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INDEX TO DOCUMENTATION OF COUNTRY CONDITIONS REGARDING PERSECUTION AGAINST HIV-POSITIVE PERSONS IN TRINIDAD & TOBAGO, IN SUPPORT OF AN APPLICATION FOR ASYLUM

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<tr>
<td></td>
<td>GOVERNMENTAL SOURCES</td>
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  • “Stigmatization of persons with HIV persisted, especially of persons in high-risk groups, creating barriers to access and uptake of prevention and treatment services.” (Pg. 10) |
  • “Stigmatization of those with HIV persisted, especially among high-risk groups, including men who have sex with men.” (Pg. 14) |
  • “Stigmatization of those with HIV persisted, especially among high-risk groups, including men who have sex with men.” (Pg. 15) |
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<td><strong>INTERGOVERNMENTAL SOURCES</strong></td>
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<td>• “The Equal Opportunity Act, 2000 does not explicitly ban discrimination based on sexual orientation, gender or HIV status. The lack of legal protection supports an environment of stigma and discrimination against persons perceived to be HIV positive and towards members of the LGBT community limiting uptake of essential public health services.” (Pg. 7)</td>
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<td>• “According to UNAIDS, HIV and AIDS related stigma and discrimination are hindering efforts to reduce new HIV infections, increase access to HIV care, treatment and support, and are impeding the rights of persons living with or affected by HIV and AIDS to lead productive lives…This is particularly true in Trinidad and Tobago as there is a deficit of laws to protect the human rights of PLHIV and myths and misconceptions about HIV and AIDS are rampant and fuel stigma and discrimination.” (Pg. 5)</td>
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<td>• “Due to high levels of HIV-related stigma and discrimination, coupled with the lack of legislation to provide avenues for redress for PLHIV in critical areas such as employment, housing and health services for example, cases of discrimination remain primarily anecdotal. Those living with and affected by HIV are hesitant to bring formal complaints to the courts and/or the Equal Opportunities Commission as HIV is not a prohibited grounds of discrimination in the Equal Opportunities Act or any other law that seeks to protect the basic human rights of citizens. Such legislative deficiencies make cases of HIV-related discrimination difficult to address and formal complaints are few.” (Pg. 5)</td>
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| | • “In addition to a weak legislative framework, PLHIV are hesitant to lodge formal complaints for fear of facing further discrimination from public disclosure of their status. Personal stories of
### TAB | SUMMARY
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| | disownment by family, loss of employment and/or housing based on disclosure are common yet often not officially recorded.” (Pg. 5)

## NGOs


- “Violence and stigma towards key affected populations and those living with HIV has remained a barrier to HIV progress in Latin America and the Caribbean.” (Pg. 2)

“Homophobia and the ‘machismo’ (strong/aggressive masculinity) culture are common throughout the region and sex between men is highly stigmatized. As a result, large numbers of men who have sex with men do not identify as homosexual (or bisexual) and have sex with women as well as men, forming a ‘bridge’ population. As one civil society worker explains, men who have sex with men are often hesitant to reveal how they became infected with HIV.” (Pg. 5)


- “Legislation introduced in Parliament in 2011 to include HIV/AIDS status in the protections of the Equal Opportunity Act lapsed in June 2012 without being brought to the floor for debate, and was never reintroduced...In March 2015, after repeated requests ‘since 2007’ to ‘Parliament, the Attorney General, and the Chief Parliamentary Counsel...to offer input on behalf of the citizens’ they ‘represent in improving the Equal Opportunity Act’, and ‘[i]n June of 2013’ writing ‘the state urging an IACHR hearing on some of the issues’, without a response, HIV, sexual orientation and other NGOs requested a hearing at the InterAmerican Commission on Human Rights (IACHR) to, among other goals...engage in dialogue with the state on adding HIV status and sexual orientation to equal opportunity legislation. The state failed to appear.” (Pg. 7)
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<td>8.</td>
<td>Julien Neaves, PSI Caribbean. SEX. Thousands of Trinidadians and Tobagonians Do it Every Day, Many Ignorant or Simply Uncaring About Healthy Sexual Practices, Trinidad and Tobago Newsday (July 1, 2014), available at <a href="http://archives.newsday.co.tt/2014/07/01/psi-caribbean/">http://archives.newsday.co.tt/2014/07/01/psi-caribbean/</a>&lt;br&gt;• “On HIV/AIDS [PSI/Caribbean’s Executive Director, Marina Hilaire-Bartlett] noted that stigma and discrimination remain an issue in Trinidad and Tobago. ‘People are still being discriminated against and I’m saying in the workplace, in their homes, people are still being evicted, children are still being expelled from school, you still have scenarios like that (in this country),’ she said. She noted there was a case of an HIV positive woman and her child, were HIV negative, attending school and teachers and parents banded together and called for the child to be removed. ‘And these are things that are not spoken of and that don’t make news but that happen to people every day,’ she said.” (Pg. 5)</td>
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<p>| MEDIA SOURCES |
| 9.  | Stephen Doobay, “‘The LGBTQI Community has no Claim to Human Rights’ says Church Council”, Trinidad Express (Feb. 20, 2019), available at <a href="https://trinidadexpress.com/news/local/the-lgbtqi-community-has-no-claim-to-human-rights-says/article_1ee1ec12-3522-11e9-804c-77c07d002a50.html">https://trinidadexpress.com/news/local/the-lgbtqi-community-has-no-claim-to-human-rights-says/article_1ee1ec12-3522-11e9-804c-77c07d002a50.html</a>&lt;br&gt;• “‘On the topic of human rights regarding to the LGBTQI community, the council disagrees that there was any legitimacy to the demand of the LGBTQI community for human rights, since scientifically and biblically, no such gender categories exist.’” (Pg. 2)&lt;br&gt;• “Where the Church’s relationship with the LGBTQI community is concerned, the council feels that given that the highest rate of HIV/AIDS infections is among the MSM [(men who have sex with men)] community, the government may do better to educate the population on the medical dangers of this behaviour and discourage it. In fact, the rate of infection among that community is an indicator that there is a high rate of hypersexuality among members of that group, suggesting that LGBTQI behavior is a manifestation of underlying psychoses. The U.S. National Institute of Health supports that assertion. According to ncbi.nlm.nih.gov, “Sexual addictions are behavioural addictions.”” (Pg. 2) |</p>
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| 10. | **Adult & Workplace Bullying on the Rise: The Victims Speak Out, Trinidad and Tobago Guardian (Feb. 27, 2018), available at http://digital.guardian.co.tt/?iid=158038&crd=0&searchKey=workplace%20bullying#folio=28**  
  
  - For another man, whom we will refer to only as L, workplace bullying led to isolation, and discrimination with absolutely little to no recourse. L worked in the public service for close to 20 years…During that time he began exhibiting symptoms of HIV and went on sick leave in 2001. When he returned in 2002, his life turned upside down. His colleagues and superiors began to discriminate against him, bullied him and because he had HIV automatically assumed he was gay. Staff members openly called him ‘AIDS man’, said ‘He don’t like women’ and also used slangs to crass for publication, when referring to L. Snide homophobic remarks were used in his presence, staff members wiped phones off after he used them and people would leave the washroom once he was using it…His desk was removed from the main office to an isolated area close to the kitchen which was not a designated office space. The area was not only lonely but had no air conditioning and because of a hole in the wall, L was exposed to the elements. He did not have a phone or computer and this affected his job function. Despite countless complaints to senior members of staff, nothing was done. L was excluded from staff training courses and had no job evaluation done, which meant he could not get a salary increase.” |
  
  For several months up to the time of her death, Sasha Fierce, aka Keon Allister Patterson, worked towards educating the local LGBTQI community about HIV/AIDS…One person who knew her said Fierce was previously a sex worker and felt strongly about HIV prevention and management, as she knew the risk of her former occupation…She said many members of their key population had no support from their family, or if they did, they and their family were ostracised so they ended up on the street. Also, if people noticed that they were different or found out they had HIV, no one wanted to employ them.” (Pg. 2) |
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<td>•</td>
<td>“[E]xtreme violence is not the only human rights abuse transgender women face. Many transgender women continue to die, not from lack of medical options, but due to intense stigma and discrimination that drives them away from health care services. . .In many Caribbean countries, transgender women often die instead of accessing stigmatizing healthcare services and treatment for HIV and AIDS.” (Pg. 2)</td>
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•  | “‘Primarily in the workplace, people living with HIV have challenges with discrimination in the workplace, either by co-workers, not getting hired or possible getting fired for their status,’ said [National HIV/AIDS Workplace Advocacy and Sustainability Centre (HASC)] manager Tania Parrott during an interview at HASC office…” (Pg. 1) |
| •  | “Parrott said even though there is so much knowledge about the disease there is still no legislation that really protects the rights of a worker with HIV.” (Pg. 1) |
| •  | “As a man living with the disease for more than 20 years, David Soomarie, coordinator of the Community Action Resource (Care), also believes a lot more can be done… ‘I think discrimination still exists. Depending on where you go and who you talk to, people still have some misconceptions. People still think you can get it from mosquitoes or sharing a cup with a co-worker or from hugging someone or giving someone a kiss.”’ (Pg. 2) |
•  | “Trinidad and Tobago says that the Acquired Immune Deficiency Syndrome (AIDS) is on the rise…[UNAIDS country coordinator Izola] Garcia emphasized the need for greater information and education. ‘Many people lose their jobs or cannot get jobs because of their perceived HIV status or sexual orientation which does not dictate their ability or fitness to work. This has an impact on the
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<td>lives of individuals, families and the economy, thrusting people sometimes into poverty or into illegal activity to make ends meet, which may also put them at further risk,’ she said.” (Pg. 1)</td>
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<tr>
<td>- “Women who know that they are HIV infected are oftentimes afraid to tell their husband, boyfriend, and others because of their fear of abandonment, family ostracism, violence, discrimination and stigmatization.” (Pg. 3)</td>
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<td>- “[M]ost HIV infected persons in the Caribbean continue to live in fear of the community “finding out” their diagnosis. There remains the inclination to associate HIV/AIDS with homosexuality, promiscuity, and prostitution (both male and female)…Homosexuality is highly stigmatized in the Caribbean region such that HIV-positive MSM in Jamaica, Trinidad and Tobago, and in other ESC countries have delayed seeking medical health services. There is research evidence on the deep-seated fears in MSM communities that there will be breaches of confidentiality by health care workers.” (Pg. 5)</td>
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<td>- “The breaches of confidentiality are of main concern throughout these small Caribbean islands where everybody knows everybody.” (Pg. 7)</td>
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<td>- “Most Caribbean countries…are reported to lack the appropriate systems in place for aggrieved persons to seek remedies for discrimination.” (Pg. 6)</td>
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TAB 1
EXECUTIVE SUMMARY

The Republic of Trinidad and Tobago is a parliamentary democracy governed by a prime minister and a bicameral legislature. The island of Tobago’s House of Assembly has some administrative autonomy over local matters. In the 2015 elections, which observers considered generally free and fair, the opposition People’s National Movement, led by Keith Rowley, defeated the ruling People’s Partnership, led by Kamla Persad-Bissessar.

The Ministry of National Security oversees three major divisions: police, immigration, and defense. Police maintain internal security. The defense force, which includes the coast guard, is responsible for external security but also has certain domestic security responsibilities. The coast guard is the main authority responsible for maritime border security in places where there are no official ports of entry. Civilian authorities maintained effective control over the security forces.

Significant human rights issues included: serious acts of corruption and laws criminalizing same-sex sexual conduct between adults, although those laws were not enforced and their constitutionality was being litigated.

The government took steps to identify, investigate, prosecute, and punish officials who committed human rights abuses, but impunity persisted.

Section 1. Respect for the Integrity of the Person, Including Freedom from:

a. Arbitrary Deprivation of Life and Other Unlawful or Politically Motivated Killings

There were no reports that the government or its agents committed arbitrary or unlawful killings.

b. Disappearance

There were no reports of disappearances by or on behalf of government authorities.

c. Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment
Although the law prohibits such practices, there were reports that police officers and prison guards sometimes used excessive force.

**Prison and Detention Center Conditions**

Conditions in some of the prison system’s nine facilities continued to be harsh due to overcrowding.

**Physical Conditions:** Gross overcrowding was a problem. All prisons had inadequate lighting, ventilation, and sanitation facilities. Conditions at the sole women’s prison were better than those in other prisons.

**Administration:** Authorities conducted investigations of credible allegations of mistreatment.

**Independent Monitoring:** The government did not permit outside observers, such as the United Nations, the International Committee of the Red Cross, or other nongovernmental organizations (NGOs), to monitor the Immigration Detention Center. The government permitted monitoring of other prisons and detention centers by UN officials and independent human rights organizations.

**Improvements:** Government repair projects improved physical conditions at some detention facilities.

**d. Arbitrary Arrest or Detention**

The law prohibits arbitrary arrest and detention and provides for the right of any person to challenge the lawfulness of his or her arrest or detention in court. The government generally observed these requirements.

**Arrest Procedures and Treatment of Detainees**

A police officer may arrest a person based on a warrant issued or authorized by a magistrate, or without a warrant if the officer witnesses the commission of an offense. Detainees must be charged and appear in court within 48 hours, and the government respected this standard. There is a functioning bail system, and bail is ordinarily available for those accused of most crimes. Persons accused of murder, treason, piracy, kidnapping for ransom, or hijacking, as well as persons convicted twice of violent crimes, are ordinarily ineligible for bail for 120 days. Authorities granted detainees immediate access to a lawyer.
The minister of national security may authorize preventive detention to protect public safety, public order, or national defense; the minister must state the grounds for the detention.

**Pretrial Detention:** Lengthy pretrial detention continued to be a problem. Pretrial detainees represented more than half the prison population. Most detainees’ trials began seven to 10 years after their arrest, although some spent even longer in pretrial detention. The length of pretrial detention frequently equaled or exceeded the maximum sentence for the alleged crime. Officials cited several reasons for the backlog, including the burden of the preliminary inquiry process. The law requires anyone charged and detained to appear in person for a hearing before a magistrate every 10 days, even if it is only to have the case postponed for an additional 10 days. This case load created further inefficiency.

**e. Denial of Fair Public Trial**

The law provides for an independent judiciary, and the government generally respected judicial independence and impartiality.

**Trial Procedures**

The law provides for the right to a fair and public trial, and an independent judiciary generally enforced this right. Criminal defendants enjoy the right to a presumption of innocence; to be informed promptly of the charges; to receive a fair, timely, and public trial; to be present at their trial; to communicate with an attorney of their choice or have one provided at public expense if unable to pay; to have adequate time and facilities to prepare a defense; to receive free assistance of an interpreter for any defendant who cannot understand or speak English; to confront prosecution or plaintiff witnesses and present their own witnesses and evidence; not to be compelled to testify or confess guilt; and to appeal.

**Political Prisoners and Detainees**

There were no reports of political prisoners or detainees.

**Civil Judicial Procedures and Remedies**
Individuals or organizations may seek civil remedies for human rights violations through domestic courts and may appeal adverse decisions to the Inter-American Commission on Human Rights.

f. Arbitrary or Unlawful Interference with Privacy, Family, Home, or Correspondence

The law prohibits such actions, and there were no reports that the government failed to respect these prohibitions.

Section 2. Respect for Civil Liberties, Including:

a. Freedom of Expression, Including for the Press

The law provides for freedom of expression, including for the press, and the government generally respected this right. An independent press, an effective judiciary, and a functioning democratic political system combined to promote freedom of expression, including for the press.

Freedom of Expression: The Sedition Act defines seditious intent as an intention to bring contempt and hatred to the government; to raise disaffection among inhabitants of Trinidad and Tobago; to engender or promote feelings of hostility against any class of citizens of Trinidad and Tobago distinguished by race, color, religion, or profession; or to promote violence against a particular group.

The government charged Watson Duke, president of the Public Services Association, a labor union, with sedition in August. The charges stemmed from Duke’s statement at a press conference that his union members were willing to die if the government came to take their jobs. Some commentators expressed concern that Duke was targeted for his frequent criticism of the government, and they criticized the Sedition Act as an outdated colonial law. After the incident the government expressed willingness to update the law, but it did not drop the charges against Duke. Duke was free on bail awaiting trial.

Violence and Harassment: The government charged a police constable and the chief executive officer of A&V Oil Gas Limited with assaulting Trinidad Guardian photographer Kristian De Silva. The case was dismissed in September but later refiled by the director of public prosecutions. As of November the matter was pending.
Internet Freedom

The government did not restrict or disrupt access to the internet or censor online content, and there were no credible reports that the government monitored private online communications without appropriate legal authority.

Academic Freedom and Cultural Events

There were no government restrictions on academic freedom or cultural events.

b. Freedoms of Peaceful Assembly and Association

The law provides for the freedoms of peaceful assembly and association, and the government generally respected these rights.

c. Freedom of Religion

See the Department of State’s International Religious Freedom Report at https://www.state.gov/religiousfreedomreport/.

d. Freedom of Movement

The law provides for freedom of internal movement, foreign travel, emigration, and repatriation, and the government generally respected these rights.

e. Internally Displaced Persons

Not applicable.

f. Protection of Refugees

Access to Asylum: The law does not provide for the granting of asylum or refugee status, and the government has not established a system for providing protection to refugees. The government agreed to let the Office of the UN High Commissioner for Refugees (UNHCR) conduct refugee status determinations. Thousands of UNHCR’s determinations affirmed refugee status. A positive determination by UNHCR, however, did not confer recognition by the government of an individual as a refugee or otherwise affect the person’s legal status in the country.
Durable Solutions: The government collaborated with UNHCR to facilitate transit of a few refugees to countries that had offered them resettlement.

Temporary Protection: In response to a large influx of Venezuelans, the government conducted a one-off registration exercise in June and agreed to allow registrants to reside, work, and access emergency health services in the country for one year from their date of registration. Approximately 16,500 Venezuelans registered with the government. Registration was unavailable to those who arrived after or who failed to register during the June exercise. Refugee children could not access public education, however, even if they were registered.

g. Stateless Persons

Not applicable.

Section 3. Freedom to Participate in the Political Process

The law provides citizens the ability to choose their government in free and fair periodic elections held by secret ballot and based on universal and equal suffrage.

Elections and Political Participation

Recent Elections: In 2015 elections the opposition People’s National Movement, led by Keith Rowley, defeated the ruling People’s Partnership (PP), led by Kamla Persad-Bissessar, winning 23 parliamentary seats to the PP’s 18 seats. Commonwealth observers considered the elections generally free and fair.

Participation of Women and Minorities: No laws limit participation of women or members of minorities in the political process, and they did participate.

Section 4. Corruption and Lack of Transparency in Government

The law provides criminal penalties for corruption by officials, but the government did not implement the law effectively, and officials sometimes engaged in corrupt practices with impunity. There were reports of government corruption during the year.

Corruption: Corruption remained a problem at many levels of government. Senior police officials acknowledged that officers participated in corrupt and illegal
activities, often accepting bribes to facilitate drug, weapons, and human smuggling, as well as human trafficking.

Opaque public procurement processes continued to be of concern. There were continued allegations that some politicians and ministers had close relationships with gang leaders and facilitated procurement and contracting of road, bridge, and construction projects to companies owned and operated by criminal enterprises.

During the year high-profile corruption cases were initiated against current and former officials from each of the two main political parties. On May 2, police arrested former attorney general Anand Ramlogan and Senator Gerald Ramdeen. Prosecutors charged both with conspiring to engage in money laundering, corruption, and misbehavior in public office. On August 12, prosecutors charged Minister of Public Administration and Member of Parliament Marlene McDonald with seven criminal charges: three charges of misbehavior in public office, three charges of conspiracy to defraud the state, and one charge of money laundering.

Financial Disclosure: The law mandates that senior public officials disclose their assets, income, and liabilities to the Integrity Commission, which monitors, verifies, and publishes disclosures. The commission publishes a list annually of officials who failed to file by the deadline. The law provides criminal penalties for failure to comply, but there were no prosecutions.

Section 5. Governmental Attitude Regarding International and Nongovernmental Investigation of Alleged Abuses of Human Rights

A number of domestic and international human rights groups generally operated without government restriction, investigating and publishing their findings on human rights cases. Government officials often were cooperative and responsive to their views.

Government Human Rights Bodies: The Office of the Ombudsman investigates citizens’ complaints concerning the administrative decisions of government agencies. Where there is evidence of a breach of duty, misconduct, or criminal offense, the ombudsman may refer the matter to the appropriate authority. The ombudsman has a quasi-autonomous status within the government and publishes a comprehensive annual report. Both the public and the government had confidence in the integrity and reliability of the Office of the Ombudsman and the ombudsman’s annual report.
Section 6. Discrimination, Societal Abuses, and Trafficking in Persons

Women

Rape and Domestic Violence: Rape of men or women, including spousal rape, is illegal and punishable by up to life imprisonment, but the courts often imposed considerably shorter sentences in cases of spousal rape. The law criminalizes domestic violence and provides for protection orders separating perpetrators of domestic violence, including abusive spouses and common-law partners, from their victims. Courts may also fine or imprison abusive spouses but did so rarely.

Rape and domestic violence remained serious and pervasive problems. According to the UN Global Database on Violence against Women, 30 percent of women in the country experienced physical or sexual violence from an intimate partner in their lifetime, and 19 percent experienced sexual violence from a nonpartner.

Victims of rape and domestic violence had access to national crisis hotlines and through a law enforcement referral could access temporary shelter and psychosocial services. The police service provided resources to their Victim and Witness Support Unit to encourage reporting rape and domestic violence. The government was training a domestic violence unit of the police service.

Sexual Harassment: The law does not criminalize sexual harassment. In March Minister of Labour and Small Enterprise Development Jennifer Baptiste-Primus launched a national workplace policy on sexual harassment, citing the 2017 National Women’s Health Survey for Trinidad and Tobago. The survey stated 13 percent of women experienced sexual harassment at work, in public transport, and in public spaces, and that as many as 84 percent of instances of sexual harassment were not reported.

The Ministry of Labour and Small Enterprise Development reported that disputes involving sexual harassment between 2016 and 2018 were 69 percent of all disputes reported during that period, a 38 percent increase since 2015.

Coercion in Population Control: There were no reports of coerced abortion or involuntary sterilization.

Discrimination: The law provides for the same legal status and rights for women as for men, and the government enforced the law effectively.
Children

Birth Registration: Every person born in the country is a citizen at birth, unless the parents are foreign envoys accredited to the country. A child born outside the country can become a citizen at birth if either parent is a citizen. The law requires every child be registered within 42 days of birth. Registration is required to access public services.

Education: Education is free and compulsory between the ages of five and 16. There are significant differences between boys and girls in enrollment, attendance, and completion in public schools. Nearly 60 percent of all dropouts between 2012 and 2019 were boys. Boys’ enrollment in primary schools exceeded that of girls, but by the upper secondary level girls outnumbered boys.

Child Abuse: The law prohibits corporal punishment of children. According to NGOs, however, abuse of children in their own homes or in institutional settings remained a serious problem. Penalties for child abuse can include a fine of up to 10,000 Trinidad/Tobago dollars ($1,500), two years’ imprisonment, or both.

Early and Forced Marriage: The legal minimum age of marriage is 18.

Sexual Exploitation of Children: The law prohibits commercial sexual exploitation of children through the sale, offering, or procuring for prostitution, and any practices related to child pornography. Authorities enforced the law.

The age of sexual consent is 18, and the age of consent for sexual touching is 16.


Anti-Semitism

There were fewer than 100 Jewish persons in the country. There were no reports of anti-Semitic acts.

Trafficking in Persons
See the Department of State’s *Trafficking in Persons Report* at [https://www.state.gov/trafficking-in-persons-report/](https://www.state.gov/trafficking-in-persons-report/).

**Persons with Disabilities**

The law prohibits discrimination based on disability but does not mandate equal access for persons with disabilities. Persons with disabilities faced discrimination, stigma, and denial of opportunities, including access to employment and education. Persons who believe they are being discriminated against can file a complaint with the Equal Opportunity Commission for conciliation. Complaints that remained unresolved may be brought before the Equal Opportunity Tribunal, a superior court that has the power to impose fines, make orders for compensation, and grant injunctions.

**Acts of Violence, Discrimination, and Other Abuses Based on Sexual Orientation and Gender Identity**

The law criminalizes consensual same-sex sexual conduct between adults, but the government did not enforce it, and a court ruling deemed the law unconstitutional. The government’s appeal of the ruling was pending and was intended to make the ruling settled law.

The law decriminalizes sexual exploration between minors who are close in age but specifically retains language criminalizing the same activity among same-sex minors.

The law does not specifically prohibit discrimination against lesbian, gay, bisexual, transgender, and intersex (LGBTI) persons. There were reports of harassment and threats against LGBTI persons, but victims tended to avoid media attention, and discrimination did not appear to be serious or widespread.

**HIV and AIDS Social Stigma**

Stigmatization of persons with HIV persisted, especially of persons in high-risk groups, creating barriers to access and uptake of prevention and treatment services. The government’s HIV and AIDS Unit coordinated the national response to HIV/AIDS, and the government employed HIV/AIDS coordinators in all ministries as part of its multisector response.
Section 7. Worker Rights

a. Freedom of Association and the Right to Collective Bargaining

The law provides for the right of most workers, including those in state-owned enterprises, to form and join independent unions, bargain collectively, and conduct legal strikes, but with some limitations. A union must have the support of an absolute majority of workers to obtain bargaining rights. Employees providing essential services do not have the right to strike; these employees negotiate with the government’s chief personnel officer to resolve labor disputes. The law stipulates that only strikes over unresolved labor disputes may take place, and that authorities may prohibit strikes at the request of one party unless the strike is called by a union representing a majority of the workers. The minister of labor may petition the court to curtail any strike he deems harmful to national interests.

The law prohibits employers from discriminating against workers due to union membership and mandates reinstatement of workers illegally dismissed for union activities.

The law’s definition of a worker excludes domestic workers (house cleaners, chauffeurs, and gardeners), but domestic workers had an established trade union that advocated for their rights.

The government effectively enforced applicable laws, although there was little information on specific penalties or on whether the penalties were sufficient to deter violations.

A union must have the support of an absolute majority of workers to obtain bargaining rights. This requirement limits the right of collective bargaining. Furthermore, collective agreement negotiations are subject to mandatory mediation and must cover a minimum of three years, making it almost impossible for such agreements to include workers on short-term contracts. According to the National Trade Union Center, the requirement that all negotiations go through the Public Sector Negotiation Committee, rather than through the individual government agency or government-owned industry, provided a further restriction that added significant delays. Some unions claimed the government undermined the collective bargaining process by pressuring the committee to offer raises of no more than 5 percent over three years.
b. Prohibition of Forced or Compulsory Labor

The law prohibits and criminalizes all forms of forced or compulsory labor. The government enforced the law effectively, and penalties were sufficient to deter violations.

In June police officers from Trinidad’s Countertrafficking Unit rescued two Chinese nationals forced to work at a Chaguanas factory against their will. A businessman brought the couple to the country and told them they would be employed as chefs at a popular Chinese restaurant. After the couple arrived, their passports were taken away and they were forced to work in the factory.

Also see the Department of State’s Trafficking in Persons Report at https://www.state.gov/trafficking-in-persons-report/.

c. Prohibition of Child Labor and Minimum Age for Employment

The law sets the minimum age for employment at 16. Children ages 14 to 16 may work in activities in which only family members are employed or that the minister of education has approved as vocational or technical training. The law prohibits children younger than age 18 from working between the hours of 10 p.m. and 5 a.m. except in a family enterprise. There is no separate minimum age for working in hazardous activities.

The government was generally effective in enforcing child labor laws, and the penalties were sufficient to deter violations, but there were anecdotal reports of children working in agriculture, as domestic workers, or involved in commercial sexual exploitation as a result of human trafficking.

Also see the Department of Labor’s Findings on the Worst Forms of Child Labor at https://www.dol.gov/agencies/ilab/resources/reports/child-labor/findings.

d. Discrimination with Respect to Employment and Occupation

The law prohibits employment discrimination on the basis of political opinion, sexual orientation, gender identity, language, age, disability, and HIV status or other communicable disease. The government generally enforced the law effectively, but discrimination in employment occurred with respect to disability, and women’s pay lagged behind men’s, especially in the private sector.
e. Acceptable Conditions of Work

The national minimum wage was greater than the official poverty income level.

Workers in the informal economy reported wages above the national minimum wage but reported other areas of labor laws, including limits on the number of hours worked, were not enforced.

The Ministry of Labor and Small Enterprise Development is responsible for enforcing labor laws related to minimum wage and acceptable conditions of work. The Occupational Safety and Health Agency enforced occupational safety and health and regulations. Resources, inspections, and penalties appeared adequate to deter violations. The law provides a range of fines and terms of imprisonment for violations of the law, but despite these penalties, a number of violations occurred.

Occupational safety and health (OSH) standards are appropriate for the main industries in the country. Responsibility for identifying unsafe situations remained with OSH experts and not the worker. The law gives workers the right to remove themselves from situations that endanger health or safety without jeopardy to their employment, and authorities generally protected this right. According to government statistics, there were 81 critical accidents and 10 fatalities in the workplace between 2017 and 2018.

The law establishes a 40-hour workweek, a daily period for lunch or rest, and premium pay for overtime. The law does not prohibit excessive or compulsory overtime. The law provides for paid leave, with the amount of leave varying according to length of service. Workers in the informal economy reported wages above the national minimum wage but reported other areas of labor laws, including the number of hours worked, were not enforced.

Domestic workers, most of whom worked as maids and nannies, are covered by labor laws.
TAB 2
EXECUTIVE SUMMARY

The Republic of Trinidad and Tobago is a parliamentary democracy governed by a prime minister and a bicameral legislature. The island of Tobago’s House of Assembly has some administrative autonomy over local matters. In elections in 2015, which observers considered generally free and fair, the opposition People’s National Movement, led by Keith Rowley, defeated the ruling People’s Partnership, led by Kamla Persad-Bissessar.

Civilian authorities maintained effective control over the security forces.

Human rights issues included refoulement of refugees and corruption.

The government took some steps to punish security force members and other officials charged with killings or other abuses, but open-ended investigations and the generally slow pace of criminal judicial proceedings created a climate of impunity.

Section 1. Respect for the Integrity of the Person, Including Freedom from:

a. Arbitrary Deprivation of Life and Other Unlawful or Politically Motivated Killings

There were no reports that the government or its agents committed arbitrary or unlawful killings. According to official figures, police shot and killed 28 persons through October 9, compared with 46 in 2017. There were occasional discrepancies between the official reporting of shooting incidents and the claims made by witnesses regarding who fired the first shot and whether the officers fired in self-defense. Police investigated all police shooting deaths.

b. Disappearance

There were no reports of disappearances by or on behalf of government authorities.

c. Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment
Although the law prohibits such practices, there were some reports that police officers and prison guards sometimes mistreated individuals under arrest or in detention.

Officials from the Police Complaints Authority (PCA), a civilian oversight body that investigates complaints about the conduct of police officers, reported receiving few cases of cruel and inhuman treatment.

**Prison and Detention Center Conditions**

Conditions in some of the prison system’s nine facilities continued to be harsh due to overcrowding.

**Physical Conditions:** Convicted inmates constituted approximately 37 percent of the country’s prison population, while the others were in pretrial status, according to figures from 2017, the most recent data available. Most prisons suffered from extreme overcrowding, although the maximum-security prison was not at full capacity. Observers noted the Port of Spain Prison, the remand prison, and the immigration detention center had particularly poor conditions and severe overcrowding, with as many as nine prisoners kept in cells of 80 square feet. The Port of Spain Prison, designed to hold 250 inmates, held 595, and the remand prison, designed to hold 655 inmates, held 1,049, according to figures from 2016, the most recent data available. By contrast, the maximum-security prison held inmates in three-person cells, each with a toilet and shower.

The remand section of the Port of Spain Prison had particularly poor lighting, ventilation, and sanitation facilities.

Although conditions at the women’s prison were better than those in the Port of Spain Prison, the women’s facility occasionally became overcrowded, since it held both women on remand and those serving prison sentences. The daily average female prison population was 109 in facilities with a maximum capacity of 158, according to figures from 2017. Since there was no female youth facility, authorities placed some underage female prisoners in a segregated wing of the women’s prison and returned others to their families. Observers raised concerns the prison held young girls who had not committed any offense but were merely in state custody.

The government also operated the Immigration Detention Center (IDC) to house irregular immigrants waiting to be deported. The average length of detention was
one week to two months, depending on the speed with which the government secured public funding for deportation, as well as transit passports and visas. In some cases detention lasted more than four years. Observers reported the men’s section continued to be overcrowded.

In June a group of Cubans, Venezuelans, and Africans held at the IDC staged two protests against the conditions of the detention center and length of their stay in the facility. Some of those protesting had been at the IDC for more than one year, even after requesting repatriation.

**Administration:** Authorities generally conducted proper investigations of credible allegations of mistreatment.

**Independent Monitoring:** The government did not permit outside observers, such as the United Nations, International Committee of the Red Cross, or other nongovernmental organizations (NGOs), free access to conduct monitoring visits or interviews in the IDC. Other than the IDC, the government permitted regular and open prison visits by UN officials and independent human rights observers upon approval of the Ministry of National Security. These observers enjoyed a reasonable degree of independence.

**d. Arbitrary Arrest or Detention**

The law prohibits arbitrary arrest and detention and provides for the right of any person to challenge the lawfulness of his or her arrest or detention in court, and the government generally observed these requirements. Reports of abuses by police remained under investigation at year’s end.

In May the government passed an updated version of the Anti-Gang Act, which bans membership in criminal gangs and gang-related activities and permits authorities to hold suspects detained under the law without a warrant for up to 14 days, subject to a court order authorizing the detention. The opposition party raised human rights concerns; however, the government rarely relied upon measures contained in the act.

**Role of the Police and Security Apparatus**

The Ministry of National Security oversees three major divisions--the police service, immigration division, and defense force. The police service maintains internal security, while the defense force, which includes the coast guard, is
responsible for external security but also has certain domestic security responsibilities. The coast guard is the main authority responsible for border security along the coastlines where there are no official ports of entry. The Customs and Excise Division and the Immigration Division are responsible for security at the ports. Members of the defense force often joined police officers in patrolling high-crime neighborhoods but do not have arrest authority (apart from the coast guard, which can arrest in territorial waters and the Southern Caribbean).

The independent Police Service Commission (PSC), in consultation with the prime minister, appoints a commissioner of police to oversee the police force. In August the PSC appointed former minister of national security Gary Griffith as the new commissioner of police. The PSC also makes hiring and firing decisions in the police service, and the Ministry of National Security typically has little direct influence over changes in senior positions. The PSC has the power to dismiss police officers, the commissioner of police can suspend officers, and the police service handles the prosecution of officers. Municipal police, under the jurisdiction of 14 regional administrative bodies, supplement the national police force. Public confidence in police was very low because of high crime rates and perceived corruption.

The PCA investigates complaints about the conduct of police officers, including fatal police shootings; however, it received insufficient funding and had limited investigative authority. By law the PCA is free from the direction or control of any other person in the performance of its functions. The PCA had 25 investigators, and from October 2017 through August 27, the unit received 373 complaints, 300 of which were pending as of November. Through investigations by the PCA and other bodies, authorities charged police officers with a number of offenses, including attempted murder and corruption. The Police Professional Standards Unit and the Police Complaints Division, both nonindependent bodies within the police service, also investigated complaints against police.

**Arrest Procedures and Treatment of Detainees**

A police officer may arrest a person based on a warrant issued or authorized by a magistrate, or without a warrant if the officer witnesses the commission of an offense. Detainees, as well as those summoned to appear before a magistrate, must appear in court within 48 hours. In cases of more serious offenses, the magistrate either commits the accused to prison on remand or allows the accused to post bail, pending a preliminary inquiry. Authorities granted detainees immediate access to
a lawyer and to family members. Attorneys representing individual clients in the IDC also generally were allowed to visit them in the center.

Ordinarily, bail was available for minor charges. Persons charged with murder, treason, piracy, kidnapping for ransom, and hijacking, as well as persons convicted twice of violent crimes, are ineligible for bail for a period of up to 120 days following the charge, but a judge may grant bail to such persons under exceptional circumstances. When authorities denied bail, magistrates advised the accused of their right to an attorney and, with few exceptions, allowed them access to an attorney once they were in custody and prior to interrogation.

The minister of national security may authorize preventive detention to preclude actions prejudicial to public safety, public order, or national defense, in which case the minister must state the grounds for the detention.

**Arbitrary Arrest:** Instances of false arrest, although infrequent, were reported. Victims may pursue legal redress and the right to a fair trial through an independent judiciary.

**Pretrial Detention:** Lengthy pretrial detention resulting from heavy court backlogs and inefficiencies in the judicial system continued to be a problem. Pretrial detainees or remand prisoners represented more than half the prison population. Most persons under indictment waited seven to 10 years for their trial dates in the High Court, although some waited much longer. Officials cited several reasons for the backlog, including an understaffed prosecutorial office, a shortage of defense attorneys for indigent persons, and the burden of the preliminary inquiry process. Additionally, the law requires anyone charged and detained to appear in person for a hearing before a magistrate’s court every 10 days, if only to have the case postponed for an additional 10 days, resulting in further inefficiency.

**e. Denial of Fair Public Trial**

The law provides for an independent judiciary, and the government generally respected judicial independence and impartiality. Although the judicial process was generally fair, it was slow due to backlogs and inefficiencies. Prosecutors and judges stated that witness and jury intimidation remained a problem.

**Trial Procedures**
The law provides all defendants with the right to a fair and public trial, and an independent judiciary generally enforced this right. Magistrates try both minor and more serious offenses, but in the latter cases, the magistrate must conduct a preliminary inquiry. Defendants have the right to be present, to be presumed innocent until proven guilty, and to appeal. Authorities inform them promptly and in detail of all charges. Defendants have the right to consult with an attorney in a timely manner and have adequate time and facilities to prepare a defense. Authorities provide an attorney at public expense to defendants facing serious criminal charges, and the law requires provision of an attorney to any person accused of murder. Although the courts may appoint attorneys for indigent persons charged with serious crimes, an indigent person may refuse to accept an assigned attorney for cause and may obtain a replacement. Defendants can confront or question adverse witnesses and present witnesses and evidence on their own behalf. Defendants may not be compelled to testify or confess guilt. The government provides free foreign language interpreters as well as sign-language interpreters as necessary in court cases.

Both civil and criminal appeals may be filed with the Court of Appeal and ultimately with the Privy Council in the United Kingdom.

**Political Prisoners and Detainees**

There were no reports of political prisoners or detainees.

**Civil Judicial Procedures and Remedies**

Individuals or organizations are free to file lawsuits against civil breaches of human rights in both the High Court and petty civil court. The High Court may review the decisions of lower courts, order parties to cease and desist from particular actions, compel parties to take specific actions, and award damages to aggrieved parties. Court cases may be appealed to the Inter-American Commission on Human Rights.

**f. Arbitrary or Unlawful Interference with Privacy, Family, Home, or Correspondence**

The law prohibits such actions, and there were no reports that the government failed to respect these prohibitions.
Section 2. Respect for Civil Liberties, Including:

a. Freedom of Expression, Including for the Press

The law provides for freedom of expression, including for the press, and the government generally respected this right. An independent press, an effective judiciary, and a functioning democratic political system combined to promote freedom of expression, including for the press.

Violence and Harassment: In contrast with 2017, there were no credible reports of journalists subjected to violence, harassment, or intimidation due to their reporting.

Internet Freedom

The government did not restrict or disrupt access to the internet or censor online content, and there were no credible reports that the government monitored private online communications without appropriate legal authority.

According to the International Telecommunication Union, 77 percent of citizens used the internet in 2017.

Academic Freedom and Cultural Events

There were no government restrictions on academic freedom or cultural events.

b. Freedoms of Peaceful Assembly and Association

The law provides for the freedoms of peaceful assembly and association, and the government generally respected these rights.

c. Freedom of Religion

See the Department of State’s International Religious Freedom Report at www.state.gov/religiousfreedomreport/.

d. Freedom of Movement

The law provides for freedom of internal movement, foreign travel, emigration, and repatriation, but the government forced some asylum seekers to return to their home country.
The government cooperated with the Office of the UN High Commissioner for Refugees (UNHCR) and other humanitarian organizations in providing protection and assistance to refugees, returning refugees, asylum seekers, stateless persons and other persons of concern under its mandate; however, this cooperation was considerably strained in numerous cases. Refugees and asylum seekers were often the subjects of immigration enforcement actions and deportations, affecting their freedom of movement.

**Protection of Refugees**

*Refoulement:* On April 21, the government deported 82 Venezuelans to their home country, some of whom were seeking asylum. Some of the deported asylum seekers expressed a well founded fear of Venezuelan authorities learning their identities, yet officials overseeing the deportation sought the assistance of the Venezuelan embassy during the process.

In principle, refugees are granted full protection from refoulement and detention if presented to the Immigration Division upon applying for asylum. In practice, however, the lack of adequate legal protection meant that valid, registered refugees and asylum seekers were often arrested and detained on immigration charges.

*Access to Asylum:* In the absence of national refugee legislation, UNHCR registered all asylum seekers, conducted refugee status determinations on behalf of the government, and attempted to promote durable solutions for all refugees recognized under UNHCR’s mandate.

The law does not provide for any exemption or nonpenalization of irregular entry or stay of asylum seekers or refugees, although the government adopted a refugee policy in June. Persons who expressed a need for international protection could be subject to detention if they entered via irregular ways or exceeded their permitted length of stay without having presented themselves voluntarily to the authorities.

The Living Water Community (LWC), a local Roman Catholic NGO and UNHCR’s operational partner, was the first point of contact for persons in need of international protection. It provided reception services, orientation, and counseling, and it notified the Ministry of National Security’s Immigration Division of the respective asylum applications. In coordination with UNHCR, the LWC engaged in case management and provided psychosocial care and
humanitarian assistance, including cash, housing assistance, and legal aid, among other services.

The Ministry of National Security’s Immigration Division authorized the stay of asylum seekers and refugees through the issuance of orders of supervision. These orders provided for protection against detention or deportation. In exchange for issuing an order of supervision, however, immigration authorities often confiscated the passports of refugees and asylum seekers and retained custody of their passports until the refugees or asylum seekers provided a financial deposit equivalent to a return flight ticket to their home country. This inhibited the freedom of movement of many refugees and asylum seekers and, in many cases, effectively trapped them in a country where they were not legally allowed to work and where their access to public services was considerably hindered. Many refugees and asylum seekers experienced xenophobia and discrimination, and sexual and gender-based violence was a particular concern for women.

