of migration patterns and recent IOM studies, the Caribbean observed patterns of intra-regional migration in particular by sex workers, tourists, business travellers, petty traders, casual labourers and others. Migration appears to be fundamentally driven by;

- socio-economic inequalities such as the differing levels of country development and available resources for residing individuals, communities and businesses in neighbouring countries
- political change
- available resources for leisure (in terms of tourism),

[6] Marshall, Dawn. "A History of West Indian Migrations: Overseas Opportunities and Safety-Valve Policies." *The Caribbean Exodus.* Ed. Barry B. Levine. New York: Praeger, 1987. 15-31

- Ease of access by air, and other means of transportation which also facilitate trafficking and structure of social services and
- the market place - relative demand for goods and services including sex and health care

Some higher income countries such as Barbados, Trinidad, Jamaica act as "receiving states" and while others, including Guyana, Haiti, St. Vincent produce large numbers of economic migrants.

" Of note in the region is the fact that the major migration streams (into the region, within it, and away from it) are increasingly dominated by females, a feature that differs significantly from historical patterns of Caribbean migration. The predominance of one sex in a migration stream indicates that immigrants are not moving with spouses or families. This presents opportunities for high risk behaviours, such as multiple sexual partners, the likelihood of engaging in or purchasing commercial sex, and increased use of alcohol and drugs, the abuse of which can impair judgement and free up inhibitions that otherwise might offer protection from undue HIV risk." (The Caribbean Regional Strategic Framework for HIV/AIDS 2002 to 2006)

Table 1: Migration and mobility in selected countries (source IOM report, 2004)

	Barbados	Curacao	Dominican Republic	Jamaica	Trinidad and Tobago
Primary regional Source countries	St. Lucia St. Vincent and Grenadines Guyana	Colombia Venezuela Dominican Republic Haiti Jamaica	Haiti Colombia Cuba	Caribbean Region	Guyana Barbados Grenada St Vincent Jamaica
Primary Extra-Regional Source Countries	United Kingdom United States India	The Netherlands United states Canada	United States Europe China	United States United Kingdom Canada India	
Patterns	Outflows to North America; Tourism important	Outflows to the Netherlands; Tourism important	Irregular Haitian migration; Tourism important	Outflows to US, Canada and UK; Transit country for irregular migration; Tourism important	Tourism important
Reasons for Mobility	Work permits required; Visas not required for US Canada, UK, Commonwealth countries; Tourists may stay 28 days	Tourists may stay 28 days Work permits required; CSW permits as dancers and hotel employees; Tourists may stay 2 weeks	New counter-trafficking law; New migration law drafted	Work permits required; New migration management system being implemented	May work 30 days without work permit
Concerns	Tourism Economic migrants (regular and irregular) Family links	Political unrest Economic migrants (regular and irregular)	Tourism Political unrest Economic migrants (regular and irregular)	Tourism Political unrest Economic migrants (regular and irregular)	Economic migrants (regular and irregular) Tourism Economic migrants (regular and irregular) Oil industry
	Illegal sale of passports Drug trafficking	Illegal sale of passports Drug trafficking	Restricted entry for HIV+ Irregular migration (smuggling and trafficking)	Brain drain Irregular migration (smuggling and trafficking) Drug trafficking	Restricted entry for HIV+ Irregular migration (smuggling and trafficking)

1.3.2 Tourism

The greatest strengths in terms of economic development (Tourism and Migration) gives rise to the greatest threats to Caribbean sustainable development if left unregulated with regards to mitigating the spread of HIV.

The largest movement of people in the Caribbean is movement into the region by recreational visitors, with more than 20 million people annually according to the Caribbean Tourism Organization. The natural beauty of the region has created an industry that sustains many of the Caribbean's people, contributing half the GDP in some countries (Dixon 2000 and Nankoe).

The tourist sector is the single most important commercial sector in the Caribbean, more so than in other regions of the world. In 2004, the region's travel and tourism generated over the expected US$40.3 billion of economic activity**.** The industry's multiplier effect in terms of direct impact includes 814,500 jobs, or 5.2% of all employment, and revenues of US$8.7 billion, or 5.2% of the region's GDP. However, since travel and tourism touches all sectors of the Caribbean economy, its real impact is even greater. The sector directly and indirectly accounts for 2.4 million jobs, or 15.5% of all employment, and US$28.4 billion, or 14.8% of the region's GDP

As highlighted in the previous sub-section, labour migration within the region is also linked to the industry, with migrant-receiving countries often being distinguished as the economies based on tourism.

1.3.3 CSME - another great economic strength

Intra-Caribbean labour migration will further be facilitated by the Single Market and Economy (CSME) of the Caribbean Community (CARICOM)[7].

The CSME envisages a Caribbean "without barriers, strengthened by its collective resources and opportunities." Free movement of persons is not yet a reality in the region, although CARICOM has approved regulations that allow for the free movement of business people, artists, sportspersons, and some categories of students; the movement of other groups has been under discussion for several years. Free trade and free movement of capital are slowly being implemented (CARICOM Secretariat 2003).

The reality is that free movement of individuals means free and unchecked movement of diseases. In the absence of adequate surveillance reporting and monitoring and evaluation systems, the regions epidemic will become indistinct between countries as each shares its neighbours' HIV incidence.

As succinctly stated by Sir George Alleyne Special envoy to the Caribbean for HIV/AIDS in the recent Conference on HIV and economic impact in the Caribbean, Jan 2007, St Croix, CSME poses a great threat to further fuelling the HIV epidemic, to unimagined proportions of new cases each year across the region as sexual networks per individual are widened through free travel. There is thus a call for exploring, developing and implementing urgent national legislation and institutional policies to gain some control over the spread of HIV/AIDS.

[7] CARICOM was established by the Treaty of Chaguaramas, signed 4 July 1973, "to provide dynamic leadership and service, in partnership with Community institutions and groups, towards the attainment of a viable, internationally competitive and sustainable Community, with improved quality of life for all." Current CARICOM members include Antigua and Barbuda, The Bahamas, Barbados, Belize, Dominica, Grenada, Guyana, Haiti, Jamaica, Montserrat, St. Kitts and Nevis, Saint Lucia, St. Vincent and the Grenadines, Suriname, and Trinidad and Tobago.

> *This initial stage (of CSM) which is seen as critical for the economic development of the region has the free movement of skills throughout the region as one of its features. ……..Although a beginning has been made with University graduates and other skilled individuals, it is clear that the day must come when there is free movement of all people throughout the region as it would border on the irrational to be advocating the free movement of capital and not of labour. This will bring with it the possibility of movement of persons with HIV and the possibility of movement from countries with high prevalence rates to those with lower. This will bring into question the capacity of the services, economic and otherwise of the receiving countries to deal with increased numbers who need treatment.*

One possible impact of open borders within a Caribbean amid failure to address the laws on prostitution, access to HIV and other health and support services by migrant workers including sex workers; and without control mechanism to guard against stigma and discrimination by those in authority, may be the adoption of more discriminatory law - enforcement practices by police and immigration officials as they try to ensure that identified sex workers are not able to work in the countries that they are visiting. This situation may further give rise to harassment and exploitation of sex workers as they are driven further underground.

1.4 Sex tourism

Concomitant with the growth in tourism is the growth in sex tourism industry as the reputation for natural beauty of the region extends far beyond the physical terrain to the perception, by visitors from colder climates, of exotic beauties and beach boys waiting to please and pleasure (Kempadoo, 2004).This background is described further in the section two.

The sex industry - an important feature of heavily tourist areas and highly mobile populations can be defined as the increased presence of a commercial sex industry. Sex workers are generally defined as women or men who provide sex for material benefit. Commercial sex work is widespread, well entrenched and on the rise throughout the region, it is conducted under a wide range of scenarios and conditions of sale. It is linked a number of hot spots where there is a collective of human interactions - to tourism in the islands; within mining villages and trading patterns in a variety of industries. With the rise in sex tourism has become more imaginative and 'socially acceptable' forms of operations. So in addition to the long standing long term and short-term brothel workers, fixed brothel workers, and mobile commercial sex workers; there also exists, single and married, women and men. In the transactional sex workers arena whereby business is conducted in a more informal manner that will ultimately ensuing that the experience for the client seamlessly fits into the overall experience of the vacation or business engagements.

Male prostitution in the form of - *beach boys, gigolos, sanky panky* (Dominican Republic), *jineteros* (Cuba), *rent-a-dread* (Jamaica), *rental* or *hustler* is increasing across the Caribbean. In the current era, the sex industry has expanded to incorporate several other professions and it is really a case of you "*can't tell (who's a sex worker) by looking"* in particular, with the male hustlers as very few men explicitly acknowledge the nature of their activities and it is often couched as a form of romantic interlude with the tourist. . In selected countries, in high tourist areas particularly within the smaller states of the Eastern Caribbean, taxi drivers have reported operating as both pimp and sex worker.

1.5 Human trafficking

Initially, in the late 1970s it was the high numbers of Dominican Women (from the DR) that brought trafficking of Caribbean nationals to the attention of researchers and policymakers. By 1996, one study cited about 50,000 Dominican women working as Prostitutes locally and another 50,000 working abroad. Poverty and trafficking were pinpointed as the main causes for the high number of Dominican women in the international sex industry. This was observed in the export of Dutch Caribbean women (from Suriname and Curacao) to the Netherlands. In reported cases, many were attracted to other ' more reputable' jobs that promised to paid more than in their home countries, only to be stuck there when they arrived and to find that their job included the provision of sexual favours. On the whole however, many of those women who are sex workers internationally were aware they that they were migrating for sex purposes but were unprepared for the conditions of slavery that awaited them. Trafficking of this form within countries of the region is highly prevalent. In Barbados for instance, the press have reported incidences of arresting pimps' for kidnapping sex workers – the pimps withhold the sex workers' passports if they do not comply with their required terms of work. In Trinidad the press has reported females being coerced from Guyana to provide massage services only to find that they were also required to provide sexual services to clients on request. Illegal nature of their migrant status prohibited them from seeking recourse from the appropriate authorities. This form of trafficking and coercion has been cited as the significant route of entry into the sex industry by sex workers in the region, but at the same time it is becoming less likely due to the growth in awareness the nature of the sex industry in the region.

The story is very different in terms of child and adolescent trafficking and coercion into the sex trade through forced means which remains highly prevalent and underground. This analysis cannot address the scope of this as the needs of children and adolescent sex workers are very different from that of adults and requires, special and separate attention since it also addresses number legislations in additions to those related to the criminalization of prostitution.

1.6 Supporting a framework for a regional response to Sex work and HIV

The above sections bring to the fore that within the Caribbean, the prevailing pockets of poverty and 'need' in the vulnerable groups described previously and coupled with dynamics of regional flows of capital, labour and of tourism set against environments of increasing socio-economic inequalities, have given rise to the drive of those in 'need' to enter into sex work, amid an increasing market based on demand for sex services of varied configurations. This set of dynamics, has been shown to promote the risk of violence, HIV and exploitation towards sex workers, in particular those that are driven by absolute poverty, or drug addictions.

For decades the sex worker profile in the Caribbean has crossed all socio-economic groups and both genders with varied motivations for entering into the industry - differing by the type of group and by socio-economic group (more research is needed on this).

It is important to note from hereon therefore, that sex workers are by no means a homogenous group with similar needs or socio-economic characteristics; that in fact individuals in the industry cut across all vulnerable populations and economic groups described above.

Given the increasing levels of HIV and AIDS in the Caribbean region and the increasing visibility and growth of the sex trade through the tourism sector and coupled with the high level of population movement, the spread of HIV through this channel is an important issue yet a poorly

understood and documented phenomenon in the Caribbean. It undoubtedly poses a very real threat to the spread of HIV in the region. (Kempadoo, 2000).

There is a dearth of real and timely data relating to sex work activity and the movement of sex workers across borders in the Caribbean. However, increased anecdotal and documented case evidence is emerging on the nature, drivers and scope of sex work in the region. This has been in direct response to the growing HIV epidemic amid the growing reliance on tourism generated income and less on agriculture, by regional governments.

Increasing numbers of civil society organizations are emerging that work with governments to meet the collective and individual health and social development needs of individuals involved in sex work. But there still remains a shortage in terms of active organizations across the Caribbean. In addition to international agencies such as IOM (International Organization for Migration), the local civil society organizations such as Maxi Linder Association, Suriname, COIN and MODEMU in Dominican Republic, Red Thread in Guyana and Others across Jamaica and Haiti, are making some headway in bringing to the attentions of policymakers and planners the urgent need to mitigate HIV spread in sex workers through policy development and the effective scale-up of treatment care and support services.

Donor and technical organizations including HTCG, UNAIDS, DFID have recognized an urgent need to develop and implement more effective responses to HIV/AIDS prevention and treatment and care in sex workers of all identities and across comprehensive dimensions of service provision (CSW, TSW, Escort, etc).

1.7 Approach of this review

Throughout this paper key realities of the current situation with regards to the needs of sex workers and HIV reduction begin to emerge;

> Reality 1 "Regional vulnerabilities and threats amid ineffective or altogether absent policies and programmes are promoting the HIV epidemic and expose sex workers to harm through HIV transmission, sexual exploitation and violence"
>
> Reality 2: Through care treatment and support and prevention, the reduction of HIV incidence and of social disorders that contribute to (1) HIV transmission to sex-workers and (2) transmission from sex workers to their clients is an attainable goal

Key areas that go beyond sex work related need, yet are feasible and therefore require urgent further attention include;

> Reality 3: Reduction and delay of entry into sex work is an attainable goal
>
> Reality 4: Supporting sex workers who actively seek it to successfully move from sex work into other income earning activities is an achievable goal
>
> Reality 5: Deeply entrenched inequity of service delivery to sex workers exists as a consequence of stigma and discrimination in providers: Sex workers are a group of diverse individuals with diverse emotional, spiritual and physical unmet needs and therefore the individual nature of each sex workers must be enabled through comprehensive targeted

holistic approaches to social service provision as is afforded other non-vulnerable recipients of social services within the region.

These realities present a set of challenges to regional partners and national governments in controlling the spread of HIV in the region. However, there are slowly emerging best practices in policies and programme development that address the control of HIV through the sex work channel. There are documented experiences of sex workers themselves who are participating in the fight against HIV and are either active sex workers or those who have left the industry. All programmes observed have a common goal – they seek

- to empower sex workers,
- to promote the human rights of sex workers and other vulnerable groups and
- to reduce the spread of HIV in order to ensure better lives and livelihoods for now and for the future.

This situational analysis was commissioned by the Horizontal Technical Cooperation Group (HTCG) and provides a description of the findings from a rapid research, producing an analysis of the current situation that aims to;

- Identify policy and programme gaps in relation to the occupational realities of sex work
- Build a body of evidence that can guide discussions in the proposed 2007 regional Consultation in Peru, and can be a frame of reference for national action plans and a regional Position paper.

This analysis represents evidence derived from existing data , unpublished documents, published literature and interviews. The author seeks to provide an unbiased viewpoint in order that all audiences and groups in the fight against HIV will be able to read and act upon the evidence presented in the analyses.

During the development of this paper, the author ensured that all persons consulted understood and agreed that regardless of political and social viewpoints, and life choices, the common goal of this analyses for all concerned *is to contribute positively to the preservation of basic individual human rights of each individual and collective of sex workers.*

"That each person has a right to be treated equal to another with equal needs in accessing all available services."

This approach is designed to be able to reach those policymakers and stakeholders of key organisation with one agreed common goal regardless of colour, creed, conceptions/misconceptions or lifestyle choices. The expected target audience is envisaged as groups that influence large community groups and therefore influence the regional response towards the rights of sex-workers .As such they also are well placed to positively or negatively influence the issues of stigma and discrimination, access and uptake of services and the vary basics issues of quality of life of sex workers and other vulnerable groups. Such groups include;

1. **Policymakers** - to address human rights and equity issues with regards to needs and access issues of vulnerable groups in particular sex workers and by placing goals for SW interventions explicitly on the regional and national Strategic plans and disbursing funds towards these.
2. **Church leaders and congregations** - to generate a stigma free and to promote action oriented responses in the church's attitude towards CSW, thereby promoting their active involvement in providing support and training their local community in issues regarding

understanding the needs and rights of CSW regardless of which way each group chooses to live their lives.

3. **Educational Establishments** – in order that those who design and implement community school and tertiary based programmes are able to recognise the importance of delivering teaching and training modules on the socio-cultural and environmental dimensions that define need and also drive vulnerabilities observed in the most at risk populations. In doing, so training programmes can encourage leadership roles - in promoting stigma-free and enabling environments at institutional and community level.
4. **International door community** – to raise the priority profile of sex-workers and HIV and highlight the need for information, and interventions on wider and more supportive scale thereby enforcing holistic approach
5. **Sex workers** - to raise their issues of concern and bring it into focus , thereby proving them with bases for self- empowerment and expression of need - to be recognised as people, mothers, workers, etc not 'sex workers in a box' and also promoting of their involvement in human rights, policy debates and outreach for strengthening country support networks.

As cited previously, there is a dearth of representative hard data/statistics to exemplify sex work trends, sexual identities, access to services and key policy opportunities and constraints with respects to universal access and stigma and discrimination reduction. However, over the past 4 years there has been a growing body of evidence gathered through interviews and observation by a growing community of researchers regionally and internationally based.

Due to the time constraints under which this situational analyses was performed, the paper essentially draws on available literature and supports these with viewpoints of expert researchers, advocates and sex workers

Where possible this paper highlights the available data and backs this up with case studies and anecdotal evidence gathered from documentation, sex workers, advocates, civil society programmes and networks, and from researchers. The following issues are discussed and regional and at country levels;

- Key HIV/AIDS Characteristics of the region
- Trends in sex worker activity and HIV prevalence in the region
- The dynamics and characteristics of sex work, sex or ' romance' tourism mobility
- Political and socio-economic factors that determine the nature of sex work and transmission of HIV through this group
- Policy frameworks with respects to human rights and access to services for sex workers and their clients to a lesser extent
- Identifying programmes and interventions that directly address the needs of sex workers – focusing on best practices, current gaps and experiences and policy implications.
- Highlighting key issues on stigma and discrimination related to HIV/AIDS and sex work.

Countries focused on are;

1. Antigua & Barbuda	4. Dominican Republic
2. Belize	5. Guyana
3. Barbados	6. Jamaica
	7. Suriname

These countries are selected based on their characteristics either as sex work hot spots, or high destination countries in terms of visiting migrants including sex workers and tourists in addition

to their increasing rates of HIV. Only countries where comprehensive and documented information on sex work is available are included - best practices have ensued and are discussed in the analyses. Countries have been kept to the limit of 7 based on the time constraints for undertaking this analysis.

1.8 Methodology

This paper was complied through;

Document review: of existing literature, national policies interviews with key informants including advocates, policymakers and sex workers and researchers.

Brainstorming session: One session was undertaken with key research and advocates for sex worker empowerment and human rights.

Face to face and telephone interviews: following individual interviews with key players above and with heads of programmes and policy makers, a sex tour operator and sex workers identified through existing community based sex work programmes.

People interviewed:

Name	Role	Organisation
Juanita Altenberg	**Advocate**	**Stitching Maxi Linder**
Marlene Taylor	**Advocate**	**Outreach officer Jamaica**
Charles Lewis	**Expert**	**Barbados**
Francesca Ferreira	**BCC for sex workers**	**COIN Dominican Republic**
Jacqueline Montero	**Outreach director/ex CSW**	**MODEMU Dominican Republic**
Kamala Kempadoo	**Specialist researcher on Sex work in the Caribbean**	**University of York CA.**
Ms F	**CSW/Entertainer Transsexual**	**Sex worker - TT**
Mr A	**CSW/Entertainer**	**Intermittent Sex worker Barbados**
Ms F	**CSW/Outreach worker**	**Sex worker - Antigua /St Kitts**
Workers in the hotel industry	**All levels of staff**	**Key Barbados Hotels**

2 Common Threads

2.1 From Sex trade to Sex tourism

The sex trade within the tourism industry has emerged as sex tourism in addition to commercial sex work and is a term which serves to encompass several types and magnitudes of transactions in exchange for sexual services extending to long distance casual and intermittent relationships with 'an understanding ' between the consenting parties.

Kempadoo emphasizes that sex work in the Caribbean as it exists today is merely an extension of prostitution relations under slavery and colonialism and moving into the post colonial era (Beckles[8]).Thus ensuring that Caribbean sex labour became well entrenched into the global economy by the late twentieth century.

It is no mere accident that Sex tourism is a main driver of the sex trade in the Caribbean. This extends again from the history of Caribbean sex work being inextricably tied to power and control exerted by European colonizers over black women since the 16th century. During this period "total access" to slaves was the norm (Beckles) [6]. Historians document that Slave owners used this right to rape and abuse sexually with concubinage and prostitution becoming he norm.

" No European Male in the Caribbean who could afford it was without his coloured mistress- either a freedwoman or his slave" (Henriques[9])

Due to the racial hegemony over whites and blacks then came the extension of this power to white lower classes - even the European bon Servant.

Even under slavery, transactional sex, whether forced or consensual was being performed. In such cases slaves were given improved work conditions, perhaps even obtaining better dwellings for themselves and their families. Post slavery, the working freed slaves continues to provided illicit sex to white males to finance lodgings houses which then became brothels for scaled up services. (Jamaica – Kerr)[10].

Tourist oriented tourism known as Sex tourism, is a growing phenomenon with far reaching social, political and economic implications for countries that depend heavily of tourism. In the larger microstates of the Caribbean the lack of viable work as agriculture and other labor intensive sectors continue to shrink, driving young men and women an now more older men, to migrate to tourist areas to earn a living. Often individuals hold an informal "respectable" day job and sex work is undertaken to supplement their existing income and to provide opportunities of material gifts, travel, etc that they may otherwise have 'missed out on' if they did not interact with tourists.

