Regional Issue Brief

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Video of the Caribbean Regional Dialogue is available on the Commission’s website at (under Photos and Videos):

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Content

Acknowledgements.............................................................................................................1

Abbreviations .......................................................................................................................3

1. Introduction .........................................................................................................................4

2. HIV in the Caribbean .........................................................................................................9

3. HIV, the Law and Human Rights .......................................................................................12

4. Criminalisation of People Living with HIV & Those at Higher Risk...............................19

4.1 Men who have Sex with Men (MSM) and Transgender People ..................................20
Law ........................................................................................................................................21
Law enforcement practices .................................................................................................22
Legal responses that protect and empower ..........................................................................24
Areas of concern ...................................................................................................................25

4.2. Sex Work .........................................................................................................................25
Law ........................................................................................................................................26
Law enforcement practices .................................................................................................28
Legal responses that protect and empower ..........................................................................29
Areas of concern ...................................................................................................................30

4.3 Criminalisation of HIV Transmission and Exposure ....................................................30
Law ........................................................................................................................................30
Law enforcement practices .................................................................................................32
Legal responses that protect and empower ..........................................................................33

4.4. Criminalisation of Drug Use .........................................................................................33
Law ........................................................................................................................................35
Law enforcement practices .................................................................................................36
Legal responses that protect and empower ..........................................................................37
Areas of concern ...................................................................................................................37

4.5. HIV in Prisons ................................................................................................................38
Areas of concern ...................................................................................................................39

5. Women and HIV ...............................................................................................................40
Law and law enforcement practices ......................................................................................42
Legal responses that protect and empower ..........................................................................44
Areas of concern ...................................................................................................................45

6. Children and HIV ..............................................................................................................46
Law ........................................................................................................................................48
Law enforcement practices .................................................................................................49
Legal responses that protect and empower and areas of concern ........................................49
This Issue Brief is dedicated to the memory of Robert Carr, intrepid and unwavering champion of justice and compassion.

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Abbreviations

ACP  Africa, the Caribbean and the Pacific region
AIDS  Acquired Immune Deficiency Syndrome
ART  Anti-retroviral treatment
CARICOM  Caribbean Community
CRC  Convention on the Rights of the Child
CTAG  Caribbean Treatment Action Group
CVC  Caribbean Vulnerable Communities Coalition
EPA  Economic Partnership Agreement
EU  European Union
FTM  Female-to-male transgender persons
FSW  Female sex workers
HIV  Human Immunodeficiency Virus
ICCPR  International Covenant on Civil and Political Rights
MDG  Millennium Development Goals
MSM  Men who have sex with men
MTF  Male-to-female transgender persons
NGO  Non-governmental organisation
NSP  Needle and Syringe Programmes
OECS  Organisation of Eastern Caribbean States
OST  Opioid Substitution Therapy
PANCAP  Pan Caribbean Partnership Against HIV and AIDS
PAHO  Pan American Health Organisation
PMTCT  Prevention of mother-to-child-transmission of HIV
STI  Sexually Transmitted Infections
UDHR  Universal Declaration of Human Rights
UN  United Nations
UNAIDS  Joint United Nations Programme on HIV and AIDS
UNFPA  United Nations Population Fund
UNICEF  United Nations Children’s Fund
UNIFEM  United Nations Development Fund for Women
UNODC  United Nations Office on Drugs and Crime
USD  United States Dollars
WHO  World Health Organisation
WTO  World Trade Organisation
1. Introduction

This Regional Issues Brief provides an overview of HIV and the law in the English-speaking Caribbean, Cuba, the Dominican Republic and Haiti, all very different countries, varying in size, economic development, legal systems and HIV and AIDS burden. The 29 nations and territories which make up the Caribbean are island states, archipelagic states, and mainland territories in South and Central America. Population size varies from smaller island states such as Anguilla with 8,000 and Cayman Islands with 35,000 to Haiti with 8 million and Cuba with 11 million inhabitants. The region’s population of 39 million is of African (predominant), European and Asian ancestry, as well as indigenous populations such as the Carib, Arawak, Garifuna and Taino peoples. Caribbean populations speak English, French, Spanish, Dutch and Kweyol. They represent diverse religious backgrounds - Christian, Hindu, Muslim and others. The majority of the territories are independent sovereign states. However, France, the United Kingdom, the Netherlands and the United States continue to exercise limited sovereign power over their dependent or overseas territories. The wealth of the Caribbean is not homogenously distributed, with Bermuda having the highest GDP per capita of USD36,000 and Haiti the lowest with USD1,600.

Despite differences between countries, the spread of HIV in the Caribbean has taken place against a common background of poverty, gender inequalities and a high degree of HIV-related stigma. Migration between islands and countries is common, contributing to the spread of HIV and blurring the boundaries between different national epidemics. Additionally, poor availability of HIV and AIDS data makes it difficult to gain a clear picture of each country’s situation.

LEGAL SYSTEMS OF THE CARIBBEAN

Diversity also characterises the legal systems of the region. With the exception of Guyana and Saint Lucia, which are mixed systems with influence of Roman-Dutch law and French Civil Law respectively, the legal system of the English-speaking Commonwealth Caribbean is based on English Common law. Haiti’s legal system is based on Roman Civil law, the Dominican Republic on French Civil Law and Suriname on the Dutch legal system incorporating French legal theory.

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1. The Bahamas
2. Guyana, Suriname
3. Belize
4. France – the Overseas Departments of Guadeloupe and Martinique and the Overseas Collectivities of Saint Martin and Saint Barthelemy; The United Kingdom – the Overseas Territories of Anguilla, The British Virgin Islands, Montserrat, Bermuda, The Cayman Islands and Turks and Caicos; The Netherlands – The Netherlands Antilles of Curacao, Bonaire, Saint Maarten, Saint Eustatius, Saba and Aruba; The United States – The United States Virgin Islands and Puerto Rico.
Relevance of International Legal Instruments

Haiti, the Dominican Republic, Suriname and the Dutch Territories which follow Dutch and French Civil law may apply conventions or international legal instruments upon ratification of these instruments in accordance with a monist theory of law. Guyana, Saint Lucia and the remainder of the Commonwealth Caribbean follow the dualist theory, in that international treaties and conventions must become law by passage through the national legislature before they are effective.

The difference between theories relates, on a practical level, to the steps that are needed before an international treaty is to have effect within a national system of law and what a court is to do in a situation where the obligations under international and national law differ.

The monist theory holds that there is just one legal system, incorporating both international and national law and that although the national constitution is the supreme ‘domestic’ law, all domestic law is subordinate to international law and must conform to its requirements. In the monist system it would be open for courts to refer to those international laws in priority over domestic laws. Such a legal system creates a single structure of law in which international law is incorporated without corresponding domestic legislation; or in which it can even override national laws.

The dualist theory holds that there are separate legal systems of international and national law and that the legislature requires to take the necessary step of passing legislation incorporating international treaties into the domestic legal system. Where the state does not do so, it remains unincorporated in the national system, although the state may have ratified that international treaty. Such a treaty cannot generally be referred to by the Courts or be given precedence over national laws.

Generally, countries which have adopted a ‘common law’ system of law follow a dualist approach and countries which follow ‘civil law’ traditions generally adopt a monist

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7 Malanczuk, P (1997), Aekhurst’s Modern Introduction to International Law Routledge, Seventh edition, at pp. 63

8 In the monist system a distinction is also drawn between self-executing treaties and non-self-executing treaties. Where a treaty is non-self-executing, there needs to be further legislation by the national legislature. Where the treaty is self-executing, no further legislation is needed to give it effect within the domestic legal system as it is sufficiently clear and precise to confer rights or obligations on individuals in domestic law without needing implementing legislation.


10 In the common law tradition, courts decide the law applicable to a case by interpreting statutes and applying precedents which record how and why prior cases have been decided, known as stare decisis. Decisions by appellate courts are binding on lower courts in the same jurisdiction and on future decisions of the same appellate court, but decisions of lower courts are only non-binding persuasive authority. The principle of stare decisis lies at the heart of all common law systems. Within the common law system, however, legislation takes precedence over case law.

11 Civil law (or civilian law) is a legal system inspired by Roman law, the primary feature of which is that laws are written into a collection, codified, and not (as in common law) determined by judges. Materially, civil law proceeds from abstractions, formulates general principles, and distinguishes substantive rules from procedural
approach. Human rights protections in the Caribbean, are contained principally in written constitutions. In the English common law jurisdictions the constitutions are supreme. In the French and Dutch systems the constitution is the supreme national law, but ratified international legal instruments would supersede the constitution. Human rights in the English Commonwealth Caribbean with the exception of Guyana and Belize to some extent, are restricted to protection of civil and political rights with social, economic and cultural rights almost completely absent.

While many of the countries of the Caribbean have signed on and ratified the international human rights framework, many in the English-speaking Caribbean have failed to pass laws incorporating some of these instruments into national law and therefore the rights and protections promulgated in international human rights treaties (particularly those relating to social, economic and cultural rights) have limited applicability in national courts.

**Judicial Activism**

In the 1990’s Caribbean courts tended to apply strict principles of dualism to human rights law; two cases are illustrative of this. In the Barbados case of *Bradshaw and Roberts v. Attorney General et al*, where the appellants sought to take advantage of rights conferred by the International Covenant on Civil and Political Rights (ICCPR) and the Optional Protocol, Chief Justice Williams delivering the judgment of the court held: “Legislation to fulfil Barbados’ treaty obligations ...not having been enacted, the provisions ...are not part of the laws of Barbados.” In the OECS case of *Spence v. Hughes*, the Chief Justice expressed the position of international legal instruments in Caribbean courts. He stated at paragraph 36:

“...the IACHR, the UDHR, and the ICCPR cannot have the effect of over-riding the domestic law or constitutions of these sovereign independent states. It is a matter of constitutional principle that if Parliament has legislated and the words of the statute are clear, the statute must be applied even if its words are in breach of international law...”

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12 These include the UN Charter, the Universal Declaration of Human Rights (UDHR) 1948, the International Covenant on Civil and Political Rights (ICCPR) 1966, the International Covenant on Economic, Social and Cultural Rights 1967, the International Convention on the Elimination of All Forms of Racial Discrimination 1965; the Convention on the Elimination of All Forms of Discrimination Against Women 1979, the Convention on The Rights of The Child (CRC) 1989, the Convention Against Torture, and Other Cruel, Inhuman or Degrading Treatment or Punishment 1984, Convention relating to the Status of Refugees 1951 and its Protocol, 1967; International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families and the American Convention on Human Rights
13 Unreported Judgment of the Court of Appeal in Barbados, Nos. 31 and 36 of 1992 dated 93-04-02
14 Saint Lucia Criminal Appeal No. 20 of 1998
15 Inter-American Convention on Human Rights
16 Universal Declaration of Human Rights
17 International Covenant on Civil and Political Rights
In 2001 however, the Privy Council in *Neville Lewis v Att-Gen of Jamaica*,\(^{18}\) (which is binding authority for the countries which retain the Privy Council as the final appellate court) held that by ratification of an international human rights treaty which confers on individuals a right of access to international tribunals, the executive makes access to the international tribunals part of the domestic justice system. Any attempt by the state to hang a condemned man before completion of the international process would therefore constitute a breach of his constitutional right to the protection of the law.

By 2005 the Caribbean Court of Justice, while not prepared to water down the dualism principle to the enforcement of international human rights treaties, creatively relied on the principle of “legitimate expectation” to protect the rights of appellants convicted for murder from being executed while their motion to the Inter-American Court of Human Rights was being considered.\(^{19}\) Justices De la Bastide and Saunders came to the conclusion that since Barbados had ratified the Inter-American Convention on Human Rights, it gave the respondents a legitimate expectation that the state would not execute them without first allowing them a reasonable time within which to complete the proceedings they had initiated by petition to the Commission.

Indeed, these cases once again deal with the protections already existing in the constitutions and allowed the courts to extend their protections based on international instruments. It is doubtful whether similar judicial activism would extend to incorporating social, economic and cultural rights where these rights are not protected in the constitution.

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\(^{18}\) (2001) 2 AC 50

\(^{19}\) See *Att-Gen v Joseph and Boyce* CCJ Appeal No. CV 2 of 2005
The Issues Brief is based on a desk review of literature, United Nations and other international organisations’ policy briefs, reports and analytical papers, analyses of selected statutes, judicial precedents and law enforcement practices. It does not aim to provide a comprehensive overview of the legislation, policies and enforcement practices in all countries of the region. Rather, the aim of the document is to provide examples of positive and negative legal regulations, policies and enforcement practices, which serve as illustrations of supportive or punitive legal environments, and point out challenges faced by the countries in the region in relation to HIV, the law and human rights. Legislation, policies and implementing practices which raise concern in terms of their possible effect are pointed out in the “areas of concern” section. A short explanation of why certain policies may be harmful for individual human rights and public health goals is provided, as well as links to international standards.

