

HIV/AIDS AND
MOBILE POPULATIONS
IN THE CARIBBEAN:
A BASELINE ASSESSMENT

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IOM International Organization for Migration
OIM Organisation Internationale pour les Migrations
OIM Organización Internacional para las Migraciones

FINAL REPORT

HIV/AIDS AND MOBILE POPULATIONS IN THE CARIBBEAN: A BASELINE ASSESSMENT

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R Borland
L Faas
D Marshall
R McLean
M Schroen
M Smit
T Valerio

International Organization for Migration (IOM)
Santo Domingo, Dominican Republic



IOM International Organization for Migration
OIM Organisation Internationale pour les Migrations
OIM Organización Internacional para las Migraciones

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List of Acronyms

AAI	Accelerated Access Initiative
AIDS	Acquired Immunodeficiency Syndrome
ARV	Antiretroviral
AZT	Zidovudine
CAREC	Caribbean Epidemiology Centre
CARICOM	Caribbean Community
CCNAPC	Caribbean Coalition of National AIDS Programme Coordinators
CHRC	Caribbean Health Research Council
CSME	CARICOM Single Market and Economy
CSW	Commercial Sex Worker
GDP	Gross Domestic Product
HAART	Highly-active anti-retroviral treatment
HIV	Human Immunodeficiency Virus
IDU	Injecting Drug User
IMP	International Migration Policy Programme
IOM	International Organization for Migration
MSM	Men-who-have-sex-with-men
MTCT	Mother-to-child transmission
NAP	National AIDS Plan
NAVAS	Netherlands Antilles Aliens Registration System
PMTCT	Prevention of mother-to-child transmission
PAHO	Pan American Health Organization
PANCAP	Pan Caribbean Partnership Against AIDS
PLWA	People Living with HIV/AIDS
PRM	Bureau of Population, Refugees and Migration of the US Government
STI	Sexually Transmitted Infections
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UK	United Kingdom
US	United States
UWI	University of West Indies
WHO	World Health Organization
VCT	Voluntary Counseling and Testing

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Executive Summary

Given the high level of population movement and the high prevalence of HIV infection in the Caribbean, the link between mobility and the spread of HIV/AIDS is an important dimension of the region's epidemic. According to the Joint United Nations Programme on HIV/AIDS (UNAIDS), HIV/AIDS now affects more than 2% of the population in Bahamas, Belize, Dominican Republic, Guyana, Haiti, and Trinidad and Tobago. The Caribbean now ranks second only to sub-Saharan Africa as the most affected region in the world. Many of the same factors that drive the spread of HIV/AIDS also drive migration, such as unbalanced distribution of resources, unemployment, political instability and conflict. Though migrants are sometimes perceived as contributing to the spread of HIV/AIDS across borders, studies have shown that migrants are often more vulnerable than local populations and face greater obstacles in accessing care and support if living with HIV/AIDS. The circumstances of movement – e.g. whether voluntary or involuntary, or whether legal or clandestine – directly affect the potential risk of HIV-infection for migrants. A better understanding of the interaction between HIV/AIDS and population movements in the Caribbean is essential in order to develop effective AIDS intervention strategies.

Recognizing the above, the International Organization for Migration (IOM) Santo Domingo has undertaken *The Baseline Assessment: HIV/AIDS and Mobile Populations in the Caribbean*, carried out in Barbados, Curaçao (Netherlands Antilles), the Dominican Republic, Jamaica and Trinidad and Tobago. These countries were selected because of their importance as destination countries of regional migrants and tourists as well as their relatively high prevalence rate of HIV/AIDS. Through an analysis of the existing literature and national policies, interviews with key informants, and a survey of target mobile populations identified as potentially vulnerable, the study revealed the following:

- HIV/AIDS is a growing problem in the Caribbean, made more complex by the high level of population mobility in the region
- Increased AIDS funding in the Caribbean is creating implementation challenges; mobile populations must be an integral part of this response
- HIV/AIDS testing, care and treatment services are uneven across the Caribbean region; mobile populations (particularly irregular migrants) have limited access to AIDS care
- Young women in particular are at risk for HIV-infection in the Caribbean
- Mandatory HIV testing is a problem that needs to be addressed in the region
- High mobility does not necessarily lead to vulnerability to HIV infection; high-risk behaviors together with high mobility lead to greater vulnerability to HIV infection
- Irregular migration, such as trafficking in persons, has been recognized as a problem which may be contributing to the HIV/AIDS epidemic in the Caribbean

The report finds that it is essential to include mobile populations in the response to HIV/AIDS in the Caribbean in order to improve their access to HIV/AIDS prevention, care and treatment. Future interventions must also address trafficking in persons, as well as the specific needs of young women and girls. Possible intervention strategies are summarized at the end of the report. The Baseline Assessment of HIV/AIDS and Mobile Populations in the Caribbean has been made possible as a result of contributions by the Bureau for Population, Refugees and Migration (PRM) of the United States Government.