As such, sex tourism s not just about sex and money but also about other forms of "fair" exchange – providing opportunities for getting ahead, studying, traveling, recreation. Increasing

[8] Beckles Hilary. *Centering Women. Gender Discourses in Caribbean Slave Society*. Kingston, Ian Randle Publishers. 1999. and
____. Natural Resources. *A Social History of Enslaved Black Women in Barbados*. London. Zed Books. 1989
[9] Henriques Fernando. *Prostitution in Europe and in the Americas.* New York. Citadel Press, 1965
[10] Kerr Pauline. Victims or Strategists; Female Lodging Housekeepers in Jamaica." *Engendering History. Caribbean Women in Historical Perspective* ed. Verene Shepherd, Bridget Brereton, and Barbara Bailey, 197 – 212. New York.St martins Press. 1995

rates of growth have been observed on internet based virtual agencies that posses a network of formal and informal sex workers of various identities and profiles. Often hotel workers who engage in sex tourism do not think of such interactions with tourism as sex work. For instance, in one survey of hotel workers in Barbados[11], when asked about engaging in sex in exchange for favours, the common responses to the open ended questions by those who said they did, can be described by the statements of a section of the workers;

Had Sex for favours?

Indirectly, I have
Girls give gifts for sex
I suppose, in exchange for some fun
"Indirect. You don't get something for nothing you know…."

Evidence linking sex tourism and HIV in the Caribbean exists in the evidence that in addition to the countries observed to have high pockets of poverty and local (in-country) labor migration such as Suriname, Haiti and Guyana, the tourism dependent economies have the highest rates of HIV in the region (Allen, McLean and Nurse) these countries have been observed by researchers to include – Dominican Republic, Cuba, Jamaica, Bahamas, Tobago, Barbados, St Maarten, Curacao with increasing documentation of sex work in St Kitts and Antigua. Evidence has also demonstrated that the nature of sex trade differs between the tourism dependent economics and those where poverty is the main driver of the sex trade.

There is little or no documentation on sex labour between white females and black male slaves on the Caribbean. However in the 70s, in one of the earliest studies on sex tourism undertaken, hustlers and beach boys in Barbados (Press: 1978, 112)[12] were identified as a viable providers of sexual relations with white female tourists in exchange for favours, gifts travel abroad, etc. This form of sex work , termed romance tourism due to the nature of transaction and styles of rendezvous itself , was defined as ' transactional sex ' or male hustling. Through to the present day the definitions of male sex workers remain extremely blurred in contrast to the more transparent sex worker terms for females - whereby identities are broad and do not always indicate prostitution. The male sex workers terms include, beach boy, hustler, rent a dread, gigolo, Sanky panky, and rental. During the 1990s a large body of research emerged from other tourism dependent economies including, Jamaica Cuba and the Dominican Republic.

2.1 Drivers of sex tourism

In many cases, economic hardship is the single most important reason given by sex workers for going into sex work. Economic difficulties in the region and the rigors of structural adjustment over the last two and a half decades have resulted in a dramatic rise in the number of women and men seeking work in a market that is less than accommodating. (HIV AIDS in the Caribbean, CAREC)

2.1.1 Growth of the all inclusive

The move of the large tourism market towards all inclusive models of resort development and even further more recently towards condominium self catering accommodation has had a devastating impact on the livelihoods of workers who previously depended on the tourism sector.

[11] The ILO workers' Survey, Barbados, 2005. Associates for International Development (AIDInc)
[12] Press Clayton M. Jr. "Reputation and respectability Reconsidered. Hustling in a Tourist Setting". *Caribbean issues 4*. 1978: (109 -119).

Those hospitality workers and entertainers who previously counted on gratuities to supplement their meager wages[13] are enticed into the sex trade as an informal operator/pimp by being paid for setting up liaisons between tourist sand sex workers or as a sex service provider themselves.

The tourism environment of the where by staff have received *training in service provision* further ensures that the transition to sex working within this setting is smooth and often provides better 'cover' for the tourism worker, whereas law enforcement can easily identify and incarcerate street or brothel based commercial sex worker. As a result, sex tourism operating within the hospitality setting has been cited as a means of subsidizing the low wages of the formal sector workers … "*thus redistributing the wealth of tourists more directly to hospitality workers*".

2.1.2 Money Money Money - Surviving within the global economy and changing support networks

Across the region reasons for entry into sex work appears to be the same due to economic hardship or perceived need to attain a higher standard of living – this ranges from absolute poverty, unemployment and the need to feed a family or maintain a lifestyle, family breakdown and poor education.

Sex tourism has grown, and increasingly new groups are being pulled into commercial and-or ¨transactional" sex (sex for food, sex for school fees, etc): they include schoolgirls, housewives and children and most recently professional workers. As such, new groups are being exposed to new risks, and merit specific analysis and targeted interventions.

However, what ever the reason may be attributable to; all reasons for entry into the industry appear to be linked to a need for economic security at various levels for various socio-economic groups. For instance, the growth in escort (high class prostitute) services within the tourism industry can still be linked to increasing " perceived need" of young women both unemployed and formally employed, with and without children, to live a desired standard of living, to gain higher education qualifications thus seeking higher levels of attainment in the professional arena. (According to findings from an interview with a regional '*operator*' – This new growth area is contributing greatly increased rate at which professional women are entering into the industry). Interviews revealed that the growth in demand by young women to enter the business may also be linked to disintegration of family through a decrease in marriages in couples with no financial commitments to one another. Therefore, for women, especially those with children, the level of economic security is reduced. From all interviews undertaken with operators and outreach workers it was clear that many women of varied socio-economic groups initially enter into different forms sex works to temporarily alleviate a poverty situation, to pay for an immediate need, saying it is only for a short while. The interesting point made by most interviewees was that in addition to the attraction of the money (the more money the harder to leave) –

"Society does not let you leave this thing; even if you have used it to gain an education for a better job……"

[13] For instance, in the high middle income country of Barbados, in some hotels waiter may earn for one week, "…about the Cost of a lunch for two at a high class local restaurant"

"To change my life and my children's"

"If your child decides to sell sex what would you do?"

"A woulda beat har
(her daughter)
If she come dance an
Sell ---- like me….
Afta me work so hard
Fi mek har comfortable"

(Jamaican Sex worker, courtesy of Marlene Taylor, 2006)

There exists an increasing " haziness" of the term sex worker as the myriad of services configurations that are offered continue to grow- from the sex worker providing romance to tourists through individual negotiations in exchange for goods, money or favours; or providing sex services through an agency – offering 'experiences' lasting hours or days; or simply providing a single sexual act or acts through commercialised street based exchange of cash. A growing area is also the provision of services for X-rated adult video entertainment which also includes the booking of 'girls' and 'guys' and locations for shooting.

The Case of emerging new formal and commercial sex tour operations in the Caribbean

High cost romance tourism operators of the Caribbean

Over the past five years, there has been the emergence of a more sophisticated less emotional form of agency on romance tourism which instead of being led informally by the direct negations and understandings between the tourism and sex workers themselves, the services or 'experience' is provided through a sex tour agency that also operates as a modelling agency. Evidence gained through direct interviews (Refs) with the CEO of one such high level of operation confirms emergence of regulated commercial high end sex industry that crosses wide reaching international borders - connecting clients visiting the Caribbean sex workers and from Europe, US , Asia and within the Caribbean and Latin America.

Essentially, these organisations function in the same way as tour operators but go beyond provision of accommodation, travel and local and regional scenic tour rides to providing experiences of sex on demand and companionship as part of the package. The term sex worker is replaced with "escort" "model" "girlfriend" and other services are also arranged such as limousine transportation, dinner and other social events to nightclubs, brothels, massage parlours or reputable spas, inter island visits, island tours on land and water or air. The escorts are usually female as it is not seen as a viable venture by the operators to provide male based escorts. This is due to the fact that males in the romance tourism sector may do better as self employed individuals and still remain undercover, and also that "males in the industry will have "sex for food" so it doesn't sell as well as female sex worker market. Additionally, many females in this high cost, higher class setting and regulated by an operator feel that (1) they benefit by attracting significantly larger incomes for their services, (2) are protected to some degree by the organisation and are able to move between other islands and countries – (3) maintain secrecy of their profession by working away from home, never opting to work within their local environment if they prefer, hence keeping their regular home job to pay the bills if they so choose.

Another form of sex tourism that is also provided by sex tour operators is emerging within the Caribbean is the adult XXX movie making industry whereby operators can organise local males and females to participate in x rated movies shot on location within the region. Males and females are available to participate in sexual activities as required by producers.

2.2 HIV and Sex work

Unlike the Latin American neighbours the epidemic has followed a course whereby initially the epidemic was driven by men who have sex with men but quickly became a generalised epidemic in which key high risk groups remain hidden within the larger general population due to prevailing stigma and discrimination. This dynamic has made the epidemic more complex and hence difficult to characterise within theses countries. The small sizes of these countries serve to contribute to the prevailing environments of stigma and discrimination not only towards vulnerable groups which also includes those living alternative lifestyles such as sex workers and men who have sex with men, single unemployed dependent young women. This phenomenon prevents adequate and timely development of programmes and policies that address the rights of these groups and access to much needed social services.

Sex work has increased in all countries of the Caribbean. On the other hand, it may have appeared to have increased simply because of the increasing visibility that is being given this industry by researchers as a result of the increasing prevalence of HIV in the region. For countries in which sex work research is being undertaken and where sex workers outreach and advocacy organisations have been established, more is known about HIV risk and trends in this group. Through observational studies and anecdotal evidence from outreach workers, epidemiologists, etc Sex workers were identified as important group in regional studies of vectors of HIV and STIs. In addition the conclusive studies coming out of Sub-Saharan Africa demonstrated cost effectiveness in HIV prevention through the targeting of sex workers and their clients. Led by PAHO- CAREC, WHO and GHESKIO in Haiti and RED Thread in Guyana, government health departments of selected countries of the region,(Jamaica, Surinam, Guyana) studies were undertaken which demonstrated alarming HIV prevalence in commercial sex workers compared to the prevalence estimates of the general population. Studies of sexual practices which undoubtedly capture portion of the sexually active population who practice sex, exchange for goods or favours demonstrated that HIV and STI transmission in the Caribbean is overwhelmingly heterosexual. Most recently, the incidence rates on women are greater in most countries than males, particularly in the youth. Sex workers were seen to form an integral part of the sexual networks. In addition, Bridging groups moving between perceived low risk groups and higher risk SW or MSM were seen to be significant vectors of the disease as opposed to groups requiring protection through prevention, due to the stigma that exists against MSM and SW. The bridging groups are predominantly, (1) MSM who remained underground, presenting as heterosexual are now viewed a key bridging population by nature of their non disclosure and poor access to information and to condoms. They form a major link in transmission between male sex workers (as a one night stand or a long term 'mistress') and their married or regular partners. (2) Men with multiple partners, including sex workers, in addition to one faithful regular partner. Research in Barbados showed that just over one in 5 young males under 29 interacted with sex worker at least once in a twelve month period.

This stigma associated with SW and being MSM and the illegal nature of the sex work industry has undoubtedly contributed to the levels low -self identification among sex workers in the informal and also in unregulated settings. As a result, studies have suggested that HIV risk and transmission are likely to be lower amongst those who self identify and hence can be targeted for prevention efforts, compared to those who engage in Quasi- prostitution (KANE 1993)[14] - exchanging sex for a love/friendship relationship with the added perks of financial support.

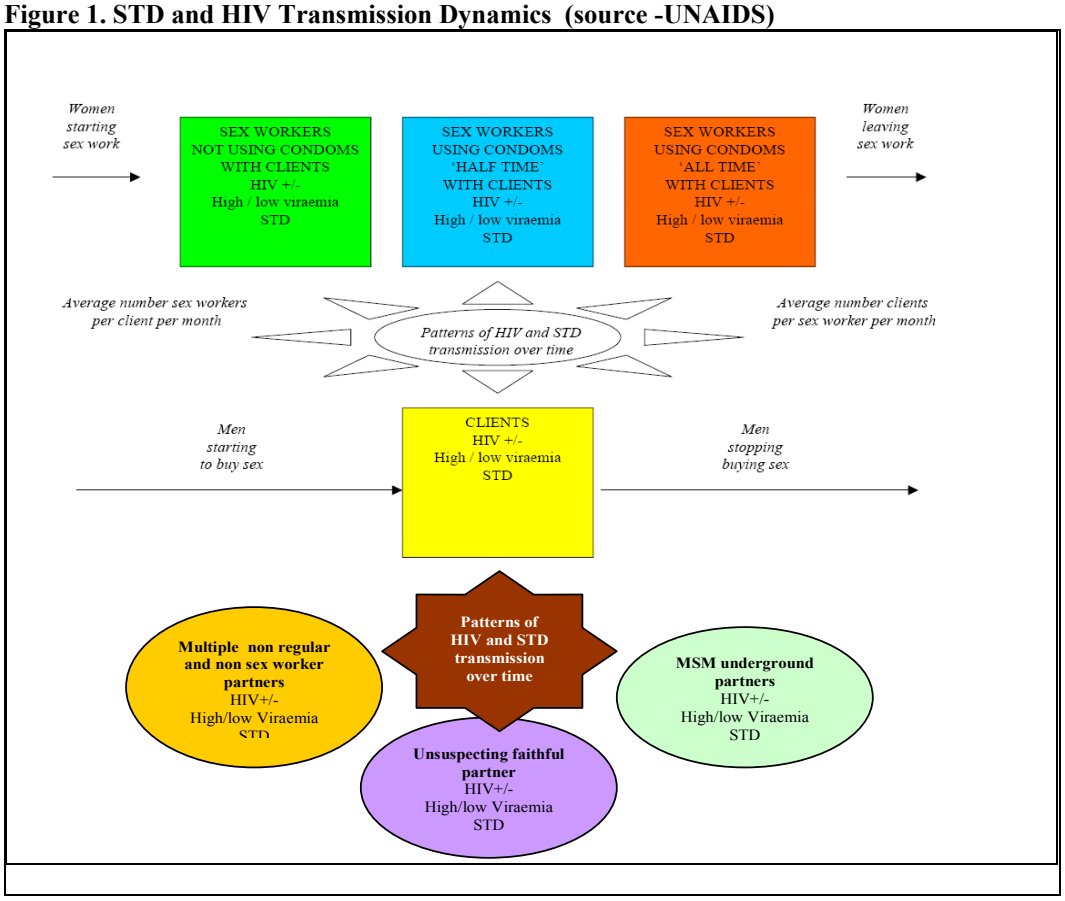
[14] Kane Stephanie C. *AIDS Alibis. Sex Drugs and Crime in the Americas. Philadelphia*. Temple University Press. 1998.

Thus, in an environment of prevailing stigma in the Caribbean and the nature of sex work existing as a loose definition across all SES, controlling the spread of HIV among non-disclosing sex-workers in this new era of longer life expectancy of People with HIV is a burden that sits on the shoulders of the entire society. This means that even members of the general population with self- perceived low risk must responsibly seek HIV tests as long as they are engaging in sexual activity with inconsistent or non- condom use. At the same time it is also the general society's responsibility to participate in behaviour change that will induce the break down of access barriers with regards to the stigma associated with taking an HIV test or using a condom.

Hence given the evidence base so far, it is an agreed perception across the LAC region that sex work is closely linked to the HIV incidence rates through the following risk factors; Multiple partnering both long and short term, inconsistent use of condoms with both clients ad regular partners; frequent use or dependency on drugs and alcohol, lack of awareness of risk in comparison to the compensation received.

Countries such as Dominican Republic, although a highly active tourism setting, continue to maintain HIV prevalence at 1.1 while sex workers prevalence ranged from 1.1percent to 12.4 percent within the DR. This prevalence in sex workers is lower than other regions where sex work and sex tourism is highly prevalent. The lower prevalence rates and successes in reduction of incidence in sex workers as observed in DR may be indicative of targeted interventions by NGOs and the best practice sections highlight these further. Looking at older males between 40 and 44years in the DR, prevalence is as high as 5% and demonstrates the highest incidence in the DR within former sugar plantation communities comprised mainly of Haitian immigrants (Bateyes).

Figure 1. STD and HIV Transmission Dynamics (source -UNAIDS)



Likewise, in Guyana, HIV prevalence rates in sex workers are significantly greater than the general population rates, where over 46% in a sample of over 200 female sex workers (FSW) in the late 1990s where found to be HIV positive the pattern remains. Where available, studies have shown that HIV prevalence in SW is highest within street based work in areas where there are more local and less wealthy clients. In Suriname, a 2004 study revealed a prevalence of 21.1 percent HIV in 194 sex workers survey. The greatest concentration of HIV prevalence was observed in The street based CSW.

Table 2: HIV Prevalence Studies Suriname - 1983 - 2002

Year	Population	Study sample	# HIV +	HIV prevalence
1986	STD Clinic Cliënt	490	0	0.0 %
1986	Registered Commercial Club Sex Workers (CCSW)	74	0	0.0 %
1989	STD Clinic Cliënt	2000	12	0.6 %
1989	Registered Commercial Club Sex Workers (CCSW)	97	1	0.01 %
1990	Registered Commercial Club Sex Workers (CCSW)	157	4	2.5 %
1991	Bezoekers SOA-poli D.D.	4236	44	1.03 %
1992	Prison population	146	0	0.0 %
1996	Commercial Street Sex Workers	189	42	22.0 %
1998	Men-who-have Sex with Men (MSM)	78	14	18%
1999	Military	140	2	1.4 %

Source: National STI/HIV/AIDS Programme

Table 3: Sex work in selected countries (Source IOM: 2004)

	Barbados	Curacao	Dominican Republic	Jamaica	Trinidad and Tobago
Source countries	Antigua and Barbuda Belize Dominican Republic Haiti Grenada Guyana St. Lucia St. Vincent Trinidad and Tobago	Brazil Colombia Dominican Republic Venezuela	Europe Haiti	China Cuba Dominican Republic Russia Venezuela	Barbados Colombia Cuba Grenada Guyana Suriname Venezuela
Settings	Brothels, clubs, streets	Brothels, clubs, streets	Brothels, clubs, escort services, streets	Apartments, brothels, clubs, streets	Clubs, escort services, fashion houses, hotels
Clients	Crew of ships in port, tourists, Barbadian men	Crew of ships in port, Tourists		Tourists, Jamaican men	Elite clientele from Europe, North America and Taiwan, ("Yachties")
Related Legislation	Prostitution illegal	Prostitution is not illegal; incitation to prostitution is illegal; regulated camp Trafficking illegal - never successfully prosecuted	Prostitution illegal	Prostitution illegal	Prostitution illegal
Concerns	Links with tourism Targeted by police and immigration authorities	Links with tourism Mandatory HIV testing for regulated prostitution Targeted by police and immigration authorities Trafficking Violence against female sex workers	Level of knowledge about transmission / prevention Trafficking Violence against female sex workers	Links with tourism Links with drug industry Trafficking Underage sex workers	Links with industry Links with tourism Targeted by police and immigration authorities

3 Sex work and HIV within the Caribbean policy framework and programmatic response

3.1 Regional response

The response to HIV/AIDS in the Caribbean has increased dramatically over the past five years. A variety of national and regional projects have been implemented, including successful applications to the Global Fund to Fight AIDS, Tuberculosis and Malaria. Recognizing the seriousness of the HIV/AIDS epidemic in the region, members of the Caribbean Community established a Caribbean Task Force on HIV/AIDS in 1998. In June 1999, the National AIDS Program Directors met in Antigua to review and approve a draft regional strategic plan (WB 2000, xi. In February 2001, the task force expanded into the Pan Caribbean Partnership against HIV/AIDS (PANCAP[15]), established by CARICOM heads of state and endorsed by the Nassau Declaration on Health 2001. The partnership is mandated to advocate for HIV/AIDS at the highest levels of Government, to coordinate regional response and mobilize both regional and international resources, and to increase country- level resources to address the epidemic (PANCAP online). Based on the 2000 regional strategic plan, PANCAP commissioned and developed The Caribbean Regional Strategic Framework for HIV/AIDS 2002-2006

The overall intention of the Framework is to provide a basis for reducing the spread and impact of HIV/AIDS in the Caribbean. The framework identifies areas for priority action at the regional level, which are focused on promoting a strengthened, effective and coordinated regional response to the epidemic, and supporting expanded multi-sectoral HIV/AIDS programmes at the national level. The Regional Strategic Framework is based largely on the efforts of these groups to coordinate and prioritize HIV/AIDS work in the Caribbean region. The priority areas are as follows:

1. Advocacy, policy development and legislation
2. Care, treatment and support of people living with HIV/AIDS
3. Prevention of HIV transmission, with a focus on young people
4. Prevention of HIV transmission among especially vulnerable groups:-
    - Men who have sex with men (MSM)
    - Sex workers
    - Prisoners
    - Uniformed populations (military and police)
    - Mobile populations
    - People in the Workplace
5. Prevention of mother to child transmission of HIV
6. Strengthening national and regional response capability
7. Resource Mobilization

[15] PANCAP members include Barbuda, The Bahamas, Barbados, Belize, Bermuda, British Virgin Islands, Cayman Islands, Cuba, Dominica, Dominican Republic, Grenada, Guyana, Haiti, Jamaica, Montserrat, Netherlands Antilles, Puerto Rico, St. Kitts & Nevis, St. Lucia, St. Vincent & the Grenadines, Suriname, Trinidad & Tobago, Turks & Caicos Islands and the US Virgin Islands. For the purpose of this review these contrities are refereed to when the term" region" or "Caribbean" is used.

