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GENDER REVIEW AND ASSESSMENT OF HIV/AIDS PROGRAMMING OF SELECTED NATIONAL AIDS PROGRAMMES IN THE CARIBBEAN

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EXECUTIVE SUMMARY

Official HIV/AIDS policies and programmes are very important in the development of strategies and plans to stop the spread of the disease. Some countries in the subregion have such policies and programmes, while others are at different stages of the process.

HIV/AIDS is clearly a development challenge as it incorporates health, social and economic dimensions, which, if not addressed, could lead to an exacerbation of an already serious problem. In this regard, the lack of recognition of the gender dimensions of HIV/AIDS is providing gaps that allow for the spread of the disease at exponential rates.

One indicator of this spread is the rate at which HIV infection is rising among females and youth in the region. In this context, the need for cross-cutting policies has become particularly evident. In some countries like Guyana, HIV infection has been rising in the general population and spreading from specific subpopulations to become a generalized epidemic. Identification of the at-risk groups is one exercise in gender analysis that is important in arriving at gender sensitive strategies to stop the spread of HIV.

An understanding of the gender dimensions of the factors contributing to the spread of HIV is also important. Research has shown that risk and vulnerability to HIV, as well as policies and programmes that are meant to prevent the spread of the disease are all influenced by gender and the inequalities that are associated with being female or male. A gender assessment of policies and programmes is therefore about utilizing and applying the tools of gender analysis in order to understand how policies and programmes to prevent the contraction and spread of HIV are differentially affecting men and women and boys and girls. The assessment will highlight gaps that actually intensify the vulnerability of males and females to HIV/AIDS because of gender or provide opportunities to implement meaningful and effective policies and programmes that achieve their objectives.

Some of the factors that contribute to the spread of HIV/AIDS and which reflect the dynamics of gender at work are: poverty and lack of employment; cross-generational relationships, specifically relationships between young/teenaged girls and older men; gender-based violence both in and out of the home, including child abuse, coercion and rape of young girls, and rape of women generally; gender socialization; migrant workers; inconsistent or non-use of condoms; multiple partnering; drug and alcohol abuse; co-infection as it relates to sexually transmitted infections and tuberculosis; stigma and discrimination; and lack of knowledge of infection status.

This review provides an assessment of HIV/AIDS policies and programmes in three Caribbean countries, Guyana, Bahamas and Trinidad and Tobago through a gender analysis of the official documentation on HIV/AIDS policies and programmes. The study reveals the variability in documentation of HIV/AIDS policies and programmes in the Caribbean, as represented by these three case studies and indicates the need to address this concern in order to achieve the objective of stemming the rising tide of HIV infections in the Caribbean. This assessment is intended to assist in the preparation and implementation of HIV/AIDS

programming in the Caribbean and will point to the gender issues that need to be addressed and integrated into proposed activities and strategic approaches developed and/or supported by the United Nations system.

Findings revealed the following:

(a) For the most part, decisionmakers and persons responsible for the formulation of HIV/AIDS policies and programmes did not demonstrate adequate awareness of the impact of gender on the issues of HIV/AIDS, and were therefore unable to implement strategies and programmes that addressed these issues as they affected males and females; and

(b) In cases where gender issues were identified when conducting a situational analysis as it related to HIV/AIDS, this awareness was not transferred in the development of strategies and programmes to deal with the problem. One of the reasons for this is that a framework for gender analysis was never adopted or established as an essential part of the development of HIV/AIDS policies and programmes.

The recommendations to correct this problem, therefore, include:

(a) The provision of technical support to national and regional HIV/AIDS committees to assist in the formulation of HIV/AIDS policies and programmes from a gender perspective;

(b) The development of training manuals that can be used to build gender awareness and capacity in gender analysis at all levels;

(c) The development of protocols for gender-sensitive interventions regarding issues of HIV/AIDS;

(d) The development of effective, gender-sensitive communication strategies and packages to relay messages and information regarding HIV/AIDS to the intended audiences, paying particular attention to young people;

(e) The development of gender-responsive budgets for HIV/AIDS strategies and programmes;

(f) In-depth research on the factors responsible for the spread of HIV in the Caribbean, with a specific focus on the way in which gender relations are reproduced among young persons, and the extent to which this impacts on the spread of HIV. This should be with a view to developing cross-cutting policies which will address the need to change gender relations among young people.

Primary research, including semi-structured interviews and focus group discussions, as well as secondary research in the form of review and analysis of documents were used in the conduct of this study which was carried out in 2004.

BACKGROUND AND GENERAL OVERVIEW

The Economic Commission for Latin America and the Caribbean (ECLAC) Subregional Headquarters for the Caribbean in collaboration with the United Nations Development Fund for Women (UNIFEM) Caribbean Office is reviewing gender issues in Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) programmes and projects being developed or implemented in the Caribbean subregion. The main objective of this review, of which this report is one component, is to assist in developing a programme for combating HIV/AIDS in the Caribbean within the context of their mandate to provide technical assistance to governments, engage in advocacy, capacity building and demonstration and dissemination of good practices and techniques and tools that can be used in the development process.

This report is specifically intended to provide feedback that will assist in the preparation and implementation of HIV/AIDS programming in the Caribbean and will point to the gender issues that need to be addressed and integrated into proposed activities and strategic approaches developed and/or supported by ECLAC, UNIFEM and other agencies within the United Nations system. This will be done by focusing on three countries in the Caribbean, namely the Bahamas, Guyana, and Trinidad and Tobago.

An understanding of the gender issues that drive the HIV/AIDS epidemic is an important aspect of prevention and advocacy strategies that seek to halt the spread of the disease. It is no accident that this disease, which started with higher proportions of men than women in most countries, is now growing at a faster rate among women. Women's vulnerability, social and cultural beliefs, and attitudes and behaviours that are gender-based are some of the factors that greatly influence the spread of the HIV/AIDS virus in the Caribbean, as with the rest of the world. Gender relations among young people are critical in this regard.

At the end of 2003, the Caribbean subregion had the second highest adult HIV prevalence rate in the world (between 1.9 per cent and 3.1 per cent), second only to Sub-Saharan Africa (between 7.5 per cent and 8.5 per cent) (UNAIDS 2003). The primary mode of transmission is sexual (76 per cent). Sexual transmission of HIV is however no longer predominantly via male homosexuals, but through a combination of homosexual, bisexual and heterosexual sexual activities, with heterosexual transmission accounting for 65 per cent of HIV transmission in the Caribbean by the end of 2002. The social stigma associated with homosexuality also means that there will continue to be underreporting of AIDS cases among this group (CAREC, 2004). In the same way, social, economic and cultural factors, as they relate to gender, are also very important for the development of programmes and policies to stop the spread of the HIV infection.

Other modes of transmission include intravenous drug use and transfusion of blood and blood products. These continue to be low in most countries, with transmission through intravenous drug use (IVDU) ranging from zero per cent to two per cent, except in Bermuda (33.5 per cent in 2002), and through blood and blood products at 0.30 per cent, from 1992 to 2002. The percentage of unknown category of transmission is up to 16 per cent of the total cumulative AIDS cases reported by Caribbean Epidemiology Centre (CAREC) Member Countries (CMCs). In some countries this figure is as high as 40 per cent of the AIDS cases,

with significantly more males than females in this category. This could be due to the fact that some males do not disclose their category of exposure because of the social rejection of homosexuality. The other is that the category of exposure among females is more likely to be known due to routine testing during pregnancy.

In the Caribbean, efforts to capture data on HIV/AIDS have been most sustained and standardized by the Caribbean Epidemiology Centre/Pan American Health Organization (CAREC/PAHO), which has responsibility for 21 countries in the Caribbean. HIV/AIDS data are collected at the national level and captured on a standardized CAREC/PAHO AIDS and HIV reporting form, which is completed on a quarterly basis. In most countries, the CAREC/PAHO case definitions for AIDS and HIV are also used to report these cases with information related to sex, age and category of transmission. These data are therefore probably the most reliable statistics on HIV/AIDS, even though CAREC recognizes that the data most likely underestimate the true situation in the Caribbean.

According to CAREC, a cumulative total of 24,567 AIDS cases have been reported between 1982 and 2002 by 20 of its 21 member countries. Given the levels of underreporting that have taken place, projections are that it is more likely that between 30,000 and 35,000 cases of AIDS have occurred in these countries. It has been further estimated that for the year 2002, the annual incidence of AIDS cases could be estimated at 52.43 per 100,000 persons, compared to 13.6 per 100,000 in 1991. This means that between 1991 and 2002, the AIDS incidence in CAREC member countries has increased almost fourfold.

Data also show that AIDS is now the leading cause of death among males and females aged 15 to 45 years in the Caribbean, and that the epidemic is one that now essentially impacts on youth. The 15-24 age group and specifically female 15-24 year olds are most vulnerable. This is evidenced by data which show that although there is a higher rate of AIDS cases among males (a ratio of 2:1), the incidence of AIDS among females in the 15-24 year old age group is three to six times higher than that of males in the same age group. The rate at which HIV/AIDS infection of females has been rising is also illustrated by the fact that while in 2002 the male to female ratio of AIDS cases was 2 to 1, in 1985, it was 4 males to 1 female. Recent national estimates also showed that HIV prevalence among pregnant women has reached or exceeded 2 per cent in eight countries, namely, the Bahamas, Belize, the Dominican Republic, Guyana, Haiti, Saint Lucia, Suriname, and Trinidad and Tobago. As a consequence of this high heterosexual transmission of HIV, Mother-to-Child Transmission (MTCT) now accounts for six per cent of reported AIDS cases. In fact, CAREC estimates that during 2002, close to 600 infants were infected with HIV via MTCT.[1]

Over the years, the guidelines for surveillance have been modified in order to fill the gaps in previous guidelines which became evident as the disease rapidly evolved. The inclusion of Behavioural Surveillance Surveys (BSS) to improve the monitoring of behaviour that puts individuals at risk of contracting HIV, and more recently, third generation guidelines[2] that recognize the importance of using other sources of information to better understand the impact of the epidemic; as well as participatory approaches with community involvement - including the

[1] CAREC (2004, 2).
[2] CAREC/WHO/PAHO (2002).

involvement of Persons Living With HIV/AIDS (PWLHA), provide greater opportunity for including relevant social factors, such as gender, in order to better understand how the disease is contracted and spread. This opportunity will however be missed if the decision makers and policy formulators are not gender sensitive and are not equipped to undertake gender analysis.

COUNTRY ANALYSIS OF NATIONAL AIDS PROGRAMMES IN THE CARIBBEAN

Summary of research undertaken

Guyana

Guyana is the only English-speaking country in South America. Although geographically located in South America, it is culturally and historically a part of the Caribbean. Guyana has an area of approximately 285,000 square miles and is divided into 10 administrative regions. As of 2002, preliminary population census results show that the sex ratio is now closest to being equally divided between males and females, with women accounting for 50.7 per cent of the total population. Region 4, the Demerara-Mahaica region has the highest proportion of the population at 42 per cent - this region includes the capital of Guyana, Georgetown. Regions 6 and 3, with 16.5 and 13.4 per cent of the population, respectively, follow Region 4 in population size. These three regions have the largest proportion of the population.[3]

Guyana has a multi-ethnic population, estimated in 2001 at 777,125 persons, of which 49 per cent are male and 51 per cent female. More than 49 per cent of the population is of East Indian descent, with 32 per cent of African heritage, 12 per cent mixed, 6 per cent Amerindian, and 1 per cent European and Chinese. This country is underpopulated. Apart from the historical fact of its large landmass relative to the existing population, this underpopulation is also due to demographic factors, among which is the high rate of net migration. Approximately 90 per cent of the population occupies the flat coastal belt consisting of fertile land, where most of the agricultural activity occurs. Guyana is also heavily forested and possesses resources in the form of minerals, aquaculture, and wildlife.

The country is primarily a primary goods producing economy which relies largely on agriculture and mining for domestic accumulation and export earnings. Following structural adjustment and economic reform in the decade of the nineties, Guyana has experienced economic growth with increased stability. Real GDP grew on average by 2.3 per cent in the last decade (1995-2004). Recovery however was from a low economic base: in the decade preceding

[3] Results of the preliminary 2002 Population Census, quoted in the Starbroek News, 15 May, 2004.

the Economic Reform Programme (1980-1990), total and per capita GDP had declined by an annual average annual rate of -3.1 per cent and -3.5 per cent respectively. This resulted in a rate of migration that exceeded the natural increase of population.