Employment: In the absence of implementing legislation, neither refugees nor asylum seekers were permitted to work. They were sometimes subjected to exploitation, including sexual exploitation.

Access to Basic Services: Refugee and asylum-seeking children did not have access to public education, because by law they do not qualify for the required student permit. Refugees and asylum seekers struggled to access all but emergency public-health facilities. They did not have access to identity documents and were obliged to surrender their passports to the Immigration Division to remain in the country legally.

Durable Solutions: Due to the absence of national legislation that would allow for local integration, resettlement was traditionally the only durable solution for refugees in the country, but this was difficult due to lack of available spaces. UNHCR, the LWC, and the International Organization for Migration continued to collaborate on the identification, submission, and transfer of refugees in need of resettlement.

Some refugees and asylum seekers abandoned their claims and left the country due to the lengthy processing time and lack of rights, particularly the right to work. Many also feared harassment and discrimination.

The government also collaborated with UNHCR to facilitate the resettlement of a few refugees to smaller Caribbean islands by allowing them to stay temporarily in
the country to complete the formalities required for resettlement and then directly travel to their new asylum country.

Section 3. Freedom to Participate in the Political Process

The law provides citizens the ability to choose their government in free and fair periodic elections held by secret ballot and based on universal and equal suffrage.

Elections and Political Participation

Recent Elections: In 2015 elections the opposition People’s National Movement (PNM), led by Keith Rowley, defeated the ruling People’s Partnership (PP), led by Kamla Persad-Bissessar, winning 23 parliamentary seats to the PP’s 18 seats. Commonwealth observers considered the elections generally free and fair. During the campaign, however, observers noted the “lack of transparency and accountability regarding the financing of political parties.” Many experts raised concerns that the lack of campaign finance rules gives any incumbent party an advantage.

Following the election, former prime minister Persad-Bissessar initiated a court challenge to overturn the election results. The former prime minister challenged the results in six key swing constituencies where the results were close and where the PP argued a last-minute decision by the Elections and Boundaries Commission to extend voting helped the PNM. The courts found that the commission was wrong to extend voting but that the action did not change election results.

Participation of Women and Minorities: No laws limit participation of women or members of minorities in the political process, and they did participate.

Section 4. Corruption and Lack of Transparency in Government

The law provides criminal penalties for corruption by officials, but the government did not implement the law effectively, and officials sometimes engaged in corrupt practices. There were reports of government corruption during the year, and the World Economic Forum and Transparency International ranked corruption as a problematic factor for doing business in the country. There were no documented instances of an individual receiving a criminal punishment for corruption.

Corruption: Corruption in police and immigration services continued to be a problem, with senior officials acknowledging that officers participated in corrupt
and illegal activities. There were allegations that some police officers had close relationships with gang leaders and that police, customs, and immigration officers often accepted bribes to facilitate drug, weapons, and human smuggling as well as human trafficking.

In September, two police officers were arrested for kidnapping and holding an innocent person for ransom. The minister of national security and commissioner of police worked quickly on the case, ensuring the safe release of the victim and arresting the suspected police officers. As of November the case was pending, but all charged officers remained incarcerated.

There were continued allegations that some ministers used their positions for personal gain.

Financial Disclosure: The law mandates that public officials disclose their assets, income, and liabilities to the Integrity Commission, which monitors, verifies, and publishes disclosures. Officials and candidates for public office were reluctant to comply with asset disclosure rules, primarily due to the perceived invasiveness of the process. The act stipulates a process when public officials fail to disclose assets and provides criminal penalties for failure to comply. The law clearly states which assets, liabilities, and interests public officials must declare.

While the commission undertook numerous investigations, it seldom referred cases to law enforcement authorities, and prosecution of those officials who refused to comply with asset disclosure rules was very limited.

Section 5. Governmental Attitude Regarding International and Nongovernmental Investigation of Alleged Abuses of Human Rights

A number of domestic and international human rights groups generally operated without government restriction, investigating human rights cases and publishing their findings. Government officials generally were cooperative and responsive to their views.

Government Human Rights Bodies: The Office of the Ombudsman investigates citizens’ complaints concerning the administrative decisions of government agencies. Where there is evidence of a breach of duty, misconduct, or criminal offense, the ombudsman may refer the matter to the appropriate authority. The ombudsman has a quasi-autonomous status within the government and publishes a comprehensive annual report. Both the public and the government had confidence
in the integrity and reliability of the Office of the Ombudsman and the ombudsman’s annual report.

Section 6. Discrimination, Societal Abuses, and Trafficking in Persons

Women

Rape and Domestic Violence: Rape of men or women, including spousal rape, is illegal and punishable by up to life imprisonment, but the courts often imposed considerably shorter sentences. Police channeled resources to the Victim and Witness Support Unit in an effort to encourage reporting.

The law provides for protection orders separating perpetrators of domestic violence, including abusive spouses and common-law partners, from their victims. Courts may also fine or imprison abusive spouses, but it was rarely done.

The NGO Coalition against Domestic Violence charged that police often hesitated to enforce domestic violence laws and asserted that rape and sexual abuse against women and children remained a serious and pervasive problem.

Sexual Harassment: No laws specifically prohibit sexual harassment. Related statutes could be used to prosecute perpetrators of sexual harassment, and some trade unions incorporated antiharassment provisions in their contracts.

Coercion in Population Control: There were no reports of coerced abortion or involuntary sterilization.

Discrimination: Women generally enjoyed the same legal status and rights as men. No laws or regulations require equal pay for equal work.

Children

Birth Registration: Every person born in the country is a citizen at birth, unless the parents are foreign envoys accredited to the country. Children born outside the country can become citizens at birth if on that date one or both of the parents is, or was, a citizen. The law requires registration of every child born alive within 42 days of birth.

Child Abuse: Child abuse cases continued to increase. During the fiscal year 2017, the Children’s Authority received and investigated more than 4,200 reports
of child abuse and maltreatment. More than half (55 percent) of all cases involved female children. Neglect and sexual abuse accounted for 24 percent and 26 percent of the cases, respectively. The law prohibits both corporal punishment of children and sentencing a child to prison. According to NGOs, however, abuse of children in their own homes or in institutional settings remained a serious problem.

Early and Forced Marriage: Child marriage is illegal. The law defines a child as younger than age 18. In June 2017 parliament passed legislation changing the legal marriage age to 18. The president formally proclaimed the enactment of the Marriage Act in September 2017.

Sexual Exploitation of Children: The age of sexual consent is 18, and the age of consent for sexual touching is 16. Sexual penetration of a child is punishable by a maximum sentence of life in prison. The law creates specific offenses such as sexual grooming of a child (gaining the trust of a child, or of a person who takes care of the child, for the purpose of sexual activity with the child) and child pornography. The law prescribes penalties of 10 years’ to life imprisonment for subjecting a child to prostitution.


Anti-Semitism

There were fewer than 100 Jewish persons in the country. There were no reports of anti-Semitic acts.

Trafficking in Persons

See the Department of State’s Trafficking in Persons Report at www.state.gov/j/tip/rls/tiprpt/.

Persons with Disabilities

Disability rights advocates were not aware of any efforts by the government to implement the Convention on the Rights of Persons with Disabilities, which it
ratified in 2015. Prior to the ratification, the law prohibited discrimination based on disability but did not mandate equal access for persons with disabilities.

Persons with disabilities faced discrimination and denial of opportunities. Such discrimination could be traced to architectural barriers, employers’ reluctance to make necessary accommodations that would enable otherwise qualified job candidates to work, an absence of support services to assist students with disabilities to study, and social stigma accompanied by lowered expectations of the abilities of persons with disabilities, condescending attitudes, and disrespect.

Acts of Violence, Discrimination, and Other Abuses Based on Sexual Orientation and Gender Identity

On September 20, the High Court issued a final ruling on the country’s Sexual Offenses Act, removing an “antibuggery” law and effectively decriminalizing same-sex sexual conduct between consenting adults. High Court Judge Devindra Rampersad first ruled in April that the law was unconstitutional and expressed his intent to amend the law, which criminalized same-sex sexual conduct between consenting adults. Although the legislation was not struck out completely, the ruling provides that consenting adults will not be liable to criminal charges if engaging in consensual sexual acts. Immigration laws also bar the entry of “homosexuals” into the country, but the legislation was not enforced during the year.

The law identifying classes of persons protected from discrimination does not prohibit discrimination based on sexual orientation or gender identity. The 2012 Children Act decriminalizes sexual exploration between minors who are close in age but specifically retains language criminalizing the same activity among same-sex minors. Other laws exclude same-sex partners from their protections.

HIV and AIDS Social Stigma

Stigmatization of those with HIV persisted, especially among high-risk groups, including men who have sex with men. There were reports of discrimination against this group but no clear evidence of violence. The government’s HIV and AIDS Unit coordinates the national response to HIV/AIDS, and the government employed HIV/AIDS coordinators in all ministries as part of its multisector response.
Section 7. Worker Rights

a. Freedom of Association and the Right to Collective Bargaining

The law provides for the right of most workers, including those in state-owned enterprises, to form and join independent unions, bargain collectively, and conduct legal strikes, but with some limitations. Neither employers nor employees listed in essential services, such as hospital, firefighting, and external communications (telephone, telegraph, wireless) industries, have the right to strike, and walkouts can bring punishment of up to 36 months in prison and a fine of TT$40,000 ($6,000). These employees negotiate with the government’s chief personnel officer to resolve labor disputes. The law stipulates that only strikes over unresolved labor interest disputes may take place and that authorities may prohibit strikes at the request of one party if not called by a majority union. The minister of labor may petition the court to curtail any strike he deems harmful to national interests.

The law also provides for mandatory recognition of a trade union when it represents more than 50 percent of the workers in a specified bargaining unit. The law allows unions to participate in collective bargaining, prohibits employers from dismissing or otherwise prejudicing workers due to their union membership, and mandates reinstatement of workers illegally dismissed for union activities. The government’s Registration, Recognition, and Certification Board determines whether a given workers’ organization meets the definition of a bargaining unit and can limit union recognition by this means. The Registrar’s Office requires accounting for union funds and can audit and restrict accounts of a union on demand. The Industrial Relations Act’s definition of a worker excludes domestic workers (house cleaners, chauffeurs, and gardeners), but domestic workers have an established trade union that advocates for their rights. Separate legislation governs the employment relationship between the government and its employees, including civil servants, teachers, and members of the protective services (fire, police, and prison services). The Industrial Relations Act prohibits employees in essential services from taking industrial action. The government effectively enforced applicable laws, although there was little information on specific penalties or on whether they were sufficient to deter violations.

A union must have the support of an absolute majority of workers to obtain bargaining rights. This requirement limited the right of collective bargaining. Furthermore, collective agreement negotiations are subject to mandatory mediation and must cover a minimum of three years, making it almost impossible for such
agreements to include workers on short-term contracts. According to the National Trade Union Center, the requirement that all negotiations go through the Public Sector Negotiation Committee, rather than through the individual government agency or government-owned industry, provided a further restriction that added significant delays. Some unions claimed the government undermined the collective bargaining process by pressuring the committee to offer raises of no more than 5 percent over three years.

The government enforced labor laws with effective remedies and penalties. Resources, inspections, and remediation were adequate, although some observers called for an increased number of unannounced inspections and additional industrial court judges. A union may request that the Industrial Court enforce the laws, and the court may order employers found guilty of antiunion activities or otherwise in violation of the Industrial Relations Act to reinstate workers and pay compensation or may impose other penalties, including imprisonment. There was no information on specific penalties or on whether they were sufficient to deter violations.

Authorities generally respected freedom of association and the right to collective bargaining. Authorities did not use excessive force to end strikes or protests or otherwise retaliate against workers seeking to exercise their rights.

In August the government announced its intentions to close portions of the state-owned oil company, Petrotrin, on November 30. The shutdown could affect an estimated 2,600 permanent jobs. Following the announcement the Oilfield Workers Trade Union filed an injunction in the Industrial Court to stop Petrotrin from dismissing all its workers. President of the Industrial Court Deborah Thomas-Felix granted the injunction by the union, and it was to remain in effect until the issue of the closure of Petrotrin was fully resolved in the court or if the company successfully appealed the decision.

b. Prohibition of Forced or Compulsory Labor

The law prohibits forced and compulsory labor. Upon conviction, perpetrators of forced labor are subject to a fine of at least TT$500,000 ($74,600) and imprisonment for at least 15 years. Penalties were sufficient to deter violations. The Counter-Trafficking Unit, housed within the Ministry of National Security, is responsible for investigating potential forced labor cases and referring cases for prosecution.
In September a businesswoman, Radica Persad, was charged with trafficking a Bolivian man for the purpose of labor exploitation. As of November the matter was pending a decision from the magistrates’ court. There were no other reports of forced labor during the year.

Also see the Department of State’s *Trafficking in Persons Report* at [www.state.gov/j/tip/rls/tiprpt/](http://www.state.gov/j/tip/rls/tiprpt/).

c. Prohibition of Child Labor and Minimum Age for Employment

There were anecdotal reports of children engaged in the worst forms of child labor in the small-scale agricultural sector and domestic service. The law sets the minimum age for employment in public and private industries at 16. Children ages 14 to 16 may work in activities in which only family members are employed or that the minister of education approved as vocational or technical training. The law prohibits children younger than age 18 from working between the hours of 10 p.m. and 5 a.m. except in a family enterprise or within other limited exceptions. There is no clear minimum age for hazardous activities.

Violation of child labor laws is punishable by six months’ imprisonment or a fine of TT$2,500 ($375). In cases of child trafficking, including forced or exploitive child labor, perpetrators are subject to fines of TT$ one million ($150,000) and 20 years’ imprisonment. These penalties were sufficient to deter violations.

The government was generally effective in enforcing child labor laws, and the penalties were sufficient to deter violations, but there were anecdotal reports of children working in agriculture or as domestic workers. The Ministry of Labor and Small Enterprise Development and the Ministry of the People and Social Development are responsible for enforcing child labor laws. There were 18 labor inspectors in the Labor Inspectorate Unit in 2016--compared with 10 in 2015--trained to investigate and identify cases of child labor and to identify and report on indicators relating to possible cases of forced labor involving children.

The Minister of Labor and Small Enterprise Development may designate an inspector to gather information from parents and employers regarding the employment of a person younger than age 18. The Industrial Court may issue a finding of contempt against anyone obstructing the inspectors’ investigation.

The government did not have comprehensive mechanisms for receiving, investigating, and resolving child labor complaints.
Also see the Department of Labor’s *Findings on the Worst Forms of Child Labor* at [www.dol.gov/ilab/reports/child-labor/findings](http://www.dol.gov/ilab/reports/child-labor/findings).

d. Discrimination with Respect to Employment and Occupation

The law and regulations prohibit employment discrimination on the basis of political opinion, sexual orientation, gender identity, language, age, disability, or HIV status or other communicable disease. The government effectively enforced those laws and regulations. Discrimination in employment occurred with respect to disability, and women’s pay lagged behind men’s, especially in the private sector.

e. Acceptable Conditions of Work

The national minimum wage was greater than the official poverty income level of TT$665 ($100) per month.

The law establishes a 40-hour workweek, a daily period for lunch or rest, and premium pay for overtime. The law does not prohibit excessive or compulsory overtime. The law provides for paid leave, with the amount of leave varying according to length of service. Workers in the informal economy reported wages above the national minimum wage but reported other areas of labor laws, including the number of hours worked, were not enforced. There were an estimated 30,000 domestic workers, most of whom worked as maids and nannies, not covered by labor laws.

The law sets occupational health and safety standards, which were current and appropriate for the main industries in the country. The Ministry of Labor and Small Enterprise Development was responsible for enforcing labor laws related to minimum wage and acceptable conditions of work, while the Occupational Safety and Health Agency enforced occupational health and safety regulations, which apply to all workers in the formal economy, regardless of citizenship. Local labor laws generally protected foreign laborers brought into the country, a stipulation usually contained in their labor contract. Resources, inspections, and penalties appeared adequate to deter violations. The Occupational Safety and Health Act provides a range of fines and terms of imprisonment for violations of the law, but despite these penalties, a number of violations occurred.
The Occupational Safety and Health Act provides workers the right to remove themselves from situations that endanger health or safety without jeopardy to their employment, and authorities generally protected this right.
TAB 3
TRINIDAD AND TOBAGO 2017 HUMAN RIGHTS REPORT

EXECUTIVE SUMMARY

The Republic of Trinidad and Tobago is a parliamentary democracy governed by a prime minister and a bicameral legislature. The island of Tobago’s House of Assembly has some administrative autonomy over local matters. In elections in 2015, which observers considered generally free and fair, the opposition People’s National Movement, led by Keith Rowley, defeated the ruling People’s Partnership, led by Kamla Persad-Bissessar, and the political transition was smooth.

Civilian authorities maintained effective control over the security forces.

The most significant human rights issues included police and prison officials’ mistreatment of detainees; refoulement of refugees due to poor training of officials; official corruption; laws that criminalize same-sex sexual activity, although such laws were not enforced during the year; and continued criminalization of the status or conduct of lesbian, gay, bisexual, transgender, and intersex (LGBTI) persons.

The government took some steps to punish security force members and other officials charged with killings or other abuse, but open-ended investigations and the generally slow pace of criminal judicial proceedings created a climate of impunity.

Section 1. Respect for the Integrity of the Person, Including Freedom from:

a. Arbitrary Deprivation of Life and Other Unlawful or Politically Motivated Killings

There were no reports that the government or its agents committed arbitrary or unlawful killings. According to official figures, police shot and killed 33 persons through September 26, more than double the 16 persons police shot and killed in 2016. Officials from the Police Complaints Authority (PCA) reported receiving more cases of police killings of mentally challenged persons than in previous years; the police killed three mentally challenged persons for the year. Analysts speculated that police shootings had increased in tandem with the rise in violent crime committed by an increasingly well-armed criminal element. Police acknowledged the shooting deaths. There were occasional discrepancies between
the official reporting and the claims made by witnesses regarding who fired the first shot and whether the officers fired in self-defense.

b. Disappearance

There were no reports of disappearances by or on behalf of government authorities.

c. Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment

Although the constitution and the law prohibit such practices, there were credible reports that police officers and prison guards mistreated individuals under arrest or in detention.

Police shot and killed Paul Marchan, an outpatient of St Ann’s mental hospital, after he reportedly attacked two separate groups of police officers. Marchan’s family claimed the circumstances police attributed to causing his death were false. The file was under investigation by the PCA.

Prison and Detention Center Conditions

Conditions in some of the prison system’s nine facilities continued to be harsh.

Physical Conditions: Convicted inmates constituted approximately 37 percent of the country’s prison population, while the others were in pretrial status, according to figures from 2016, the most recent data available. Most prisons suffered from extreme overcrowding, while the maximum-security prison was not at full capacity. Observers often described the Port of Spain Prison, the remand prison, and the immigration detention center as having particularly poor conditions and severe overcrowding, with as many as nine prisoners kept in cells of 80 square feet. The Port of Spain Prison, designed to hold 250 inmates, held 610, and the remand prison, designed to hold 655 inmates, held 1,071, according to figures from 2016, the most recent data available. By contrast, the maximum-security prison held inmates in three-person cells, each with a toilet and shower.

The remand section of the Port of Spain Prison had particularly poor lighting, ventilation, and sanitation facilities.

Although conditions at the women’s prison were better than those in the Port of Spain Prison, the women’s facility occasionally became overcrowded, since it held
both women on remand and those serving prison sentences. The daily average female prison population was 130 in facilities with a maximum capacity of 158, according to figures from 2016, the most recent data available. Since there was no female youth facility, authorities placed some underage female prisoners in a segregated wing of the women’s prison and returned others to their families.

Authorities held a daily average of 10 female juveniles at the women’s prison in 2016, the most recent year for which data was available. Observers raised concerns that the prison held young girls who had not committed any offense but who were merely in state custody.

The government also operated the Immigration Detention Center to house irregular immigrants waiting to be deported. The average length of detention was one week to two months, depending on the speed with which the government secured public funding for deportation, as well as transit passports and visas. In some cases detention lasted more than four years. Observers reported that the men’s section continued to be overcrowded.

In August the minister of national security announced that the Cabinet approved 53.6 million Trinidad and Tobago dollars (TT$) ($7.9 million) to upgrade the remand section of the Golden Grove Prison, which would enable prisoners to use toilets and not pails.

Administration: Independent authorities investigated and monitored prison and detention center conditions but did not document the results in a publicly accessible manner.

Independent Monitoring: The government permitted regular and open prison visits by UN officials and independent human rights observers upon approval of the Ministry of Justice. These observers enjoyed a reasonable degree of independence.

d. Arbitrary Arrest or Detention

The constitution and the law prohibit arbitrary arrest and detention and provide for the right of any person to challenge the lawfulness of his/her arrest or detention in court, and the government generally observed these requirements. Reports of abuses by police remained under investigation at year’s end.

The Anti-Gang Act bans membership in criminal gangs and gang-related activities and permits authorities to hold suspects detained under the law without being
charged for up to 120 days, after which the suspect may apply to a judge for bail if the case has not yet reached trial. Authorities continued to arrest many individuals pursuant to the anti-gang law but subsequently released most arrestees.

Three men charged under the Anti-Gang Act during the 2011 state of emergency won their malicious prosecution lawsuits in September and received TT$220,000 ($32,000) in compensation. Many lawsuits filed by some of the approximately 450 other suspects remained pending before the courts.

Role of the Police and Security Apparatus

The Ministry of National Security oversees the police service, immigration division, and defense force, which includes the coast guard. The police service maintains internal security, while the defense force is responsible for external security but also has certain domestic security responsibilities. The coast guard is the main authority responsible for border security along the coastlines where there are no official ports of entry. The Customs and Excise Division and the Immigration Division are responsible for security at the ports. Members of the defense force often joined police officers in patrolling high-crime neighborhoods. Defense force members do not have arrest authority, apart from the coast guard, which can arrest in territorial waters and the Southern Caribbean.

The independent Police Service Commission, in consultation with the prime minister, appoints a commissioner of police to oversee the police force, although there has not been a permanent commissioner assigned since 2012. The commission also makes hiring and firing decisions in the police service, and the ministry typically has little direct influence over changes in senior positions. The Police Service Commission has the power to dismiss police officers, the commissioner of police can suspend officers, and the police service handles the prosecution of officers. Municipal police under the jurisdiction of 14 regional administrative bodies supplement the national police force. Public confidence in police was very low because of high crime rates and perceived corruption.

The PCA is a civilian oversight body that investigates complaints about the conduct of police officers, including fatal police shootings; however, it received insufficient funding and had limited investigative authority. By law the PCA is free from the direction or control of any other person in the performance of its functions. The PCA had 22 investigators, and from October 1, 2016, through September 30, the unit received 283 complaints, 211 of which were pending as of November. Through investigations by the PCA and other bodies, authorities
charged police officers with a number of offenses, including attempted murder and corruption. The Police Professional Standards Unit and the Police Complaints Division, both nonindependent bodies within the police service, also investigate complaints against police.

**Arrest Procedures and Treatment of Detainees**

A police officer may arrest a person based on a warrant issued or authorized by a magistrate, or without a warrant if the officer witnesses the commission of an offense. Detainees, as well as those summoned to appear before a magistrate, must appear in court within 48 hours. In cases of more serious offenses, the magistrate either commits the accused to prison on remand or allows the accused to post bail, pending a preliminary inquiry. Authorities granted detainees immediate access to a lawyer and to family members.

Ordinarily, bail was available for minor charges. Persons charged with murder, treason, piracy, kidnapping for ransom, and hijacking, as well as persons convicted twice of violent crimes, are ineligible for bail for a period of up to 120 days following the charge, but a judge may grant bail to such persons under exceptional circumstances. When authorities denied bail, magistrates advised the accused of their right to an attorney and, with few exceptions, allowed them access to an attorney once they were in custody and prior to interrogation.

The minister of national security may authorize preventive detention to preclude actions prejudicial to public safety, public order, or national defense, in which case the minister must state the grounds for the detention.

**Arbitrary Arrest:** False arrest, although infrequent, occurred. Victims may pursue legal redress and the right to a fair trial through an independent judiciary.

**Pretrial Detention:** Lengthy pretrial detention resulting from heavy court backlogs and inefficiencies in the judicial system continued to be a problem. Pretrial detainees or remand prisoners represented approximately 63 percent of the prison population. Most persons under indictment waited seven to 10 years for their trial dates in the High Court, although some waited much longer. Officials cited several reasons for the backlog, including an understaffed and underfunded prosecutorial office, a shortage of defense attorneys for indigent persons, and the burden of the preliminary inquiry process. Additionally, the law requires anyone charged and detained to appear in person for a hearing before a magistrate’s court every 10
days, if only to have the case postponed for an additional 10 days, resulting in further inefficiency.

e. Denial of Fair Public Trial

The constitution and the law provide for an independent judiciary, and the government generally respected judicial independence and impartiality. Although the judicial process was generally fair, it was slow due to backlogs and inefficiencies. Prosecutors and judges stated that witness and jury intimidation remained a problem.

Trial Procedures

The constitution and the law provide all defendants with the right to a fair and public trial, and an independent judiciary generally enforced this right. Magistrates try both minor and more serious offenses, but in the latter cases, the magistrate must conduct a preliminary inquiry. Defendants have the rights to be present, to be presumed innocent until proven guilty, and to appeal. Authorities inform them promptly and in detail of all charges. All defendants have the right to consult with an attorney in a timely manner and have adequate time and facilities to prepare a defense. Authorities provide an attorney at public expense to defendants facing serious criminal charges, and the law requires provision of an attorney to any person accused of murder. Although the courts may appoint attorneys for indigent persons charged with serious crimes, an indigent person may refuse to accept an assigned attorney for cause and may obtain a replacement. Defendants can confront or question adverse witnesses and present witnesses and evidence on their own behalf. Defendants may not be compelled to testify or confess guilt. The government provides free foreign language as well as sign-language interpreters as necessary in court cases.

Both civil and criminal appeals may be filed with the Court of Appeal and ultimately with the Privy Council in the United Kingdom.

Political Prisoners and Detainees

There were no reports of political prisoners or detainees.

Civil Judicial Procedures and Remedies
Individuals or organizations are free to file lawsuits against civil breaches of human rights in both the High Court and petty civil court. The High Court may review the decisions of lower courts, order parties to cease and desist from particular actions, compel parties to take specific actions, and award damages to aggrieved parties. Court cases may be appealed to the Inter-American Commission on Human Rights.

f. Arbitrary or Unlawful Interference with Privacy, Family, Home, or Correspondence

The constitution and the law prohibit such actions, and there were no reports that the government failed to respect these prohibitions.

Section 2. Respect for Civil Liberties, Including:

a. Freedom of Expression, Including for the Press

The constitution and the law provide for freedom of expression, including for the press, and the government generally respected this right. An independent press, an effective judiciary, and a functioning democratic political system combined to promote freedom of expression.

自由 of Expression: The law prohibits acts that would offend or insult another person or group on the basis of race, origin, or religion or that would incite racial or religious hatred.

Violence and Harassment: In September a Trinidad Guardian newspaper photojournalist, Kristian De Silva, was assaulted while on the job. The incident took place on the compound of a company accused of defrauding the government. One of the journalist’s attackers was a police officer, Corporal Billy Ramsundar, who was later was charged with assault and damaging a camera. The matter was before the court at year’s end.

Internet Freedom

The government did not restrict or disrupt access to the internet or censor online content, and there were no credible reports that the government monitored private online communications without appropriate legal authority. According to the International Telecommunication Union, 69 percent of citizens used the internet in 2016.
Academic Freedom and Cultural Events

There were no government restrictions on academic freedom or cultural events.

b. Freedoms of Peaceful Assembly and Association

The constitution and the law provide for the freedoms of peaceful assembly and association, and the government generally respected these rights.

c. Freedom of Religion

See the Department of State’s *International Religious Freedom Report* at [www.state.gov/religiousfreedomreport/](http://www.state.gov/religiousfreedomreport/).

d. Freedom of Movement

The constitution and various laws provide for freedom of internal movement, foreign travel, emigration, and voluntary repatriation, and the government generally respected these rights.

The government cooperated with the Office of the UN High Commissioner for Refugees (UNHCR) and other humanitarian organizations in providing protection and assistance to refugees, returning refugees, asylum seekers, stateless persons, and other persons of concern under its mandate.

Protection of Refugees

Refoulement: Due to a lack of training and awareness of refugee rights by officers at points of entry, reported cases of refoulement continued to occur at airport and ports.

Access to Asylum: The government has not passed legislation to implement its obligations under the 1951 UN Convention and its 1967 Protocol Relating to the Status of Refugees. In the absence of national refugee legislation, UNHCR registered all asylum seekers, conducted refugee status determinations on behalf of the government, and promoted durable solutions for all refugees recognized under UNHCR’s mandate.
The immigration law neither adequately considers the needs of persons in need of international protection nor provides for the granting of refugee status. The law does not provide for any exemption or nonpenalization of irregular entry or stay of asylum seekers or refugees. Persons who expressed a need for international protection could be subject to detention if they entered via irregular ways or overstayed their permitted time of entry without having presented themselves voluntarily to the authorities. Generally, the government observed the principle of nonrefoulement, but there were reported cases of persons who claimed asylum at the border or while in detention being returned to their country of origin. In principle refugees were granted full protection from refoulement and detention if presented to the Immigration Division upon applying for asylum. They lived throughout the country, worked illegally, and had access to public-health facilities and in limited circumstances, public education.

The Living Water Community (LWC), a local Roman Catholic nongovernmental organization (NGO) and UNHCR’s operational partner, was the first point of contact for persons in need of international protection. It provided orientation and counseling and notified the Ministry of National Security’s Immigration Division of the respective asylum applications. In close coordination with UNHCR, the LWC engaged in case management and provided psychosocial care and humanitarian assistance, including cash, housing assistance, and legal aid, among other services.

Pending parliament’s approval of implementing legislation, the Ministry of National Security’s Immigration Division authorized the stay of asylum seekers and refugees through the issuance of orders of supervision.

Employment: In the absence of legislation, neither refugees nor asylum seekers were permitted to work. They were sometimes subject to exploitation, including sexual exploitation.

Access to Basic Services: Refugee and asylum-seeking children had access to education, but the majority faced difficulty in enrolling in public schools due to insufficient spaces and other administrative obstacles. Refugees and asylum seekers had access to most primary health-care services. They did not have access to identity documents and were obliged to surrender their passports to the Immigration Division.

Durable Solutions: Due to the absence of national legislation that would allow for local integration, resettlement was traditionally the only durable solution for
refugees in the country, but this was a difficult, due to lack of available spaces. UNHCR, the LWC, and the International Organization for Migration continued to collaborate on the identification, submission, and transfer of refugees in need of resettlement.

The government also closely collaborated with UNHCR by facilitating the resettlement of a few refugees recognized under its mandate in smaller Caribbean islands by allowing them to stay temporarily in the country to complete the formalities required for resettlement and then directly travel to their new asylum country.

In the first half of the year, seven individuals were resettled to the United States through this mechanism of regional cooperation.

Some refugees and asylum seekers abandoned their claims and left the country due to the lengthy processing time and lack of rights, particularly the right to work.

Section 3. Freedom to Participate in the Political Process

The constitution and the law provide citizens the ability to choose their government in free and fair periodic elections held by secret ballot and based on universal and equal suffrage.

Elections and Political Participation

Recent Elections: In 2015 elections the opposition People’s National Movement, led by Keith Rowley, defeated the ruling People’s Partnership, led by Kamla Persad-Bissessar, winning 23 parliamentary seats to the Partnership’s 18 seats. Commonwealth observers considered the elections generally free and fair. During the campaign, however, observers noted the “lack of transparency and accountability regarding the financing of political parties.” Many experts raised concerns that the lack of campaign finance rules gives any incumbent party an advantage.

Following the election, former prime minister Persad-Bissessar initiated a court challenge to overturn the election results. The former prime minister challenged the results in six key swing constituencies where the results were close and where the People’s Partnership argued that a last-minute decision by the Elections and Boundaries Commission to extend voting helped the opposition. The courts found
that the commission was wrong to extend voting but that this action did not change the results of the election.

Participation of Women and Minorities: No laws limit participation of women and/or members of minorities in the political process, and they did participate.

Section 4. Corruption and Lack of Transparency in Government

The law provides criminal penalties for corruption by officials, but the government did not implement the law effectively, and officials sometimes engaged in corrupt practices. There were reports of government corruption during the year, and the 2016-17 World Economic Forum Global Competitiveness Report ranked corruption as the second-most problematic factor for doing business in the country. There were no documented instances of individuals receiving a criminal punishment for corruption.

Corruption: Corruption in the police and immigration services continued to be a problem, with senior officials acknowledging that officers participated in corrupt and illegal activities. There were allegations that some police officers had close relationships with gang leaders and that police, customs, and immigration officers often accepted bribes to facilitate drug, weapons, and human smuggling and trafficking. There is no internal affairs unit responsible for investigating incidents of professional misconduct attributed to law enforcement officials.

In February a Trinidad and Tobago Police Service officer was convicted and fined TT$40,000 ($5,925), for soliciting and accepting money from a driver to forgo charges in an accident. The officer was on suspension from duty.

There were continued allegations that some ministers used their positions for personal gain.

Financial Disclosure: The law mandates that public officials disclose their assets, income, and liabilities to the Integrity Commission, which monitors, verifies, and publishes disclosures. Officials and candidates for public office were reluctant to comply with asset disclosure rules, primarily because of the perceived invasiveness of the process. The act stipulates a process when public officials fail to disclose assets and provides criminal penalties for failure to comply. The law clearly states which assets, liabilities, and interests public officials must declare.
While the commission undertook numerous investigations, it seldom referred cases to law enforcement authorities, and prosecution of those officials who refused to comply with asset disclosure rules was very limited.

Section 5. Governmental Attitude Regarding International and Nongovernmental Investigation of Alleged Abuses of Human Rights

A number of domestic and international human rights groups generally operated without government restriction, investigating human rights cases and publishing their findings. Government officials generally were cooperative and responsive to their views.

Government Human Rights Bodies: The ombudsman investigates citizens’ complaints concerning the administrative decisions of government agencies. Where there is evidence of a breach of duty, misconduct, or criminal offense, the ombudsman may refer the matter to the appropriate authority. The ombudsman has a quasi-autonomous status within the government and publishes a comprehensive annual report. Both the public and the government had confidence in the integrity and reliability of the Office of the Ombudsman and the ombudsman’s annual report.

Section 6. Discrimination, Societal Abuses, and Trafficking in Persons

Women

Rape and Domestic Violence: Rape of men or women, including spousal rape, is illegal and punishable by up to life imprisonment, but the courts often imposed considerably shorter sentences. Police channeled resources to the Victim and Witness Support Unit in an effort to encourage reporting.

The law provides for protection orders separating perpetrators of domestic violence, including abusive spouses and common-law partners, from their victims. Courts may also fine or imprison abusive spouses, but it was rarely done.

The NGO Coalition against Domestic Violence charged that police often hesitated to enforce domestic violence laws and asserted that rape and sexual abuse against women and children remained a serious and pervasive problem.
Sexual Harassment: No laws specifically prohibit sexual harassment. Related statutes could be used to prosecute perpetrators of sexual harassment, and some trade unions incorporated anti-harassment provisions in their contracts.

Coercion in Population Control: There were no reports of coerced abortion, involuntary sterilization, or other coercive population control methods. Estimates on maternal mortality and contraceptive prevalence are available at: www.who.int/reproductivehealth/publications/monitoring/maternal-mortality-2015/en/.

Discrimination: Women generally enjoyed the same legal status and rights as men. No laws or regulations require equal pay for equal work.

Children

Birth Registration: Every person born in the country is a citizen at birth, unless the parents are foreign envoys accredited to the country. Children born outside the country can become citizens at birth if on that date one or both of the parents is, or was, a citizen. The law requires registration of every child born alive within 42 days of birth.

Child Abuse: Child abuse cases continued to increase; from October 1, 2015, to September 30, 2016, the Children’s Authority received and investigated 5,522 reports of abuse. More than one-half of all cases involved female children. Neglect and sexual abuse accounted for 27 percent and 25 percent of the cases, respectively. The law prohibits both corporal punishment of children and sentencing a child to prison. According to NGOs, however, abuse of children in their own homes or in institutional settings remained a serious problem.

Early and Forced Marriage: Child marriage is illegal. On June 9, parliament passed legislation changing the legal marriage age to 18. The president formally proclaimed the enactment of the Marriage Act on September 28.

Sexual Exploitation of Children: The law defines a child as less than 18 years of age. The age of sexual consent is 18, and the age of consent for sexual touching is 16. Sexual penetration of a child is punishable by a maximum sentence of life in prison. The law creates specific offenses such as sexual grooming of a child (gaining the trust of a child, or of a person who takes care of the child, for the purpose of sexual activity with the child) and child pornography. The law
prescribes penalties of 10 years’ to life imprisonment for subjecting a child to prostitution.


Anti-Semitism

There were fewer than 100 Jews in the country. There were no reports of anti-Semitic acts.

Trafficking in Persons

See the Department of State’s Trafficking in Persons Report at www.state.gov/j/tip/rls/tiprpt/.

Persons with Disabilities

Disability rights advocates were aware of no efforts by the government to implement the Convention on the Rights of Persons with Disabilities, which it ratified in 2015. Prior to the ratification, the law prohibited discrimination based on disability but did not mandate equal access for persons with disabilities.

Persons with disabilities faced discrimination and denial of opportunities. Such discrimination could be traced to architectural barriers, employers’ reluctance to make necessary accommodations that would enable otherwise qualified job candidates to work, an absence of support services to assist students with disabilities to study, lowered expectations of the abilities of persons with disabilities, condescending attitudes, and disrespect.

Acts of Violence, Discrimination, and Other Abuses Based on Sexual Orientation and Gender Identity

Although the law criminalizes consensual same-sex sexual activity, providing penalties of up to 25 years’ imprisonment, the government generally did not enforce such legislation, except in conjunction with more serious offenses such as rape. Immigration laws also bar the entry of “homosexuals” into the country, but the legislation was not enforced during the year.
The law identifying classes of persons protected from discrimination does not prohibit discrimination based on sexual orientation. The 2012 Children Act decriminalizes sexual exploration between minors close in age but specifically retains language criminalizing the same activity among same-sex minors. Other laws exclude same-sex partners from their protections.

**HIV and AIDS Social Stigma**

Stigmatization of those with HIV persisted, especially among high-risk groups, including men who have sex with men. There were reports of discrimination against this group but no clear evidence of violence. The government’s HIV and AIDS Unit coordinates the national response to HIV/AIDS, and the government employed HIV/AIDS coordinators in all ministries as part of its multisector response.

**Section 7. Worker Rights**

**a. Freedom of Association and the Right to Collective Bargaining**

The law, including related statutes and regulations, provides for the right of most workers, including those in state-owned enterprises, to form and join independent unions, bargain collectively, and conduct legal strikes, but with some limitations. Neither employers nor employees listed in essential services, such as hospital, fire, and external communications (telephone, telegraph, wireless), have the right to strike, and walkouts can bring punishment of up to 36 months in prison and a fine of TT$40,000 ($5,970). These employees negotiate with the government’s chief personnel officer to resolve labor disputes. The law stipulates that only strikes over unresolved labor interest disputes may take place and that authorities may prohibit strikes at the request of one party if not called by a majority union. The minister of labor may petition the court to curtail any strike he deems harmful to national interests.

The law also provides for mandatory recognition of a trade union when it represents more than 50 percent of the workers in a specified bargaining unit. The law allows unions to participate in collective bargaining, prohibits employers from dismissing or otherwise prejudicing workers due to their union membership, and mandates reinstatement of workers illegally dismissed for union activities. The government’s Registration, Recognition, and Certification Board determines whether a given workers’ organization meets the definition of a bargaining unit.
and can limit union recognition by this means. The Registrar’s Office requires accounting for union funds and can audit and restrict accounts of a union on demand. The Industrial Relations Act definition of a worker excludes domestic workers (house cleaners, chauffeurs, and gardeners), but domestic workers have an established trade union that advocates for their rights. Separate legislation governs the employment relationship between the government and its employees, including civil servants, teachers, and members of the protective services (fire, police, and prison services). The Industrial Relations Act prohibits employees in essential services from taking industrial action. The government effectively enforced applicable laws.

A union must have the support of an absolute majority of workers to obtain bargaining rights. This requirement limited the right of collective bargaining. Furthermore, collective agreement negotiations are subject to mandatory mediation and must cover a minimum of three years, making it almost impossible for such agreements to include workers on short-term contracts. According to the National Trade Union Center, the requirement that all negotiations go through the Public Sector Negotiation Committee rather than through the individual government agency or government-owned industry, provided an additional onerous restriction that added significant delays. Some unions claimed the government undermined the collective bargaining process by pressuring the committee to offer raises of no more than 5 percent over three years.

The government enforced labor laws with effective remedies and penalties. Resources, inspections, and remediation were adequate, although some observers called for an increased number of unannounced inspections and additional industrial court judges. A union may request that the Industrial Court enforce the laws, and the court may order employers found guilty of antiunion activities or otherwise in violation of the Industrial Relations Act to reinstate workers and pay compensation or may impose other penalties, including imprisonment. There was no information on specific penalties or on whether they were sufficient to deter violations.

Authorities generally respected freedom of association and the right to collective bargaining. Authorities did not use excessive force to end strikes or protests or otherwise retaliate against workers seeking to exercise their rights.

In January and February, the Industrial Court ordered 11 companies to pay approximately TT$11,000,000 million ($1.6 million) to 26 workers who were wrongfully dismissed. The largest individual judgement was against the natural
gas company BG Trinidad and Tobago Limited in which the employee was awarded TT$ three million ($500,000).

b. Prohibition of Forced or Compulsory Labor

The law prohibits forced and compulsory labor. Upon conviction, perpetrators of forced labor are subject to a fine of at least TT$500,000 ($74,600) and imprisonment for at least 15 years. Penalties were sufficient to deter violations. The Counter-Trafficking Unit, housed within the Ministry of National Security, is charged with investigating potential forced labor cases and with referring cases for prosecution.

There were no confirmed cases of forced labor, or specific cases reported by NGOs or media. There were no prosecutions or convictions through October. One of the cases brought to the court in 2015 concluded in the magistrate court, with a decision pending as to whether it would progress to the High Court.