The brief is organised in five parts: the first part provides a brief overview of the HIV situation in the Caribbean. The second part aims to create a snapshot of anti-discrimination laws and policies in the region. The third part concentrates on the application of criminal law to people living with HIV and key populations at higher risk. It briefly explores legislative frameworks in relation to men who have sex with men (MSM), sex workers, HIV exposure and transmission, drug use, and HIV in prisons, and examines their negative or positive implications for the affected populations. The fourth part provides an overview of how the legal framework protects or exacerbates the effects of HIV on women; and the fifth part touches upon the specific issues related to children and HIV. Parts two to five are divided into four sections, and aim to provide a picture of the laws, law enforcement practices, and positive and negative aspects that deserve attention of law makers, implementers and other stakeholders including civil society groups and affected populations.
HIV prevalence among adults in the Caribbean is about 1% - the second highest adult prevalence after sub-Saharan Africa. However, the number of people living with HIV is relatively small at 260,000 and has been stable since the late 1990s.\(^\text{20}\)

The burden of HIV varies significantly between and within countries. It was estimated that in 2009 approximately 70% lived in Haiti and the Dominican Republic. 12% of pregnant women using antenatal facilities in one of Haiti’s cities have tested HIV-positive, compared with less than 1% in the west of the country.\(^\text{21}\)

In the Dominican Republic, HIV infection levels also vary, with HIV prevalence among communities near sugar plantations about four times higher than the national average.\(^\text{22}\) The very low HIV prevalence in Cuba (0.1%) contrasts, with 2.2% in Haiti, 2.4% in Suriname, and the Bahamas with the highest rate of adult prevalence 3.1%.\(^\text{23}\)

New infections have declined slightly between 2001 and 2009. An estimated 17,000 people became newly infected with HIV in 2009, about 3000 less than the 20,000 in 2001.\(^\text{24}\) 18,000 new HIV infections took place in

\(^{21}\) Ibid.
\(^{22}\) Ibid.
\(^{23}\) UNAIDS (2010), *The Status of HIV in the Caribbean*, UNAIDS Caribbean Regional Support Team.
2009, an average of 50 new infections per day. There were 12,000 AIDS-related deaths in 2009, or 33 per day.

Increased access to antiretroviral treatment has led to a 40% decrease in mortality since 2001. An estimated 12,000 people died because of AIDS in 2009 compared with 19,000 deaths in 2001. However, coverage of treatment is estimated to be approximately 51% across the region. HIV/AIDS continues to be one of the leading causes of death among men and women aged 20 – 59.

The Caribbean remains the only region, besides sub-Saharan Africa, where women and girls outnumber men and boys among people living with HIV. In 2009, an estimated 53% of people with HIV were female. Unprotected sex between men and women – especially paid sex – is believed to be the main mode of HIV transmission in this region. HIV prevalence is highest among MSM and sex workers. Infection levels of 4% in the Dominican Republic, 9% in Jamaica, and 27% in Guyana are registered among female sex workers. Unsafe sex between men is a significant facet of the epidemics in this region – one in five MSM surveyed in Trinidad and Tobago were living with HIV, and one in four said they also regularly had sex with women. In Jamaica, there is an HIV prevalence of 32% among MSM. Studies show increasing HIV infections among MSM in Cuba and the Dominican Republic.

Injecting drug use is relatively rare in the region, with the exceptions of Bermuda and Puerto Rico, where unsafe injecting drug use contributes significantly to the spread of HIV. In Puerto Rico, contaminated injecting equipment accounted for about 40% of males becoming newly infected in 2006 and for 27% among females. It has been recorded that prisons have higher HIV rates than the general population.

Despite these problems, there have been notable successes in the Caribbean response to the HIV epidemic, specifically in the area of blood safety and universal precautions. Antiretroviral treatment coverage rose from 1% in 2004 to 51% in 2008. In the area of

Source: UNAIDS Caribbean Regional Support Team – The Status of HIV in the Caribbean 2010

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25 Ibid.
26 Ibid.
28 Ibid.
paediatric AIDS treatment, the coverage has reached 55% which has contributed to the reduction of AIDS-related mortality. In 11 Caribbean countries, more than 90% of pregnant women are tested for HIV every year.\textsuperscript{29}

However, HIV continues to spread among most-at-risk-populations, fueled by the stigma and discrimination that these groups face. Outdated social attitudes reflected in laws and policies create negative environments for people at higher risk of HIV, and for vulnerable and stigmatised communities, pushing them away from testing, treatment, care and support.

\textsuperscript{29} Ibid.
The right to health is recognised in several Caribbean constitutions including Cuba, the Dominican Republic, Haiti, Guyana and Suriname. Notably Commonwealth Caribbean constitutions with the exception of Guyana do not recognise the right to health. The constitution of Cuba for example provides that the state guarantees medical care and that everyone has a right to health care and protection. The state guarantees this right with the provision of free medical and hospital care, through a network of rural medical facilities, polyclinics, hospitals, preventative and specialised treatment centres. In the constitution of the Dominican Republic, Article 8 proclaims that the state shall ensure the improvement of nutrition, sanitation and hygienic conditions, seek the means for the prevention and treatment of epidemic and endemic diseases and all other measures, as well as provide medical and hospital care to those with limited financial resources. In Guyana section 24 of the constitution provides that every citizen has the right to free

Freedom from discrimination is usually guaranteed in constitutional provisions with few instances of specific anti-discrimination legislation. Constitutional guarantees are largely restricted to the grounds of sex, race, place of origin, political opinions, colour or creed, for example in the constitutions of Antigua and Barbuda, Dominica, Grenada, Saint Kitts and Nevis, Saint Lucia, Belize, The Bahamas, Trinidad and Tobago and Barbados. Provisions related to “other status” that may arguably envisage categories including health status, disability or sexual orientation are not available in most Caribbean constitutions. Suriname, however, is a clear exception. Article 8 subsection 2 of the constitution, states that no one shall be discriminated against on the basis of birth, sex, race, language, religion, education, political opinion, economic position or any other status. Only Dutch territories have laws applicable to the Netherlands Antilles and Aruba which provide protection on the basis of sexual orientation. In Guyana the grounds include, race, place of origin, political opinion, colour, creed, age, disability, marital status, sex, gender, language, birth, social class, pregnancy, religion, conscience, belief or culture. In 2000 a bill to amend the constitution which would have added sexual orientation as a prohibited ground of discrimination, was passed by the Parliament but lapsed after the President failed to sign it into law.

33 UNAIDS (2010), Mapping of Punitive Laws which Impede Universal Access to HIV Prevention, Treatment, Care and Support in the OECS and Barbados, Antigua and Barbuda, Dominica, Grenada, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines and Barbados.
34 UNAIDS (2008), Keeping the Score II: A Progress Report towards Universal Access to HIV Prevention, Care, Treatment and Support in the Caribbean, Vol. 2, UNAIDS Caribbean Regional Support Team.
35 See Section 149(2) of the constitution.
36 Bulkan A (2004), National Assessment on HIV/AIDS, Law, Ethics and Human Rights in Guyana, National AIDS Committee at p.76
Very few countries have explicit anti-discrimination laws and where they exist, they are not fully used because of the risk of disclosure of confidential information (sexual orientation, sexual practices or HIV status) during proceedings in the legal system.  

Non-discrimination legislation exists in the Bahamas, Bermuda, Guyana, Saint Lucia and Grenada. In the Bahamas the Employment Act 2001 prohibits discrimination in public or private employment, except the disciplined forces (armed forces, police & prison services). The Act prohibits discrimination on the grounds of race, creed, sex, marital status, political opinion, age, HIV and AIDS status, or disability (subject to reasonable accommodation). The Act defines the acts of prohibited discrimination as refusal to offer employment, not affording access to opportunities for promotion or training or other benefits, dismissal of the employee, subjecting the employee to other detriment. It also expressly prohibits the pre-screening of an employee for HIV and AIDS.

Some countries have chosen to prohibit discrimination on the broader grounds of disability, and included HIV-infection and AIDS within the definition of disability. In Bermuda for example the Human Rights Act 1981 was amended in 2000 to revise the definition of ‘disabled person’ to include a person who has any degree of physical disability, infirmity, malformation, or disfigurement that is caused by bodily injury, birth defect or illness, including ...acquired immune deficiency syndrome, human immunodeficiency virus...’

The Act prohibits discrimination on the grounds of disability in the areas of housing; goods, facilities and services; employment; membership in organizations; advertising; and contracts. An exception exists if the discrimination was reasonable or excusable in all the circumstances. Employers are required to take reasonable steps to accommodate employees with disabilities.

“Disability” has also been defined, in UK, Canadian and US statutes to include HIV. In Grenada, and Saint Lucia which have broad anti-discrimination legislation in relation to employment the prohibited grounds of discrimination include “race, colour, national extraction, social origin, religion, political opinion, sex, marital status, family responsibility or disability”. In Saint Lucia, the grounds of discrimination include race, sex, religion, colour,  

37 UNAIDS (2010), UNGASS Report from Antigua and Barbuda.  
38 See www.lexbahamas.com/Employment%20Act%202001.pdf.  
39 See http://portalimages.gov.bm/HRC.  
40 The Disability Discrimination Act 1995 of the United Kingdom was amended by the Disability Discrimination Act 2005 to include HIV infection as well as AIDS in the definition of disability. ‘HIV infection’ is defined in the Act to mean ‘infection by a virus capable of causing the Acquired Immune Deficiency Syndrome’ (s.18); The Americans with Disabilities Act of the United States gives federal civil rights protections to individuals with disabilities similar to those provided to individuals on the basis of race, colour, sex, national origin, age, and religion. Persons living with HIV, both symptomatic and asymptomatic, are also protected by the law; In Canada the federal constitution includes the Charter of Rights and Freedoms, which prohibits discrimination by state actors (at all levels of government) on numerous listed and analogous grounds (s. 15). In addition, the federal Canadian Human Rights Act, which applies to both the federal state and to non-state actors in spheres regulated by federal law, prohibits discrimination on the grounds of race, national or ethnic origin, colour, religion, age, sex (including pregnancy and childbirth), sexual orientation, marital status, family status, disability, and conviction for which a pardon has been granted. ‘Disability’ means any previous or existing mental or physical disability and includes disfigurement and previous or existing dependence on alcohol or a drug. Case law in Canada has established that HIV is a disability.  
41 The Employment Act 1999 of Grenada  
ethnic origin, family responsibilities, pregnancy, marital status and disability. Therefore, although the law itself makes no specific mention of HIV or health status, disability may be interpreted to include HIV and provide protection against discrimination in employment.43 Also, according to the Education Act of Saint Lucia, a child may not be refused admission on the grounds of race, place of origin, political opinion, colour, creed, sex, or in accordance with mental or physical handicap.44

Stigmatising and discriminatory legal and policy measures are common in the regional legal systems. These include compulsory and mandatory HIV testing of the purposes of employment (in the military and police forces)45 and for prisoners; involuntary HIV testing of pregnant women; travel restrictions for persons applying for visas, citizenship or work permits; the introduction of criminal laws to punish transmission and exposure to HIV; and restricting access to services, in particular, treatment and care to nationals.46

Data from national assessment reports and other regional studies47 shows that several human rights violations against people living with HIV and other key affected populations exist including, unfair dismissal from employment, discrimination within the workplace, high levels of discrimination within the health sector (i.e. breaches of confidentiality, refusal of services, death resulting from refusal to treat, ill treatment and abuse), denial of housing, denial of entry into school, denial of insurance coverage even in cases of perceived HIV status, denial of access to transportation services, and refusal of work permits.48

**Employment and other instances of HIV testing:** In the majority of the study countries (with the exceptions of countries mentioned above which have anti-discrimination provisions), there is no protection against dismissal or other forms of discrimination within the workplace on the basis of health/ HIV status or sexual orientation (see for example, Antigua and Barbuda, and Dominica).49 In Barbados, although it is not mandated by law, the Police Force conducts HIV testing for its recruits50. In Saint Kitts and Nevis, the Defence Force

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43 UNAIDS (2010), *Mapping of Punitive Laws which Impede Universal Access to HIV Prevention, Treatment, Care and Support in the OECS and Barbados, Antigua and Barbuda, Dominica, Grenada, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines and Barbados.*

44 The Education Act Chapter 18.01 of the Revised Laws of Saint Lucia 200, Section 29

45 For example, note the exception in the Bahamas Employment Act 2001 to the armed forces, police and prison services referred to herein.

46 UNAIDS (2010), *Mapping of Punitive Laws which Impede Universal Access to HIV Prevention, Treatment, Care and Support in the OECS and Barbados, Antigua and Barbuda, Dominica, Grenada, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines and Barbados.*


49 UNAIDS (2010), *Mapping of Punitive Laws which Impede Universal Access to HIV Prevention, Treatment, Care and Support in the OECS and Barbados, Antigua and Barbuda, Dominica, Grenada, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines and Barbados.*

conducts mandatory HIV examination as part of its pre-employment testing and for its personnel.\textsuperscript{51}

In some instances, mandatory HIV testing occurs not only during recruitment or employment, but also for prisoners, applications for citizenship, health or life insurance, in clinical settings for particular conditions, and during pregnancy.\textsuperscript{52} The extent of pre-employment screening is not known despite the fact that it has been reported to be widespread.\textsuperscript{53} Testing of pregnant women occurs in Grenada and Suriname.\textsuperscript{54} In Saint Kitts and Nevis prisoners are tested for HIV.\textsuperscript{55} Mandatory HIV testing violates a person’s rights to autonomy and bodily integrity, and may have further negative human rights and public health impacts, including the perpetuation of discrimination against people living with HIV and vulnerable groups, and pushing people away from testing and health services.