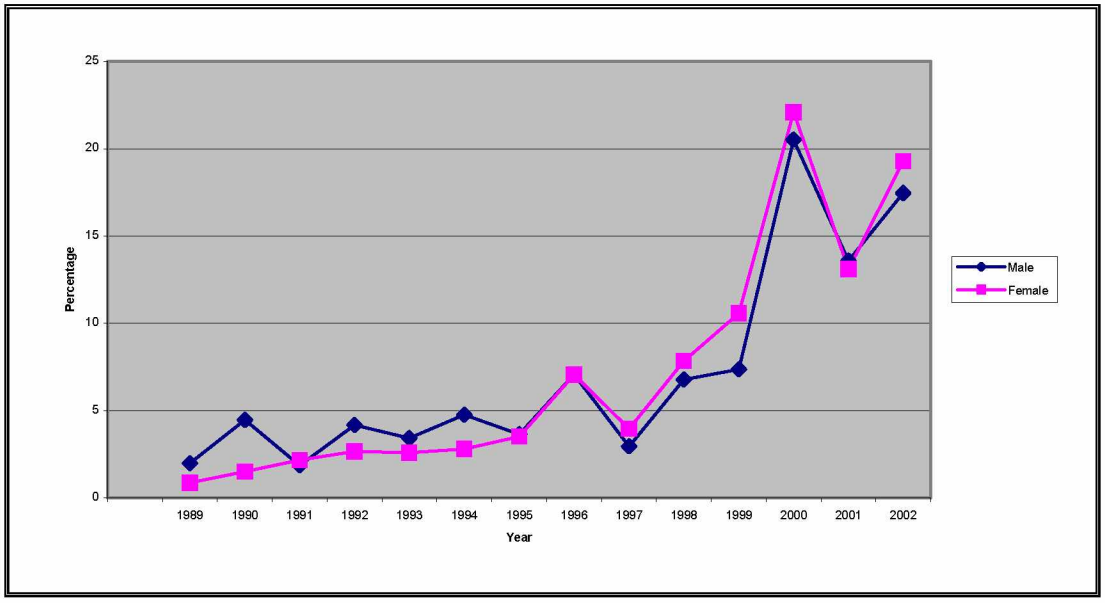
Growth was fuelled by activity in the main drivers of the economy: agriculture, mining and services. Over the decade, agriculture, forestry and fishing averaged 33.5 per cent of GDP, buttressed by sugar and rice production, while mining and quarrying contributed 11 per cent. Services accounted on average for 40 per cent of GDP, with strong value added in financial services, transport and communications and distribution. With regard to sugar, Guyana is expected to lose US $40 million per year in export earnings over the next four years as a result of the European Union price cuts. The broad macro-economic situation in Guyana also improved over the decade with a strengthening of government finances and lower levels of inflation. However, high levels of indebtedness, reflecting past fiscal excesses are a major constraint on government operations. In 2004, public external debt stood at 140 per cent of GDP, while debt service payments were equivalent to 8.5 per cent of export of goods and non-factor services. The high debt burden is an important constraint on the availability of resources for social programmes. Despite the significant economic growth, levels of poverty and unemployment have not been reduced to levels which matched expectations and remain relatively high.

Guyana is facing a generalized HIV/AIDS epidemic. Between 1989 and the end of 2002, a total number of 3,163 HIV cases were reported to the National Surveillance Unit. In 2002, based on the number of HIV cases that have been reported, the incidence of HIV in Guyana was assessed to be 79.5 per 100,000 persons. This however masks regional variations, which show Region Four (Demerara-Mahaica) accounting for 70 per cent of reported cases, Regions Six (East Berbice-Corentyne) and Ten (Upper Demerara-Upper Berbice) accounting for about 24 per cent of reported cases, and the remaining seven regions accounting for about six per cent.[4]

Like the rest of the Caribbean, the male to female ratio of HIV cases reveals an alarming increase in the rate of infection among women (Figure 1). Between 1990 and 2002, the ratio of males to females with HIV fell from 3.7 to 1.1 (See Table 1). The Table shows that in 1996, the number of HIV cases had risen to an all time high of 122 for males and 98 for females, 94 per cent and 100 per cent over the 1995 figures for males and females, respectively. By 2002, these figures had increased by 146 per cent for males and 173 per cent for females.

[4] "As many as two-thirds of AIDS cases are going unreported". Stabroek News, 30 November 2000

Figure 1
Trends among males and females with HIV, 1989-2002: Guyana



Source: CAREC (2004); based on Table 1

Table 1
Annual HIV incidence, Sex ratio and Cumulative Incidence 1989-2002: Guyana

YEAR	MALE	FEMALE	UNKNOWN	SEX RATIO	TOTAL	CUMULATIVE TOTAL
1989	34	12	0	2.8	46	46
1990	77	21	0	3.7	98	144
1991	32	30	0	1.1	62	206
1992	72	37	0	1.9	109	315
1993	59	36	0	1.6	95	410
1994	82	39	0	2.1	121	531
1995	63	49	0	1.3	112	643
1996	122	98	0	1.1	220	863
1997	51	55	0	0.9	106	969
1998	117	109	0	1.1	226	1195
1999	127	147	0	0.9	274	1469
2000	354	307	0	1.2	661	2130
2001	234	182	9	1.3	425	2555
2002	301	268	39	1.1	608	3163
Total	1725	1390	48	1.2	3163	

Source: CAREC (2004, 98).

Notwithstanding this, it has been estimated that over 60 per cent of HIV/AIDS cases are going unreported.[5] Programming and planning interventions need to take account of the groups that are considered most vulnerable to the threat of the disease. This is in order to halt the spread

[5] CAREC (2004).

of the disease, in general, and also because very often these groups act as bridges of transmission, which enables the disease to spread faster. It should be noted that the epidemic in Guyana has left the confines of specific vulnerable groups and has spread to the general population. This means that even while information on 'at-risk groups' is important, there is also need to identify interventions that address the entire population.

In Guyana, the vulnerable groups identified are pregnant women; blood donors; migrant workers, especially males working in the mining sector; persons with STIs; persons with tuberculosis; and female sex workers. Although some weaknesses have been identified in the statistical methodologies used to conduct some of the HIV seroprevalence surveys among these groups, the general trends point upwards for the periods in which the data are available. Rates among female sex workers in Georgetown, for example, increased from 25 per cent in 1992 to 47 per cent in 1997, with slight declines of 46 per cent and 31 per cent in 2000 and 2001, respectively[6]. CAREC also notes that among patients with STIs, studies conducted in 1992/1993 showed a seroprevalence rate of 13.2 per cent and 6.6 per cent among males and females respectively. In 2002, this rate went up by 82 per cent, with rates among males rising to 15.1 per cent and among females to 12 per cent, an increase of almost 100 per cent.

In terms of the AIDS epidemic itself, CAREC estimated that between 20,000 and 25,000 people were living with HIV and AIDS at the end of 2001. The cumulative number of AIDS cases at the end of 2001 was 3068, of which 2065 were males, 1344 were females and 44 unknown. In 1997, AIDS patients occupied 25 per cent of beds in the Georgetown General Hospital. AIDS has also emerged as the leading cause of death among males – with a crude death rate of 71.4 per cent per 100,000 males, and the fourth leading cause of death among females – with a crude death rate of 38.3 per cent per 100,000 females.[7] An examination of AIDS mortality risk by age groups shows an increase in all age groups. Figures for the 0-14 age group moved from 1.09 in 1990 to 12.3 in 2000. This was also reflected among the age groups 15-24 years (5.87 to 28.09); 25-44 years (14.59 to 123.62); 45-64 years (3.65 to 72.22); and 65 years and older (0.00 to 20.23). However, this data are not available by sex. Data on the annual AIDS incidence however show how quickly and drastically the disease has spread among females. See table and graph below.

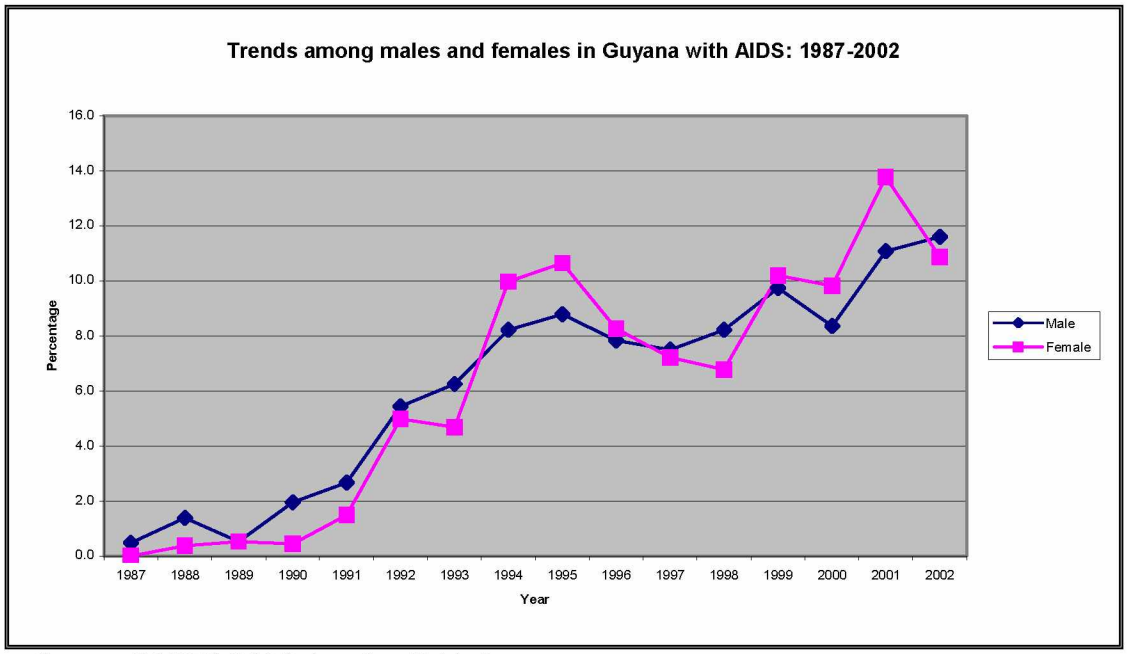
[6] GOG/OPEC Fund/UNFPA Project for HIV-AIDS. Prevention among Youth in Especially Difficult Circumstances (2004-2006), 5th May 2004.
[7] CAREC (2004, 103).

Table 2
Annual AIDS incidence, sex ratio and cumulative incidence, 1987-2002: Guyana

YEAR	MALE	FEMALE	UNKNOWN	SEX RATIO	TOTAL	CUMULATIVE TOTAL
1987	10	0	0	All males	10	10
1988	29	5	0	5.8	34	44
1989	11	7	0	1.6	18	62
1990	41	6	0	6.8	47	109
1991	56	20	0	2.8	76	185
1992	114	67	0	1.7	181	366
1993	131	63	0	2.1	194	560
1994	172	134	0	1.3	306	866
1995	184	143	0	1.3	327	1193
1996	164	111	0	1.5	275	1468
1997	157	97	0	1.6	254	1722
1998	172	91	0	1.9	263	1985
1999	204	137	0	1.5	341	2326
2000	175	132	0	1.3	307	2633
2001	232	185	18	1.3	435	3068
2002	243	146	26	1.7	415	3483
Total	2095	1344	44	1.6	3483	

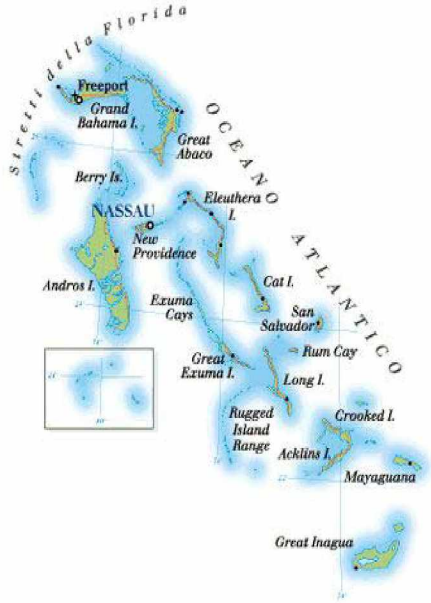
Source: CAREC (2004, 102).

Figure 2
Trends among males and females in Guyana with AIDS, 1987-2002



Source: CAREC (2004); based on Table 2.

The Commonwealth of the Bahamas



The Commonwealth of the Bahamas, or the Bahamas as it is commonly known, is a nation-State comprising nearly 700 islands that form an archipelago 590 miles long, located between Florida and Haiti. There are 29 main islands in the Bahamas, the two most well known being Grand Bahama and New Providence. The capital of this country is Nassau and is located in New Providence, with the second largest city, Freeport, in Grand Bahama. According to the 2002 population census, there are approximately 312,000 persons living in the Bahamas in an area of 5,382 square miles. Eighty-five per cent of the Bahamian population is of African heritage, with 12 per cent European and 3 per cent Asian and Hispanic. About two thirds of the population reside in New Providence.

The Bahamas economy has been relatively stable, with economic activity taking place in the areas of tourism, banking, e-commerce, cement, oil refining and transshipment, salt, rum, aragonite, pharmaceuticals and spiral-welded steel pipes. The services sector accounts for approximately 90 per cent of GDP, with tourism as the major contributor in this sector followed by financial services. Over three million tourists visit the Bahamas yearly, and 50 per cent of the labour force is employed in this sector. Industry and agriculture in the Bahamas account for 7 per cent and 3 per cent of the GDP respectively. In 1999, the unemployment rate stood at 7.8 per cent, with males at 6 per cent and females 9.7 per cent.

Table 3
Annual HIV incidence, sex ratio and cumulative HIV cases, 1985-2002: Bahamas

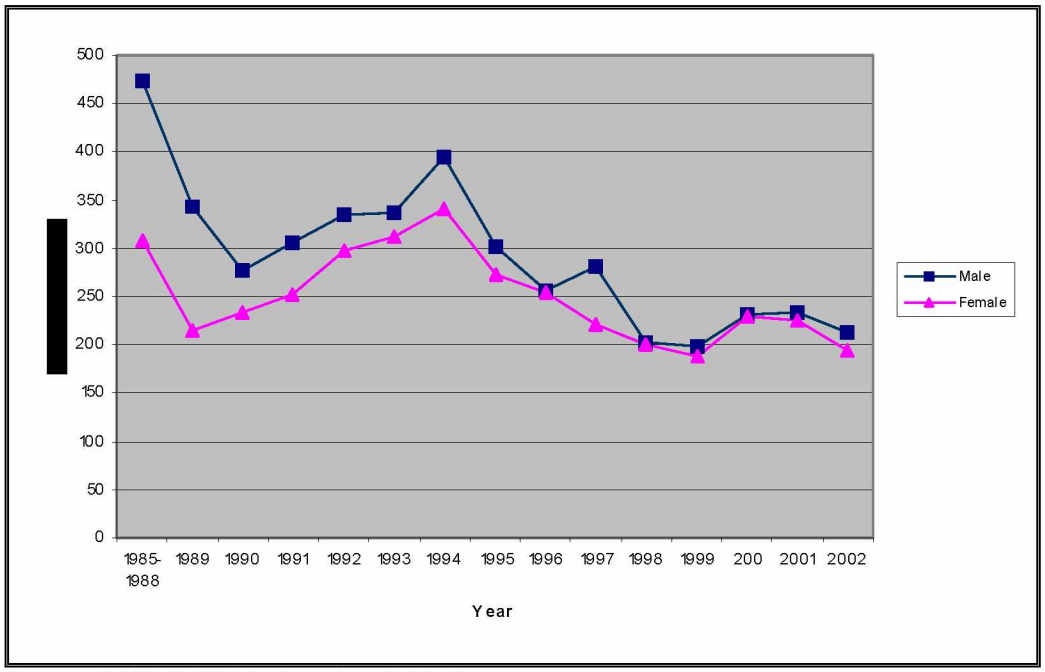
YEAR	MALE	FEMALE	SEX RATIO	TOTAL	CUMULATIVE TOTAL
1985-1988	474	308	1.54	782	782
1989	342	215	1.59	557	1339
1990	276	234	1.18	510	1849
1991	306	253	1.21	559	2408
1992	334	298	1.12	632	3040
1993	336	312	1.08	648	3688
1994	394	340	1.16	734	4422
1995	302	272	1.11	574	4996
1996	256	254	1.01	510	5506
1997	281	221	1.27	502	6008
1998	202	201	1.00	403	6411
1999	199	187	1.06	386	6797
2000	231	230	1.00	461	7258
2001	233	225	1.04	458	7716
2002	213	195	1.09	408	8124
Total	4379	3745	1.17	8124	

Source: CAREC (2004, 30).