PART ONE

1. Introduction

Acquired immunodeficiency syndrome (AIDS) has become the leading infectious cause of adult death in the world, according to the World Health Organization's *World Health Report 2003* (WHO 2003.) While the number of people living with HIV/AIDS (PLWA) and the number of AIDS deaths continued to increase during 2003 (UNAIDS 2003, 2), access to information, services, and treatment remains well below goals set out by the international community (see Figure 1).

Figure 1: Access to HIV/AIDS information, services and treatment

- Fewer than one in four people at risk of infection are able to obtain basic information regarding HIV/AIDS
- Only one in nine people seeking to know their HIV serostatus have access to voluntary counseling and testing services
- Less than one in 20 pregnant women presenting for antenatal care are able to access services to prevent mother-to-child transmission of the virus
- Less than five percent of those who could benefit from anti-retroviral treatment are currently able to access such treatment

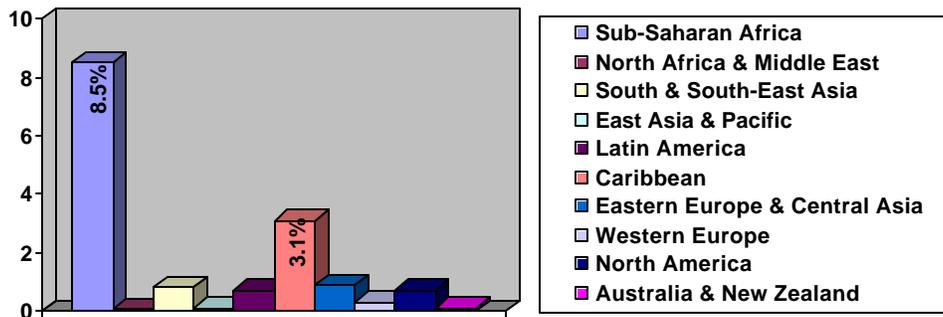
Source: United Nations *Progress towards implementation of the Declaration of Commitment on HIV/AIDS*, Report of the Secretary-General, 25 July 2003

AIDS disproportionately affects the world's poor, with more than 95% of HIV infections occurring in developing nations. Countries struggling with poverty have limited resources for prevention and care and often have poor education and health systems, further fueling the spread of the epidemic (UNAIDS 2001, 4). In much of the most-affected countries of the world, access to life-extending antiretroviral medication (ARVs) is minimal or non-existent, making HIV infection "a very different experience depending on where you have the misfortune to contract it" (Farmer 1999, 28). Both on a global scale and within countries, populations that are marginalized – due to socioeconomic status, ethnicity, gender or a variety of other factors – are more vulnerable to contracting the disease and less likely to receive comprehensive care.

Many of the same factors that drive the spread of HIV/AIDS also drive migration, such as unbalanced distribution of resources, unemployment, political instability and conflict (IOM 2002, 1). Since the beginning of the AIDS epidemic, governments have been concerned about migrants and other mobile populations potentially spreading HIV between countries (UNAIDS 2001, 2).

The Caribbean is a region with both high mobility and high levels of HIV/AIDS. While national and regional responses to the disease have increased in recent years – including several successful applications to the Global Fund to Fight AIDS, Tuberculosis and Malaria – these efforts are only a beginning in the necessary long term efforts against the disease. AIDS continues to affect a significant proportion of the population, more than 2% in some countries (UNAIDS 2003, 23). This rate of infection makes the Caribbean one of the most affected regions in the world, second only to sub-Saharan Africa (see Figure 2).

Figure 2: HIV/AIDS Adult Prevalence* by Region



* The proportion of adults (15-49) living with HIV/AIDS in 2003, using 2003 population numbers.

Source: UNAIDS *AIDS epidemic update December 2003*

With tourism accounting for 25% of all regional export earnings (compared to an average 7% worldwide) (Nankoe forthcoming), significant outward migration to North America, and all countries experiencing both inward and outward regional flows (Marshall 1998, 16), the Caribbean can also be characterized as highly mobile.