\textit{Privacy:} Except for a reference to “respect for [his] family life, personal privacy, the privacy of his home and other property”, no substantive “right to privacy” exists for the individual in the constitutions of Saint Lucia, Saint Vincent and the Grenadines, Saint Kitts and Nevis, Barbados, Grenada, Belize. Redress for infringement of rights is available only with respect to those rights contained in the enforcement provisions in relation to protections against unlawful search and seizure. The absence of a clear provision protecting the right to privacy is a major gap in tackling stigma and discrimination related to HIV and AIDS. Although the right to privacy is protected in Suriname, it was cautioned that human rights can be restricted by law. In Suriname, the Law of 7 December 1953, concerning the regulations to prevent and combat contagious diseases (\textit{Bulletin of Acts and Decrees 1953 no.137}) is an example of such a legal restriction. This law regulates that a matter of overriding importance will have preference before the oath of confidentiality and thus the right to privacy.

Not all countries have strong privacy provisions, and frequent violations of privacy take place.\textsuperscript{56} Saint Kitts and Nevis is one country which has a clear requirement in the law for nurses to respect the privacy of their patients. This is particularly important for persons living with HIV where stigma and discrimination is widespread.\textsuperscript{57}

\textit{Residence and Freedom of Movement:} Generally, the study countries do not specifically restrict freedom of movement for persons living with HIV (i.e. Antigua and Barbuda, Saint Lucia, Grenada and Dominica).

\textsuperscript{51} \textit{Defence Forces Act} 1997.\textsuperscript{52} No. 10 of 1997
\textsuperscript{53} PANCAP (2010), \textit{Regional Policy and Model Legislation to Address HIV and AIDS related Stigma and Discrimination, Desk Review Report}
\textsuperscript{54} UNAIDS (2010), \textit{The Status of HIV in the Caribbean UNAIDS Caribbean Regional Support Team.}
\textsuperscript{56} UNAIDS (2010), \textit{Mapping of Punitive Laws which Impede Universal Access to HIV Prevention, Treatment, Care and Support in the OECS and Barbados, Antigua and Barbuda, Dominica, Grenada, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines and Barbados.}
\textsuperscript{57} PANCAP (2010), \textit{Regional Policy and Model Legislation to Address HIV and AIDS related Stigma and Discrimination, Desk Review Report, pages 28-31}
\textsuperscript{57} \textit{The Nurses and Midwives (Registration) Act} (Saint Kitts and Nevis), cited in ibid.
Notably, in several countries under review there is a general prohibition on entry into the
country by anyone suffering from a communicable, infectious or contagious disease as
defined in public health legislation. HIV or AIDS are however not so defined in, for example,
Suriname, Antigua and Barbuda, Barbados, Guyana and Suriname. The effect of this is that
there is no power to authorize the restriction of liberty or the detention of persons living
with HIV; there is no power to quarantine particularly within a prison environment; there is
no restriction on persons entering the State under the Immigration Acts which generally
restrict the entry of a person suffering from a communicable, contagious or infectious
disease.

However it is so defined in The Bahamas and Trinidad and Tobago as an “infectious
disease”. Therefore a person living with HIV may be prevented the entering the State.
Notwithstanding the legal position there has been no policy or practice giving effect to
these provisions in any of the countries. Although Belize defines HIV as an infectious
disease in public health law, an Immigration Officer may restrict entry to someone suffering
from a ‘communicable’ disease not an infectious disease.

Yet, an HIV test may be necessary for application for citizenship and work permits, even
where it is not required for entry. In Saint Kitts and Nevis an HIV test is required as part of
the application for citizenship; and proof of having passed an HIV test is necessary for
work permit applications. In Dominica too, HIV-positive applicants for work permits,
residency applications and citizenship are denied. These legislative restrictions are
generally contained in citizenship, immigration, and work permit Acts and regulations.

Reports from the Caribbean show that stigma and discrimination against people living with
and affected by HIV remain prevalent in the region, and these are major barriers to
accessing prevention, testing and treatment. Stigma is named as the main reason for the
lack of attention to marginalised groups in the prevention efforts, and their general lack of
access to HIV-related services: most individuals from high-risk contexts are not being
reached by prevention programmes and the focus of prevention is not where prevalence is
highest. It has also been noted that health care settings in the Caribbean are prime
sources of stigma.

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58 The Immigration and Passport Act Cap 208 Section 7 (1) (a) – (h)
59 Immigration Act Chapter 191 Section 22 (1) (a) – (l)
60 Immigration Act Cap 18:01 Section 8 (1)(a) – (q)
61 Immigration Act Chapter 156 2000 Section 5 (1) (a) – (n)
62 The Saint Christopher and Nevis Citizenship Act No.1 of 1984 – except for children under 12 years who are
applying on the basis of descent
63 PANCAP (2010), Regional Policy and Model Legislation to Address HIV and AIDS related Stigma and
Discrimination, Desk Review Report.
64 The Immigration and Passport (Amendment) Act 19 of 2003
65 UNAIDS (2010), Mapping of Punitive Laws which Impede Universal Access to HIV Prevention, Treatment,
Care and Support in the OECS and Barbados, Antigua and Barbuda, Dominica, Grenada, Saint Kitts and
Nevis, Saint Lucia, Saint Vincent and the Grenadines and Barbados.
67 UNAIDS Regional Report (2010), The Status of HIV in the Caribbean, UNAIDS Caribbean Regional Support
Team.
68 Ibid.
Legal responses that protect and empower: Regional governments and the Caribbean Community (CARICOM) are making efforts to address stigma and discrimination and strengthen regional and national capacities to protect people from discrimination. The new Caribbean Regional Strategic Framework (2008 – 2012) places emphasis on developing an “enabling environment” which focuses on the “development of policies, programmes and legislation that affirm human rights and counter deep underlying social barriers.”

All countries in the region have established national coordinating bodies as part of their response to HIV. Barbados, Belize, the Dominican Republic and Trinidad and Tobago established National AIDS Commissions under the leadership of the President or Prime Ministers’ Office. Other countries have located the HIV response under the leadership of Ministries of Health. While these initiatives are commendable Governments in the region are facing pressure in guaranteeing the sustainability of National AIDS Programmes in the face of reduced international attention and funding to HIV and AIDS.

National Strategic Plans on HIV and AIDS have been developed in several countries in the region. A 2009-2010 review of National Strategic Plans by The Pan Caribbean Partnership Against HIV/AIDS (PANCAP) revealed that of the 16 study countries, only 10 have plans, eight have costed plans, six have implementation plans and five have plans with monitoring and evaluation frameworks. The plans are generally comprehensive, but according to the conclusions of the study, there are implementation challenges in areas such as policy issues and stigma and discrimination.

Some positive developments are particularly important. In 2008 Saint Kitts and Nevis removed the requirement for an HIV test for work permit applications (however, the requirement is still in place with respect to applications for citizenship). In 2006, Saint Lucia passed the Health Services (Complaints and Conciliation) Act Cap 11.19 of the Revised Laws of Saint Lucia 2005 which regulates the conduct of medical professionals and provides sanctions for refusing to treat a patient. There is also provision for the revocation of a doctor’s practicing certificate.

As mentioned above, Grenada and Saint Lucia have broad anti-discrimination employment legislation, which provide for a broad category of prohibited grounds of discrimination. Although HIV or AIDS are not specifically mentioned they can be included based on the interpretation statutes in pari materia referred to above under the ground of “disability” which is present in both laws as a ground of discrimination.

71 The Pan Caribbean Partnership against HIV and AIDS, created in 2001 by the Caribbean Community (CARICOM) member states, is a regional umbrella organisation that brings together national HIV programmes with international and regional organisations involved in the fight against AIDS in the Caribbean (http://www.pancap.org). CARICOM has 15 member states (Antigua and Barbuda, the Bahamas, Barbados, Belize, Dominica, Grenada, Guyana, Haiti, Jamaica,Montserrat, Saint Lucia, Saint Kitts and Nevis, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago) and five associate members (Anguilla, Bermuda, British Virgin Islands, Cayman Islands, Turks and Caicos Islands), http://www.caricom.org.
72 UNAIDS (2010), The Status of HIV in the Caribbean, UNAIDS Caribbean Regional Support Team.
73 The Immigration and Passport (Amendment) Regulations SI No. 33 of 1991 as amended
Many countries in the region do not deem HIV and AIDS to be an infectious disease except The Bahamas and Trinidad and Tobago. Although Saint Lucia deems HIV to be a “notifiable disease”, which means that certain persons (for example doctors and masters of ships) under the Public Health Act are obliged to inform the authorities if they are aware of an individual suffering from a notifiable disease, these results are codified and confidentiality is protected as far as possible.

In this constitutional and legislative context several areas of concern persist and need scrutiny and review. They include the lack of constitutional and other legislative guarantees including informed consent requirements, confidentiality standards, and equality in access to health care, and where anti-discrimination provisions do exist, a more rigorous enforcement of these norms. These efforts need to be supported with concerted efforts to sensitize and train health care workers on rights and responsibilities. Finally, restrictions on immigration and work permits are unfounded and do not serve the public health.

\[74^{\text{Antigua and Barbuda, Dominica, Grenada, Saint Kitts and Nevis}}\]
\[75^{\text{The Public Health Act Chapter 11:01 of the Revised Laws of Saint Lucia 2001}}\]
\[76^{\text{Saint Lucia, National HIV/AIDS/STI Protocols, March 2006}}\]
It is often the melding of morality and legality that creates a lethal environment of punitive and discriminatory laws and practices, which enables, sustains and encourages higher rates of infection among most-at-risk-populations. These populations encounter severe violence, stigma and discrimination resulting in restricted access to HIV prevention, treatment, care and support. Many of the arguments supporting the criminalisation of HIV transmission, consensual male-to-male sex, sex work, abuses by police against gay, lesbian and transgendered communities, sex workers and drug users, and laws restricting young people’s access to sexual and reproductive health have rested on the preservation of public morality. Legislators argue that these provisions are necessary to prevent countries from sinking into moral decay. Another point of view posits that there is a need to frame law based on evidence and not prejudice, which strikes a careful balance between individual rights and the broadly and often erroneously understood ideas about “public good” and “public morals”. It has been demonstrated that punitive measures aimed at vulnerable and marginalised groups only fuel public health concerns like HIV and violate human rights, instead of altering behaviour or mitigating public concerns around safety and health.

Criminalisation and punitive and repressive measures contribute to marginalisation of people, decrease access to health care services and negatively affect HIV prevention, treatment and care. The United Nations (UN) has noted that legislation that creates obstacles to effective HIV prevention, treatment, care and support need to be reviewed with a view to repeal.77 Common areas of concern that create negative legal environments and exacerbate HIV across key populations of MSM, transgendered people, sex workers and drug users are:

- Criminalisation that contributes to oppression, marginalisation and reduced access to services.
- Stigma & discrimination: Religious, socio-cultural and gender-based norms, values and stereotypes contribute to disapproval, exclusion, persecution and even violence towards persons and groups associated with these identities, orientations and behaviours.
- Lack of understanding of issues affecting key populations and failure to provide appropriate services to these groups. These omissions may include aiming prevention measures at wrong populations, failure to attract marginalised groups due to inappropriate HIV prevention, treatment, care and support measures.
- Lack of concern for and protection of privacy, confidentiality and personal information.

- Information gaps regarding population size, behaviours, and health issues of key populations: in most countries, surveillance and service delivery data is not collected or analysed in a disaggregated manner that provide a realistic picture of key populations.
- Lack of sustainability of services provided by non-governmental organisations: to date, civil society organisations have played a major role in the provision of care and support services, and in some cases basic medical services for key populations. In many countries these organisations and services are not recognised or supported by their governments.

In November 2006, Caribbean Vulnerable Communities Coalition (CVC) and Caribbean Treatment Action Group (CTAG) issued the Bahibe Declaration, calling on governments regional and international health authorities, and international donors to address the situation of vulnerable groups including members of socially marginalised groups -- sex workers, MSM, drug users, prisoners, young people in especially difficult circumstances, children who have lost one or more parent to AIDS who face heightened risk of HIV infection and unequal access to care and treatment.

4.1 Men who have Sex with Men (MSM) and Transgender People

As mentioned earlier, MSM are among groups most affected by HIV in the Caribbean. The HIV prevalence among MSM varies from 6.1% in the Dominican Republic to 32% in Jamaica. One in five MSM surveyed in Trinidad and Tobago was living with HIV, and one in four said that they regularly had sex with women.

<table>
<thead>
<tr>
<th>Country</th>
<th>Adult HIV Prevalence Rate in 2007</th>
<th>HIV Prevalence Among MSM</th>
</tr>
</thead>
<tbody>
<tr>
<td>BHA</td>
<td>3%</td>
<td>8.2%</td>
</tr>
<tr>
<td>GUY</td>
<td>2.5%</td>
<td>21%</td>
</tr>
<tr>
<td>SUR</td>
<td>3.4%</td>
<td>6.7%</td>
</tr>
<tr>
<td>JAM</td>
<td>7.6%</td>
<td>31.8%</td>
</tr>
<tr>
<td>TNT</td>
<td>2.2%</td>
<td>20%</td>
</tr>
<tr>
<td>DOR</td>
<td>1%</td>
<td>11%</td>
</tr>
</tbody>
</table>

Source: UNAIDS Caribbean Regional Support Team, 2008

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78 CVC, CTAG Bahibe Declaration, November 2006 available at [www.cvccoalition.org](http://www.cvccoalition.org)
Consensual sex between adult men is illegal in 11 countries of the Caribbean. Among the English speaking Commonwealth Caribbean countries, the Bahamas is alone in not criminalising consensual sex between men. The criminalised offences are either “sodomy”, “buggery”, “unnatural acts” or “gross” and “serious indecency”; and are included in the Criminal Codes or Sexual Offences Acts inherited from the British colonial era. While the UK has moved forward and abolished these punitive laws, the former colonies cling tightly to this remnant of colonialism. Some countries including Antigua, Saint Lucia, Trinidad and Tobago, Barbados and Dominica have even included these offences in revised editions of their laws. Some offences are drafted to appear neutral (such as the offence of “unnatural sex” or “carnal intercourse against the order of nature”), Penalties can be severe - imprisonment of five to ten years is not uncommon and life imprisonment is prescribed in Antigua and Barbuda and Guyana.