Also see the Department of State’s Trafficking in Persons Report at www.state.gov/j/tip/rls/tiprpt/.

c. Prohibition of Child Labor and Minimum Age for Employment

The law sets the minimum age for employment in public and private industries at 16. Children ages 14 to 16 may work in activities in which only family members are employed or that the minister of education approved as vocational or technical training. The law prohibits children under 18 from working between the hours of 10 p.m. and 5 a.m. except in a family enterprise or within other limited exceptions. There is no clear minimum age for hazardous activities.

Violation of child labor laws is punishable by six months’ imprisonment or a fine of TT$2,500 ($373). In cases of child trafficking, including forced or exploitive child labor, perpetrators are subject to fines of TT$ one million ($150,000) and 20 years’ imprisonment. These penalties were sufficient to deter violations.

The government was generally effective in enforcing child labor laws, and the penalties were sufficient to deter violations, but there were anecdotal reports of children working in agriculture or as domestic workers. The Ministry of Labor and Small Enterprise Development and the Ministry of the People and Social Development are responsible for enforcing child labor laws. There were 18 labor inspectors in the Labor Inspectorate Unit in 2016, compared with 10 in 2015,
trained to investigate and identify cases of child labor and also to identify and report on indicators relating to possible cases of forced labor involving children.

The minister may designate an inspector to gather information from parents and employers regarding the employment of a person under 18. The Industrial Court may issue a finding of contempt against anyone obstructing the inspectors’ investigation.

The government did not have comprehensive mechanisms for receiving, investigating, and resolving child labor complaints. There were anecdotal reports of children engaged in the worst forms of child labor in the small-scale agricultural sector and domestic service.

Also see the Department of Labor’s *Findings on the Worst Forms of Child Labor* at [www.dol.gov/ilab/reports/child-labor/findings/](http://www.dol.gov/ilab/reports/child-labor/findings/).

d. Discrimination with Respect to Employment and Occupation

The law and regulations do not prohibit employment discrimination on the basis of political opinion, sexual orientation, gender identity, language, age, disability, or HIV status or other communicable disease. The government effectively enforced those laws and regulations. Discrimination in employment occurred with respect to disability, and women’s pay lagged behind men’s outside the public sector.

e. Acceptable Conditions of Work

The national minimum wage was greater than the official poverty income level of TT$665 ($99) per month.

The law establishes a 40-hour workweek, a daily period for lunch or rest, and premium pay for overtime. The law does not prohibit excessive or compulsory overtime. The law provides for paid leave, with the amount of leave varying according to length of service. Workers in the informal economy reported wages above the national minimum wage but reported other areas of labor laws including the number of hours worked were not enforced. There were an estimated 30,000 domestic workers not covered by labor laws.

The law sets occupational health and safety standards, which were current and appropriate for the main industries in the country. The Ministry of Labor and Small Enterprise Development was responsible for enforcing labor laws related to
minimum wage and acceptable conditions of work, while the Occupational Safety and Health Agency enforced occupational health and safety regulations, which apply to all workers in the formal economy, regardless of citizenship. Local labor laws generally protected foreign laborers brought into the country, a stipulation usually contained in their labor contract. Resources, inspections, and penalties appeared adequate to deter violations. The Occupational Safety and Health Act provides a range of fines and terms of imprisonment for violations of the law, but despite these penalties a number of violations occurred.

The Occupational Safety and Health Act provides workers the right to remove themselves from situations that endanger health or safety without jeopardy to their employment, and authorities generally protected this right.
TAB 4
Trinidad and Tobago 2016 UPR: Joint Submission from the United Nations Country Team for Trinidad and Tobago

I. Background and framework

A. Scope of international obligations
The United Nations Country Team for Trinidad and Tobago (“UNCT”) notes that during the 2011 Universal Periodic Review of Trinidad and Tobago (“2011 UPR”) the country received numerous recommendations to ratify or accede to various international human rights treaties. Trinidad and Tobago (“Trinidad” or “T&T”) has ratified/acceded to many of the core international human rights treaties including, most recently, the Convention on the Rights of Persons with Disabilities. However, Trinidad has made reservations with respect to certain provisions of these instruments and has not ratified any of the Optional Protocols.

With regard to regional human rights mechanisms, Trinidad does not recognize the jurisdiction of the Inter-American Court of Human Rights to hear individual petitions.

Recommendations to the Government:
• Consistent with the recommendations issued in the 2011 UPR, the UNCT encourages Trinidad to accede to all core UN human rights instruments as soon as possible.

B. Constitutional and legislative framework
• Trinidad is a parliamentary democracy modeled on the British Westminster system and observes the principle of the separation of powers. The Government consists of the Executive, the Legislature and the Judiciary. The Constitution recognizes and guarantees the protection of the fundamental rights and freedoms of T&T citizens consistent with the principles of the ICCPR. Trinidad has a Republican Constitution, which establishes the Office of the President as Head of State. The Presidency is an independent Office, which plays no part in party politics. Whereas the President is the Head of State, the Prime Minister is the Head of Government.
• In May 2015 Trinidad proclaimed The Children Act 2012, the Children’s Authority Act 2000 and the Children’s Community Residences, Foster Care and Nurseries Act.
• In January 2013, Trinidad proclaimed the Trafficking in Persons Act 2011 which criminalizes human trafficking and creates very specific protection for women and children who are victims.
• The Legal Aid and Advice (Amendment) Act, 2012, provides legal aid services to indigent persons and to those who cannot afford exorbitant private legal fees/representation.
• The Administration of Justice (Deoxyribonucleic Acid) Act 2012, allows for the mandatory sampling of certain categories of accused persons and offenders and the keeping of DNA record, was partially proclaimed in August of 2012.
The Constitutional Amendment Bill 2014 and 2015 have lapsed.

C. Institutional and human rights infrastructure and policy measures

• During its 2011 UPR, Trinidad “noted” recommendations to establish an NHRI in compliance with the Paris Principles, as well as for the Office of the Ombudsman to be accredited under the same principles. While Trinidad does have an Ombudsman, it is mandated to investigate cases of administrative injustice only and it is not an ICC accredited institution.

• The International Law and Human Rights Unit within the Ministry of the Attorney General has a mandate to fulfill the country’s human rights reporting obligations. It also has the responsibility of liaising with international organizations in relation to human rights matters.

• A “Human Rights Desk”, a non-governmental entity, was established in 2006 as a regional project of the Caribbean Regional Network of People Living with HIV/AIDS. This Desk no longer exists.

**Recommendations to the Government:**

• Promote accountability systems for results as well as allocation of resources among institutions involved in the implementation of human rights related plans and policies.

• Re-establish Human Rights Desk with strengthened capacity and official links to the Office of the Ombudsman.

II. Cooperation with human rights mechanisms

A. Cooperation with treaty bodies

• With the support of UN Women, in 2015 Trinidad submitted its 4th to 7th Periodic State Report to the Committee on the Elimination of Discrimination against Women.

• UNICEF continues to monitor the preparation of the overdue report to the Committee on the Rights of the Child and has been advocating for its completion and submission.

C. Cooperation with the Office of the High Commissioner for Human Rights

• The UNCT notes that the Government of Trinidad and Tobago (“GOVTT”) demonstrated its commitment to the UPR process through its submission of a midterm report to the Human Rights Council in 2015.

• To date, the GOVTT has had limited engagement with the OHCHR with regard to seeking technical assistance in meeting its international human rights obligations or facilitating human rights training and education.

III. Implementation of international human rights obligations, taking into account applicable international humanitarian law

A. Equality and non-discrimination
Gender equality and women’s rights

- The Constitution prohibits discrimination on the basis of sex, and speaks specifically to the right of the individual to equal treatment under and protection by the law, as well as from any public authority. However, the Constitution does not have a section that expands on equality and specially gender equality under the law. The **Equality Opportunity Act, 2000**, prohibits discrimination on the basis of status, which includes sex and marital status as one of among seven bases upon which discrimination is prohibited. However the act explicitly excludes sexual preference and orientation and does not explicitly reference gender equality.

- Before September of 2015, the **Ministry of Gender, Youth, and Child Development** had primary responsibility for protecting women’s rights and advancement, and it sponsored income generation workshops for unemployed single mothers and nontraditional skills training for women. After the 2015 general election, the GOVRTT chose to split and decommission the Ministry of Gender, Youth & Child Development. The Gender Unit was merged into a new **Ministry of Social Development and Family Services**.

- The draft **National Gender Policy**, which has been pending for almost 15 years, is yet to be implemented. Cabinet twice deferred action on an omnibus national gender policy, which had been the subject of considerable consultation and resources, and intended to achieve domestication of CEDAW. Issues primarily related to sexual orientation and abortion have prevented the GOVRTT from passing the gender policy.

- A draft version of the **2012 National Policy on Gender and Development** has not yet been adopted.

- There is systematic lack of sex disaggregated data in the English-speaking Caribbean, including Trinidad. However, efforts have been made on the part of GOVRTT, academia and civil-society to provide updated gender analyses.

- Domestic violence is an endemic problem in Trinidad. Episodes of gender-based violence ("GBV") are published daily in the local newspapers. Sexual and gender-based violence, in particular domestic violence and incest, is an ongoing challenge. Figures provided by the Crime and Problem Analysis (CAPA) Unit of Trinidad and Tobago Police Service (TTPS) indicated that from 2004 to 2014, the police received 15,312 reports of domestic violence. Between 1991 and 2014, there were 125,166 applications for protection filed in magistrates’ courts. This represented a rate of just over 10,000 applications a year.

- In addition, reported instances of crimes related to sexual assault and domestic violence increased from 551 in 2013 to 825 in 2014.

- Although significant gains have been made in Trinidad regarding legislative reform relating to violence against women, legal gaps and challenges remain regarding operationalization of the laws and barriers to women’s ability to access justice. For example, the domestic violence legislation emphasizes protection and not punishment. The **Domestic Violence Act, 1999** does not give the police powers of arrest without warrant upon receipt of a complaint of a domestic violence offence.
Also, the process of obtaining a protection order continues to be difficult for many women. Civil society actors working in the area of gender-based violence also report that the legislative framework addressing domestic and sexual violence is not adequately implemented or enforced.

- The GOVRTT continues to implement a number of efforts in favour of prevention, punishment and eradication of all forms of violence against women. The GOVRTT and civil society have supported increased sensitization on the Domestic Violence Act, 1999 which provides protection orders for victims, as well as penalties, fines and possible imprisonment for breaches of the Protection Order. Revision of this act is currently ongoing under the Ministry of Social Planning and Family Services. The GOVRTT also financed the State Accountability Framework Initiative which, with collaboration with UN Women, UNFPA and other UN agencies, involves the mapping of programmes/policies and the development of a strategic framework to address sexual and gender based violence in Trinidad.

- Programmes and policies to support ending violence against women have been implemented across T&T. A multi-sectoral Committee on Domestic Violence produced a Procedural Manual for Police Officers and a Report including comprehensive recommendations for addressing domestic violence. The Procedures Manual was approved by Cabinet. Also, the National Domestic Violence Unit of the Gender Affairs Division of the former Ministry of Gender, Youth and Child Development, operates a Hotline 24 hours, seven days a week and receives approximately 30,000 calls annually. NGOs supported by the GOVRTT provide eleven shelters for female victims of domestic violence and a rape crisis centre. Counselling services, support groups and resource facilities are also available within communities to assist in the prevention and treatment of domestic violence.

- In 2013 the Tobago House of Assembly partnered with the Global Centre for Behavioural Health (GCBH) USA, in hosting the 1st Caribbean Conference on Domestic Violence and Gender Equality: Breaking the Silence. The conference brought together technical experts and stakeholders from several countries, including Trinidad, and facilitated critical conversations about strengthening prevention strategies and responses to GBV.

- Also in Tobago, the Division of Health and Social Services implements prevention strategy workshops to empower women. This incorporates better services for women surviving violence, such as hotlines, shelters, legal advice, access to justice, counselling, police protection, and health services. The Division pursues more accurate reporting rates and better data collection.

- There are no laws that specifically prohibit sexual harassment. Although related statutes could be used to prosecute perpetrators of sexual harassment, and some trade unions incorporated anti-harassment provisions in their contracts, both the GOVRTT and NGOs suspect that many incidents of sexual harassment go unreported.

- Women continue to experience inequality in the labour market, with higher unemployment levels than men despite educational advancements, suffer substantial pay inequity for equivalently qualified men and women in the same job and industry categories of work and are segmented in the lowest paying jobs.
• In T&T the unemployment rate was 3.7% in the first quarter of 2013, which is the lowest unemployment rate ever recorded in T&T. During this time, although women still had a higher rate of unemployment than men, the unemployment levels for women decreased at a slightly faster rate. While this was positive, many of the jobs women gained were temporary, so when the economy began to contract in 2014 -2015 the Central Bank of Trinidad and Tobago noted that the majority of persons leaving the labour force were females (9,100 persons) who were previously employed under temporary arrangements.

• After the last election cycle, women represent 29.16% of elected parliamentarians. There are 9 women out of the current 23 members.

Recommendations:

• Complete the review of the draft National Gender Policy to submit to Cabinet for approval as soon as possible.

• Either adopt the 2012 version of the National Policy and Gender Development or revisit via a consultative process the 2009 document which is less progressive on human rights issues (particularly LGBT and abortion).

• Strengthen all plans and policies to eradicate violence against women, taking into account factors that increase inequality and discrimination.

• Engage in public education initiatives to improve critical understanding of gender based violence, domestic violence, sexual harassment, rape, and child sexual abuse, including the legal rights and implications, and access to redress and support services.

• Ensure adequate and efficient coordination mechanisms are in place to ensure effective multi-sectoral response to sexual and domestic violence.

• Establish the systematic collection of sex disaggregated data, as per the UN agreement on the Global Set of Minimum Gender Indicators, to identify, measure and track gender equality in Trinidad and Tobago.

• Reform the Sexual Offences Act to allow for the introduction of a National Sex Offenders’ Registry.

• Implement legislation and policies to address sexual harassment in the workplace and in public life.

• Promote more gender responsive programmes to engage men and boys in ending violence against women and girls initiatives using a gender justice approach.

• Amend the Domestic Violence Act to ensure punishment as well as protection.

• Introduce legislation to provide incentives to political parties that implement temporary special measures to promote gender parity in the list of candidates for parliamentary and local government elections and senatorial appointments.

The rights of children

• The GOVRTT has taken steps to improve the state of child protection. In May 2015, it proclaimed the Children’s Authority Act; Children’s Community Residences, Foster Care and
Nurseries Act, 2000; Children Act, 2012; and Adoption of Children Act, 2000. While this legislation represents a strong step forward, more needs to be done to give full effect to this package of children’s legislation.

- The Children’s Authority, mandated to implement the Children's Authority Act, has a core complement of staff, is operational and has the power to intervene in the best interests of children that are in need of care and protection. An issue of prevailing concern is that under the 2000 Sexual Offences Act, the legislation requires teachers, health care providers and parents to report knowledge of sexual activity amongst minors (under the age of 18). This may discourage young people from accessing sexual and reproductive health services. Health care providers are also reluctant to provide services as they know they will have an obligation to report.

- In Trinidad marriage of girls as young as 12 and boys at 14 is permitted. The Children Act provides exemptions from criminalization for sexual offences against minors by the spouses of minors. The new legislation decriminalizes non-coercive sexuality between minors close in age in non-familial or custodial relationships. However, it explicitly withheld this decriminalization provision when children are of the same sex. This makes non-coercive sexual activity between minors of the same sex subject to life imprisonment, regardless of their ages.

- There are more than 2,500 teenage pregnancies reported annually in Trinidad. According to the former Minister of Health, most of the teenagers become pregnant from fathers who are between the ages of 25-40 and some mothers are below the ages of 12.

- The GOVRTT is currently developing a comprehensive National Child Policy which will provide long-term guidance and set the framework to provide adequate legislation, interventions and infrastructure that affect the safety, wellbeing and development of all children.

- The GOVRTT, with the support of numerous stakeholders, launched the Break the Silence campaign which is a project that seeks to break the silence on the taboo subject of child sexual abuse.

- Under the newly proclaimed Children Act, 2012, corporal punishment is lawful in the home but is no longer lawful in schools, state institutions or as a criminal sentence. It is however still widely practiced in schools, without any significant consequence. Enforcement of this is therefore a challenge.

- The age of criminal responsibility in Trinidad is effectively seven years old. Although the GOVRTT has recognized that this is a specific human rights issue which must be addressed, the Children Act fails to repeal legislation.

- Some juvenile offenders are separated from adult inmates and are placed in separate institutions. Options include: The St. Jude’s Home for Girls, the St. Michael's Home for Boys as well as the Youth Training Centre for boys. However, both civil society actors and UNICEF note that there have been cases where juveniles, especially juvenile females, were sent to the adult prisons primarily due to capacity constraints.

- UNDP is currently working with the Children’s Authority to establish facilities for girls and boys who come into conflict with the law and require institutionalization.
• There are currently inadequate monitoring procedures of the treatment of children placed in institutions under the authority of the state such as juvenile detention centers, orphanages, foster care and adoption living arrangements. The new Children’s Authority is charged with establishing standards for all child institutions and monitoring their compliance.

• The T&T judiciary, in partnership with UNDP and the National Centre for State Courts, launched the **Juvenile Court Project**. The objective of the project is to strengthen the capacity of the judiciary to deal with juvenile justice matters using a rehabilitative and less retributive approach.

• The GOVRTT, along with UNDP, is currently drafting a **Family and Children Division Bill** to address the legislative gaps in the justice system on the treatment of children.

**Recommendations:**

• Ratify the **Optional Protocols to the Convention on the Rights of the Child**.

• Abolish child marriage and implement comprehensive sexuality education in schools. Access to sexual and reproductive health education and services should also be provided for young people to avoid early pregnancy.

• Reconcile the **Marriage Act, Muslim Marriage and Divorce Act, Hindu Marriage Act, and the Orisa Marriage Act**, so that minimum age of marriage for both girls and boys is in line with definition of the age of the child as outlined in the CRC.

• Establish protocols for the periodic review of the treatment and the circumstances of children who have been placed by the authorities, for the purpose of care, protection or treatment of their health, in state and/or private facilities.

• Introduce in schools comprehensive sex education that is age appropriate, gender responsive and life-skills based, with the view to addressing teen pregnancy and positive relationships between young women and men of school age.

• Establish a facility to house young female offenders.

**Discrimination, violence and stigma against persons living with HIV/AIDS, lesbian, gay, bisexual, transgender and intersex persons**

• The **Sexual Offences Act** criminalizes sexual relations between consenting individuals of the same sex. The law barring homosexuals from immigrating to Trinidad is also still in effect, although not enforced.

• UNFPA supports the training and sensitization of health care providers who work with the most at risk populations, including the LGBT community and sex workers, as a means of building capacity to meet their needs, and to reduce stigma and discrimination in the health care environment so as to facilitate universal access to services.

• The **Equal Opportunity Act, 2000** does not explicitly ban discrimination based on sexual orientation, gender or HIV status. The lack of legal protection supports an environment of stigma and discrimination against persons perceived to be HIV positive and towards members of the LGBT community limiting uptake of essential public health services.
• The GOVTT has not indicated any intention to remove laws that criminalize same sex relationships. However, some government representatives are taking a human rights approach to ensuring that all citizens have access to public services regardless of their sexual orientation.

• Civil society & stakeholders have reported that the LGBT community is sometimes subject to forced marriages and corrective rapes.

B. Right to life, liberty and security of the person

• Although 2014 police crime statistics show a decrease in overall serious criminal activity, violent crime remains a major concern. The majority of violent crimes (homicides, kidnappings, assaults, sexual assaults) are attributed to the influence of gangs, illegal narcotics, and firearms (approximately 100 criminal gangs have been identified in T&T). Not all crimes are reported. There are also instances in where crimes are reported, but not documented. Approximately 23% of reported crimes result in an arrest.

• The US Department’s 2015 Trafficking in Persons (TIP) Report, T&T is a destination, transit, and possible source country for adults and children subjected to sex trafficking and forced labor. T&T received a Tier 2 ranking indicating that T&T has not fully complied “with the minimum standards for the elimination of trafficking.”

• In January 2013, Trinidad proclaimed the Trafficking in Persons Act, 2011 which is intended to improve prosecution of trafficking offenders and the protections for victims of forced labor and sex trafficking. Human trafficking in T&T is particularly relevant to the sex industry where primarily Latin American women are being brought into the country to work in the sex industry. In September & October 2015, police conducted two raids on illegal brothels which uncovered two human trafficking rings. The victims, including 22 women from the Dominican Republic, where rescued and taken into government care while investigations continue.

• The Counter Trafficking Unit in the Ministry of National Security has partnered with IOM to provide training/sensitizations on human trafficking for a number of government ministries and agencies as well as engaging in public awareness activities such as community outreach initiatives as well as public service announcements via radio, television and YouTube.

• With regard to the death penalty, in his opening address for the 2015/2016 law term, the Chief Justice stated that there is currently an unofficial moratorium on the death penalty in Trinidad. He indicated that, although the ultimate fate of the death penalty should be left to the legislature and the people of the T&T, practical difficulties relating to process and capacity make it unlikely that the sentence will be implemented again.

• The death penalty continues to be a mandatory sentence for murder and death sentences. By the end of 2012 there were 36 prisoners under the sentence of death and, according to the opening speech of Chief Justice this year, over the past few years the number of persons awaiting trial for murder has risen to 514. No executions have taken place since 1999. The 2013 report of the Constitution Reform Commission recommended the retention of the death penalty.

Recommendations:
• Increase capacity building efforts in human trafficking by extending training and sensitization programs to other law enforcement agencies outside the TTPS.

• Introduce human trafficking modules into law enforcement training academy.

C. Administration of justice, including impunity, and the rule of law

• One of the more serious human rights challenges were police killings during apprehension or in custody and poor treatment of suspects, detainees, and prisoners. Other human rights problems involved inmate illnesses and injuries due to poor prison conditions and high-profile cases of alleged bribery.

• The U.S. State Department identifies killings by police during apprehension and the mistreatment of suspects, detainees, and prisoners as major human rights concerns for T&T. In 2014, 42 persons were shot and killed by police. There have been consistent and significant discrepancies between the official reporting of shooting incidents and the claims made by community witnesses.

• In August 2014 the army’s Defence Force Reserves were called to assist with street patrolling until January 2015, despite serious concerns that the force was not trained to carry out these duties.

• In May 2014, prosecutor and senior attorney Dana Seetahal was murdered by a group of men who were arrested in September 2015. It is suspected that her murder was an assassination given the nature of her high-profile cases which included the kidnapping and murder of a businesswoman.

• Law enforcement and civil society report that some police and immigration officers facilitated trafficking in the country, with some law enforcement officials directly exploiting victims. Anti-trafficking activists reported some police officers had ties to sex trade establishments, which is likely to inhibit law enforcement’s willingness to investigate allegations of trafficking in the sex trade.

• While the GOVRTT has previously demonstrated a willingness to investigate and sanction public security officials who were involved in human rights violations, allegations of the abuse of sex workers and undocumented migrants suggest impunity and indicates that access to justice for these vulnerable groups is questionable.

• A Victims and Witness Support Unit was established within the TTPS as part of reforms aimed at bridging the gap between the police and the victims and witness of crimes. The unit is also intended to address issues of sexual and gender based violence. The UNCT commends the work of the unit and notes that it has resulted in increased reporting in the communities where interventions are conducted.

• Severe case backlog is one of the institutional deficiencies of the T&T judicial system. According to the US State Department Human Rights report, pre-trial detainees or remand prisoners represented approximately 50% of the prison population. Most persons under indictment waited between six to ten years for their trial dates in the High Court. Officials cited several reasons for the backlog, including an understaffed and underfunded prosecutorial office, a shortage of defence attorneys for indigent persons, and the burden of the preliminary inquiry process. However, the Chief Justice recently announced that the new Criminal Case Management Rules, which will go into effect in 2016, would facilitate early disposal of preliminary issues, impose stricter timelines and also impose a positive obligation on all parties to assist in progressing cases in accordance with the overriding objective of dealing with cases justly and expeditiously.
Recommendations to Government:

- Prioritize investigation and sanctions of public security officials in cases of human rights violations.
- Conduct sensitisation sessions with all law enforcement officers on human rights issues in Trinidad.

D. Right to work and to just and favourable conditions of work

- The Equal Opportunity Act, 2000, contains no specific provisions regarding equal remuneration for men and women for work of equal value. In 2007 women earned 80.3% of men’s monthly income (average and median), and that the gender wage gap had been highest in the occupational group of service and sales workers (47%) and legislators, senior officials and managers (39.4%).
- There are discriminatory provisions in several government regulations, such as those requiring that married female officers might have their employment terminated if family obligations affected their efficient performance of duties.
- The Equal Opportunity Commission, established under the Equal Opportunity Act, 2000 has suggested amending the legislation. The GOVRTT has indicated that the Equal Opportunity (Amendment) (No. 2) Bill, 2011, has been drafted and is being reviewed by the Law Review Commission.
- With regard to the worst forms of child labour, the GOVRTT has indicated that it is consulting with the social partners on the list of occupations deemed hazardous to children under the age of 18. However, these consultations have been ongoing since 2004 and the list is not yet updated.
- The current Industrial Relations Act, 1972 (“IRA”) contains a number of antiquated provisions relating to collective bargaining, in particular those related to the right to strike and take industrial action and negotiation by minority unions in the absence of majority unions. The GOVRTT indicates that an advisory committee was appointed in February 2012 to review the IRA and to propose specific amendments to this legislation.
- Both the current Shipping Act, 1987 and the Trade Disputes and Protection of Property Act allow for imprisonment as a sanction if an employee engages in “breaches of labour discipline” or “wilful and maliciously breaks a contract of service.”

Recommendations:

- Ratify ILO Convention 189 to promote domestic workers’ rights.
- Take steps to give full legislative expression to the principle of equal remuneration for men and women for work of equal value.
- Amend or repeal the Industrial Relations Act.

H. Right to social security and to an adequate standard of living

- According to the Household and Budgetary Survey for 2011, the poverty level stands at 21.8%.
- The Ministry of Social Development and Family Services is mandated with responsibility of addressing the social challenges of poverty, social inequality and social exclusion. The Ministry
conducted the **Survey of Living Conditions** in 2014/2015 to assess the situation of poverty in Trinidad which would contribute to future programme and policy planning for poverty eradication. The government is working to combat poverty through the provision of various social programmes including, but not limited to, the **Poverty Reduction Programme**, the **Public Assistance Grant**, **Disability Assistance Grant**, **General Assistance Grant** and the **Targeted Conditional Cash Transfer Programme**.

- Many women who have little access to economic resources perceive the **Public Assistance Program** as offering an alternative pathway for child support and some measure of economic stability.
- The GOVRTT conducted a **Population Situation Analysis** which identifies those most vulnerable in society, including the poor. Based on this analysis, Cabinet approved a **Population Policy** and a **Population Council** has been proposed. The Council would be responsible for monitoring population data to address inequality in the society.

**Recommendations:**

- Introduce a social safety net floor which allows for the specific needs of families with children who are most vulnerable to benefit from social security.

**I. Right to health**

- According PAHO, between the years 2010 to 2013, maternal mortality rates rose 40% from 46 per 100,000 births in 2010 to 64 in 2013.
- In July 2015, according to several media reports, the former Health Minister announced that one of the explicit goals of introduction of a new national health card was to make it harder for migrants to access HIV care and services. In September 2015, following a change in government, the new Health Minister promised to review this policy and indicated that anyone can go to any health care facility and receive treatment.
- Although abortion is legal in T&T to preserve the health and life of the woman, many women are uninformed and unsure of their rights. Civil society organizations indicate that there is a vital need for appropriate public awareness campaigns as a way to combat belief that abortions are absolutely illegal in T&T (this misconception often leads to alternative solutions to fulfil abortions which put pregnant women’s lives at risk).
- With the support of the UNFPA and PAHO, the GOVRTT has drafted a **Sexual and Reproductive Health Policy** and has committed to the establishment of a **Women’s Health Unit** in the Ministry.
- The new Minister of Education, who took office in September 2015, has stated that efforts to provide sexual education and health services for school-age children must be coupled with “religion education to form a part of the curriculum in all our schools. Sex education is something we need to discuss and we feel it is the responsibility of the parent to educate his or her child with respect to their sexual well-being.”
• The Ministry of Health has not placed essential medicines as a priority on the national agenda. As such, there are consistently stock-outs of penicillin, contraceptives, HIV testing kits and other items.

• Coordination around HIV/AIDS has declined and Trinidad is the only Caribbean country to observe an increase in persons with HIV/AIDS over the last four years. UNAIDS estimated that 14,000 persons in Trinidad were living with HIV in 2013.

Recommendations to Government:

• Revise or implement policies and protocols governing provision of reproductive health services to young persons, including young women, to ensure provision of contraceptive and other sexual and productive health services. Policies and protocols should be accompanied by educational programmes for health care providers.

• Conduct a complete study regarding ascertaining the incidences and causes of abortion related deaths in T&T.

• Reform the Offences Against the Person Act and implement common law which provides for safe and legal abortion services for women and girls.

• Continue to strengthen current efforts to increase the accessibility and quality of health services and education for all its citizens.

• Upgrade quality of care in child and maternal health services to diminish infant and child mortality and neonatal mortality.

• Introduce medical and public health interventions that are timely and appropriate for mothers who are pregnant, especially those who have expressed a need to manage NCDs.

• Review of the use of the PAHO Strategic Fund to obtain medications at a lower price that currently procured through national procurement mechanisms.

I. Persons with Disabilities

• UNDP reports that, according to the 2011 Trinidad and Tobago Population and Housing Census, there are approximately 52,244 persons living with a disability (PWDs), which is equivalent to 4% of the total population of 1,328,019. Of this total, 96.5% resides in Trinidad & Tobago and 3.5% in Tobago. With regard to children with disabilities (CWDs), the data indicates that 3,302 persons between the ages of 0 — 17 have some type of disability.

• PWDs in T&T have not had, and continue to be deprived of, the opportunity to participate fully in society due to physical and social barriers. Persons with disabilities in Trinidad face discrimination and denial of opportunities, such as: architectural barriers; employers’ reluctance to make necessary accommodations that would enable otherwise qualified persons living with disabilities to work; an absence of support services to assist children with disabilities; lowered expectations of the abilities of persons with disabilities; and condescending attitudes and disrespect towards persons with disabilities.
• With the new Government in place, the Disability Unit, under the Ministry of Social Development and Family Services, is working on several projects including new legislation, a National Register and disability sensitization workshops.

• Although the law prohibits discrimination on the basis of disability, it does not mandate equal access for persons with disabilities to the political process, employment, education, transportation, housing, health care, or other citizen services.

• The GOVRTT is currently reviewing the yet been implemented 2006 National Policy on Persons with Disabilities. This policy includes initiatives to strengthen services for children with disabilities, support their families, train professionals in the field and encourage the inclusion of children with disabilities into regular educational system and their integration into society.

• The UNCT notes that Trinidad’s Immigration Act, 1969 prohibits entry to “persons who are idiots, imbeciles, feeble-minded persons, persons suffering from dementia and insane persons, and who are likely to be a charge on public funds” and “persons who are dumb, blind or otherwise physically defective, or physically handicapped, which might endanger their ability to earn a livelihood, or render them likely to become charges on public funds”. The Act also prohibits entry to persons afflicted with any infectious or dangerous infectious disease.

**Recommendations to Government:**

• Review and revise domestic legislation and policies to reflect the provisions and principles of the Convention on the Rights of Persons with Disabilities.

• Finalize and fully implement the updated National Policy on Person with Disabilities.

• Develop a national register of persons with disabilities.

• Increase public awareness initiatives regarding the rights of persons living with disabilities and the CRPD.

• Conduct sensitization sessions to raise public awareness about the challenges faced by PWDs.

**N. Migrants, refugees and asylum seekers**

• There remains a clear lack of oversight with regard to the protection of migrant rights: Lengthy administrative detention stays, costly deportation, accusations of discrimination against certain foreign nationalities, unfavourable detention center conditions, allegations of ill-treatment and abuse against detainees, migrants detainees held in prisons, including asylum seekers and refugees, lack of access to places of detention by NGOs and a substantial amount of undocumented migrants.

**Recommendations:**

• Conduct a migration profile

• Develop a comprehensive migration policy

• Reduce detention periods for migrants

• Build capacity in migrant rights and human rights
TAB 5
UNAIDS Global AIDS Response Progress Reporting 2014
Trinidad and Tobago Country Progress Report

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I. Status at a Glance

The report writing and review process consisted of a collaborative multisectoral effort among government ministries, civil society, and UNAIDS, coordinated by the Interim HIV Agency. Government ministries included in this process represented Health, Labour, Education, National Security, People and Social Development, and the Attorney General. Civil society represented groups that work with general and key populations as identified in the national strategic plan 2013-2018. A civil society consultation was held on March 19, 2014 to facilitate the completion of the national commitment policy instrument component of the GARPR and was hosted by UNAIDS Trinidad and Tobago.

II. Overview of the AIDS Epidemic

![Chart: Trends in HIV and AIDS in Trinidad and Tobago, 1983-2012](image)

Data Source: National Surveillance Unit, Ministry of Health, HIV/AIDS Morbidity and Mortality Reports
In 2012, The HIV prevalence rate was 1.5% indicating that Trinidad and Tobago is categorized as having a generalised epidemic. Since the start of the epidemic in 1983 to December 2012, there were 22,085 persons (estimated) diagnosed with HIV. During 2011-2012, there was an increase in newly diagnosed HIV cases from 1077 in 2011 to 1284 in 2012, an increase in AIDS cases from 33 in 2011 to 47 in 2012, and an increase in AIDS related deaths from 42 in 2011 to 55 in 2012. Given that Figure 1 indicates that the previous trend has shown a decrease in new HIV cases, AIDS cases, and AIDS-related deaths, more research needs to be done to determine whether this increase is a cause for concern or whether this is attributable to increase prevention efforts, increased reporting due to increase testing sites, data quality, or some other issue.

The main mode of transmission is through sexual contact. In 2012, males accounted for 49.5% of new HIV cases while females accounted for 43.5% and 7% were of unknown sex as indicated by Figure 2.

Data Source: National Surveillance Unit, Ministry of Health, HIV/AIDS Morbidity and Mortality Reports

In 2012, the 30-44 age group accounted for majority of new HIV cases, that is, 35.5% followed by the under 30 age group(32.8%) and the 45 and older age group(23.1%) based on HIV/AIDS Morbidity and Mortality reports. However, 8.6% were of unknown age. These statistics represent data from the public health sector and some of the private labs that comply with reporting to the Trinidad Public Health Laboratory. There are currently data strengthening activities in process to improve on apparent data gaps as current data many not be completely reflective of characteristics of the epidemic in certain risk groups.

III. National Response to the AIDS Epidemic

In 2010, consultants were hired to develop the national strategic plan. Consultations were held seeking input from various multi-sectoral stakeholders to develop the National Strategic Plan 2013-2018 (NSP). The NSP was finalized and launched in 2013 and focused on five priority areas: Prevention; Treatment, care and support; Advocacy, human rights, and an enabling environment; Strategic information; and Policy and programme management. The goals of the NSP are 1) To reduce the incidence of HIV infections in Trinidad and Tobago; 2) To mitigate the negative impact of HIV and AIDS on persons infected and affected in Trinidad and Tobago; and 3) To reduce HIV related stigma and discrimination in Trinidad and Tobago.
The NSP also includes 18 strategic objectives and a two-year operational plan 2013-2014.

The strategic objectives of the NSP:

1. To improve sexual health knowledge, attitudes and behaviours of men and women aged 15-49
2. To increase the % of the population who have had an HIV test and know their results
3. To promote healthy sexual health attitudes and practices in youth aged 15 to 24 years
4. To improve the availability and acceptability of condoms as part of good sexual health practice
5. To reduce high risk HIV behaviours and infection in key populations
6. To eliminate mother to child transmission of HIV
7. To improve accessibility and availability of sexual health and HIV services through integrated health services
8. To increase the % of eligible adults and children receiving ART and care
9. To increase adherence to taking ARV medication
10. To improve national and regional laboratory services
11. To improve the care and treatment of people living with HIV who develop other infections
12. To improve the quality of services provided to people living with HIV
13. To ensure the rights and dignity of people living with HIV and key populations
14. To improve the evidence related to the nature and causes of poor sexual health and HIV infection amongst the general and key populations
15. To strengthen the national HIV/AIDS surveillance system
16. To establish a comprehensive monitoring and evaluation system for the national HIV response that informs decision makers
17. To Establish a Policy Framework for Facilitating the National HIV Response, Reducing New Infections and Mitigating the Adverse Impact of HIV
18. To improve the capacity of the Interim HIV Agency and implementing partners for an effective HIV response

The NSP also focuses on general and key populations that include children born to HIV positive women, Men who have Sex with Men (MSM), prisoners, sex workers, substance abusers, and youth.

A legal and policy framework that protects the rights of key populations provide an enabling environment for their access to HIV prevention, treatment, care, and support, human rights, and strategic information related services. In 2013, the process began to revise and finalize the draft national HIV Policy. Consultations were held to revise the national HIV counselling and testing policy, and national sexual and reproductive health policy has been drafted. In 2014, there are also plans to review certain laws, regulations, and policies and propose amendments to protect key populations from discrimination such as the Equal Opportunity Act to include HIV status discrimination, and to review the Human rights desk.

The Ministry of Labour and Small and Micro Enterprise Development through its National HIV/AIDS Workplace Advocacy and Sustainability Centre (HASC) has signed Memoranda of Understanding (MOU) with twenty enterprises to-date from a variety of sectors ranging from trade unions, private sector, non-governmental organisations (NGOs), public sector and the informal economy. The signing of these MOU’s signals managerial commitment to treating HIV and AIDS as a workplace issue and demonstrates dedication on behalf of the participating organisations to addressing issues of HIV-related stigma and discrimination. HASC will provide technical support to each enterprise by assisting them to develop an HIV and AIDS workplace policy and programme and training HIV and AIDS peer educators within each organisation. In
2014, HASC will aim to double the amount of enterprises that are currently developing HIV and AIDS workplace policies by offering policy development workshops, sector based sensitisation sessions, outreach activities and developing its own HIV and AIDS workplace peer education programme. Additionally, the HASC will work alongside the Interim HIV Agency to advocate for legislation to protect persons living with and affected by HIV in the workplace from discrimination.

Civil society also facilitated a number of initiatives to implement the national HIV response in 2013, through peer education training, outreaches, training and sensitizations workshops, provision of HIV counselling and testing services, HIV treatment and care, strategic information activities, and HIV advocacy and human rights activities. The national coordinating agency partnered with The University of the West Indies (UWI) to assess and build the capacity of civil society to implement the national response and includes a communication and monitoring and evaluation component, this project should roll out in 2014.

**Prevention**

The number of persons counselled and tested increased from 52,393 in 2011 to 55,221 in 2012 but declined to 53,186 in 2013. Although testing and counselling in large volumes has been a challenge, there have been improvements in community access of testing and counselling between 2012 and 2013.

During 2012-2013, the number of HIV counselling and testing sites increased from 43 to 57 HIV counselling and testing sites with one new site in Tobago. Available data on HIV counselling and testing sites represent public sector, civil society, and academia but does not include the private sector. Civil society and government ministries implemented a number of initiatives to increase HIV awareness and education in the general population and in key populations.

The national coordinating agency supports the work of civil society and their prevention efforts (as they focus on key populations) through the availability of funding and provision of IEC materials and other items. While HIV related information was communicated to populations through the internet via Interim HIV website, and the development and distribution of IEC materials at outreaches and sensitization sessions, a behaviour change communication (BCC) plan, policy, and strategy needs to be developed and implemented to aid in translating HIV knowledge, and attitude to safe HIV behaviours and practice. In 2013, the process was initiated to develop a BCC plan and this should be completed in 2014. However, in the interim, some HIV Coordinators in the government ministries and representatives from civil society organizations received training in BCC in 2013.

In 2013, the national coordinating agency hosted a youth symposium to actively engage and involve youth and organizations that focus on youth in the implementation of the national HIV response. The Family Planning Association of Trinidad and Tobago (FPATT) established the first and only youth friendly site “De Living Room” that provides reproductive and sexual health services to youth a site, and has further expanded concept to reach the youth in their communities through “rovin caravan”. However, the implementation of Health and Family Life Education (HFLE) curriculum in primary and secondary schools remains a challenge to HIV prevention efforts for in school youth (key population). In 2013, The Ministry of Education collaborated with UNFPA to assess the implementation of HFLE in secondary schools and a preliminary draft report has been produced.
Advocacy and Human Rights

According to UNAIDS, HIV and AIDS related stigma and discrimination are hindering efforts to reduce new HIV infections, increase access to HIV care, treatment and support, and are impeding the rights of persons living with or affected by HIV and AIDS to lead productive lives(http://www.unaids.org/en/resources/presscentre/featurestories/2014/april/20140411zcaribbean/). This is particularly true in Trinidad and Tobago as there is a deficit of laws to protect the human rights of PLHIV and myths and misconceptions about HIV and AIDS are rampant and fuel stigma and discrimination. Due to high levels of HIV-related stigma and discrimination, coupled with the lack of legislation to provide avenues for redress for PLHIV in critical areas such as employment, housing and health services for example, cases of discrimination remain primarily anecdotal. Those living with and affected by HIV are hesitant to bring formal complaints to the courts and/or the Equal Opportunities Commission as HIV is not a prohibited grounds of discrimination in the Equal Opportunities Act or any other law that seeks to protect the basic human rights of citizens. Such legislative deficiencies make cases of HIV-related discrimination difficult to address and formal complaints are few. In addition to a weak legislative framework, PLHIV are hesitant to lodge formal complaints for fear of facing further discrimination from public disclosure of their status. Personal stories of disownment by family, loss of employment and/or housing based on disclosure are common yet often not officially recorded.