Table 4:HIV/AIDS in selected countries (IOM- 2004)

	Barbados	Curacao	Dominican Republic	Jamaica	Trinidad and Tobago
First known case	1984	1985	1983	1982	1983
Total known cases	1,531	1,332	6,830	6,038	11,000
Population*	268,000	215,000	8,506,000	2,598,000	1,299,000
Prevalence	1.75%	2%	2.5%	1.5%	1.2%
Age of PLWA	25-49 years	25-44 years	15-44 years	20-39 years	15-45 years
Gender of PLWA	Young women increasingly infected	43% women	37% women	Young women increasingly infected	37% women; Young women increasingly infected
Transmission	Heterosexual (MSM, CSWs)	Heterosexual (MSM, CSWs)	Heterosexual (MSM, CSWs IDUs)	Heterosexual (MSM, CSWs)	Heterosexual (MSM, CSWs)
Notes on Health System	Universal healthcare - must present ID card; PMTCT available at public health clinics	Two levels of government (central and each island); Lack of access for uninsured or undocumented	New law being implemented to provide universal access to healthcare for nationals; Access to services limited for poor or undocumented	Ministry of Health works with Parish AIDS Committees (PAC), and NGO coalition (NAC)	Response through Ministry of Health and Regional Health Authorities (RHAs); Implementing health sector reform – shift to primary level care for chronic diseases; Lack of access for migrants
National AIDS Plan	Action Plan for a Comprehensive Programme on the Management, Prevention and Control of HIV/AIDS 2001-2006	National Strategic Prevention Plan 2003-2008	National Strategic AIDS Plan (PEN) 2000-2003	National Strategic Plan HIV/AIDS/STI 2002-2006	National Strategic Plan for HIV/AIDS (2002)
Mobile populations addressed by NAP?	No	Yes	Listed as possible target groups	No	Not explicitly; Some high-risk groups are mobile populations
Notes on Response	National Advisory Committee on AIDS (NACA); National HIV/AIDS Commission (NHAC); HIV/AIDS Prevention and Control Project (2001)	National AIDS Committee (NAC)	National Program to Control AIDS and Sexually Transmitted Diseases (PROCETS); Presidential AIDS Council (COPRESIDA); AIDS network, REDOVIH; Youth network; PLWA groups	National AIDS Programme (NAP); National Planning Council of Jamaica; National AIDS Committee (NGO coalition)	National AIDS Committee
Concerns	Stigma and discrimination; Lack of access for undocumented migrants; Increased incidence of HIV+ babies despite increased knowledge; Young women increasingly infected	Stigma and discrimination; Lack of access for the uninsured or undocumented; Regulated prostitution; Not a political priority; Cannot buy low-cost ARVS negotiated by PANCAP; Gender inequality and violence; Restricted entry for HIV+ migrants	Stigma and discrimination; Lack of access for migrant populations; Populations working on sugar plantations	Stigma and discrimination; Lack of access; Vertical transmission; No strategy for MSM or IDUs; Young women increasingly infected; High levels of domestic violence and sexual assault	Stigma discrimination; Lack of access, especially to ARVs; Gender inequalities, violence; HIV tests take 6-8 weeks; Lack of appropriate standards of treatment and care; Lack of education; Young women increasingly infected; Restricted entry for HIV+ migrants

**World Health Report 2003*; UN Population Database online

With respects to priority area 1 (*Advocacy, policy development and legislation*) the issue of human rights and stigma and discrimination against vulnerable populations including sex workers is integrated within broad stipulations on human rights and not explicitly stated in recognition of the special circumstance of vulnerable groups. Likewise, with respects to area 2 (*Care, Treatment and Support for People Living with HIV/AIDS*), given the mobility and barriers to access to

treatment and care, coupled with poorer mental health and coping mechanisms within vulnerable groups, the access to treatment and care by sex workers is placed within the broad agenda of the priority area and is not explicit.

Countries of the region have based their responses on guidance articulated in the regional framework and thus embrace a comprehensive approach which includes: a) prevention; b) care and treatment; and; c) institutional development, management and coordination (including M&E). However, very few countries have translated their commitment or plans into rolling, results-oriented action frameworks; positively, more recently countries are moving into more focused attacks on stigma and discrimination and towards controlling the epidemic within the most at risk groups (vulnerable groups), but still require more action on the development of a legal framework and institutional policies to address these issues head on.

3.2 National Responses

National plans mandate a multi-sectoral response to address country epidemics however; the National HIV/AIDS programs have placed the highest priority on the health sector response. The focus for the past five years has been on treatment scale- up and the establishment of systems to support treatment access, with less attention being paid to prevention and support. The move is now rather towards a multi-sectoral response focused on attaining a more efficient balance of efforts directed towards both prevention and life prolonging therapy. Improved coordination and referral between the health sectors in particular STI, Family planning, HIV care and the non-health (Education, social transformation, etc) is an urgent requirement if those at risk of HIV are to gain exposure to consistent and continuous prevention services.

In addition, the meaningful engagement of civil society in order to strengthen the multi sectoral approach requires greater effort and emphasis within the national programme agendas. This is an urgent requirement in particular, with regards to the involvement of grass roots organizations that able to reach CSW and other vulnerable groups as a result of their community focus.

Selected countries - Barbados, Bahamas, Suriname, Jamaica and Trinidad and Tobago, Belize and Haiti and Dominican Republic have scaled up their efforts over the last 2 years to involve selected members of civil society such as FBOs and Private sector foundations and fledgling NGOs. In the Dominican Republic and Haiti Civil Society Organizations (CSOs) are well organized but the smaller countries tend to have less developed CSOs with limited implementation capacity to respond to HIV/AIDS.

Suriname, Belize, Dominican Republic, Cuba, Curacao, Jamaica and Haiti are significantly further ahead than the other countries in working with civil society to deliver targeted prevention and to address the treatment needs of CSW and other hidden vulnerable groups at the grass roots. These best practices are discussed in the country level analyses in section 4.

The establishment of links with civil society development partners has been evident in the strategic planning processes within all countries. The efforts directed to strengthening and maintenance of these partnerships through to the programme implementation levels is fraught with gaps to varied extents across the region. In many countries where links are observed, implementation input of civil society is hindered by lack of information for them to plan their institutional response, insufficient human resources and skills base with the community organizations and inadequate resources to attract committed long term staff to maintain skills transfer, training and management of the continuous inflows and outflows of volunteers.

To different extents again, the gaps in achieving sustained active engagement of civil society in particular, FBOs, NGOs and CBOs by governments have been taken up as a priority area for intervention through funding from international donor agencies and technical implementation assistance from international NGOs. This is intended to strengthen community-based grass roots responses. The focus of these organizations is on outreach activities such as condom distribution, improving access to services for vulnerable groups, PLACE methods in reaching proprietors and clients of sex workers. The allocation of funds for building and institutional strengthening in particular in the smaller countries, including the training and hiring of vulnerable groups including sex workers still remains a very real gap.

3.2.1 The Three Ones Principles

The three one was endorsed in 2004 by UNAIDS in a effort to generate consensus among key donors with respects to achieving greater coordination of national AIDS responses and leadership by the affected countries themselves, thus creating country level ownership of responses.

They endorsed the "Three Ones" principles, aimed at achieving the most effective and efficient use of resources, and to ensure rapid action and results-based management:

- One agreed AIDS action framework that provides the basis for coordinating the work of all partners
- One national AIDS authority, with a broad-based multi-sectoral mandate
- One agreed country-level monitoring and evaluation

The principle is specifically designed to address the urgent need for greater support and collaboration with heavily-affected countries and to avoid duplication and fragmentation of resources. At the same time the principal recognizes that more resources are needed therefore pooling of resources is also encouraged.

The guiding Principles and Approaches are;

- Government in the driver's seat—National ownership
- Strong focus: national priorities, capacity building, stakeholder participation
- Flexible approach from country to country, not "one-size-fits-all. (which also means greater emphasis on monitoring and evaluation and cost-effective modeling in order to translate effective best practices"
- Enhanced impact of partnership with all sectors/groups in particular developing and scaling up the work of private sector foundations.
- Reduction of transaction costs
- Defined roles, responsibilities and levels of accountability

The three ones principals and guiding approaches support the scaling up of a regionally standardized monitoring and evaluation system to address dynamics of sex worker interactions in particular with regards to HIV transmission patterns, vulnerabilities, need and the likely flow patterns between countries of the region. In addition the guiding approaches call for greater involvement of privates sector and CBOs.

3.3 Stigma and discrimination of Sex workers and those at risk of becoming sex workers - as cross cutting issue

Throughout the preceding sections it has been highlighted that;

- ⇨ Stigma and discrimination represents the single greatest obstacle to an effective national response, but most programs have not yet found ways to address the problem effectively.

- ⇨ Stigma and discrimination makes it difficult for infected persons to come forward for testing, treatment and care, for vulnerable groups to be reached, for politicians to speak out publicly, and for laws against discrimination, where they do exist, to be enforced.

- ⇨ The epidemic is still largely, hidden with the impacts of the disease on households and communities and workplaces remaining underground. This situation in many countries of the region mirrors where Sub-Saharan Africa was a decade ago. As such, the danger signals are self –evident in terms of the urgent need to break down the access barriers created by stigma and discriminations. The key problems are;

1. Discrimination at the point of health care delivery towards people who are perceived by providers to be sex workers in is still present
2. Efforts to address mitigating impact of HIV through the development of policies and programmes aimed at reducing health care access barriers are slow to materialize. This is a particular concern within the health sector, where reports continue to emerge across most countries of the region that there are still factions of health workers are still be uncomfortable in dealing with people living with HIV/AIDS, and where breaches of confidentiality continue to occur.

3.4 Human rights Legislation and Stigma and Discrimination Policies for vulnerable groups and key populations and sex work

a. The legal framework of the English-speaking Caribbean has been perceived to perpetuate stigma and discrimination against some high risk groups, particularly MSMs and CSWs. Prostitution is illegal, cited as a criminal offence in most countries of the region (it is not explicitly outlawed in Dominican Republic) and in St Maarten, adult entertainment and escort services are permitted. However, some countries such as the Bahamas recently decriminalized homosexual behavior and a more inclusive attitude toward PLHIV was described in most countries and however, did not alter the laws prohibiting prostitution. Most countries have not explicitly articulated their position on prostitution off the law books, for political reasons. However selected countries such as Barbados are exploring ways in which modification to existing legislation or complimentary new laws may contribute to reduction of stigma and discrimination.

b. Efforts to enforce the rights of those living with HIV that discriminated against are also underway through the development of stigma registry, in particular in Barbados. These plans are articulated on paper but the reality of implementation has met with obstacles and unanswered questions. For instance it has become evident in Barbados that a viable and functional registry requires that the victimized feel 'free' to report discriminatory acts without fear of reprisals or having to disclose their status- This cannot be guaranteed to a sex worker in light that their nature of work is illegal in Barbados. Therefore, alternative reporting approaches need to be structured, reporting flows outlined and pilot tested if the law on prostitution is not

urgently addressed. Hence there has been no provision or recommendations made so far as to how best to ensure that their confidentially will not be breached.

c. Further to this, the fact that prostitution is illegal serves as a deterrent to sex workers in reporting any acts of discrimination towards them by immigration officials enacted during entry in a country or upon reporting violence to police;

d. At the same time, significant barriers remain. For instance, in order to effectively address the prevention needs of youth who are at risk of entering into sex work, the age of consent among adolescents must be addressed. This legislation as it stands, in most countries prohibits young people from visiting a health centre for care without an adult present and is thus prohibitive to access by the youth. If this public health legislation is to remain, then policymakers need to urgently explore the development of a menu of service provision for young people who are below the age of consent. Such a menu will describe services that youth can access without an adult attending with them. In doing so, the contradiction between law and practice can be addressed - since, currently in most countries many young people below the age of consent are sexually active but can be legally refused information, services or products, leaving them in some cases, at risk and unable to access the necessary information. In addition harm reduction strategies that go further to protect the rights of the youth are urgently called for. For instance, in the case of sex abuse through incest, youth need to be able to seek health and social services without the accompaniment of a member of the family.

e. By keeping sex work invisible and off the policy agenda in many countries the issue of access to comprehensive services for sex workers means that sex workers themselves can only be viewed by service providers as a problem and not as people with individual and collective needs like the general population at large.

f. As a result, sustainable development through the mitigation of HIV spread is further hindered; as prevention of future HIV cases in the sex workers and the children of sex worker who are risk is ignored.

g. Contact tracing is inefficient or non existent within many programmes due to the lack of confidentiality that exist son small islands in particular,; those who seek other alternative to change their lives whether in the short term or as a future goal are left unaided in terms of personal development, welfare, and access to welfare driven professional and skills development services.

h. With regards to harm reduction in terms of protection from violence and exploitation - such services remain as acute care delivery and responsive only in the form of treatment due harm caused. This incomprehensive and incomplete care is due to the lack of visibility of this group as a result of the existing legal framework that criminalizes prostitution, thus preventing a full understanding by providers of the scope of the needs in order to implement effective long term and ongoing harm reduction solutions. As such, no country legally enforces the human rights of the sex worker or stipulates the reporting and action that have been taken to protect a sex workers in the event highly irregular breaches of the sex workers safety through the of violence of rape, harassment by law enforcement and immigration, service providers, mental abuse, homicides, households suicides, or trafficking.

3.4.1 Treatment care and support

a. Most programmes are aiming to provide a comprehensive set of treatment care and support services which encompass not just ARV provision, but also interventions to assist patients and

their families in coping and to promote emotional well being, as physical and health and vitality is maintained.

b. *Prevention of transmission* support groups for PLHIV are also mandated. However, despite the will and commitment to move into the holistic approach to caring for patients, not enough has been enacted.

c. Within national strategic plans, the distinct treatment care and support needs of sex workers are not addressed outside of the broad category of vulnerable groups - in particular with respects to services and programmes that are designed to accommodate and address the risks associated with the high degree of mobility and stigmatization within this group.

CARICOM Accelerated access Initiative

Notable among the responses in the Caribbean have been efforts to make antiretroviral medications more accessible. The CARICOM Secretariat initiated the Accelerated Access Initiative (AAI) in 2002 with the establishment of a task force to negotiate with pharmaceutical companies for better prices on ARVs (Brohim 2003, 2). Barbados, the Dominican Republic, Haiti, Jamaica, Trinidad and Tobago were among the participating countries.

On July 2002, CARICOM and several pharmaceutical countries signed a memorandum of Understanding during the International Conference on AIDS in Barcelona reducing the price of first- line triple therapy regimen to the price offered to Sub-Saharan Africa, around US$ 1,100. Though the negotiations were successful in lowering prices for some countries in the region, "the increasing availability of generic ARVs at even lower prices" has made the generic market increasingly important (Brohim 2003, 4).

Countries that continue to purchase non-generic ARVs are paying significantly higher prices than those mainly purchasing generic ARVs (Brohim 2003, 5). The Clinton Foundation recently facilitated and negotiated favorable ARV prices with manufacturer CIPLA for the Bahamas, Grenada and Anguilla (Brohim 2003, 2).

d. Although sex workers are cited as part of the vulnerable groups that have been specified within a majority of countries, national programmes, particularly within the OECS, do not target the specific treatment and care and support needs of Sex workers in relation to their profession such as the targeted delivery of harm reduction, psychosocial and mental health support services and STI diagnosis and management and control.

3.4.1.1 Universal Access

With respects to planning universal access of HIV services;

a. The service scope of health systems varies across the region - from providing universal healthcare including HIV/AIDS services, such as Barbados, to countries whose poorest populations currently do not have access to even primary care, such as the Dominican Republic.

b. Despite these differences, access to HIV/AIDS care is a serious problem for vulnerable groups, in particular sex workers and migrant populations in all countries. In Barbados, universal care for HIV/AIDS is being implemented, but an ID card is necessary to access these services, for example and as a result migrant workers with illegal status do not access services. Accounts of being turned away have been given, only for the individual to appear at the emergency room

hours or days later. Ultimately, the episode of care is more costly for the migrant worker and for the health system, is of higher risk, and often associated with poorer outcomes than would otherwise have been if services were provided at a less acute demand phase. In Curaçao, those who do not have health insurance have minimal access to healthcare in general.

c. Access to comprehensive HIV and AIDS care, including treatment with life-extending antiretroviral medications (ARVs), varies greatly in the Caribbean and falls within the scope of the health care and welfare systems of countries.

d. While some non-governmental organizations do provide ARVs, the supply is uncertain and inadequate for treating all those in need. On a regional scale only 23%f those who need antiretroviral treatment were receiving it in 2005 , while in others such as Barbados, Bahamas, Bermuda and Cayman Universal access is being implemented and more than 60% of those who require ARV therapy receive it.

e. In 2004, about 5,000 people were receiving anti-retroviral therapy (ART) in the nine countries with World Bank-funded projects in Haiti, accounting for about 10 percent of the population needing treatment.

f. And in 2005 in Haiti and Dominican Republics, despite best practices in areas that provide ARV treatment and care, less than 20% of those requiring ARVs were receiving it. In most of the Caribbean with the exception of Haiti countries' coverage of antenatal services is high. More than 75 percent of mothers in the region are in contact with a clinic before giving birth, and many deliveries occur in hospitals.

g. Treatment is expanding rapidly in 2005 due to funding assistance from both the World bank and from the Global Fund; In Jamaica between 2002-3 less than 5% were receiving ARVs and in 2005 the Jamaica Ministry of health was providing 50% of AIDS patients with ARV and Suriname also recorded significant scale up of ARV provision following receipt of a Global Fund grant in 2004.

h. Access to VCT has been hindered and therefore uptake across most countries is slow reaching between 1% and 10% of the general population seeking testing as a means health screening. Many people are testing for the following reasons; pregnancy, Insurance, travel, following risky practices of offered in response to a diagnosis of an STI. Widespread stigma associated with AIDS, "its perceived association with homosexuality," and sexual activity in general has also affected access to voluntary counseling and testing (VCT) and care in the Caribbean. Most recently, as the epidemic has become more generalized and feminized, there is an association of the need to test with risky or promiscuous sex thus further deterring members of vulnerable groups from seeking VCT services.

i. Perhaps as a result of the priority placed on the health sector responses within national programmes, the health sector appears to have made good progress in many countries.

j. Key health sector staff are generally in place although there is still a dearth of skilled staff for provision of social support services for PLHIV. In addition, activity is being scaled up, and the procurement of equipment and supplies (condoms, lab supplies, STI drugs) has been undertaken, even though the procurement of basic items, supplies, equipment , reagents and drugs is often very slow, due to bottlenecks caused by government bureaucracy and/or unclear and often lengthy procurement processes.

k. Smaller countries in the region, in particular within the OECS have been slow to scale up ARV treatment due not to lack of political will but to weak institutional and human capacity.

l. Although there are good examples of effective implementation and national commitment that can form the basis of an accelerated response, overall the Regional response through PANCAP and other regional agencies has great promise which is yet to be fully realized. External funding exceeds $460 million for the Region, but World Bank and Global Fund financed programs have been slow to implement and treatment access has been fraught with poor planning and incomplete projections of required services costs.

m. This lack of available information for planning is mainly due to poor M&E systems to monitor need in particular for vulnerable groups. Hence despite a keen effort to apply the "Three Ones" principles in some countries, for most countries, national strategies, M&E systems and organizational and governance structures are ineffective for sufficient planning and implementation of programmes.

n. In countries Dominican Republic and Suriname the increasing presence and voice of sex workers is due to the active work of agencies such as MODEMU[16] and Stitching Maxi Linder association (SMLA)[17] , respectively. As such, access to ARVs for sex workers has been scaled up and in Suriname special focus in being given to sex worker- client hotspots such as the mining areas in the country's interior. These programmes are discussed in the country analyses and best practices sections.

o. In Barbados a sex worker project is underway in order to identify specific intervention needs of sex workers and also to implement treatment strategies to incorporate sensitive and stigma free approaches to provision of care to sex worker and other vulnerable groups.

p. Preliminary findings of the Barbados surveys, and from recent work in Suriname and Jamaica support findings from the rapid assessment interviews with sex workers and outreach workers that were conducted to further inform this analysis; These indicate that;

i. Although sex workers may access services, their emotional and mental health support needs often remain unaddressed.

ii. They have described feeling marginalized at the point of care delivery once their profession is 'suspected' by the attending personnel. Their needs as mother, women, and citizens with rights are not addressed.

iii. Sex workers often resort to seeking care therefore across different unlinked settings and a mixture of private and public outlets, some far from their homes and often with no follow up. Under such scenarios there is usually no communication between the treating services - by physicians, social workers, etc. Resorting to this form of fragmented care as opposed to receiving comprehensive treatment and support via effective referral networks

[16] MODEMU, a Dominican organization that focuses its efforts on creating opportunities for women living with HIV/ AIDS in the Dominican Republic.