It is in this socio-economic environment, that 8,124 cumulative HIV cases have been reported between 1985 and 2002[8]. In 2002, this amounted to an annual incidence rate of 131 per 100,000 population down from 268 per 100,000 in 1994 when the highest number of HIV cases (734) was reported. Approximately 50 per cent of these HIV cases grew into full-blown AIDS, with 71 per cent of these AIDS cases resulting in death.[9] Since 1994, there has been a decline in the incidence of reported HIV cases, generally, as well as among males and females. Between 1994 and 2002, this decline was greater among males than among females, with males experiencing a 46 per cent decline and females, a decline of 43 per cent. Table 3 also indicates that the rate of increase among females with HIV has resulted in a sex ratio that is almost equal. Between, 1985–1988 the sex ratio stood at 1.54; in 2002 it was 1.09. This means that the number of females with HIV is almost equal to the number of infected males. Statistics from the Infectious Diseases Division and Department of Public Health (Bahamas) reveal that at December 2003, the cumulative total increased to 9764.

[8] CAREC (2004, 29).
[9] Ibid.

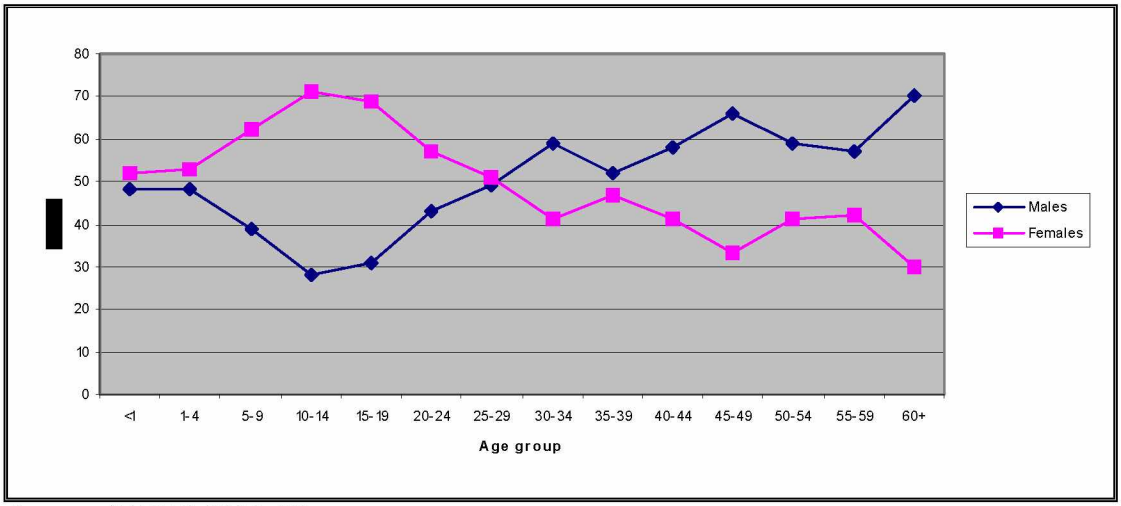
Figure 3
Reported HIV cases in the Bahamas: Trends among males and females



Source: CAREC (2004); based on Table 3.

Although the figures show a general trend of more males than females with HIV, an analysis of HIV cases by age group in the Bahamas shows that there are more women than men with the virus in the younger age groups. According to the Bahamas Ministry of Health, adolescents and young people account for the fastest growing group of new HIV infections. See below for a graphic representation.

Figure 4
Sex and age distribution of HIV cases in the Bahamas



Source: CAREC (2004, 33).

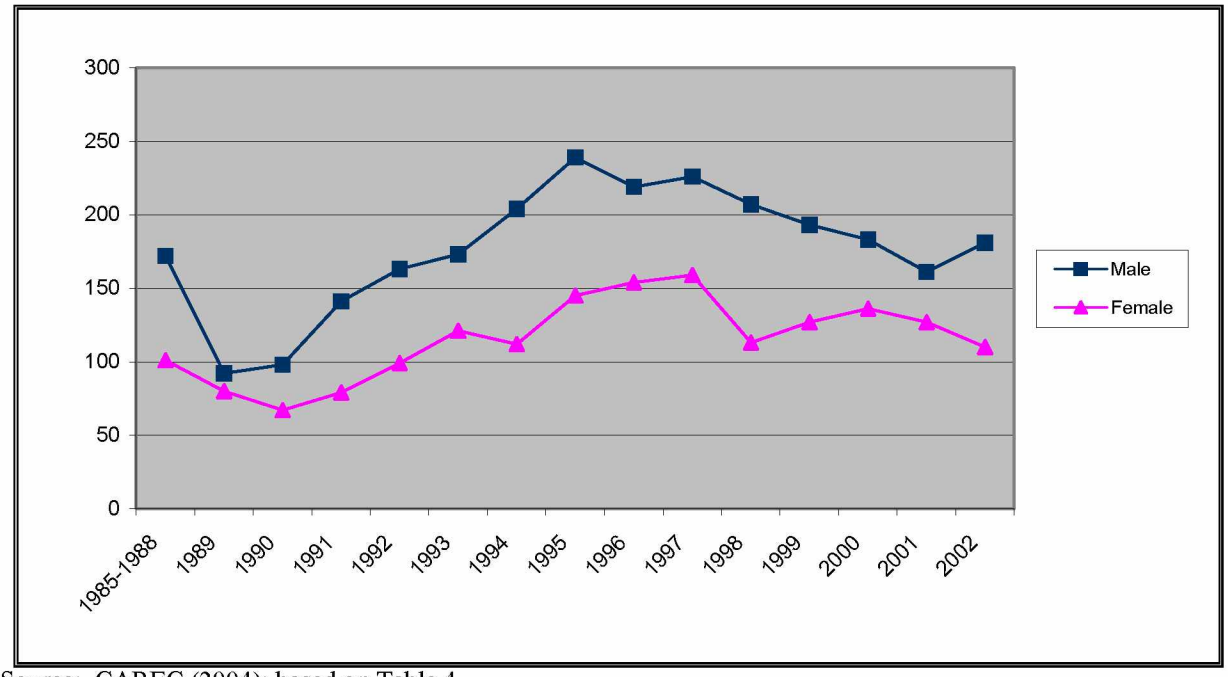
Like the first HIV case, the first AIDS case in the Bahamas was reported in 1985. From 1985 to 2002, a total number of 4,382 AIDS cases have been reported. Compared to HIV cases, there is a higher male to female sex ratio of AIDS cases among the population.

Table 4
Annual AIDS incidence, sex ratio and cumulative incidence, 1985-2002: Bahamas

YEAR	MALE	FEMALE	SEX RATIO	TOTAL	CUMULATIVE TOTAL
1985-1988	172	101	1.70	273	273
1989	92	80	1.13	172	445
1990	98	67	1.46	165	610
1991	141	79	1.78	220	830
1992	163	99	1.65	262	1092
1993	173	121	1.43	294	1386
1994	204	112	1.82	316	1702
1995	239	145	1.65	384	2086
1996	219	154	1.42	373	2459
1997	226	159	1.42	385	2844
1998	207	113	1.83	320	3164
1999	193	127	1.52	320	3484
200	183	136	1.35	319	3803
2001	161	127	1.27	288	4091
2002	181	110	1.65	291	4382
Total	2652	1730	1.53	4382	

Source: CAREC (2004, 35).

Figure 5
Reported AIDS cases in the Bahamas: Trends among males and females



Source: CAREC (2004); based on Table 4.

The incidence of AIDS in the Bahamas in 2002 was 93 per 100,000 population. The primary modes of HIV transmission are sexual contact among heterosexuals and the use of crack cocaine. People living in the two larger islands – New Providence and Grand Bahama - are mostly affected.

CAREC[10] has identified the Bahamas as a success story in terms of the impact of HIV/AIDS messages and programming, leading to declining trends in HIV and AIDS cases and AIDS mortality. This was especially the case among STI patients and pregnant women. These groups revealed a 41 per cent and 38 per cent reduction rate in HIV infections, respectively. The number of persons developing AIDS declined from 291 in 2002 to 165 in 2003. AIDS has however been identified as the leading cause of death among 15-29 year olds.

Another success in the Bahamas is the Vertical Transmission programme which has led to a reduction in the vertical transmission rate from 30 per cent to 3 per cent.

Trinidad and Tobago

Trinidad and Tobago is a twin-island republic, located in the south of the Caribbean, just 11.2 kilometres from the coast of Venezuela, with a population of 1.3 million persons. It has a total area of 5128 square miles, with Trinidad comprising 4828

[10] CAREC (2004, 39).

square miles and Tobago, 300 square miles. The island of Trinidad in particular is marked by ethnic, cultural and religious diversity. In 2000, 40 per cent of the population were of East Indian descent, 37.5 per cent of African descent, 20.5 per cent of mixed ethnicity, and the remaining 2.0 per cent of the population comprised persons of Amerindian, Chinese, Syrian, Lebanese and European descent. Net migration and declining fertility rates have resulted in declining rates of population growth over the past three decades. The urban population was estimated at 74 per cent in 2000.

The country is rich in petroleum and natural gas, with a fairly stable economy boosted not only by its petroleum and gas products, but also by manufacturing and agriculture, as well as tourism in Tobago. Tobago relies mainly on tourism and transfers from the Consolidated Fund for its economic welfare. The energy sector dominates both production and exports. Trinidad and Tobago recorded its eleventh consecutive year of economic growth in 2003 mainly due to favourable developments in the energy sector and associated expansion of downstream industries.

The first response to the initial diagnosis and notification of AIDS in Trinidad and Tobago was to set up a National Surveillance Unit in the Ministry of Health in 1983. The National Surveillance Unit, (NSU), continues to be the main repository of information on HIV/AIDS. Sources of data are primarily the public hospitals and clinics. However, data also come from the Queen's Park Counselling Centre and Clinic, registries of births and deaths, public laboratories, the National Blood Transfusion Service, private laboratories, private hospitals and clinics, and private doctors.

The reported increase of the disease between 1983 and 1987 resulted in the establishment, by the Cabinet of Trinidad and Tobago, of a National AIDS Committee (NAC) in September 1987. This committee comprised mainly health experts and was chaired by the Chief Medical Officer. The NAC was responsible for policy formulation, programme monitoring and evaluation, and consisted of a number of subcommittees, namely: surveillance and research; education and training; non-governmental organizations (NGOs); care and support; legal; and ethical.

Cabinet also created the National AIDS Programme (NAP), with a government officer as the coordinator, and this served as the administrative arm of the NAC, implementing the policies and programmes of the subcommittees. The areas of information, education and communication were identified as the most functional of the subcommittees. Among the initiatives that were identified as being effective on a continuing basis were: (a) Rapport, a Youth Information Centre for persons aged 13 to 25; and (b) training of health professionals and other relevant persons to be able to counsel and provide information on HIV/AIDS. In March 2004, the Five-Year National HIV/AIDS Strategic Plan, 2004-2008, and the National AIDS Coordinating Committee were launched.

A number of reports and studies have been conducted in Trinidad in the area of HIV/AIDS. A gender-sensitive perspective to the issue being studied could have enhanced many of them. Nonetheless, information arising out of the research points to the general increase in the HIV/AIDS cases being reported and the rate at which specific subpopulations are being affected,

among other things. Data also suggest that the actual incidence of HIV/AIDS may be much higher than reports suggest since the surveillance system needs considerable strengthening in order to capture data from all available sources.

Trinidad and Tobago has a generalized epidemic. The number of reported HIV cases in Trinidad and Tobago rose rapidly from 1983 to 1993 and from 1993 to 2003: the figure rose from 8 in 1983 to 624 in 1993 and 1718 in 2003. Geographical analysis of the data suggests that urbanization and tourism are important factors in the contraction and spread of HIV infection. St. George County, which includes Port of Spain, and Tobago, which is a popular tourist destination, has always had the highest incidence of reported HIV cases. Nonetheless, surveillance officers have observed that a number of suspected cases have not been tested, suggesting a growing number of cases outside of these two geographical areas.

Table 5
HIV positive cases (asymptomatic) by county per 10,000 population, 1984-1998

YEAR	ST. GEORGE	CARONI	ST. ANDREW/ ST. DAVID	NARIVA/ MAYARO	VICTORIA	ST. PATRICK	TOBAGO
1984-1987	0.528	0.000	0.167	0.291	0.199	0.087	1.292
1988-1991	3.959	0.407	0.500	0.873	1.043	0.785	3.015
1992-1995	12.549	1.976	2.000	0.582	1.838	1.658	10.768
1996-1999	25.194	5.173	5.000	3.202	5.564	3.665	27.565

Source: 1990 Population and Housing Census, Trinidad Public Health Lab Data (unpublished) cited in HEU (2001).