In 2013, the Advocacy and Human Rights (AHR) Subcommittee started to address some of the above challenges by reviewing gaps in legislation and developing proposals for legislative amendments. The AHR Subcommittee met with representatives from the Office of the Chief Parliamentary Council to seek guidance on the process for making requests for amendments to legislation and is currently focusing on proposing changes to the Equal Opportunities Act. Before any concrete amendments are proposed however the AHR Subcommittee will facilitate stakeholder consultations. Guiding documents being used by the AHR Subcommittee for this initiative include a legislative assessment conducted by the National AIDS Coordinating Committee in 2009 (Reference: Legislative Assessment – HIV and AIDS: Law, Ethics and Human Rights in Trinidad and Tobago, Sept 2009), and a Legal Gap Analysis conducted by the International Labour Organization (ILO) in collaboration with the Ministry of Labour and Small and Micro Enterprise Development in 2013. The ILO Gap Analysis examined gaps and deficiencies in employment and other related laws of Trinidad and Tobago in relation to guidelines set by ILO Recommendation Concerning HIV and AIDS and the World of Work, 2010 (No.200) and made specific recommendations.

Plans for the AHR Subcommittee for 2014 include the development of a national campaign on stigma and discrimination. The campaign will focus on dispelling myths and misconceptions about HIV and AIDS that prevail throughout the general population and which exacerbate HIV-related stigma and discrimination. Sensitisation sessions will be held with a focus on parliamentarians, media personnel and the judiciary and proposals for the implementation of a desk to assist persons with human rights related complaints will be undertaken. A human rights desk is important as it will provide a confidential means of reporting cases of discrimination and will document the types and number of complaints. Support will be provided to the National HIV/AIDS Workplace Advocacy and Sustainability Centre (HASC), Ministry of Labour and Small and Micro Enterprise Development, to strengthen the workplace response to HIV and AIDS. In 2014, a high-level meeting will be carded to discuss the National Workplace Policy on HIV and AIDS with union leaders in an effort to garner support for the inclusion of HIV and AIDS Workplace Policies as an essential component of the collective bargaining process.
Treatment, care and support

In 2011/2012 period, the Ministry of Health removed stavudine, indinavir, and didanosine and DD1 ARVs from the national formulary/list of approved ARVs and added 3rd line HIV treatment to the approved list. HIV treatment and care is provided by the Government of Trinidad and Tobago, one of the few countries regionally whose programme is not dependant on external funders. The estimated percentage of adults and children on anti-retroviral treatment reduced from 73% in 2011 to 67% in 2012, to 48.0% in 2013 although the number receiving treatment increased from 4991 to 5565 to 6134 during the same period. The Spectrum computer program determines the denominator, the total number of eligible adults and children for ARV treatment: 6817 in 2011, 8359 in 2012 and 12,776 in 2013. The assumptions of the Spectrum model are not always reflective of the current national situation and may result in an overestimate or underestimate in some cases in its calculations. Moreover, the change of the CD4 requirement from 200 to 350 adults resulted in a larger group of people being in need of ARV with implementation of this guideline only occurring fully in late 2011 into 2012. Using the national approved treatment guidelines, in 2013 the percentage of adults and children on ARV treatment was 72.3% where the denominator was 8,413 PLHIV.

Trinidad and Tobago is close to eliminating mother to child HIV transmission. The national target for the elimination of infections among children entails two components (1) reduce the transmission of HIV from HIV+ pregnant women to their infants to 2% or less and (2) the reduction of the Incidence of mother-to-child transmission of HIV to 0.3 cases or less per 1000 live births.

The estimated number of children who were newly HIV infected due to mother to child transmission in was 2 cases in 2012 indicating a 60% reduction from the baseline figure of 5 cases in 2011. During 2006 to 2011, the percentage of HIV positive women who received anti-retrovirals to reduce the risk of mother to child transmission increased from 68.1% to 85.9%.

Nationally, psychosocial support is provided for the general population through the Ministry of People and Social development who provide counselling and social welfare grants (This covers housing, household items, domestic help, nutrition, clothing, funeral, disability, education for children under 18 and special needs, pharmaceutical, senior citizens, public assistance, and urgent temporary assistance). The assistance provided is neither limited to nor specific to PLHIV.

Civil society provides psychosocial support to key populations. In an attempt to strengthen the psychosocial support within the Health Sector, some civil society groups have partnered with Ministry of Health to establish a peer support programme, to provide psychosocial support for newly diagnosed persons living with HIV (PLHIV) clients and their partners through referrals and access to HIV treatment and services. In 2012, seven civil society groups signed a Memorandum of Understanding (MOU) with the Ministry of Health and the Regional Health Authorities. However, challenges remain related to availability and access to treatment and care sites through integration into primary care, decentralisation of services, and the development of public partner partnerships particularly in rural areas to service the wider PLHIV community. The negative stigma associated with accessing services through public health system that still exists is also a challenge.

In addition, there is a greater need to increase pharmacological monitoring systems, increase awareness of psychosocial support services available to PLHIV persons and increase accessibility to social support inclusive of social and welfare grants. Many of these activities are temporary and/or have stipulations, which do not completely service the needs of PLHIV.

Other challenges include the increased cost of ARV’s due to the new PAHO treatment guidelines that increased CD4 threshold treatment level to 500, attracting sufficient medical personnel, the expansion of the
prevention programme for PLHIV, and the additional systems and monitoring tools to support the additional persons of sustained ARV therapy.

Knowledge and behaviour change

Although the Multiple Indicator Cluster Survey 2011 is the most recent related national survey that provides information on the HIV knowledge, attitudes, practices, and behaviours (KAPB) on national population, it is limited to women and child; and the report will be finalized this year. The last national HIV related KAPB on the general population was conducted in 2007. However, there are plans to conduct a national AIDS Indicator survey (AIS) for the general population in 2014. Similarly, few national HIV-related KAPB studies have been conducted on key populations and vulnerable populations. However, a biological and behavioural surveillance study (BBSS) on men who have sex with men was conducted in 2013 and is still in progress. Similarly, there are plans to conduct a BBSS on female sex workers in 2014. In 2013, the process was initiated to conduct a synthesis of all the studies conducted on HIV and AIDS since the start of the epidemic in 1983. This study should also provide information on changes in HIV knowledge and behaviours over time.

IV. Best Practices

PMTCT Programme

Programmatically the PMTCT (Prevention of Mother To Child Transmission) programme is well integrated into the ANC system and serves a link between primary care screening and transition to tertiary treatment and care sites. Regular meetings facilitate discussion between the public health and treatment site teams, allowing for interventions for difficult cases and migration of patients between clinics. PMTCT nurses work together with ANC nurses and Primary care nurse managers to achieve documented high screening rate of patients, achieving 96% screening for HIV in the public sector in 2012. The PMTCT nurse also follows patients into the treatment care sites. Patients are then followed by a multidisciplinary team, inclusive of the PMTCT nurse, at the tertiary level antenatal clinics and treatment sites to ensure initiation of antiretroviral therapy, ANC follow up, social worker follow-up and follow up of infant post-partum. The programme was able to achieve 84% adherence to ARV by pregnant women and 93% screening of HIV exposed infants with 1% transmission rate in 2012.

Establishment of national HIV/AIDS Workplace Advocacy and Sustainability Centre

The National HIV/AIDS Workplace Advocacy and Sustainability Centre (HASC), was established in the Ministry of Labour and Small and Micro Enterprise Development in 2009 and formally launched in 2011 to implement the National Workplace Policy on HIV and AIDS. The HASC advocates that eliminating stigma and discrimination of any kind in the workplace is critical to creating a safe, healthy and productive work environment and ensures that the fundamental rights of workers are met. This is directly linked to the work of the HASC whose primary objectives are to:

1. Reduce employment related stigma and discrimination against persons living with or affected by HIV and AIDS
2. Reduce behaviours that put workers at risk of contracting HIV (and other sexually transmitted infections), by providing employers and employees with information and behaviour change strategies.
The development of a National HIV/AIDS Workplace Advocacy and Sustainability Centre is considered a best practice because it is a nationally sustained entity and the only organisation of its kind in the Caribbean solely dedicated to coordinating the workplace response to HIV and AIDS. This is achieved through the provision of training, technical support and guidance in HIV and AIDS policy and programme development for employers, employees, government ministries, unions, PLHIV, civil society and other stakeholders.

The establishment of the HASC signalled that the government recognizes the critical role of the workplace in reducing the spread of HIV and curbing its effects on the economically active population. It is recommended however, that countries clearly recognize that in order for such an organization to be successful the following should be considered:

i. HASC-like organizations although coming out of a government policy should be carefully thought out with regards to the restrictions this organization may encounter by nature of its placement in Government Ministries. e.g bureaucratic processes, restrictive policies and procedures. These include and are not limited to sharing of and the prioritizing of funds allotted to the host Ministry and autonomy to make decisions free from political agendas.

ii. The staffing of similar centres or units should be carefully thought out with specific reference to the required skills set and competences of staff.

iii. A clear mandate and plan for sustainability is necessary (i.e. what the organization plans to achieve, how it is going to achieve it, identification of key partners, allocation for capacity building and support for and dissemination of research and research findings.). The Centre or Unit along with the policy needs to be strategically marketed similarly to the way in which Health and Safety Organizations have been established, as it is enshrined as a go to organization for assistance and guidance.

V. Major Challenges and Remedial Actions

One of the main challenges to coordinating and implementing the national HIV response is the management changes to the country coordinating mechanism. In 2010, World Bank funding came to an end and the life of the then coordinating committee, NACC also ended, with plans to restructure the NACC to a statutory authority. Although the Ministry of Health and other Ministries were implementing the response during that period, there was no coordinating body until 2013. The Interim HIV Agency was established in 2013 with a life of two years to transition the NACC into a statutory authority. In September 2013, the ministry responsible for national HIV and AIDS coordination was changed from the Office of the Prime Minister to Ministry of Health. Consequently, the work of the Interim Agency was at a lull until January 2014. This would have delayed the implementation of a number of initiatives including but not limited to the engagement of and partnership with civil society and other key stakeholders in the national response, and the recruitment of additional technical staff in the HIV Secretariat. Now that the work of the Interim HIV Agency has resumed, implementation of some of these initiatives have already taken place or are forthcoming.

Another challenge is promoting a culture of monitoring and evaluating that is results driven and focuses on data utilization. The Ministry of Planning and Sustainable Development has the mandate for monitoring and evaluating progress of national goals and is poised to take the lead in this initiative. In terms of the national HIV response, data reporting tools are being revised to reflect the priorities of the national strategic plan and the requirements of the monitoring and evaluation system and there are plans to promote an M&E
culture through collaborations with stakeholders vis-a-vis training, funding guidelines, and data dissemination and use workshops.

VI. Support from the Country’s Development Partners

While the government of Trinidad and Tobago funds the national HIV programme, the Government partnered with UNAIDS, UNFPA, and PANCAP, and PEPFAR through Center for Disease Control, and CARPHA to provide support to coordinate and implement the national HIV/AIDS response in a sustainable manner. Support is needed to complete the National AIDS Spending Assessment (NASA), to develop and finalize the M&E Plan and to strengthen the M&E system, conduct national AIS survey, and develop and implement a BCC plan.

VII. Monitoring and Evaluation Environment

Although Trinidad and Tobago has identified the need for monitoring and evaluation (M&E) evident by the development of a national M&E results-based framework, the national M&E HIV system of Trinidad and Tobago traditionally have been weak. However, there have been improvements to the monitoring and evaluation environment where the current national strategic plan has a monitoring and evaluation framework; there have been improvements in the surveillance system such as the adoption of a case-based surveillance system and improved data collection tools including the prevention of mother to child transmission cohort register system. Reporting formats for the public sector have been drafted and are currently being reviewed.

The M&E plan is currently being developed with assistance from the Caribbean Public Health Agency (CARPHA) and UNAIDS. Consultations will be held with stakeholders including civil society before finalization of document. The M&E technical working group was established in early 2014 with representation from various stakeholders, including civil society aimed at reviewing and finalizing the M&E Plan and improving the national M&E tools and system.

The main challenges to establishing a strong M&E HIV system are related to organizational structure and human resource. An M&E unit is yet to be established in the national coordinating agency and the structure of the national coordinating agency’s secretariat has only facilitated one monitoring and evaluation post. In the interim, the national coordinating agency’s secretariat would recruit an additional temporary M&E officer and CARPHA and UNAIDS have also offered technical assistance in strengthening the national M&E system.

Coordination and implementation of the national monitoring and evaluation system poses a challenge when key stakeholders in civil society, government ministries, and private sector have limited M&E competency and capacity. In 2013, civil society and the HIV/AIDS Coordinators in government ministries received basic M&E training facilitated by CARPHA in 2013 with plans for an Advanced M&E workshop to be held in 2014. However, many of the civil society groups and government Ministries do not have dedicated personnel to M&E only. Moreover, the majority of the government ministries have one person coordinating HIV in their sector and HIV coordinating units are yet to be established; this is also similar for M&E personnel in government ministries. Currently the required skill sets of M&E personnel in the public sector are being reviewed and the national coordinating agency’s capacity building initiative for the civil society should increase their capacity and competency in M&E.
VIII. CHALLENGES IN PREPARING REPORT

There were a number of challenges in preparing this report. The 2014 GARPR guidelines were only made available in early February and included the reporting of new indicators and as such, the country was unable to report on those indicators. Some of the data usually required for the GARPR were either unavailable such as the data on AIDS spending, or if the data was available there were issues of timeliness, completeness, and representativeness. In addition, some of the assumptions of the spectrum model to derive the estimates related to treatment do not reflect the Caribbean context, and may not reflect the national HIV/AIDS situation. The country intends to meet with relevant stakeholders involved in data collection and compilation process to discuss the challenges they faced and the way forward.
<table>
<thead>
<tr>
<th>Target</th>
<th>Indicator</th>
<th>2013/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Target 1: Reduce sexual transmission of HIV by 50% by 2015</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>General population</strong></td>
<td>1.1. Percentage of young women and men aged 15-24 years who correctly identify ways of preventing HIV and who reject major misconceptions about HIV transmission</td>
<td>Data not available</td>
</tr>
<tr>
<td></td>
<td>1.2. Percentage of young women and men 15-24 years who have had sexual intercourse before the age of 15</td>
<td>Data not available but 27.1% 13-15 year old ever had sex based on 2011 Global school based student health survey</td>
</tr>
<tr>
<td></td>
<td>1.3. Percentage of adults aged 15-49 who have had sexual intercourse with more than one partner in the past 12 months</td>
<td>Data not available</td>
</tr>
<tr>
<td></td>
<td>1.4. Percentage of adults aged 15-49 who had more than one sexual partner in the past 12 months who report the use of condoms during their last intercourse</td>
<td>Data not available</td>
</tr>
<tr>
<td></td>
<td>1.5. Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results</td>
<td>Data not available</td>
</tr>
<tr>
<td></td>
<td>1.6. Percentage of young people aged 15-24 who are living with HIV</td>
<td>Data not available</td>
</tr>
<tr>
<td><strong>Sex workers</strong></td>
<td>1.1. Percentage of sex workers reached with HIV prevention programmes</td>
<td>Data not available</td>
</tr>
<tr>
<td></td>
<td>1.2. Percentage of sex workers reporting the use of a condom with their most recent client</td>
<td>Data not available</td>
</tr>
<tr>
<td></td>
<td>1.3. Percentage of sex workers who have received an HIV test in the past 12 months and know their results</td>
<td>Data not available</td>
</tr>
<tr>
<td></td>
<td>1.10 Percentage of sex workers who are living with HIV</td>
<td>Data not available</td>
</tr>
<tr>
<td><strong>Men who have sex with men</strong></td>
<td>1.11 Percentage of men who have sex with men reached with HIV prevention programmes</td>
<td>Data not available</td>
</tr>
<tr>
<td></td>
<td>1.12 Percentage of men reporting the use of a condom the last time they had anal sex with a male partner</td>
<td>Data not available</td>
</tr>
<tr>
<td></td>
<td>1.13 Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results</td>
<td>Data not available</td>
</tr>
<tr>
<td></td>
<td>1.14 Percentage of men who have sex with men who are living with HIV</td>
<td>Data not available</td>
</tr>
<tr>
<td><strong>Target 2: Reduce transmission of HIV among people who inject drugs by 50% by 2015</strong></td>
<td>2.1 Number of syringes distributed per person who injects drugs per year by needle and syringe programmes</td>
<td>National data for these indicators are not available. Trinidad and Tobago is by and large not an injecting society</td>
</tr>
<tr>
<td></td>
<td>2.2 Percentage of people who inject drugs who report the use of a condom at last sexual intercourse</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.3 Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.4 Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.5 Percentage of people who inject drugs who are living with HIV</td>
<td></td>
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<tr>
<td>Target</td>
<td>Indicator</td>
<td>2013</td>
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<td>--------</td>
</tr>
<tr>
<td>Target 3: Eliminate new HIV infections among children by 2015 and substantially reduce AIDS-related maternal deaths</td>
<td>3.1. Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission</td>
<td>85.8%</td>
</tr>
<tr>
<td></td>
<td>3.1.a. Percentage of women living with HIV receiving antiretroviral medicines for themselves or their infants during breastfeeding</td>
<td>Breasting of HIV mothers is not advised in national treatment guidelines</td>
</tr>
<tr>
<td></td>
<td>3.2. Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth</td>
<td>53.3%</td>
</tr>
<tr>
<td></td>
<td>3.3 Estimated percentage of child infections from HIV-positive women delivering in the past 12 months</td>
<td>6.3%</td>
</tr>
</tbody>
</table>
**Target 4:** Reach 15 million people living with HIV with lifesaving antiretroviral treatment by 2015

- **Indicator 4.1** Percentage of adults and children currently receiving antiretroviral therapy
  - **2013 Data:** Children 78.5%, Adults 47.6%
  - **Comments:** Denominators are based on global criteria – 15+: 12590 and for <15: 186. However, denominator based on national criteria – 15+: 8230 for and <15: 183.

- **Indicator 4.2** Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy
  - **2013 Data:** Children 100%, Adults 93.4%

**Target 5:** Reduce tuberculosis deaths in people living with HIV by 50% in 2015

- **Indicator 5.1** Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV
  - **Data Not Available**

**Target 6:** Close the global AIDS resource gap by 2015 and reach annual global investment of US$22-24B in low-middle income countries

- **Indicator 6.1** Domestic and international AIDS spending by categories and financing sources
  - **Data Not Available**
  - **Comments:** Most recent National AIDS Spending Assessment (NASA) conducted in 2009

**Target 7:** Eliminating gender inequalities

- **Indicator 7.1** Proportion of ever married or ever-partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months
  - **Data Available for Numerator Only (424) through routine monitoring from Crime and Problem Analysis Branch, TT Police Service.

**Target 8:** Eliminating stigma and discrimination

- **Indicator 8.1** Discriminatory attitudes towards PLHIV
  - **Data Not Available**

**Target 9:** Eliminate Travel restrictions

- **Indicator 9.1** Travel restriction data collected directly by the Human Rights and Law Division at UNAIDS HQ, no reporting needed

**Target 10:** Strengthening HIV integration

- **Indicator 10.1** Current school attendance among orphans and non-orphans aged 10-14
  - **2013 Data:** 33.3%
  - **Comments:** Data is limited to orphans in institutions and excludes general population. Data from Children’s Authority of Trinidad and Tobago

- **Indicator 10.2** Proportion of the poorest households who received external economic support in the last 3 months
  - **Data Not Available**
HIV AND AIDS IN LATIN AMERICA THE CARIBBEAN REGIONAL OVERVIEW
Caribbean (2018)

340,000 people living with HIV
1.2% adult HIV prevalence (ages 15-49)
16,000 new HIV infections
6,700 AIDS-related deaths
56% adults on antiretroviral treatment*
42% children on antiretroviral treatment*

*All adults/children living with HIV
Source: UNAIDS Data 2019

Latin America (2018)

1.9m people living with HIV
0.4% adult HIV prevalence (ages 15-49)
100,000 new HIV infections
35,000 AIDS-related deaths
63% adults on antiretroviral treatment*
48% children on antiretroviral treatment*

*All adults/children living with HIV
Source: UNAIDS Data 2019

KEY POINTS

- Impressive progress has been made in Latin America in increasing the number of people who know their HIV status and receive treatment.
- Latin America has shown strong commitment to funding its HIV response, yet many services for high-risk groups are being funded by donors.
- The Caribbean has the second highest HIV prevalence after sub-Saharan Africa.
- The percentage of people in the Caribbean with suppressed viral loads is well below the global average.
- Of the Caribbean countries, 11 out of 16 rely heavily on external funding.
- Barriers to progress include violence and stigma towards key affected populations and those living with HIV in Latin America and the Caribbean.
Explore this page to find out more about the people most affected by HIV in Latin America and Caribbean, testing and counselling, prevention programmes, antiretroviral treatment availability, barriers to the response, funding and the future of HIV in Latin America and Caribbean.

An estimated 2.2 million people were living with HIV in Latin America and the Caribbean in 2018 (1.9 million in Latin America and 340,000 in the Caribbean). This equates to an HIV prevalence of 0.4% in Latin America and 1.2% in the Caribbean. In the same year, there were 100,000 new infections in Latin America and 16,000 in the Caribbean, and 41,700 people died from AIDS-related illnesses (35,000 in Latin America and 6,700 in the Caribbean).¹

Antiretroviral treatment (ART) coverage has been relatively high and AIDS-related deaths relatively low in Latin America for many years. However, little progress has been made on slowing the rate of new infections in the last decade, which overall have fallen by just 1% between 2007 and 2017, and new infections among young people within key populations are on the rise. However, AIDS-related deaths over the same period have fallen by 12%.²

In 2018, 80% of people living with HIV in Latin America were aware of their HIV status. Of those who were aware, 62% were accessing antiretroviral treatment (ART). Of those on treatment, 55% were virally suppressed.³

There has been moderate progress made on both prevention and treatment in the Caribbean. The annual number of new HIV infections among adults in the Caribbean declined by 18% between 2010 and 2017, and deaths from AIDS-related illness fell by 23%. In this part of the region, there was a large gap in awareness of HIV status at the start of the HIV testing and treatment cascade.⁴

In 2018, 72% of people living with HIV in the Caribbean were aware of their HIV status. Of those who were aware, 77% were accessing antiretroviral treatment (ART). Of those on treatment, 74% were virally suppressed.⁵

Nearly 90% of new infections in the Caribbean in 2017 occurred in four countries - Cuba, Dominican Republic, Haiti and Jamaica - while 87% of deaths from AIDS-related illness occurred in the Dominican Republic, Haiti and Jamaica. Haiti alone accounts for nearly half of annual new HIV infections and AIDS-related deaths.⁶
Despite its small population size, the Caribbean has a high HIV prevalence globally at 1.2% (West and Central Africa stands at 1.5% and the highest prevalence global is in East and Southern Africa at 7%).

Latin America and the Caribbean has a concentrated epidemic, which means HIV prevalence is low among the general population but among certain groups such as men who have sex with men and transgender women, prevalence is particularly high. Young people are also disproportionately affected by HIV in the region.

In 2017, gay men and other men who have sex with men accounted for 41% of HIV infections in Latin America, and key populations and their sexual partners represented more than three quarters of new infections overall. In the Caribbean, gay men and other men who have sex with men accounted for nearly a quarter of new infections in 2017. In total, key populations and their sexual partners represented two thirds of new infections.

Brazil has played a key leadership role in the reinvigoration of HIV prevention in Latin America. However, the election of Jair Bolsonaro of the Social Liberal Party (PSL) as president in October 2018 could significantly reverse the progress made on HIV in Brazil and possibly the wider region, as well as deny human rights for many vulnerable populations. Bolsonaro has described himself as a ‘proud homophobe’ and is opposed to state-funded treatment for people living with HIV. Many in Brazil’s LGBTI community say they experienced an increase in violence and threats during the election campaign and there were record numbers of murders of LGBTI Brazilians between 2016 and 2018.
Populations most affected by HIV in Latin America and the Caribbean

Men who have sex with men (MSM)

Men who have sex with men (file:///C:/node/382) (sometimes referred to as MSM) are the group most affected by HIV in Latin America and the Caribbean.

In the Caribbean, HIV prevalence among gay men and other men who have sex with men is particularly high in Trinidad and Tobago (32%), Bahamas (25%) and Haiti (13%). The lowest prevalence percentages are still high at 5% in Guyana and around 6% in Suriname and Cuba.11

In Latin America, HIV prevalence among this population is lowest in Guatemala and El Salvador at around 7%. Most other countries have prevalence ranging between 11% and 17%, although Bolivia, Mexico and Paraguay all report prevalence above 20% (25%, 21% and 21%, respectively).12

There are many reasons for high levels of HIV transmission among this group. In 2014, only 51% of men who have sex with men were reported to have access to HIV services, a level that has remained unchanged for several years.13 Moreover, access to HIV testing among men who have sex with men varies enormously from country to country, ranging from 5% to 70%.14

Homophobia and the 'machismo' (or aggressively masculine) culture are common throughout the region and sex between men is highly stigmatised. Large numbers of men who have sex with men also have sex with women, forming a 'bridge' population.15 16
As one civil society worker explains, men who have sex with men are often hesitant to reveal how they became infected with HIV. Many are mistakenly classed as heterosexual:

“Unless he’s a total queen, a man will always be [counted as] heterosexual. Plus, people don’t want to be recognised [as homosexual].”

- Ruben Mayorga, civil society worker, Guatemala City

Transgender people

Transgender women are highly affected by HIV in Latin America and the Caribbean. HIV prevalence among this group is thought to be 49 times higher than among the general population.

In countries where data is collected on this key population, transgender women experience some of the highest HIV prevalence. In Latin America, recorded prevalence is lowest in El Salvador at 7.4% and highest in Ecuador at 35%. It is over 20% in Colombia, Costa Rica, Guatemala, Panama and Paraguay. In the Caribbean, data on transgender people is scarce, with only Guyana and Cuba reporting HIV prevalence, which stands at 8% and 20%, respectively.

Research has shown that between 44% and 70% of transgender women have felt the need to leave, or were thrown out of their homes. One study from Mexico indicated that 11% of transgender women living with HIV were excluded from family activities.

Transgender people in the region have fewer educational and social opportunities, often resorting to sex work for an income. Country-level data collected between 2011 and 2015 also shows much higher HIV prevalence among transgender women sex workers compared to other sex workers. Transgender people also face high rates of violence. According to the Observatory of Murdered Trans People, 2,016 transgender people were reported as murdered between 2008 and 2015 across the world, 1,573 (78%) of them were in Latin America and the Caribbean. The highest number of these murders occurred in Brazil, where 938 were reported.

Such high levels of stigma and violence remain significant barriers to transgender people accessing HIV services.

Sex workers

HIV also disproportionately affects sex workers, although there are variations between country situations and genders. In Latin America, around 1% of sex workers in Chile, Colombia, Costa Rica, Guatemala, Paraguay, Peru and Uruguay were living with HIV in 2017, compared to around 5% in Bolivia, Brazil and Panama. In the Caribbean, where reported, prevalence ranges from between 2% in Jamaica and Guyana.
Male and transgender sex workers tend to be more affected by HIV than cis-female sex workers. For example, 69% of male sex workers in Suriname were estimated to be living with HIV in 2014, compared to 4% of female sex workers.\textsuperscript{27}

Testing coverage among sex workers is higher among female sex workers (ranging from 39% to 98%) than male sex workers (ranging from 17% to 70%). Condom use during last transactional sex ranges from 57% in Belize to greater than 95% in Panama and Antigua and Barbuda.\textsuperscript{28}

Across the region, particularly in the Caribbean, sex workers experience a range of human rights violations and social injustices, including the denial of access to healthcare, poor working conditions, violence and harassment by law enforcement. Sex workers are also frequently marginalised by social and religious institutions and subject to discrimination. For these reasons, many people who engage in sex work do so covertly.

One study of female sex workers in Argentina reported that 24.1% had experienced sexual abuse; 34.7% reported rejection; 21.9% reported having been beaten; while 45.4% reported having been arrested because of their sex work activity. Higher levels of inconsistent condom use were also reported among those who experienced sexual abuse, rejection and police detention.\textsuperscript{29}

All these factors act as significant barriers to sex workers accessing effective HIV prevention and treatment services.

**People who inject drugs (PWID)**

An estimated 1.9 million people inject drugs\textsuperscript{(file:///C:\node\386)} Latin America and the Caribbean. A wide-ranging evidence review, published in 2017, found 51% of people who inject drugs (sometimes referred to as PWID) are aged 25 and under, a higher proportion than any other region in the world.\textsuperscript{30}

Reliable HIV-related data on people who inject drugs is extremely limited. The 2017 evidence review mentioned above estimates prevalence at 35.7% in Latin America and 13.5% in the Caribbean. However, this is based on the only data available, which came from just five Latin American countries, and one Caribbean territory (Puerto Rico).\textsuperscript{31} The only country reporting prevalence among people who inject drugs to UNAIDS in 2017 was Mexico, which estimated it to be 2.5%.\textsuperscript{32}

This lack of data affects the planning and development of effective, targeted responses for people who inject drugs.

UNAIDS estimates that 2% of all new HIV infections in Latin America and 1% in the Caribbean were the result of unsafe injecting practices in 2017,\textsuperscript{33} levels that are disproportionately high, considering only 0.5% of people in Latin America and 0.4% in the Caribbean are thought to inject drugs.\textsuperscript{34}

In Puerto Rico, where poor access to sterile injecting material has been identified as a significant contributor to the HIV epidemic, 51% of people who died while living with HIV between 1981 and 2013 acquired the infection via unsafe injection practices.\textsuperscript{35}

**Young people**
Young people in Latin America and the Caribbean, especially those who are from key populations, are disproportionately at risk of HIV infection. One factor contributing to this are the barriers to accessing prevention services.

In many countries minors require parental or guardian consent to test for HIV. In Mexico and Panama, adolescents have to be accompanied by a parent, a legal guardian or another state-recognised person in order to receive their test results. In Paraguay, health staff can request authorisation to conduct an HIV test in the absence of parents or guardians.

However, a few countries in the Caribbean have developed policies allowing minors to access HIV testing without parental consent, either allowing it at any age (such as in Guyana) or above the age of 14 (as in Trinidad and Tobago).\textsuperscript{36}

\begin{center}
\begin{table}
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\begin{tabular}{|c|c|}
\hline
\textbf{Population Group} & \textbf{2017 Infections} \\
\hline
Sex workers & 13\% \\
People who inject drugs & 1\% \\
Gay men and other men who have sex with men & 23\% \\
Transgender women & 1\% \\
Clients of sex workers and other sexual partners of key populations & 30\% \\
Rest of population & 32\% \\
\hline
\end{tabular}
\end{table}
\end{center}

In the Caribbean, the cultural norm of young women (aged 15-24) having sexual relationships with older men increases their risk of HIV infection. In Haiti, for example, HIV prevalence among young women is more than double that among young men.\textsuperscript{37} Between 9\% and 24\% of young women in the region reported having sex with a man at least 10 years older than themselves within the last 12 months. Other risk factors, such as multiple sexual partners and inconsistent condom use, compound the risk of age mixing in these countries.\textsuperscript{38}

In Latin America, high prevalence among gay and other men who have sex with men results in young men being significantly more likely to be living with HIV than young women.\textsuperscript{39}
HIV testing and counselling (HTC) in Latin America and the Caribbean

In 2017, 77% of people living with HIV in Latin America and 73% of people living with HIV in the Caribbean were aware of their status.\textsuperscript{40}

Different approaches to testing are being taken in the region to increase the number of people who are aware of their status. Around a third (62%) of LAC countries that offer testing services within flexible hours, are generally provided by civil society organisations (CSOs).\textsuperscript{41}

HIV self-tests are available in the Bahamas, Brazil, El Salvador, Jamaica, Peru, and Trinidad and Tobago. However, as of 2017, most governments were yet to document their use, provide them at subsidised cost, or use this method to expand testing to people from key populations, whose need is significantly greater due to the concentrated nature of the epidemic.\textsuperscript{42}

An exception is Brazil, which introduced self-testing kits in 2015. These kits were made available free of charge from pharmacies, medication distribution centres, health services and government health programmes, as well as through the mail. The oral self-testing kits feature clear instructions and a telephone helpline.\textsuperscript{43}

Just under two-thirds of countries in the region (68%) offer testing in community centres. Argentina, Dominica, Guatemala, Jamaica, Mexico and Paraguay allow HIV testing to be done by trained individuals who are not health professionals.\textsuperscript{44}

Late HIV diagnosis is a serious issue in Latin America and the Caribbean. In at least half the countries in the region, one in three people had a CD4 count under 200 when tested for the first time.\textsuperscript{45,46}
Barriers to testing are numerous. For example, in the majority of the countries, testing centres are concentrated in large cities, creating problems for people living in non-urban communities. Although 92% of countries provide sensitivity training for healthworkers involved in HIV screening for key populations, civil society organisations in 12 countries that participated in national consultations on HIV prevention reported a lack of sensitivity among these professionals. Furthermore, many countries do not collect data on testing for transgender women or female sex workers, which obstructs initiatives to increase testing among these key populations.47

HIV prevention programmes in Latin America and the Caribbean

In 2017, there were 100,000 new infections in Latin America and 15,000 in the Caribbean.48 Brazil, which has 35% of the total population of people living with HIV in Latin America and 47% of new infections in 2017, has been at the forefront of renewed HIV prevention efforts in Latin America.49 However, the election of President Bolsonaro of the far-right PSL party in October 2018 has the potential to reverse progress.

In the Caribbean, renewed commitment to combination prevention that is tailored to key populations is needed to accelerate reductions in new HIV infections.50

Condom availability and use

Although limited in scope, the latest available data from Latin America and the Caribbean indicates that condom use varies widely.

Men engaging in sex with a non-regular partner are more likely than women to use condoms. The lowest rates of condom use at last high-risk sex among women range from 20% in Barbados and Guatemala to 76% in Cuba. Among men, the lowest reported rates are in Barbados (42%) and Chile (49%), and highest in Cuba (80%) and Colombia (71%).51

In the Caribbean, levels of condom use among young people (aged 15-24 years) who are having sex with non-regular partners ranged from 67% in Belize to 79% in Jamaica among young men and 49% in the Dominican Republic to 57% in Jamaica among young women.52

The regional median for condom use among men who have sex with men in their most recent sexual encounter is 63%; among female sex workers 80%; and among transgender women 88%.53

All countries provide free condoms to key populations and young people but levels are often inadequate. Only one third procure condoms using domestic resources. It is essential to increase the availability, access, affordability and use of condoms (and compatible lubricants) among key populations through targeted distribution schemes.54

HIV awareness, education and approach to sex education

Most countries in the Caribbean provide comprehensive sexuality education (CSE) in primary and secondary schools, which includes topics beyond the reproductive system to include HIV, s
transmitted infections, sexuality, gender identity and gender equality.

Knowledge about HIV among young people (aged 15-24 years) in the Caribbean is highest in Cuba where 76% of young women and 80% of young men are aware of HIV and how to prevent it. In the rest of the Caribbean, it is much lower at around 40 to 50%.

An exception to this is Haiti, where CSE is not available. As a result, just 37% of 15 to 24-year-olds in Haiti have good knowledge about HIV prevention. In Latin America, implementation of CSE has slowed down in most countries due to a lack of agency within education ministries. Some countries, such as Brazil and Chile, are moving youth-friendly CSE services into schools. Venezuela has one of the highest teenage pregnancy rates in Latin America yet comprehensive sexuality education in schools is not mandatory.

As a result, in most Latin American countries, only around 30% of young people are aware of HIV and how to prevent it, with the exception of Peru where 75% of young women are aware of HIV prevention.

Preventing mother-to-child transmission (PMTCT)

Mother-to-child transmission of HIV in Latin America stood at 11.4% in 2017, down from 16.2% in 2010. This largely reflects the strength of programmes in Brazil and Mexico - two countries that are home to 62% of people living with HIV in the region. Almost 75% of pregnant women living with HIV in 2017 received antiretrovirals to prevent vertical transmission of HIV and protect their own health. In addition, almost half (46%) the infants exposed to HIV received early infant diagnosis, a crucial intervention for early initiation of treatment.
Seven countries and island states in the Caribbean have been validated as having eliminated mother-to-child transmission of HIV: Anguilla, Antigua and Barbuda, Bermuda, the Cayman Islands, Cuba, Montserrat, and Saint Kitts and Nevis. The rate of mother-to-child transmission (including breastfeeding) in the Caribbean in 2017 was 13.3%. This is significantly lower than the 18.7% rate in 2010. PMTCT treatment coverage was 75% in 2017, and almost half (48%) of HIV-exposed infants received an early infant diagnosis before eight weeks of age.60

As a result, new HIV infections among children (aged 0-14 years) have declined across Latin America and the Caribbean, down from an estimated 4,700 in 2010 to 3,500 in 2017. Progress was greatest in the Caribbean, where new infections among children fell from an estimated 2,300 in 2010, to 1100 in 2017.61,62
However, some countries continue to lag behind. PMTCT coverage is 21% in Guatemala, and 49% in Mexico. Difficulties in reaching those belonging to key affected populations, such as indigenous people, sex workers, and young women, contribute to these low coverage rates.

**Pre-exposure prophylaxis (PrEP)**

Brazil is the only country in Latin America where pre-exposure prophylaxis (PrEP) is available through the public sector. The country’s Ministry of Health aims to provide PrEP to more than 50,000 sex workers, gay men, and other men who have sex with men, and transgender people between 2018 and 2023. In Chile, Costa Rica, Guatemala, Mexico, and Uruguay, PrEP can be obtained through private healthcare providers, the internet, or research projects.

The Bahamas and Barbados were the only Caribbean countries providing PrEP through the public health system in 2018, although PrEP is available through private providers in the Dominican Republic, Jamaica, and Suriname. It is not yet available in Cuba, Dominica, or Haiti.

**Harm reduction**

Access to harm reduction programmes across Latin America and the Caribbean is extremely limited.
Only eight countries provide needle and syringe programmes (NSPs): Argentina, Brazil, Colombia, Dominican Republic, Mexico, Paraguay, Puerto Rico and Uruguay. In some cases, coverage of NSP services is believed to have declined due to the reduction in the number of people who inject drugs, such as in Argentina, Brazil and Uruguay.67

In 2016, the proportion of people using sterile injecting equipment the last time they injected drugs stood at 54% in Brazil, 71% in Mexico and 92% in Paraguay. No other countries in the region reported official data on this or any other indicator relating to drug use, further highlighting the severe lack of information about this key population.68

The close of Global Fund support has had a big impact on NSP provision in Mexico. NGOs in Tijuana and Cd. Juarez report that distribution of needles and syringes per person who injects drugs fell by between 60% and 90%.69

As of 2016, opioid substitution therapy (OST) services were only available in Argentina, Brazil, Colombia, Mexico and Puerto Rico.70

**Antiretroviral treatment availability in Latin America and the Caribbean**

Access to antiretroviral treatment (ART) across Latin America and the Caribbean is uneven and far behind many other regions. Treatment coverage was 61% of all people living with HIV in Latin America in 2017 and 57% in the Caribbean.71 72

By 2017, 45% of countries in the region had adopted a ‘treat all’ policy whereby anyone testing positive for HIV is offered treatment, regardless of the level of viral progression.73 However, coverage varies hugely between countries: from 36% in Bolivia to 67% in Peru (in Latin America) and from 31% in Belize to 66% in Cuba (in the Caribbean).74 75

The success of treatment also varies, indicated by differing levels of viral suppression among people living with HIV. Viral suppression is achieved when the level of HIV in someone’s blood is so low the virus becomes undetectable, meaning they will not be able to transmit HIV on to others and should be in good health. Data is limited, although UNAIDS reports overall viral suppression to be 52% in Latin America and 40% in the Caribbean. Again, suppression varies widely between countries. In Latin America it ranges from 21% of people on treatment in Panama to 59% in Brazil. In the Caribbean it ranges from 17% of people on treatment in Jamaica to 43% in Cuba, Dominican Republic and Suriname.76

In 2018, a study into adherence to ART in Latin America and the Caribbean found the average adherence rate to be 70% (it is estimated that to achieve viral suppression an adherence rate of 95% is needed). Factors that contribute to poorer levels of adherence include substance misuse, stigma, depressive symptoms and high pill burden.77

Key populations and young people often face barriers to accessing treatment. For example, research from Puerto Rico found that people who inject drugs constitute the highest percentage of people living with HIV who did not have access to treatment (between 41% and 53%). This was despite the fact that highest retention rate once they initiated treatment.78
A study among 13 to 17-year-olds living with HIV in Peru found most barriers to adherence centred on a lack of family or caregiver support, a history of declining health due to previous poor adherence, side effects from ART, and misinformation about treatment. 79

**Drug resistance**

HIV-transmitted drug resistance (HIVTDR) remains at a moderate level in Latin America and the Caribbean at 7.7%. However, a wide-ranging evidence review published in 2016 found it to be increasing, rising more rapidly in the Caribbean than in Latin America. 80

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Civil society’s role and HIV in Latin America and the Caribbean

There is a strong presence of civil society organisations (CSOs) and community-led networks in Latin America and the Caribbean, with civil society instrumental in both the region’s HIV response and human rights activism, particularly in Latin America. For example, Latin America is now recognised as a major leader in the global LGBTI movement.

“ This victory is much more than just the legal challenge and constitutional reforms. It is a rallying cry for the LGBT community and our allies to stand up and be counted! This represents the first COVID-19
in the history of the English speaking Caribbean that we have become truly visible and in a populist and meaningful manner. Yes, there was pushback but we are pushing forward in ways never seen before. This is the Rosa Parks moment for LGBT people of the Caribbean and we shall NEVER sit in the back of the bus again."

-LGBT activist Jason Jones after winning a legal case against the government of Trinidad and Tobago, challenging the legality of a law prohibiting same-sex relationships.81

In 2016, Civicus reported that civil society in Latin America and the Caribbean is coming under increasing pressure. According to the report, much of the danger for civil society results from webs of corruption that mesh the interests of politicians and other public officials with those of large private entities and, in some cases, organised crime.82

HIV and tuberculosis (TB) in Latin America and the Caribbean

While tuberculosis (TB) is far less of a severe public health issue than in parts of Africa and Asia, it remains a significant problem in some countries in the region, and particularly affects people living with HIV.