[17] SMLA's overall goal is to optimise the social, economic, mental and physical health and wellbeing of female commercial sex workers. This is goal is pursued through education, information and skills training; support and advice on social, legal and health matters, raising social awareness and encouraging a positive self-image and solidarity; and offering protection against violence and abuse.

has been reported by those who care for PLHIV as resulting in poor attendance of the most at risk of secondary transmission, such as sex workers.

iv. As no recourse exists to dealing with abuse from staff within health clinics, sex workers have recount incidences of discontinuing attendance to services for Sexually transmitted diseases.

v. Clinics providing ARVs have begun discussions on treatment outreach to centres where sex workers are found. However due to the policy issues surrounding the illegality of prostitution some countries are finding it harder than others to move into this form of service provision. The Jamaica Ministry of health and the Suriname Medical mission have developed clinical services for sex workers in the community despite the fact that prostitution is illegal in these countries.

q. In several of the smaller islands, there is a dearth of civil society organizations which primarily deals with addressing the needs of sex workers, HIV prevention and treatment and their empowerment. The ALLIANCE, an international NGO works within selected OECS countries, however due to stipulations within their funding agreements, they do not conduct explicit sex workers-focused programmes. As of the end of 2006 a section of these programmes came to a close. The result is that with the exception of Guyana, Haiti, Jamaica, DR, there is a significant dearth of civil society organizations with built institutional capacity and with this, limited public private partnerships that address the prevention needs of vulnerable groups including sex workers.

r. It is imperative that collective viewpoints, obstacles to universal access to services and effective action are addressed to ensure that sex workers and other migrant workers are able to receive a comprehensive care continuum instead of care that is fragmented and often leading to more costly medical complications such as resistant virus and to subsequent circulation thus making the epidemic even harder to combat through treatment.

s. The lack of consensus on the policies regarding sex work contributes significantly to the lack of focused intervention to address the specific needs of sex workers with regards to treatment care and support.

t. In the absence of a regional consensus on the legal framework on sex work, there is required a revision to the roll out of supportive care to all attendees to HIV/AIDS related clinical and supportive services in the region. Regionally devised guidance on care pathways must incorporate definitive approaches that recognise social and QoL issues that will impact on care outcomes across all groups and regardless of scope the of need.

u. Therefore, an all inclusive approach to care and support will remove the need for a health provider to question the profession of an individual.

v. It is prevention and the urgent need to address the socio - cultural and environmental factors that contribute to HIV risk that requires more individualist approaches to care.

w. The impact of non-collective action and policies across borders and neighbouring countries with regards to treatment and care has been reported through interviews with the Maxi Linder Association in Suriname whereby - HIV positive Sex workers from visit French Guyana are unable to access ARVs and are attracted to Suriname for purposes of both work and access to ARV medication. In St Maarten positive sex workers from other countries have

experience barriers to refilling their prescriptions for ARVs drugs in order to avoid an untimely break in therapy. Access to the care continuum is therefore impeded by country specific access policies or by the availability of differing drug regimens in each country.

3.4.2 Prevention of HIV

Within the Regional Strategic framework specific mention of sex workers is made within the prevention priority areas;

- To strengthen understanding of role of sex workers in regional epidemiology of HIV/STIs, and to use information in appropriate prevention and care strategies
- To support development of regional networks of NGOs addressing HIV prevention and care needs of sex workers

In the area of prevention, most national plans also prioritize selected vulnerable groups (generally including youth, CSW, MSM, prisoners, and people living with HIV/AIDS-PLWHA) in addition to their focus on sensitization of the general public and health sector prevention activities; however, not many countries have moved beyond awareness raising for the general public toward a more focused approach on vulnerable population groups. Specifically with respects to commercial sex workers, targeted programmes within national strategic plans or government work plans are lacking specific reference to the prevention needs of sex workers.

There are of course exceptions, in particular emerging over the past 3 years since 2004, in response to scaling up of country programmes through the Global fund grants and other donor sources. Haiti and Dominican Republic have been working for almost a decade on targeted approaches to HIV prevention in sex workers and best practices exist and are discussed in section 4.

Also significant in their scale up has been Belize and more recently, in response to the regional framework and Global fund assistance in 2004, Jamaica, Antigua and Trinidad and Tobago. Smaller countries with high levels of tourism, despite, their income status and financial and political commitment to fighting the epidemic have been slower to define the issues regarding the role of sex workers and their clients as determinants of the trajectory of the HIV epidemic, or to respond to the call for targeted prevention strategies and the elucidation of needs of sex workers and other hidden vulnerable groups. It may be that many of the approaches in the smaller islands with tourism-driven economies require active engagement from ministries of tourism and their commitment to working with and supporting sex worker outreach services and other vulnerable groups CBOs; and these links have been slow to emerge. These slower countries have included, Antigua, Bahamas and Barbados,

The multi-organization review of 2006 recommended that:

Priority attention for the national response includes;

(i) Restoring a strategic balance in national programs with intensified focus on prevention,
(ii) Launching a concentrated attack on stigma and discrimination through better analysis communication strategies and legal action,
(iii) Adopting simple, low-tech M&E systems to support interventions based on evidence.
(iv) Enhancing local capacity through innovative, collaborative means rather than increases in numbers of staff.
(v) Simplifying implementation processes, especially for smaller states.

The scale up of condom social marketing programmes has been promoted by partnerships between the international agency, population services international (PSI) and the National commissions resulting in the increased availability of condoms through public health facilities in selected countries, these include, Haiti, Dominican Republic, Antigua, Guyana, Barbados, Trinidad and Tobago and other small islands of the OECS. PSI works closely with local vulnerable group organisations where they exist and with clinics – Haiti, Guyana, Dominican Republic. These approaches ensure that there is a focus of condom distribution to vulnerable groups.

Due to the legal framework and an absence of effective monitoring and evaluation by the small local CBOs and clinics involved in the condom distribution services, a reliable total count of distribution to sex workers is unknown in most countries.

The disproportionate cost of the female condoms as almost 4 times more costly than the male condom, promotes poor access to more empowered HIV prevention methods through condom use by female sex workers who seek to gain control over their choice to protect themselves.

Unfortunately, most prevention approaches or plans in several Caribbean countries do not seek to address the socio-cultural and environmental factors that influence HIV risk behavior. It appears that sex workers are still "*placed in a box*" within the agendas of the policy makers and planners - Despite highlights of their needs through ad hoc assessments and evidence from outreach organizations, the needs of sex works still remains unmet, underground and often unexpressed (not demanded) even at the point at which the sex worker seeks the provision of care or support services.

Table 5: Sex-worker felt issues and needs

Socio-cultural or environmental Issue	**Need**	**Scope of Service required**
Fear of violence, exploitation, homicide, etc.	Protection from the state as much as any other citizen	Institutional Policy development Private sector NGO -Community led support/advice
Harm from violence and HIV risk from Rape , harassment , from law enforcement, providers, gangs, etc	HIV prevention Coping support Support to dependents i.e. children (who are also at risk)	Treatment services and psycho-social services
Low self esteem and emotional well being as a result of loss of rights	Building self esteem and diagnosing/recognition of emotional needs	Counseling and psychosocial services
Breaking the cycle of *subsistence* sex work or sex work linked to dependency on substances	Need for an alternative future , breaking the cycle - of addition or sex work or both	Social service interfacing with community development, education, small business enterprises (microfinance options) , etc.
The future of sex work - prevention of youth at risk of entering into sex work and contracting HIV	Psycho sexual counseling support top youth and children of sex workers, vision building and other targeted youth empowerment interventions STI treatment and control	Youth development, family planning and child support, youth enterprise schemes, sexual health services and community youth programmes
Exiting sex work - *moving on*	Empowerment to be able to choose alternatives, personal poverty alleviation strategies and financial planning, visioning	Job training and development, skills building, financial management training, mentorship programmes, interview training, welfare support during transition, training and inclusion in service delivery and outreach roles

3.4.3 Recent Best Practice Regional Initiatives

3.4.3.1 Champions for change, November 2004, St Kitts. PANCAP, DFID_UK

The C***hampions for Change*** programme commenced in November 2004 with a 3 day high level conference hosted by the Caribbean Community (CARICOM) in partnership with the Caribbean-led Pan Caribbean Partnership Against HIV/AIDS (PANCAP) and the United Kingdom Department For International Development (DFID). The purpose of the Meeting was to share International Best Practices on reducing stigma and discrimination against people living with HIV/AIDS (PLWHA). Its overall objective was to accelerate the process of reducing HIV/AIDS-related stigma and discrimination in the Caribbean, and to identify and empower persons who would be Champions for Change in the fight to reduce HIV/AIDS-related stigma and discrimination; considered to be a major cause of the spread of the epidemic.

In attendance were more than 15 CARICOM Ministers, representatives from Associate Member States, the International Community including the European Union (EU), India, Mexico, Brazil, the United Kingdom (UK), the United States of America (USA), the Regional private sector, the media, faith-based organisations, labour, the Caribbean Regional Network of PLWHA, donor agencies, United Nations Agencies, Regional Universities and Parliaments, international experts in HIV/AIDS and Youth Organisations, participated in the deliberations of the Meeting. Caribbean Cultural Icons including Ambassador Courtney Walsh, former West Indies Cricket Captain and Pace Bowler and the Mighty Gabby, renowned Barbadian Calypsonian, also made their impact on the Meeting.

The High Level Conference was preceded by a Technical Meeting of regional and international experts to present and discuss **Best Practice Models and Approaches** in reducing stigma and discrimination in the Region. This Meeting was chaired by Dr. Peter Figueroa, Coordinator, National AIDS Programme, Jamaica. The Technical Meeting considered working papers on a range of issues including law, ethics and human rights, Policies used with regard to stigma and discrimination as well as Prevention and Control.

The outcome objective was to arrive at consensus on the factors underlying stigma and discrimination; initiating a framework for a Plan of Action for regional leaders; and initiating a process for the Development of a Toolkit for the Reduction of Stigma and Discrimination.

The Meeting considered four key technical presentations which focused on moving policy to action; Caribbean context of law, ethics and human rights; socio-cultural practices that perpetuate stigma and discrimination; and leadership in reduction of stigma and discrimination.

Three Working Groups discussed and analysed issues relating to definitions of and conceptual framework for stigma and discrimination. Specific outputs of the Working Groups included:

i. A Framework Plan of Action against Stigma and Discrimination. The target audience for this framework included political leaders and decision leaders; opinion shapers - private sector, community leaders at various levels, civic leaders and faith-based leaders; regional leaders such as CARICOM and the PANCAP. This Plan of Action also

addressed issues such as building ownership, the supportive legal and policy environment, advocacy, research, and monitoring;

ii. A draft outline of an Anti-Stigma Regional Toolkit. This Toolkit addressed a range of issues including resources to support champions; 'mentoring'/ongoing support for champions; sustained communication and information exchange and capacity-building to catalyze action at other levels in the community; and

iii. An outline of the Role of the Media in Anti-Stigma Advocacy in Action. Issues addressed included communication strategy; the media and the socialisation process; messages and training.

Since then the programme has moved forward into implementation. Activities have comprised of the implementation of CFC II and CFC III described as follows;

Mobilizing the Churches to join the Battle CFC II

REGIONAL church organisations met to, identify challenges relating to HIV/AIDS stigma and discrimination and define a role in which they can make their contributions, have deemed the meeting a success.

To this end, a collective decision was taken that a working committee would be formed soonest and a plan of action developed.

The conference dubbed Champions for Change II and held under the theme "Reduce HIV/AIDS Stigma and Discrimination", was convened by the CARICOM-coordinated Pan Caribbean Partnership Against HIV/AIDS (PANCAP) in collaboration with the British Department for International Development (DFID).

Among those sharing the head table was Canon Byamugisha who is the first practicing priest to break the "silence" by declaring his HIV status more than a decade ago.

Conference resolved to;

- ⇨ Continue to lift our voices against stigma and discrimination in order to break down barriers between people and with institutions
- ⇨ Commit at the leadership and other levels to stay informed about the HIV/AIDS pandemic and to inform our membership in order to strengthen our response
- ⇨ Commit to cooperate with and actively support governmental, non-governmental and other agencies in collaboration with People Living with HIV/AIDS in efforts to prevent HIV/AIDS and to provide care, support and treatment to people infected with, and affected by HIV/AIDS
- ⇨ Affirm a constant and ongoing reflection on the moral, spiritual and ethical issues raised by the pandemic; clarify and interpret these issues in their local context; and offer guidance to those confronted by difficult choices at the personal and programmatic levels
- ⇨ Engage the emerging theological and educational developments at a time when HIV/AIDS is an imminent threat to all
- ⇨ Engage our respective faith-based organisations in at least one programme of action which will contribute to victory over this pandemic
- ⇨ Nominate the Caribbean Council of Churches, in collaboration with CARICOM/PANCAP, to establish a working committee to carry forward the elements of the Plan of Action arising from the Champion for Change Regional Conference.

Engaging the Media CFC III - Regional Conference to accelerate the Media's Role in Reducing HIV and AIDS Stigma and Discrimination.

The two and a half day conference was organised into three segments: A Technical Meeting, a Forum and a Town Hall Meeting.

Three main issues that emerged from the presentations and discussions of the Technical Meeting were mainstreaming HIV and AIDS media coverage, enhancing HIV and AIDS media and communication programmes through increased use of ICTs, and capitalising on the lessons learnt from media best practices.

These formed the basis for the development of a draft action plan by the Technical meeting which was later refined by the wider forum. The Action Plan put forward a number of recommendations and identified specific activities to achieve these. A small committee comprising representatives of a number of PANCAP partners, the regional media association and the PANCAP Coordinating Unit was identified to advance the agenda for implementing the Action Plan.

Out of this, DFID indicated that it would support a Unit on HIV/AIDS stigma and discrimination to assist in implementing the recommendations from the Champions for Change process.

3.4.3.2 Regional Consultation and workshop on Sex Work in Barbados and the Caribbean

The SW Final Project Workshop and Regional Consultation was conceptualised in order to disseminate the findings of its Baseline Study and additionally provide a forum to facilitate the discussion of the activities of Sex Worker Projects and Programmes throughout the Caribbean. Objectives were;

- To disseminate the preliminary project baseline study findings to the project stakeholders
- To discuss the proposed interventions (and interventions currently being implemented in regional programmes) which would be forth-coming from the project findings
- To provide an opportunity for funding agencies and those requiring funding to meet and potentially reach mutually beneficial positions with regard to investment in Projects of this nature.
- To facilitate regional networking and the provision of a forum for further collaboration among Sex Worker project and programme staff from a number of territories within the confines of Latin America and the Caribbean. This is particularly necessitated due to the transient nature of sex work and its implications, specifically, with the advent of the CSME.

4 Where do we go from here?

Developing a holistic approach to prevention of HIV in sex workers within a sustainable development agenda.

Sex work has been in existence in the Caribbean for decades, is a thriving regional phenomenon within the tourism industry, and also mostly illegal in several countries. The true extent and nature of sex work both within a direct industry and indirectly cannot be fully determined. The increasing evidence gained over the past 2 decades in the Caribbean has shown that the industry has been rapidly expanding as a result of various factors, including changes in political, civil and socioeconomic conditions and increased population mobility.

Effectively addressing the HIV/AIDS epidemic among sex workers and their clients' calls for a multi-faceted approach that coordinates a range of diverse responses. To determine which responses will be appropriate, it is important to understand the forces that drive people into sex work. This approach is further reinforced if prevention of HIV is to be sustained in a cost-effective way (using the resources in the best possible configurations to ensure greater gains across time and numbers of HIV cases prevented) – that is to ensure that risk factors that put men and women at risk by entering into sex work at the outset are identified and addressed. These include the need to address women's rights, gender- based violence, family welfare policies, personal development strategies, poverty alleviation strategies and other factors that induce the entry into sex work. Only with such approaches that comprehend and encompass the socio-cultural, economic and environmental dimensions of entry into sex work can countries seek to sustain a reduction in HIV incidence in would be sex workers, practicing sex workers and their offspring.

A deep understanding of sex work drivers is important because although the general strategies will be similar across countries of the region, it can be expected that as entry into sex work can also have socially rooted causes that can be traced to traditions, beliefs and norms that perpetuate gender inequalities, there will be the need to tailor interventions based on understanding of the root causes and drivers in each country. For example, most societies have different sexual standards for men and women and some societies may be at different levels of empowerment based on existing policies or emerging political agendas that have been embraced by the community at large. .

Studies indicate that factors that appear to heighten sex workers' vulnerability to, and risk of, HIV infection include:

- Stigmatization and marginalization
- Limited economic options, in particular for women
- Limited access to health, social and legal services
- Limited access to information and prevention means
- Gender-related differences and inequalities
- Sexual exploitation and trafficking
- Harmful, or a lack of protective, legislation and policies
- Exposure to risks associated with lifestyle (e.g. violence, substance
- use, mobility)

According to the UNAIDS sex work review of 2002, the HIV/AIDS epidemic has highlighted the need for responses on three levels that will promote an all inclusive holistic approaches to HIV prevention in sex workers:

1. Prevention of entry into sex work
2. Protection of those involved in sex work;
3. Assistance in exiting from sex work.

Each of these can, in turn, be addressed on three tiers:

1. Individual - identifying and fulfilling needs that are both unexpressed and expressed
2. Community – empowering and informing the community to take an active role and to understanding the plight of sex workers in the fight for their human rights
3. Policy-making – to address barriers to safety and promoting HIV prevention and empowerment of sex workers

At all response levels, it is necessary to have clear policy standpoints, and to establish programmes with multiple components. These must encompass

- Regionally driven collective standpoints
- National policies and action
- Institutional standpoints and guidance

There is a general lethargy to address the prevention of entry into sex work as many policymakers and researchers might argue that sex work has always been around and will always be around and hence it is 'not worth it ' to address the beyond sex work needs of sex workers. However the expressed need (demand) of a sex worker who would like to exit the industry and therefore requires support and consistency of exposure to self esteem building, skills development and other programmes cannot be ignored. In turn, the hopes and dreams of a young person are often shattered by exposure to the very same conditions or factors that predispose them to enter into sex work in the first place. It is crucial that these conditions are identified and alleviated.

In this regard, it is in the interest of human rights and of ensuring a country's sustainable development that is imperative to respond to the often unheard cry for help to rediscover the dreams and visions, capabilities and hence qualities of life of a young person at risk cannot be ignored. Instead youth -focused prevention into sex work and not just youth HIV prevention must be addressed by more comprehensive youth preventions, harm reduction and self development programmes in order to promote or maintain the health, emotional well being of these young and productive would-be nation builders;

A nation's greatness is achieved by dreams, visions and talents of its people….

……With each new case of HIV, a set of dreams and hopes of the youth, of men and of women, dies from the imprisonment of their latent talents ….to bring ensuing mental and physical poverty….brought by the prevailing self-stigma…brought by collective and enacted stigma and discrimination dished out to them from within a once trusted economic and social environment….

……. Unfortunately, as each hope and dream dies, so does a cornerstone of its nation's future greatness.

PART TWO - COUNTRY LEVEL ANALYSES

The second part of this paper delivers a profile of country trends with regards to sex workers, sex work and best practice responses to the increasing HIV prevalence in sex workers. It provides a backdrop to further reinforce the discussion points raised in part one of this paper.

5 *Dominican Republic*

Figure 2.The Dominican Republic in the Wider Caribbean

Source: EMPACA 2000

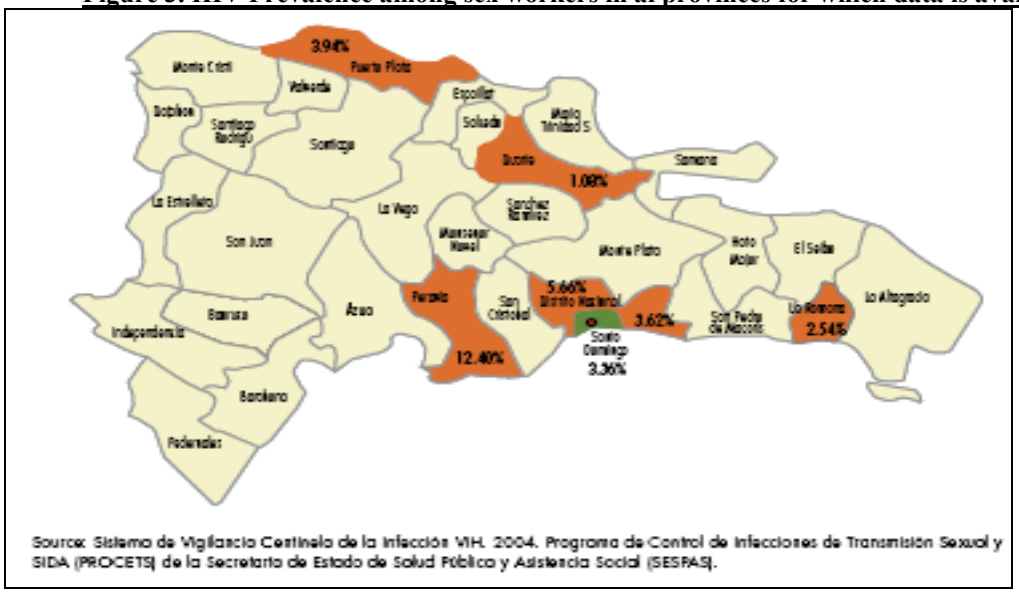
5.1 HIV country trends -

Dominican Republic shares the island of Hispaniola in the Caribbean with Haiti and has a population of approximately 8.7 million people. Tourism is the country's primary economic development strategy. As with other tourist led countries the most significant social impact of tourism in DR is tourist oriented prostitution which has been shown to have far reaching social and economic and political consequences. Both tourism and remittances represent the major earners of the state which signifies a reliance on former colonial powers and outside forces for economic stability.

HIV prevalence in pregnant women has remained relatively stable overall, with national adult prevalence estimated at 1.1% [0.9%–1.3%] in 2005 (UNAIDS, 2006; Secretaria de Estado de Salud Pública y Asistencia Social de Republica Dominica, 2005a). The country's epidemic is considerably linked to extent on HIV transmission between sex workers and their clients, with HIV prevalence being disproportionably high compared with the general population - with the country's estimated 100 000 female sex workers ranging from 2.5% to over 12%, depending on the locale (Cohen, 2006b).

The epidemic is concentrated in the Bateyes. An original sugar plantation that housed Haitian sugar workers originally, the locality is now a shanty town filled with descendents of the original sugar workers or are Haitian immigrants. Prevalence as high as 12% has been found among 40–44 year-old male residents in some Bateyes (Cohen, 2006b). It is estimated that about one quarter of Bateyes are serviced by government health-care clinics, but the marginalization of these communities, along with language barriers and a wariness of officialdom, means the services often are not accessed (Cohen, 2006).