The incidence of HIV cases was reported to be 93 per 100,000 in 2002. An analysis of the data reveal that like Guyana and the Bahamas, the male to female ratio of HIV cases has decreased, signifying an increase in the rate at which females are being infected. Overall however, there are more males being infected with HIV than females. The data also show that women are infected at a much earlier age than men, with a median age of infection of 28 and 34 years, respectively, and an overrepresentation of females in the '15-19' age group among the reported cases of HIV infection.[11]

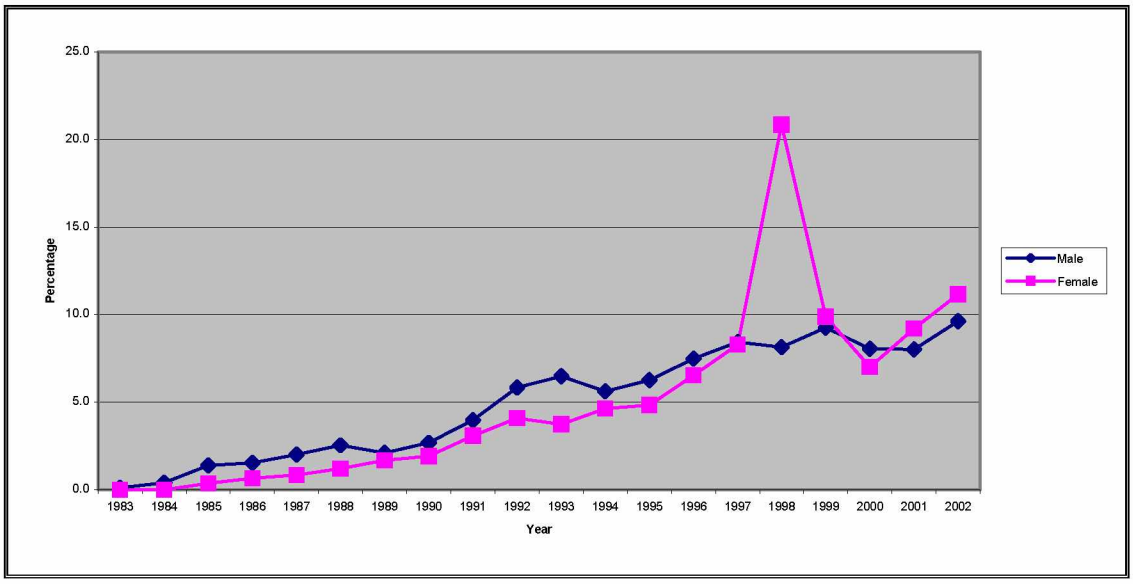
[11] CAREC (2004, 158).

Table 6
HIV incidence, sex ratio and cumulative HIV cases 1985-2002: Trinidad and Tobago

YEAR	MALE	FEMALE	UNKNOWN	SEX RATIO	TOTAL	CUMULATIVE TOTAL
1983	8	0	0	All Males	8	8
1984	27	0	0	All Males	27	35
1985	94	17	2	5.5	113	148
1986	104	31	1	3.4	136	284
1987	136	40	4	3.4	180	464
1988	172	57	12	3.0	241	705
1989	142	79	13	1.8	234	939
1990	182	91	5	2.0	278	1217
1991	269	146	7	2.8	422	1639
1992	396	193	18	2.0	607	2246
1993	439	177	8	2.5	624	2870
1994	381	219	23	1.7	623	3493
1995	424	229	31	1.9	684	4177
1996	507	309	51	1.6	867	5044
1997	571	392	36	1.5	999	6043
1998	551	986	28	1.4	965	7008
1999	627	467	33	1.3	1127	8135
2000	545	331	39	1.6	915	9050
2001	543	435	82	1.2	1060	10110
2002	651	527	31	1.2	1209	11319
Total	6769	4726	424	1.4	11319	74934

Source: CAREC (2004, 158).

Figure 6
Annual Incidence of HIV by sex: Trinidad and Tobago



Source: CAREC (2004); based on Table 6.

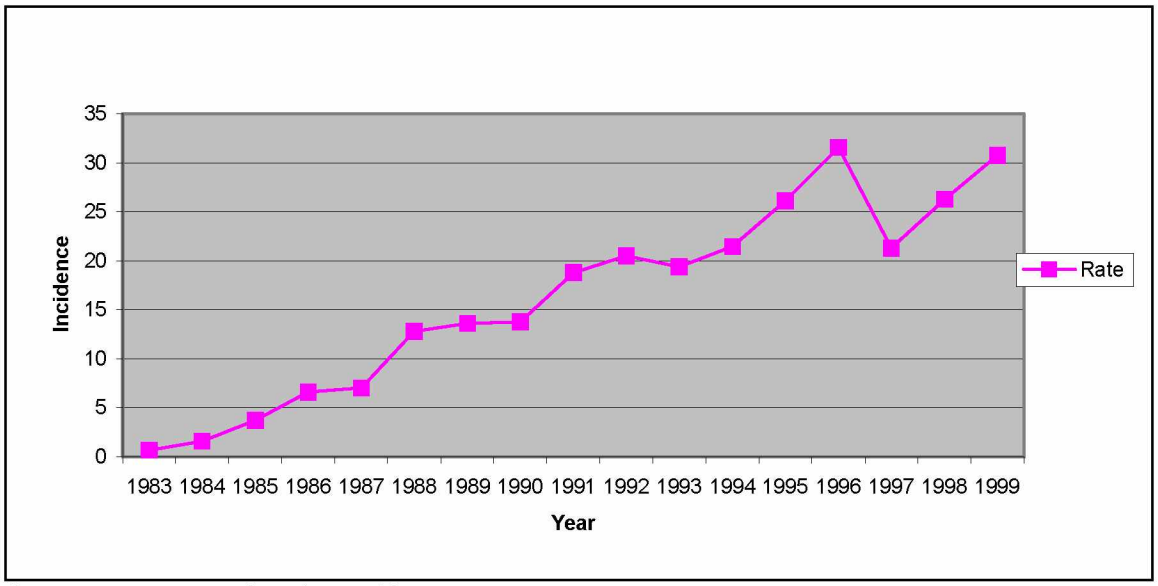
The number of AIDS cases as reflected in the incidence rates per 100,000 population is also on the rise, moving from 0.7 cases per 100,000 persons in 1983 to 30.8 cases by the end of 1999. See table below.

Table 7
Annual incidence of AIDS cases per 100,000 population, 1983-1991: Trinidad and Tobago

YEAR	RATE	YEAR	RATE
1983	0.7	1992	20.5
1984	1.58	1993	19.4
1985	3.75	1994	21.5
1986	6.6	1995	26.15
1987	7.08	1996	31.6
1988	12.8	1997	21.3
1989	13.6	1998	26.3
1990	13.8	1999	30.8
1991	18.8		

Source: Cited in HEU (2001, 15).

Figure 7
Annual incidence of AIDS cases per 100,000 population



Source: HEU (2001); based on Table 8.

The sex ratios in Table 8 show that males continue to be the subpopulation that is most affected by AIDS. However, the declining male to female ratio of 4.5 in 1985 to 2.8 in 1993 and 1.5 in 2002, reveal that women are contracting the disease at an increasingly faster rate. Up to 1992, females accounted for 25.5 per cent of all reported AIDS cases among adults. By 1999, over 45 per cent of new cases were female, and 50 per cent of new infections were found in the age group 15-24 years old.[12] Females, 15-24 years old, outnumber males in reported AIDS

[12] HEU (2001, 17).

cases.[13] This is the only group in which there are more females than males, suggesting substantial transmission of the disease to teenaged girls.

Data also suggest that the incidence of AIDS cases may be underreported by almost 50 per cent. One of the reasons for this is that in addition to confirmed cases, the NSU also captures suspected AIDS cases. A suspected AIDS case is one with AIDS-related signs and symptoms without a confirmed laboratory result. When suspected AIDS cases are added to confirmed cases, it represents a 34 per cent increase in the total number of confirmed cases. Added to this is the fact that the NSU does not capture a considerable amount of cases, both suspected and confirmed that have not passed through the public system. Lee et al (1997) estimated that the surveillance error for Trinidad and Tobago may be as much as 45 to 50 per cent.

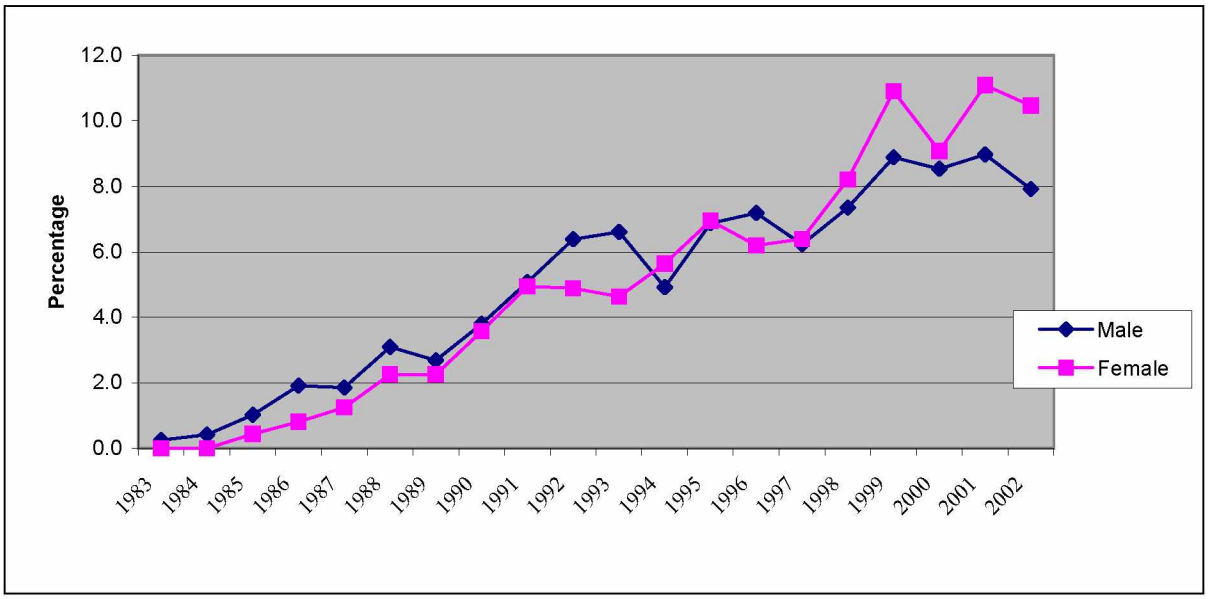
Table 8
Annual AIDS cases, sex ratio and cumulative incidence 1985-2002: Trinidad and Tobago

YEAR	MALE	FEMALE	UNKNOWN	SEX RATIO	TOTAL	CUMULATIVE TOTAL
1983	8	0	0	All Males	8	8
1984	13	0	0	All Males	13	21
1985	32	7	0	4.5	39	60
1986	60	13	0	4.6	73	133
1987	58	20	0	2.9	78	211
1988	97	36	0	2.7	133	344
1989	84	36	0	2.3	120	464
1990	119	57	0	2.0	176	640
1991	159	79	0	2.0	238	878
1992	200	78	0	2.5	278	1156
1993	207	74	0	2.8	281	1437
1994	154	90	0	1.7	244	1681
1995	215	111	0	1.9	326	2007
1996	225	99	2	2.2	326	2333
1997	195	102	0	1.9	297	2630
1998	230	131	2	1.7	363	2993
1999	278	174	0	1.6	452	3445
2000	267	145	0	1.8	412	3857
2001	281	177	9	1.6	467	4324
2002	248	167	3	1.5	418	4742
Total	3130	1596	16	2.0	4742	

Source: CAREC (2004, 163).

[13] CAREC (2004, 168).

Figure 8
AIDS cases by sex, Trinidad and Tobago



Source: CAREC (2004); based on Table 8.

Not only are AIDS cases underreported, the number of persons dying of AIDS is also underreported. This has been estimated to be as high as 40 per cent and a common conclusion is that AIDS might have claimed the lives of 4,500 to 5,000 persons in Trinidad and Tobago over the period 1983 to 2002. [14] The overall male to female sex ratio among confirmed AIDS deaths is 2.1, while among suspected AIDS deaths the ratio is 2.8. This suggests that more men are dying from AIDS than women. The median age for death from AIDS among males is 36 years, while for women, it is 32 years. Among the confirmed cases of AIDS deaths, there has been a 42 per cent increase between 1997 and 2002.[15]

Factors contributing to the spread of HIV

A gender analysis of the HIV/AIDS epidemic enables an understanding of how the social constructs of men and women/boys and girls affect their susceptibility to HIV, their access to treatment and care and treatment services. It also brings to light cultural and economic differences, how gender roles affect the responsibility of men and women/boys and girls, as well as gaps in gender-related data. It also highlights the risk that men and boys take sexually, since socio-cultural attitudes and values associated with gender roles and identity prescribe the attitudes and behaviour, especially those related to sex and sexuality, that men and boys are expected by society to demonstrate. This overarching perspective of gender interacts with other factors to produce particular manifestations of attitudes and behaviours that contribute to the spread of HIV in the Caribbean. This study identifies the dynamics of the relevant factors that contribute to the spread of HIV in Guyana, the Bahamas and Trinidad and Tobago.

[14] CAREC (2004, 170).
[15] Ibid.

Guyana

Sexual transmission continues to be the primary mode of direct transmission of HIV in Guyana, as it is regionally and internationally. There is, however, a clear link between the spread of the disease and other socio-economic and cultural factors. Specifically, these include, among others:

- Poverty and lack of employment;
- Transactional sex, especially within the context of, but not confined to, cross-generational relationships;
- Gender-based violence both in and out of the home, including child abuse, coercive sex and rape of young girls, and rape of women generally;
- Gender socialization, which impacts on traditional notions of gender roles and identities, as well as factors of gender inequality, and gender inequity;
- Internal migration into the hinterland to work in the mines;
- Co-infection as it relates to sexually transmitted infections and tuberculosis; and
- Lack of knowledge of infection status.