Although some countries are now moving towards eliminating TB, eight are still experiencing significant TB epidemics. In 2016, more than half of people newly infected with HIV were concentrated in four countries: Brazil, Peru, Mexico and Haiti. Among those newly infected with TB in the region, 13% were living with HIV.83 In 2015, around 6,000 people living with HIV died from TB.84

Health system weaknesses continue to undermine TB diagnoses in the region. In the Americas, according to PAHO/WHO data, 50,000 people with tuberculosis were not diagnosed in 2015. Early detection and effective treatment are essential to prevent TB-related deaths, especially among people living with HIV.85

Inadequate linkages to care after diagnosis, poor follow-up, failure to reach the people most at risk of disease - particularly marginalised populations, including people who use drugs, prisoners and migrant workers - and poor treatment outcomes contribute to the lack of progress.86

Barriers to the HIV response in Latin America and the Caribbean

Legal, cultural and socio-economic barriers

Discrimination against key populations and HIV-related stigma continue to proliferate through many societies in the region, and discriminatory practices are widespread in health and other sectors.
Key populations and women living with HIV are subject to practices such as forced sterilisation and denial of health services. Discriminatory and punitive laws and policies further limit access to services.\textsuperscript{87}

Some Latin American countries have passed national drug policy reforms in recent years, shifting away from a punitive approach. Despite this progress, across the region large numbers of people who use drugs are still imprisoned. Around one in five prisoners in the region are detained due to drug-related offences and their numbers have been rising.\textsuperscript{88}

Latin America offers a contradictory narrative when it comes to men who have sex with men, and LGBTI people. Some countries have made significant progress in recognising LGBTI rights. For example, Argentina, Brazil, Chile, Colombia, Costa Rica, Ecuador, Mexico and Uruguay allow marriage or civil unions between people of the same sex.\textsuperscript{89}

However, the region has the highest rate of violence against LGBTI people in the world. Transgender people, in particular, face very high levels of transphobia. Furthermore, the arbitrary detention of transgender women, including torture and inhumane treatment, is not investigated and prosecuted. Transphobia is reported to be widespread among police forces in Guatemala and Honduras.\textsuperscript{90}

Discriminatory laws against sex between men exist in the majority of Caribbean countries. While seldom enforced, existing legislation has the impact of institutionalising discrimination against men who have sex with men.\textsuperscript{91} However, in 2018 a legal case against the government of Trinidad and Tobago challenging the legality of a law prohibiting same-sex relationships suggests things might be changing. Although the government has appealed the decision, the move forward is seen as a significant step for LGBTI rights in the Caribbean.\textsuperscript{92}

The region’s culture of ‘machismo’ and gender inequality drives all forms of gender-based violence and gender inequality. Cis-boys and men are expected to be manly and have an exaggerated masculine pride. Cis-women are expected to be submissive to their husbands. People who do not fit into these accepted norms of masculine and feminine behaviours face stigma, rejection, discrimination, harassment and violence.

Intimate partner violence is a major issue in a number of countries. In Colombia and Nicaragua, more than one in three women reported being physically or sexually assaulted by a partner in the previous 12 months, compared with around one in six women in Dominican Republic and Haiti, one in seven in Cuba and one in 10 women in Guatemala, Mexico and Peru.\textsuperscript{93}

The majority of countries in Latin America and the Caribbean have no restrictions on entry, stay and residence for people living with HIV. Nicaragua and Paraguay have restrictions on the permanent stay of people living with HIV who have been in the country longer than three months. In both countries, resident permits are withdrawn in the case of a positive HIV test.\textsuperscript{94}
introduced social protection measures to mitigate against the negative impacts suffered by those affected by HIV.\textsuperscript{95}

In Uruguay, the 'Social Card' is a social protection programme aimed primarily at transgender women. Cardholders receive US $30 a month to buy food and cleaning products. The initiative reaches 1,000 people, the majority of whom belong to the transgender community.\textsuperscript{96}

**Structural and resource barriers**

The cost of antiretroviral medicines (ARVs) remain an issue. Many countries in the region are classified as middle-income, and do not benefit from access to the price reductions available to low-income countries. In Venezuela, the economic crisis makes it difficult to procure and distribute medical commodities, including for HIV testing and treatment. Shortages of antiretroviral medicines, opportunistic infection treatment and condoms are common.\textsuperscript{97 98}

Stock-outs of ARVs are another major structural obstacle. While efforts have been made to decrease the likelihood of this happening, 10 countries reported at least one stock-out in the previous 12 months when an analysis took place in 2012.\textsuperscript{99}

In the Caribbean, efforts to reach men and boys, and particularly gay men and other men who have sex with men, are constrained by health services insufficiently tailored to their needs and limited community-based services.\textsuperscript{100 101}

**Stigma and discrimination**

Many people remain ignorant and fearful of HIV and AIDS, and myths about HIV and how it’s transmitted persist. UNAIDS reports that in several Latin American countries, at least one third of people said they would not buy vegetables from a person who is living with HIV. Discrimination towards people living with HIV by healthcare workers is common to varying degrees. In Paraguay, 17% of people living with HIV said they had been denied healthcare services because of their HIV status within the last 12 months, and 20% said that healthcare professionals had revealed their HIV status to others without consent. In Nicaragua, discrimination was less frequent, reported at 4% and 8% respectively.\textsuperscript{102 103}

Larger numbers of people in the Caribbean stigmatisate and discriminate in similar ways. For example, in Jamaica, 71% of people said they would not buy vegetables from a vendor who is living with HIV, as did 58% of people in Haiti and 49% of people in Dominican Republic.\textsuperscript{104}

A number of Caribbean countries are showing progress in addressing the stigma and discrimination experienced by key populations. A regional transgender advocacy coalition works on issues relating to human rights, social justice and HIV. In Cuba reports are encouraging: less than 1% of gay men and other men who have sex with men and about 2% of female sex workers said they had avoided taking an HIV test in the previous 12 months due to stigma and discrimination.\textsuperscript{105}
“[His family] fed him in the same plate ever, and like that, he had his own cup, glass, fork, knife, spoon, you get the idea, he was isolated by his own family. His razors where always trashed, and his tooth brush too, also, no one was ever taking care of his pills... One week before he died, in the middle of a discussion because of having AIDS he was thrown out of his house by his older sister... he died alone.”

- Lover of an HIV-positive man in Honduras

Data issues

A lack of data is a major issue in the region. Data is particularly lacking on people who inject drugs and transgender people, as well as on a number of key indicators such as treatment adherence and viral suppression.

Funding for HIV in Latin America and the Caribbean

The total funding available for the HIV response has nearly doubled over the last decade, with more than 95% coming from domestic resources. Between 2006 and 2017 domestic resources increased by 189%, and international resources decreased by 11.6%. It is estimated than an additional US$ 293 million, a 9.3% increase, is needed to reach the 2020 funding target.

Funding for the Caribbean’s HIV response in particular has been declining since 2012, mostly because international support has been gradually withdrawn. In 2017, the United States President’s Emergency Plan for AIDS Relief provided 57% of all HIV resources in the Caribbean and the Global Fund to Fight AIDS, Tuberculosis and Malaria provided 8%. In 2017, approximately US$ 315 million was available for HIV programmes in the Caribbean, half of what is needed to reach the UNAIDS 90-90-90 targets by 2020. Domestic funding for prevention programmes is also low.

In Haiti, which has the largest epidemic in the region, the HIV response is more than 90% externally funded and reliant on external support.

The future of HIV in Latin America and the Caribbean

While some countries in Latin America and the Caribbean have made significant progress, particularly in terms of treatment availability, it has been patchy. Even where treatment is available, a number of cultural and legal barriers prevent many groups from accessing the services they need. For example, HIV-related crimes, which need to be addressed by laws and policies that protect the rights of all people.
Prevention programming needs to focus on key populations and although regional prevention targets have been endorsed by country stakeholders, and by prominent civil society organisations, financial investment in prevention is lacking.\textsuperscript{115, 116}

Brazil has played a major part in advancing Latin America’s HIV response and improving rights for LGBTI people and other marginalised communities. The success of the far-right is seen as a severe threat to progress in Brazil, with unwelcome consequences for Latin America as a whole.

In the Caribbean, early diagnosis and linking to care, retention in treatment and adherence need special attention. In addition, focusing on the knowledge and service access gaps facing young people and key populations is necessary.\textsuperscript{117, 118}

In both sub-regions, implementing sensitisation programmes that target national uniformed personnel, aimed at reducing stigma and discrimination towards key affected populations and people living with HIV, are needed in order to reduce hate crimes and improve access to HIV, health and other essential services.

There is also a pressing need for better quality data on a number of key populations and for national strategic information systems to be strengthened to make sure that progress is effectively monitored.\textsuperscript{119}

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\textbf{Last full review:} 23 November 2018  
\textbf{Next full review:} 21 November 2021

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TAB 7
Stakeholder Submission to the United Nations Universal Periodic Review for the 2nd-Cycle Review of Trinidad & Tobago, during the 25th Session
Submitted: 21 September 2015

Joint NGO Submission by:

1. CAISO (Coalition Advocating for Inclusion of Sexual Orientation)
   47 Norfolk St, Belmont, Port of Spain, Trinidad & Tobago • caisott@gmail.com • +1 868-322-7373 • gspott.wordpress.com • Contact: Colin Robinson, Executive Director • CAISO (est. 2009, inc. 2012, Trinidad & Tobago) works to make sex/gender diversity part of T&T’s national identity through: a multi-organizational casework programme using law and social work to prevent and redress violations of human rights and dignity related to sexual orientation, gender identity and expression, and to strengthen human rights self-efficacy and advocacy by LGBTI persons; advocacy leadership to strengthen national human rights machinery and mobilize collaborative civil society use of human rights mechanisms; and work to shift public understanding, discourse and policy on sexuality, gender, citizenship and rights.

2. CariFLAGS (Caribbean Forum for Liberation and Acceptance of Genders and Sexualities)
   47 Norfolk St, Belmont, Port of Spain, Trinidad & Tobago • carifлагssecretariat@gmail.com • +1 876-844-9366 • www.facebook.com/groups/cariflags • Contact: Dane Lewis, Co-Chair • CariFLAGS (est. 1997, Curacao; inc. 2014, Trinidad & Tobago) incorporates national NGOs in Belize, the Dominican Republic, Grenada, Jamaica, St. Lucia, Suriname and Trinidad & Tobago as directors of a regional network whose mission is to build Caribbean nations where LGBTI people enjoy full fruits of citizenship, and to strengthen cultural understanding, policy, litigation, leadership and domestic movements that enable that.

3. Family Planning Association of Trinidad & Tobago
   79 Oxford St, Port of Spain, Trinidad & Tobago • ed.fpatt@gmail.com • +1 868-623-4764 • www.ttpta.org/fpa • Contact: Dona Da Costa Martinez, Executive Director • FPATT (est. 1956, Trinidad & Tobago) has a mission to advance sexual and reproductive health and rights, through advocacy and the provision of quality services to men, women and young people in Trinidad and Tobago. FPATT is an affiliate of the International Planned Parenthood Federation.

4. Friends for Life
   47 Norfolk St, Belmont, Port of Spain, Trinidad & Tobago • friendsforlife-tt@live.com • +1 868-379-1952 • Contact: Luke Sinnette, Social Worker • FFL (est. 1997, inc. 1999 Trinidad & Tobago), Trinidad & Tobago’s oldest LGBTI NGO, is a grassroots organisation with a focus on working-class issues, trauma and resilience, Trans MTF sex work, and transformative social work pedagogy. A founding partner in Wholeness & Justice (a casework and advocacy initiative which blends clinical practice with critical consciousness and therapeutic social action), FFL also runs a volunteer hotline and HIV outreach programme, provides group and family counseling, and finds emergency housing for those made homeless by discrimination.

5. Silver Lining Foundation
   thesilverliningfoundation@gmail.com • www.silverliningtt.com • Contact: Jeremy Steffan Edwards, Chairman • SLF (est. 2012, inc. 2013 Trinidad & Tobago) is an NGO which primarily acts as a guardian body for marginalized youths seeking to prevent suicide and discrimination. The focus, while on bullying and discrimination, is centered on youth with regards to LGBT issues and those of gender identity and expression.
Submission Focus & Goals

1. This joint thematic submission focuses on human rights practice and protection related to fulfilment of sexual and reproductive rights (with the exception of violence against women and children, which deserves its own thematic focus) in Trinidad and Tobago.

2. It reviews implementation steps and assesses achievements by Trinidad & Tobago with regard to each recommendation accepted and voluntary commitment made by the state, at all stages of the UPR first cycle, that are related to the submission theme.

3. It assesses the development of normative and institutional frameworks for ensuring and protecting human rights in Trinidad & Tobago, in particular state machinery and initiative.

4. In the course of the review and framework assessment, it highlights relevant developments in domestic law, policy and international cooperation since March 2012, and identifies challenges and constraints they present in domesticating human rights norms.

5. It makes recommendations with specific indicators for achieving unmet commitments and outstanding obligations.

Review of First-Cycle Commitments

6. Six recommendations on the theme of our submission were described by the state during the first cycle as already “implemented or in the process of implementation” (A/HRC/19/7, para. 87). One additional first-cycle recommendation on this theme enjoyed the support of the state (A/HRC/19/7, para. 86.10). We reproduce these in blue italics, indented, along with the paragraph number from UPR documents in which they appear, and review each in the paragraphs that follow it.

7. 87.17. Continue to develop and implement measures aimed at protecting the rights of all children, particularly those in vulnerable situations (A/HRC/19/7)

8. 87.26. Continue and strengthen current efforts to increase the accessibility and quality of health services and education for all its citizens (A/HRC/19/7)

9. New child protection legislation and improvements in health and education services leave critical gaps in sexuality education, maintain laws enabling child marriage, and radically increase criminal penalties for same-sex sexuality between minors, while decriminalizing similar conduct between children of opposite sexes.

10. Important pieces of child protection legislation have been passed since March 2012, and a Children’s Authority has accomplished critical advances in functionality. Sections of the landmark Children Act of 2012 which became law in May 2015 revised and expanded the regime of sexual offences against children, with generally enhanced penalties, raised the age of sexual consent to 18 years, and decriminalised non-coercive sexuality between minors close in age in non-familial or -custodial relationships. It explicitly withheld this decriminalisation provision when children are of the same sex (paragraphs 20(1)(c), 20(2)(c) and 20(3)(c)), and by repealing previously age-scaled penalties for sexual offences when committed by minors, makes non-
coercive sexual activity between minors of the same sex subject to life imprisonment, regardless of their ages. The age of criminal responsibility in Trinidad & Tobago is effectively seven years. Further, although “GOTT has recognized that this is a specific human rights issue which must be addressed” (A/HRC/19/7/Add.1, para. 8), the Children Act not only fails to repeal legislation that drew attention in the first cycle permitting marriage of girls as young as 12 and boys at 16—it provides exemptions from criminalisation for sexual offences against minors for the spouses of minors. Overall, the Act deliberately seeks to entrench pre-existing laws known to be violations of human rights; e.g., excluded from the child marriage exemption is “buggery” (anal intercourse), because it is criminalized even when consensual. Every Independent (non-political) member of the Senate withheld support for the legislation, and members of that bench forced a voice vote on the unequal decriminalization provision.

11. Statistics on teenage pregnancy and HIV in Trinidad & Tobago underline the link between inadequate education, early sexual activity and negative sexual health outcomes. These include data from the Central Statistical Office that since the turn of the century teen pregnancy rates have not declined. Little “debate” remains regarding children’s right to access age-appropriate comprehensive sexuality education as a norm. The August 2008 Mexico Declaration on Comprehensive Sexuality Education in Schools (“Prevention through Education”) united Ministers of Health and Education across Latin America and the Caribbean to commit to reducing “by 75% the number of schools [administered by the Ministries of Education] that do not provide comprehensive sexuality education” and “reduce by 50% the number of adolescents and young people who are not covered by health services that appropriately attend to their sexual and reproductive health needs”. Yet, the Minister of Education who took office in September 2015, at his swearing-in, addressed efforts to access to sexual education and health services for those of school-age with “religious education must form a part of the curriculum in all our schools. Sex education is something we need to discuss and we feel it is the responsibility of the parent to educate his or her child with respect to their sexual well-being, so although it might form part of our social studies curriculum it is largely a matter of the parents to deal with that.”

12. 87.25. Further action to reduce maternal mortality (A/HRC/19/7)

13. Maternal mortality rates rose 40% over a three-year period. Media reports on the Third Annual Report 2014—Making Progress, Strengthening a Nation, laid in Parliament in April 2015, quote the then Planning minister that the maternal mortality rate rose from 46 per 100,000 births in 2010 to 64 in 2013. “That means that this is something that we did not do well. And this is an issue of major concern,” he acknowledged. He also told Parliament, the mortality rate was among indices that “fell below their targets, and therefore require immediate and urgent attention”

14. 87.5. Adopt measures so that traditional stereotypes referring to the roles of men and women in society and family can be overcome (A/HRC/19/7)

15. 87.3. Continue its significant efforts to promote gender equality, in particular the implementation of the “Draft National Gender Policy” (A/HRC/19/7)

16. With the September 2015 change in Government, a six-year-old document criticized by human rights advocates as weak will displace the policy referenced, which was never
enacted. The gender portfolio moves to its fourth ministry in five years, as a sub-unit of a broad social development and family services umbrella, after gender rights machinery with a Ministry-level champion had been put in place over four years.

17. Between May 2010 and September 2015, a suite of gender-focused programmes (including Defining Masculine Excellence, addressing stereotyping of masculinities) has been shifted across four different government ministries (community development, gender, planning, social development). A gender-centred ministry, established in June 2011, with a “gender development” mission to “provide expertise and support to government agencies and other stakeholders or focal points, as well as institutionalizing gender in the planning process”, in response to human rights frameworks, had a defined mandate that included masculinity, femininity, sexual orientation and gender and special interest groups. After four years, that Ministry of Gender, Youth & Child Development (cited four times by the state during the first cycle) is currently in the process of being split and decommissioned and the gender units are reportedly being merged into a new Ministry of Social Development and Family Affairs.

18. Cabinet twice deferred action on an omnibus national gender policy before it, which had been the subject of considerable consultation and resources, and intended to achieve domestication of CEDAW. It languished without action for close to three years of the last Government’s term, which ended without its enactment. Religious opposition to recognition of the rights to LGBTI persons, to decriminalization of abortion, and to recognition of gender as a social construct were widely reported as the barriers to government leadership in moving it forward. However, even when the media reported that “God still reigns supreme in T&T, according to the Constitution, and gay rights will not be a part of the Government’s draft national policy on gender and development…Minister of Gender, Youth and Child Development Marlene Coudray, finally breaking her silence on the controversy…said14, the Policy still failed to be implemented. Whether the policy proposed measures related to workplace discrimination based on sexual orientation was the subject of a media dispute between Coudray15 and a former minister of state in the Gender ministry16. In September 2015, a new government took office and has adopted its manifesto17 as government policy. That manifesto declares an intention to enact an older, 2009 gender policy document,18 which states explicitly in its executive summary that it “does not provide measures dealing with or relating to…same-sex unions, homosexuality or sexual orientation” (p. 5).

19. 87.23. Increase measures to ensure that violence and discrimination against members of vulnerable groups, such as women and lesbians, gay, bisexual, and transgender persons, are both prevented and prosecuted (A/HRC/19/7)

20. 86.10. Undertake proactive policies to promote the rights of individuals, especially with regard to their sexual orientation and HIV/AIDS status (A/HRC/19/7)

21. No new measures or policies have been adopted, despite recommendation by other state bodies. The first clear institutional framework for doing so will be weakened.

22. No new measures or policies related to promotion of rights or prosecution or prevention of violence or discrimination with respect to LGBT persons or sexual orientation have been implemented since 2011. Proposals by arms of the state to do so have not yet been enacted by Government or Parliament (see paras. 24 & 43).
23. A Gender ministry with a clear mandate to “provide expertise and support to government agencies and other stakeholders or focal points”, accountability to human rights frameworks, and an explicit responsibility for sexual orientation will be subsumed into a Ministry of Social Development & Family Affairs (see para. 17).

24. The Equal Opportunity Commission, an independent state body created by legislation, has recommended to Government, pursuant to its mandate to keep the legislation under review, (see paras. 43 & 50) that it be amended to include sexual orientation as a protected status on the basis of which discrimination is prohibited in employment, education and the provision of housing, goods and services. That recommendation does not have the force of policy, and no amendment to the legislation has yet been introduced.

25. Trinidad & Tobago made several additional written statements of commitment at adoption. We again reproduce these in blue italics, indented, along with the paragraph number from UPR documents in which they appear, and review each in the paragraphs that follow it.

26. One of these has come to life as a repeated policy statement of majoritarianism in recognizing human rights of LGBTI persons and other rights. Others have been undermined by policy and practice.

27. 24. The Government seeks to recognise the human rights of all citizens, which includes the LGBT community…. The development of law is a dynamic process which adapts to the development of any given society. The law must evolve and grow to suit the needs of a continually developing society…. GOTT recognised the need for a definitive debate on the protection of same sex couples. (A/HRC/19/7/Add.1)

28. The intention to afford rights recognition was repeated by the then Justice minister for an audience of representatives of other states and international organizations in March 2013, and reported in the local media. No legislative developments have been enacted; the last legal measure recognizing LGBT-related rights came into force in January 2012. Parliamentary debate on the LGBT community and the protection of the law has been ongoing and encouraging, but led in almost all instances by non-Government Parliamentarians.

29. Of greater concern, “the need for a definitive debate” is repeatedly framed by Government and political parties as a need for debate and assent of a majority of citizens as to whether members of the LGBT community should enjoy human rights and their protection. Most recently, in August 2015, this was articulated by the then Prime Minister as: “Our position is…that that is not a decision that could be made by us or the Cabinet sitting. It is a matter that requires tremendous…stakeholder consultations to arrive at the consensus view…Gay rights…with the greatest of respect is not my decision to make, but is one that will require full consultation with the national population.”

30. 26. In relation to incidents of violence against a member of the LGBT community, Section 4 of the Constitution enshrines fundamental rights and freedoms, namely, the right of the individual to life, liberty and security of the person. (A/HRC/19/7/Add.1)

31. A University of the West Indies Faculty of Law report, Adjudication in Homicide Cases involving Lesbian, Gay, Bisexual and Transgendered (LGBT) Persons in the Commonwealth Caribbean, after “a close examination of how justifiable homicide and provocation doctrines have been applied by
courts in the Commonwealth Caribbean”, finds “significant tensions between the constitutional rights [to life, due process and equality] and obligations and the law as applied to homicide cases involving LGBT persons” “in which a ‘homosexual advance defence’ has been raised by the defendant in a homicide case”. It concludes “the relevant criminal law shows insufficient regard for the life of a deceased LGBT person; the law fails to respect the criminal law principles of reasonableness and proportionality; and the law reflects a perception of the LGBT person as criminal.” A pair of Trinidad & Tobago cases, *Cox v The State* and *Marcano v The State*, are at the core of the analysis.

32. With particular reference to violence against the LGBT community, the definition of rape in the Sexual Offences Act, 1986 was amended by Act 31 of 2000 to reflect a gender neutral position with regard to the complainant and the victim. This amendment serves to include protection for victims of violent same sex activity. *(A/HRC/19/7/Add.1)*

33. Sexual violence involving a perpetrator’s mouth and a victim’s penis are not covered in the 2000 amendments to the definitions of rape and grievous sexual assault in the Sexual Offences Act. They are prosecuted using section 16 “serious indecency”, which carries a far lesser sentence if both parties are adults, of five years (ten for a subsequent offence).

34. Further, buggery (section 13) is still routinely used to prosecute anal rape because of the ease of conviction without needing to prove a lack of consent, since buggery criminalizes all anal intercourse, regardless to age, gender or consent. Buggery carries a maximum sentence of 25 years, compared to life for rape, so such prosecutions deny justice to both victim and accused.

35. Further commitments and statements of policy were made by the state during the interactive dialogue in November 2011. These include:

36. It clarified that laws criminalizing same-sex activity were not enforced... *(A/HRC/19/7)*

37. This remains accurate as a description of prosecutorial practice. However, prosecutorial policy is the province not of the executive but an independent Director of Public Prosecutions. A policy statement/moratorium by that Office with regard to ending prosecution of consensual adult sexuality should be recommended during the 2016 UPR.

38. It explained that the immigration laws were being reviewed and it was not yet clear what the result of the review would be. Moreover a new policy to afford easier access to HIV care and services for migrants was being developed. *(A/HRC/19/7)*

39. Notwithstanding the review, the immigration law provisions with respect to homosexuals, persons living off their earnings, persons reasonably suspected of coming to the state for the purposes of living off the earnings of homosexuals or of attempting to bring persons into the state for homosexual purposes, and persons who practise, assist in the practice or share in the avails of homosexualism, remain on the books. They have been challenged in the Caribbean Court of Justice under the freedom of movement provisions of the Revised Treaty of Chaguaramus of the Caribbean Community. Despite conflicting testimony at times, the acting Chief Immigration Officer told the court that Trinidad & Tobago would not apply the law, in breach of the Treaty, to CARICOM nationals. Counsel for the state, however, told the Court the
state had no plans to repeal the legislation, but saw an interest in keeping it, and twice made reference to its role with regard to terrorists from other states.\textsuperscript{25}

40. In July 2015, the then Health minister announced that one of the explicit goals of introduction of a new national health card was to make it harder for migrants to access HIV care and services.\textsuperscript{26,27,28,29,30} In September 2015, following a change in government, the new Health minister promised to review this policy and told the media that at present “Anyone can go to any health care facility and receive treatment.” He announced plans for a universal health insurance system “especially for vulnerable groups… regardless of their personal financial circumstances”.\textsuperscript{31} (Trinidad & Tobago also indicated a first-cycle recommendation to 87.33. \textit{Endeavour to sustain the maximum humane care for “illegal immigrants” and assist them to utilize, on a timely basis, the prevailing legal system in the country to address their situation (A/HRC/19/7)} was already in the process of implementation.

41. In both \textit{A/HRC/19/7/Add.1} and during the interactive dialogue at adoption, Trinidad & Tobago made a number of bold assertions about its human rights leadership. Two of note, regarding domestic human rights legislation and human rights dialogue with civil society, it has honoured in the breach:

\begin{quote}
42. \textit{479. Trinidad and Tobago's domestic legislation dealing with discrimination was in the process of being amended to include a person's HIV/AIDS status, as one of the recognized categories under which a person is protected from discrimination. This legislative recognition is not only necessary but pioneering in the region. It noted this maverick attitude towards the protection of human rights of all would propel national debate and eventual change in Trinidad and Tobago, in relation to issues such as sexual orientation. (A/HRC/19/2)}
\end{quote}

\begin{quote}
489. Trinidad and Tobago reiterated its appreciation for the active and constructive exchange…throughout the UPR process…as well as its continuing dialogue with non-governmental organizations at the consideration of its UPR report to the Government which prides itself on dialogue and transparency in the amendment of all legislation. (A/HRC/19/2)
\end{quote}

43. Legislation introduced in Parliament in 2011 to include HIV/AIDS status in the protections of the Equal Opportunity Act lapsed in June 2012\textsuperscript{32} without being brought to the floor for debate, and was never reintroduced. The legislation was re-drafted to frame HIV/AIDS status as a disability; however, non-governmental HIV/AIDS organizations (who object to this) were not consulted on this step. When sent the legislation for comment, the HIV/AIDS Advocacy & Sustainability Centre at the Labour ministry requested permission to include one HIV NGO with which it partners in its response. No sexual orientation NGOs have been included in dialogue on amendment of the equal opportunity legislation. In March 2015, after repeated requests “since 2007” to “Parliament, the Attorney General, and the Chief Parliamentary Counsel…to offer input on behalf of the citizens” they “represent in improving the Equal Opportunity Act”, and “[i]n June of 2013” writing “the state urging an IACHR hearing on some of the issues”, without a response, HIV, sexual orientation and other NGOs requested a hearing at the InterAmerican Commission on Human Rights (IACHR) to, among other goals (see paras. 51–52), engage in dialogue with the state on adding HIV status and sexual orientation to equal opportunity legislation. The state failed to appear.\textsuperscript{33,34} Trinidad & Tobago’s mission to the Organization of American States made a telephone apology, but the state has not followed up with the NGOs who requested the hearing in any other way. A written submission sent by the Equal Opportunity Commission to the IACHR has not been shared with the NGOs.
Normative & Institutional Framework: 
Progress in Strengthening Human Rights Machinery, Promoting Human Rights, and Achieving Paris-Principles Compliance

44. During the interactive dialogue

45. Trinidad and Tobago further indicated that the Ministry of the Attorney General in conjunction with the Equal Opportunity Commission was in the process of developing a nationwide human rights awareness campaign. A feasibility study was conducted to determine the most effective mechanism to reach the widest demographic by the International Law and Human Rights Unit of the Ministry. (A/HRC/19/7)

46. In late 2015, such a campaign has not yet materialized.

47. As part of Parliamentary reforms, new Standing Orders have been adopted for both houses of Parliament, which in November 2014 established a standing Joint Select Committee (JSC) on Human Rights, Diversity, the Environment and Sustainable Development—an important development in engaging the Parliament with oversight over human rights. The Committee has “the duty of considering from time to time, and reporting whenever necessary on all matters related to…the compatibility of Acts of Parliament with human rights, and any matters relating to human rights in Trinidad and Tobago (but excluding consideration of individual cases)”35. LGBTI advocates met with the Committee in March 2015 through the aegis of a global parliamentary organization, briefed it on LGBTI matters and the forthcoming equal opportunity hearing (see para. 43), and made themselves available to the JSC on legislative and other matter. The Committee established domestic violence as its first priority and produced a June 2015 report examining programmes and services which provide support to victims of domestic violence. It invited 28 NGOs to make submissions. LGBTI NGOs were not among them, and the report makes no recognition of the gaps in services for victims of same-sex domestic violence and the stigma they face in existing programmes.

48. Trinidad & Tobago does not have a Paris Principles-compliant NHRI. In Cycle 1, the state indicated that

49. 20…seeking technical expertise via the Special Procedure Mechanism of Human Rights Council would be a matter for consideration in the future (A/HRC/19/7/Add.1)

50. and that it was “reviewing the process of” the constitutionally constituted Office of the Ombudsman “becoming accredited under the Paris Principles” (para. 10, A/HRC/19/7/Add.1). A focus on the Equal Opportunity institutions—a Commission and quasi-judicial Tribunal—established through 2000 legislation that extends rights protections beyond those in the Constitution and creates horizontal rights would provide an institutional framework with greater potential, and allow the Government greater legislative agility, for establishing a compliant NHRI. They meet seven of eight key characteristics of NHRIs,36 and enjoy greater functional power, compared to the Office of the Ombudsman, described in the Government Constitutional Reform Commission report as “viewed as an ineffective institution” and “Parliament does not take it seriously” (para. 225, p. 36)37.

51. Human rights defenders requested a hearing with Government at the InterAmerican Commission on Human Rights in March 2015 (para. 43) “to dialogue with dutybearers…about
how we strengthen relatively weak, but promising, human rights machinery in Trinidad and Tobago”, noting that “new opportunity exists for state institutions outside of the political branch to seize and fulfil our human rights obligations”. We noted that “Section 5(2)(h) of our Constitution enumerates a ‘right to such procedural provisions as are necessary for the purpose of giving effect and protection’ to its Bill of Rights” and quoted parliamentarian Wade Mark’s comment that “If there are no institutions available to give effect to…fundamental rights, they become meaningless.” Government did not participate.

52. Post-colonial, small-island developing states like Trinidad & Tobago, with still-maturing institutions and long colonial cultures of inequality, have a heightened obligation to strengthen human rights machinery and protect minority rights. Rightsbearers in such states (where extrajudicial punishment of difference is likely, impunity common, social interdependence high, stigma amplified, redress machinery admittedly weak, and state regimes of evidence-based sexuality education underdeveloped), especially those who are sexual minorities, are well documented to be vulnerable to victimization, violence and other rights violations, and single violations can effect multiple ruptures to safety, dignity and livelihood. Other than the IACHR, Trinidad & Tobago affords rightsbearers no access to supranational human rights adjudication mechanisms, which are expressly designed to backstop failures, negligence or weaknesses in domestic mechanisms. In 1998 the state renounced the jurisdiction of the InterAmerican Court of Human Rights, to which it had acceded in 1991. It declined to embrace several recommendations in the first cycle regarding the adoption of convention optional protocols to provide such access, and demurred on greater embrace of special procedures.

53. Strengthening of national machinery and accountability, beyond the facile rhetoric of the first cycle, and use of technical assistance and special mechanisms in this regard, must be an outcome of the second-cycle review.

54. Trinidad & Tobago in its bloc-voting with other CARICOM states also plays a dangerous role in retarding global progress in norming and development goal-setting on sexual and reproductive health and rights. CARICOM, which votes according to the lowest common denominator of the Caribbean bloc, repeatedly resists advances on sexual and reproductive rights norms, often in tandem with the OIC and Holy See. This voting not only undermines the maturation of global human rights norms, but holds Trinidad & Tobago’s own rightbearers to a lower standard than the state’s commitments. In December 2013, the executive director of UNFPA visited the Caribbean to convene a high-level summit in response to the crisis of teenage pregnancy (see para 11). Trinidad & Tobago, as the host nation, wrote UNFPA to resist inclusion in the working document of the terms “sexual and reproductive health”, “sexual education”, “contraception” and “contraceptives”. A letter from the Ministry of Foreign Affairs noted “the term ‘sexual’ is vague and open to different interpretations and may incorporate issues of Lesbian, Gay, Bisexual and Transgender” and that “It is also unclear if the term ‘sexuality education’ includes references to sex between men and men or sex between women and women.” This behaviour has done particular harm within the InterAmerican system, which leads the globe in advancing sexual rights norms. Trinidad & Tobago has joined other Caribbean states in attaching footnotes to consensus resolution on human rights, sexual orientation and gender identity and expression. In 2014, the state noted: “In the context of existing policy and legislation, the Republic of Trinidad and Tobago is unable to support the resolution. However, Trinidad and Tobago is signatory to the Universal Declaration of Human Rights. The Equal Opportunity Act 2000 which aims to ‘prohibit certain kinds of discrimination, to promote
equality, opportunity between persons of different status’, ensures that persons cannot be discriminated against in employment, education, health, protection and other social good based on characteristics including their religion, race, class, sex and socio-economic status. Under the Sexual Offences (Amendment) Act (No. 31 of 2000) the act of sodomy whether between same sex partners or heterosexual partners is illegal. However, this legislation is rarely enforced.”

55. A testament to the right to public participation, during recently concluded Parliamentary elections, a well-known transgender woman ran for a seat. Though her right to do so was challenged in a front-page newspaper story that interviewed only clergymen, her campaign was largely well received.

**Recommended Indicators For Fulfilment of Recommendations, Voluntary Commitments & Outstanding Obligations**

56. The Government, in partnership with state institutions—the Office of the President, the Office of the Ombudsman, the Equal Opportunity institutions, the Parliamentary Joint Select Committee on Human Rights &c—and human rights advocates, develop and implement from 2016 onward a national campaign of human rights and anti-discrimination education in the national media, in schools and in local communities, that explicitly includes sexual and gender diversity and NGOs and representatives from LGBTI communities.

57. In consultation with the Judiciary and a broad range of human rights stakeholders, and with the technical assistance of the Office of the United Nations High Commissioner for Human Rights and others, a Joint Select Committee of Parliament draft, introduce and bring to a debate by 2017 enabling legislation to amend the authority and functions of the Equal Opportunity institutions and the Office of the Ombudsman to establish therefrom a Paris Principles-compliant national human rights institution.

58. The Government and Opposition jointly pass legislation to amend the Constitution’s Bill of Rights (currently Section 4) to protect sexual orientation and gender from discrimination.

59. The Government introduce and bring to a debate in Parliament a legislative amendment to the Equal Opportunity Act to add sexual orientation, age and HIV to statuses protected from discrimination under Section 3.

60. The Government introduce and bring to a debate in Parliament legislation to repeal paragraphs 8(1)(a), (c), (f) and 9(4)(a) of the Immigration Act.

61. The Director of Public Prosecutions declare a formal moratorium on prosecutions of consensual sodomy (including under Sections 13 and 16 of the Sexual Offences Act, and paragraphs 20(1)(c), 20(2)(c) and 20(3)(c) of the Children Act).

62. The Police Service and the Director of Public Prosecutions end use of Section 13 of the Sexual Offences Act (buggery) to prosecute anal rape.

63. The Government, the Equal Opportunity institutions and other state institutions make requests of special procedures mandate-holders and enter into technical cooperation and assistance agreements with neighbouring governments, regional and international institutions (e.g. Brazil’s
Special Secretariat for Human Rights, Cuba’s Centro Nacional de Educación Sexual (CENESEX), the United Nations Development Programme’s sexual diversity practice) to build state capacity to strengthen human rights recognition and develop policy and programmes in response to the needs of LGBTI members of the national community.

64. The Office of the Prime Minister fund and staff for a minimum of 24 months a desk dedicated to policy development, training and capacity-building on sexual orientation, gender identity and expression and sexual and bodily diversity.

65. The Ministry of Labour & Small Enterprise Development bring to Cabinet for adoption a simple policy statement on nondiscrimination in public employment, including all uniformed services, on the basis of sexual orientation and gender identity. The Ministry of Labour & Small Enterprise Development negotiate a Decent Work joint initiative with the International Labour Organisation, Joint Trade Union Movement, domestic labour unions and chambers of commerce focused on “promoting structures and programmes to reduce discrimination” against LGBTI persons.

66. The Children’s Authority, Cabinet Ministers responsible for Health, Children & Youth, and health training institutions develop and promulgate protocols for the clinical care and counseling of intersex children and their families that delay gender assignment, foster autonomy of gender identity, and permit adults to make legal adjustments to gender markers on identity documents.

67. The Government ensures that women have universal access to equitable, quality health care, including reproductive health services.

68. Cabinet Ministers responsible for Education, Health and Gender ensure delivery of accurate, developmentally-appropriate sexuality and gender education to all schoolchildren; programmes to equip parents and teachers and other school personnel to perform these roles and manage their faith beliefs; initiatives to prevent bullying and bias violence and promote school cultures of diversity and tolerance; and to promote public education and knowledge-based discourse about sexuality, sexual diversity and sexual citizenship.

69. The Government ratify the InterAmerican Convention Against All Forms of Discrimination & Intolerance.

70. The Government convene a CARICOM working group and summit meeting to engage in political dialogue and mutual cooperation on human rights, sexual orientation and gender identity/expression.
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InterAmerican Commission on Human Rights video of the hearing: [https://www.youtube.com/watch?v=fybingG2xwTs](https://www.youtube.com/watch?v=fybingG2xwTs)


independence of appointment; multipartite representation; legal establishment; human rights monitoring; advisory role to government; adjudication function; public education


See 33, supra


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PSI Caribbean

JULIEN NEAVES    TUESDAY 1 JULY 2014

So how do you get these sexually active people, including marginalised groups such as sex workers and men who have sex with men (MSM), to be cognizant of their own sexual health, and even change their practices and adopt a safer, healthier lifestyle? If you are PSI/Caribbeans, which created the very popular “Got it? Get it.” condom campaign, then you approach it like a business product - you market it.

“What makes PSI different is that yes we are an NGO but we market health. The same way that Nike would market shoes,” says Kevon Foderingham, PSI Caribbean’s Marketing and communications manager.

He was speaking with Newsday during a recent interview at the NGO’s offices at Connor Street, Woodbrook. He was joined by the vibrant and affable executive director, Marina Hilaire-Bartlett. The staff at the office are all youthful and fresh faced, dressed in brightly coloured T-shirts.

Population Services International (PSI) is a “global health organisation dedicated to improving the health of people in the developing world by focusing on serious challenges like a lack of family planning, Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS), barriers to maternal health, and the greatest threats to children under five, including malaria, diarrhoea, pneumonia and malnutrition”. It was founded in 1970, is headquartered in Washington DC, United States, has more than 8,900 staff and has programmes in 69 countries.

Hilaire-Bartlett explains that PSI globally is strong in social marketing.

“Social marketing is essentially how private sector organisations do marketing around their own brand so that you choose them over somebody
have a healthy lifestyle as opposed to a non-healthy behaviour,” she said.

She noted they marry with this the process of Behaviour Change Communication (BCC) “which takes the person along a continuum of change”. She gave the example of moving from a person not even thinking about condom use to starting to think they may be somewhat at risk and finally to the point when they believe they need to access condoms. She said there was the same BCC process for sexual health, which encompasses HIV.

PSI Caribbean was founded in 2005 with Trinidad as the head office. As years passed they expanded into other islands: Antigua and Barbuda, Barbados, Belize, Dominica, Grenada, Jamaica, St Kitts and Nevis, St Lucia, St Maarten, St Vincent and the Grenadines and Suriname. Although they operate in 12 Caribbean countries they only have three physical offices — the Trinidad regional headquarters and country offices in Jamaica and Suriname, with the latter two established in 2011.

Beginning with a focus on HIV/AIDS, in 2009 they began work in sexual and reproductive health and got into service delivery such as sexually transmitted infection (STI) screenings and contraception. They work through the International Planned Parenthood Affiliates and they administer the programme across the region.

GETTING IT

PSI Caribbean’s “Got it? Get it.” campaign for regular and consistent condom use was launched in 2006 and was spread throughout the region. Foderingingham described the campaign as their “greatest accomplishment”. He explained that before PSI Caribbean, condoms were not sold anywhere other than pharmacies. But now, through their efforts, condoms are sold in beauty parlours, corner shops and gas stations with the “Got it? Get it.” sticker as a notification that condoms are available.
Hilaire-Bartlett noted a lot of work goes into a campaign, starting with research and knowing your audience.

“What we focus on is behaviour. So you might be a straight man but you are still having multiple partners, anal sex, what have you. So how we start the development of a campaign is to really digging into those communities, walking through the life of someone,” she said.

She noted after they have a profile they apply another marketing mechanism of the four Ps - Product, Place, Promotion, Price. Then they get the campaign going by digging into those four Ps from the health perspective and looking into communities.

She explained that Got it? Get it focused on young and young at heart; persons aged 16-25 are one of their at risk groups.

“If I were to articulate how Got it? Get it was so powerful was again it started to engage discussions around condom use. It put in a package essentially that it was okay to be speaking about condoms. We need to get the discussions going. It is okay to access it,” she said.

She noted that there were sexually reproductive health advertisements around condom use, celebrity endorsements, and they also had people in the field. She also noted that the campaign was very interactive and has a social media presence which Hilaire-Bartlett believes is one of their great strengths. Their social media office is in touch on a daily basis to get their communities information on HIV, SRH prevention and gender-based violence.

“All the things that are attached to healthy living,” she added.

She said the success of the campaign has been different in different countries for varying reasons. Foderingingham noted that it also depends on the culture of the country, as certain things may be more taboo than others. He stressed
REACHING SEX

WORKERS & MSM

Two of the at risk groups that PSI Caribbean focuses on are sex workers and MSM. Foderingham noted they had an active team which would go into brothels and do SRH education and distribute condoms.