Figure 3. HIV Prevalence among sex workers in al provinces for which data is available



Source: Sistema de Vigilancia Centinela de la Infección VIH. 2004. Programa de Control de Infecciones de Transmisión Sexual y SIDA (PROCETS) de la Secretaría de Estado de Salud Pública y Asistencia Social (SESPAS).

Despite the surge in sex tourism in the state, the trade between local men and female sex workers remains the mainstay of the country's sex industry. (Cohen, 2006b UNAIDS doc).

Starting in the mid-1990s, a decline in HIV prevalence has been noted at antenatal clinics in the capital, Santo Domingo—a trend that has been attributed to best practice efforts to promote safer commercial sex in the city (Secretaria de Estado de Salud Pública y Asistencia Social de Republica Dominica, 2005b). For example, the measure of *condom use in the last 12 months* increased from 75% to 94% among sex workers who participated in a community solidarity prevention project in the capital (Kerrigan et al., 2006)[18]. Despite this, however, in 2005 an estimated 85% of the people living with HIV in the Caribbean were within the island of Hispaniola and this was75% in 2006.

5.2 HIV and Sex work

With no explicit prohibition in the National legislation, sex work is effectively legal in Dominican Republic with no legal recourse for anyone operating in the sex trade. Hence the majority is regulated though direct sex establishments or indirect units. These include brothels, (casa de citas) and more commonly bars discos and other entertainment and leisure establishments. The law in DR mandates that all motels, hotels etc provide at least 2 free condoms in each room.

In addition to the thriving female sex trade, male sexworkers in the Dominican Republic also work in the informal tourism sector and are called *Sanky Pankys* (or *beach boys or gigolos*). They provide services only to foreign tourists and companionship to both men and women in the form of 'romance tourism' described in part 1. The beach boys and gigolos go mainly with women and

[18] Kerrigan, D., et al. 2006. "Environmental-Structural Interventions to Reduce HIV/STI Risk Among Female Sex Workers in the Dominican Republic." *American Journal of Public Health.* 96:1 (January). Washington, D.C.: American Public Health Association.

seek to provide foreign female tourists more than a one night stand in all instances so as not to 'exploit' them.

Condom use- a recent IOM study in 2004 demonstrated that 65% reported consistently using a condom while 10% said they had sex with a client while having STI symptoms and half did not use a condom. Condoms are highly stigmatised in the DR which is partly due to Catholic reinforcement against its use and gender roles with regards to who controls the use of condoms. This is the norm in many countries of the region. Even amongst long terms couples, condom use is frowned upon as this signifies infidelity. Hence, long term partners who also had multiple partners including sex workers were not likely to use condoms promoting HIV transmission risk among various groups (see figure 1). Studies have shown that it is the sex workers stable relationship that is most at risk of HIV transmission as these interactions do not often involve condom use.

5.3 Legislative framework

There is no legislation that explicitly prohibits sex work in the DR – that is

Prostitution is not prohibited in any expressed manner by any legal text and is based on the agreed premise that there is no punishment without a law (*Nulla poena sine lege*).

Despite this, there are still multiple reports of intense daily occurrence of violence and abuse from the police, described as exploitation, coercion and incarceration. Case studies for the DR provide accounts from several sex workers, of multiple arrests from the police often for fabricated reasons. The arrests occur outside clubs, discos, restaurants and streets. Despite the fact that special tourism police are assigned to address the needs of tourists while the regular police are assigned to 'regulate' the sex tourism industry labour force, the police instead wield fear into he lives of the sex workers through the above described actions. As such, *it is the actions against the sex workers that are the only criminal offences occurring in such scenarios*. There is rarely any recourse for the rights of the sex workers in response to violence and abuse at the hands of police.

The only law that addresses prostitution speaks to the practice of intermediaries and those who benefit from a sex workers earnings - in other words pimps are outlawed.

The fact that the absence of legislation does not protect the rights of sex workers indicates that the stigma and discrimination that exists across the DR and other Caribbean countries will not be automatically be reduced by decriminalisation of prostitution itself. Additional approaches to seeking community awareness recognition of the human rights of sex workers and extending to the provision of equal provision for equal need according to the dictates of social justice. The development of community anti-stigma leaders and champions within institutions and communities is urgently required. Law enforcement often use mass arrests to keep local women perceived to be sex workers - usually working class dark skinned women from bothering clients (simply because their dress and demeanour and their claim to public spaces constructs them as dangerous and of suspect morality).

Women visiting night clubs as guests are often beaten robbed abused and arrested and then thrown into jail for five days.

This is reinforced consistently through Kempadoo's study in 1999 which highlights the elements of stigmatisation and discrimination of sex workers in particular at the hands of the police with accounts for the sex workers themselves;

> The unfairness and mistreatment that sex workers receive at the hands of the police is coupled with the lack of protection from the violence that they receive at the hands of tourists and other clients. Whether they are abused, tortured and not paid, they have little recourse. They tell many stories of misplaced justice that is purchased from the police from tourists. Furthermore, in addition to the hatred and stigma that the sex workers face in society and at the hands of the police they are seen as already guilty and not entitled to equal protection from the law;
>
> *"The police have mistreated me. They have hit me and one time they gave me a black eye. They hit me because I told them that there was no justice here that justice was for their convenience. But if you offer them money, they let you go, because he who has nothing is of little value here.*

5.4 Access to prevention and treatment services for Sex workers

Funds for the national response have been supplied by the World Bank, Clinton Foundation as well as through the Global fund regional funding mechanism. The multi-sectoral organisation, COPRESIDA has coordinated the response of the government since 2000. The national plans include institutional strengthening of labs, blood banks, surveillance and PMTCT. Vulnerable populations including sex workers are considered in the national plan while mobile populations including the Haitian migrants are not addressed.

On paper …..
Public health and social insurance cover 70% of the population, however in rural areas and local slums (the Bateyes), access to health services is limited and fraught with stigma and discrimination towards vulnerable groups.

With the recent social insurance law (Law 87-00) the country on paper is working to provide universal access to health care thorough the social security fund.

In Practice…….
Despite the 20 years (since 1987) of a response towards HIV prevention in sex workers and resulting best practices, access to health services has been low.. In fact, unlike the progress observed in Haiti in the past two decades, clinicians working in and out of the DR state that the country's HIV/AIDS treatment programmes are sorely lacking. "It is 1000 times better in Haiti".

For instance, in a recent IOM study, 20% of sex workers reported that they had had an STI symptom in the last 12 months while none sought or received medical attention.

Clinic workers have reported that people with AIDS from the region of the Bateyes where the epidemic is most concentrated, are "just dying without any kind of help"

Although ARVs are offered in the cities such as Santa Domingo, the rural areas including the Bateyes are lacking. In addition, other support services and subsidies promised by the

government programmes are lacking and do not appear to be even forth coming according to a study undertaken by Cohen in 2006[19].

UNAIDS estimated that 17,000 PLHIV require ARVs but as of the end of 2005, only 2500 were receiving it (6.8%) through the government's programmes. The lack of response by the government toward the concentration of the epidemic in the Bateyes has been attributed in part to Bad blood that exists between Haiti and DR since 1821.

NGOs appear to have taken up the slack and made some headway in both treatment and prevention programmes and many best practices ensue and are discussed below.

5.5 Best practice in the Dominican Republic

The example of the DR shows how achieving a balanced HIV/AIDS programs in LAC can be slow to get off the ground, but that interventions with "bridging" groups including MSM, and sex workers and their clients, can help stem the spread of the disease.

Despite the odds of stigma and discrimination and violence towards sex workers and stigma of condom use, the DR has succeeded in promoting consistent condom use and other safe behaviours of sex workers. Their strategy evolved in the simplest sense into a three passed approach over the past 20 years;

Strategic approach to Sex work and HIV prevention in the Dominican Republic 1988 to 2007

Phase 1.	Addressing HIV risk practices and self-empowerment at the individual level and moved steadily over the years across 2 decades to
Phase 2.	considering community and policy standpoints and approaches and then
Phase 3.	Scaling up the role of communities and government;

Key non- governmental organizations have led the fight and include Centro de Orientation e Investigación Integral (COIN); Movimiento de Mujeres Unidas (Modemu); Comité de Vigilancia y Control del SIDA (CORVICOSIDA); Population Services International (PSI).

In 1989 CORVICOSIDA was established in response to the large incidence of AIDS cases in the Puerto Plata region and the NGO joined with COIN and with the National AIDS Programme with funding an d technical assistance from Family health international FHI and academy of educational development (AED) to form a project called *Avancemos*.

These organizations are comprised of activists, advocates, scholars, health care practitioners, sex workers and behaviour change specialists.

With the emergence of this intensive scaled-up response at grass roots since the early 1990s, HIV prevalence 17 years later has declined in Santo Domingo and the surrounding areas except for Peravia where prevalence remains at 12.4%. In the 2005 public health report for the DR, 87% of

[19] Jon Cohen. *DOMINICAN REPUBLIC: A Sour Taste on the Sugar Plantations.* Science 28 July 2006: Vol. 313. no. 5786, pp. 473 - 475

sex workers reported using condoms during the last sexual encounter while 76% reported consistent condom use compared with the 65% in 2003 (IOM study). This success has not been without the hard work involving well planned;

- ⇨ strategic partnerships with clearly defined complimentary roles or each partner (this still requires improvement as there are areas of duplication and wastage still in existence)
- ⇨ intensive resource allocation,
- ⇨ development of policies for rapid responses,
- ⇨ and effective programming and reprogramming in responses to attained outcomes.

Response strategies moved across 3 phases mentioned above.

The first phase of Avancemos revealed the need address the support and empowerment needs of sex workers external to the provision of information, education and communication with regards to AIDS and prevention. Hence the first level was centered on the personal and social empowerment of sex workers to improve their ability to protect themselves from HIV. Emerging from the first phase in 1995, the first national congress of sex workers was held in the DR, thus launching a process of personal and social empowerment through this unprecedented peer-led network of women.

Swiftly following and emerging out of this event, MODEMU, a union of approximately 400 sex workers was formed in 1996 and the following response path was observed.

Best practice approaches and integrated roles of partners

- ⇨ **COVICOSIDA and COIN continued in their roles in education and training and**
- ⇨ **COIN also addressed the mental health and reproductive health needs of sex workers, while**
- ⇨ **COVICOSIDA employed cutting edge educational and outreach programmes using methodologies involving audience participation (comics, posters, manuals, videos, drama, guerilla theatre, workplace workshops, etc)**
- ⇨ **COVICOSIDA also targeted poor Haitian male sugarcane workers who engage with the prostitutes**
- ⇨ **MODEMU gained strength in promoting the integration of sex workers into the process of democratic participation of the country.**
- ⇨ **Primary Funding for joint units through the key NGOs came from Democratic initiatives programme of USAID, the Dominican Government and PAHO , FHI, AED**
- ⇨ **COIN and Modemu developed a new series of workshops and materials for sex workers around the country which combined elements of individual and social empowerment through examination of individual self esteem as the bases for promoting self development, economic independence, self expression and self defense of ones social and legal rights.**
- ⇨ **Modemu published the first book on sex work by sex workers in DR**
- ⇨ **COIN and Modemu are among NGOS that partner with PSI to distribute condoms for social marketing. Approximately 1000 condoms are sold each month through these local NGOs, each with different mandates for reaching sex workers in high concentration areas.**

MODEMU is recognized as one of the strongest and leading sex worker organisation in the region. It adopts an integral approach to improving the lives of sex workers through the provision

of health education, HIV prevention, while increasing women's awareness of the issues. The organisation interacts with all levels of policymaking and is vocal regionally and is internationally recognised. MODEMU is essentially the voice of Dominican sex workers, creating mechanisms of solidarity and mutual support among sex workers to collectively fight the violence, to prevent STIs and AIDS, to promote the creation and uptake of health services, to provide legal and psychological support, to train women beyond the scope of sex work, supporting the acquisition of other jobs and protection of their children.

5.6 Current Gaps

The response to HIV/AIDS in the Dominican Republic is led by the Presidential Council on HIV/AIDS - COPRESIDA - an umbrella organisation which is chaired by the Minister of Health and its Director is directly appointed by the Minister of Health. COPRESIDA has membership of various relevant government bodies, civil society organizations and HIV/AIDS service providers. It is the principal recipient of funds from the Global Fund to Fight AIDS TB and Malaria in the Dominican Republic. COPRESIDA also manages a World Bank loan for HIV/AIDS.

DIGECITSS, which is located within the Ministry of Health, is responsible for overseeing the implementation of the National HIV/AIDS Strategic Plan. It is the technical agency responsible for the government HIV/AIDS services, including the national treatment programme.

One key concern expressed by civil society representatives is the lack of coordination among the different agencies who work on HIV/AIDS. This leads to duplication in activities and inefficiencies within the response to the epidemic. Although COPRESIDA and DIGECITSS involve NGOs, people living with HIV/AIDS, and other civil society groups, the civil society organizations continue to question the extent to which such participation translates into actual influence over HIV/AIDS - related policy and programmes.

Although MODEMU is making great strides in leaps and bounds, addressing *beyond sex-working* for sex workers who desire to exit the industry, this is a strategy area still operating with gaps. As such there is no clearly detailed best practice example of comprehensive set of interventions to guide this group of sex workers through an extremely difficult transition process often fraught with the repeated unsuccessful attempts to exit the industry over a number of years.

However in the last ten years the NGOS and government officials have been developing broad based holistic approaches to responding to the need of the sex worker, initial education has indeed expanded in to community mobilisation and empowerment based strategies to involve community organisations that are well placed to positively affect stigma reduction in the groups they represent. In addition, structural ecosystem therapy (SET), a form of environmental –structural approaches to inducing behaviour change is being adopted. Multiple simultaneous approaches have been deemed the most effective as it is agreed that the sex worker is exposed a multitude of issues that promote many routes of risk of infections at any given time.

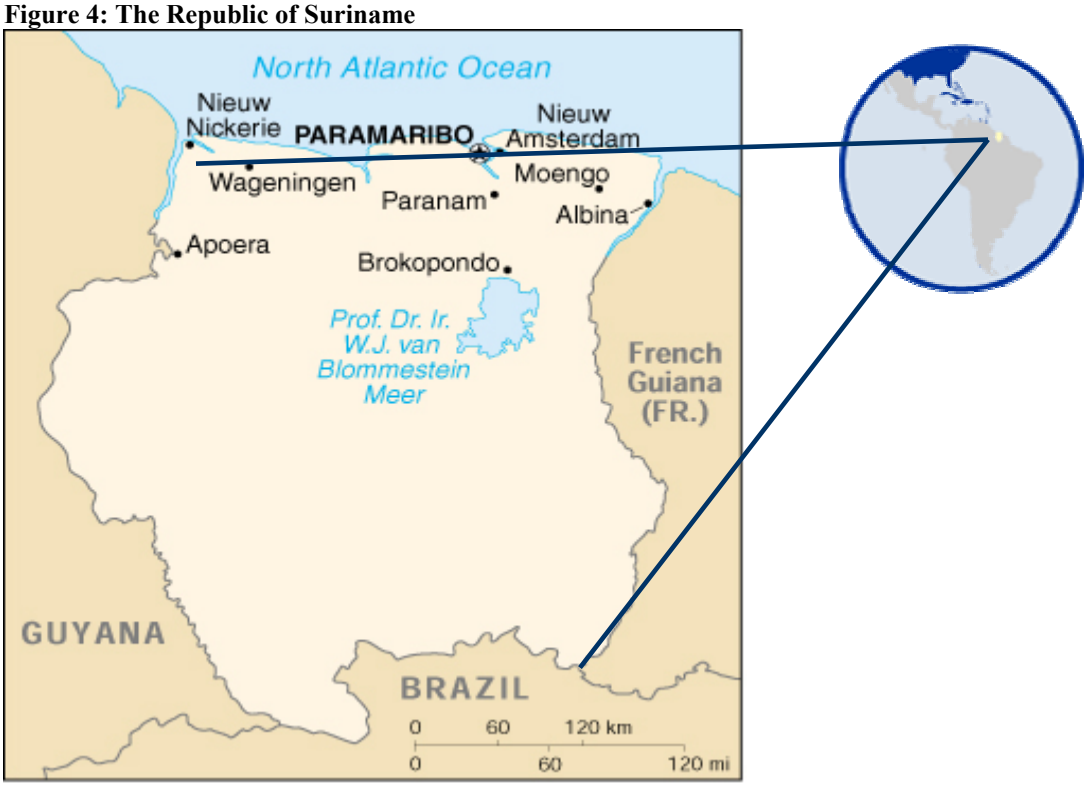
Clearly, if access to treatment for sex workers and other positive persons is not scaled up in particular to encompass provision of drugs to the high concentration areas, the hard won gains of prevention may be outweighed by the transmission from local clients who transmit to other partner that are not sex workers. The added clinical prevention/reduction of the probability of transmission of HIV that is usually derived from ARV therapy through the suppression of viral load of an HIV positive sexually active client is lost.

The experiences of the DR pave the way for other countries with similar profiles of their HIV epidemics to pilot models of best practice that have been observed here. The DR approach illustrates that a carefully tailored approach, phased in over a defined period and with partnerships and roles clearly defined to the level of involvement of communities (when and how) can positively produce outcomes of sustained change.

Deserving an important mention - The fact that national policy on sex work is absent did not serve to alleviate stigma or discrimination at the institutional or community levels, but did serve to create an enabling environment where the sex worker could self empowered through direct sex work outreach organisations and hence could directly seek recourse and assistance for protection, behaviour change and HIV prevention and also opportunities for an alternative life course

6 *Suriname*

Figure 4: The Republic of Suriname



Suriname lies of the north-eastern part of the continent of South America. It borders on the Atlantic Ocean in the North and Guyana in west, French Guiana in the East and Brazil in the South. The country with it's the administrative district is largely the interior – tropical rain forests with a surface areas of 162,820 square kilometres and a population of approximately, 414,000. Approx 90% of the population lives in the coastal areas and the Capital, Paramaribo is densely populated with concentrations of sex workers and direct and indirect sex work establishments. The multi-cultural and multilingual nature of the population means that programmes targeted towards vulnerable groups from all cultures requires detailed insight into socio-cultural factors the fuel HIV transmission and also entry into sex work.

Over the past 2 decades several intrinsic and extrinsic factors have adversely impacted upon the Surinamese economy. These include; reduction of income from bauxite, withdrawal of Dutch aid, a massive brain drain and a flourishing black market. As such, a coping response has been that many people support a formal job with an informal job, hustling in buying and selling of goods and services. This lifestyle has not afforded mainly women with financial security that they seek. Hence, amid spiralling poverty and the increasing phenomenon of single parenting and often the absence of committed or supportive partners, they turn to sex work for supplementing their income (Antonius –Smits et al 2004).

6.1 HIV country trends -

Little new data is available for Suriname for2006. The first case of HIV/AIDS was registered in Suriname in 1983 and the adult national HIV prevalence was estimated to be 1.9% [1.1%–3.1%] in 2005 (UNAIDS, 2006).

The total number of registered HIV/AIDS cases was 3032 in 2004 (Ministry of Health), corresponding to 40-50% of the estimated number of persons infected. Preliminary 2005 data recorded 602 new cases. The gender distribution of new HIV+ cases has shifted over the years and since 2004 there are more females than males. In terms of age distribution, the highest registered prevalence is in the age-group 15-49 years. Sixty to eighty percent of the annual new cases are in this age-group. In 1990 HIV prevalence in club workers was 2.5% wile in 2004 this figure rose to 21% and in 2004 Sero-surveys found prevalence rates of 24% among street sex workers and 6.7% among men who have sex with men in 2005. This data places Suriname in the category of countries with a generalized epidemic, with concentrated epidemics in sub-populations.

Table 6: HIV Prevalence Studies suriname - 1983 - 2002

Year	Population	Study sample	# HIV +	HIV prevalence
1986	STD Clinic Cliënt	490	0	0.0 %
1986	Registered Commercial Club Sex Workers (CCSW)	74	0	0.0 %
1989	STD Clinic Cliënt	2000	12	0.6 %
1989	Registered Commercial Club Sex Workers (CCSW)	97	1	0.01 %
1990	Registered Commercial Club Sex Workers (CCSW)	157	4	2.5 %
1991	Bezoekers SOA-poli D.D.	4236	44	1.03 %
1992	Prison population	146	0	0.0 %
1996	Commercial Street Sex Workers	189	42	22.0 %
1998	Men-who-have Sex with Men (MSM)	78	14	18%
1999	Military	140	2	1.4 %

6.2 HIV and Sex work

Migrant work in particular in the rainforest interior of Suriname, creates conditions that contribute to the development of sex work. There exists a thriving sex work industry in the gold mining areas and plans are underway to address the HIV prevention in sex workers and miners through the Global fund Project. The conditions of sex work in the interior are diverse and often, levels of violence, risk and social needs are different between groups. These groups operate essentially in sex work conditions that are; the club setting; sex-on-credit system; women's camps; sales women and cooks and local Maroon women.

In the capital there are two distinct groups: the club (brothel) based sex worker and the street based sex worker. Many of the clubs are regulated and therefore the sex workers are monitored while street based workers are wholly underground. In addition, other groups include juveniles and teenagers, illegal residents, male sex-workers. These street-based groups work with less hygiene and under more dangerous conditions.

Condom use- A baseline needs assessment study in 1994 by the NAP demonstrated that among 67 street-based sex workers 84 percent said they did sex work to support their children; all were unregistered and out of fear of stigmatisation did not go for STD Check ups. Forty four percent had not heard of HIV, AIDS or other STDs and condom use was low and irregular. In addition, men offered two to three times more money for unprotected sex. Generally they painted picture of low self esteem and disempowerment - unable to take control of their lives.