The main subpopulations that are targeted as bridges of transmission of the HIV virus are men who have sex with men (MSMs); commercial sex workers; marginalized youth involved in unsafe sexual practices; pregnant women; and migrant workers, especially those who work in the hinterland mining for gold and precious stones.

In an interview with the Executive Director of Lifeline Counselling Services in Guyana[16], it was revealed that there have been changes in the profile of clients who come in for counseling since the facility was established in 1996, which is supportive of some of the available data. From about 2000, the average age of the client has dropped from 25-40 years, to 18-25 years. There has also been a shift in the gender profile to include more women and girls among the clients. The average age of the majority of female clients tends to be between 15-21 years.

Most of the male clients who access the Lifeline Counselling Services are persons from the armed service and security labour force – policemen, soldiers and private security workers; miners; labourers; and a few persons from among the middle class. The requirement of a HIV test to obtain a United States visa, or information on the health status of an infected partner (more often than not, the female partner), are among the ways in which clients learn about their HIV status. A number of male clients reported sexual contact with as many as 10 to 20 partners, and approximately 10 to 15 per cent of clients were in bisexual relationships.

Poverty and unemployment

That the transmission of HIV is fundamentally related to the issue of poverty is a perception that has been repeated throughout interviews with key officials in this area, including

[16] Mr Jimmy Bhojedat. Lifeline Counselling Services is a counselling facility for People Living with HIV-AIDS (PLWHAs). It was established in October. 1996 and provides counselling services, as well as care and support and education. Approximately 35 clients are seen on a monthly basis, for about three visits.

the Chief Medical Officer, [17] and the Programme Manager of the National AIDS Programme Secretariat[18].

The incidence of poverty in Guyana is high. According to the 1999 Guyana Survey of Living Conditions, 36.4 per cent of the population live in absolute poverty and 19.1 per cent are indigent. These high levels of poverty, although an improvement over previous poverty figures of 78 per cent below the poverty line and 35 per cent indigent[19], point to a situation of prolonged economic decline. This is evidenced by the deterioration in the economic and social infrastructure, and the limited social services available to the population. It is important to note that poverty is highest in the rural areas, with the rural interior or the hinterland region having more than twice the level of poverty that exists in the country as a whole.

Table 9
Poverty in Guyana by geographical area

Geographical Area	Absolute Poverty	Critical Poverty
All Guyana	36.4	19.1
Urban Georgetown	16.1	3.0
Urban Other	16.3	16.3
Rural Coastal	39.8	18.1
Rural Interior	78.4	70.8

Source: Guyana Survey of Living Conditions, 1999.

In spite of improvements in the economic growth figures between 1998 and 2001 (from – 1.8 per cent in 1998 to 1.9 per cent in 2001), Guyana still faces many economic and social difficulties. This has, over the years contributed to a high outward migration, especially of skilled and professional workers, resulting in a weakening of the human resource base needed for development.

Economic growth in Guyana has also been constrained by the burden of external debt, which in 1998 stood at US$1.5 billion. It has had a number of rescheduling of its debt repayments, as well as write-offs to help reduce its external debts.

In terms of employment opportunities and availability of personal income, women are more severely affected than men. Data from the Guyana Survey of Living Conditions conducted in 1999 indicate that only 39 per cent of women are in the labour force, compared to 76 per cent of men. The unemployment rate for these women stood at 14 per cent compared to 6 per cent for men. Among household heads, 56 per cent of female heads as opposed to 87 per cent of male heads of households were employed; 5 per cent as opposed to 2 per cent of male heads were unemployed; and 39 per cent of female heads as opposed to 11 per cent of male heads of households were classified as inactive or formally outside of the labour force. In terms of population groups, the 1999 Survey of Living Conditions found that an estimated 50 per cent of women in Guyana were living in absolute poverty, as were 29.7 per cent of female heads of households.

[17] Dr Rudolf Cummings
[18] Dr. Morris Edwards.
[19] Guyana Human Development Report, 1996.

According to the Cooperative Republic of Guyana Report on the Convention for the Elimination of All Forms of Discrimination Against Women (CEDAW), [20] although the majority of development initiatives have not been gender specific, women have benefited from them. The Social Impact Amelioration Programme (SIMAP); the Basic Needs Trust Fund (BNTF) and the Government of Guyana Poverty Programme, implemented through the Ministry of Labour, Human Services and Social Security have also been established to assist poor women and children. The service that they provide includes benefits to children who have lost parents because of AIDS and widows who have lost husbands as a result of suicide.

Factors of poverty and unemployment contribute to the spread of HIV in several ways. For women, economic vulnerability and limited employment opportunities often increase dependence on male partners as a source of income and limit their ability to make decisions in sexual relationships. Concerns about providing for the household therefore take priority over issues of safety and lead to a number of unsafe sex practices and activities. Commercial sex work is one such activity that increases the vulnerability of women to HIV infection and is linked to concerns of poverty and unemployment. Limited economic opportunities and poverty increase the temptation, especially among youth, and particularly among young women, to become involved in transactional sex for money and other material needs. Poverty and unemployment also cause women to remain in relationships plagued by domestic violence for the sake of their children and household members for whom they are responsible. In all of this, the vulnerability of women is further increased, when considerations of providing for material needs override women's ability to negotiate condom use, especially if the male partner is reluctant or refuses to wear a condom.

Commercial sex work

Commercial sex work is one of the means used by some women in Guyana to obtain income in situations of poverty and unemployment. A study conducted in 2001 by Red Thread Women's Development Programme in Guyana, in order to more fully map the population of sex workers and address health and safety issues, reported that sex workers who participated in the project were predominantly from the working class and lower middle class population, with primary level education and few formal skills. Even in cases where a few sex workers had higher levels of education, the reason for turning to sex work was due to an inability to find work in the formal labour market. According to the study, *"Sex work, notwithstanding the immense stigma attached to it and dangers for unprotected workers, easily remains among the most economically viable options for poor women with limited education".*

Low paying jobs, such as domestic work, were also cited as reasons for entering into commercial sex work. Some commercial sex workers indicated that they received low wages, were less independent and were not treated with dignity when working as household helpers as opposed to commercial sex workers.

The vulnerability to HIV caused by poverty and unemployment, when linked to commercial sex work, brings into sharp focus some of the associated problems as these relate to

[20] Report of the Cooperative Republic of Guyana under Article 18 of the Convention on the Elimination of All Forms of Discrimination Against Women: 1998-2002.

the spread of the disease and the subpopulations that are affected. Studies have shown, for example, that girls as young as 9 or 10 years old are involved in sex work. Sex workers also tend to move from where they live to wherever the demand for their services is located. This has implications for the spread of the disease. Another finding of the study has to do with the part-time nature of sex work. This means that women who are involved in sex work may also be found working as cooks, child-minders, household helpers or traders and/or vendors.

The age difference between the clients of sex workers, many of whom are gold miners, foreigners, sailors and middle class professional men, and the sex worker themselves, many of them being young women, including teenagers and school girls, is a factor to consider in the spread of HIV. Older, more experienced men are also able to coerce young sex workers to take part in activities that are considered high risk. There have also been reports of coercion and rape, not only to perform straight sex, but also to engage in anal and oral sexual activities. Issues of gender socialization also become relevant in examining the ability of women and young girls to negotiate and demand the use of condoms. In terms of condom use, commercial sex workers also admit to foregoing the use of condom protection for more money.

Although much research has not taken place in this area, young men living in poverty are also vulnerable to the risk of HIV because there is an increasing demand for their services as commercial sex workers.

Transactional sex

Women's vulnerability to HIV is not only confined to those involved in commercial sex work. The socio-economic climate and accompanying poverty in Guyana has resulted in women and schoolgirls entering into sexual relationships, sometimes multiple ones, for the purpose of obtaining money and satisfying material needs. The importance of cross-generational relationships is especially noteworthy in relation to this issue since according to interviewees, these relationships are driven by the ability of the older partner to provide for the material and financial needs of the younger partner. The involvement of schoolgirls with mini bus drivers and conductors for free transportation, money and other material needs has been reported. Condom use, in transactional sex, as in other activities generally depends on the negotiating space that the woman has – usually limited in cross-generational relationships.

Any strategy to halt the spread of HIV in Guyana must, therefore:

- Consider the vulnerability to exploitation created by poor economic circumstances and limited opportunities for obtaining employment and create employment opportunities as well as provide affordable child-care support systems, particularly for female single parent poor households;

- Be able to identify the various subgroups that enter into sex work, and how they fit into the scenario presented. For example, the Red Thread reports that "…none of the schoolgirls we interviewed worked on the street … for all the women, the average age of the highest earners was 20 years, compared with 24 years for women in mining camps, 31 years for street workers and 32 years for women

working guest houses". They also found that Amerindian sex workers were less likely to work in the hinterland, and more specifically in their own communities. Many of them were also lured into the city through offers of jobs as waitresses and bar workers, and then tricked into sex work.

- Address the situation of young boys in poor circumstances who are also engaged in sex work since this is another source of the transmission of HIV that might not have received attention, given the stigma associated with men having sex with men.

- Be able to reach through education and other means the clients who obtain the services of sex workers. These clients act as important bridges of transmission since their partners very often do not know of their high-risk sexual behaviour.

Gender socialization

Gender refers to the socially constructed expectations placed on a person as a result of his/her sex. Gender socialization, which begins from birth for boys and girls, therefore teaches and reinforces notions of what it means to be male and female, within the context of the society in which they live. This socialization impacts on the expected roles of men and women in society and on their gender identities. Through gender socialization, cultural norms become established and accepted and impact on notions of equality and equity between men and women.

Gender roles in Guyana, as with the rest of the Caribbean, still find women burdened with domestic responsibility and household duties, thus limiting their ability to access opportunities for formal, full-time employment. This creates socio-economic inequality among women and men and greater vulnerability of women to HIV. As Table 10 shows, women continue to have higher rates of unemployment than men in every age category.

This situation increases the burdens of women when they or other household members develop AIDS. Apart from the increased responsibility, based on traditional expectations regarding the role of women, of caring for the ill household member, any loss of income represents a financial burden in the face of increased costs associated with ill health.

Women who are responsible for the maintenance and care of their households are also socialized to make sacrifices for the good of their households. This often results in poor nutritional habits, which can have negative health outcomes for women who are infected with HIV.

Table 10
Unemployed persons by sex and age

Age	2001		
	Both Sexes	Male	Female
14-19	28.1	26.7	30.1
20-24	14.9	11.9	20.4
25-29	8.1	4.3	15.6
30-34	5.2	2.6	10.2
35-39	5.4	2.1	11.2
40-44	4.8	2.6	8.6
45-49	4.9	1.9	10.6
50-54	7.0	4.2	12.8
55-59	3.4	1.2	7.6
60-64	4.1	2.8	6.4
65+	7.0	5.9	9.0
Total	9.1	6.2	14.3

Source: ILO Caribbean Labour Statistics (2002).
(http://www. ilocarib.org.tt/system_links/link_databases.html).

In the Caribbean, cultural norms relating to sexual activity are more accepting of promiscuity among men as opposed to women. Also, popular attitudes remain unshaken in the belief that the major cause of HIV infection is immorality.[21] In this context, a woman tends to be judged more harshly than a man when it is discovered that she has an STI or is infected with HIV. This affects a woman's willingness to be tested and to seek treatment for the condition. Knowledge of one's HIV status, is said to be an important factor in self-protection and prevention of the spread of the disease. Stigma and discrimination that negatively influence the willingness of persons to seek such knowledge need to be addressed.

Gender roles and norms also influence the behaviours and attitudes of youth to HIV. Apart from the general perception of youth that the disease could not affect them – externalizing the threat of HIV to themselves, young men are culturally impelled to have sex without condoms and to prove their manhood by having sex as early as possible. This is why, according to the Executive Director of the Lifeline Counselling Services, although HIV/AIDS awareness is close to 100 per cent, this awareness has not translated into behavioural change, especially around the message to use condoms. Apart from their own stated trust of their partners, he also revealed that when asked to wear condoms by their female partners, men were inclined to question their partners fidelity, as well as infer from the request that the women did not trust them.

Gender-based violence

The combination of gender roles and economic vulnerability has resulted in the perception of limited negotiating spaces for women both in and out of the household. This has meant, among other things, that females, especially from poor households are exposed to the

[21] The National and Regional AIDS Committees (NAC/RACs) quoted in Stabroek News, December 2, 2003.

threat of HIV infection through rape and other forms of sexual abuse. Studies reveal that early childhood disempowerment of girls result in their inability to negotiate safer sex since in most cases they become sexual subordinates.[22]

Key informants reported a high incidence of child sexual abuse which places children, particularly young girls, at risk of HIV infection. Studies have also shown that such abuse may lead to adolescent sex work. Rape outside of the home also increases transmission risks for women and girls and again the incidence is perceived to be high in Guyana.

Other

Other factors contributing to the spread of HIV in Guyana are lack of knowledge of infection status; and transmission of the disease through other infections, also known as co-infection.

Patients with STIs are normally seen at the Genito-Urinary Medicine (GUM) Clinic in Georgetown. They are tested for HIV antibodies when seeking the services of this facility. The result of HIV tests conducted in 2002 reveals high seroprevalence rates among STI patients. The HIV seroprevalence rate among Tuberculosis (TB) patients has remained above 30 per cent during the past three years demonstrating the seriousness of HIV infection among TB patients and the strong link between TB and HIV in Guyana.

Bahamas

The information gleaned from research that exists,[23] as well as interviews conducted, reveal that unlike Guyana, factors of poverty and unemployment were not among the major causes of the spread of HIV in the Bahamas. This is not surprising given the socio-economic profile of the Bahamas. In addition, the preliminary figure of 9.3 per cent of the population below the poverty line[24] is relatively low compared to poverty figures in many countries of the subregion.