“Really get in there with that particular population because they couldn’t come out. So we had to go in,” he explained.

The team, which included Spanish speakers, focused especially on Spanish-speaking sex workers. Foderingham pointed out that there were also educators who were part of the sex worker population “so they could build that trust”. He noted that with the MSM community they also have educators which are part of that population.

“So they will go to the parties, they will go the house limes. And they would get their trust because it is the same people, it is part of the community,” he said.

He reported that the communities were very receptive to the information.

Hilaire-Bartlett chimed in that there is a level of trust you have to build and this takes time with a relationship. She also pointed out that you have to know boundaries and have agents to enter the field.

The educators, she stressed, are mandated to be responsive with whom they to those engage with and it is not “them and us” but they are in service to people.

“So when we’re programming we’re constantly going back to the drawing board — what are they saying are their needs?” she explained.
to that “so they feel respected and that we really value (their views).”

“I really think that they trust us with that and the individual members of our clientele, even in Suriname, in Jamaica, all of them are very entrenched already in the work,” she said.

She noted that PSI is not government-aligned and does not have certain agendas.

Foderingham noted that some educators are HIV positive and they disclose their status “so it’s real” when they conduct sessions. He explained that these educators do not talk down to them but tell a bit about their lives so it is a lot more relatable. He added that in general their campaigns are relatable and are not “preachy”.

HIV/AIDS STIGMA REMAINS

On HIV/AIDS Hilaire-Bartlett noted that stigma and discrimination remain an issue in Trinidad and Tobago.

“People are still being discriminated against and I’m saying in the workplace, in their homes, people are still being evicted, children are still being expelled from school, you still have scenarios like that (in this country),” she said.

She noted there was a case of an HIV positive woman and her child, were HIV negative, attending school and teachers and parents banded together and called for the child to be removed.

“And these are things that are not spoken of and that don’t make news but that happen to people every day,” she said.

She said in Trinidad people are still walking around with the fear to come out and say you are HIV positive.

She explained that stigma is a mindset and what you conceptualise someone to be, and all persons have a certain level of prejudice. She noted that stigma
because of stigma of HIV status or sexual orientation.

“I think (stigma is) still quite pervasive. I think certain groups that may not have been as vocal as before, for example the LGBT (Lesbian, Gay, Bisexual and Transgender) community, I think there are forums now where there is a lot more voice and advocacy where there had not been in the past decades,” she said.

Hilaire-Bartlett noted that knowledge about HIV/AIDS remained an issue as well and myths continue to persist.

“Even though we see that knowledge is high there are still a lot of myths that exist around HIV,” she said.

She noted, from the feedback they receive from their field teams, there are people who believe you can get HIV from mosquitoes, using the same utensils as a from person with HIV or using the same toilets.

She said perceptions is also an issue perceived positive status and actual positive status “can almost end up being the same thing”. She explained that if your sexual partner may have died of AIDS then people believe “of course you have it”.

She noted that PSI Caribbean partner organisation Caribbean Broadcast Media Partnership for HIV and AIDS, headquartered in Barbados, has a stigma unit.

She explained that though PSI Caribbean is not a specific component of their work it is entrenched in what they do and this includes hiring practices. She said in their recruitment process they make it clear that they work with populations who are difficult to reach and some people may have perceptions about, including sex workers and MSM. When they develop campaigns they are very careful about those aspects and they are inclusive and not exclusive.
region, has a dedicated stigma unit that collates information across the region and bring to a national response for strategic plans which every country should have. There is a three to five year plan how a nation should respond to HIV and that includes stigma and discrimination.

DONOR RESTRICTIONS

Hilaire-Bartlett noted that they have done a lot of work around the region, including in the Eastern Caribbean islands, but in Trinidad the work has been smaller due to donor restrictions.

She explained that, as a global organisation positioned in the Caribbean, when you look at the donor environment and how you implement projects sometimes there is a blanket approach for countries or regions. Because of that blanket approach they do not really reap the benefits or have the impact that you would need.

“But we are very careful to ensure that you’re culturally relevant. And even though we’re the Caribbean across the board every country is different and every community (is different),” she said.

She noted that generally the donor landscape around HIV in the 1980s and 1990s donation funds were “flowing” and “international aid agencies were very generous with HIV because it was the hot topic essentially” but that has since changed.

“Through the years international donors and the donor pot of money has dwindled a bit because of priorities essentially,” she said.

She noted there is a challenge for donor funding for the Caribbean because it is middle income.

“When you are looking, for example, from the donor’s perspective, where is the most need we (in the Caribbean) don’t look like (we have the most need). If you look at GDP and how ‘rich’ we are. And even across the Caribbean and
resources and how we advocate for our need is really, really important for us nationally to be able to invest in our country,” she said.

She noted that for health financing and national budgeting around HIV and other health related areas the development community is becoming more aware of the fact that it has to be an integrated approach.

“Generally the donor landscape we have to know how to manoeuvre it well and to really be able to speak to what is best for our nations,” she said.

For PSI Caribbean two of their major donors are international agencies. They do get “small pots of funding” for training and the Ministry of Labour under their HIV/AIDS Advocacy and Sustainability Center (HASC), has subcontracted them to do training for their members. She noted how they mobilise resources with the ministries and the Government is important even if it is a matter of cost sharing.

She also noted that they do partner in some ways, and in that partnership may receive things in kind and different contributions. They do not, however, receive a large pot of money coming from the local Government. She noted that there are multiple players locally in the HIV/AIDS response and PSI has a great benefit being a global organisation. She said there are others that may need funding in a different way “and we understand there is a kind of pull and tug and governments have to prioritise as well”.

On the positive side, Bartlett noted the world has advanced in the HIV response in a number of regards. In the Caribbean, for example, prevention of mother to child transmission “has almost been eliminated which is really a powerful advancement”.

In the area of stigma and discrimination Bartlett said a number of communities that did not have a voice were now able to access services, there are free anti-retroviral drugs and HIV testing done widely. She noted that the
On the impact of the efforts of PSI Hilaire-Bartlett explained that their marketing aspects are measurable; the PSI slogan is “healthy lives, measurable results”.

“At the end of the day we have to know the impact that we’ve made. So you can’t know your impact unless you know where you’ve come from. You have to be able to measure it,” she said.

She noted that they utilise “disability adjusted life years “ to check how your intervention has made an impact and would save lives, and the amount of years that are added to a life. They also measure the positive changes in the community due to their interventions.

Foderingham said that, like any organisation selling a product, they operate by targets and have to reach those targets. If they have to reach 100,000 people, for example, they will have to record how many they have reached and if they are going to reach that benchmark they will need to beef up their efforts.

He explained that educators go prepared with forms and tools and materials and capture all the information. They record what they did and these are sent back to PSI headquarters and they upload the information to their online system. They have a data warehouse that helps to guide all of their marketing efforts. On a monthly basis every country and every intervention has to report to PSI global.

EXCITING NEW FRONTIERS

With their work in HIV/AIDS and SRH, PSI Caribbean will be adding in the next couple of years Non-Communicable Diseases (NCDs) and gender-based violence. The mortality rates for chronic NCDs in the Caribbean are among the highest in the world. In Trinidad and Tobago, which has one the highest diabetes rates in the Caribbean, Health Minister Dr Fuad Khan has cited NCDs as one of the major health issues facing this country.
to NCDs. She also noted that the donor landscape is currently focused on NCDs.

As they venture in this issue she explained that the prevention of NCDs is a lot about lifestyle choices. They will be returning to BCC and will try to articulate with clients the question - “what are the choices you are making that are not giving you the healthiest results?”.

“We focused on that with HIV; to the same extent we are going to focus on it with non-communicable diseases,” she said.

She noted it is an “exciting territory” for them because it is a public health response when look at social determinants of health.

“If you have all of the services, if you have all of the hospitals and the clinics, what is it that’s happening in the community and in people’s lives that prevent (healthy behaviour),” she said.

She recalled that the Pan American Health Organisation hosted a virtual consultation for the region where all CARICOM countries came together to state their response to NCDs, what they need and how they can support each other.

“Trinidad and Tobago is really making a lot of progress,” she recalled.

She said the intention for this country is to have an NCD Unit and PSI wants to offer their services.

“Our social marketing expertise and our behaviour change successes can really support this national response,” she said.

They are currently developing proposals at this point and reaching out and are hoping for 2015 to “really dig into it”.

She noted they are also entering into a gender-based violence prevention project, which is linked to HIV, SRH and STI prevention “because they are all
This country has been granted one million dollars to do work here and it will run for three years; a similar project is being conducted in India.

Hilaire-Bartlett noted there are other players in the field and doing work for many years. They have been working with the Coalition Against Domestic Violence, headed by Diana Mahabir-Wyatt. She said they are focusing on healthy relationships and gender dynamics. Their target group will be young women between the ages of 18-30, though it will not exclude the engagement of men and boys,

“Over the next three years you are really going to be seeing PSI much more visible around (gender-based violence,” she said.

She noted that their work will be married with intervention in SRH and HIV. Work on this project begins this year.

“So it’s exciting ground,” she added.
TAB 9
“The LGBTQI community has no claim to human rights” says Trinidad Church Council

By Trinidad Express
February 21, 2019

Members of the lesbian, gay, bisexual and transgender (LGBT) community celebrate victory at the Hall of Justice in Port of Spain on April 11, 2018 following a ruling in a constitutional motion claim brought by Trinidad-born gay rights activist Jason Jones, (not in photo) against this country’s sodomy laws. *STEPHEN DOOBAY photo

(TRINIDAD EXPRESS) — The Trinidad and Tobago Council of Evangelical Churches last Friday attended the National Faith Leaders Consultation, hosted by the Pan-Caribbean Partnership against HIV and AIDS (PANCAP) in collaboration with the National AIDS Coordinating Committee (NACC) in the Office of the Prime Minister.

Issues discussed included the removal of barriers to stigma and discrimination, how the Church’s response to HIV/AIDS can be strengthened, the resolving of the tension between the Church’s value system and the recent court judgement in the Jason Jones’ case, human rights and the Comprehensive Sexual Education (CSE) curriculum.
In a statement issued on Wednesday, Public Relations Officer for the TTCEC and Chairman of the Faith Based Network of Trinidad and Tobago (FBNTT), Reverend Winston Mansingh, celebrated the work that the Church has already done towards assisting HIV/AIDS victims.

He said that “Church will continue its work in assisting HIV/AIDS victims to the best of its ability, but will do so without compromising its doctrinal, spiritual and moral values.”

According to the statement, during the discussion on the resolving of tension between the Church’s doctrinal stance and the recent Jason Jones’ judgement, the council, in agreement with other representatives of the Christian faith, maintained that while the Church is always open to counselling and assisting members of the LGBTQI community who acknowledge the wrongfulness of their behaviour, it cannot and will not condone LGBTQI behaviour.

“On the topic of human rights regarding to the LGBTQI community, the council disagrees that there was any legitimacy to the demand of the LGBTQI community for human rights, since scientifically and biblically, no such gender categories exist”

And while while the council acknowledges and applauds some of the initiatives of the government towards eliminating the scourge of HIV/AIDS from our nation, it feels that the government is somewhat misguided in its approach, particularly as it relates to its consideration of the inclusion of the CSE curriculum in schools and its suggestion that the Christian community should sanction the behaviour of LGBTQI individuals so that they no longer feel “discriminated” against.

Regarding the CSE, the council said it believes that sex education should begin with parents.

“Where the Church’s relationship with the LGBTQI community is concerned, the council feels that given that the highest rate of HIV/AIDS infections is among the MSM community, the government may do better to educate the population on the medical dangers of this behaviour and discourage it. In fact, the rate of infection among that community is an indicator that there is a high rate of hypersexuality among members of that group, suggesting that LGBTQI behavior is a manifestation of underlying psychoses. The U.S. National Institute of Health supports that assertion. According to ncbi.nlm.nih.gov, “Sexual addictions are behavioural addictions.”

According to the council, for the well-being of those who engage in that behaviour, and the wider population, the better course of action
for the government to pursue is to join the Church in its stance against that behaviour and offer counselling to LGBTQI individuals.

Regarding helping to change improper sexual behaviours nationwide, said the council, one initiative that the government can take is the banning of certain songs from the airwaves to discourage the immoral sexual behaviour that many of our local songs promote.

“Of course, this would apply to foreign songs as well. Therefore, the council would like to advocate that the Telecommunications Authority of Trinidad and Tobago (TATT) begin to give serious consideration to banning certain songs – those containing lewd, vulgar lyrics and that promote immoral behaviour – from our airwaves” said the council.
TAB 10
Adult & Workplace Bullying on the Rise: the Victims Speak Out

Last week, we looked at bullying among school children and parents. But did you know that bullying in the workplace is said to be on the rise? Experts and studies have concluded that adults suffer from the same health issues like children who are victims of bullying.

While statistics are not forthcoming about how many adults are affected by bullying in Trinidad and Tobago, in the United States of America it is estimated that more than half of all American workers have been affected by workplace bullying. A 2016 article in Forbes magazine by Christine Crawford quoted a University of Phoenix study which revealed that 75% of workers are affected by bullying in the workplace. Some workers who experienced bullying were absent from work quite often, affecting not only their productivity but also that of the company/industry. Others suffered from low self-esteem, suicidal thoughts and had to seek counselling for mental health issues.

Aide from what happens in the workplace, many adults are also bullied because of their sexual orientation and even because of assumptions.

Sexual Orientation Bullying
44-year-old Kerwyn Jordan was forced to seek counselling and use anti-depressant medication for years because of the bullying and harassment he experienced for his sexual orientation.

“I have been a victim of bullying in many places I’ve lived. I have had to change my approach to where I live to avoid being bullied.” He said his first outright incident of bullying occurred when he lived in Petit Bourg. He told us, he was about to go shopping but was returning home to collect something when he forgot he was carrying.

“A group of boys ganged up on me, they began beating, cuff, kick. I called out the lady in the shop who helped, she watched me and closed up the shop. A friend who lived close by was seeing what was happening. I called out to him to call the police or help and he just stood there staring. So I took the beating. They dispersed, and I called the police, they said they had no vehicle. I went to the San Juan Police Station reported it, and nothing came of it. When I got back home later I contacted a family friend who referred me to officers from the Belmont Police Station. They eventually came, pulled out the guys and warned them to not interfere with me again. The officers took them to the area station, where they spent the weekend in a cell. So I was able to get some redemption.”

Although Kerwyn saw his attacker punished, the incident left him permanently scarredemotionally. Even while talking about, he still feels the fear. He said it lingers on.

“Bullying lingers on. Since then I have been living in areas which are above my means, gated communities, where I can feel safe. I still feel vulnerable. There is no family nearby, no familiar relation. I still have a sense of apprehension.”

But that was not the only time Kerwyn was bullied because of his sexuality. He said in Diego Martin it was “torture” being constantly heckled by residents. One time he was even beaten with a cutlass. The emotional pain, he said caused in comparison to the physical assaults.

“I went to therapy to deal with depression because of bullying. For three years straight I was in deep, deep depression. I was diagnosed with acute depression and acute level of PTSD (post traumatic stress disorder). I had to get a dual dose of treatment with medication and counselling.”

Kerwyn said it was during therapy that he dealt with the bullying he experienced at home, school, where he lived and at the workplace.

Workplace bullying goes to the extreme
For another man, whom we will refer to only as L., workplace bullying led to isolation, and discrimination with absolutely little or no recourse.

L. worked in the public service for 20 years and had been at the Central Statistical Office for 12 years. During that time he began exhibiting symptoms of HIV and went on sick leave in 2001. When he returned in 2002, his life turned upside down.

His colleagues and superiors began to discriminate against him, bullied him and because he had HIV automatically assumed his gay.

Staff members openly called him “AIDS man”, said “He doesn’t like women” and also used slangs too crass for publication, when referring to L. Snide homophobic remarks were used in his presence, staff members would go on phone after he was gone and people would leave the washroom.

Those incidents and the name calling were just the tip of the iceberg when it came to the bullying L. encountered. His desk was moved from the main office to an isolated area close to the kitchen, which was not a designated office space. The area was not only hot but had no air conditioning and because of a hole in the wall, L. was exposed to the elements. He had a phone or computer and this affected his job function.

Despite countless complaints to senior members of staff, nothing was done. L. was excluded from staff training courses and no job evaluation done, which meant he could not get a salary increase.

The bullying has affected L. psychologically and altered his attitude. He has become angry and frustrated. He said he is certain the bullying, discrimination and unfair treatment at the workplace was as a result of his HIV status. L. said, he did not go to any other institution to seek redress for what happened to him at work.

“What’s been learned from being bullied...”

But despite the challenges and time dedicating psychological trauma from being bullied, Kerwyn said has found ways to cope.

“Having a network of friends I can de-stress with helps. Also having allies in the police service has helped as well, because when stuff hits the fan, you have somebody to get there and be there. Speaking to someone about my experiences was very useful. I was able to air my head of issues.”

For Kerwyn the ability and willingness to open up to someone about the ways being bullied has impacted his life, is the message he wanted to share with those are being go through a similar experience.

“Talk about it, talk to someone about the feelings of depression, hurt, humiliation. It doesn’t matter if you’re a man, woman or child being bullied will cause you to be hurt. We all want peace, no one wants to be treated like that. So find a confidant and friend who you can openly open up to and be yourself.”
TAB 11
NEWS

Sasha Fierce, an agent for change

JANELLE DE SOUZA       SATURDAY 23 DECEMBER 2017
Sasha Fierce

For several months, up to the time of her death, Sasha Fierce, aka Keon Allister Patterson, worked towards educating the local LGBTQI community about HIV/AIDS. LGBTQI stands for lesbian, gay, bisexual, transgender, queer or questioning, and intersex.

One person who knew her said Fierce was previously a sex worker and felt strongly about HIV prevention and management, as she knew the risk of her former occupation.

Her latest job was as a peer educator with the LINKAGES Project funded by the United States (US) Agency for International Development (USAID) and the US President’s Emergency Plan for AIDS Relief (PEPFAR).
The project provided support for people who belong to their “key” population including sex workers, men who have sex with men, people who use drugs, and transgender people, as they were a section of the population most affected by HIV because they operate on the margins of society.

A LINKAGES co-worker said Fierce started working with the project in August and was with them until she was shot and killed at Nelson Mandela Park, St Clair on December 5.

She said that in October, Fierce reached 20 members of the key population, and supported a few who were victims of violence. In November, she reached 17 people, including three who were tested, supported six people already known to be positive, and two whom she encouraged to go to an outreach centre providing care for sexually-transmitted infections.

“What Sasha did was work with people one-on-one and, because she had a lot of respect in her community, she was ideal as an agent of change. She was one of the more productive persons on the platform. Sasha was doing really good work.”
She said many members of their key population had no support from their family, or if they did, they and their family were ostracised so they ended up on the street. Also, if people noticed that they were different or found out they had HIV, no one wanted to employ them. Therefore, they clung to each other and formed communities.

“With all the glitz and glamour in the community, all the make-up and fun, many times their family alienates them. There is a collective experience most persons have – being born male but feeling female or vice versa. Sometimes our families and the people of TT are not prepared to treat with persons who are different.”
had high praise for Fierce’s work with LINKAGES. He said, “Her emotional intelligence was a bit more. I think she understood it was not just about her, that she was part of a movement and it needed to happen. In the process she affected a lot of lives.”

Agreeing with Fierce’s co-worker, he said many trans-women had limited employment opportunities, and sex work ended up being one of the few options available to them...and it was lucrative. “I think she knew if you are out there (as a sex worker), there is a huge risk to it, so it was important that she talk about the risk and how not to get HIV and ruin your life. And if you are positive, taking your medication on time, all the time.”

Sinnette said he met Fierce as Patterson about three years ago at a Caribbean Vulnerable Community Coalition (CVC) sex-positive workshop.

There, it was taught if you felt good about who you were and about your sexual orientation, you made better choices about sex.

He said Fierce attended many of their workshops, then joined the TT Trans Coalition, which Sinnette believed emboldened Fierce, who began attending workshops dressed as a woman.

Sinnette said around that time Fierce’s confidence grew. She wanted to go to school to become a social worker.

“If you were around her she would always make you laugh and she would go out of her way to make you feel good.”
TAB 12
The Struggle for Transgender Rights in Today’s Caribbean

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Today, 17 May in 1990 the World Health Organization decided homosexuality was not a mental disorder. Since 2004 the day has been celebrated to draw attention to the violence and discrimination experienced by Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) people internationally.

In Latin America, the life expectancy of transgender women is 35 years old, according to the Inter-American Commission on Human Rights. Across the Caribbean the lives of transgender women are affected by criminalizing laws, stigma, marginalization and terrifying violence by state and non-state actors.

In a 2014 report on police violence towards transgender sex workers in the Dominican Republic, TRANSSA, a Dominican transgender-led group, documented the unlawful detention of Ana. She was stripped by the police and detained in the back of an open wagon. The police then removed her wig, and paraded her around the streets naked. Later at the police station, when she was trying to sleep, they threw buckets of water on her. Police said if she said anything about the abuse, she would “disappear.”

Like in Ana’s case, most States in the Caribbean fail to protect transgender people from violence, and their gender identity and expression is rarely taken into account as grounds for hate crimes during murder investigations, resulting in impunity. TRANSSA estimates that 34 transgender people have been murdered in hate crimes over the past 10 years in the Dominican Republic and only 3 people have been convicted.

Guyana Trans United estimates 9 people have been killed due to their gender identity and expression since 2014 in the South American country. Of those cases, only one person has been charged, but there have been no convictions.
excluded from homes, schools and families because of their gender identity.

In Jamaica, transgender children and teens are often kicked out of their homes and some had at one time even sought refuge in storm drains in Kingston’s business district. JFLAG, Jamaica’s leading LGBTI group, has repeatedly called on the government to intervene in families to stop the exclusion of LGBTI children and to increase shelters for the homeless.

According to a study by the Caribbean Vulnerable Communities Coalition (CVC) in the Dominican Republic less than 35 percent of transgender women sex workers have completed secondary school. As they are pushed away from education, many become involved in transactional sex as early as 16. This early social exclusion leads to poverty and more violence. Transgender people are often pushed into criminalized work, such as sex work, which further exposes them to police abuse and arbitrary detentions. Eighty percent of Dominican transgender women involved in sex work have been arrested or detained at least once, and 36 percent had exchanged sex with police officers to avoid being arrested.

But extreme violence is not the only human rights abuse transgender women face. Many transgender women continue to die, not from lack of medical options, but due to intense stigma and discrimination that drives them away from health care services. Data reflecting HIV prevalence within the Caribbean transgender community is scarce, but according to a 2013 study published in the Lancet that reviewed HIV data in 10 low and middle income countries, almost 18 percent of transgender women live with HIV. In many Caribbean countries, transgender women often die instead of accessing stigmatizing healthcare services and treatment for HIV and AIDS.

With few exceptions, Caribbean political leaders are silent on transgender issues. When politicians do speak, their comments are often shameful and offensive. In May 2016, Bahamian media reported that a local Member of Parliament had publically advocated for transgender people to be exiled to an isolated island.
Despite this unacceptable reality, across the Caribbean, brave human rights defenders push for change.

Quincy McEwan, Director of Guyana Trans United, is a litigant in a constitutional challenge to colonial laws which criminalize cross-dressing. Her organization runs programs that help transgender women access healthcare services, support groups and activities to raise visibility of transgender women. Accessing public spaces is still a major challenge for transgender people in Guyana, and her organization recently protested a magistrate’s decision to bar a transgender woman from entering his courtroom whilst she was dressed in female clothing. Quincy says things “change very slowly” but believes it’s increasingly easier to approach Ministers of Parliament in Guyana and to engage people on transgender issues.

Cuba is the only country in the Caribbean where gender reassignment treatment is permitted, but there is little publicly available information on how accessible the treatment is. In Puerto Rico, the Governor issued instructions in August 2015 allowing for gender to be changed on driving licenses, but as in the rest of the Caribbean, there are no provisions for changing gender in other identity documents.

Yet in the neighboring Dominican Republic, Christian King, who leads TRANSSA, says his organization and others are bringing the issue of legal gender recognition to the national debate. Christian believes there is a need for a “legal tool” against entrenched discrimination. TRANSSA also runs programs for HIV positive transgender women, helping them to navigate the healthcare system and fight the stigma and discrimination transgender women experience in services.

Christian believes there have been many advances.

*We have a public prosecutor’s office trying to resolve some small cases, there are diverse social actors interested in the general situation of LGBTI people, and in the health system there is a specific strategy for key populations (those at higher risk for HIV). There are also many trans leaders, the result of voluntary community*
Alexus D’Marco heads the Caribbean’s newest transgender organization, Bahamas Transgender Intersex United (BTIU), founded only in April 2016. Alexus says the group was formed as the government was saying there were no transgender people in the country; a huge irony Alexus says, because the same Bahamian government receives US funds to run programs for transgender people. Since its first press conference, Alexus says members of the group have received direct and indirect threats from members of the public and the Deputy Prime Minister has reportedly been critical of transgender people. Alexus says, “We need sensitivity and diversity training for members of government on what it is to be LGBTQI because they don’t know.”

So the struggle for transgender rights in the Caribbean continues. Civil society are raising their voices and getting stronger because people want visibility. It’s already created backlash. But, at the very least, it’s becoming harder for Caribbean governments to deny transgender people exist.

BEFORE YOU GO

Trump praises Trump's response to the COVID-19 crisis

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https://www.huffpost.com/entry/the-struggle-for-transgen_b_10007452
TAB 13
World Aids Day

Making strides against HIV discrimination

Shirvan Williams
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What would your reaction be if a co-worker, who is also your close friend, reveals to you that they have HIV/AIDS?

While people in T&T have made immense strides in the way that they treat people who are HIV positive in the workplace, there is still a lot of room for improvement, according to the experts at the National HIV/AIDS Workplace Advocacy and Sustainability Centre (HASC).

The unit was formed by the Ministry of Labour in 2009 and pays special attention to an International Labour Organisation initiative to get companies involved in understanding HIV/AIDS.

“Primarily in the workplace, people living with HIV have challenges with discrimination in the workplace, either by co-workers, not getting hired or possibly getting fired for their status,” said manager Tania Parrott during an interview at HASC office, Duke Street, Port-of-Spain.

Many people who are infected still face discrimination at work because of a lack of education. This is why HASC visits workplaces throughout the country to try and create a supportive environment for those infected.

When they started educating people about HIV a lot of them did not understand the disease. She shared a story where one worker broke down because she had been treating a family member horribly due to her ignorance, she had been separating her relative’s cutlery and other items from the rest of the family. To get people to truly understand the disease HASC has someone who is currently coping with HIV come in and share their personal experience with workers.

“There are a lot of myths and misconceptions out there still and our sessions are hopefully dispelling some of these myths. There is still a long way to go because we only work with a few organisations, so we’re just a grain of sand in the whole workspace response.”

They have already convinced about 25 companies, from both the private and public sector, to sign a Memorandum of Understanding to ensure that the rights of HIV-infected workers are protected. It’s not just in the workplace that employees may have issues with the disease and a clause in the MOU asks employers to accommodate a worker who has to care for a close relative with HIV.

The organisation has even worked with maxi-taxi drivers of Route one (Diego Martin, Petit Valley, Carenage) and Route three (Curepe, Chaguanas, South and Caparo).

Salim October, an HIV/AIDS Advocacy Officer of HASC, who was also present at the interview said HASC’s work is primarily focused on policy development for the HIV and Aids National Workplace Policy.

“Our department draws from ILO’s guidance, specifically the ILO recommendation 200 which was based on new developments on the international HIV front and issues related to HIV in the workplace,” he said.

People living with the disease should not be ostracised in any way and should be included in all company benefits including insurance plans. This is because there is no evidence to suggest that covering a person with HIV will increase claim rates.

Parrott said even though there is so much knowledge about the disease there is still no legislation that really protects the rights of a worker with HIV.

According to the executive director of the Employees Consultative Agency and a member of the HIV Interim Agency, Linda Besson, this is because the issues surrounding HIV/Aids are now on the back burner.

“In the period 2004 to 2008/9 there was a lot of hype about HIV/Aids in the workplace not just in Trinidad but regionally because the Caribbean Employers Federation and the Caribbean Congress of Labour worked together in eliminating the stigma of discrimination. My feeling, however, is that within the last couple of years it has not been in the forefront as it used to be,” she said during an interview at the ECA office in Aranguez.
“There has been a draft policy for some time and I think the current government is revising it. That has been long, long overdue and they have allowed the issue to get very cold and we are trying to bring this back up.”

She said the only law that may protect employees from being dismissed based on their HIV status is the Equal Opportunities Act. Another step in the right direction is the Employee Assistant Programmes which many companies have now set up to help people gain access to counseling.

She may be an advocate for the proper treatment of people living with the disease but Besson admitted that she is not a fan of World Aids Day.

“I have a problem that we only talk about HIV in this manner on this one day and there are 365 days in a year. There should be much more sensitisation. It’s great that we have that day but what she should be aiming for is zero tolerance. We must keep it on the front burner. If we want a healthy nation let us be pro-active not reactive.”

As a man living with the disease for more than 20 years, David Soomarie, coordinator of the Community Action Resource (Care), also believes a lot more can be done to help people living with HIV/AIDS. He revealed that when he was diagnosed, he ignored it for some years until he had a life threatening seizure. He discovered Care which opened his eyes to the fact that a person can have HIV and live a long, healthy life.

“I think discrimination still exists. Depending on where you go and who you talk to, people still have some misconceptions. People still think you can get from mosquitoes or sharing a cup with a co-worker or from hugging someone or giving someone a kiss. We have made some headway but there are some challenges particularly among our key populations which are men who have sex with men, young people, people who use drugs and sex workers,” he said while speaking from Care’s office on the Eastern Main Road, Barataria.

Care is celebrating its 25th anniversary and has helped thousands of HIV positive people but he believes many more people could be helped if education efforts were ramped up.

He said that more men in particular need to get tested because they have a tendency to shy away from medical care.

More info

According to statistics from 2012 there are 22,085 persons who have been diagnosed with HIV in T&T.

Unaided recently set a 90 per cent target for 2020 for people living with HIV. They hope that by 2020, 90 per cent of all people living with HIV will know their HIV status, 90 per cent of all people with diagnosed HIV infection will receive sustained antiretroviral therapy and 90 per cent of all people receiving antiretroviral therapy will have viral suppression. To achieve this goal in T&T at least 500,000 people will have to be tested a year for the next three years. As of 2013 only four per cent of T&T’s population had been tested.

Popular in the Community
TAB 14
Trinidad concerns about high HIV/AIDS rate

By Caribbean Medical News Staff

Trinidad and Tobago says that the Acquired Immune Deficiency Syndrome (AIDS) is on the rise in that country and UNAIDS Country Coordinator for the twin-island republic Izola Garcia said that while there has been a decline in new infections and deaths between 2008 and 2011, the numbers are increasing as it relates to new infections as of 2012. World AIDS Day was observed on December 1 and the theme this year, and until 2015, is Getting to Zero – zero new HIV infections, zero AIDS-related deaths, zero stigma and discrimination.

“It is estimated that 14,000 persons are presently living with HIV in Trinidad and Tobago. Based on the 2010 Treatment Guideline, 5,565 of the estimated 7,495 persons who need treatment are receiving it. With the new treatment guideline where persons are recommended to be placed on treatment earlier, it is estimated that the number of persons who need to be placed on treatment will increase to 12,000 persons,” she said.

She also indicated that the increase was likely based individuals having unprotected sex, using inconsistent protection, multiple partners or not using protection/condoms correctly. She also said that people living with HIV were not always staying on their treatment which made their partners open to infection.

Garcia emphasized the need for greater information and education. According to Garcia, this education must involve the public and private sector, NGOs, individuals, partnerships and the community while building a stigma-free environment.

“Many people lose their jobs or cannot get jobs because of their perceived HIV status or sexual orientation which does not dictate their ability or fitness to work. This has an impact on the lives of individuals, families and the economy, thrusting people sometimes into poverty or into illegal activity to make ends meet, which may also put them at further risk,” she said.

She indicated that the observance of human rights was critical not only to HIV/AIDS but in general.

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| TAB 15 |
While many persons in small English-speaking Caribbean countries (ESC) have not been tested for HIV, it is estimated that in excess of 250,000 persons are living with HIV/AIDS. UNAIDS estimated the HIV prevalence among Caribbean adults at about 1% (0.9-1.1%). In the Caribbean, the primary mode of HIV transmission is heterosexual contact (79.3%), followed by men who have sex with other men (MSM) accounting for 12.4%, and the remaining reported cases by hemophilia/coagulation (0.1%), perinatal infection (7%), adult intravenous drug users ("IDU") (0.7%), and (0.4%) blood transfusion.

The English-speaking Caribbean countries (ESC) are comprised of fifteen (15) relatively small island states and the two continental countries of Belize and Guyana. This review focuses on the HIV/AIDS epidemic in selected ESC countries, including the two largest countries Jamaica and Trinidad and Tobago. There is also emphasis on HIV/AIDS in the Bahamas, Barbados, and Guyana.

The Intersectionality Framework for Addressing HIV/AIDS in the Caribbean Region

There appears to be a paucity of theoretical frameworks informing research investigations on HIV/AIDS in the ESC region. This theoretical gap disallows for a more comprehensive understanding of this public health crisis as well as a holistic approach to treatment and prevention. This review relies on the intersectionality conceptual framework in the effort to elucidate the macro-level drivers of HIV/AIDS in the region, including poverty and income inequality, genderpower imbalances, sociocultural norms, low educational status and governmental policies. The conceptual model, as shown in the figure, also highlights the micro-level drivers, including risky sexual behaviors, internalized and institutionalized stigma, internalized homophobia, and illicit drug use.

Intersectionality theorizing assumes dynamic interplays between and among macro-level and micro-level variables. For instance, about seventy percent (70%) of HIV infections in ESC countries are in the age group 15 to 44 years old. In Jamaica, for example, with a population of approximately 2.7 million, it is estimated that 1.5-1.7 percent of the adult population is HIV-positive. These infections are concentrated among impoverished and socially disenfranchised citizens, particularly among women and girls. The percentage of Caribbean people living below the poverty line ranges from 14-39 percent, and Caribbean societies are defined by economically challenged female-headed households.

A corollary observation is that the holistic and intersectionality approach emphasizes the interrogation of neglected and marginalized social groups. As Cole wrote: "Intersectionality makes plain that gender, race, class, and sexuality simultaneously affect the perceptions, experiences, and opportunities of everyone living in a society stratified along these dimensions. To focus on a single dimension in the service of parsimony is a kind of false economy." Hence, this paper addresses the intersections of the described macro-level and micro-level variables and the encountered difficulties of Caribbean persons impacted by HIV/AIDS. While there is a focus on the feminization of the epidemic, there is also emphasis on the health and psychosocial concerns of socially marginalized populations, including commercial sex workers and lesbian, gay, bisexual, and transgender (LGBT) groups.

In the Caribbean, in 2012, an estimated 11,000 individuals died of AIDS. HIV/AIDS and STDs contributed to the second leading cause of death among Jamaican women and men aged 30-34, while in Guyana, with a population...
of about 767,000, and with more than 56% of its population in the age group 15-49 years, HIV/AIDS is the leading cause of death for 20-49 year olds [9]. Moreover, in 2012, a significant number of Caribbean residents were estimated to be living with HIV in the Bahamas, Jamaica, and in Trinidad and Tobago. Women are disproportionately represented among those living with the virus [10]. Guided by the intersectional analytic framework, the paper addresses prevention interventions for Caribbean persons living with HIV/AIDS, and for decreasing the current HIV prevalence rates among diverse groups of English-speaking Caribbean persons [11,12].

Women and AIDS

HIV and poverty tend to reinforce each other throughout these small Caribbean countries. Economically marginalized and vulnerable Caribbean women are more likely to be infected with the virus than their male counterparts. An estimated 53% of individuals with HIV were women living in the Caribbean [13]. Caribbean women 15 to 24 years old have an estimated HIV prevalence rate of 1.8 to 3.2 percent, while for males in that age group it is lower at 1.4 to 2.4 percent [14]. In Trinidad and Tobago, with an estimated population of 1.3 million in 2010, and an estimated adult HIV prevalence rate between 1.5-1.7%, the number of HIV-positive women between 15 and 19 years is five times higher than among their male counterparts [15], and, in this country, 69.8% of new cases of HIV are derived from females 15-29 years of age [5].

There is a growing research literature on women’s vulnerability to HIV. Epidemiological studies suggest that during unprotected vaginal sexual intercourse with an infected partner, women are twice as likely as men to be infected with the virus. Women have a longer duration of exposure to infectious fluids than men and women are vulnerable to tissue injury during sexual intercourse [16]. It has been shown that “the likelihood of HIV transmission during a single act of vaginal intercourse increases more than five times when there is a co-occurring genital ulcer disease” [17]. In addition to the many HIV-related diseases and ailments suffered by both sexes, HIV-positive women experience recurrent vaginal yeast infections and severe pelvic inflammatory diseases which increase their risk of cervical cancer compared to women without the virus [18]. Figueroa [19] wrote that Jamaican women with inflammation of the cervix because of gonorrhea and syphilis were vulnerable to male-ta-female HIV transmission. To compound these difficulties, HIV-positive women on highly active antiretroviral treatment may experience stronger side effects [20], and women tend to discontinue antiretroviral treatments at greater rates than men which can contribute to excess morbidity and mortality[21]. Consistent with the intersectionality framework, the theory of gender and power contends that the unequal power which women experience in sexual relationships is a consequence of their unequal status in the labor market, extreme poverty, patriarchal masculinity, and behavioral norms [22]. Social norms including laws and cultural prohibitions governing appropriate sexual behavior for women can also inhibit women's ability to make decisions in their sexual relationships.

Norman [23] reported that gender-related power dynamics make it difficult for some Caribbean women to request the use of condoms by their sexual partners. Likewise, cultural beliefs that condom use promotes promiscuity in women are associated with women's reports that they do not use condoms [24]. For some women to insist on condom use and to carry condoms themselves is to imply that they are actively looking for sex. Women might be reluctant to request that their partners use a condom because this might be implying that they are skeptical about their partner’s HIV status; that their partner is sexually involved outside of the relationship, or had a risky sexual past. There are reports of some inner city Caribbean women being physically and sexually abused when they requested condom use from their partners [25]. In addition, abusive men are more likely to have multiple sexual partners and are unlikely to use condoms consistently [10]. Yet, some women may engage in unprotected sex because they fear sexual violence and the loss of economic support. Norman [23] found in Trinidad that only 89% of individuals had used condoms with their most recent sex partner. Other studies conducted in the Caribbean region on HIV-positive adults found that nearly 40% did not use condoms, and that over 25% did not know their partner’s HIV status[26].

There is also the contention that some Caribbean women engage in unprotected sexual intercourse because of their adherence to the cultural requirement that women “have children” to prove their womanhood/fertility. Such women are likely to engage in unprotected sexual intercourse and are susceptible to HIV infections. Also, while it is difficult to ascertain the proportion of women having multiple sexual partners because of cultural sanctions, it is estimated that between 15-15% of Jamaican women between 15-49 years old report having sexual intercourse with more than one partner in the year assessed. Other qualitative studies put the number at 30-40% of women having multiple sexual partners [27].

Women who know that they are HIV infected are oftentimes afraid to tell their husband, boyfriend, and others because of their fear of abandonment, family ostracism, violence, discrimination and stigmatization. Anticipating negative responses in the form of emotional, verbal or physical abuse has been linked to the inability to negotiate the circumstances and safety of sexual interactions and to increase the risk for HIV infections [21].

Concerning seropositive Caribbean women, lack of quality education, sexual and physical abuse, economic hardships, community violence and neighborhood disorder, inadequate health care services, stigmatization, alcohol and substance abuse, and mental health burdens can be viewed as mutually reinforcing dynamics which could undermine women’s adherence to antiretroviral treatments and their ability to adequately cope with the AIDS disease [21]. Moreover, significant levels of depressive symptoms, including negative cognitions and somatic symptoms have been found more among HIV-infected Caribbean women than their male counterparts. One suggestion is that HIV-infected individuals should be routinely screened for depression [28]. However, psychiatric and psychological services remain underdeveloped in the Caribbean.
Several studies have addressed concurrent multiple partnerships, infidelity, and Caribbean men having "outside women" as normative and culturally accepted practices, particularly if women are perceived to derive economic benefits from these arrangements [29]. One-third of men aged 15–39 years indicated that they had multiple sexual partnerships [30]. Some Caribbean women are deeply troubled by their male partner’s infidelity. However, these women’s fear of physical abuse, feelings of low self-efficacy, and the primacy of security needs might prevent them from negotiating condom use with their partners. Research shows however that some Jamaican adults who were married and had strong Christian religious affiliations were less likely to engage in high-risk sexual behaviors compared to those in casual and visiting intimate relationships and who never or infrequently attended religious services [31]. In general, Caribbean countries are defined by conservative Christian doctrines and values. It has been found in other studies that some Caribbean women with strong Christian religious beliefs might internalize the view that women must remain virgins until marriage and therefore might be reluctant to use condoms. Also, Christian women might not have optimistic attitudes about antiretroviral treatment placing their faith in God instead of complying with the treatment protocol, while other women with similar religious beliefs self-reported that God’s divine power would work through the medicine [32]. Other findings suggest that a subset of Christian Caribbean HIV-positive women believed that they would be healed through prayers and their strong religious faith without medications [33]. The heterogeneity of this social group’s perceptions of sexuality and intimate sexual relationships should be more explicitly explored within the context of an overarching intersectional framework.

Caribbean women confront religious, interpersonal, physiological, psychological, social, cultural, and socioeconomic challenges that place them at risk for HIV transmission and STDs. Research-based evidence, derived from national epidemiological studies, is required on these purported relationships. More importantly, empirical data is lacking on women who are most susceptible to these drivers and feel disempowered to protect themselves from HIV and STDs.

Concerning Sexually Transmitted Diseases (STDs), research indicates that persons with STDs have a risk of contracting HIV infection that is 3 to 50 times that of uninfected persons, depending on the STD involved [34]. The estimated annual incidence of curable STDs (syphilis, chancroid, gonorrhea, chlamydia, and trichomoniasis) among 15 to 45 year olds is 7-44% in Latin America and in the Caribbean countries. Trend analyses by WHO [35] for the years, 2007-2011, showed an increase in the rates of genital ulcers for males and females in Jamaica and Guyana, and there were increased rates of urethral discharge in Jamaican men during this time period. The data also indicated the high prevalence of syphilis in Jamaica (1.3%), the Bahamas (1.1%), Barbados (0.5%), and St. Lucia (0.7%). However, these might be conservation estimates of the prevalence of STDs due to the incomplete STI surveillance data provided by Caribbean countries to the World Health Organization [35].