By 2004, in a study by SMLA 22% reported using condoms during the last sexual encounter while 10 who tested positive were not using condoms. Only 25% reported consistent condom use demonstrating that risk taking was still high. The efforts of the SMLA outreach programme appeared to have increased awareness of condom and promoted condom use yet additional approaches was required to ensure consistency of practice. An alarming 51% were using substances. Many sex workers and their clients still felt that they could recognize HIV when they saw it and as a result many request additional information on how to recognise the disease. This resistance to condom use represented an area of focus in delivery of behaviour change approaches to the sex workers and their clients

Following the first sero-prevalence assessment in 1996 of 21%, the prevalence in sex workers remained relatively unchanged at 21.1%. However the prevalence in male sex workers was high at 36.2%.

6.3 Legislative framework

Under the Surinamese Penal Code, since is inception during the colonial era, the act of prostitution itself is not a criminal offence. The law prohibits the promotion of commercial sex –

"The promotion of female indecent behaviour and obvious sexual provocation".

This law is rarely enforced, leaving plenty of room for undertaking of commercial sex under various configurations of service delivery. Club based sex work is unofficially recognised and regulated.

There are approximately 40 registered and licensed nightclubs in Paramaribo that employ mainly foreign female sex workers. The workers are primarily from Brazil, Dominican Republic and Colombia. The group is very mobile, also tending to pass through to St Maarten and Curacao.

The migrant sex workers stay in Suriname for approximately four to six months, many using their stay as a springboard to journeying to Holland. The largest clubs in Paramaribo has more than 80 sex workers working there. These clubs (brothels) are licensed as a means for government to control the activities. All women must register with immigration and at the National Dermatology STI/ sexual health clinic and undergo bi-weekly checkups at the clinic. If a sex workers is found to have an STI, under agreement with the club owner, they must stop work until adequately treated and cured. HIV tests are not mandatory but when an STI is diagnosed, it is routine under clinical guidelines to offer VCT to all patients in Suriname under the current National AIDS Programme.

When a client claims to have contracted and STI from a sex workers at a particular club, that club is shut down until all the women working here are screened. If this is not followed through by the club owner, then the Clinic has authority to call in the military police. Unregistered sex workers have no official governing polices or regulation and are mainly street based Surinamese or Guyanese women.

In terms of stigma and discrimination, police harassment in Suriname appears to be falling slightly as a result o self empowerment of the sex workers and is observed participating in case studies through out the research undertaken between 1994 and 2006.

Harassment by clients and refusal to pay were also common in the interior and streets. Women's most immediate needs with regards to regulation of the sex industry was more information on how to prevent other health problems including malaria and other women's health issues, condom distribution networks, regulation of the gold sector and police protection in the interior.

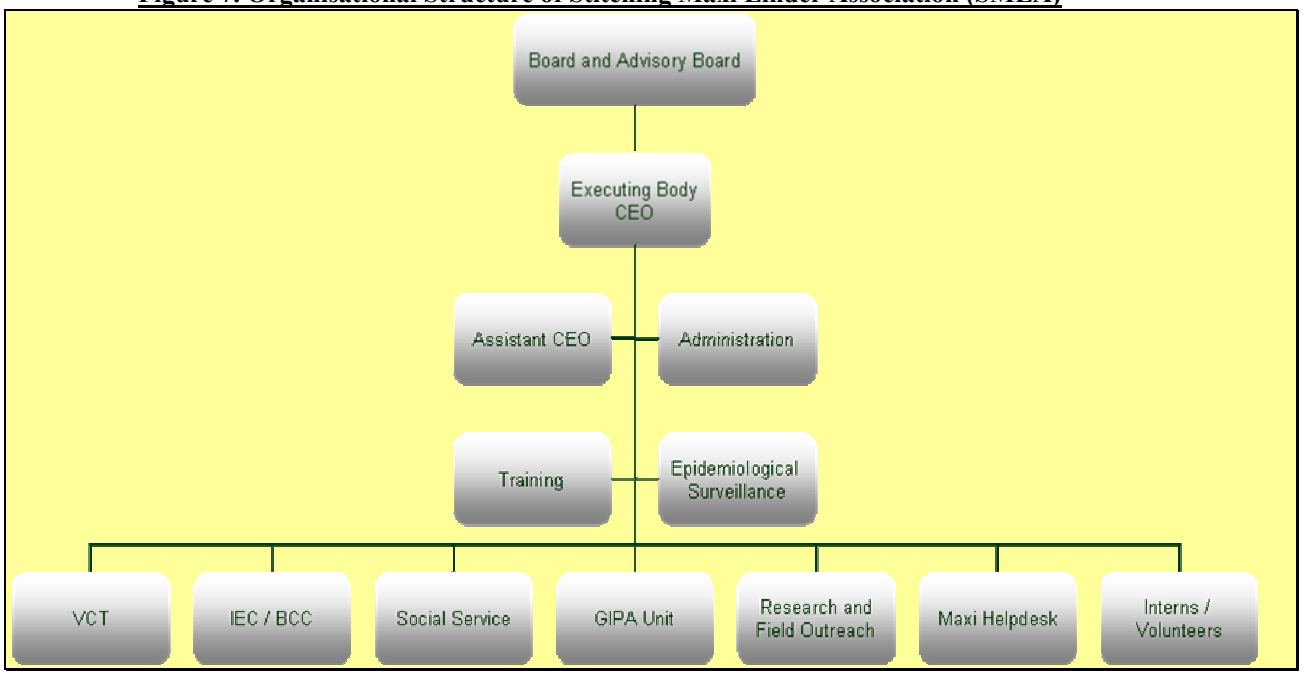
6.4 Best practice in the Suriname

The only sex workers outreach organisation in Suriname is the Stitching Maxi Linder Association (SMLA). Currently there are over 400 registered sex workers with SMLA, however, pimps of street-based sex workers do not allow there sex workers to participate in the programmes of the SMLA centre. This group is relatively unaddressed in addition to the home based sex worker and those who do not self-identify.

To institutionalize the CSW outreach programme, the Stitching Maxi Linder Association (SMLA) was established in1994 as a result of the baseline needs assessment. The organisation is named after the first prostitute in Suriname who was also madam and a great social worker, supporting many educational ventures.

The overall goal of the foundation is to optimize the social, economic, mental and physical health and well-being of female commercial sex workers and now more recently male sex workers as recently Maxi Linder observed an increasing trend of MSM sex workers as - young boys, transvestites and men in the commercial sex business. The organisations' key strengths are that they combine research to gain sound and valid information to inform their actions and advocacy, with empowerment and political awareness raising through lobbying and other approaches.

Figure 7. Organisational Structure of Stitching Maxi Linder Association (SMLA)



BASTA unit included & operational

- **Be**
- **Against**
- **Secrecy of sexual exploitation**
- **Trafficking**
- **Abuse of child rights**

Their goal is attained by adopting a 3 tiered approach as is mandated as by UNAIDS.

1. Individual - identifying and fulfilling needs that are both unexpressed and expressed. Their informed approach recognizes the distinct needs of the sex workers in the interior compared to the sex workers in Paramaribo; and in turn they use different approaches to address the sex workers in the clinics compared to the street based sex workers as the2 have distinct different urgent issues that affect their empowerment and promote HIV risk exposure (see table 8). Additionally, sex worker identities are recognized to have different needs. The emergence of the male sex worker and a subsequent needs assessment in the 2004 study revealed that this group is subjected to significantly more aggressive violence, stigma and discrimination by law enforcement. This group, in particular the transsexual sex workers have demonstrated specific health care needs and those who are undergoing intramuscular hormone therapy have reported receiving less than adequate health care; they often receive their treatment in French Guiana and thus the language barrier means that the sex workers are not always full appraised on the process, outcomes and side effects of therapy. The SMLA serves to support them through information gaining process and decision-making processes as well as dealing with cases of adverse outcomes such as when the transsexual is devastated about a 'shrinking penis' and in fact really "did not want a complete sex change". Under these situations there is no recourse, but psychosocial support is stepped up.

2. Community – through education and awareness, raising with key and influential sectors of the community they are empowering and informing the community to take an active role and to understanding the plight of sex workers in the fight for their human rights. One such example is the way in which the organization has addressed the church' head on by taking the sex workers issues to them;

From "Taking it to the Church" to "The Church taking to the streets"

Sex workers themselves have reported that they look to God to protect them in their daily Endeavour with clients, in particular when they do not use condoms. Culturally the church and religion plays a significant role in many Caribbean people's lives, whether or not they attend a place of worship. The need to draw on faith has been deeply defined in the upbringing of most. Hence no country has in the Caribbean has been able to literally separate the church from the state's plans in address their approach to mitigating HIV among sex workers. As such, the current approaches in government plans have been to work with the key strengths of the church and not against it, and for the church to work with the key strengths of other agencies involved.

The significance of the role of spirituality in the sex workers in Suriname was recognized early on by SMLA.

SMLA recognized that the first step to empowerment of sex workers – was to reduce stigma and discrimination that emerged from the churches by promoting the understanding of the church on the human rights of sex workers using the very messages they preach in addition to the concepts of sex work and its drivers. SMLA sought to promote a non judgmental attitude in the church.

Instead of excluding the church from their approaches, SMLA put the church's role and message up front and center at the organization's activities……*literally ... this was a very bold move as the 'wrong' message can turn vulnerable groups away rather than cause them to see the organization as a safe haven.*

Their vision statement in the entrance reads:

"Never give up on a child of God, but lift it up in the name of Jesus.
Because there is no saint without a past and no sinner without a future"

According to the Director of SMLA, this message speaks to the fact that according to the message preached in the church itself, every man is equal, no one is greater and each deserves to be raised up (recognized) in his own right. The organization also enforces that through self- empowerment - by holding on to ones life goals no matter how realistic or distant, that each person is a person of worth.

In addition to this head on approach, the organization developed peer education and counseling programmes for designated church counselors. They started by targeting the largest most visible churches with a very long reach into the Christian community.

As a result, today several members of congregation and it's local community participate in outreach and support to the sex workers and offer 'no condemnation' just understanding of their situation and SMLA and the sex workers themselves recognize them as partners in the process.

3. Policy-making – to address barriers to safety and HIV prevention and empowerment of sex workers; Stigma and discrimination at the hands of the health provider is still a factor that prohibits or deters access to services for sex workers. The staff of the SMLA provides a support service whereby they will take the sex workers (s) to the clinics for STI checks, for HIV test or for addressing other health or reproductive needs. In addition on a wider scale, SMLA campaigns for the destigmatization and regulation of sex work in order to reduce vulnerability and lack of rights of women working in the sector and to ensure access to health and social services and insurance. They have participated in a number of regional initiatives including the 1996 project on trafficking in women in LAC. They participated in a regional study of the Caribbean sex trade and works publicly demanding public accountability for social conditions that make prostitution a danger for many women.

From research to Practice

Qualitative and quantitative research into needs and context of sex work enables the organisation to better target and address the specific issues that lead to empowerment of sex workers; Through education information, skills training and support; and advice on social, legal and health matters; raising social awareness and encouraging a positive self image and solidarity among their peers.

Simultaneously, they focus on prevention and human rights preservation at the key levels of;

4. Prevention of entry into sex work: there is targeted approach sex workers who are likely to force their teenager or force (or allow a pimp to force) their children into sex work.
5. Protection of those involved in sex work; a harm reduction (HR) approach is used whereby the outreach officers encourage a *small steps* approach to change as apposes to the all or nothing approach which often set unrealistic goals and sets up a vulnerable person to 'fail'. The HR approach has been shown to steadily and systematically result in longer term sustained change. Whether the issue is alcohol use, drug use or unprotected sex, the HR approach identifies the risks and encourages the sex workers to start where they feel comfortable and able in order for them to protect themselves or their partners. As such they set their own realistic targets and hence own the solution and move at their own pace.
6. Assistance in exiting from sex work. – This incremental approach is also used in supporting individuals who desire to exit sex work. In much the same way a drug addict needs to walk through a series of steps and progressive milestones before one is able to deem themselves as having dropped the practice of drug taking for good, so also must a sex worker who seeks to exit the industry and therefore SMLA 'walks' with them despite how long things may take and ensures through support that the sex worker never feels beaten by his/her circumstance of dependency even if he or she is unable to leave the business for a number of years after expressing their desire to do so. To date there is no one approach to supporting individuals that are trying to exist the industry- perhaps because the 'habit' of sex work is most often linked to the need to survive. Hence, 'Kicking the habit' is yet to be a happy reality for more than a few who attempt it. Despite the difficulties here, expressed demand for assistance by vulnerable groups must be met and SMLA enforce this. SMLA are aggressively scaling up their efforts to ensure that they have tailored programmes that will lead to more stories of sex workers fulfilling their desire to exit sex work.

SMLA have been lobbying international partners and agencies for funds to establish an institute that will be dedicated solely to support exit from sex work through a variety of self development approaches that they already implement. These include; finding alternative professions; schooling for the sex workers and their children, self supporting income generating activities such as sewing and handicraft to create other economic options which can serve to reduce the number of sex workers-client contacts. In addition there are financial management classes. Attempts at lobbying have been proving successful and planning is in the pipeline

Over the past ten years SMLA has been working with commercial sex workers, providing a drop-in facility, social services, vocational training, HIV testing, and condom distribution. As a result of the advocacy work from Maxi Linder, the authorities have become more responsive to the human rights of street sex workers, and police brutality has reduced.

SMLA also attempt to address the need of sex workers in the hard to reach interior they are the main NGO working with the NAP through MoH and the medical Mission (the health services coordination unit for the interior) and the Global fund programme to address prevention and treatment needs in Sex workers

Hence apart from sex workers in clubs or brothels, prevention progress is relatively unmonitored in the underground groups. SMLA continue to restructure and tweak their programmes in order to reach the street based workers. A number of Novel approaches have been employed.

Some Key Achievements of SMLA

- ⇨ Sex workers trained and serving as government personnel
- ⇨ Rescued Sexually exploited children
- ⇨ Consultancy Status
- ⇨ Designed affective one day workshop to reduce Stigma & Discrimination at the work place
- ⇨ Gained momentum in society
- ⇨ Established partnership with 2 Pentecostal Churches
- ⇨ Twenty-three Reborn Christians Trained to work with SMLA
- ⇨ Achievements of SMLA cont'd
- ⇨ Students from secondary schools, high schools the university & nursing college assisted in writing individual (research) papers/reports
- ⇨ Achievements of SMLA cont'd
- ⇨ Since January 1995, SMLA has been functioning as a remote unit of the National AIDS program.
- ⇨ Human Rights Advocacy
- ⇨ Achievements of SMLA *cont'd*
- ⇨ Facilitating Agency for the National UN Volunteers who are working with People Living With HIV/AIDS.
- ⇨ Fundamental Social Research

Objectives for 2006- 2010

- ➢ Increase local awareness of:
- •HIV/AIDS
- •Socio-economic situation of SWs
- •Abused / Extorted Children
- ➢ Behavior Change Communication in order to Increase condom use within the society
- ➢ Address several social issues facing At-Risk-Youth and commercial sex
- ➢ Implementing a Gospel-based, empowerment strategy
- ➢ Voluntary Counseling and Testing
- ➢ Strengthen GIPA strategy
- ➢ Increase Field Outreach / Purchase an all terrain vehicle or two
- ➢ Raising awareness with regards to CSM & CS
- ➢ *Strengthen our watchdog role in society*
- ➢ Maxi Mobile Unit Operational for coastal outreach
- ➢ Purchasing an office and training space
- ➢ New office space operational in east Suriname
- ➢ French Guyana-Brazil-Dominican Republic-Suriname network operational
- ➢ Policy document in place to guarantee access to treatment for SWs
- ➢ Vocational Training Centre for SWs operational
- ➢ Cooperative Hotline with Mamio Namen & SMU operational

Table 8 outlines the challenges faced in reaching the various sex worker groups that were highlighted previously;

Table 8. sex workers conditions and challenges faced by outreach organisations

Conditions of sex work	Location	Source countries	Regulations	Programme & policy implications
Club based	Paramaribo	Mainly from Brazil, Dominican republic, Colombia	Mainly registered and regulated with regular STI checks and ongoing prevention and empowerment outreach services provided. females	Can be targeted for ongoing prevention and treatment including VCT. Easier to develop government-NGO partnerships in addressing needs of this group. Easier it address stigma and discrimination and exploitation and to prevent child prostitution and child and adult trafficking
Street based	Paramaribo	Mainly Surinamese and Guyanese females	Underground mainly females and increasingly young males and transvestites	As a result of pimps 'blocking' access of sex workers to SMLA activities in their outreach centre, there are continued challenges in reaching this group for the provision of comprehensive and consistent prevention and empowerment outreach and to address prevalent psycho-social problems that predispose them to HIV such as drug abuse in addition to the prevention of child prostitution. SMLA takes the activities and programmes directly to the sex workers wherever they are working. Also police brutally including rape, is a reality in this group of female sex workers and more so in the MSM male sex workers. Police often close down small locales and units of unregistered sex workers
Club based	Interior, often recruited by	Brazil, Dominican republic, Colombia	Unregistered	Of major concern is the push of teenagers into sex work by their mothers. The choice is not theirs. Clients refusing to pay is a reality By 2001, out of 40 sex workers in the interior and representing all conditions of sex work identified, only 3 get regular STD check and 17 use condoms at all. The medical missions with the SMLA are aggressively starting to target the sex workers in the mining areas with mobile health units, but this has been sow to get moving through the MoH GF programme General health needs are also unmet and competition between Brazilian sex workers and others is an issue. Despite taking continued risks, concerns about HIV fears where much less than other health needs and issues of poverty , violence and other problems linked to daily survival that they faced daily
Camps		Street workers from Suriname and Guyana	Unregistered	
Sex on credit	Interior locations which housed Brazilian miners	Designed by Brazilian miners. Sex workers are mainly Brazilian	Unregistered	
Saleswomen and cooks	Interior	Women who are petty traders between the 3 Guyanas and the gold mining areas, stayed or rented accommodation at camps	Unregistered	
Local maroon women	Interior	Women and their teenage daughters who mainly work in the low income , small scale agricultural activities in the interior	Unregistered	

7 *Guyana*

Figure 5. The Republic of Guyana

Guyana is a country rich in natural beauty, but its people are among the poorest in the Western Hemisphere: poverty stood at 35 percent in 1999. The country's economy was in recession until early 1990s. In addition, a 1998 drought hit the country hard. Guyana still suffers frequent power outages. Many regions lack trash service, so people often throw garbage in the rivers or canals. School textbooks are often unavailable. Schools and hospitals are in a very bad condition as there is not enough money to fix them. However, in 2000, the World Bank (WB) and the International Monetary Fund (IMF) approved $590 million in debt relief for Guyana contingent on the continued implementation of social programs to reduce poverty. According to the WB, the government has made sufficient progress to warrant continued assistance by reducing poverty by almost 10 percent since 1993.

Generally, Guyana has a high prevalence of female-headed households, and their number has been increasing in the last decade. There are marked differences in the number of such households depending on the ethnic group and geographical location: Fifty-one percent of Afro-Guyanese households are female-headed as compared to 32.5 percent among Indo-Guyanese and 2.6 percent among Amerindians. Female-headed households typically have lower incomes.

7.1 HIV Trends

In Guyana, UNAIDS reports that a serious epidemic is underway. HIV prevalence was at 2.4% in 2005 and AIDS was the leading cause of death among adults aged 25-44. However, the country's aggressively scaled-up antiretroviral therapy programme, which reached more than half the persons in need by mid-2006 (WHO/UNAIDS, 2006) may yet reverse the rising trend in AIDS deaths seen there in recent years.

In 2005, AIDS still ranked among the leading causes of death among 25–34-year-olds in this, the second-poorest country in the Caribbean (Guyana Presidential Commission on HIV/AIDS, 2006). HIV appears to have spread into the general population from most-at-risk populations, with national adult HIV prevalence estimated at 2.4% [1.0%–4.9%] in 2005. With a concentrated epidemic in sex workers and other vulnerable groups

7.2 HIV and Sex work

HIV transmission during paid sex remains the most important risk factor for infection. Exceptionally high HIV infection levels are still being found among female sex workers, although a reduction has been observed between 1996 and 2005 - reaching as high as 45% in 2000. A high prevalence of 31% was observed in sex workers in Georgetown in 2006, for example (Allen et al., 2006). Prevalence of 17% among people attending sexually transmitted infection clinics was recorded in 2005, providing further evidence that unsafe sex remains commonplace. A study to determine the role of sex between men in Guyana's epidemic has found that 21% of men who have sex with men in its Demerara-Mahaica region (in the northeast) were infected with HIV (Guyana Presidential Commission on HIV/AIDS, 2006). As with most countries of the Caribbean, HIV positivity was most prevalent amongst sex workers from poorer locations and in street-based sex workers.

Median HIV prevalence of female sex workers in major urban aeas in selected countries: 1999-2001

Country	Year	median HIV prevalence (percent)
Ecuador	2001	1.1
Bangladesh	2000	20.0
Cambodia	2000	26.3
Guyana	2000	45.0
Kenya	2000	27.0
Lao PDR	2000	1.0
Mali	2000	21.0
Myanmar	2000	38.0
South Africa	2000	50.0
Thailand	2000	6.7
UR Tanzania	2000	3.5
Vietnam	2000	11.0
Angola	1999	19.4
Benin	1999	40.8
Cote d'Ivoire	1999	36.0
Honduras	1999	7.7
Mexico	1999	0.3
Nepal	1999	36.2

Source: UNAIDS Report on the Global HIV/AIDS Epidemic, 2002.