Other countries of the Caribbean (including Suriname, Dutch territories, and the French Overseas Departments of the Caribbean) have no legal restrictions on consensual sex between men.

As discussed earlier, very few of the countries have any anti-discrimination protection on the basis of sexual orientation or transgender status. Only Dutch laws (relevant to Aruba

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80 Antigua and Barbuda, Barbados, Belize, Dominica, Grenada, Guyana, Jamaica, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Trinidad and Tobago.
81 For a detailed listing of various criminal law provisions, relating to buggery, sodomy or unnatural acts with associated penalties in the Caribbean see Ottosson D (2007), State Homophobia, International Lesbian and Gay Association.
82 Ibid.
83 See for example Belize section 53 of the Criminal Code Cap 101
84 Section 12 of the Sexual Offences Act 1995
85 Section 354 of the Criminal Law (Offences) Act Chapter 8:01
86 Jurisdictions in the Caribbean that do not criminalise sex between men are: Suriname, Independent Spanish Caribbean: Cuba; the Dominican Republic, The Dutch Caribbean: the Netherlands Antilles (Bonaire, Curacao, Saba, Saint Maarten, and Saint Eustacius and Aruba); the UK Overseas territories of Anguilla, Bermuda, British Virgin Islands, Cayman Islands, Montserrat and the Turks and Caicos Islands; the US Commonwealth of Puerto Rico and the US Virgin Islands; and the Overseas Departments of the French Republic: French Guyana, Guadeloupe (including Saint Bartholomew and Saint Martin), and Martinique.
and the Netherlands Antilles) prohibit discrimination against individuals on the basis of sexual orientation.  

Law enforcement practices

In a review conducted by Dr John Waters of issues affecting MSM and transgender people (and sex workers) in the Caribbean in 2009 in preparation for a Pan American Health Organisation (PAHO)-sponsored Consensus Meeting on Access of Most-At-Risk Populations to HIV Prevention, Treatment and Health Care Services in the Caribbean, held in the Dominican Republic it was found that:

(i) Sodomy offences are rarely prosecuted in cases involving consenting adults, but nonetheless provide a basis for extortion, harassment, and violence directed towards MSM and transgender people by police and others.
(ii) Sodomy laws are used in the absence of legislation criminalising male-on-male rape.
(iii) In all countries of the region, MSM and transgender people face stigma and violence. In countries that do not prohibit MSM or transgender behaviour there is no protective legislation in place to protect from or mitigate the effect of discrimination and violence.

The review states that “the existence of sodomy offences creates an atmosphere of fear and intimidation in which MSM risk violence and abuse, particularly if they are open about their sexuality. MSM report that police often use the threat of criminal prosecution to harass them. They are highly stigmatised, and fear discrimination or prosecution if they identify themselves to health authorities.”

A study conducted by the CVC in four countries (Guadeloupe, Suriname, Cuba and Antigua) noted that people perceived to be gay are more likely to experience stigma and discrimination as a major obstacle to accessing health care. The CVC Health-care Working Group study found that with the exception of Cuba, and to a lesser extent Suriname and Guadeloupe, the majority of MSM, transgender people and sex workers were accessing healthcare primarily through one of two routes: private general practitioners (especially on the smaller Islands), and NGO community clinics/family planning associations (especially larger Islands). This has important policy and programmatic implications in the region for improving access for marginalized groups, such as supporting further use of those health care sources, or emulating their strong points in public sector programmes.

Direct adverse impacts of the high levels of discrimination, stigma and criminalisation include:

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87 UNAIDS (2008), Keeping the score II: A Progress Report towards Universal Access to HIV Prevention, Care, Treatment and Support in the Caribbean, UNAIDS Caribbean Regional Support Team, Vol. 2 - 2008.
89 This finding is also supported in the national legal assessments conducted in the Caribbean and compiled in the PANCAP (2010), Regional Policy and Model Legislation to Address HIV and AIDS related Stigma and Discrimination, Desk Review Report.
90 Waters, J (2009), MSM, Transgender Persons, and Sex Workers in the Caribbean – A Level Ground Look at Underground Behaviour and How it Affects Us All, PAHO.
91 Ibid.
92 Ibid. at p. 86
93 Ibid. including (i) and (ii)
Men reluctant to disclose sexually related health issues to health care providers.

Government programmes reluctant to engage in HIV prevention outreach over concern for being seen as supporting “criminal” behaviours.

Indirect adverse impacts, which are often more profound than direct impacts, include:\(^94\)

(i) High levels of stigma associated with sexual and gender variance, which drive MSM and transgender people underground and away from services.

(ii) Under-representation of identified MSM and transgender people in policy development and management of HIV programmes, leading to a lack of resources for research and targeted programmes.

(iii) Lack of appropriate HIV services for MSM and transgender people catering to their specific needs, as a result of lack of funding, research and appropriate policies.

(iv) Legitimisation of discrimination and unethical treatment by health care workers, including official diagnostic criteria that stigmatise transgender status as a ‘disorder’.

(v) Low self-esteem among MSM and transgender people, leading to mental health issues and substance abuse.

(vi) Failure of schools to address sexual orientation and gender identity in their curricula.

(vii) Lack of legal protections from discrimination.

(viii) Poor education and work opportunities for MSM and transgender people, with the result that many turn to sex-work, greatly increasing their vulnerability to HIV.

Transgender persons face multiple social and institutional barriers to physical and mental health care. High rates of sexually transmitted infections (STI) and HIV, an array of special healthcare needs, and a life filled with discrimination and dehumanisation that often contributes to substance abuse and detrimental mental health is common within this population.\(^95\)

In the Caribbean, there is virtually no empirical data to document the realities that community-based service organisations witness on the ground with transgender people. This invisibility, plus associated isolation and marginalisation, has profound consequences for the health and well-being of the transgender community. While male-to-female transgender (MTF) issues are often the most visible, female-to-male transgender persons (FTM) also face many barriers in the broader healthcare context. Issues such as high levels of depression, suicide, substance abuse, violence and discrimination are similarly prevalent in both MTF and FTM transgender persons. However, many of their needs are distinct and the differences must be considered when designing or expanding programmes geared toward the transgender community.

In addition to sodomy laws, other criminal offences such as “cross-dressing” are applied against transgender persons who are criminally charged for expressing their gender identity. Section 153 of the *Summary Jurisdiction (Offences) Act*, Laws of Guyana, establishes criminal liability for anyone who “being a man, in any public way or public place, for any improper

\(^{94}\) Ibid. including up to (viii) 

\(^{95}\) Ibid at p. 87

\(^{96}\) Ibid at p. 88
purpose, appears in female attire or being a woman, in any public way or public place, for any improper purpose, appears in male attire...”

There are no specific laws regulating sex reassignment, recognition of alternative genders or protection of transgender people.

**Legal responses that protect and empower**

Legal environments that support effective HIV responses are ones in which sex between consenting men or involving transgender persons has been decriminalised and in which police ensure protection of rights. No progress has been made using this approach in the Caribbean.

However, in some jurisdictions there has been progress in improving relations between police and MSM or transgender communities even though sex between men remains criminalised. Pragmatic approaches have been adopted and police have sought to develop constructive working relationships with MSM and transgender communities. In Guyana, after a transgender sex worker was harassed by police and taken to the station, the president of the local sex worker association went to the station to support the individual. This visit led to the police inviting the president back to give sensitisation workshops for recruits.

In some countries, although sodomy laws remain on the statute books, police and prosecutors have a policy of not actively enforcing the laws. However, even in countries where offences are no longer actively enforced, the mere existence of the offence adds to stigma and legitimises violence against MSM and transgender people. In a recent incident in Saint Lucia, Tourism Minister Allen Chastanet was quick to condemn an attack on gay tourists as “unacceptable behaviour”.

In June 2008, the Organisation of American States passed a resolution, on Human Rights, Sexual Orientation and Gender Identity by consensus. For the first time, a document agreed upon by the 34 countries of the Americas contained this language: “The resolution recognises the serious human rights violations faced by people due to their sexual orientation and gender identity.”

The Resolution highlights the importance of the adoption of the Yogyakarta Principles on the Application of International Human Rights Law in relation to Sexual Orientation and

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98 An excellent example of this approach was successfully adopted by JFLAG (Jamaica Forum for Lesbians and All Gays) and JAS (Jamaica AIDS Support for Life) in building a partnership with Human Rights organisations in Jamaica.
99 Personal communication between Ms. Miriam Edwards, President of the Sex Worker Coalition of Guyana and Dr. Marcus Day, Co-Chair of the Caribbean Vulnerable Communities Coalition.
100 http://www.the-vibe.co.uk/2011/03/21/the-dilemma-of-the-gay-tourist/
Gender Identity. It also reaffirms the fundamental principles of non-discrimination in international law.\textsuperscript{102}

\textit{Areas of concern}
Repressive legal environments can result in a range of adverse consequences for HIV prevention, care, support and treatment services. In order to be more effective in reaching MSM and transgender people and meeting their needs, the following is necessary:

- Police harassment, violence and discrimination against MSM and transgender people must cease.
- Outdated punitive laws criminalising sex between adult men need to be rejected.
- Protective and enabling laws and law enforcement practices should be introduced. These include provisions on protection from discrimination on the basis of sexual orientation and transgender status.
- Laws should be introduced to protect human rights and interests of transgender people, such as recognition of alternative gender identities.\textsuperscript{103}

\subsection*{4.2. Sex Work}
Commercial sex has been identified as one of the key factors in the Caribbean HIV epidemic. Female\textsuperscript{104} sex workers (FSW) are frequently at a higher risk of HIV exposure as they are often not in a position to negotiate condom use.\textsuperscript{105} High HIV infection levels have been found among FSW in the region: 4\% in the Dominican Republic, 9\% in Jamaica and 27\% in Guyana.\textsuperscript{106} Another study of HIV prevalence among FSW in Georgetown, Guyana, showed that 30.6\% were infected with HIV.\textsuperscript{107} In Jamaica 25\% of reported cases of AIDS indicated unprotected sex with FSW as mode of acquisition of their HIV infection.\textsuperscript{108}

\begin{flushleft}
\textsuperscript{102} UNAIDS (2010), \textit{Mapping of Punitive Laws which Impede Universal Access to HIV Prevention, Treatment, Care and Support in the OECS and Barbados, Antigua and Barbuda, Dominica, Grenada, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines and Barbados.}

\textsuperscript{103} Waters, J (2009), \textit{MSM, Transgender Persons, and Sex Workers in the Caribbean – A Level Ground Look at Underground Behaviour and How it Affects Us All}, PAHO.

\textsuperscript{104} Lehmann, L (2008), PANCAP Regional Model Condom Policy at p. 9


\textsuperscript{108} UNAIDS (2010), \textit{The Status of HIV in the Caribbean} UNAIDS Caribbean Regional Support Team.
\end{flushleft}
In recent years, some countries have documented a decline in the rate of new HIV infections among sex workers, together with some other positive developments. In Haiti, for example, HIV prevalence among female sex workers attending an HIV voluntary counseling and testing centre rose from 50% in 1985 to 63% in 1987. It then declined to 22% in 1999 and 2003. This decline has been attributed to better education and knowledge about HIV prevention.

Sex workers may be local or migrant, male, female or transgendered and in many cases highly mobile. For mobile sex workers, socio-cultural and mobility factors act as further barriers to accessing basic services and leave immigrant sex workers highly exposed to stigma and discrimination. Mental health is a significant issue for many migrant women. Being foreign, isolated, and away from support networks of family and friends tends to exacerbate mental health concerns. Local sex workers also have mental health issues due to the anxiety and stress related to sex work generally, as well as the cultural disenfranchisement to which they are subjected. Accessing sexual health services is often affected by the fear of being identified as a sex worker.

There are no comprehensive health programmes targeting sex workers in the CARICOM region, despite large and diverse sex worker communities. Traditional programming for sex workers is aimed almost exclusively at female sex workers. However, the sex worker community also includes men who sell sex to women, men who sell sex to men, and transgender sex workers.

Law

Almost all countries of the Caribbean criminalise aspects of sex work, such as soliciting in public or keeping a brothel, living off the earnings of sex work and use of premises for sex

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111 Waters, J (2009), MSM, Transgender Persons, and Sex Workers in the Caribbean – A Level Ground Look at Underground Behaviour and How it Affects Us All, PAHO at p. 71
112 UNAIDS (2010), The Status of HIV in the Caribbean UNAIDS Caribbean Regional Support Team.
work, or encouraging others to become sex workers. With the exception of the Dutch Territories, sex work itself is criminalised.