Tourism

For the Bahamas, one of the major contributing factors to the spread of HIV has been tourism. Over three million visitors enter the Bahamas annually and this becomes a bridge of transmission to locals. According to one interviewee, the sexual contacts are made and associated, on the one hand, with the fascination of the locals with the white tourists, and on the other hand, the fascination of the tourist with the reputation of the virile black man.

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[22] Mainstreaming Gender into the Kenya National HIV-AIDS Strategic Plan (2000-2005)

[23] For example "Community-based research on Gender and HIV-AIDS in the Bahamas". The Research Unit, College of the Bahamas, October 27, 1999.

[24] Quoted in the 'Field Inquiry Summary of Findings on the Assessment of the Implementation of the ICPD (1994) Programme of Action (May 2003). Prepared by Audrey Ingram-Roberts.

External migration

Another contributing factor that has been identified is external migration. According to CAREC (2004), in 1985, 71 per cent of the PWLHAs were non-nationals and 29 per cent were from the Bahamas. In 2002, this trend had reversed to show 25 per cent of PLWHA were non-nationals and 75 per cent were from the Bahamas.

Drug Use

In addition to and linked to these factors is the use of crack cocaine that has already been identified in this document. Drug use, which causes impaired judgment, has resulted in some persons having sex with multiple partners, while others have sex with multiple partners in exchange for drugs. This situation has been further complicated by an increase in STIs, which leads to increased vulnerability to HIV infection.

Multiple partners/sexual preferences/sexual exploitation

The Director of All Saints Camp of St. John the Divine[25], an NGO that provides care, treatment and counselling to PLWHA, identified multiple partnering as an important source of HIV transmission in the Bahamas. He also pointed to alternative sexual preferences (bisexuality and homosexuality) among the male and female populations as important bridges of transmission. The Field Inquiry Summary of Findings on the Assessment of Implementation of the ICPD (1994) Programme of Action of the Government of the Commonwealth of the Bahamas (May, 2003) notes that the society condones men with many sexual relationships but frowns upon women with more than one partner.[26]

Interviews with the Assistant Director of Health Social Services[27] and a Senior Welfare Officer [28]also support these perspectives. In addition, they identified the re-emerging drug culture among men and male commercial sex as important factors implicated in the spread of HIV in the Bahamas. The 2003 IPCD Report, referred to above, also points to intergenerational transactional sex between older men and young girls and boys. As noted in the report , "*They (older men) entice these youngsters by giving them attractive material items in exchange for sex. These men usually play on the ignorance of the young girls and boys. They engage in unprotected sex, resulting in many young girls being infected with the virus".* [29]

Other

Although issues of poverty and unemployment have not been identified as major contributors to the spread of HIV in the Bahamas, interviews with key informants support the perspective that as long as women are faced with economic and financial crisis, notwithstanding

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[25] Father Glenroy Nottage
[26] Page 17.
[27] Ms. Sandra Neville.
[28] Ms. Ernestine King.
[29] Page 21.

their proportion in the population, then issues of commercial sex work and transactional sex are economic options to which women may have to resort.

Gender socialization practices are also seen as an important factor that contribute to HIV transmission among the population in the Bahamas. In this regard, the issue of condom use has also been identified as being important in the spread of AIDS, since it was recognized that the message to use condoms does not translate into action. According to persons interviewed in the Bahamas *"flesh to flesh takes you to a higher level"*. Girls were also said to be scared to face the wrath of their boyfriends if they insisted on the use of condoms.

Trinidad and Tobago

Trinidad and Tobago has many similar behavioural factors to Guyana and the Bahamas which contribute to the spread of HIV. Like the other two countries these are conditioned by culture and underlying societal structures. An examination of these factors, however, point to the need to understand the specificities of the socio-cultural environment in which they operate in order to better understand the dynamics at work and how to develop strategies to prevent the spread of the disease. Although an attempt is made here to identify the determinants of the spread of HIV by highlighting specific factors, the complexity and diversity of this society, and the multiplicity of factors interacting with each other speak to a dynamism that is more intricate than the analysis is able to capture in a report of this nature. Nonetheless, some attempt will be made to capture the recursive nature of the interaction of these factors in their contribution to the contraction and spread of HIV.

Poverty

In spite of its relative wealth, high levels of poverty persist in Trinidad and Tobago. Henry (2004), based on his analysis of the 1997/1998 Household Budget Survey (HBS) (the most recent survey) estimates 24 per cent of households as poor. Thomas' analysis of the 1997 SLC gives the figure as 22.3 per cent of households for Trinidad[30]. The 1997/1998 HBS further revealed that the counties with the lowest population density (Nariva/Mayaro, St Andrew/St David) as well as Victoria and St Patrick had the highest proportions of their population among the poor. However, major pockets of poverty were identified in Port of Spain, St George and Caroni. The 1997 SLC also revealed that , 77.6 per cent of the poor households in Trinidad lived in St George, Caroni, Victoria and St Patrick suggesting that urban poverty is an important aspect of poverty in Trinidad.

Marked gender differentials in income between male-headed and female-headed households, as revealed in the 1997/1998 HBS, support the contention that many women are in situations of economic vulnerability. In 1997, single-parent households headed by females had the lowest household incomes and lowest expenditure: average gross monthly income in such homes was 19.6 per cent lower than the national average of TT$3,850 and 17.0 per cent lower than single-parent male-headed households. Single parent, female-headed households also had the largest average household sizes and the largest number of children and outnumber their male counterparts by a ratio of 4:1. Households in the lowest quintile, however, irrespective of

[30] Thomas (2003).

whether they were male-headed or female-headed earned incomes far below the national average. Female-headed households comprised at least 20 per cent of the households in all areas, but were found to be concentrated in the urban areas.

Gender differentials are also seen in the labour force participation rates. Notwithstanding the growing female labour force over the past decade and a half, female participation rates still lag way behind the rates for males. In 1990 the female participation rate was 37.8 per cent, increasing to 47.5 per cent in 2000. Over the same period the national rates for males were between 74 and 75 per cent.[31] Women also continue to be overrepresented in the low-paid clerical and services sectors. Further, unemployment rates for women are higher than the rates for men and together with youth bear the heaviest burden of unemployment. In 2002, the overall rate was 10.8 per cent with 7.8 per cent for males and 14.5 per cent for females. These figures, nevertheless, mask the high rates of unemployment among the youth.[32] Among the youth, female unemployment rates surpass that of their male counterparts.[33] Gender disparities are also manifested in the levels of incomes for males and females: with the exception of the public sector, at all occupational levels, females earn less than males.

The above paints a picture of economic vulnerability for many women who very often have the sole responsibility for the care and well-being of their children. As discussed earlier, this increases women's dependence on male partners as a source of income and limits their ability to make decisions in sexual relationships making them more vulnerable to HIV infection. Participants in a Women and AIDS Project carried out in 1998/1999 in four lower income urban communities in Trinidad and Tobago by the NAP, reported that they felt totally disempowered in their relationships and were entirely dependent on their male partners for material and emotional support. One participant related that each time she refused sex she was beaten. In other cases, requests to use a condom by a female partner (usually upon discovery of an outside relationship) were met by violent threats or accusations of infidelity.

As emerged in the Red Thread study in Guyana, poverty can also lead to risk-taking activities such as commercial sex work in order to put food on the table. A 2004 study carried out by the Caribbean Association for Feminist Research and Action (CAFRA) on the commercial sex trade in Trinidad and Tobago, identified poverty as one of the factors which drove women into sex work. Poverty is also a factor which propels young girls into sex work in Trinidad and Tobago (Lee and Felix, 1997). Anecdotal evidence suggests that it may also be a factor in transactional sex, that is, the satisfaction of material needs in exchange for sex, particularly between young girls and older men. The power imbalance in these relationships leaves the females with little negotiating space around safe sexual practices.

Multiple partners

Multiple sex partnering (MSP) has been identified as a major risk factor in the spread of HIV in Trinidad and Tobago. In 1999, 40 per cent of persons reporting HIV infections also reported involvement in multiple sex partnering. Although the statistics are given for one year

[31] ILO. Caribbean Labour Statistics. http://www.ilocarib.org.tt/system_links/link_databases.html
[32] Henry (2004, 56-58).
[33] UNDP (2001).

only, and include contacts through commercial sex work (both sex workers and clients), they nevertheless suggest that MSP is an important risk factor in the spread of HIV.

A 2001 study[34], which found that multiple partnering occurred among both the male and female population but was nevertheless higher for males supports the contention that gender socialization practices in the society condone such types of sexual behaviour among boys/men while it is disapproved of in girls/women. Among adolescents, males usually report more partners than females.

Early onset of sexual activity

Cleghorn et al (1995) found that age at first intercourse and having engaged in commercial sex work were significant predictors of HIV status in women. A 2003 study by Jameson and Hutchinson [35] also found early onset of sexual activity was a significant factor associated with HIV infection. In that study, HIV prevalence among 535 women attending urban antenatal clinics was 6.84 per cent. Studies have also shown that a high proportion of young persons are sexually active by age 17 in Trinidad and Tobago. [36] Gender socialization practices and crimes of child abuse are among the factors associated with early onset of sexual activity.

Transactional sex/intergenerational sex

Early internalization of the ideology of "the male as provider" is frequently associated with girls entering into risky sexual activity with older men to satisfy their material needs and has been advanced as an important factor in the increasing infection rates seen among young girls and the overrepresentation of females infected with HIV in the 15-19 age group.[37] Poverty and peer pressure may also play a role in transactional sex.

Cocaine users

Cocaine abuse has been found to be significantly associated with HIV infection and transmission. [38] The drug is commonly used as crack cocaine and among crack cocaine addicts HIV prevalence is high. In 1999, crack cocaine users comprised 30 per cent of new infections. [39] Crack cocaine users frequently engage in unsafe sex in exchange for money in order to support their habits.

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[34] Camara et al (2001, 42)
[35] Jameson and Hutchinson(2004).
[36] Jagdeo (1986); Allen et al (2000).
[37] CAREC (2004,158).
[38] Fengwei (1999).
[39] CAREC (2004, 168).

Documentation of HIV/AIDS policies and programming

Guyana

HIV/AIDS Policies and Programming can be found primarily in two documents, namely, 'Policy Document on HIV/AIDS in Guyana'; and the 'National Strategic Plan for HIV/AIDS', which has, so far, been produced for 1999-2001 and 2002-2006.

The Policy Document outlines the measures to be adopted by government regarding education of the population regarding HIV/AIDS, as well as care of persons affected by the disease. In this regard, medical and ethical issues of confidentiality, rights and responsibilities of patients, testing and counselling, and norms and standards as they relate to, among others, the handling of blood and blood products, management of infected persons, sterilization processes, storage of condoms and management of infected persons are also discussed. Other areas dealt with in the Policy document include, social benefits to be accorded to persons with HIV/AIDS; and protocols to be observed surrounding data collection and research, the provision of laboratory services and the setting up of national and regional AIDS committees.

Guyana's national HIV/AIDS Strategic Plan for 2002–2006 has been produced after a review of the implementation of the Strategic Plan for 1999-2001. Although the latter plan had addressed a number of issues of importance and achieved important goals, there were limitations in this document, which the 2002-2006 strategic plan sought to address. As a result, the stated goals of this recent plan are:

1. To reduce the risk and vulnerability to infection through prevention and control of the transmission of Sexually Transmitted Infections (STIs) and HIV, and promoting sexual health.

2. To save or prolong and improve the quality of life of persons living with STIs and HIV/AIDS.

Bahamas

The document that speaks directly to programmes and policies is the Ministry of Health paper on the HIV/AIDS Programme for the Bahamas.[40] The stated objective of the National Programme in the Ministry of health paper was to *"Reduce the incidence and impact of HIV/AIDS and other STIs, providing a strategic, holistic approach to HIV prevention, education, clinical management, care, support, treatment and training"*.

The document spoke of the need to focus on adolescents and young adults when addressing issues of HIV prevention. It looked at the National HIV/AIDS response and management; outlined interventions to reduce the spread of HIV; and made recommendations on how to accelerate work considered to be important in the prevention efforts. A list of some of

[40] Undated.

the important organizations and institutions involved in working with PLWHAs was also highlighted.

Trinidad and Tobago

Several studies that have been undertaken on HIV/AIDS in Trinidad and Tobago, and many of them include recommendations that have implications for policy and programming. Only a few can be said to have integrated a gender perspective in the conduct of the research. However, there are specific documents that officially address policy and programming, with the Five-Year National HIV/AIDS Strategic Plan: 2004-2008, being the most recent, authoritative document on the way forward for achieving the objective of preventing the contraction and spread of HIV in Trinidad and Tobago. This outlines the policies and programmes to be undertaken, as well as the goals and objectives that are to be achieved with respect to HIV/AIDS in Trinidad and Tobago. Arising out of this Strategic Plan, is the Ministry of Health's "Comprehensive HIV/AIDS Prevention, Treatment and Care: Health Sector Work Plan, January-December 2004". These are the documents, from which this country's HIV/AIDS policies and programmes will be examined from the perspective of gender in this report.

Gender assessment of policies, programmes and plans

Any understanding by policy and programme formulators that the spread of HIV is primarily through sexual activity, and that HIV infection is contracted mainly through heterosexual activity, and this is the case in the Caribbean, must also acknowledge that both an understanding and integration of gender issues are critical to the formulation of policies and programmes to prevent the spread of HIV. In other words, heterosexual sexual relations have to do with sexual relations between men and women and sexual relations between men and women are rife with issues of gender.

Men and women in all societies experience life differently. Gender identities, roles and responsibilities, influenced in large part by gender socialization, and to some extent by biology, result in vulnerabilities and strengths that are intensified by issues of gender, that is, based on constructs of what it means to be male or female. Life in the Caribbean, as in the rest of the world, reveals a number of inequalities between men and women in the socio-political and economic spheres. These inequalities often result in the subordination of 'femaleness' to 'maleness', with a number of outcomes that include increased burden and responsibility on women, devaluing of the work that they do, the tendency to try and silence their voices in many ways including through the use of violence, and constraints on their access to resources. Analysis has shown that the result of this is often detrimental, not only to women, but also to children and other males. It is, therefore, important to understand the gendered nature of these inequalities and how this affects the success or failure of policies and programmes that are implemented for the benefit of the population.