In a survey of sex workers undertaken by Red Thread in 1997, the single most important reason for entering into the sex trade was economic hardship. In the same survey just 25% of the women said that sex work was their main income earning occupation, indicating that sex work was simply a route to a supplementary income. Several petty traders cited offering sex in exchange for their goods to sell or to by pass customs restrictions. Sex work appeared to be a lifestyle and main income earner for younger girls and cases have been told of girls sending earnings to their home town to be banked and, obtaining fancy clothes, cars and more sophisticated lifestyle overall, to the extent of eventually building houses from their income. This pattern has been observed throughout the islands of the Caribbean, whereby young girls go to neighboring island to work and send the processes home to be banked

While the growth in the sex trade industry has been linked to a concomitant growth in the tourism industry in many of the wealthier countries of the region, the dynamics of the sex work industry is very different in Guyana – a country in which tourism is much less developed. Further to this

even compared to other countries where tourism is not necessarily linked to sex work such as in Surname, it is even less so in Guyana. Guyana does not serve as a source country for migrant sex workers although other variations of sex workers are growing, such as the exotic dancers from abroad. As a result of the economic disparities, the more developed countries of the region in fact serve as a source destinations for Guyanese workers. In addition , forced sex through human trafficking and coercion is undertaken by operators locally and from other countries- many incidences of Guyanese young women and school girls being tricked by being lured to 'other forms of work' only to become stuck in sex work with their passports held, hiding out and disempowered as illegal/irregular migrants.

As in Suriname, the gold and diamond mining industry have given rise to thriving sex work hubs within these locales.

In terms of socio-economic status, education and formal sector employment, there are stark disparities between males and females while at the same time there is a significantly high rate of female headed households in Guyana - giving rise to vulnerabilities associated with the single dependent woman and her offspring. These obviously include sex work and exploitation of their children into under-aged and forced sex work.

Condom Use: There is a lack of targeted HIV prevention and harm reduction programmes towards sex workers in Guyana. This impasse appears to be driven by the stigma that enforces societal taboos in terms of speaking out or investigating sexuality and sex at household and institutional levels (schools, places of worship, homes). Despite this, the general information campaigns targeted at the general population and more recent targeting of miners appear to have demonstrated an increase in condom use from 65% to 87% between 1997 and 2000. But can this be sustained in the absence of targeted approaches?

7.3 National Laws and policies

As in Suriname, the law on prostitution dates back to the colonial era. Under the offences, the penalty for keeping a brothel is 2 years imprisonment. A more recent summary jurisdiction enforces a further penalty for the undertaking of prostitution related activities. The law also prohibits the pimping operations in terms of running a brothel or making an earning off prostitution. In addition to incarceration and fines, whipping and flogging still apply to the law books but are rarely enforced.

7.4 Current gaps:

Currently there are very few programmes that specifically target sex workers in terms of HIV prevention, health services needs and social support. Although the country continues to scale up its access to ARV therapy and related services there is no clear mention of programmes targeting sex workers in the 2007 to 2011 National Strategic pan for HIV and AIDS, but one mention of a GATC funded sex worker project that operates with limited funds. This is a clear gap in light of the prevalence of HIV and STIs in this group and also in light of urgent need to mitigate the circumstances through which women become involved in sex work whether through poverty, drug addiction or exploitation and coercion.

As a result, there are no established sex worker- specific organisations in Guyana therefore their rights are often wholly ignored in reality despite promises that appear in broad context in national plans. The need is for a strong grass roots organisation to bring to life the plans that have been articulated by government agencies. In a recent surveys of sex workers views and needs many

said an organisation should be established for their safety and protection, for giving sex workers a voice and for legalising sex work. And equal proportion also expressed that sex workers should be assisted in securing alternative opportunities of earn a living.

Stigma and discrimination remains a key obstacle in reaching this group - The CSW study by Allen et al (2006) concluded that;

Condom promotion services are reaching sex workers at highest risk, but factors such as stigma and discrimination, violence and exploitation must addressed as it is likely that they would also undermine the impact of programmes such as the one which makes antiretroviral treatments available to all people living with HIV/ AIDS in Guyana.

To date, the Red Thread women's development programme offers a supportive role to sex workers, (space to meet, breaking the barriers between sex workers and non sex workers and helping with the organisation of educational workshops and condom promotion).

7.5 Best Practice

The Establishment of Red Thread

Guyana is the fourth country in the Caribbean where sex worker empowerment is underway. Their approaches are less comprehensive than observed in Dominican Republic, Suriname and Belize and as such there are no clear best practices currently emerging from Guyana, perhaps due to the absence of any comprehensive grass roots interventions as discussed previously. In terms of information on sex workers, Guyana was one of the first countries in the region to receive funding from PAHO to undertake a sex workers project under the supervision of the National AIDS programme in the early nineties and in 1997 established a baseline of HIV and STI prevalence and need in sex workers in Georgetown.

Red Thread, a woman's development organisation started to address the support of sex workers. Red Thread, founded in1986, aimed at creating income generating opportunities for women in Guyana while challenging the power structures defined around race, class, political affiliation and undervaluation of women's work. By participating in the regional sex trade action research project the organisation commenced its first investigations into the sex trade in Guyana and made close contact with the sex workers mainly in Georgetown. A former Sex worker Dusilley Canning, also a peer educator and sex worker counsellor formed the bridge between government and the sex work community.

The organisation concluded from its needs assessment studies that a significant proportion of sex workers desired a specific worker organisation or project that would help them to find alternative work if they wished to exist the sex trade. They also specified the need to develop literacy skills, other skills, organise their own self defence, self empowerment. As seen in the recent assessment many also expressed the desire for an organisation that would meet their on going need according to their situations.

There are funding shortages with respects support of sex worker initiative in particular in terms of government commitment, as a result of the existing legislation and the existing cultural taboos on open discussion on sex and sexuality. Therefore, it is expected that regional best practices will be slow to emerge from Guyana. However, despite the silence on sex, sex work and sexuality,

the government *have* taken steps towards addressing the significant problem of human trafficking of both children and women;

Small steps on moving forward with policies in anti - human trafficking[20];

Guyana is a country of origin, transit, and destination for young women and children trafficked for the purposes of sexual and labor exploitation. Most reported cases involve internal trafficking of adolescent girls. Much of this trafficking takes place in remote areas of the interior and within mining camps, or involves Amerindian girls from the interior trafficked to coastal areas to engage in prostitution and involuntary domestic servitude. Girls promised employment as domestics, waitresses, and bar attendants are trafficked into prostitution; young Amerindian men are exploited under forced labor conditions in timber camps. In some instances, victims are forcibly abducted. Guyanese girls and young women are trafficked or tricked into travel for sexual exploitation to neighboring countries such as Suriname and Barbados.

The Government of Guyana does not fully comply with the minimum standards for the elimination of trafficking; however, it is making significant efforts to do so;

- ⇨ The government was one of the first in the Hemisphere to publish a review and self-assessment of its anti-trafficking efforts.
- ⇨ The Government of Guyana also increased financial support for NGOs that provide victim assistance, expanded the reach of prevention activities, and began applying new laws to investigate and arrest suspected traffickers.

The government should expand training efforts to include more rural officials, aggressively prosecute traffickers, and continue working with NGOs to assist victims.

Prosecution

Law enforcement efforts to identify cases improved, but no traffickers were convicted in 2005. The country's slow judicial process contributed to the lack of progress in convicting traffickers.

Law enforcement authorities applied Guyana's newly enacted Combating of Trafficking in Persons Act and arrested at least 10 suspects under the Act. The Act requires sentences ranging from three years to life imprisonment and the confiscation of trafficking-related assets.

Fifteen investigations of cases initiated in 2005 and previous years remained pending in pre-trial status.

Rural court and law enforcement officers lacked adequate training to identify and deal effectively with trafficking.

Technical training and sensitization efforts should be expanded to reach officials in rural areas where most trafficking occurs. Law enforcement officials worked with source and destination countries such as Brazil, Suriname, and Barbados to share information on potential trafficking and assist victims. There was no evidence of government officials complicit in trafficking.

Protection

The Government of Guyana made modest progress in victim assistance. It funded $30,000 of repairs for an NGO-run shelter to supplement the government's limited shelter capabilities, and included NGO funding assistance in its 2006 budget. There were no reports of victims jailed or mistreated by officials. Law enforcement officers referred victims to social workers and a local NGO for assistance. The government provided medical attention, housing, and funds to return victims to their homes.

Prevention

The government expanded on prior prevention efforts. It trained social workers, launched a new awareness campaign via print and radio media, and met with key religious, business, mining, and local government stakeholders. Ten trafficking-detection training sessions reached 361 community facilitators around the country. In January 2006, the government released a review of its counter-trafficking activities for 2004-2005, which recognized that better policing of and outreach to rural communities is still needed.

[20] Information is sourced from - U.S. State Dept Trafficking in Persons Report, June, 2006

8 *Jamaica - Snapshot on Sex work*

Country Name	**JAMAICA**
Population	2,651,000
Human Poverty Index	Rank: 21
Estimated Number of PLWHA	25,000: Adults aged 15 to 49 HIV prevalence rate 1.5 [0.8 – 2.4]%
Epidemic Profile/ Trends	• Increasing feminisation of the epidemic • MOH estimates 19.4% of all HIV/AIDS cases involve SWs or their clients • 35% of all reported HIV/AIDS cases in Jamaica are found in those aged from 30 to 39 years of age and 20% of all cases are in those aged 20 to 29 • HIV/AIDS in Jamaica has spread to the general population, fuelled by commercial sex workers.
HIV/AIDS National Response	• National response Prevention programme addresses: VCT, PMTCT, Blood safety, condom promotion, STI control, BCC, and workplace initiatives • Treatment, care and support includes access to antiretrovirals for all PLWHA since 2005: 56% of HIV-infected women and men receiving antiretroviral therapy • Red Cross has youth programme but none directed at SWs. • The Global Fund grant, worth more than US$ 23 million over five years, targets specific communities such as youth, commercial sex workers and men who have sex with men, all of this underpinned by a drive to establish a national HIV/AIDS policy that reduces stigma and discrimination throughout society. o 60 treatment centers with the help of Global Fund resources. o Sex education and counseling to urban residents, sex workers and nightclub dancers. o A large number of condoms and lubricants are being distributed to vulnerable populations o 164% of targeted MSM/CSWs have received condoms and lubricant o 232% of CSW/MSM have been reached through prevention activities
Nature of Sex Work (Settings)	Apartments, hotels, bars/Go-go clubs (>400 clubs), brothels, nightclubs, streets.
Remuneration	
Approximate number of sex workers	~ 22,000, MOH estimates 2005/6
Sexual Identities	• Go-go dancers, Beach boys, ‘Rasta Men’

	• Increasing emergence of informal sex workers undertaking sex work on part-time basis; (Merlene Taylor)
Profile of MSWs	• 'Rasta man' seeks tourist clientele of both sexes
Country Category (Source or Receiving)	Receiving however increasing source country for regional sex trafficking
Source Countries	China, Cuba, Dominican Republic, Russia, Venezuelan
Clients	Tourists, Jamaican men
HIV/AIDS Prevalence among sex workers	• >9% of 450 SWs (Gebre, 2000) • 20% (MOH, 2002) • In one area 87% of SWs tested HIV+ (Merlene Taylor)
HIV related risk behaviour	• 50 Go-go dancers reported STIs, most of which did not receive treatment for themselves or their partners; 76% drank alcohol on a regular basis; 38% have either tried or used Ecstasy; 40% have been sexually abused (Merlene Taylor)
Interventions for Sex Workers - Prevention	• Jamaica AIDS Support – extensive programme consisting of outreach education, condom distribution, referral for STI/HIV testing; monthly doctors clinic for CSWs • Independent consultant working with SWs – Merlene Taylor: outreach education, condom distribution, referral for STI/HIV testing, support and counselling • The GF has supported the expansion of many SW programmes involving IEC, condom distribution ○ UNAIDS estimates 60% of CSWs reached by prevention initiatives • Outreach programmes originally through 4 community NGOs (funded by MOH) provided condoms and referrals for HIV/STI testing and treatment; programme is now based within MOH • MOH PLACE programme – outreach programme • MOH also working with exotic clubs to provide condoms and access to STI testing and treatment for dancers: *"We have been a part of the Ministry of Health's National HIV/STI Control Programme for six years now and we have engaged well over 300 clubs, bars and street sites in that period," said Boris Bloomfield, prevention coordinator for vulnerable populations. July, 2006.*
Interventions for Sex Workers – Treatment Care & Support	• MOH PLACE programme – refer for treatment care and support • JAS – refer for treatment care and support but actively participate in delivering the support services and hence provide an active link between the clinic staff and the sex workers (as a buffer against the adverse affects of Stigma and discrimination)
Role of Civil Society	• No formalised SW organisations • JAS

	• Merlene Taylor
Migration	• Some of the SWs enter the country as tourists • Work permits are required for all Non-nationals
Related Legislation	• Prostitution/sex work illegal.
Other Concerns	• Child prostitution • Sex tourism (supported by trends in trafficking of SWs and internal migration of SWs according to tourist season) • Trafficking related to sex growing industry (US Department of State 2002) • Links with substance abuse • Increasing poverty and dependence upon alternative sources of income among those with minimal education • Increasing reliance on sex work as an supplemental income among middle class individuals to sustain higher standards of living • Physical abuse of SWs by clients • Growing acknowledgment that sex work is an significant income generator - "We must stop sweeping these things under the carpet," he said yesterday. "Sex is a big income earner, it is big in the workforce and if we can ... deal with that mentally and treat those people as human beings ... then we can also have 100 per cent condom use." *LASCELLES CHIN, chairman of Lasco Group of Companies. April 2006.*
Best Practice	Jamaica has recognized the importance of public private partnerships and the role of the NGO in addressing safe sex among sex workers. The Ministry of Health, JAS and private exotic clubs come together to provide education and prevention materials for sex workers. The SWs are not only educated and provided with condoms, some are also trained as peer counsellors. • "The health authorities come in periodically and give lectures and demonstrations to our girls. They have interesting debates and sometimes they bring people from abroad (who provide funding) to monitor the progress," Mr. Cameron related. He added that his girls also attended seminars on sexually-transmitted diseases and that some of them were trained as peer counsellors. • As a result there has been a visible change in the attitude of the industry towards safe sex: *A consultant in the exotic club industry and current chief executive officer of the popular Gemini Club, in Kingston, Denzel "Sassa Frass" Naar, agrees that the culture of the industry, with specific regard to safe sex practices, has been changing over the years.*

	http://www.jamaica-gleaner.com/gleaner/20060723/news/news7.html

"***I feel relieved……with a sigh…. or…. It's the first I told anyone that…...or I am glad to hear JAS has a Clinic we can come to 'cause dem treat we so bad at the odda clinics...or I'm glad I could talk…or…It's the first I hear about Lubricants……. or me neva know se me mussin douche."***
(Courtesy, Marlene Taylor, 2006)

Antigua & Barbuda - Snapshot on Sex work

Country Name	Antigua & Barbuda
Population	85,000
HIV/AIDS Prevalence	553 confirmed cases at end of 2005
Epidemic Profile/ Trends	• 65% of all cases are in the 15-49 age group • 46% of cases in 15-49 age group are females • Increasing feminisation of the epidemic: women ages 15 to 29 are the fastest-growing population of people infected with HIV-AIDS (John Maginley, Antigua and Barbuda's Minister of Health, Caribbean Summit on HIV/AIDS, Jan 2007)
HIV/AIDS National Response	• National response Prevention programme addresses: VCT, PMTCT, Blood safety, condom promotion, STI control, BCC, and workplace initiatives • Treatment, care and support includes access to antiretrovirals for all PLWHA since 2005 • Red Cross has youth programme but none directed at SWs. • Antigua Planned Parenthood Association (APPA) provides reproductive health services but none directed towards SWs
Nature of Sex Work (Settings)	• Bars, brothels, discotheques, streets (Main Street), home, casinos (dominated by English SWs). • Sex industry relatively organised therefore numerous open commercial sex establishments
Remuneration	• EC$30-$50/client for brothel based SWs
Approximate number of sex workers	• No comprehensive studies done to date to assess size of population. • ~4-5000 sex-for-hire workers (John Maginley, Antigua and Barbuda's Minister of Health, Caribbean Summit on HIV/AIDS, Jan 2007)
Sexual Identities	• SWs tend to be women 20-40yrs (and some younger 18-19 years)
Profile of MSWs	• No identified businesses of MSWs. • 'Rasta man' seeks tourist clientele of both sexes
Country Category (Source or Receiving)	Receiving however some SWs are Antiguan nationals.
Source Countries	Guyana, Jamaica, Dominican Republic, Colombia, Venezuela, England
Clients	Tourists and local males to lesser extent
HIV/AIDS Prevalence among sex workers	Information not available
HIV related risk behaviour	No data available about HIV risk behaviour
Interventions for Sex Workers - Prevention	• Prevention programme for Sex Workers implemented in 2003 and 2005. This is through the Ministry of Health and consists of condom provision but no STI testing and management. ○ No data available yet on numbers of SWs reached through this programme • No general health services for sex workers and language is a barrier as many are Spanish speaking.

Interventions for Sex Workers – Treatment Care & Support	• Although treatment is available for all PLWHA in Antigua there are no treatment initiatives targeting SWs for access • Language barrier and legal issues prevent significant proportion of non-Antiguan SWs who may be HIV+ from accessing care
Role of Civil Society	• There are no visible SW organisations • No formalised NGO support activities for SWs
Migration	• Migrant populations from Dominican Republic (8-9000), Cuba, Colombia, Venezuela, Jamaica, Guyana, Canada and England. • 60% of the Dominicans are women and many of them engage in sex work. 40% of the Dominican sex workers in Antigua are illegal. Appears to be substantial xenophobia towards Dominicans based on racism and language.
Related Legislation	• Prostitution/sex work illegal. • Buggery illegal • No laws and regulations to protect PLWHA therefore request made to PANCAP to review laws and regulations and recommend appropriate legislation as it relates to the protection of all vulnerable groups
Other Concerns	• Government actively pursues sex workers and has already closed various businesses. • Taxi drivers are good access points as they serve as intermediaries between SWs and tourists • Gaps in current national M&E system and special studies significantly restrict the ability of programme planners to identify present and future needs of sex workers; the national programme acknowledges this as a gap and plan to work with the proprietors of establishments in developing programmes for CSWs

9 *Barbados - Snapshot on Sex work*

BARBADOS

Figure 6 . Map of Barbados in the wider Caribbean.