Differences and similarities in sex work laws in the Caribbean region can be traced to British, Dutch and French colonial laws. In the English-speaking Caribbean almost all activities for female and male sex workers are criminalised. These include aiding prostitution and procuring for the purposes of prostitution; soliciting, loitering or wandering in a public place for purposes of prostitution; the use of premises as a brothel; living off or on, partially or wholly, the earnings of prostitution; sexual intercourse with a minor (person under the age of 16), and same-sex sexual intercourse (buggery and gross indecency). In effect, these laws make it a criminal offence for a woman or man to practice either heterosexual or homosexual prostitution.¹¹³ Vagrancy laws can also be applied against sex workers - in Antigua and Barbuda, Barbados, the Bahamas, Belize, Dominica, Guyana, Saint Kitts and Nevis, Saint Lucia - and can be traced to English vagrancy laws.¹¹⁴

The French Departments in the Americas - Guadeloupe, Martinique, Saint Martin and French Guyana - are governed by the laws in France which prohibit prostitution and brothels and define both active and passive soliciting as an offence. Procurers are defined as “anyone who, in whatever way, knowingly helps, assists, or protects the prostitution of another person, as well as anyone who knowingly lives with a prostitute and is unable to show sufficient resources.”¹¹⁵

Laws in the Dutch Caribbean do not criminalise sex work or sex workers, but focus on the activities of third parties (men such as brothel-keepers, facilitators, procurers and sex industry managers) who profit from and manage the prostitution of another person. However, during the 20th century local governments in Curacao, Saint Maarten, Bonaire and Aruba ignored or suspended the laws to allow some brothels to operate legally under hotel licences, and permitted the regulation of sex work in particular ways. In 1980, a ban on streetwalking was brought into effect in Curacao, seeking to remove sex workers from public view.¹¹⁶ Despite the fact that sex work itself is not illegal in any part of the Dutch Caribbean, discrimination and stigma against sex workers still exist.

Aspects of sex work criminalised in law include, soliciting, living off earnings, loitering and wandering in public places, procuring for the purposes of prostitution, use of premises as a


¹¹⁶ The lifting of the ban on brothels and the legalising of sex work that occurred in the Netherlands in 2000 was not extended to the Dutch Caribbean. However, in 1997 revisions to the regulations of the Criminal Code took place in the Netherlands Antilles and Aruba and revisions of the Suriname Criminal Code were begun in 2005. In 2009 the Code in the Netherlands Antilles was also under revision. It is expected that the new law would not change the older articles on prostitution, but would add new regulations on trafficking, in keeping with the laws in the Netherlands. Cited from PANCAP (2009), Prostitution, Sex work and transactional sex in the English, Dutch- and French-speaking Caribbean: A literature review of definitions, laws and research.
brothel, laws sanctioning idle and disorderly persons, rogues, vagabonds and vagrants, immigration laws, procuring of minors, and buggery and indecent assault.

Belize\textsuperscript{117}, Guyana\textsuperscript{118} and Jamaica\textsuperscript{119} also have legislation on trafficking of persons.\textsuperscript{120} A review of Caribbean sex work laws identified a trend towards more severe penalties for sex work or involvement in the sex industry.\textsuperscript{121} Seven of twelve Caribbean countries reviewed in 2007 (Antigua and Barbuda, the Bahamas, Barbados, Belize, Dominica, Saint Lucia and Trinidad and Tobago) have introduced new sexual offence laws, increasing the severity of penalties for sex work and sex between men. Under these new sexual offences laws “prostitution” is defined in gender-neutral terms, which means that a man or transgender person can be charged with sex work; the penalties for offences dealing with activities related to sex work as a business have been increased; soliciting is a more serious offence and is no longer restricted to soliciting in public places; and acts of “indecenty” and “unnatural sex” are more heavily penalised.

Apart from criminalisation of sex work (or its elements) per se, there are other laws that may lead to violations of sex workers rights. In Belize and Trinidad and Tobago a male or female sex worker who engages in anal sex is liable to arrest for the offence of buggery. If convicted of buggery the law requires them to be tested for HIV. International standards postulate that compulsory HIV testing violate the rights to autonomy and integrity of person, increase marginalisation and discrimination of already stigmatised populations, and as research shows does not have any public health value.\textsuperscript{122}

In some Dutch territories, such as Saint Maarten, where sex work is not criminalised, sex workers are required to take an HIV test for a permit to work in brothels. When sex work is regulated, health requirements such as STI and HIV testing can be legitimately encouraged for sex workers. Encouraging signs of enlightened policy approaches were seen when a proposal from Antigua and Barbuda’s Ministry of Health, Sports and Youth Affairs in 2006 sought to licence sex work during the Cricket World Cup held in 2007 in the Caribbean.\textsuperscript{123} However, so far there have been no long-lasting and concerted attempts to reassess the legal environment as it pertains to sex work in the English-speaking Caribbean.

**Law enforcement practices**

Sex workers identify the most critical problems they encounter as being laws that criminalise their lives, stigma and prejudice that they and their children must endure, and

\textsuperscript{117} Trafficking in Persons (Prohibition) Act 2003 of Belize
\textsuperscript{118} Trafficking in Persons (Prevention, Suppression and Punishment) Act 2007 of Guyana.
\textsuperscript{119} Combating of Trafficking in Persons Act 2005 of Jamaica.
\textsuperscript{120} Sex work and trafficking should be distinguished as fundamentally different concepts, with trafficking being a violation of human rights, and abuse of person’s vulnerability, when the affected persons are made to work long hours, without labour law protections and/or without pay, often without the possibility of leaving (i.e. deprived of identity documents). However, trafficking laws used against adult sex workers voluntarily in the business, are known to be used to harass and extort money. These practices need to be eliminated as they lead to further marginalisation of sex workers and violations of their rights.
\textsuperscript{121} Robinson, T (2007), A legal analysis of sex work in the Anglophone Caribbean, UNIFEM.
\textsuperscript{122} PANCAP (2009), Prostitution, Sex work and transactional sex in the English, Dutch- and French-speaking Caribbean: A literature review of definitions, laws and research.
\textsuperscript{123} Robinson, T (2007), A legal analysis of sex work in the Anglophone Caribbean, UNIFEM.
the violence and harassment they face from the state (i.e. police and immigration laws). Furthermore, the discrimination sex workers face from health and social workers, the constant worry about contracting STIs from clients, and the often dirty conditions in which they have to work compound the problems they face on a day-to-day basis.\(^ {124}\)

Sex workers from many countries in the region report police roundups, sometimes accompanied by violence and abuse from law enforcement officers and other government officials. Many sex workers also report that they are subjected to police abuse during street clean-up operations, police-led brothel closures or “rescue” operations. Particular problems arise due to police action against sex workers justified on the basis of anti-trafficking crackdowns. Sex workers reported incidents of arbitrary detention, violation of due process rights, physical violence, rape, sexual harassment, forced labour, extortion, confiscation of their belongings, and other ill-treatment. Some report being sexually assaulted by police when in detention as a form of humiliation. Common issues voiced by sex workers are police extortion and demands for bribes. Police officers sometimes force sex workers to have sex with them in exchange for being released.\(^ {125}\)

**Legal responses that protect and empower**

In a Sex Work and HIV Technical Working Group meeting convened in Barbados in October 2010, Miriam Edwards, president of the Caribbean Sex Work Coalition, whose organisation has members in 13 Caribbean countries, and is working for sex workers’ voices to be heard and for the institution of a legal framework in order to obtain medical and other necessary services, said: “We need to accept sex workers as human beings and we want the same level of treatment and service when we come forward as anyone else.”\(^ {126}\)

Removing legal penalties for sex work allows HIV prevention and treatment programmes to reach sex workers and their clients. Rather than arresting sex workers and closing down brothels, a more effective approach to preventing HIV is to support sex workers to engage in sexual health promotion as peer educators and advocates.\(^ {127}\)

Involving sex workers directly in HIV prevention and sexual health promotion can raise their self-esteem and increase their trust and confidence in HIV and sexual health services. When sex work is decriminalised and regulated, health and safety standards could be applied to sex work. Legally backed workplace standards can contribute to a reduction in HIV transmission and improvements in overall working conditions. Standards can require the use of condoms, proper lighting, sanitation and measures to ensure the personal security of sex workers.\(^ {128}\)

With knowledge of their employment rights, brothel workers are better able to assert these rights with brothel operators and clients. The relationship between sex workers and police

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\(^ {124}\) PANCAP (2009), *Prostitution, Sex work and transactional sex in the English, Dutch- and French-speaking Caribbean: A literature review of definitions, laws and research.*

\(^ {125}\) Robinson, T (2007), *A legal analysis of sex work in the Anglophone Caribbean*, UNIFEM.

\(^ {126}\) Opening address by Miriam Edwards, President of the Caribbean Sex Work Coalition at the Sex Work and HIV Technical Working Group meeting convened in Barbados in October 2010.

\(^ {127}\) Ibid.

\(^ {128}\) Ibid.
Decriminalisation should not impose compulsory HIV and STI testing as sex worker advocates argue\textsuperscript{130} that it is contrary to best practice models of voluntary testing and self-regulation of sexual health amongst sex workers; endorses a false sense of security in the form of a ‘certificate,’ which, due to window periods does not actually confirm a sex workers’ sexual health status; overloads sexual health services denying access to sex workers with symptoms; leads to sex workers hiding their profession from medical experts or avoiding the health system altogether; and has the unintentional consequence of endorsing stigma.

Apart from the recognition and regulation of sex work as legitimate employment, and the necessity to end coercive programmes such as mandatory medical treatment, testing, forced rehabilitation, police abuse, raids and detention of sex workers, better human rights protection of sex workers by health care providers is necessary. In addition to removing criminal sanctions, legal environments for HIV prevention can be improved by introducing legal protections from discrimination. Harm reduction for sex workers, such as condom distribution, provision of safer sex information and needle and syringe exchange programmes (NSP) for sex workers who use drugs needs to be part of creating an enabling legal environment.

**Areas of concern**

- Criminalisation of sex work and related activities such as soliciting and living on the earnings of sex work is detrimental to sex workers’ health and safety. It leads to their stigma and discrimination and to negative consequences for public health.

- Stigma and discrimination result in low access to health services, harassment by police, discrimination by health care professionals and other human rights violations.

### 4.3 Criminalisation of HIV Transmission and Exposure

**Law**

Offences related to criminalisation of HIV include criminalisation of non-disclosure and exposure to HIV, criminalisation of negligent HIV transmission, and criminalisation of willful HIV-transmission, or the combination of the above. Criminalisation may be included in HIV-specific clauses contained in national Criminal Codes; on the basis of general criminal laws (i.e. grievous bodily harm or personal injury); or in public health legislation.

At least three countries in the region specifically criminalise both exposure and transmission of HIV - Belize, the Bahamas and Bermuda. Saint Lucia criminalises transmission of HIV as opposed to exposure - the offence is for intentionally or recklessly infecting another person

\textsuperscript{129} Waters, J (2009), *MSM, Transgender Persons, and Sex Workers in the Caribbean – A Level Ground Look at Underground Behaviour and How it Affects Us All*, PAHO.

\textsuperscript{130} Ibid.
An attempt was made in Trinidad and Tobago to include the offence in a revised Sexual Offences Bill, which was finally not enacted.

Belize\textsuperscript{132}, the Bahamas\textsuperscript{133} and Bermuda criminalise non-disclosure and exposure of consenting partners to infection by knowingly having sex with them without informing them of one’s status (in Belize it also includes donating blood).\textsuperscript{134} Non-disclosure is equated with sexual assault and punished accordingly. In Bermuda, the Criminal Code (Sexual Offences) Amendment Act states that a sexual assault has been committed, if a person has a sexually communicable disease and does a sexual act with another without informing the other party about the disease. The Bahamas Sexual Offences and Domestic Violence Act now provides that a person who knows they are infected with HIV and has consensual sex without disclosing this to the other party commits an offence and is liable to be detained for up to five years. In Belize similar legislation exists, criminalising non-disclosure of HIV status in cases of consensual sexual intercourse.\textsuperscript{135}

It has been argued that in other countries, where there are no special clauses criminalising HIV transmission, general personal injury criminal laws can be applied to situations of both intentional and unintentional HIV transmission. For example, section 291, chapter 124 of the Saint Vincent and the Grenadines Criminal Code provides that any person who unlawfully or negligently does any act which he knows, or has reason to believe, to be likely to cause the spread of any infectious or contagious disease is guilty of an offence to imprisonment for one year. Similarly, sections 21 and 22, chapter 141 of the Barbados Offences against the Person Act relates to maliciously administering poison to endanger life and maliciously administering poison with intent to injure. However, in the case of the Saint Vincent and the Grenadines legislation neither HIV nor AIDS have been defined as an infectious or contagious disease in law. Yet it has been argued that even the common definition of an infectious disease may prove problematic if applied in these circumstances. With respect to the Barbados legislation neither HIV nor AIDS are defined in law as a poison

\textsuperscript{131} Section 140 of the Criminal Code 2004 of Saint Lucia.
\textsuperscript{132} Section 46.01 and 73.01 of the Criminal Code of Belize.
\textsuperscript{133} Section 8(2), Chapter 99 of Sexual Offences and Domestic Violence Act of the Bahamas.
\textsuperscript{134} For example, see Sections 46.01, Chapter 101 of the Criminal Code of Belize: “(2) Every person who deliberately or recklessly transmits or spreads HIV/AIDS shall (a) on summary conviction, be liable to imprisonment for a term not exceeding five years; and (b) on conviction on indictment, be liable to imprisonment for a term not exceeding ten years.” Further, section 73.01 of the Code provides that: “(1) A person deliberately or recklessly spreads HIV/AIDS if the person does any act specified in subsection (2) or (3). (2) Subsection (1) applies where the person (a) knows that he is infected with HIV/AIDS; and (b) does a sexual act with another person which involves bodily contact and is capable of transmitting bodily fluids; and (c) does not inform the other person that he is infected with HIV/AIDS. (3) Subsection (1) applies where the person (a) knows that he is infected with HIV/AIDS; and (b) donates blood or does anything not provided in subsection (2) which is likely to cause another person to be infected with HIV/AIDS. (4) In this section “Sexual Act” means vaginal, oral, or anal intercourse.” Cited from UNAIDS (2010), Mapping of Punitive Laws which Impede Universal Access to HIV Prevention, Treatment, Care and Support in the OECS and Barbados, Antigua and Barbuda, Dominica, Grenada, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines and Barbados.
\textsuperscript{135} PANCAP (2009), Prostitution, Sex work and transactional sex in the English, Dutch- and French-speaking Caribbean: A literature review of definitions, laws and research.
and the common definition of poison would not apply. It is therefore unlikely that these provisions will be sufficient to support criminal prosecution.\textsuperscript{136}

There are no specific criminal laws in Suriname regarding transmission of HIV. Based on the Surinamese criminal law, it is virtually impossible to prosecute people who intentionally infect others, as evidence to show the intent is necessary. Moreover, it is necessary to prove that the defendant was HIV-positive at the moment of transmission and that the victim could not have been infected with HIV other than through the defendant.\textsuperscript{137} There is no legislation against willful transmission in Grenada, Saint Kitts and Nevis and Dominica and Saint Vincent.\textsuperscript{138}

\textbf{Law enforcement practices}

There have been no recorded prosecutions under these above provisions in the Bahamas, Belize, Bermuda or Saint Lucia. There are anecdotal reports from Suriname where prosecutions have been filed for ‘reckless’ transmission using assault offences under the criminal law, however, the reports were not confirmed up to the time of publication of this brief.