Sexually Transmitted Diseases (STDs) are precursors for the possible spread of the HIV virus among individuals [14]. The risk factors for STDs include early onset of sexual activity, unprotected sex, multiple sexual partners, and high-risk sexual partners [36]. It is generally agreed that the early diagnosis and treatment of gonorrhea, syphilis, chancroid, herpes, and other STDs are effective interventions against HIV transmission. Research shows that the targeting of treatable STDs and the consistent use of condoms by male partners can effectively reduce the risk of sexually transmitted diseases and HIV transmission [37].

**Men Who Have Sex with Other Men (MSM)**

With respect to LGBT groups, in the Caribbean, the scant research evidence is on men who have sex with other men (MSM). While there are no reliable estimates of the general population of males who have sex with other males (MSM) due to stigmatization and homophobia[38], studies relying on cross-sectional and convenience samples indicate that in the Caribbean, men who have sex with other men represent about ten percent (10%) of the HIV transmission rate[26]. However, in Guyana, in 2007/2008, it was reported that 21.25% of MSM in the capital city were HIV-positive, while in Trinidad and Tobago, it was at 20% [13]. It was also reported that only 47% of the men used a condom the last time they had sex with a male partner [5]. According to the research literature, intolerance of homosexuality, coupled with economic and emotional dependence, fear and anxiety about ostracism and violence, may influence the AIDS epidemic by increasing the likelihood that men who have sex with men will also have female sexual partners to present the appearance of being heterosexual[21]. These secret and double-life sexual practices are said to be also prevalent in the Caribbean because of the cultural valuing of heterosexual relationships with multiple women, and the emphasis on the fathering of children [39]. Research findings from the Caribbean, the USA, and Africa indicate that men who have sex with both men and women, and who do not identify as gay, are less likely to be HIV infected than men who report sex exclusively with other men [40]. Beyrer, Baral, et al.[41] indicated that men engaged in having sex with both men and women might be more willing to use condoms with other men, and they might be less likely to engage in receptive anal intercourse than men who have sex with only men. Research studies however are needed in the ESC countries to replicate these purported empirical relationships.

The transmission of HIV infections among MSM is related to the engagement with both unprotected receptive and insertive anal sexual intercourse. Beyrer, Baral, et al.[41] reported a “1.4% per act probability of HIV transmission for anal sex and a 40.4% per partner probability” (p 371). Landovitz & Currier [42] provided estimated HIV transmission risks of 1 to 30% with receptive anal sex, and 0.1 to 10.0% with insertive anal sex. Within the Caribbean context, MSM risk of HIV infection is related to contextual drivers such as poverty, sex work, drug use, the lack of social support, marginalization from the dominant culture, homophobic discrimination and violence, homelessness, and self-rejection of the stigmatized homosexual gender identity [43,39].
Sexually Transmitted Diseases (STDs) including syphilis, the herpes simplex virus type 2, Human Papilloma Virus (HPV), the Hepatitis C Virus (HCV) and hepatitis B virus (HBV) are co-infections with HIV infections and are related to high morbidity and mortality rates among MSM in developing and resource-limited countries[44]. According to Millett, Jeffries, et al.[40], in the Caribbean, HIV prevention programs reach less than 40% of MSM. It is unclear from the current research evidence if HIV-positive MSM who receive antiretroviral therapy are also being diagnosed and treated for the co-infections of HCV and HBV, as well as for other symptomatic sexually transmitted diseases throughout ESC countries.

Internalized homophobia and feelings of disenfranchisement, and same gender-loving disclosure fears may also contribute to HIV risk-taking behaviors by increasing the likelihood of having multiple partners rather than entering a stable relationship with one partner, and by indifference to HIV/AIDS prevention because of the disease’s association with homosexuality [45]. Figueroa [19] indicated that the HIV prevalence rate in Jamaica among MSM was 10% in 1985 and increased to about 32% between 1993–2007. For him, effective methods have not yet been implemented to reduce these rates primarily because of the stigma linked to homosexuality in Jamaica and in other Caribbean countries. This stigma operates to drive the HIV epidemic among the MSM group underground thereby making it problematic to provide this group with prevention and treatment services. Similar to other regions of the world, in the Caribbean, MSM are at risk for HIV infections when they have inadequate access to HIV services such as counseling and testing, accessible condoms and lubricants, antiretroviral therapy, and exposure to prophylaxis against infection, among other HIV prevention services and technologies [46].

Commercial Sex Work

The Caribbean HIV epidemic has spread from commercial sex workers (men and women) to the general population. Many sex workers are transient migrants to and from Caribbean countries. These migrants leave high HIV prevalence areas and return to low prevalence areas to infect their primary partners and other individuals [16]. Surratt found that drug users engaged in sex work in more countries. They had more sexual partners and they were 5.1 times more likely to engage in unprotected sex. They also reported more violence victimization than users of alcohol and non-substance abusers. Surratt [47] reported that migrant undocumented sex workers have little access to legal, medical and social services.

There are high infection levels among female sex workers in Jamaica (9%) and in Guyana (27%), according to UNAIDS [13]. The poorest Caribbean domestic and migrant commercial sex workers are vulnerable to HIV infection and to STDs due to their multiple sex partners and their elevated use of illicit drugs, particularly, crack-cocaine and cocaine. Allen, Edwards, et al., [48], in their study of commercial female sex workers in Georgetown, Guyana, found a relationship between crack cocaine use, cocaine and marijuana use and risky sexual behaviors. They also found that women not knowing the results of their last HIV test were also likely to have large numbers of partners from the streets and hotels/brothels. There was also an association between women’s illicit drug use and vaginal ulcerations, which are precursors of HIV infections. These researchers concluded that sex workers in Georgetown also worked in Trinidad and Tobago, Barbados, St. Martin, and French Guyana thereby contributing to the spread of HIV/AIDS. Kempadoo [49] indicated that attempting to map these sexual networks is a problematic task because of the "stigmatization and criminalization of homosexuality, bisexually, and prostitution, and the persistent ideal of heterosexual monogamy that is reinforced through many civil and state institutions". Male sex workers were identified as one of the high-risk groups for HIV infections. These individuals are less likely to consistently use condoms with regular customers. Many individuals who engage in high risk sexual behaviors such as bisexuals and homosexuals who have sex with locals or commercial sex workers have reported not using condoms and not knowing their HIV/AIDS status [50]. The reluctance and/or delay to experience HIV testing may be related to the fear that others will suspect that they are engaged in unlawful and stigmatized behavior[51]. The high rate of HIV infections and full-blown AIDS among commercial sex workers is also reported to be related to the inadequate regulations of the sex trade industry, to the stigmatization of this industry, and to a lack of attention to the needs of commercial sex workers [2]. Moreover, commercial sex workers living with HIV who perceive stigma from others are less likely to access HIV care and HIV treatment health facilities. They are more likely to receive inadequate HIV care, and they are more likely to miss clinic appointments for this care. The research evidence indicates that people living with HIV/AIDS who engage in stigmatized sexual behaviors, and who had abused or continue to abuse illicit drugs are likely to be perceived by health care providers to have poor HIV treatment adherence thereby potentially influencing treatment recommendations [51].

Commercial sex is illegal in most English-speaking Caribbean countries. These countries are also defined by conservative social values. There is no reliable data on HIV/AIDS prevalence rates among sex workers. Many countries are said to be reluctant to discuss the HIV epidemic for fear of losing tourism revenues. Surratt [47] also indicated that Caribbean tourist-dependent economies and the active commercial sex industries have "become the most HIV impacted countries in the region."

AIDS-Related Stigma and Discrimination

While confidential HIV testing is widely accessible in Jamaica and in other small Caribbean islands from both private and public health institutions[8], Claudette Francis[52] reported that most HIV-infected persons in the Caribbean continue to live in fear of the community "finding out" their diagnosis. There remains the inclination to associate HIV/AIDS with homosexuality, promiscuity, and prostitution (both male and female). The relationship between feelings of lack of social support and feelings of loneliness and isolation has been related to risky sexual behavior. Individuals
who feel internalized stigma are more likely to "participate in risky sexual situations as a temporary escape from shame and depression or because they seek self-validation through sexual encounters" [51].

Homosexuality is highly stigmatized in the Caribbean region such that HIV-positive MSM in Jamaica, Trinidad and Tobago, and in other ESC countries have delayed seeking medical health services. There is research evidence on the deep-seated fears in MSM communities that there will be breaches of confidentiality by health care workers. For instance, Jamaican MSM were hesitant to accept free lubricants because of the cultural belief that the primary use of lubricants is for homosexual anal sexual intercourse [39,40].

Several Caribbean nations have anti-sodomy or buggery laws which contribute to anti-gay discrimination and abuse. The Bahamian government in 1991 legalized same-gender sexual activity between consenting adults of eighteen years old. However, homosexuality is wrong and unnatural in the minds of many Caribbean individuals. The 2010 UNAIDS global report includes Jamaica, the Bahamas, and Trinidad and Tobago as countries that criminalize same-sex activities, among other countries with government laws that pose obstacles in reducing the risks for men who have sex with men (MSM), and for Lesbian, Gay, Bisexual, And Transgender (LGBT) persons. The socially conservative Christian church throughout the Caribbean is strongly resistant to the decriminalization of homosexuality. There are also recent reports of adherents of Rastafarianism being against decriminalization on the grounds that the homosexual lifestyle is against Africa's cultural traditions and values. Also, in Caribbean societies, masculinity is purported to be defined in terms of men producing children, and by virility and sexual prowess with women. To be a "soft man" is frowned upon. There is the viewpoint that male homosexuals transmit diseases to the general public because these "homosexual" men are actually heterosexuals who occasionally have sex with other men [29].

It is well established that institutionalized stigma can undermine the survival of impoverished and socially ostracized Caribbean people living with HIV/AIDS. For instance, Mays, Cochran & Barnes [53] reported that individuals who show heightened sensitivity to societal stigma are also more vulnerable to chronic stressors which can have deleterious effects on their physical health (e.g., the brain, immune system, and the autonomic system), and on mental health (e.g., depression, anxiety, hopelessness).

There are legislations and proposed ones to reduce discrimination against people living with HIV/AIDS in several Caribbean countries. For example, the Bahamas, Guyana, and the Dominican Republic introduced laws to prohibit pre-employment HIV screening. Most Caribbean countries, however, are reported to lack the appropriate systems in place for aggrieved persons to seek remedies for discrimination [14]. Moreover, in many Caribbean countries, there does not seem to be longitudinal epidemiological studies tracking changes in the unfavorable attitudes and behaviors directed at persons dealing with HIV/AIDS.

### HIV/AIDS Prevention and Treatment

A priority for many countries is the testing of individuals at greatest risk for HIV to ensure that HIV-positive persons have access to quality treatment and care, and to provide prevention services to both those at risk and to the general population. HIV testing is available in private and public health institutions throughout the Caribbean. Notwithstanding these emphases, Losina, Figueroa, et al. [27] wrote of the limited data on "the etiology of common clinical presentations of HIV disease and the relative frequency of opportunistic diseases in the Caribbean region" (p. 136). These authors also noted the essential problems of incomplete data on microbiologic analyses of CD4 cell counts, T-cell counts, and clinical progression. These are important assessments for informed decisions on the development and implementation of prevention and treatment protocols.

As it relates to the relationship between HIV/AIDS and mental health, about 58.9% of people estimated to need treatment for depression do not have access to mental health workers in Caribbean and Latin American countries [3]. Significant levels of depressive symptoms, including negative cognitions and somatic symptoms have been found more among HIV-positive Caribbean women than their male counterparts. Women also reported higher levels of sadness, pessimism, irritability, guilt, and loss of interest in sex when compared to men, and some women reported the lack of social support [28]. Other studies suggest that HIV-infected women report concentration and sleep difficulties as well as changes in eating habits in response to stress[54]. An increase in mental health workers is essential for HIV-infected individuals to undergo psychosocial assessments and to be routinely screened for depression symptomatology to ensure effective diagnoses and treatment [28].

Abel, Kestel, et al.[3] wrote on the progress in the construction of mental health policies and structures; in the delivery of mental health services in English-speaking Caribbean countries, and in the estimated expenditures in mental health ranging from 1% to 7% of health budgets. However, as they noted, most countries provide mental health treatment in mental and general hospital settings. There are few countries that rely on community-based mental health treatment models. Currently, the number is quite low of psychologists, psychiatrists, mental health nurses, and social workers throughout the Caribbean. Health care providers and religious leaders should be appropriately trained in psychosocial and mental health issues in caring for HIV-infected persons [54]. A balance between community-based, home-based, and hospital-based services is said to provide the most comprehensive model of mental health services for people infected and affected by HIV/AIDS [3].

There is a relationship between poverty and extreme difficulty in accessing antiretroviral medications, nutritional, and other resources to adequately cope with this disease. The out of pocket expenditures for health care services place poor people at risk for not having adequate access to appropriate HIV/AIDS services and incurring debts for health...
care that push them further into poverty. It is estimated that about 50% of HIV-positive Caribbean individuals are receiving antiretroviral therapy (CARICOM, 2008). Based on HIV/AIDS surveillance data for the period from 1993 to 2005, there were significantly higher mortality rates for over one-third of HIV-positive adult Jamaicans who were identified late with an AIDS diagnosis compared to asymptomatic persons [37]. Similarly, Kumar, Kilari, et al. [55] examined the records of 431 adults admitted to the main hospital in Barbados for the years 2004-2006. They found that while 60% of adults were known to be HIV-infected prior to their current hospitalization, a diagnosis of HIV was made for the first time during the current hospitalization of 40% of admitted patients at an advanced stage of their disease. The delays in diagnosing HIV infections and AIDS have implications for the transmission of HIV as well as for the morbidity and mortality of those living with HIV/AIDS.

Throughout the English-speaking Caribbean countries there appears to be a lack of national well-functioning surveillance systems for data gathering on the number of HIV/AIDS cases with the result that there might be underreporting of the HIV prevalence rates [2]. Moreover, empirical data is needed on the estimated number of Caribbean people in need of HIV treatment. Infected persons are susceptible to reinfections both with the virus and sexually transmitted infections. Several studies report that knowing one’s HIV status is linked to improvements in the person’s sense of well-being, particularly when there is social support and other forms of support for the individual. Countries also benefit from HIV testing as this is related to HIV-positive persons reducing or eliminating their transmission behavior [56]. For instance, research findings showed that Jamaican men displayed a significant increase in condom use after being tested for sexually transmitted infections and being provided with safer-sex counseling [57]. Many Caribbean males could benefit from these services and do not receive them.

It is well established that sustained and chronic psychological and emotional stress and depression can undermine the physiological well-being of individuals, which can be especially difficult for those who are HIV-positive and dealing with fullblown AIDS. The success of prevention and treatment services will require the involvement of mental health care providers, health care providers, faith-based organizations, the private sector, community leaders, and community resources to address the whole person instead of his or her disease status [58]. Low cost and high impact sustainable interventions and prevention programs can be delivered by each of these sectors to a broader range of Caribbean individuals who are at risk for HIV/AIDS and STDs. For example, the private sector is quite efficient in permeating the daily lives of Caribbean people with a variety of consumer products. Hence, private enterprise can play a more significant role in promoting the avoidance of risky behaviors and the commitment to a healthy lifestyle [59].

The breaches of confidentiality are of main concern throughout these small Caribbean islands where everybody knows everybody. There is persistent disclosure anxiety even in therapeutic environments [51]. It has been suggested that extensive counseling for HIV-negative individuals and widespread testing of populations could reduce the stigmatization of HIV-positive persons and their families. Douglas [60] recommended that Caribbean governments set up more urban and rural clinics and hospitals to adequately meet the needs of affected citizens. He also suggested the usefulness of technology and distance learning for the training of young professionals and technicians working on HIV/AIDS throughout the Caribbean region.

Throughout Caribbean countries, HIV/AIDS intervention includes focusing on behavior change, bolstering coping resources, and making lifestyle choices that promote healthy living, primarily through the educational sector by offering comprehensive sex education and school-based guidance and counseling, including HIV/AIDS education [61]. As previously noted, this individual-change approach is insufficient in addressing the HIV/AIDS epidemic. For instance, there is still much resistance in Caribbean countries for condoms and contraceptive resources being available to young people in educational settings. The intersection analytic approach suggests that comprehensive sex education should include structural interventions such as broad-based condom distribution in educational and community settings to have a more profound effect on HIV/AIDS prevention.

Studies suggest that there is reduced risk for illicit drug abuse and sexually risky behavior with appreciable improvements in vulnerable individuals’ housing status [62]. Improved community conditions have been found in studies to be related to lower levels of alcohol and illicit drug abuse, to better health, and to more confidence in the health care system. The incorporation of community members in the delivery of culturally sensitive HIV care services to Caribbean people is a possible effective mechanism to reduce the HIV transmission rate [50]. The issue of the working poor and the high unemployment rates in the Caribbean must also be addressed. There should be emphasis on employment opportunities for vulnerable social groups, including poor women. Female unemployment is a significant contribution to the increase in HIV infections. Caribbean males should also be exposed to interventions that influence them to see their significant role in reducing the risk to females and to assist males "to give up the power they now have over sexual choices" [10]. These multifocal interventions could also increase feelings of self-efficacy and the acquisition of skills, and increase compliance with health care recommendations in dealing with HIV/AIDS [21].

Caribbean males also bear the burdens of HIV/AIDS in the Caribbean region. Studies have reported on low-income Caribbean males in Jamaica, Barbados, and Trinidad and Tobago being particularly at risk for HIV infections. Caribbean males tend to be diagnosed later when they seek medical services for illnesses [55]. For instance, African Caribbean males were the majority of HIV patients admitted to medical wards in Barbados [55]. The higher HIV infection rates among these males are attributed primarily to heterosexual males’ risky sexual behaviors such as multiple sexual partners and commercial sex. Primary prevention among Caribbean males must be a priority in order to scale up early voluntary counseling, HIV-testing and antiretroviral therapies.
For several years the research literature has discussed male circumcision to potentially reduce heterosexual males’ HIV susceptibility [63]. There is compelling evidence on the protective effects of male circumcision, the surgical removal of most of or all of the male foreskin (or prepuce), to reduce the risk of HIV infection and STDs in males compared to uncircumcised males, particularly in areas of high HIV and STDs prevalence [64]. The research evidence strongly indicates that male circumcision reduces the risk of ulcerative STDs, chancroid, syphilis, and genital herpes by 50% or more [63]. Male circumcision is said to protect women who may be exposed to fewer HIV-positive males, especially if there is substantial circumcision community coverage and if men discontinue their high-risk-taking attitudes and behaviors, including having multiple sexual contacts [36].

The foreskin of the penis is said to have a greater concentration of target cells for HIV infections such as Langerhans cells and macrophages than other penile tissue. The foreskin is also susceptible to tears, scratches, and abrasions during sexual intercourse thereby facilitating portals of entry for the virus [63]. The inner mucosa of the foreskin has less keratinized skin in contrast to the external skin surface which increases the probability of viral survival [36]. While circumcisions are not without absolute medical risks, there is compelling scientific evidence on medically safe male circumcisions from the neonatal period to adulthood performed by qualified medical personnel with the appropriate follow-up to ensure the treatment of infections and wound healing [36]. The research evidence indicates that male circumcision could offer the same level of protection against HIV and STDs regardless at which age it was done, as long as the procedure is done before HIV transmission [63].

Duncan [65] wrote on the very limited medical literature on circumcision in the Caribbean. He suggested that this region is still grappling with questions on when is the optimal time for males to undergo circumcision and the associated financial costs for this medical procedure. Duncan recommended that Caribbean males be sensitized on the protective benefits of circumcision against STDs and HIV "even if this knowledge only allows some to make an individual choice in keeping with lifestyle risks" [65].

Research studies are needed in Caribbean countries to determine the efficacy of male circumcision against heterosexual HIV transmission, the potential disinhibiting effects of male circumcision on sexually risky behaviors, the benefits and risks of this medical procedure, cost effectiveness comparisons with other prevention strategies, as well as the cultural and ethical challenges related to this medical procedure [66]. Assessments are also needed on the HIV/STD transmissions attributed to uncircumcised heterosexual males compared to their circumcised counterparts. Currently, research evidence is lacking on the biological mechanisms of HIV infection among circumcised and uncircumcised males [63].

Other predictors of effective risk reduction strategies for HIV/AIDS include strong cognitive information on HIV/AIDS; teaching participants specific skills in negotiating sex and protecting their health, and setting normative behaviors, coupled with the structural interventions (i.e., governmental actions on condom distribution, HIV testing, and antiretroviral therapy). Interventions work best when they are locally designed (along with people infected and affected by HIV/AIDS), and launched by peers and persons who are closest to those who are at risk for infection [67]. The most successful interventions are grounded in holistic and comprehensive theories, provide skills training, and are culturally sensitive to the needs of infected and affected persons, and are conducted over multiple sessions for longer time periods [68].

**Conclusion**

It is generally agreed that many Caribbean countries have a limited number of trained human resources, several weaknesses in the health care infrastructure, and inadequate social support systems which significantly constrain the implementation and delivery of a comprehensive response to the HIV/AIDS epidemic [26]. Moreover, the ESC countries have a disproportionate number of citizens living in extreme poverty. Poverty and income inequality are primary drivers of the HIV/AIDS epidemic in the region. Hence, poverty reduction is essential for reducing the HIV transmission rate. For instance, educated and economically independent women feel empowered in their relationship in negotiating condom use with their partners. These women also show their willingness to extricate themselves from nefarious situations that could place them at risk for STDs and HIV infections [8]. In the Caribbean region, there should be special attention to the social and structural forces such as unemployment and educational status which might constrain even those persons who are high in self-efficacy to consistently engage in HIV/AIDS prevention behaviors. Strategies are needed for empowering more women through income-earning opportunities, the removal of biased attitudes in the workplace which unfairly exclude women from job opportunities in some areas, and social support for mothers and female caregivers so that they can earn an income to educate and take care of children and orphans as well as HIV/AIDS affected family members [5].

It is problematic that reliable research findings are lacking on the resilient individual, familial, and community factors that could stem the growth of the HIV/AIDS epidemic among Caribbean women living in economically disadvantaged neighborhoods. Research studies are needed to explore these women’s levels of social and emotional support, individual and behavioral resilient characteristics, and their institutional and community supports.

Evidence is currently lacking on the pervasiveness of perceived threat and fear and mental distress experienced particularly by economically challenged Caribbean persons living with HIV/AIDS. Future research is needed on the resources and mechanisms at the structural and individual levels that can reduce discriminatory attitudes and behaviors directed at individuals living with HIV/AIDS. A corollary concern is the paucity of data from Caribbean nations on sustained viral suppression in low-income people living with HIV/AIDS. Research evidence is needed on
this group gaining access to HIV care, on their retention in care, and on their sustained adherence to antiretroviral treatment. As [69] concluded: "Capacity building efforts are needed that enhance, in an integrated way, the community, public health, and medical expertise needed to successfully deliver combination prevention to the public" (p. 243).

There is the need for research designs to address the complexities underpinning gender identity in the Caribbean, including men having sex with other men (MSM), lesbians, and transgender individuals. Consistent with intersectionality theory, the individual, relational, community and institutional forces influencing attitudes and behaviors which place Caribbean persons at risk for HIV/AIDS and STDs must be adequately assessed in future research studies. For more active and comprehensive STDs and HIV/AIDS intervention and prevention research investigations in the Caribbean region, as Gordon, Forsyth, et al. [70] advised, it is useful to rely on "more complex social-ecological models that identify multiple determinants of health including the interactions among individuals, dyad/family, social/community (e.g., networks, media), organizational (e.g., institutional policies), structural (e.g., public policy, laws, built environment), and societal/ cultural factors (e.g., macroeconomics, stigma)" (p. 15). The crux of the matter is to derive from these assessments more holistic and comprehensive frameworks, which are culturally informed, to guide research investigations on the significant relationships between core determinants and attitudinal and behavioral outcomes in individuals infected and affected by HIV/AIDS and STDs.

The cultural relevance for the Caribbean of Western psychological theories on condom use and HIV/AIDS prevention/interventions should be persistently evaluated. It is essential that Caribbean scholars examine cultural dynamics distinctive of Caribbean societies that are relevant to reducing the HIV transmission rate; for tackling societal stigma, and for promoting meaningful and sustainable community and individual changes for positive health [71].

Another priority is for greater collaborative work with foreign scientists who are assessing "vaginal microbicides," the gels for blocking or killing the HIV virus during intercourse; the vaginal ring which has the antiretroviral compound called TMC120 which is purported to kill HIV, cervical diaphragms, and female condoms. More broad-based training of Caribbean females on how to appropriately negotiate condom use and how to empower themselves in their relationships is an important objective. These resources can afford women greater control in protecting themselves from being infected with the HIV virus.

There are new biomedical developments such as the pre-exposure prophylaxis, or PrEP, which when combined with existing prevention measures can significantly reduce the risk of HIV infection to seronegative sexual partners by 96% in heterosexuals and in the LGBT population [11]. These new biomedical HIV prevention drugs are very expensive. Caribbean populations have not been included in the initial trials in the development of these drugs. Hence, the effectiveness of these drugs in this population must be assessed in future studies. The research literature is also addressing the possibility that these new products and procedures could make individuals more optimistic about these protections and thereby engage in various forms of sexually risky behaviors, including less condom use and increasing the number of sex partners [72].

Caribbean countries are heavily dependent on external funding from the U.S. and European countries in addressing the HIV/AIDS epidemic, particularly in the delivery in antiretroviral therapies. The Caribbean must become financially independent to sustain the development and delivery of antiretroviral therapies. Brazil represents a useful model to Caribbean governments on how to respond to the HIV/AIDS epidemic. Brazil has been producing generic versions of antiretroviral drugs for several years now, and the Brazilian government also negotiated drug discounts thereby lowering the cost for antiretroviral therapy. This country is well-known for its pioneering policy decision in 1996 to offer free combination antiretroviral therapy to all Brazilians with AIDS, and to promote condom use. Access to free AIDS treatment influenced Brazilians to undergo HIV-testing. The Brazilian government between 1997 and 2005 spent $3.5 billion of its national budget for drug treatment [73]. Hence, Caribbean governments must integrate HIV prevention and treatment into existing social and national development programs [26].

A multi-sector coordinated approach between the government, the health and education sectors, the media, civil society, and the private sector is required for a comprehensive and sustainable response to control the HIV/AIDS epidemic. Without this response, many more Caribbean people will die of AIDS or be severely affected by its consequences.

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TAB 16
Abstract

One of the most pervasive stigmatising conditions in society today is HIV/AIDS. In Trinidad and Tobago, stigma and discrimination are still pervasive especially against persons living with HIV/AIDS (PLHIV) and at-risk groups. HIV stigmatisation takes place at all levels including health care institutions, and is a major obstacle to effective HIV/AIDS prevention and care. This study examined health care students' reactions towards HIV patients. A stratified random sample of 339 health care students from Trinidad was used. A 2 × 2 factorial design using vignettes manipulated a male
patient's sexual orientation (heterosexual/homosexual) and HIV onset controllability (high/low). Multivariate analysis of variance and discriminant function analysis were used to analyse the data. There was a significant main effect of HIV onset controllability on participants' attribution of blame, emotions, prejudicial evaluation and willingness to interact with PLHIV, \( \Lambda (.64) R(6, 330) = 31.44, p < .001, = .37 \). Attribution of blame and prejudicial evaluation discriminated between reactions to patients in low onset control and high onset control vignettes. Cognitive-affective appraisal processes are instrumental in determining health care providers' reaction towards PLHIV.

Keywords: attributions, attitudes, HIV/AIDS stigmatisation, prejudice, emotions
TAB 17
Full Length Research Paper

Hyperheterosexualization and hypermasculinity: Challenges for HIV/AIDS intervention in the Caribbean Trinidad and Tobago

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This work aims to understand how one's understanding of Caribbean manhood, hyperheterosexualization, masculinity, and gender shape or impact HIV/AIDS education and one's understanding of self and feelings. Further, given the colonial and religious nature of Trinidad and Tobago, the study wants to untangle the multilayered complex historical, social and political cannons through which identification/gay profiling, prejudice; homophobia, dominant masculinity, and power are produced, performed and understood. This work is a continued extension of the author's previously published book titled Buller Men and Batty Bwoys: Hidden Men in Toronto and Halifax Black Communities [2004].

Key words: HIV/AIDS, colonial and religious nature, Trinidad and Tobago.

INTRODUCTION

I'm 19 years old and I never thought of HIV/AIDS. It was just some letters that I saw as a white man thing. Before I found out I had HIV/AIDS, I always feel I could not get it because they say it's a gay white man's disease. I don't fit in that category. How in the hell I get this thing? (Interview respondent)

At the end of 2007, an estimated 230,000 people in the Caribbean were living with HIV/AIDS (UNAIDS Report, 2008). In three of the seven countries in the region—the Bahamas, Haiti, and Trinidad and Tobago—more than 4% of the adult population was living with HIV/AIDS.¹ That same year, the disease claimed an estimated 24,000 lives, making it the leading cause of death in the Caribbean among adults aged 15 to 44. Higher prevalence rates are found only in sub-Saharan Africa, making the Caribbean the second most affected region in the world (AVERT, 2009). In a report released by the Joint United Nations Programme on HIV/AIDS, they estimate the number of people living with HIV has slightly increased from 33.3 million to just over 34 million (2011).

Now the world has reached a crossroads, ―writes the U.N. secretary-general in the preface to AIDS at 30, a reference to the fact that the epidemic first surfaced in 1981.‖

The number of people becoming infected and dying is decreasing, but the international resources needed to sustain this progress have declined for the first time in 10 years, despite tremendous unmet needs (UNAIDS Report, 2011). HIV/AIDS education delivered by the state and health care officials in the Caribbean has tended to focus on bringing down mortality rates by strengthening

¹ In the year 2004 in Trinidad & Tobago, an average of four new cases of HIV/AIDS were reported every day. The predominant mode of HIV transmission is heterosexual, with a male to female ratio of 55:45 and with more females than males in cases reported in the 15–34 age group. ‘Multiple sexual partners’ is cited as the most frequent risk factor for HIV infection. The median age of reported HIV positive cases is 35 in males and 29 in females, with more than 85% of all reported AIDS cases occurring among people aged 20–59 (United Nations Programme on HIV, 2008).
treatment and delivery programs. Other approaches by religious organizations (Muslims, Hindus, Shouter Baptist, Jehovah Witness, Seven-day-Adventist and other Christian Denominations) and conservatives have stressed sexual abstinence or sex after marriage. Government advertising and posters have also been very heteronormative and conservative in their approach, increasing the ostracism, moral panic, discrimination and stigma faced by men with fluid sexual identities, those sexually abused (incest and rape) injection drug users, sex workers, and MSM reinforcing the legacy of taboo, disorder, decay, and scorn in the minds of many in the Caribbean toward these communities. Homosexuals may be accepted today in some pockets in the Caribbean in a general sense, but “out or publicly known” homosexuals are not as easily accepted. There exists in some Caribbean Islands, Trinidad and Barbados in particular, an interesting form of communal village or societal acceptance and accommodation for LGBTQ life, effeminate gay men and drag queens. LGBTQ groups, human rights activists and drag queens are to be credited for taking the risk, while working against homophobia within these communal and village forms of acceptance. Despite these small gains of communal accommodation LGBTQ resistance, powerful religious and conservative values mute efforts to reach vulnerable populations on the margins of acceptability, including sexually active males MSM2 and SAM. As Stall et al. (2008) remind us “young men’s development is influenced by many contextual factors, including socioeconomics, race/ethnicity, and familial variables. However, sociocultural pressures, including the pressure to meet socially valued masculinity norms (not the least of which includes heterosexuality) also affect the development and behavioral patterns of MSM and SAM. Masculine Socialization stress results from the ‘shaming and other punishment of gay males for failing to achieve masculine ideals’... (Stall et al., 2008).

The Caribbean Epidemiology Centre (CAREC) informs us that infection rates among men who have sex with men are between 6 and 66% (December, 2006). Further, in one Trinidad and Tobago daily newspaper, the Trinidad Express, reports from “a six-year (2004-2011) comparative study on HIV/AIDS in the elderly in Trinidad and Tobago by the Medical Research Centre and Foundation, of 4,566 'new' patients who were enrolled for the first time in the clinic before ever receiving treatment; as many as 1,216 (26 per cent) of the patients were 50 years and over (588 males and 628 females) and 128 (2.7 per cent) were 65 years and over (70 males and 58 females), as compared to 14-15 per cent in the 50 age group and over and 1.5 per cent in those 65 and over in the US studies." (16/02/2012). These statistics cause us to ask why we are seeing such a high increase among MSM populations.

As Treichler et al. (1999) have argued, AIDS is an “epidemic of signification” that allows us to think about flows of information and the fluidity of categories, racial, national, gender, sexual and particularly with respect to research and policy decisions. Because sexuality and gender intersect with race and nation, research on HIV risk requires us to unpack multiple significants simultaneously. In other words, labels such as “men who have sex with men MSM & SAM offer us an array of opportunities to identify vulnerable populations and to question social positions with respect to risk. It is observed over the years how HIV/AIDS is deployed to define and stigmatize communal categories. How can we reduce the mortality rate and transmission of HIV other than through the delivery of prevention/treatment programs that are limited due to stigma, discrimination and ostracism, particularly for MSM?

In this paper, it is argued that educational interventions by government and AIDS workers are blocked by the discourses of hyperheterosexualization and forced performances of stylized and signifying performances of a dominant or hypermasculine behavior that lead men who have sex with men to believe that AIDS is not a problem for them. Further, structural inequalities such as the lack of LGBTQ rights, abject poverty in some situations, and HIV/AIDS illiteracy create additional obstacles. Better intervention strategies are needed not only to reduce the spread of HIV, but also to empower the many gay men who feel powerless and hopeless because they have no recourse to a rights-based agenda (Carr and Lewis, 2007). This paper contributes to the debate on the intersection of HIV and gender-driven roles, money for sex, sexual fantasy, sexual desire, and power in MSM relationships. Beginning with a discussion of the history of HIV/AIDS education in Trinidad and Tobago, this paper is organized in the following manner. Four important themes are discussed in this paper:

1) How do feelings of self-worth, manhood, and the fragility of masculinity shape gay men’s and MSM ability to negotiate safe sexual practices and relationships?
2) How has the colonial and religious nature of Trinidad and Tobago influenced homophobia, sexual taboos, and the profiling of gay men?
3) How do hyperheterosexualization and hypermasculinity impact HIV/AIDS education among young and adult gay men?

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2 Many Caribbean Christian organizations and religious individuals see AIDS as God’s punishment of homosexuals for sexual misdemeanors and crimes that go against God’s will of Adam & Eve. While I accept the concept and or terminology MSM and understand it’s intention – I would like to add that MSM shortfalls to account for sexually active males (SAM) that is men have sex with both genders or anyone: simply because they enjoy the sensation, are sex workers, might be questioning their sexual orientation, enjoys the excitement of not been caught, impact of sexual abuse and sexual violence: reliving their trauma (vivid memories, phantasm, or acting them out and transforming them in victory). This is a challenge for HIV/AIDS education to include in their educational narrative, tools and outreach an analysis that accounts for SAM, who are not talked about in HIV/AIDS education as much as MSM.
4) How does immigration, migration and ongoing interactions to Canada and North America set in motion a process of recognition, and evaluation premised with a growing awareness of racialized men displacement and one’s underestating of risk associated HIV behaviors?

**Brief history of HIV/AIDS education in the Caribbean**

Initially HIV/AIDS was a taboo subject and attributed to white gay males and homosexuals. Many in the Caribbean were afraid to be tested for fear of stigma, discrimination, guilt, shame, and the negative social connotations associated with being HIV positive. To that end, groups of gay and lesbian activists in the Caribbean, in conjunction with their counterparts in North America, started to engage in local community AIDS education initiatives despite great community and public resistance.

As a public health nurse in this study commented, this was when the slogan "don’t be afraid, be aware" was born. In a clandestine manner, people sought testing from the few health centers that were set up by the government. The problem, however, with early testing in the Caribbean and elsewhere was the length of time needed for getting results back, usually four to six weeks. This waiting period created anxiety and hesitancy for those who wanted to modify their behavior immediately and seek treatment.

In 1991, Ervin announced that he had tested positive for HIV and would be retiring from professional basketball. Entertainers in Trinidad and Tobago and globally were used to promote and send messages in their music to enlighten people about the seriousness of HIV. Posters and banners were posted all over the Caribbean and in Trinidad encouraging people to know their status and get tested. As one of the public health nurses in this study reported, a pilot study was done in 1998 in Tobago on pregnant women and mother-to-child transmission. The following year the program was up-scaled to a national level and all pregnant women were encouraged to be tested. Testing sites all over Trinidad and Tobago now offer pre- and post-test counseling, and results are obtained within half an hour. Services such as Voluntary Counseling and Testing (VCT) and Provider Initiated Testing and Counseling (PITC) were set up to facilitate testing. In addition, a group of young adults under the name RAPPORT were used to spread the message to young people in a way they could relate to. Students were given HIV/AIDS education at school via an interactive feed/back teach/back system. More persons from all walks of life were trained and encouraged to spread the message through group discussion and information booklets. Traditionally HIV/AIDS education in the Caribbean has focused on strengthening treatment and delivery programs to bring down the mortality rates. Other approaches by religious organizations and conservatives have stressed sexual abstinence, or sex after marriage.

Government advertising and posters have also been very heteronormative and conservative in their approaches, reinforcing or increasing the ostracism, alienation, discrimination and stigma faced by injection users, sex workers and men who have sex with men (MSM).

These approaches reinforce the ignorance faced by many that AIDS is a gay white man’s disease, sex workers problem and men who have sex with men as homosexuality carries a very heavy legacy of taboo, disorder, decay, and scorn in the minds of many in the Caribbean. Homosexuals may be accepted today in a general sense, but “out or publicly know” homosexuals are not in the Caribbean. Given that many in the Caribbean still see AIDS as a gay white male disease or plague, by extension gay Caribbean male disease.

Governments advertising and education targeting (MSM) populations on television or public posters will only create a moral panic and increase the violence and discrimination faced by MSM and gay men. To this end, Caribbean governments have been muted by powerful religious and conservative values on reaching vulnerable populations including (MSM) persons who remain on the margins of acceptability. The religious and Christian values that embrace sex as intimately between men and women and sex as for the purposes of reproduction, is still alive as the “norm” for many in the World. Due in part to the conservative religious and Judeo-Christian values, patriarchy emerges, threatening “normative masculinity” gendering AIDS education interventions, while the rate of infections continues to increase among (MSM) populations. The Caribbean Epidemiology Centre (CAREC) informs us that infection rates among (MSM) are between six (6) and sixty-six (66) percent [December 2006]. These statistical facts raise the question why are we seeing such a high increase among (MSM) populations. As Paula et al. (1999) have said, AIDS is an "epidemic of signification," because it allows us to think about flows of information and the fluidity of categories, racial, national, gender, sexual and particularly with respect to research and policy decisions. Sexuality and gender intersect with the categories of race and nation, such that research on HIV risk requires us to unpack all the above terms. In other words, labels such as "men who have sex with men [MSM]," like the labels "men," offer us an array of opportunities for identifying vulnerable populations allowing us to question social positions with respect to risk.

To this end, this study focuses on MSM and SAM in Trinidad and Tobago, framed within the context of hyperheterosexualization and hypermasculinity as a means to an end. As a gay out identified Trinidadian living in Canada, it is observed over the years how HIV/AIDS is deployed to define and stigmatize communal categories. How can we reduce the mortality rate and transmission of HIV other than through the delivery of prevention/treatment programs which have limitations due to stigma and ostracism in particular for (MSM)? The forced gender performances of hyperheterosexualization
and hypermasculinity, as survival means blocks successful interventions by government and AIDS workers to curb the transmission of HIV/AIDS and educate (MSM) populations, because they see themselves as outside the "normative frames of heterosexualization. Discourses of hyperheterosexuality lead MSM to believe that AIDS is not a problem for them. Further, structural inequalities such as the lack of LGBTQ rights, abject poverty in some situations, and HIV/AIDS illiteracy must be targeted. Carr and Lewis (2007) also point out that most governments fail to address structural vulnerability, because they are concerned about been reelected if they go against deeply religious and conservative views of the electorate and the culture of hegemonic heterosexuality and purity. This study contributes to the debate around the intersection of gender-driven roles and HIV, money for sex, sexual fantasy, sexual desire, power, and HIV in same-sex (MSM) sexual relationships, which are complicate to study and very few empirical studies have been done on this subject.

Hyperheterosexualization and hypermasculinity

For most young men in the Caribbean, the success and strength of their manhood to a large degree depends on how well they can perform 'normative, straightjacket or dominant masculinity' to obfuscate any form of tenderness or effeminacy'. Their hypermasculinity is an apparatus or sum total of collective surveillance and regulation of what is supposed to be male, masculine and not effeminate. To that end, most men police and deny expressions of tenderness in order to perform, instead, a certain cheerful obsequiousness, hypermasculinity and, by extension, hyperheterosexualization. As Connell (1987, 1995, 2005) argues, dominant forms of hegemonic masculinity reside alongside less powerful, subordinated forms of masculinity (e.g., of sexual minorities, disabled men) and marginalized or discriminated forms of masculinity (e.g., of racialized minorities, working class men, under-employed men, and low income men). The subordinated position of working class masculinities by comparison to their middle class financially secure brothers makes their masculinities seem very fragile. To prevent this, working class men engage in roles and performances that police soft masculinity by acting macho. Morgan (in Crichlow, 2004) comments that "our fights usually indicated an overt disdain for anything that might appear soft or wet—more a taboo on tenderness than a celebration of violence" (Crichlow, 2004 quoting Morgan). Hypermasculinity and hyperheterosexualization, or acting "macho" within Caribbean and among working class men and boys affirms one's allegiance to the policing of a soft masculinity. The dominant culture demands physical responses from boys and makes toughness the hallmark of the real male. As Bailey et al. (2002) observe, young boys knew that if they performed outside the expected, traditional roles they would be ridiculed and labeled 'sissy'. Some Black gay working class men in the Caribbean, in particular those who reject soft forms of masculinities and in some cases education as upward mobility, embrace instead fighting, fucking and flirting, which is a source of the crisis for some HIV interventions, making it gendered and risky. Barrow (1998) argues that the contemporary social-gender system that operates in the Caribbean was built on an "insecure and ambivalent" foundation. This ambivalence, along with the tropes and strictures of Black working class and gay masculinities, is played out in the risk some men take with unprotected sex, making their masculinity fragile at times.