Country Name	Barbados
Population	270,000
Human Poverty Index	Rank: 4
Estimated Number of PLWHA	4,000
Epidemic Profile/ Trends	• HIV infection levels among young pregnant women declining in early 2000s from 1.1% in 2000 to 0.6% in 2003 (UNAIDS 2006 AIDS Epidemic Update,). • Widespread access to antiretroviral has triggered a steep decline in AIDS death rates from 34.2 per 100,000 persons in the late 1990s to 17.2 per 100,000 persons in 2003-2005. • Despite these successes however, most recent estimates (2004) indicate that there is a new HIV infection in Barbados every 30 hours. • The ratio of men to women is 1.7:1 (for every woman infected there are 1.7 men). (2005 MOH) • 73.3% of reported HIV cases in 2005 were in the 19 - 49 age group
HIV/AIDS National Response	• National response consists of a comprehensive Prevention and Treatment programme addressing: VCT, PMTCT, Blood safety, condom promotion, STI control, BCC, workplace initiatives, access to treatment for all, a scaled up holistic social support programme • Treatment, care and support includes access to antiretrovirals for all PLWHA since 2002 • MOH partially funds CSW Project (2yrs). Main goal of the

	study is to map sex work on the island and administer a KAPB to sex workers. In-depth interviews administered to 30 street and club based sex workers. • Barbados Family Planning Association (BFPA) provides reproductive health services but none directed towards SWs • Stigma and discrimination registry
Nature of Sex Work (Settings)	Bars, nightclubs, streets (beach based), apartments, hotels.
Remuneration	BDS$30-$60/client for brothel and street based SWs and up to $1000BDS/hr for high end 'escorts'
Approximate number of sex workers	No comprehensive studies done to date to assess size of population but some surveys have found revealed approximate numbers.
Sexual Identities	• Beach boys/ beach girls, 'Sugar daddies' • >50% of SWs in the field for over 5 years (MOH CSW study, 2006)
Profile of MSWs	• No identified businesses of MSWs. • MSWs operate informally in the street and through clubs and private parties • 'Beach boys' may have male clients
Country Category (Source or Receiving)	Receiving however increasing source country for regional sex trafficking
Source Countries	Antigua and Barbuda, Belize, Dominican Republic, Haiti, Grenada, Guyana, St. Lucia, St. Vincent, Trinidad and Tobago, South America, Eastern Europe
Clients	Tourists (pleasure and business), Crews of ships in port, Barbadian men
HIV/AIDS Prevalence among sex workers	• No data is available on HIV prevalence among SWs in Barbados – so sero-prevalence studies of this group and surveillance currently does not capture this category •
HIV related risk behaviour	• 55% of 'Beach Boys' used condoms all the time; 35% never used condoms; 10% used condoms sometimes; ~ 50% had HIV tests; 100% never diagnosed with an STI; 20% reported sex with 4 or more visitors in the previous 3 month period. (Fantasy Island Survey Findings, Dawn Marshall, 1999) • The following preliminary data was released by the MOH CSW in late 2006. o 20% of the SWs never used condoms o 73% reported using condoms at last sexual encounter o ~1/3 SWs always drank before starting 'work' and 1/3 drank between clients. o 19% of the SWs reported a symbiotic relationship with bar owners who provided the sex workers with rooms and free drinks in exchange for a percentage of the fees.
Interventions for Sex Workers - Prevention	• The MOH CSW programme also educates SWs about STIs, safe sex and condom use when they collect data • UGLAAB distributes condoms to female and male SWs at hotspots (ALLIANCE funded programme) • Upcoming DFID funded project (2007) will fund expansion of the condom distribution programme to more SW hotspots and

	include BCC component; the programme will also target beach based SWs for a KABP survey and peer education
Interventions for Sex Workers – Treatment Care & Support	• The MOH CSW programme educates SWs about availability and importance of treatment care and support • Although treatment, care and support is available to all nationals, many SW are not Barbadian, thereby precluding them from accessing comprehensive care
Role of Civil Society	• No SW-led support organisations • Currently one NGO (UGALAB) provides condoms to SWs but no BCC programmes
Migration	• Some of the SW enter the country as tourists • Work permits are required for all Non-nationals • Many Barbadian SW go elsewhere to offer their services (37%; MOH CSW, 2006)
Related Legislation	• Prostitution/sex work illegal. • Buggery illegal • No laws and regulations to protect PLWHA
Other Concerns	• Sex tourism (supported by trends in trafficking of SW and internal migration of SW according to tourist season) • Need to educate workers (taxi drivers, hotel staff [one hotel staff member in 2005 ILO/USDoL study noted that his staff works in the hospitability industry and therefore they are there to provide anything the tourist desires], vendors etc.) in the tourism industry about HIV and HIV risk as they act as intermediaries between SW and clients • Targeted by police and immigration authorities • Increase organised prostitution rings supported by women trafficked in from the outside – potential links to drug • Increasing reliance on sex work as an supplemental income among middle class individuals to sustain higher standards of living • Growing demand for high-class 'escorts' fuelling increased trafficking of Eastern European and South American women for sex work in Barbados – no regulation on conditions under which illegal SWs are maintained in Barbados and many are threatened with deportation if they do not comply with pimps • Poor education about HIV testing in these communities (One high end 'pimp' did not know about the window period for HIV testing and therefore was sending his 'girls' for tests immediately after unprotected sex) • SW highly stigmatised • Growing underground pornography industry • Expanded NGO support is needed to assist SWs in dealing with job related risks such as violence, non payment, robbery, and deportation (non nationals) • Prostitution of minors – male beach boys and young girls

Concentration of Sex Work by Tourism Hot Spots

10 Belize - Snapshot on Sex work

Country Name	BELIZE
Population	283,000
HIV/AIDS Prevalence	Estimated 2.5%; one of the most severe in Central America; Estimated 3700 PLWHA; Adults >15yrs living with HIV – 3600.
Epidemic Profile/ Trends	• 40% of all new cases in 2002 were 20-29 yrs • Increasing feminisation of the epidemic with current 1:1 ratio; almost 50% of reported AIDS cases in 2003 were among women • 0.9% of antenatals HIV+ (2003) • Rising HIV Prevalence • Belize district is most populous and shows highest prevalence rates • Heterosexual dominant transmission route
HIV/AIDS National Response	• Multicultural National HIV/AIDS Commission • National response Prevention programme addresses: VCT, PMTCT, Blood safety, condom promotion, STI control, BCC, and workplace initiatives • Provision of antiretrovirals needs to be scaled up considerably. 2005 data indicate coverage of less than one third with only 180 of the 531 in need of HAART actually accessing the drugs. Access has been particularly challenging for PLWA in rural areas
Nature of Sex Work (Settings)	• Brothels, bars, hotels, streets, home • Belize only has two official brothels where it is openly known that sex work happens…most common are bars • As with most of Central America there are 2 main types of SWs – brothel based and street based. • There is also transactional sex work that is very common in the city…sex workers have sex in exchange of getting their bills paid for either school fees or utilities. • Brothel-based sex workers regularly visit STI clinics for check-ups and report higher condom use rates • Street-based workers much harder to reach with prevention services and do not get regular check ups.
Remuneration	
Approximate number of sex workers	• 4,450 average estimates (Sex Work & HIV/AIDS, UNAIDS 2002) • Estimated 7.4% of female population (15-49)
Sex worker Identities	• SWs tend to be women 20-40yrs (and some younger 18-19 years) from Central American countries. • Many of them do not speak English • Most have not completed primary school • '*Muchachas*' (FSWs) in rural areas such as Orange Walk (Kampadoo)
Profile of MSWs	• PASMO has worked with a few MSWs and can only say from that that MSW are younger males (15-19 yrs old)No information available

Country Category (Source or Receiving)	Receiving, however some SWs are Belize nationals.
Source Countries	• Neighbouring countries in Central America • Majority of women working in brothels from Honduras, El Salvador, and Guatemala • Roy Young, 2003. Honduras (65%) and Guatemala (17.5%), El Salvador, and Nicaragua. Approximately 75% entered the country legally.
Clients	Local men. (Kampadoo notes that unlike other countries in the Caribbean, tourism is not a driver of sex work in Belize, in fact there was no observable increase in the SW population with the rise in Belize tourism industry) It is well known that on days that crew ships come into the city there is an increase in SW for the women; many of these women are Belizean.
HIV/AIDS Prevalence among sex workers	• Information not available however high rates of infection have been observed in source countries (Guatemala, 15%; El Salvador, 16%)
HIV related risk behaviour	• Condom use mandatory at the largest brothels in Belize City, however, CSW report not using condoms with their lovers (boy friend) or with customer they have grown to like (Young, 2003) • 94% of SWs knew how STIs and HIV are transmitted (Young, 2003) • Condom use low with regular partners (Young, 2003)
Interventions for Sex Workers - Prevention	• No general health services for sex workers and language is a barrier as many are Spanish speaking. • 46% of SWs would be willing to participate in a HIV/AIDS prevention campaign • Doctors visit some of the brothels to educate, give check-ups, medication and provide condoms to SWs; this is a potential avenue for the distribution of HIV/AIDS related information.
Interventions for Sex Workers – Treatment Care & Support	• No specific interventions for sex workers within the National Programme although
Role of Civil Society	• NGOs working with local brothels build HIV awareness and distribute condoms • PASMO – Pan American Social Marketing Organisation (an NGO targeting Commercial sex workers (CSW), men who have sex with men (MSM), migrants, truckers, men in uniform, Garifuna, people living with AIDS, low income youth and Caribbean populations) can you describe any best practice programmes from PASMO or any other organisations? • PASMO uses BCC to reach FSWs. PASMO implements outreach activities which is an individualized conversation between educator and participant to help increase personal risk perception and look at alternative behaviours, condom negotiation skills etcetera.
Migration	• Many SWs worked in the sex industry in their home countries, but migrate to Belize where they earn more money prostituting. • Migration laws strictly prohibit sex work in contrast to some of

	the neighbours in Central America in which there is greater legal tolerance to sex work and SWs must submit to mandatory registration and regulatory health checks for STIs
Related Legislation	• The law prohibits loitering for prostitution, operating a brothel, or for a man to solicit for prostitution. The laws, which carry penalties of fines up to $500 (Bz$1,000) or 1 year of imprisonment, are weakly enforced. Several prominent brothels openly operated, and sex tourism increased. • The government of Belize, for example, has "Recognized prostitution...[as] a gender-specific form of migrant labor that serves the same economic functions for women as agricultural work offers to men, and often for better pay." (WEDO, 1998, p. 32) (http://sisyphe.org/article.php3?id_article=689)
Other Concerns/ Comments	• Internationally documented trafficking of minors for sexual exploitation: • Child prostitution: 2001, National Committee for Families and Children (NCFC) and UNICEF commissioned study of sex trafficking, which concluded that many minors were involved in the sex industry and that some women and children were trafficked to Belize from other Central American countries. 35% of SWs under age 18 (the Corozal region ranked the highest, with 45 percent of sex workers reportedly being minors), with the youngest girls being only 13 years old. • CSWs aspire to leave sex work and start their own businesses (selling clothes, grocery shop, etc.) but they don't have the start-up capital therefore identified need for skills building in other more financially viable job areas • Official language is English but almost everyone speaks Creole and more than 50% speaks Spanish therefore language barriers exist in terms of providing information and education • Studies that are started and not completed by outside organizations… this allows for the few organizations who are really working with the SW become mistrusting of external assistance. Eg: PASCA Prevalence study

11 Conclusions and Recommendations;

This analysis has attempted to highlight important aspects of the sex trade industries and the rights of sex workers in the Caribbean. The analyses has been relatively brief and only highlights key issues that require urgent attention with respects to rights of adult sex workers. Exploitation and trafficking of children is a fast growing area of concern and has not been the subject of analyses and this requires a special separate and more detailed analyses and consideration of the current situation and of approaches that been undertaken by several countries in the region to address this issue[21]. Another area that requires more research and assessment is male sex work. Evidence from many countries (or lack of it) indicates that male sex work, in particular heterosexual contact is not viewed as sex work but rather, romance tourism on a longer time scale and for exchange of emotions and 'is not just about sex'. On the other hand, male sex workers with identities akin to transgender, transvestites and male to male sexual contact is in existence in most countries where sex work is reported, however due to the policies surrounding Homosexuality and sodomy this is largely an underground market with many of the sexual identities in this category operating within the entertainment industry. Essentially, in the Caribbean with the exclusion of Cuban and to a lesser extent , the Dominican Republic *with respects to females – a sex worker is a sex worker and for males - it is anything and every thing but that.*

There is a virtuous cycle that is in existence regarding sex work in the Caribbean: The fact that governments appear to be stagnating - by remaining in a *political comfort zone* and failing to explicitly acknowledge the existence of a fast growing sex trade in the region, has left the way open for the very same governments and the tourism industry to inadvertently violate the existing laws and conventions that criminalize prostitution. At the same time, the existence of these laws provides the basis for governments to be exonerated from ignoring the human rights and protection of sex workers and as such ignoring their very basics needs in order for them to live fuller lives complete with dreams, hopes, possibilities and choices that is available to individual on non-vulnerable populations.

Policies addressing sex tourism require careful consideration. Sound information about every day practices must be gathered to inform policy development. In addition, although sex tourism is the main route of prostitution in the region, non-tourism types of prostitution are highly prevalent especially in countries where tourism development has yet to be scaled up and this form of prostitution has been in existence long before the emergence of sex tourism. This form of sex work in highly dangerous and offers women no form of protection from their pimps, no alternatives or exit routes and as remuneration is often below decent wages promotes in accessibility to non-stigmatising, more confidential services which are often private requiring payment of a fee for service rendered..

Country analyses have highlighted that increasingly sex workers and advocates are forming their own organisations with a focus on personal safety and dignity of sex workers, while other groups address issues such as abuse, empowerment, and self development. The best practices cited in this paper must be discussed and documented further in terms of the lessons learned and how to translate the processes and subsequent gains to other countries of the region.

[21] The needs of children and adolescents involved in prostitution are different form those of adults and must be addressed in the context of the general economic injustice which places people in the position of having to work for their survival before they have achieved physical and intellectual maturity. (Ref: Sun sex and gold , Kamala Kempadoo)

11.1 Policy and programme recommendations

The CEDAW Convention[22] on the Elimination of all Forms of Discrimination against Women, recognizes that the respect of human rights of vulnerable women including sex workers extends to a recognition of sex worker Health and social needs. In addition, there are other United Nations instruments that emphasize the right to health and to the socio-economic conditions that enable good health to be achieved. These are the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights, the International Covenant on Civil and Political Rights, the Convention on the Rights of the Child and the Convention on the Elimination of All Forms of Racial Discrimination.

The health and well-being of sex workers as defined by the WHO definition of health refers to the prevention of physical and mental health problems, harm reduction, equal access to treatment care and support and access to social and self development programmes that promote mental and emotional well being of sex workers and their jurisdictions.

In recognition of an holistic health and rights based approach to controlling the spread of HIV and STIs, UNAIDS recommends 4 focus areas to be addressed in the development of health and social interventions sex workers:
:

1. prevention of entry or delaying entry
2. prevention of HIV transmission and harm reduction
3. treatment care and support of HIV positive sex workers and prevention of transmission
4. Beyond sex work support to sex workers who seek to exit the industry

–This analyses has broadly revealed a number of key areas that require more analyses and subsequent programme and policy development

[22] The Convention on the Elimination of all Forms of Discrimination against Women (the CEDAW Convention) is a human rights treaty for women. The UN General Assembly adopted the CEDAW Convention on 19th December 1979. It came into force as a treaty on 3rd September 1981; thirty days after the twentieth member nation became a States party to it. CEDAW is one of the most highly ratified international human rights conventions, having the support of 185 States parties. This is one of the many benefits of the CEDAW Convention; it can stand as a treaty that has achieved a global consensus and thus reflects the normative standards applicable to women's human rights. WOmens health is explicitly cited as a general recommendation (GR24) area of major concern. Under GR24, the convention committee affirmed that access to health care, including reproductive health, is a basic right under the Convention on the Elimination of All Forms of Discrimination against Women, decided at its twentieth session, pursuant to article 21, to elaborate a general recommendation on article 12 of the Convention. The committee also noted that special attention should be given to the health needs and rights of women belonging to vulnerable and disadvantaged groups including, women in prostitution. Note 7 of the convention highlights that women's right to health can be achieved only when States parties fulfil their obligation to respect, protect and promote women's fundamental human right to nutritional well-being throughout their lifespan by means of a food supply that is safe, nutritious and adapted to local conditions. To this end, States parties should take steps to facilitate physical and economic access to productive resources, especially for rural women, and to otherwise ensure that the special nutritional needs of all women within their jurisdiction are met. In addition, under article 12(1) of G24 the convention Women in prostitution are also particularly vulnerable to these diseases. States parties should ensure, without prejudice or discrimination, the right to sexual health information, education and services for all women and girls, including those who have been trafficked, even if they are not legally resident in the country. In particular, States parties should ensure the rights of female and male adolescents to sexual and reproductive health education by properly trained personnel in specially designed programmes that respect their right to privacy and confidentiality.

1. Countries of the region should collectively devise a strategic approach to the clarification of the definition of sex work and the impact of decriminalisation of the activity. They need to focus in approaches and legislation that will avoid the promotion of power of the brothel owners, pimps and others in positions of power. Policymakers must also ensure that in addressing the legislation on criminalisation they will balance this with enforced policies that ensure that sex workers' rights as individuals with expressed and unexpressed needs, and with hopes and choices with resects to promoting their social and economic productivity are respected.

2. In order create regional development and economic sustainability strategies, governments must address the needs and problems of the majority of the economically under-privileged. There is an urgent need to scale up the creation of economic and job opportunities in all countries of the region with a particular focus on sex workers, single dependent young women, children of sex workers, and other youth a risk of entering the trade through forced sex and exploitation. Job training programmes linked to job creation and development programmes must be created and operate at hours that are accessible to women in various forms of employment. In addition child care services provided free of cost by government welfare departments across the region must be introduced and scaled up to recognise the needs of the underserved that cannot afford child care, otherwise. As such, the creation of an enabling environment becomes not just the reduction of stigma and discrimination, but also the provision of community based reasonable accommodation by the governments that aims to promote the inclusion and social and economic productivity of women (not only sex workers) at risk of HIV through various identified vulnerability channels.

3. Job creation and support does not necessarily enable sex workers to switch jobs altogether, as these jobs may pay two to three times less than sex work. It must be noted that job creation and training alone does not create a financial alternative to sex work and a combination of strategies are required. These include programmes focused on improving the economy and remuneration on a whole, such as creating concessions on essential goods and services (ref: Kempadoo and Melon 1998). In addition, emotional intelligence strategies in conjunction with job creation, training and social support has been shown to be successful in supporting the exit of sex workers from the industry. Times away from sex work continues to vary - some for the long term, never returning to the trade while others leave and return in spurts.

4. More tailored policies are required in order to address migration throughout the region for work and recreational purposes with a focus on CSME. The policies also need to address current practices of immigration and custom service providers that stigmatise and discriminate against "women who fit the profile of sex worker". This should involve exploring institutional policies and introducing guidance on interrogation of migrants and information to migrants on their rights to recourse. Such service delivery habits serve to promote exploitation and trafficking of sex workers who feel that they cannot turn to anyone in authority without being terrorised further.

5. The CSME envisages a Caribbean "without barriers, strengthened by its collective resources and opportunities." Free movement of persons is not yet a reality in the region, although CARICOM has approved regulations that allow for the free movement of business people, artists, sportspersons, and some categories of students; the movement of other groups has been under discussion for several years. Free trade and free movement

of capital are slowly being implemented (CARICOM Secretariat 2003).The reality is that free movement of individuals means free and unchecked movement of diseases. In the absence of adequate surveillance reporting and monitoring and evaluation systems, the regions epidemic will become indistinct between countries as each shares its neighbours' HIV incidence.

6. One possible impact of open borders within a Caribbean with failure to address the laws on prostitution, access to services HIV and other health and support by migrant workers including sex workers and without control mechanism to guard against stigma and discrimination by those in authority may be the adoption of more discriminatory law - enforcement practices by police and immigration officials in order to ensure that identified sex workers are not able to work in the countries that they are visiting. This situation may further give rise to harassment and exploitation of sex workers as they are driven further underground.

7. Overall, there is an urgent need to address the 'abuse of power' by public services providers, including immigration and customs officials, the police force and health providers. Regardless of legal status of a migrants' situation in the host country, governments must produce more comprehensive guidance on service provision, client charters and policies that ensure accountability for actions taken by providers. Issues raised in addition to (4) above include the abuse and physical violence from police and protection of the rights of the clients over the sex worker's rights.

8. Decriminalisation of prostitution alone at the national level is not enough to address the breach of human rights observed through active discrimination and stigma practiced by the community at large and institutions towards sex workers. The development of institutional policies and practices that promote an enabling environment is vital. The development of lines of accountability and other service guidelines as well as creating leadership and awareness within service providers with regards to their key role in reducing stigma and discrimination and in promoting equitable delivery of care is vital.

9. Promotion of workers rights for women in informal and unstable employment and payment conditions which forces them to extend their income through unsafe sex work and in some cases involving their teenage daughters, as observed in Suriname and Guyana.

10. While access to health care is a right contained within the international convention on Economic and social and Cultural Rights, there are problems relating to access to health and social support services by sex workers and their families. Government partnerships with civil society organisation require strengthening in order to provide a more holistic form of support to sex workers and their families;

⇨ Sex worker organisations require assistance in developing and funding strategies and human resources that would promote the ongoing development of support programmes that address the emotional mental and spiritual well-being of sex workers while recognising the scope and variation of needs of the different sex worker identities

⇨ Promote the access to more responsive health care for promoting their physical well being and timely access to preventative health information, materials and condoms. Prevention approaches through Behaviour change communication must be focused on the whole person and recognize the overall household situation, societal mores[23], and

[23]These are the customs and habitual practices, especially as they reflect moral standards, which a particular group of people accept and follow.

economic environment of the individual and also adopt a combination of emotional intelligence, health promotion and harm reduction approaches, in harmony, that promote self-empowerment, senses of self-esteem and self-worth.

⇨ As in (7) above, ministries of health must become more proactive in the drive to respect of the human rights and dignity of sex workers or even those who are perceived to be sex workers , in particular young sexually active females or single mothers[24].

11. Sex workers and single young sexually active females who are not in the sex trade experience discrimination in their local communities and as such this promotes their lack of full participation in civil society, including the withdrawal or inability to pursue education, skills building. This cycle promotes further disadvantages and societal discrimination and greater reliance by these women on sex work, whether formally, through the sex trade or informally through more emotional connections. Therefore stigma and discrimination reduction strategies targeted towards the general population in must be scaled up. Approaches must encompass recognition of the various forms of Stigma and discrimination towards sex workers exhibited within different community settings – the local communities, educational establishments, social support service, formal workplaces and the informal employment sectors.

12. Not least, despite the separation between church and state on how best to proceed to address the issue of HIV prevention, sex work and homosexuality, it emerged clearly in some of the country analyses that in the Caribbean the church and the perception of God in the life of many sex workers plays a key role in how they step out each day into the world of sex work. In addition, it has been well documented by governments of the region in their HIV strategic plans that their programmes must urgently find ways of working in harmony with faith based organisations given that religion and church is the cornerstone of existence in the lives of Caribbean peoples despite the confusing messages on sex and sexuality that have emerged. With such a strong reliance on spirituality by members of vulnerable groups including sex workers, their marginalisation and exclusion from their FBO is likely to have a significant impact, heightening their sense of isolation and reducing their ability to cope with stigma and discrimination as has been highlighted by the workers at Stitching Maxi Linder Association, in Suriname (SMLA). In Suriname and Dominican Republic sex workers commonly reported praying to God for protection. Best practise have emerged in Suriname, where prostitution is still a criminal offence, as to how best to involve the Christian based church in promoting community respect for the human rights of sex workers. In addition, regional initiatives such as the champions for change - stigma and discrimination reduction initiative have demonstrated that all community based organisations and groups including the FBOs can be reached to actively participate in stigma free HIV prevention among all vulnerable groups in the region including sex workers. Regardless of the legal status of sex work, these initiatives and best practices in working with FBOs need to be scaled up at country level , owned and led by civil society, including FBOs and sex workers organisations and mandated publicly by government and church leaders.

[24] Research on stigma and discrimination has demonstrated clearly that many young women who are HIV positive, received intense stigma and discrimination by health workers prior to becoming HIV positive, whether during pregnancy and delivery of their children, or when seeking treatment for a past STI. As such, many did not freely return to the services for prevention information or follow up treatments or check-ups. This placed them at greater risk of HIV regardless of their sex work status (ref: The context causes and consequences of HIV related stigma and discrimination in Barbados 2003, Adomakoh et al, Impact report from the BHIP project Ministry of Health Barbados)

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