The enforceability of provisions criminalising the wilful, deliberate or reckless transmission of HIV is highly debatable as the elements to prove the offence are burdensome such as evidentiary rules against self-incrimination, the window period in testing and proving conclusively that it was the accused who infected the complainant. These provisions raise the following concerns:\textsuperscript{139}

\begin{itemize}
  \item Proof of the offence: The elements of the offence must be proved beyond a reasonable doubt. Therefore, the prosecution has a burden to prove that at the time of the offence the accused was HIV-positive. Further, it must be proved that the complainant himself/herself is, as a result of that contact, HIV-positive. The prosecution must therefore show conclusively that the complainant at the time immediately preceding contact was HIV-negative.
  
  \item Rules of evidence: There have been suggestions that there should be compulsory testing of those accused of transmitting HIV. However, bodily evidence taken without the consent of the accused and obtained in non-compliance with strict and burdensome evidentiary rules is inadmissible in a court of law. Further, testing a person for HIV without their consent on the basis of an accusation constitutes a serious constitutional infringement of their rights associated with liberty, security of the person and privacy.
\end{itemize}

\textsuperscript{136} See more in UNAIDS (2010), \textit{Mapping of Punitive Laws which Impede Universal Access to HIV Prevention, Treatment, Care and Support in the OECS and Barbados, Antigua and Barbuda, Dominica, Grenada, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines and Barbados}.

\textsuperscript{137} PANCAP (2010), \textit{Regional Policy and Model Legislation to address HIV and AIDS related Discrimination: Desk Review Report}.

\textsuperscript{138} Ibid.

Additionally, compulsory testing has little value as it will only establish the accused’s status at the time of the test. An HIV test performed within the window period (before 3 months from first contact) will usually result in a negative result which must be repeated to confirm the result. If there is transmission following the initial test then the second test also may not produce a positive result. Therefore, where a complainant tests HIV-positive immediately following contact with the accused, it is highly likely that the complainant was infected before said contact. If the complainant was negative before contact with the accused, then a test is only conclusive some three months following the contact and only where the complainant does not expose himself or herself to a further risk of infection within the window period.

**Legal responses that protect and empower**

All of the above provisions require knowledge of one’s status which can only be confirmed with an antibody test. The law therefore will deter voluntary counselling programmes and all programmes focused on testing. Its validity as protective of the public interest is unfounded as it moves the responsibility from both parties in a relationship to one party. The spread of HIV can only be halted if every individual person takes personal responsibility for their sexual choices.

Criminalisation of HIV non-disclosure, exposure, or negligent transmission reinforces HIV-related stigma. Criminal sanctions are generally accompanied by inflammatory and ill-informed media coverage contributing to misinformation and the perception that persons living with HIV are criminals and the public requires ‘protection’ from them. These provisions also operate as a disincentive to testing. “Coercive public health measures drive away the people most in need of such services and fail to achieve their public health goals of prevention through behavioural change, care and treatment.”

Criminalisation is therefore considered an inappropriate and disproportionate response.

It is therefore recommended (according to international policy documents) that general criminal laws are applied in cases of intentional HIV transmission (as opposed to creating specific HIV-related provisions that criminalise both exposure and non-intentional transmission).

4.4. Criminalisation of Drug Use

With the exception of Puerto Rico, injecting drug use remains rare (or at least an unexplored phenomenon) in much of the Caribbean region. Data on injecting drug use and HIV are only available for Puerto Rico, where 29,130 people inject drugs, and 12.9% of them are estimated to be living with HIV. In Puerto Rico, an estimated 40% of new HIV infections in men and 27% in women in 2006 resulted from contaminated injecting equipment. In 2008,

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142 UNAIDS (2010), *The Status of HIV in the Caribbean,* UNAIDS Caribbean Regional Support Team.
among crack cocaine users, another high risk group, the HIV prevalence varied between 7% and 5% in St Lucia and Jamaica respectively.\(^{143}\)

The data is more limited for other Caribbean countries: in 2008 a systematic review by the Reference Group to the UN on HIV and Injecting Drug Use found very limited reliable data on the numbers of people who inject drugs and the prevalence of HIV among injecting populations in the Caribbean. The Reference Group found reports of injecting drug use in only seven countries/territories in the region. It is possible, however, that injecting drug use occurs elsewhere in the region, but there are at present no reliable data to confirm this information. For example, there are anecdotal reports of injecting drug use among the upper classes in Guyana and Trinidad and Tobago, and there are indications that it may occur in Cuba.

The role of injection drug use in the spread of the HIV epidemic is widely explored in other regions of the world; but less is known about HIV and non-injection drug use, which may be more relevant to the majority of the Caribbean countries. In the Caribbean region, a link between non-injecting drug use and sexual HIV transmission has been noted, as drug use proves to be a facilitating factor for risky sexual behaviours. Crack cocaine is widely available on most Caribbean islands, due to drug transhipment routes, and its use is reported to be ‘extensive’.\(^{144}\) It is observed that HIV prevalence estimates among crack cocaine-smoking populations reach those found among injecting populations elsewhere.\(^{145}\) Crack cocaine users often sell sex to support their habit and engage in unsafe sexual behaviours that increase both their own risk and the risk of the public. The role of crack cocaine in the Caribbean HIV epidemic is not well documented and this knowledge gap was identified as a priority area in both the past and present Caribbean Regional Strategic Frameworks for HIV and AIDS.\(^{146}\)

As injection drug use remains low in the HIV epidemic in the majority of the countries in the region, drug use in general has been largely ignored in most Caribbean HIV prevention work, with the exceptions of Jamaica, Saint Lucia and Puerto Rico. Most programmes that address the needs of other vulnerable populations ignore the issues of drug use.\(^{147}\) The harm reduction response remains very limited, and the predominant response in the region is characterised by abstinence-based, high-threshold services for people who use drugs. The use of illicit drugs is highly criminalised, with harsh sentencing resulting in large numbers of people who use drugs in Caribbean prisons.\(^{148}\)


\(^{145}\) International Harm Reduction Association (2010), The Global State of Harm Reduction: Key Issues for Broadening the Response.

\(^{146}\) Anonymous Caribbean Regional Strategic Framework (2005), Priority Areas & Strategic Objectives, PANCAP Perspective, 1 (issue 1) October -December.

\(^{147}\) UNAIDS (2010), The Status of HIV in the Caribbean, UNAIDS Caribbean Regional Support Team.

\(^{148}\) International Harm Reduction Association (2010), The Global State of Harm Reduction: Key Issues for Broadening the Response.
In the past two years, there have been indications that the need for a harm reduction approach to drugs is increasingly recognised on some Caribbean islands. Still, NSPs exist only in Puerto Rico, where there are thirteen NSP sites serving an estimated 29,130 people who inject drugs. The sites are all based in communities around San Juan, the capital city. However, coverage remains inadequate, as it is estimated that there are only 0.4 NSP sites per 1,000 people who inject drugs. Similarly, Puerto Rico remains the only opioid substitution therapy (OST) provider in the region, with six OST sites (five in the community and one in a prison). In 2007 there were an estimated 5,570 people receiving methadone in Puerto Rico.\textsuperscript{149}

There are a small number of drop-in centres and other harm reduction programmes for people who use drugs. These programmes exist in Santo Domingo (Dominican Republic), Port of Spain (Trinidad), Kingston (Jamaica) and Vieux Fort and Castries (Saint Lucia). The Castries programme offers shelter and other services for homeless crack users living with HIV. The shelter also provides adherence support for residents receiving antiretroviral therapy (ART) and advocates for the therapeutic use of cannabis.\textsuperscript{150}

\section*{Law}

Regional drug control policies remain heavily influenced by the ‘war on drugs’ policy imperatives. Drug use is highly criminalised in the Caribbean, and the ‘war on drugs’ leads to large numbers of people incarcerated for drug-related offences. Countries under review criminalise the use of all controlled drugs, including marijuana, cocaine, and heroin.\textsuperscript{151} In addition the legislation criminalises possession of drugs, self-administration of drugs and possession of equipment for drug use such as needles, syringes and crack pipes. All countries of the region criminalise the sale of illicit drugs. The penalties for possession and use can be disproportionate to the behaviour involved, as laws often make little distinction between trafficking and possession. There are also laws that create criminal penalties for incitement to use drugs, or aiding and abetting drug use, which can criminalise outreach workers.

National policies and strategies on drugs are in place for all Caribbean islands, but do not include a harm reduction approach and generally tend toward a criminal justice response to drug use and drug users rather than a public health approach. The Barbados Plan of Action (1996) has been endorsed by all CARICOM countries with a target of a ‘drug free Caribbean’. The exception to this is the National Anti-Drug Plan of the Republic of Trinidad and Tobago 2008-2012, which explicitly includes harm reduction as a key part of the national response to drugs.\textsuperscript{152} However, there have been indications that the need for a harm reduction approach to drugs may be becoming increasingly recognised in some Caribbean islands and the PANCAP 9\textsuperscript{th} Round Global Fund Project contains a small sum to pilot harm reduction programmes for crack cocaine users.

\textsuperscript{149} Ibid.
\textsuperscript{150} Ibid.
\textsuperscript{151} Antigua and Barbuda Misuse of Drugs Act, Barbados Drug Abuse (Prevention and Control) Act. In Saint Lucia Section 8 of the Drugs (Prevention of Misuse) Act criminalises the possession of and trafficking of controlled drugs including heroin, cocaine, opium, morphine and cannabis. Cited from UNAIDS (2010), \textit{The Status of HIV in the Caribbean}, UNAIDS Caribbean Regional Support Team.
\textsuperscript{152} The National Anti-Drug Plan (2008-2012) for Trinidad and Tobago.
National drug and HIV policies remain largely unlinked. It is said that Caribbean crack cocaine drug users have not been included in regional or national HIV strategic plans, primarily due to the fact that Caribbean HIV strategies have been “donor driven”. Donors have consistently stated that due to the lack of injecting drug use in the Caribbean, Caribbean drug users are not at risk. As mentioned above, the exception to this is Trinidad and Tobago’s National Anti-Drug Plan 2008-2012, which explicitly includes harm reduction as a key component of the national response to drugs.\textsuperscript{153}

**Law enforcement practices**

Crime and drug-related violence are all outcomes of the criminalisation of drugs and subsequent war on drugs. In countries that approach drug use as a public health issue, these problems exist in much smaller measure. It is interesting to note that the prevalence of cannabis use in Amsterdam where it is decriminalised is less than any major European city. Conversely, in the Caribbean where 60 – 70% of incarcerated populations are interned for crimes associated with drugs, prisons are overcrowded and there is continuing pressure to increase capacity.\textsuperscript{154}

Police crackdowns on people who use illicit drugs undermine relationships between health services and law enforcement agencies. They impact the capacity of harm reduction services to maintain continuity and retain clients.

When drug use is heavily penalised and subject to harsh police enforcement, harm reduction services have difficulty even starting up. Due to the intense stigma associated with being a drug user organisations are reluctant to start programmes to address the needs of people who use drugs. Drug users also may not access services, seek treatment or attend harm reduction services for fear of arrest or other negative consequences that can follow from identification as a drug user, such as harassment, violence or dismissal from employment.

Crack cocaine use and risky sexual behaviours, both associated with increased risk of medical and psychiatric complications, have been described as common behaviours among the homeless in Trinidad.\textsuperscript{155} Sex work as opposed to just risky sexual behaviour was identified by Persaud\textsuperscript{156} in research conducted in Guyana. Qualitative research conducted in a drug treatment programme found a high frequency of sex exchanged for drugs in Trinidad and Tobago.\textsuperscript{157} At present, there are no estimates of the number of people receiving ART who inject or otherwise use drugs in the Caribbean.