Gender assessment or analysis is useful in diagnosing opportunities or constraints to the successful implementation of policies and programmes. It is important for identifying effective strategies and interventions for achieving important objectives, and it must be used at every stage

of policy and programme formulation, including design, planning, implementation, monitoring and evaluation. Analysis of the official policy and programme documentation of Guyana, Bahamas and Trinidad and Tobago reveals varying levels of gender sensitivity in the policies and programmes, where such documentation exists.

A summary of the assessment of policies and programmes from a gender perspective in the three countries in which the research was undertaken reveals that gender is insufficiently integrated into existing policies and programmes and even in cases where an understanding of the gender dimensions of the epidemic was demonstrated, this was not translated into policy or action.

Guyana

Since the problem of HIV/AIDS began to develop in Guyana, a national programme has emerged, consisting of four main elements. This includes the establishment of three main institutions with the mandate to respond to the disease through laboratory testing, and another to deal with aspects of planning and programming. The three laboratory testing units are the Genito-Urinary Medicine (GUM) Clinic which has responsibility for the diagnosis and management of all STIs, including HIV; the National Laboratory for Infectious Disease (NLID), which is the public sector institution responsible for all HIV testing, with CAREC conducting confirmatory testing, when necessary, and quality control; and the National Blood Transfusion Service (NBTS).

The NAP was established under the Ministry of Health and the NAC in 1989. In 1992, the National AIDS Programme Secretariat (NAPS) was formed. Following work carried out by the Legal and Ethical Committee of the National AIDS Committee and a review of the surveillance systems for STIs and HIV/AIDS, an HIV/AIDS Policy Document was developed in 1998 and presented to the Cabinet for consideration. Arising out of this was the 1999-2001 Strategic Plan.

Highlights of the implementation of the 1999-2001 Strategic Plan were:

- Increased availability of voluntary counseling and testing (VCT);
- Provision of sage blood and blood products through donor screening;
- Provision of treatment for sexually transmitted infections, in order to reduce transmission;
- Greater involvement of NGOs and some larger private enterprises;
- Programme to prevent PMTCT;
- Limited provision of antiretroviral (ARV) therapy.

The limitations of this strategic plan were identified as:

- Insufficient resource;
- The preoccupation of the NAPS with implementation rather than management and coordination;
- A limited multisectoral response, with involvement coming mainly from the Ministry of Health and, to a lesser extent, the Ministry of Labour;
- Continued stigmatization and discrimination of HIV-infected persons;
- Limited geographical coverage of interventions.

The aim of the 2002-2006 plan is to address these limitations and achieve its stated objectives by revising the National Policy on AIDS; restructuring and repositioning the NAPS; and changing the composition of the National and Regional AIDS Committees.

More specifically, the new Strategic Plan focuses on the following:

- Surveillance;
- Care, treatment and support;
- Risk reduction; and
- Management, coordination and policy formulation

An assessment of both the National Policy Document on AIDS and the 2002-2006 Strategic Plan for HIV/AIDS in Guyana reveals inadequate focus on gender in the development of plans and programmes to deal with the disease. Two possible reasons for this are: (i) the limited multisectoral involvement that has been identified as a limitation of the implementation of the 1999-2001 strategic plan; and (ii) the inadequacy and inaccuracy of research and data collection on HIV/AIDS. This includes research on the dynamics of the transmission of the disease. HIV/AIDS data are said to be incomplete and seroprevalence data outdated. There are also serious problems as they relate to the underreporting of HIV and AIDS cases in the country.

More importantly, however, is the general lack of understanding of gender issues and how to conduct gender analysis and integrate issues of gender into policies and programmes that are apparent in the current programmes and policies.

In this context, an examination of the 2002-2006 strategic plan, as they relate to the four components that are intended to reduce the risk and vulnerability of the population to HIV and save or prolong the quality of life of persons living with sexually transmitted infections and HIV and AIDS, reveal the following:

Surveillance

Data and information are integral to good surveillance. The collection of basic disaggregated data by sex is an important step in the right direction. However, the existence of gender-sensitive surveillance systems and activities seems to be limited and inadequate.

This relates especially to the expected result of *'producing data to provide information on prevalence and a better understanding of the dynamics of the epidemic'*. The 'activities and tasks' identified under surveillance in order to produce the 'expected result' include surveys that target specific at-risk groups such as youth, commercial sex workers, antenatal women, and men who have sex with men. While this is important, so are the surveys that have been identified to be undertaken biennially among the sexually active general population. Such surveys can provide information on general gender issues related to the dynamics of the transmission of HIV. However, due to the lack of gender awareness that was apparent in the documentation and in interviews with officials, this may represent a missed opportunity for the collection of such data. As it stands, the strategic plan identifies, for collection in this survey, information on the number of non-regular sex partners in the past three and 12-month period; the percentage of persons in a mutually monogamous relationship; the percentage of condom use at last sexual contact; and risk perception of the population to HIV/AIDS starting 2002.

Expanded research is required, to collect both quantitative and qualitative information, among the general population in order to elicit other gender issues involved in the transmission of HIV in Guyana. The study of commercial sex workers conducted by Red Thread is a good example of how the qualitative aspect of such research can be done. In this way, issues of socio-economic status, gender-based violence, the impact of cultural mores and issues specific to young people can be investigated and addressed.

Such research will also have recursive implications for other expected results and activities as outlined in the National Strategic Plan 2002-2006. For example, information on gender differences regarding cultural attitudes and practices as it relates to sexuality and sexual relationships in Guyana, and the differential stigma and discrimination that is accorded to men and women in this area, can be used in the training of staff who carry out surveillance functions.

Care, treatment and support

The component indicators of this element of the strategic plan again reveal some amount of gender sensitivity in the identification of sub-populations that need to be targeted for care and treatment regarding STIs and HIV/AIDS. While this partially reflects awareness of issues of gender, there is need for further research to inform policy that will demonstrate greater sensitivity to some of the principles of gender that are at work in the outcomes that are observed, but not very well understood.

Expected results 3 and 4, namely, 'Persons living with HIV/AIDS (PLWHA) and families must be empowered to provide mutually supportive care' and 'Support services must be established to complement care and treatment of Persons living with HIV/AIDS' – need greater gender analysis in arriving at the tasks and activities that are needed to achieve these expected results. Also, arriving at the assumptions that are identified as being of importance in the achievement of these results need greater gender analysis.

For example, in ensuring that PLWHAs and families are empowered to provide mutually supportive care, it must be recognized that women are still the primary care givers in the households, and that men are hardly involved in this activity. The development of information

and education aimed at encouraging PLWHA to participate in support groups must, therefore, be done with the awareness that: (i) the groups are likely to consist mostly of women; and (ii) messages aimed at encouraging participation must include elements that target males.

Gender sensitivity under this component will also take account of the burden that women face in taking care of their households and the extent to which female heads of households or those with limited resources often result in women making sacrifices in terms of care of themselves so that other members may benefit. In this regard, any activity that is aimed at ensuring that PLWHAs understand the importance of nutrition to the prolonging of their lives, must take into account the need to encourage and motivate women to take care of their nutritional needs, and to provide them with the wherewithal for doing so.

Risk reduction

This is an area that needs far greater gender analysis than currently exists in the National Strategic Plan. The component indicators of this element of the strategic plan reveal that risk reduction is associated with attitudinal and behavioural change and modification, yet it is limited in its assumptions and activities that have been proposed to achieve these objectives.

The expected result of encouraging behavioural change would be, therefore, enhanced by analysis that recognizes the gendered behaviour that puts persons at risk of being infected with HIV/AIDS. Activity indicators would therefore include:

- Promotion of female-controlled STI/HIV prevention methods, including the availability and use of the female condom;
- Dissemination of messages that encourage the use of condoms in a gender-sensitive context. Messages that encourage the use of condoms are usually disseminated without regard for context and seemingly without an awareness that factors of power and culture that are gender-specific are at play in decisions to use or not to use the condom;
- Promotion of programmes aimed at empowering women – e.g, improving economic opportunities of women and children through social programmes; enacting and enforcing of legislation that protects women against domestic violence and provides them with legal recourse for the obtaining of economic dues in the form of child maintenance and divorce settlement;
- Promotion of programmes aimed at empowering youth – e.g improving educational and employment opportunities. This must include providing non-traditional employment opportunities for young women, which usually are higher paying;
- Development of messages aimed at behavioural change that is targeted, appropriately and representatively towards specific groups in a gender-sensitive manner. For example, in seeking to stem the increase of teenage pregnancy, both young men and older men, and not primarily or only young women, will be targeted in efforts to modify behaviour;
- Development of public education campaigns regarding issues of cross-generational relationships and vulnerability to HIV infection.

Management, coordination and policy formulation

Management, monitoring and evaluation and coordination have been identified in the National Strategic Plan as key to the success of the programmes and policies that were outlined. One critique of the former Strategic Plan (1999-2001) was that too much responsibility for implementation was placed on the NAPS, leaving little time for management and coordination functions.

This critique is important to note in the context of the absence of gender sensitive policy documents on HIV/AIDS that currently exist. The need to integrate gender into policy and programmes means that the NAPS would require even more time to focus on the tasks of managing, formulating, monitoring and coordinating policies and programmes that are developed to deal with HIV/AIDS. Gender awareness among the NAPS staff and the ability to conduct gender analysis is important in obtaining gender-sensitive policies and programmes in the National Strategic Plan. This capacity and awareness would also be important to develop in partners responsible for the implementation process.

Since gender expertise seems to be absent from within the Secretariat, a technical sub-committee on gender and HIV/AIDS to develop strategies for mainstreaming gender in the National Strategic Plan is recommended. Multisectoral participation in such a committee is essential for success. The objectives of a technical sub-committee on gender would include:

- Gender audits of all HIV/AIDS policies and programmes;
- Development of gender responsive policies for the implementation of HIV and AIDS programmes;
- Provision of training in gender awareness and gender analysis at all levels in order to build the capacity of national and regional HIV/AIDS committees and their partners to understand gender issues and integrate these into policies and programmes;
- Engender the NAPS budgets to ensure equity in the availability of resources to HIV/AIDS programmes.

Bahamas

In the case of the Bahamas, a National Policy on HIV/AIDS or a National Strategic Plan had not yet been developed at the time of this study. However, as noted earlier, the Ministry of Health Paper on the HIV/AIDS programme for the Bahamas documents policies and programmes which are being implemented.

The first official response to the epidemic, was the establishment in 1985 of a National Standard Committeee on HIV/AIDS. A National AIDS Programme was also developed with the following aims[41]:

[41] As stated in the Ministry of Health Paper on the National HIV/AIDS Programnme for the Bahamas. (Undated).

- Prevention of sexual transmission;
- Prevention of transmission through blood/blood products;
- Prevention of perinatal transmission;
- Epidemiological surveillance and research;
- Reduction of the impact of HIV infection on individuals, groups and society; and
- Development of treatment protocols for HIV/AIDS.

Subcommittees on epidemiological surveillance, public education, blood banking, treatment and research and a department of HIV/AIDS dealing with HIV/AIDS education prevention; clinical management; clinical research and laboratory diagnosis were established. An AIDS Secretariat was set up in July 1988 to coordinate HIV/AIDS prevention education which was later replaced by the HIV/AIDS Centre.

To some extent, the HIV/AIDS education and prevention programmes, as outlined in the Ministry of Health paper, attempt to incorporate gender. Thus for example, a Focus on Youth Programme - an STI (including HIV/AIDS) and teen pregnancy prevention programme - addresses, *inter alia*, the important issues of teen pregnancy and negotiating skills (around safe sex).

The HIV/AIDS Unit also addresses responsible male sexual behaviour through a "Men Make a Difference Programme". Strategies to promote responsible healthy reproductive behaviours among high risk groups have also been implemented and these have extended to training and sensitization of children, adolescents and the Haitian community in the Bahamas; the establishment of a Sexually Transmitted Infections Unit; a programme, geared towards the continuing education of pregnant teens and teenage mothers (implemented in 1997) and an Adolescent Health Unit which provides reproductive health services and information regarding their health, including their reproductive health. In addition to the education strategies focusing on at risk and vulnerable subgroups there is also an ongoing mass media campaign to educate the public on HIV and AIDS and related issues.

A Health and Family Life Education curriculum (HFLE) administered by the Department of education and incorporated into all grade levels (1-12) has a module on 'Gender Roles and Responsibilities' under the topic 'Human Sexuality'. The curriculum also incorporates a rights-based approach.

There is also a recognition that gender related factors contribute to the spread of HIV and this is reflected in the 'Gender and HIV/AIDS' sensitization and advocacy workshops which have been conducted. However, these initiatives were not part of an overall policy to mainstream gender into HIV/AIDS policies. Lack of capacity to conduct gender analysis and lack of a gender awareness have been identified as reasons for the absence of a gender framework governing existing policies and programmes.

Many key informants identified male and female sexual behaviour as one of the key areas requiring gender analysis. A much deeper understanding of the cultural norms governing this behaviour and of gender differences is necessary for the formulation of policies and

programmes targeting behaviour change in the Bahamas. This highlights the need for research and for behavioural studies to be conducted in order to inform the analysis.

Trinidad and Tobago

An analysis of the two documents, 'The Five-Year National HIV/AIDS Strategic Plan' and the 'Comprehensive HIV/AIDS Prevention, Treatment and Care' reveal similar concerns as they relate to the integration of gender into policies and programmes. The assessment reveals a partial awareness of gender issues in the situational analyses that provide the foundation for the responses. For example, the introduction and situational analyses of the documents under review refer to the following: "...[the] percentage of women infected has increased significantly ... [this] seems to suggest that younger girls may be having relations with older men ...". While this reflects some concern and understanding of the gender issues at work in the creation of risk factors for the spread and contraction of HIV/AIDS, the analysis misses many other equally important gender factors that are relevant.