Many of the seeds of this foundation are planted in childhood and adolescence by parents and communal pressure. According to Bailey et al. (1998), having multiple sexual partners earns respect both in the heterosexual and MSM worlds in the Caribbean. The term 'one burner' applied to a faithful male in some Jamaican and Caribbean communities is a phrase of derision (p. 66). Those who did not have many women were regarded as "sick," suspected of "being bullers," or not being "average young black males" (Crichlow, 2004). For many men, the enduring consequences of these lessons mitigate against their playing a positive role in the fight against AIDS and expose them and those they have sex with to a greater risk of HIV infection through non-negotiation.

In the next sections, the author takes up questions of hypersexualization and hypermasculinity in his work on HIV and risk among MSM, in Trinidad and Tobago; ethnographic study on men who have sex with men in Trinidad and Tobago. The study also draws on subsequent meetings in 2011 with medical and academic practitioners in the field, and explores three main questions:

1) How do feelings of self-worth, manhood, and the fragility of masculinity shape gay men's and MSM ability to negotiate safe sex practices and relationships?
2) How has the colonial and religious nature of Trinidad and Tobago influenced homophobia, sexual taboos, and the profiling of gay men?
3) How do hyperheterosexualization and hypermasculinity impact HIV/AIDS education among young and adult gay men?

RESEARCH CONTEXT AND METHODOLOGY

The lacuna of academic literature in the Caribbean on HIV, gay men, and MSM motivated this study. The author wanted to interrogate hyperheterosexualization and hypermasculinity as socializing agents for young men in and from the Caribbean, and understand their experiences of HIV education, prevention and criminalization or gay criminology. He used the interpretative frameworks of McKee and O'Brien (1982) and Oliffe and Mroz (2005) to invite men to talk about their private and personal experiences.

The study involved 46 participants from different parts of Trinidad.
and Tobago, and from different race, class, ethnic, religious, educational and occupational backgrounds. The participants included MSM ranging in age from 18 to 60, nurses and doctors, AIDS educators/workers, author's family members, and professors from the University of the West Indies.

Some of the participants identified as "men who like to have sex with men" but did not consider themselves "gay." Some identified as "bullers"—the term in Trinidad and Tobago for men who have sex with men. Others identified as "gay," and some said there was "no need to use a label." Three of the men were homeless or living in shelters. Ten identified as living with HIV/AIDS, but did not say where they were living or with whom. Four of the men lived alone and were skilled professionals. Three were living in shared accommodation with friends. Ten were students attending college or university.

In addition, the author interviewed eight couples. Two of the couples were living together in intimate relationships and the other six couples were living separately with their parents and families. The remaining participants were health care workers from public health community clinics, and family members, bringing the total for the study to 46 participants.

Data collection

Data were collected through a mixed-method qualitative approach that included formal and informal in-depth interviews, daily ethnographic observation of social events including the 2007 and 2011 Trinidad and Tobago Carnival celebration, two semi-structured meetings with a local gay men's discussion group, and local newspaper media analysis.

As same-sex sexual practices are still illegal in Trinidad and Tobago, meeting and interviewing participants and finding private spaces for interviews required care. The Sexual Offences Act of 1986 makes sex between two men punishable by 5–10 years imprisonment. In essence the state of Trinidad and Tobago represents itself as heterosexual and legally promotes heterosexuality. As a result, some of the interviews took place in public parks while others took place in the private backyards and homes of key informants who provided a space for men to meet socially. Some were conducted at the author's home; others happened at social events and clubs. The author had to enter these interviews on the terms and in the spaces of comfort determined by the participants.

The interviews were recorded and transcribed. As the participants used different forms of local Trinidadian dialect, it was important that the transcriptions were accurate. A continuous exchange of data evolved over the course of the study with some of the participants who agreed to assist with language interpretation and wanted to be sure they were not misrepresented.

Researcher position—reaching out

As Garfinkel (1957) points out, estrangement is helpful for bringing into view the background expectations of participants (p. 37). This was an important methodological intervention as it gave the author the ability to understand the men, make them feel at ease, and gain their support and confidence. To paraphrase Freud (1990), emotional work can be taxing, stressful and painful for all involved and is connected to the issues at hand. As an outsider/researcher, a healthy outlook and attentive listening one with care and empathy was embraced and performed as the author listened to the men with care and empathy. Simmel (1950) makes it clear that the native/stranger role carries with it a certain objectivity that does not commit the researcher to "the unique ingredients and peculiar tendencies of the group" (p. 405). This combination of estrangement, memory, and objectivity were the author's experience with many of the meeting places and interviews, doing ethnographic observations, and understanding the different forms of language used by the participants.

Hooks (1990) refers to the politicization of memory as a practice of remembering that serves to illuminate and transform the present (p.147). In so doing, she distinguishes it from nostalgia—the longing for something as it used to be. Indeed, the author went through different degrees of culture shock while trying to understand how gay men understood their relationships or adapted to living as gay men in Trinidad and Tobago. He also had some limitations in understanding, as Louis Wirth (1964) explains, "the more complex nuances and saliency of class, race, mixed race, and colourism shape and impact sexual discussions, taken-for-granted issues, and unexplained stories and life experiences" (p. 60-83).

Wirth argues that the most important thing to understand about a group or society is what it takes for granted. Indeed, the author Canadian tourist gaze made him take nothing for granted about gay life, gay men, Trinidadian and Tobagonian culture and the deeply ever-changing religious and superstitious nature of Caribbean society and people in general.

Doing field research for the study also heightened his awareness and understanding of marginalization, discrimination, bias and taboos. The homophobic culture of Trinidad meant negotiating, as it did for the participants as well, which parts of my identity to make public, which parts to keep private, and which acts of masculinity or hypermasculinity to perform in order to erase effeminate behavior. Identity as performance is theorized by Goftman (1959) who argues that in face-to-face interactions, people use a "front stage performance" including clothing, sex, age, racial characteristics, size, posture, speech patterns, facial expressions, and bodily gestures (p. 24). The work of feminist film critics on the male gaze (Mulvey, 1990) was also very applicable to this negotiation of identity and to observing others who 'might be gay.' It assisted the author especially in public spaces and in meeting with participants. Some participants, for example, warned him not to wear bright colours when going out with them so that they would not be gazed at or perceived by hyperheterosexual men as gay.

As a researcher, the author benefitted greatly from being able to interview men conversationally in Trinidadian dialect, slang, and formal and standard English. Without knowing, understanding, and feeling the cultural nuances of the participants in our research, we risk misrepresenting, permanently damaging, and pathologizing minoritized communities. If we are to be more methodologically sound, reflective, and theoretically sophisticated in doing qualitative research, the gaze of the stranger researcher has to be interrogated more deeply and complexly. Finally, and most important in doing this work in a hypermasculine, heteronormative and violently homophobic culture was the trajectory of potential problems with police, communal homophobic attacks against the author and study participants, and his family's concerns. To that end, it was a matter of safety, privacy and ethics. The four ethical principles and work of Beauchamp and Childress (1989)—respect for persons, beneficence, non-maleficence, and justice—guided this research work. The participants' names as well as other identifying details have been removed to ensure confidentiality and anonymity.

FINDINGS AND ANALYSIS

This section is divided into three parts. Part one analyzes the men's negotiation of self-worth and the common struggles and vulnerability some of them face in forming relationships. Part two interrogates the perpetuation of colonialism and the sexualization of racism. Part three demonstrates the relationship between hyperhetero-
sexualization, hypermasculinity and gay profiling.

**Negotiating self-worth and relationships**

There is a great deal of sadness, unhappiness and constructed hopelessness in the lives of many of the MSM interviewed. These conditions affected how they negotiate relationships, who they have sex with, and the degree to which they are comfortable in finding a language of negotiation and sense of self-worth in both sexual encounters and relationships.

The first interview took place with a group of 15 young men from the Chat Room, a discussion group that met weekly at a private residence. The first issue raised by one of the men in the group was the meaning of gay relationships. As the discussion got started a number of the participants commented, “What relationship?” When asked what they meant, a young man explained:

It is more about what I can give you; better yet, what you could give me, and who you can catch at the club. You know, the tourists, they have lots of money and they spend it wild on drinks. It’s not about love, but money and a fast life. It’s fast romance.

Another participant said, “Look, we gay people who bulling, we know that we have no human and legal rights, so why bother about having a meaningful relationship when it means nothing in society?” Their insights quickly reminded the author of the materialist nature of Triniadian culture and the sense of hopelessness that some men express and feel. It was best summed up by a young man in the group:

*I am young, my body is my gift to older men who have the money. Not the young boys—they have nothing, they’re unemployed and still living at home. I want a man who has a good job, a car, a big house and a place for me to go to. I want to be able to have sex with him and have a good time.*

In these conditions, HIV/AIDS education is muzzled by poverty and who feeds you. When power is vested in an older person with money, it also jeopardizes the possibility of negotiating safe/er sexual practices.

**The perpetuation of colonialism**

The tropes and legacy of colonialism still dominate the minds and thinking of many white Westerners on racialized peoples. It is therefore important to examine its effects on the construction of and interaction between different kinds of interracial sexual and relationship encounters both globally and locally. The permutations and racist sexual stereotypes are endless, whether examining the effects of white domination and white power in the Caribbean or in North America. One commonly held power white stereotype is the attribution of inferiority and sexual decadence. This sexual profligacy equates blacks with sexual energy and hypersexuality—what is termed the sexualization of racism. This is best summed up by Baldwin (1972) who writes “no name in the street” in describing his unbelieving shock when he visited the American southern states. It is absolutely certain that white men, who invented the “N” big black prick, are still at the mercy of this nightmare and are still, for the most part, doomed in one way or another to attempt to make this prick their own (p. 482). This sexual phobia, when acted upon, is done with whites feeling pitiful while blacks and racialized peoples suffer the consequence, especially around effective HIV prevention strategies. Inevitably, these racist fears and images are internalized by racialized peoples themselves and acted out unconsciously because they are legitimized by whites. This was the main message of Frantz Fanon's *Black Skin, White Masks* (1967), namely that racialized men who have sex with white men act out sensuous sexual imagining.

**The sexualization of race**

A number of men in the discussion group and in the study as a whole felt that tourists were the best men to meet. As one young man said:

*I go to the club to look for and meet tourists only so that I can get American or other foreign currency. The tourist will pay for anything and buy me anything. I don’t have to worry about a place to have sex, something to eat, and money. I stay in their hotels, if they are in one, or see them regularly when they want to have sex with me, and I am cool with that. A gay relationship for me is about sex and money, not love and commitment. I’ll do anything for money, and the same thing with the tourists—they do anything for sex. It is all about sex, good looks, and money.*

It would appear that the colonized or, in this case, the gay men who seek out mainly white tourists for American dollars, are living out the self-fulfilling prophecy of the sexualization of racism and the black stud/jock/Mandingo image, all dick and no brain. By “Mandingo”, the author refers to the film by the same name (1975) in which director Dino De Laurentis portrays sex acts between masters and slaves as intensely paradoxical sites of pleasure and racism. Similar to the fantasy that white tourists are looking for love, the racist Mandingo fantasy is constructed as a romantic encounter that, according to Caribbean men, local men are not capable of giving. By contrast, as Philips (1999) argues in her work on Barbados, men who receive money from female tourists are “able to harness the racial image of Afro-Caribbean men as studs in order to realign their subordination to
white heterosexual masculinities” (p. 45).

The predicament of racism is a matter of philosophical, psychological and institutional contamination, and must be addressed at its core. Rousseau and Porter (1990) argue that the invention of the exotic and the labeling of the anthropological “other” as exotic legitimated treating the peoples of the “developing world/third world” both as a projection of Western fantasies and as fit to be despised, destroyed, or doomed to extinction (p. 7). In essence, the colonizer view of non-whites deployed within the coded language of sun, sex, tourism ignores white racist practices in the name of civilizing men who have sex with men in the Caribbean. The construction of Caribbean MSM as primitive by those who extol the virtues of the sexual freedom and liberation of developing countries relies on the belief that these men do not know better or do not value their lives. By extension, the non-negotiation of safer sexual practices is almost seen as taboo or forbidden if they are racialized men.

**Sex tourism**

Some of the men in the study felt that allowing the sex tourism industry to flourish was the government’s way of addressing the abject poverty and high unemployment in Trinidad and Tobago. There are ways in which sex acts trespass the intimate boundaries of the racial and legal divide between colonizer and colonized, affirming a new humanity and sexual desire along the lines of economic exchange. Puar, in *Circuits of queer mobility: Tourism, travel, and globalization* (2002), explains the link between colonialism and sex tourism as follows:

> A politically charged, religiously driven, and culturally defined homophobia does not, after all, deflect the lure of an exotic (queer) paradise; instead, it encourages a continuity of colonial constructions of tourism as travel adventure into uncharted territory laden with the possibility of taboo sexual encounters, illicit seductions, and dangerous liaisons—a version of what Renato Rosaldo terms ‘imperial nostalgia’ (p. 113).

Tourism, white or otherwise, in places where there is a lack of human and civil gay rights, and where there are people living in abject poverty, large communities of illiteracy, and in areas still in need of development create a ripe environment for exploitive, abusive sexual excitement and the spread of HIV/AIDS. The Caribbean and other sun, sex vacation resorts are places where tourists tend to adventure, wanting to take part in risky unprotected sex and illegal acts with the wild, uncivilized, child-like native. This practice only serves to reinforce developing nations as ‘safari cave like’ and in need of white or foreign salvation.

Such relationships and encounters complicate how we understand racialized sexuality and the sexualization of racism. Tourist sexual encounters with local natives challenge the site of the sex act and paradoxically create an antagonism between freedom and domination. However, most local gay men are oblivious of the sexualization of racism, while internalizing some aspects of the dominant definitions of dependency and constructed sexual powerlessness. Given that most white tourists come from racist societies where they are often afraid to engage in publicly displayed interracial relationships, they fulfill their repressed sexual fantasies through temporary vacations and relationships that are easily left behind and forgotten as they show their passports to customs officers on their way out. In addition, as Kincaid (1988) observes, foreigners or tourists are rarely aware of the intentions and perceptions of local people:

> It never occurs to the tourist that the people who inhabit the place cannot stand you ... that behind the closed doors they laugh at your strangeness. Nor are tourists aware that the well-practiced rituals of dissemblance that characterize friendliness have more to do with the rituals of asymmetry and survival, or the desire to keep a job when few are available, than with the fiction of ‘native’ character (p. 38).

This was evident among some of the men in the study who said they look for tourists to have sex with because they can be paid for it. The colonized subject who sees tourists as having more romantic finesse and, by extension, as being more civilized and better lovers, is best explained by Fanon (1967). As Fanon reminds us, the colonized who have fully accepted their colonization and the discourses that surround them are deeply embedded in the psyche and behavior of the colonized (p. 252–3). Such practices are a part of a broader colonial regime of oppression that is sedimented in the hearts and minds of Caribbean men and women as subjects and victims:

> When the colonized makes contact with the white world, a certain sensitizing action takes place. If the psychic structure is weak, one observes a collapse of the ego. The colonized stops behaving as an actionable person. The goal of his behavior will be the “other” (in the guise of the white man), for the “other” alone can give them worth. That is on the ethical level: self-esteem. [...] Man is only human to the extent to which he tries to impose his existence on another man in order to be recognized by him. As long as he has not been effectively recognized by the other, that other will remain the theme of his actions. It is on that other being, on recognition by that other being, that his own human worth and reality depend. Is that other being in whom the meaning of his life is condensed (p. 217).

**Hyperheterosexualization and gay profiling**

The gender roles, class dynamics, and idealizations of
hypermasculinity and hyperheterosexualization that influence the negotiation of same-sex relationships complicate HIV/AIDS education interventions. Many older gay men embody traditional hyperheterosexual and hypermasculine gender roles to fulfill their sexual needs, using chat lines and social media sites, as well as cell phone cards and other gift offerings for sex with younger or less financially stable partners. In the extraction of cash benefits, there appears to be a silence on gender role expectations and the negotiation of safe sex practices. Most of the younger men interviewed who were not financially stable said that the decision to have safe sex was not up to them. Instead, it was up to the more financially stable or older person. As one participant explained, echoing others, “a man with money has a place. I could go and have sex with him, sleep over sometimes, and spend a nice weekend. My neighbors don’t have to know I am bullying.”

The power relations vested in a person who has a good job, combined with the belief that money = guaranteed sex = relationship, define the social and cultural constructions of gay male relationships in Trinidad and Tobago. According to Parker et al., (2000), the politics of gender sexuality—who one is permitted to have sex with, in what ways, under what circumstances, and with what specific outcomes—are never random. Such possibilities are defined through “explicit and implicit rules imposed by the sexual cultures of specific communities and the underlying power relations” (p. 7). These explicit and implicit rules resonate with the history of slavery, in which young slaves were often defined as the sexual property of their masters. Beckles (1989) informs us that slavery meant not only compulsory extraction of labour from Blacks, but also, in theory at least, slave owners’ right to total sexual access (p. 141–2).

Indeed some of the participants talked about their first love and sexual experiences at the age of 13 and 14 with much older, more mature men in their 30s and 40s. A number of men in the Chat Room group reflected on their childhood same sex experiences and coming out. As one young man in particular said: “When I was 13, I met my first love of my life. He was 35. I went to him place daily for sex and he would take care of me and buy me everything I want. He was also the top or the man in the relationship.” This relationship, he added, lasted for two years. This raises fundamental questions about the point at which sex, love, and the exchange of money turns into rape and the abuse of power. Is it possible for a thirteen-year-old to talk about his first love with a person in their forties? Or are we talking about sexual exploitation and child prostitution? Do older men see their masculinity as threatened, weakened or emasculated if they have relationships with men their own age? Or does homophobia and the illegality of homosexuality force them into relationships with younger men to secure and maintain their own masculinity?

As Hope (2001) reminds us in her work on homophobia in Jamaica, for some, “the intense paranoia of male homosexuality is a reflection of the hyperheterosexualization of Caribbean masculinities, most apparent among working classes.” For many Caribbean men, as she explains, the location of their masculine gender identity must be understood in relation to how men see and understand women, their roles, and socialization. This negotiation of identity is complex and multilayered, and always in dialogue with women; that is, erasing all signs of effeminophobia. “Here,” as she states, “heterosexual conquests and a hatred of homosexuality (internalized homophobia and self hate) are ways in which men who do not want to be outed access their entire cache of masculinity, and manhood is secured” (p. 5).

It is clear that these various practices—young men seeking older men, older men seeking young men, and local men seeking tourists—produce forms of gay sexual profiling. Such dangerous and limiting categories, along with the construction of masculinity, sexuality, and love as economically driven, raise a number of important issues. First, does being gay in Trinidad and Tobago mean needing to have money in order to meet other gay men and have sex? Does it mean that men who are financially poor do not have sex with other financially poor men? Does the consumerist nature of same-sex practices mean that the buyer can do anything he wishes, including engaging in unsafe sexual practices? Does it mean that gay male sex or sexual relationships equate with the destruction of the body and self image?

**Denial and representation**

The complexity of disclosing or denying HIV status creates further challenges for AIDS education. As one participant said, “I do not want him to leave me because I love him. So if he know I have HIV, he will leave me. I want love, not rejection and stigma, so I lie to him or anybody who love me and can take care of me.” Not only do homophobia and heteropatriarchy force both heterosexual and gay men to lie from young, but the betrayal can have a snowball effect—no one told me they were HIV positive, so why should I have to tell other people that I am? What is disturbing here is that HIV positive persons who willingly and knowingly pass on the virus are not only aware of the dangers of unprotected sex and non-disclosure, but also of the need for honesty, preventative measures, the need to know, to seek treatment and how to live healthy with HIV. Disclosing their status also becomes violently complicated for some because it increases fears of violence, stigma, discrimination, and communal out-casting and ostracism. Other participants said: “I do not need to tell anybody my status” or “I am bi-sexual, you know—on the “down low” as they say in America—and will not tell anybody who I having sex with, and my child mother doh know I does have sex with man them.” To avoid responsibility, these men do not label themselves as gay or bisexual, nor do
they tell their female partners that they have sex with men. It is also very easy for them to use American terms to make serious issues seem painless and cool. As men are socialized not to show their true feelings, using these terms helps them to mask their feelings and the pain of living with HIV.

Other comments by participants reflected the deep social taboos, emotional complexity, and forms of resistance surrounding gay relationships and HIV status. As one man confessed: “I went into the relationship knowing that he had HIV. I wanted to take the risk of having sex without condoms with him to prove my love for him was pure.” Another said: “I know two guys who are HIV and they say they want to bring down as many others with them. They say they on a mission.” And as a third participant made clear:

You know in Trinidad, if you want to be gay, do not flaunt/show it and people will say you are nice and they will love you for not pushing it in their face. But the minute you try to let people know you are gay, they will stone you, beat you, laugh at you, and you doh want to pass in front of them. So you think I will tell people I have HIV/AIDS? Yuh crazy?

Lying to find love by not disclosing one’s HIV status is complex, and unfolding its many complicated layers requires more work. However, it was clear from some of my discussions with men from the Chat Room that those who identified as heterosexual and those who saw themselves as hypermasculine and embodying a hyperheterosexual orientation tended to be the men who, for the most part, did not want to discuss their status because it was or should be assumed that they were HIV negative. Chng and Gelia-Vergas (2000), in their research on ethnic identity, gay identity, and HIV risk taking, also found that MSM who identified as heterosexual were more likely to have unprotected sex and lie about their status (p. 326–339). Given the epidemic nature of HIV, Decena (2008) has questioned the “orthodoxy of compulsory disclosure,” insisting that Black MSM should disclose their same-sex realities and actions on purely epidemiological or programmatic grounds (p.397–413). Further complications for HIV education include how to reach men who construct themselves as heterosexual because they are married to female partners. MSM who sometimes engage in unprotected sex with one male partner outside of their married relationship, for both to understand the need and importance for engaging in protected sex and to realize that unprotected sex is not about building and sustaining relationships or a demonstration of trust that his bi-sexual encounters will be protected from his wife.

Stigma and discrimination toward homosexuality in the Caribbean have a negative and pervasive effect on MSM. They have high levels of internalized homophobia, self-hate, religious guilt, effemophobia, and seldom disclose their orientation and, by extension, their HIV status. Caribbean men also care a great deal about what their family, friends and neighbors think about their sexual preferences. This was clearly communicated in interviewing one of the participants in the study who said he avoided wearing any bright clothing colours coming to his home because he did not want the neighbors to think he has gay friends or that he might be gay. Religious guilt is also a conduit for blocking effective HIV interventions and HIV disclosure in the lives of many MSM who attend organized religious institutions that have negative effects on homosexuality. Greater internalized homophobia, according to Huebner et al., (2002), is also associated with lower awareness of HIV prevention services and with fewer changes in the perception of one’s ability to use condoms (p. 30).

Stigma and the fear of being found out

Many participants talked about not looking at or cruising other men in public in order to avoid being stigmatized as gay or bullers. As Brown and Chevannes (1998) inform us in their work on masculinity, young men and boys are restricted from displaying overt signs of tenderness toward one another and are expected to show affection by “greeting each other with clenched fists, backslaps, hey bro, and other brotherly or manly aggressive expressions” (p. 30). Further, the expectation to hide any form of homoeroticism acts as a male opium, making it impossible to engender a discussion on affection, tenderness and feelings as it relates to how to men understand themselves and, by extension, their level of comfort in talking about HIV, safer sex negotiations and stigma.

Both the male gaze and public stigma are hindrances to HIV education. In the interviews, many of the men said: “If I tell my family and friends how I get HIV, I will have to explain too much, and that is too stressful.” Some argued, “it will be stress and pressure for the rest of my HIV life.” The fear of being identified as having HIV clearly shows the pressures of stigmatization. Although most of the men interviewed were looking for love, affection, family approval, security and public affirmation, they all knew the social, economic, violent, and alienating consequences of telling their partners the truth about their status. Homophobia and heteropatriarchy make young gay and heterosexual men prisoners of a particular system of ideological oppression that teaches them to not tell the truth about themselves. Further, as young men or boys they measure themselves and their self-worth in relation to others that they estimate to be similar and to other siblings in their communal and immediate families. Hiding their HIV status secures them a temporary sense of security and validation about who and what they are.

The tabooing and illegality of homosexuality drives individuals underground and leads them to seek social acceptance by adopting a visible hyperheterosexual lifestyle. For example, the participants pointed out that, in some of the younger-to-older relationships, the older men...
are the more “straight or hyper-heterosexual acting one.” When asked how safe sex is negotiated in relation to self-perception and age differences, the younger men said that most older men do not identify as gay because they feminize the younger men in their relationships. By feminizing the younger men, they act out their hegemonic heterosexualization and put up a hypermasculine front in order to protect their sexual identities.

Chevanne’s work (2001) on Caribbean masculinity is very instructive here. He informs us that socialization into heterosexuality leads Caribbean men to construct, maintain, and celebrate hypermasculinity. He writes that having one’s first sexual experience, having a child, and/or setting up an independent household are more important indicators of reaching adulthood than other social factors like jobs or education (p. 215). Power plays an important role in the social construction of masculinity, especially in the opposition, in male same-sex relations, between wealthy hegemonic masculinity and marginalized or working class masculinity. In wealthy hegemonic same-sex masculinity, the dominant Caribbean consumerist cultural ideals of what it means to be a man become the terrain on which all marginalized or subordinated masculinities are constructed and performed.

Thinking of wealthy same-sex hegemonic masculinity in this way allows us to understand why the older men feel they have to provide all the material possessions for the younger boys/men. It reassures their wealthy hypermasculinity and their ability to control the relationship without negotiation. In addition, most young Caribbean men do not feel that they are really men unless they are sexually active and acting out hetero-hypermasculinity. As Brown and Chevannes (1998) write about young men’s hypermasculinity: “Boys greet each other with clenched fists and backslaps, and often use other forms of aggression to express their feelings” (p. 30). This aggression also plays itself out in the roles that drive some of their sexual encounters and relationships. The main reason the young men in the study said they engage in unsafe sexual practices was fear of losing the older, more financially secure man who is providing for them. The man who provided was also the active, top or insertive partner, while the younger, and in some cases, the lighter skinned man, was the passive, bottom or receptive partner. When the older men were asked why they assumed the dominant and penetrative role with younger men, they replied that they were seen as the masculine one and that they liked acting out heterosexual roles within their relationship to reassure their masculinity. It is clear for these older men who have sex with younger men that the articulation or action of penetration reinforces power, domination, hypermasculinity and hyperheterosexualization. In addition, as mentioned above, the passive partner does not negotiate the conditions for having sex. As an older man informed me: “I am paying for everything he wants. I am paying for everything he has and I will decide if we use the condom.” When I asked what that meant to him, he said, “power, masculinity and control.”

Unprotected sex in these situations is not only seductive, random or unintentional, but rather a form of hypermasculine barebacking driven by a form of hyperheterosexualization that erases all safe sex negotiation. There is also the myth in the minds of some that ‘skin to skin is in’ or that going bareback is ‘the real deal.’ This prevailing myth makes some couples not negotiate the use of condoms because skin to skin is in and ‘if you love me you do not have to worry.’ The role of gendered imbalances sex between MSM sexual relationships reinforces the argument that gender roles in the Caribbean and elsewhere, along with failing to disclose one’s status, is a major contributor to the spread of HIV/AIDS. Barebacking sex in these situations is not the same as for two HIV negative partners who are in a long-term relationship, have been tested, and agree to having unprotected sex. Of particular concern here is the extent to which internalized homophobia, religion, guilt and stigma have created a sense of constructed hopelessness and respect for the men and their partners. “Stigma against people living with HIV/AIDS and homosexuality was implicated in low levels of use of HIV testing, treatment and care services, and the reluctance of HIV positive people to reveal their serostatus to their sexual partners. Data reveal a pressing need for anti-stigma measures for both homophobia and HIV/AIDS, and for training for health and human service professionals” (Ruth and Robert, 2005).

Danger

Other risky sexual practices leading to unsafe sex also emerged from the interviews. The family situations that some of the men were living in forced them to meet for sex outside or in public spaces such as parks, below bridges, washrooms, abandoned buildings, or near the river and beach areas. Some also took the risk of having sex at the dance clubs they frequent, as the security closes their eyes to it. One young man told me he has sex with men for money and is subjected to repeated abuse. He also told me he became friends with a group of male street sex workers who socialized him into street prostitution. He could not tell his parents. He was living at home and prostituting. He said the men had threatened to kill him or have him arrested if he stopped. Like the lives of others, his life is endangered not only by the various settings in which he conducts his sexual activities, but also by unsafe sexual practices. Given the lack of legal and sexual protection, rampant homophobia, and the multiple partners with whom men engage for the purpose of sex money, the risk of HIV/AIDS infection increases dramatically. These street sex workers also feel very disenfranchised from the larger culture, society and community due to the taboo nature of prostitution.
sex, homophobia and discrimination.

**Saga Boy Calypso**

Trinidad and Tobago are known for their steel pan and calypso. Claysonian themes include but are not limited to issues and topics such as the role of women in society, family issues, sports, nationalism, education, ethnicity, race, global issues, and above all the reinforcement of dominant and persistent forms of masculinity and father. As a dominant cultural tradition and integral part of the social imaginary, calypso contributes to constructions of hypermasculinity and hyperheterosexuality. Calypsonian Penguin’s song “Soft Man” (1983), for example, reinforces ideologies of male dominance over women by suggesting that masculinity is centered on an erect penis. At the same time, Shurwayne Winchester’s popular calypso song “Woman By My Side” (2007) goes like this:

Listen now, hear me now  
God made Adam first, he was the first man  
Then he found out Adam was lonely, and his companion was Eve, a woman Lord Why should I go against myself thinking this is wrong eh  
But it was written in Leviticus  
Man should not lie with man, it is an abomination.  
Many in the Caribbean will argue that Winchester is only reinforcing the religious values of the Caribbean and, by extension, the heteronormative nature of a society where LGBTIQ persons are religiously condemned. Delmano’s 1981 song “Sodom and Gomorrah” also contributes to this perception. As the chorus goes:

For we are living in this modern Sodom and Gomorrah  
And very soon an angel go visit we here in the near future  
So if your wife turn into a pillar of salt, I want you to know that is your fault  
And if the fire and brimstone fall down on we, I know we are all guilty.

Calypso as popular culture text not only celebrates antigay paranoia, morality, sexual perversion, hyperheterosexualization and hypermasculinity, but also takes great joy in elevating and policing a form of phallocentric masculinity that makes a mockery of gays and effective HIV intervention and awareness. These songs, and others, embody contradictory notions about a fixed or policed masculine identity.

This policing of masculinity influences and shapes the social practices, behaviors, and attitudes of MSM as they navigate the role-playing of top and bottom, safe and unsafe sex, and who decides if a condom is to be worn. In addition to the practices of younger men acquiescing to the power of older men in same-sex relationships, and men engaging in heterosexual dating, marriage and fathering to conceal their homosexuality, other practices also reinforce hypermasculinity. In Trinidad and Tobago, men with socially constructed feminine qualities are sometimes called “ex-layers.” They are ostracized by society and other gay men in general. As an expression for chickens that no longer lay eggs, this feminized derogatory term reinforces the misogyny within Caribbean and Trinidadian culture and demonstrates how gay men socially construct gender roles for other gay men within an already complex and oppressed context. These men are often seen as the ones who are penetrated in sexual encounters, and also as men not to be seen with in public because of the harassment that occurs in a violently homophobic culture. Participants who described themselves in the interviews as “macho” or “butch” made it very clear that they do the penetrating while the feminine men are the receivers without negotiation or discussion.

This policing of constructions of gender poses a number of health risks and challenges for HIV/AIDS education. Intervention HIV research and development in the Caribbean have not done much to reduce stigma and discrimination against sexual minority communities. For example, more research needs to be done in the Caribbean on serosorting or on how MSM select partners according to their assumed/guessing/profiling behavior or known HIV status. We also know very little about different sexual networks. There is still a tendency to target HIV education interventions to stigmatized and non-stigmatized communities.

**DISCUSSION AND STRATEGIES OF CHANGE**

Knowingly spreading HIV/AIDS and going from person to person is a carnival of barbarity and cocktail for disaster that, for some, combines self-hate and anger at having HIV with the goal of pulling others down with them. The findings from the study reveal the extent to which homophobia, heterosexualization, neo-colonialism, popular culture, and ideologies of hypermasculinity impact the sexual practices, relationships, lives, security, and self-worth of men who have sex with men in Trinidad and Tobago. First, it is clear that some of the men who have unprotected sex are both subject to and, in turn, create and promote a system of gender, race, class, and cultural norms that place them in extremely risky unsafe sexual situations. Second, these situations are masked and kept silent in the effort to avoid stigmatization, violence and legal repercussions. Third, issues of migration, colonialism, and racialization within the Caribbean highlight

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4 While I was delivering a guest lecture in 2007 on men and masculinity, a student told me the following story: At his home, there were mangoes hanging on his side of the yard from his neighbour’s mango tree. He thought this was great because he would get some mangoes. But when his two boys didn’t pick the mangoes, he worried that they were gay. He asked if they saw the mangoes. Then he made them pick them to prove that nothing was wrong with their masculinity.
social problems associated with sex work or sex for money. Taken together, the unwritten rules of hypermasculinity, class, and power complicate effective HIV/AIDS education interventions and the changing of behaviors. There is no doubt that better interventional strategies are needed not only to reduce the spread of HIV, but also to empower the many men who feel powerless and hopeless without recourse to a rights-based agenda.

Homosexuality is still illegal in most of the Caribbean, with the exception of the Bahamas. The Buggery, Sexual Offences and Morality Acts make sex between two people of the same sex punishable by imprisonment. The accompanying fear and silence of daily homophobic attacks and the fear of being criminalized or beaten by the police if caught makes it hard on stigmatized populations. These activities include torture, drowning, stoning, burning by being placed in car tires (UNAIDS; Robert and Lewis, 2007), as well as employment discrimination and other forms of persecution. Homosexual persecution combined with a positive HIV status is a frightening reality for many in the Caribbean. These fearful feelings and hegemonic acts of hypermasculine and hyperfeminine violence coupled with state criminalization force people to be secretive about their status and sexual orientation. By extension, this contributes to the spread of the virus through a lack of protection, fear, stigma, and not being tested or avoiding knowing one’s status.

The Buggery laws make it harder for MSM to seek out their status and, in some cases, when their status is known, to seek out available treatment options. Male sex workers, gay men, and drug injector users, by virtue of their disfranchised or marginalized status, are thought to have lost themselves and their right to equal human rights and protection from the law. Traumatized by fears of HIV stigma and homophobic persecution, they sometimes contemplate or even commit suicide, withdraw from LGBTQ social activities and women’s support groups, live in seclusion, or seek asylum abroad. Asylum seekers also run the risk of not returning to their country of origin because of their sexual orientation or because they expose the Caribbean's poor human rights track record on protecting persons living with HIV/AIDS.

### Structural change

Structural inequalities such as the lack of LGBTQ rights, poverty, and HIV/AIDS illiteracy need to be targeted in a language and manner that makes sense to the communities of men involved. Vulnerable populations can only change their behaviors and gain a sense of self-worth when the social and political climate embraces them and grants them rights and civility. Because the engine driving human rights and law reform today is undoubtedly the HIV/AIDS pandemic or epidemic and the economic impact it has on the economies of the Caribbean, government interest in sex and sexual politics should be positive and liberating, and not only focused on moral regulation. UNAIDS argues that 85,000 children have been orphaned since 1999 in the Caribbean alone by parents who have died from AIDS (2008). The future of youth is at risk. We and the governments of the Caribbean collectively need to quantify the economic, cultural and social cost of HIV/AIDS in the Caribbean. For example, what stresses has HIV/AIDS placed on health care systems, loss of productivity, and loss of technical and professional expertise? Also, with an unemployment rate of 14.2% (Central Bank of Trinidad & Tobago, 2007), we need to consider to what extent the sex tourism industry and racialized constructions of gay relationships are a by-product of the economy and how this has affected the rate and spread of HIV/AIDS among gay men.

### Education and research

The homophobic gendering of discrimination and taboos against MSM in particular have to be more publicly addressed by government education initiatives to secure peoples’ safety. Hyperheterosexualization, hypermasculinity, religion, and a culture that virtually celebrates the violation of gay peoples’ rights, combined with a gay culture of sexual secrecy, makes HIV and gender education a huge task. Men who have sex with men must be able to talk about their feelings and sense of self, and have pride in who they are.

The lack of empirical research on the linkage between Caribbean masculinities and HIV transmission perpetuates a vicious cycle in which assumptions, stereotypes and fear trump the advancement of effective educational and policy interventions. Clearly the link between masculinities and HIV is not an easy one to understand and get honest answers from. However, as a result of lobbying by LGBTIQ groups and organizations, the Center for Disease Control and Prevention and other public health agencies in Trinidad and Tobago have launched campaigns to study men who have sex with men that do not identify as gay.

### Challenging homophobia

A major challenge for HIV/AIDS education is how to turn feelings of repulsion against men who have sex with men into feelings of love, respect and civility. Homophobia in Trinidad and Tobago, as in the Caribbean more generally, is located within a particular system of ideological thought and practice that includes a cocktail of resistance from conservative religious and parental views.

In this climate, what are the opportunities and challenges for sexual rights in Trinidad and Tobago today? We
need to work on unlearning and relearning how to over-
come the draconian cultural biases against LGBTQ rights 
in the Caribbean. Here we are talking about addressing 
generations and generations of colonially reinforced 
restrictive and dehumanizing thought processes. How 
do we learn to unlearn an entire generation of taboos, 
sexual stigmatization, and Caribbean mores around a 
fixed and nationalistic understanding of masculinity, sex 
and homosexuality? It starts with overturning our archaic 
laws, addressing poverty and illiteracy, and promoting 
youth education, feminist education, and education on 
human rights.

Conclusion

The moral regulation, bionationalism, and state-ordained 
homophobic violence that construct a heteronormative 
discourse where words hurt, the social action of gay men 
is shamed, assaulted and embarrassed, and men are 
forced into a hypermasculine masking of their true 
desires and behaviors, must shift from hate to love, 
respect and acceptance. To cure HIV/AIDS we cannot 
and must not suffer from a shortage of love, kindness, 
empathy, respect and forgiveness. The pernicious forces 
are not the men themselves but the social, cultural, 
religious and political forces and relations producing fear, 
stigma, shame, and response, namely homophobia, 
hypermasculinity and heteropatriarchy. These forms of 
discrimination are ample evidence that Caribbean MSM 
want the same rights as everyone else.

The complex, multilayered gender roles and sexual 
taboo embedded in a colonial system must be challenged 
and unlearned in order to create a more successful 
human rights and HIV/AIDS education that gets the message across. Because masculinity is tied to how 
dominant, violent or hypermasculine you are, and how 
much risk you can engage in, the challenge is to develop 
HIV/AIDS strategies sensitive to the many forms that 
dominant hypermasculinity takes while also embracing 
different and/or soft masculinities. Masculinity is not a 
fixed concept and is fraught with conflicting and contra-
dictory behaviors, attitudes and messages in different 
contexts and situations. To this end, HIV interventions 
must understand the link between the fragilities of 
different masculinities and the tropes they embrace as 
they are constructed and reaffirmed. There are also 
cultural, racial and the colonial sexualization of racism 
issues to be unpacked here, such as economics and 
colourism to relationships and the conservative traditional 
masculine roles that are maintained and produced in 
sexual encounters between MSM. The challenge is how 
to reach MSM who do not adhere to the norms of 
Caribbean hyperheterosexualization and hypermas-
culinity. More challenging is the modern construction of 
family, non-cohabiting couples, same-sex or same 
gender loving couples, non-sexually exclusive couples 
alongside monogamous homosexual and heterosexual 
couples, raises more challenging interventions for 
education and social change. We know very little about 
and do not want to talk about these different forms of 
families; hence there is limited information or research to 
work from. This type of education needs to be directed 
towards health care providers, HIV educators, the family, 
the community and others involved in HIV prevention and 
awareness campaigns.

Opportunities exist therefore for research that can 
investigate and address HIV and health promotion in 
ways that challenge hegemonic masculinity and non-
conforming traditional stereotypical constructs of 
manhood. We have done a great deal of work for MSM 
but very little has been done for “gender nonconforming” 
men who blend attributes stereotypically associated with 
various forms of masculinities and femininities (Connell, 
1987). More risk taking in HIV public discourses must be 
taken through poster, media messages, and social 
media outreach (twittering, blogging, facebook and inter-
active websites for comments and education). More men 
who are gay in public life and have high profiles need to 
join the struggle, take coming our risk, and be constructively engaged, because we all have levels and 
measures of responsibly. By been open about our sexual 
orientation, we by extension seek our rights to public 
expression, public intimacy and our sexual identity. As 
MSM, we must also ask ourselves what stands to be 
gained or lost if we commit and connect personally with 
the work and lives of others in order to achieve 
recognition, respect and rights. Admittedly, one’s mouth 
is muzzled by who feeds it and what it eats, but one’s 
body also belongs to oneself. Therefore it is important to 
ask what social meanings and violence are inscribed in 
silence and how it relates to freedom, justice, respect and 
equality.

When people are empowered, have better access to 
resources without the attachment of taboos, they can 
take control of and make healthier choices around HIV 
prevention. To be an agent means to be capable of 
exerting some degree of control over the social relations 
in which one is enmeshed and that one lives through 
daily. In turn, this implies the ability to transform those 
social relations that violently socially and culturally police 
men who “act effeminate and men who have HIV lives, 
bodies, minds and conditions. AIDS education needs to 
assist male MSM, street sex workers, and those living in 
isolation, denial, shame, and poverty become agents who 
understand their situation and vulnerability. Understanding 
marginalization, stigma, and discrimination is equally im-
portant as while promoting speaking out and challenging 
internalized homophobia and emotionality. But most 
importantly, MSM must see that homoerotism can be 
used as resistance and this seems to be an appropriate 
starting point.

REFERENCES