\textsuperscript{153} International Harm Reduction Association (2010), *The Global State of Harm Reduction: Key Issues for Broadening the Response*.
\textsuperscript{156} Persaud, N.P. et. al. (2000), *Sexually transmitted infections, drug use, and risky sex among female sex workers in Guyana*, Sexually Transmitted Infections 76:318.
Legal responses that protect and empower

The 2011 report of the Global Commission on Drugs, concluded that the global war on drugs has failed and that law enforcement efforts directed at elimination of drug supply do not lead to better public policy and public health results impact the supply per se. It has been noted, that a punitive law enforcement approach to drugs leads to many unintended consequences, such as high prison population, developed black market economy, policy and geographical displacement, and marginalisation of people who use drugs.

Supportive police attitudes are critical to the success of harm reduction programmes. Partnerships between police and public health services can occur where police use a community policing approach, with referral systems to health and welfare services, and training for police on HIV and human rights-based approaches. Law reform options include decriminalisation of drug use and diversion of drug offenders from the prison system to community-based treatment.

One of the few harm reduction services in the region is based in Saint Lucia and offers shelter and other services for homeless crack users living with HIV. As well as providing adherence support for residents receiving ART, the shelter advocates for the therapeutic use of cannabis (though it does not distribute or provide cannabis) as a method of combating crack cocaine addiction and the nausea which is often a side effect of ART.

Despite the evidence that drug use is playing a role in HIV epidemics in the Caribbean, national drug and HIV policies remain largely divorced. The intersection between drug use and sex work as well as drug use and prisoners continues to be a major gap in prevention efforts. There is considerable merit in shifting the focus from criminalisation of drug users to reducing harm and addressing rehabilitation.

Areas of concern

- Criminalisation of drug use and other non-violent offences related to drugs need to be re-examined as an approach. Good policies in this regard include decriminalisation of drug use and change of the ‘war on drugs’ law enforcement approach to a public health and human rights-based one. It is necessary to acknowledge that drug dependence is an illness and treat it accordingly, lowering the number of people incarcerated for non-violent drug related offences.

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159 United Nations Office on Drugs & Crimes (UNODC) (2008), Making drug control fit for purpose: Building on the UNGASS Decade, report by the Executive Director as a contribution to the review of the Twentieth Special Session of the UN General Assembly.
160 There are drop-in centres in Santo Domingo, Dominican Republic, Port of Spain, Trinidad and Kingston, Jamaica.
• Repeal of offences, which criminalise possession of drug equipment are necessary. Related proscriptions based on overly broad laws, including those that define ‘incitement to drug use’ that discourage people from providing or using harm reduction facilities, NSPs, and can endanger outreach workers also need to be repealed.

• Lack of harm reduction interventions in the region raises concern. More NSPs and OST sites to cover all who need it would lead to better public health results and ultimately less drug-related crime. More attention should be paid to harm reduction of non-injection drug use. These may include distribution of crack pipes and condoms to people who use drugs and promotion of safer sex practices.

4.5. HIV in Prisons

Data shows that as elsewhere in the world, people in detention facilities and prisons are more heavily affected by HIV than the general population. Caribbean countries have among the highest number of incarcerated people per 100,000 of population: if the USA with the highest prison population rate in the world has 756 per 100,000 of the national population, St Kitts & Nevis is fourth on that list, with 588 incarcerated people per 100,000 of the national population, followed by Cuba (c.531), U.S. Virgin Is. (512), British Virgin Is. (488), Palau (478), Bahamas (422), American Samoa (410), Grenada (408) and Anguilla (401). In the Caribbean the median rate is 324.5, whereas for South American countries it is 154. In this context, the Caribbean region is in danger of developing significant HIV epidemics in prisons. HIV prevalence levels of 5% have been reported in the prison populations of Guyana. In Saint Lucia HIV in prisons is already estimated at 7.5%, whereas the sero-prevalence rate among the general population is estimated at 0.55%. In Grenada a 2005 sero-prevalence study revealed a 2.2% HIV rate in prisons compared to an estimated 0.42% among the general population.

Research did not render significant results on the legal framework of HIV prevention and treatment in prisons in the Caribbean region. The main modes of HIV transmission and the rates of injecting drug use in prisons are not known. Considering the alarmingly high HIV prevalence rates among people in prisons, it is an urgent priority to improve data and research on the above matters, as well as introduce harm reduction and HIV prevention interventions in the prisons of the region.

There are some legal and policy issues of importance in the context of health services in prisons. For example, HIV testing is required at entry into prison in several countries of the region. In Grenada and Saint Vincent and the Grenadines the law provides that every prisoner should be examined on entry, but there are no reports that inmates are compulsorily tested for HIV. In addition, in Saint Vincent and the Grenadines there are no

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164 UNAIDS (2010), The Status of HIV in the Caribbean, UNAIDS Caribbean Regional Support Team.
165 UNAIDS (2010), Mapping of Punitive Laws which Impede Universal Access to HIV Prevention, Treatment, Care and Support in the OECS and Barbados, Antigua and Barbuda, Dominica, Grenada, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines and Barbados.
requirements of confidentiality of medical information in prisons, and any officer could have access to inmates' medical records.\textsuperscript{166} In other countries, while there is power to remit a sentence there is no specific mention of illness as a factor to be taken into account.\textsuperscript{167}

Harm reduction measures are not well established in the prisons in the region. In countries where homosexuality is illegal distribution of condoms is not accepted: in Grenada, Saint Lucia, Saint Kitts and Nevis distribution of condoms to prisoners is considered to be illegal based on sodomy laws. It is said that prison authorities believe that distribution of condoms would be equal to an admission that homosexuality happens in prisons and may be seen as condoning it. In other countries, condom distribution although not considered illegal, does not happen for the similar reasons.\textsuperscript{168}

There is no information about the availability of other harm reduction services in prisons, such as distribution of needles and syringes, OST and safer tattooing practices. It has to be noted that high levels of incarcerated people constitute not only heavy burden of the states’ budget, but also lead to negative public health outcomes. People in prisons are vulnerable to many health risks, especially when there are no adequate health care services, HIV prevention and treatment interventions and harm reduction measures.

\textit{Areas of concern}

- Alarmingly high levels of incarcerated people, many of whom serve sentences for drug-related offences.
- Absence of HIV prevention and treatment in prisons.
- No available data on modes of transmission and levels of drug use in prisons and detention facilities.
- Compulsory testing for HIV before entry in prison in legislation and/or policy.

\textsuperscript{166} Ibid.
\textsuperscript{167} Ibid.
\textsuperscript{168} Ibid.
5. Women and HIV

Women – and especially young women – account for 53% of all persons living with HIV in the region. This number has risen significantly in the last years: if in 1990, 35% of the total number of persons living with HIV in the Caribbean were female, in 2008, they already represented 50 percent of all persons living with HIV.\textsuperscript{169} There is wide variation by country in the estimates of females living with HIV, ranging from 26% in the Bahamas to 59% in Belize, Guyana and Trinidad and Tobago.\textsuperscript{170} In the Dominican Republic and Haiti young women are up to 2 to 3 times more likely to be affected by HIV than young males in the same age group.\textsuperscript{171} According to the United Nations Population Fund (UNFPA) statistics young women in the Caribbean are approximately 2.5 times more likely to be infected with HIV than young men.\textsuperscript{172}

Mother-to-child transmission of HIV constitutes nearly 10% of all HIV transmissions in the Caribbean.\textsuperscript{173} It is said that women may not seek prenatal care, testing, and adhere to treatment due to the need to prioritise child care or paid work over health seeking – especially if asymptomatic and if financial resources are limited, as documented in Haiti.\textsuperscript{174} Prevention of mother-to-child transmission (PMTCT) coverage is 52%, which also means that 48% of women in need do not receive PMTCT, despite the high levels of HIV testing for pregnant women.\textsuperscript{175}

\textsuperscript{169} According to different estimates, during the period 1990-2007, the male to female ratio in the population living with HIV has altered year on year from 65% male to 35% female in 1990 to 52% male to 48% female in 2007.
\textsuperscript{170} UNAIDS (2010), \textit{The Status of HIV in the Caribbean}, UNAIDS Caribbean Regional Support Team.
\textsuperscript{171} Ibid.
\textsuperscript{174} UNAIDS, UNICEF, PAHO (2009), \textit{Challenges Posed by the HIV Epidemic in Latin America and the Caribbean}.
\textsuperscript{175} UNAIDS (2010), \textit{The Status of HIV in the Caribbean}, UNAIDS Caribbean Regional Support Team.
Women are more vulnerable to HIV and to its negative effects. The effects of poverty are inter-generational, limiting social mobility due to poor education and minimal employment opportunities.

Gender-based Violence affects a significant percentage of women and girls in the Caribbean. According to police records in the Dominican Republic, women between the ages of 15 and 34 account for nearly two-thirds of all violent deaths among women, despite only representing 36% of the female population. Those at highest risk are young women working as domestic laborers and those having recently ended an intimate relationship. In approximately 63% of cases, the perpetrator is the victim’s husband (boyfriend) or ex-husband (ex-boyfriend), followed by mothers (14%) and fathers (10%). Violence against women increases the vulnerability of girls and young women to HIV in the Caribbean region. Sexual violence against women and girls is widespread, yet its punishment is often minimal or non-existent. This is particularly problematic due to the dual impact of violence and sex on exposure to HIV infection. Assault rates in the Caribbean are also reported to be significantly higher than any other region in the world. Given their dependence on men for economic support and endemic violence against women, women are reluctant to insist on condom use for fear of economic abandonment or physical harm. Very often sexual crimes against young girls go unpunished.

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176 Women are twice as likely to become infected with HIV through unprotected heterosexual intercourse as men. They may be not able to negotiate condom use and are more likely to be subjected to non-consensual sex.

177 Violence against women was defined by a declaration of the General Assembly of the United Nations (Declaration on the Elimination of Violence against Women, 1993) as “any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.”


179 Ibid.

180 Halcon, L. et al (2000), A portrait of adolescent health in the Caribbean, University of Minnesota and PAHO. See also ibid.
There is a lack of data on gender-based violence. Police statistics offer an imperfect picture of violence against women, since the majority of these incidents are not reported to police. There are no victimisation surveys using a common methodology that have been widely used across the Caribbean to document levels of violence against women. Reliance then has to be placed on country-specific official crime reports but this does not allow inter-state comparisons.

One notable exception is a regional study carried out in 1997 and 1998 on adolescent health in nine countries – Antigua and Barbuda, Bahamas, Barbados, British Virgin Islands, Dominica, Grenada, Guyana, Jamaica, and Saint Lucia. According to this study, 48% of adolescent girls’ sexual initiation was ‘forced’ or ‘somewhat forced’. In Kingston, Jamaica in the early 1990s, 17% of 13 and 14 year-olds had been raped or been victims of attempted rape, and 33% had experienced unwanted physical contact or verbal enticements to have sex.

Older data from nationally representative surveys undertaken in Antigua and Barbuda and Barbados in 1990 indicated that 30% of all women in each country had been victimised by physical violence at the hands of an intimate partner at some point in their lives. These lifetime prevalence rates are within the range of those found outside the region in a study recently undertaken by the World Health Organisation (WHO), which showed a non-population weighted average prevalence rate of 36.3% over 15 study sites in ten countries.

Law and law enforcement practices

Some but not all Caribbean constitutions provide for the protection from discrimination on the basis of ‘sex’. Despite this women continue to experience extreme levels of gender-based violence, poverty and structural inequalities. Hidden taboos and attitudes towards sex and sexuality where males are in control are prevalent. Incest exists where fathers and other male relatives rape girls because ‘they had to have them first before another man touches them’. Insisting on condom use is met with threats of violence or abuse and domestic violence is pervasive.

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184 Some exceptions are Barbados and the Bahamas. Women do not enjoy equal citizenship rights in the Bahamas.
Some parts of the region have developed legislative protection from gender-based violence. In recent years, several countries have enacted legislation aimed at combating domestic violence based in large measure on the model formulated by the CARICOM Secretariat, e.g. the Domestic Violence Act of Jamaica passed in 1996. These acts provide for courts to issue protection orders aimed at protecting an applicant from further abuse. They also prohibit the perpetrator from entering or remaining in a residence occupied by the victim, or granting the victim the right to occupy the premises forming part of the household. Non-molestation orders may also be made restraining the abuser from contacting the affected person in any public place or being within a specified distance from her or him, and also from making persistent telephone calls to the residence or place of work. The Domestic Violence Act of Trinidad and Tobago (1999) amended the 1991 Act to widen the definition of ‘domestic abuse’ to include psychological, emotional and financial abuse, and recognised visiting and cohabitating relationships. Countries which hitherto had no separate legislation governing sexual offences have adopted the CARICOM model Sexual Offences Act as well as the Sexual Harassment Act. Violence within the confines of the home is still generally regarded by law enforcement officers as a family matter to be settled privately, and not to be aired publicly in courts of law.