In this regard, neither the documents under review, nor Situational and Response Analysis, on which the Strategic Plan draws much of its information, conduct a holistic or complete assessment of the gender factors at work in the spread of HIV. Multiple partnering is therefore mentioned without identifying the gender issues that contribute to that situation. Are there different reasons why men and women have multiple partners? Why is it that men are more likely than women to have multiple partners? The strategic plan does not, therefore, present in its situational analysis a discussion of issues of gender-based violence; the construction of gender identities; and the relationship between high-risk behaviour and cultural norms based on gender socialization. This represents a partial analysis of gender, and is a feature of most of the documents that present a situational analysis of HIV and AIDS in Trinidad and Tobago.

This of course affects the responses - policies and programmes that are put in place to achieve the objectives of preventing the spread of HIV. The recommendations arising out of two major studies, 'The Situation and Response Analysis (SARA)' and 'The Audit of National Programmes and Laboratories' conducted by KPMG Consulting in 2001, identify major weaknesses but stop short of recommending that a gender analysis be undertaken to enhance the corrective measures that need to be undertaken. Thus, some of the broad recommendations arising out of SARA and the Audit of National Programmes and Laboratories have a direct need for gender awareness, sensitivity and analysis. These include:

- Enhancement of the HIV/AIDS surveillance system to ensure epidemiology monitoring, identification of risk groups, effective programme planning and evaluation;
- Initiatation of training for health care professionals in the area of HIV testing, diagnosis, treatment, counselling, and psychological support to patients and families, as well as in the area of STD management;
- Implementation of targeted behavioural change intervention for specific groups.
- Development of a legal and policy framework to protect the rights of individuals and families from discriminatory practices;
- Decentralization of HIV counseling and testing;

- Expansion of the MTCT programme; and
- The need for a sustainable health promotion and education strategy dealing with HIV/AIDS, focusing on both the general public as well as those groups most at risk.

The absence of a gender framework in the context of these recommendations may result in missed opportunities to adequately and effectively put them in place. The SWOT analysis that outlines the Strengths, Weaknesses, Opportunities and Threats to the success of the plan, must therefore include in their weaknesses and opportunities: (i) the absence of a framework for gender analysis, which can be seen as a weakness in their diagnostic capability; and (ii) the ability to partner with gender experts, including the national gender machinery in Trinidad and Tobago to correct this weakness.

The Strategic Plan outlines five priority areas for the execution of its strategic response to HIV/AIDS. These areas are:

1. Prevention;
2. Treatment, care and support;
3. Advocacy and human rights;
4. Surveillance and research; and
5. Programme management, coordination and evaluation.

Examples in each priority area will be used to demonstrate the existence of partial gender analysis and the absence of gender integration into HIV/AIDS policies and programmes.

Priority area 1: Prevention

The promotion of safe and healthy sexual behaviour among the general population is one of the main areas requiring gender analysis and gender sensitive messages targeted to males and females. It will therefore not be enough to target young women in the context of the problem that has been identified (having sexual relationships with older men). A gender framework will require that older men specifically, and other men, in general, be also targeted in order to change behaviour.

Another example of the need for greater gender analysis is the focus on youths in and out of school. Youth abstinence programmes must be contextualized and gender sensitivity and awareness be brought to bear on any programmes designed to achieve the objective of abstinence. Gender issues in this context include, inter alia, an understanding of the pressures on male youth to prove their masculinity through sexual conquests; and the sexual abuse of young girls, including rape, which could then diminish the power of messages to abstain from sex and create psychological trauma and confusion in the minds of young women who did not have a choice to abstain or not.

Priority area 2: Treatment, care and support

The provision of appropriate economic and social support to PLWHA and to those affected is an area under Priority area 2 that needs a special gender focus. Gender roles are especially important in this context, since women are still expected to assume the responsibility of caring for the sick. Women who have to take care of spouses who contract AIDS and are debilitated, often find themselves in the role of caregiver for another household member and possibly the main breadwinner to augment the household income. Female-headed households will be exceptionally burdened if household members are sick and the female head continues to be the main breadwinner. Other issues of gender that must be taken into consideration when developing programmes to provide economic and social support include, households with children when the breadwinner is infected and homosexuals who are infected and fall ill from the contraction of AIDS. In the latter case, men who contract the disease through homosexuality often find themselves discriminated against and abandoned by family and relatives, leaving them particularly vulnerable and in need of special economic and social support.

Priority area 3: Advocacy and human rights

The objectives under this priority area are to:

1. 'Reduce Stigma and Discrimination against PLWHA by promoting openness and acceptance of PLWHAs in the workplace and in the wider community.

2. 'Ensure human rights for PLWHA and other groups affected by HIV/AIDS' through i) the creation of a legal framework that protects the rights of the PLWHA and affected groups; and ii) the monitoring of human rights abuses and implementation of avenues for redress; and iii) mobilizing opinion leaders on HIV/AIDS and related human rights issues.

Without a gender framework that recognizes the specific vulnerabilities of males and females in the context of HIV/AIDS and the gender inequalities that obtain in the relationships between men and women, measures to effect these rights and discontinue abuses will not be effective and can, in fact, create worse situations of discrimination. Legislation, for example, that announces punitive measures for violence against women, but that is not supported by effective implementation programmes that take account of gender, can result in increased violence.

Priority area 4: Surveillance and research

Of special importance under this priority area is the objective of undertaking and participating in effective clinical and behavioural research on HIV/AIDS and related issues (Objective 2). Gender issues are central and critical to each of the relationships that have been outlined for assessment through behavioural studies. These are: the relationship between poverty and HIV/AIDS; drug abuse and HIV/AIDS; and domestic violence and HIV/AIDS. This strategy is also an important preventive strategy and underlines the importance of a gender framework, for design to implementation, monitoring and evaluation, as important for attaining the objective of HIV prevention. The other objective under this priority area is to 'strengthen the

surveillance systems by improving existing surveillance systems and strengthening national laboratory systems'.

Priority area 5: Programme management, coordination and evaluation

All activities related to the management, implementation and evaluation of the nation's expanded response is incorporated under this Priority. The first objective is to *'Achieve National Commitment, support and ownership of the expanded strategic response to HIV/AIDS'* by developing an appropriate management structure for the national expanded response; gaining wide support for the National Strategic Plan; and mobilizing adequate and sustained resources to support implementation of the strategic plan. Other objectives include *'Monitoring the implementation of the expanded response'*; and *'Building capacity among critical stakeholders in the expanded national response'*, by strengthening the key constituents of National AIDS Coordinating Committtee (NACC); and strengthening support groups for PLWHAs and increasing the number of these support groups.

It is very important to use this priority area to establish a gender sensitive environment in which to formulate policies and programmes. In this regard, gender training for programme and policy coordinators and their staff in order to create awareness, sensitivity and capacity to use the tools of gender analysis, is of critical importance.

Protocols and frameworks for analysis, monitoring and evaluation must be created and their use established. It may be important to expand and strengthen the key constituents of the NACC by including the relevant gender expertise and also by partnering with the Gender Affairs Division, Ministry of Community development, Culture and Gender Affairs and the Centre for Gender and Development Studies, University of the West Indies, to ensure more gender sensitive policies and programmes and to conduct gender training of relevant personnel. One of the first tasks for such expertise, would be to audit the strategies of the HIV/AIDS action plan to ensure greater gender sensitivity.

CONCLUSION AND RECOMMENDATIONS

Gender mainstreaming is a strategic priority in the work programme of any organization that is interested in providing support and direction to strategies and interventions to deal with the HIV/AIDS problem. It is so obviously a critical component in any attempt to deal with HIV/AIDS, because of the sexual risk factors that have been highlighted, that it should be a simple task to create gender awareness among programme and policy formulators who might not have hitherto been sensitive to these issues.

This assessment of the three countries under review reveals the need for more focused and targeted HIV/AIDS interventions and strategies based on an awareness of gender issues and a capacity to conduct gender analysis. While training for policy formulators is absolutely necessary for the success of HIV/AIDS policies and programmes, so is the need for training and sensitization of health care workers, as it relates to stigmatization and discrimination. Information, education and communication is also necessary to target specific groups among the general population. Messages must, however, be based on research and analysis that understands the gender dimensions of the situations that they seek to address.

All research therefore needs to address the importance of gender socialization, gender identity and roles and gender relations in order to understand the factors at work in determining the behaviour of at-risk groups and their responses to HIV/AIDS. This understanding will enable the links between these gender factors and others such as poverty, drug use and violence to be better understood, and for more targeted interventions and strategies to be implemented with greater success.

The need for financial and other material resources, as well as expert psychological counselling are also needed to support interventions and create opportunities and an enabling environment for vulnerable groups, including marginalized youth and poor women. Educational and employment opportunities, free from stigma and discriminatory practices are essential in this regard.

Recommendations regarding strategic directions and priorities for a gender and HIV/AIDS agenda: Guyana, Bahamas, and Trinidad and Tobago.

The following are general recommendations to develop the objective of creating more gender sensitive HIV/AIDS policies and programmes in the Caribbean.

- The provision of technical support and training to national and regional HIV/AIDS committees by gender experts in the formulation of HIV/AIDS policies and programmes. Wherever possible, the opportunity can be used to build the capacity for gender analysis, of programme and policy formulators;
- The development of training manuals that can be used to build gender awareness and capacity in gender analysis at all levels and for all staff members involved in HIV/AIDS work;

- The development of protocols for gender-sensitive interventions regarding issues of HIV/AIDS. These can be simple and standard, with the flexibility to be modified to suit the cultural needs and circumstances of the countries in which they are to be used;
- The development of effective, gender-sensitive communication strategies and packages to relay messages and information regarding HIV/AIDS to the intended audiences. Again these must be culturally sensitive;
- The development of gender responsive budgets for HIV/AIDS strategies and programmes;
- In-depth research on the factors responsible for the spread of HIV in the Caribbean, with a specific focus on the way in which gender relations are reproduced among young persons and the extent to which this impacts on the spread of HIV. This should be with a view to developing cross-cutting policies which will address the need to change gender relations among young people;
- Gender audits of all HIV/AIDS policies and programmes.

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Annex 1

Interviews

GUYANA

The Honourable Bibi Safora Shadick, Minister, Ministry of Labour, Human Services and Social Security

Ms. Jacquline Mounter, Director of Youth, Ministry of Youth, Sports and Culture

Dr. Rudolf Cummings, Chief Medical Officer, Ministry of Health

Ms. Esmae Semple, Health Education Officer, Division of Health Sciences Education, Ministry of Health

Mr. Wilton Benn, Division of Health Sciences Education, Ministry of Health

Ms. Glenis James, Senior Programme Officer, Commonwealth Youth Programme

Ms. Karen DeSouza, Red Thread Women's Development Programme

Ms. Lorna McPherson, Coordinator, Health and Family Life Education Programme, Ministry of Education

Mr Jimmy Bhojedat, Executive Director, Lifeline Counselling

Dr. Morris Edwards, Programme Manager, National AIDS Programme Secretariat

Ms. Hymawattie Lagan, Administrator, Women's Affairs Bureau, Ministry of Labour, Human Services and Social Security

BAHAMAS

The Honourable Melanie Griffin, Minister, Ministry of Social Services and Community Development

Mrs. Elma Garraway, Permanent Secretary, Ministry of Health

Ms. M. Dahl Regis, Chief Medical Officer, Ministry of Health

Mrs. Christine Campbell, Director, Public Relations & Communications, Ministry of Health

Ms. Rose Mae Bain, Director, HIV/AIDS Centre, Ministry of Health

Mrs. Camille Barnett, The AIDS Foundation

Ms. Cheryl Thompson, Health Education Office, Health Education Division, Ministry of Health

Ms. Philabertha Carter, Special Projects Officer/Health Systems Officer, Ministry of Health

Ms. Camille Deleveaux, Epidemiologist, Health Information and Research Unit, Ministry of Health

Ms. Ampusam Symonette, Office of Director, Ministry of Health

Fr. Glenroy Nottage, Director, All Saints Camp of St. John the Divine

Dr. Sandra Dean-Patterson, Ministry of Social Services and Community Development; Director, The Crisis Centre

Mrs. Phedra Rhaming, First Assistant Secretary/Officer-in-Charge, Bureau of Women's Affairs, Ministry of Social Services and Community Development

Ms. Sabrina Skinner, Family Life Education, Ministry of Education

Ms. Ruthmae Young, Family Life Education, Ministry of Education

Ms. Glenda Russell-Rolle, Family Life Education, Ministry of Education

Dr. Amalia Del-Reigo, Health Systems Adviser, PAHO/WHO

TRINIDAD AND TOBAGO

Ms. Patricia Belmar, Deputy Technical Director, National AIDS Coordinating Committee (NACC)

Ms. Caroline Alexis-Thomas, Programme Officer, Strategic Planning & Development, NACC

Dr. Violet Duke, Coordinator, "Comprehensive HIV/AIDS Prevention, Treatment and Care: Health Sector, Work Plan, January – December 2004".

Ms. Monica Williams, Director, Gender Affairs Division, Ministry of Culture, Community Development and Gender Affairs

Mr. Gerard Peters, Epidemiologist, National Surveillance Unit, Ministry of Health

Ms. Clare Sandy Robinson, National Coordinator, MTCT Programme

Ms Peggy Ann Mitchell, Senior Medical Laboratory Technician, Ministry of Health in charge of HIV testing

Ms. Ingrid Neckles, Coordinator, National AIDS Programme

Ms. Patricia Williams, Ministry of Education

Ms. Hazel Brown, Coordinator, Network of NGOs

Ms. Patricia St Bernard, Executive Director, Rape Crisis Society of Trinidad and Tobago

Ms. Eswick Padmore, Activities Coordinator, Community Action Resource (CARE)

Ms Sommer Williams, Activities Coordinator, CARE

Ms Stephanie Thomas, Activities Coordinator, CARE

Ms. Natasha Maillard, CARE

Ms. Debra Joseph, Social Worker/Counsellor, CARE

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