The domestic violence model legislation was considered by virtually every country. These reforms were the most important legislative initiatives to advance the rights of women in the 1990s as well as the most significant family law reform effort in the region in that period. A few countries have reformed their sexual offences legislation, both in the substance of the laws and the procedures for hearing sexual offences cases. There has been a move towards gender-neutral rape laws. Generally, there is an increased range of sexual offences, such as grievous sexual assault and unlawful sexual connection, and strengthening of penalties. There is some criminalisation of non-consensual sexual intercourse between a husband and his wife.

Preventing mother-to-child HIV transmission (PMTCT): The transmission of HIV from mother to child can occur during pregnancy, at childbirth and via breast feeding. In the absence of treatment, the transmission rate up to birth between the mother and child is around 25%. However, where combination ART and caesarean section are available, this risk can be reduced to as low as 1%. Coverage rate for PMTCT was 59% in 2009. That equals 4,400 pregnant women receiving treatment, but the remaining 3,000 were not covered by

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186 Quamina-Aiyejina L, and Brathwaite J (2005), Gender-Based Violence in the Commonwealth Caribbean, An annotated bibliography, Centre for Gender Development Studies, University of the West Indies, Mona & UNIFEM Caribbean office.
existing programmes. That means there were approximately 750 babies born HIV-positive whose transmissions were preventable.

Several countries have instituted mandatory HIV testing for pregnant women. For instance, in Suriname and Grenada pregnant women are tested for HIV without their consent\textsuperscript{192}. This policy is not recommended by international standards, as it potentially can lead to women avoiding health care services out of fear of stigma and discrimination, and being shunned by their families.\textsuperscript{193} Restrictive abortion laws exist in many countries of the region: usually abortions are only permitted to save a woman’s life, to preserve her health, including mental health or because of socio-economic reasons.\textsuperscript{194}

Social support and economic opportunities: Single parenthood is not a category of eligibility for social safety net support by the state in any country. Pre-school child care, when available, is privatised and\textsuperscript{195} women nearly always carry the cost or role of carer.

With limited education and skills, women often use their bodies as assets to support themselves. Though not necessarily formalised as ‘sex work’, women are nonetheless financially dependent on men for support in return for sex. These circumstances make the Caribbean an unsafe place for women.

Schoolgirls from female-headed low-income households are often lured into transactional sexual relationships with older men who contribute money to the household. Research conducted by the Institute of Social and Economic Research at the University of the West Indies indicated that schoolgirls are coerced to engage in transactional unprotected sex with these men because it provides ‘material goods’ such as books and pocket money for school, as well as clothes for recreational outings. This transactional sex may also result from a search for what constitutes a ‘father figure’ or ‘Sugar Daddy’ who can give them the material things they want.\textsuperscript{196} The subordination of women and girls in the Caribbean is complex, multi-faceted, and culturally entrenched.

**Legal responses that protect and empower**

Violence, poverty, inequality and the lack of basic rights all need to be addressed if HIV is to be brought under control. The Caribbean Coalition on Women, Girls and AIDS (CCWA) is a regional network of individuals and organisations committed to advocating for improved HIV and AIDS programming for women and girls. A meeting of CCWA Advocates in February 2011 called for laws and policies to:

\textsuperscript{192} PANCAP (2010), *Regional Policy and Model Legislation to Address HIV and AIDS related Stigma and Discrimination*, Desk Review Report, pp. 28-31

\textsuperscript{193} Ibid.


\textsuperscript{196} This paragraph was adapted from Morrison, S et al (2005), *Social Capital, Health and HIV Awareness of Girls in a Rural Caribbean Community*, International Electronic Journal of Health Education 8: 135-145.
reduce violence against women and girls, given the link between sexual violence and HIV transmission;
• improve access to reproductive healthcare including female condoms;
• promote universal access to prevention options;
• support women’s care-giving work within the household and community; and
• promote women’s leadership in the AIDS response.¹⁹⁷

Areas of concern

• Widespread discrimination on the basis of gender; lack of effective protection even where there is legislation;
• Comparatively low levels of prevention of mother-to-child transmission.
• Low economic and societal status of women, lack of social support to single parents.

6. Children and HIV

The number of children receiving treatment in the Caribbean region has increased significantly from 10,628 in 2005 to 16,100 children in 2008. ART coverage among children is 55% in the Caribbean, which reduced the number of new infections among children by 18%. Despite the fact that coverage rates for HIV testing and prevention of mother-to-child transmission of HIV achieved an 18% reduction of new HIV infections among children from 2001 to 2008, this number is low compared to proclaimed goals of universal access.

In 2007, there were between 46,400 and 70,000 children younger than 15 years of age with HIV in the Latin America and the Caribbean region, most of whom acquired HIV infection through mother-to-child transmission. Each year, the comparatively low coverage of HIV PMTCT interventions further raise these figures by an estimated 4,200 to 8,300 children. Without therapy, half of them will die before their second birthday and, in 2007 alone, an estimated 3,200 to 5,800 HIV-positive children died in Latin America and the Caribbean. A study has shown that early HIV diagnosis and early ART can reduce early infant mortality by 76%.

Furthermore, each year thousands of children are born with HIV and congenital syphilis — a highly preventable infection with serious health consequences if left untreated. Based on


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198 UNAIDS (2010), The Status of HIV in the Caribbean. UNAIDS Caribbean Regional Support Team.
199 UNAIDS, PAHO, UNICEF (2009), Challenges posed by the HIV epidemic in Latin America and the Caribbean.
200 UNAIDS (2010), The Status of HIV in the Caribbean. UNAIDS Caribbean Regional Support Team.
201 UNAIDS, PAHO, UNICEF (2009), Challenges posed by the HIV epidemic in Latin America and the Caribbean.
2007 estimates on number of births and prevalence of HIV and syphilis among pregnant women, each year in Latin America and the Caribbean an estimated 250,000 are born with congenital syphilis — while more than 100,000 pregnancies are lost to fetal death or spontaneous abortion as a result of maternal syphilis. The estimated toll of children under the age of 15 living with HIV in the region is between 46,400 and 70,000 children, while between 3,200 and 5,800 died from AIDS in 2007 alone.\(^\text{202}\)

There are high levels of child poverty and low access to education reported in the region. Children who grow up in poor households are likely to remain poor as adults. For example, one out of every two children in Grenada (53%) is income-poor. In St. Lucia, over 50% of the income-poor are under the age of 20 and the incidence of poverty is higher among children than among adults. In St. Vincent and the Grenadines, children account for about 36% of all income-poor persons, though they represent only 31% of the population. Children account for about 40% of all income-poor persons in St. Kitts and Nevis meaning more than one out of every three children is income-poor.\(^\text{203}\) These children live predominantly in female-headed households where there is no residential father contributing regularly and dependably to child care.

Young people generally face significant problems in relation to HIV and AIDS. Statistics show that young girls are the fastest growing group for new infections.\(^\text{204}\) Early sexualisation influences sexual activity amongst girls and boys. Up to 25% of teenagers in the Organisation of Eastern Caribbean States (OECS) region reported that their first sexual encounter was forced.\(^\text{205}\)

Girls engaging in transactional sex are stereotyped by their communities as ‘loose’ without acknowledgment of the power imbalances in transactional sex between young women and older men. Accountability typically is placed on the more vulnerable party, without addressing the actions of the adult. Furthermore, transactional sex among minors and older men is an ‘accepted fact’ in many Caribbean societies and rarely acknowledged as child sexual abuse.\(^\text{206}\)

A study of adolescent health conducted in by Pan American Health Organisation (PAHO) in 2000 in six countries in the region\(^\text{207}\) found that among youth there is:

- early sexual initiation;
- unprotected sex with multiple partners;

\(^\text{202}\) Ibid.

\(^\text{203}\) National Social Safety Net Assessments (2009) supported by UNICEF, UNIFEM and World Bank. This paragraph was adapted from UNICEF written comments on the first draft of this report.


\(^\text{206}\) The report of a study carried out across the Eastern Caribbean during the period October 2008 to June 2009 by Adele D. Jones and Ena Trotman Jemmott. The study emerged out of the UNICEF Governments of the Eastern Caribbean Programme of Cooperation 2008-2011 and was a joint initiative of UNICEF/UNIFEM together with stakeholders from the region, aimed at reducing sexual violence against children.

- lack of concern about consequences of unprotected sex;
- lack of concern about contracting HIV;
- sex for emotional and material benefit;
- sexual abuse, particularly of school aged girls from male authority figures - bus drivers, taxi drivers, etc.

Some of the reasons which have been advanced for these trends include:
- high levels of school drop-out and unemployment among youth;
- ineffective education on sexuality and sexual and reproductive health under the Health and Family Life Education programme in schools;
- lack of ability of parents to demystify sex to their children;
- ineffective HIV and AIDS campaigns which do not target youth appropriately;
- the perception by young people that adults, health care providers and school counsellors cannot be trusted to maintain confidentiality.

Law

Research has not uncovered much legislation that is specifically detrimental to children in relation to HIV. However, there are policies that need to be improved in order to decrease the high vulnerability of children to poverty and increase HIV prevention and voluntary testing for pregnant women.

There is a lack of data regarding laws related to children and HIV in the region. Studies from other regions indicate that street children, orphans, and children belonging to marginalised groups are more vulnerable to HIV. Where the age of consent is applicable to consent to HIV testing and access to health care services, children may be limited in their access to health care, harm reduction and testing, as they may not want these facts to be known to adults.

Age of Consent: There is no uniform definition of a ‘child’ in the region and the definitions that do exist in various laws do not always correspond with the definition of a child in the International Convention on the Rights of the Child, which defines that a child is someone under 18 years old. For example, in St. Lucia there is a legal distinction between the terms ‘child’ (a person under the age of 12 years) and ‘juvenile’ (a person under the age of 16 years). Another law in St. Lucia defines a ‘child’ as a person under the age of 14 years; and ‘young person’ as a person who is 14 years of age or upwards and under the age of 18 years. The Criminal Code offers yet another definition. This is troublesome, as it may mean that children older than 12 (or 14) years old are entitled to lesser protection than ‘children’ according to the law.

Sexual contact with minors is viewed as a betrayal of trust and involves taking advantage of persons legally incompetent to make appropriate judgments, such as consent to sex. The statutory age of consent varies by country and by the type of behaviour that is being regulated. 16 is the average age of consent in Caribbean countries for male-female sexual contact. In St. Kitts and Nevis, however, the age of consent has recently been increased to 18 years. While the age of consent is 16, the age of majority in most jurisdictions is 18. This

208 Chapter 3.09, section 2 of the Children and Young Persons Act of St. Lucia.
gap between the two creates a limbo (ages 16 and 17) where girls may consent to have sex but are unable to access sexual and reproductive health services without parental approval. In St. Vincent and the Grenadines the *Age of Majority Act* makes specific provision for a minor who is over 16 years old to consent to surgical, medical or dental treatment as if he or she were of full age.

The age of consent also determines a person’s access to various services, including health care, without parental consent. Consent from parents or guardians is also needed for HIV testing in most countries. Providers need procedural and/or practical guidance in relation to adolescents’ competence to give consent for medical treatment, their right to confidentiality and their right to the provision of information. Termination of unwanted pregnancy, HIV testing, and testing and treatment for sexually transmitted infections are situations where an adolescent may not want disclosure to parents or guardians. Consent will also be an issue when adolescents are sex workers, street children, MSM or transgender people.

**Law enforcement practices**

Violations of age-of-consent laws are common, and violators are often not penalised. A study of the UN Office on Drugs and Crimes (UNODC) & the World Bank,210 conducted in nine Caribbean countries, indicated that 48% of adolescent girls’ sexual initiation was either ‘forced’ or ‘somewhat forced’. Even where special adolescent health services are provided, their use is often limited. Factors such as lack of privacy, confidentiality and judgmental attitudes of service providers deter youth from utilising services.

Health professionals may refuse to see unaccompanied adolescents under the age of 16 years (18 years in some countries) because of uncertainty about their ethical and legal rights and responsibilities. This reluctance is usually based on fear of legal authorities, parents or the church. There is no legislation that states the age at which minors do not require consent of parents to access health care services. In common law a minor who is sufficiently mature can consent to medical treatment, but often health professionals do not know how to determine this in order to provide services.

**Legal responses that protect and empower and areas of concern**

The denial of access to sexual and reproductive health services to minors without parental consent results in increasing rates of infection among youth, as they engage in sexual intercourse and other risky behaviour without adequate knowledge on protection and risk reducing strategies. Adolescents have a right to age-appropriate sexual and reproductive health information, education, and services that enable them to deal positively and responsibly with their sexuality.

Integration of the prevention, diagnosis, and treatment of both HIV and syphilis into routine maternal and child health care is an urgent public health priority that cannot continue to lag behind.

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• There is a lack of data regarding children and HIV, and policies and legislation which may have detrimental impacts on children’s rights.

• Economic poverty and lack of social protection may be the main reasons of high HIV rates among children, especially young girls.

• Lack of uniformity of definition of a “child” may lead to confusion regarding when to apply protection; and if parents’ or guardian’s consent is necessary in order to access services and HIV testing.
“Every day, stigma and discrimination in all their forms bear down on women and men living with HIV, including sex workers, people who use drugs, men who have sex with men, and transgender people. Many individuals most at risk of HIV infection have been left in the shadows and marginalised, rather than being openly and usefully engaged... To halt and reverse the spread [of HIV], we need rational responses which shrug off the yoke of prejudice and stigma. We need responses which are built on the solid foundations of equality and dignity for all, and which protect and promote the rights of those who are living with HIV and those who are typically marginalised.”

- UNDP Administrator Helen Clark

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