1.1 Mobility and HIV/AIDS

Given the high level of population movement and the high prevalence of HIV infection in the region, the link between mobility and the spread of HIV/AIDS is an important dimension of the Caribbean epidemic, though poorly understood. The Joint United Nations Programme on HIV/AIDS (UNAIDS) has recognized the “urgent need to develop and implement more effective responses to HIV/AIDS for migrants and mobile populations” in a 2001 publication co-authored by the International Organization for Migration (UNAIDS/IOM 2001b, 4). Though migrants are sometimes perceived as contributing to the spread of HIV/AIDS across borders, studies have shown that migrants are often more vulnerable than local populations (IOM 2002) and face greater obstacles in accessing care and support if living with HIV/AIDS (UNAIDS/IOM 2001b). The circumstances of movement – e.g. whether voluntary or involuntary, or whether legal or clandestine – directly affect the potential risk of HIV-infection for migrants. Studies in other regions have shown “strong linkages between vulnerability to HIV/AIDS and the movement of people that occurs in structures and conditions that lead to disproportionate vulnerability to HIV infection” (Nankoe forthcoming). A better understanding of the interaction between HIV/AIDS and population movements is essential in order to develop effective AIDS intervention strategies in the Caribbean.

The need to respond is made more urgent by the high prevalence rate of the region. Studies in African countries have shown that once the prevalence rate reaches 5% in the general population (as is now the case in Haiti) the virus spreads very quickly (WB 2000, vii). HIV/AIDS can no longer be seen as merely a health issue in developing countries, but rather is a “development catastrophe that threatens to dismantle the social and economic achievements of the past half century” (WB 2000, vii). In the Caribbean, pediatric AIDS is already becoming a concern due to its potential to “compromise major achievements made in maternal and child health” in recent decades (Camara, O’Neil and Russell-Brown 1996, 5). The diversity, geography and mobility of the Caribbean require contextually appropriate responses to AIDS, and mobile populations must be at the forefront of that response.

In the Caribbean context, the possible link between sex work related to tourism and the spread of HIV/AIDS is also of concern. Sometimes referred to as “romance tourism” (Kempadoo 1998b, 6), tourism-oriented prostitution has become an important topic of research and discussion, particularly due to “the growing reliance of national governments on income generated by tourism” (Kempadoo 1999, 13). There is some evidence that tourism and HIV/AIDS are related in the Caribbean. Tourism-dependent economies have some of the highest HIV prevalence rates and reported AIDS incidence in the region (Allen, McLean and Nurse 2004, 17; CAREC 2002, vii). However, very little research exists on tourism-driven sex work in the region; the connection between this population and HIV/AIDS is not well developed in the existing literature. Governments have begun to take notice of this apparent connection and have called for further study. At the International Migration Policy Seminar held in Jamaica in May 2001, government representatives noted the need to “further identify the link between HIV/AIDS and migration, particularly tourism, business travel and internal migration” (IMP 2001a, 8-9).

In the Caribbean, petty traders – called higglers or hucksters in some parts of the region – are also an important mobile population. Studies of highly mobile groups (such as truck drivers) in other parts of the world have identified travel or migration as a factor related to infection, showing higher rates in “regions reporting higher seasonal and long-term mobility . . . [and] along transport routes and in border regions” (UNAIDS 2003a). In the vibrant regional trade of the Caribbean, small merchants transport fruits and vegetables, crafts and other goods among the islands. No studies exist of the possible link between this highly mobile group and HIV/AIDS.

Recognizing the above, the International Organization for Migration (IOM) Santo Domingo has undertaken the present study to analyze HIV/AIDS and mobile populations in the Caribbean. As part of a mandate to promote humane and orderly migration, IOM works with governments to meet the individual and collective health needs of migrants. Through an analysis of the existing literature and national policies, interviews with key informants, and a survey of target mobile populations identified as potentially vulnerable, this study contributes to a further understanding of HIV/AIDS and mobile populations in the Caribbean by addressing the following:

- Characteristics and dynamics of populations movements in the region
- Factors that promote vulnerability or resilience to HIV (risk- and health-seeking behaviors)
- Level of knowledge, awareness and skills with regard to HIV/AIDS and other STIs
- Migration and health policies in the areas of origin and destination

The Baseline Assessment of HIV/AIDS and Mobile Populations in the Caribbean has been made possible as a result of contributions by the Bureau for Population, Refugees and Migration (PRM) of the United States Government.

2. Background

In order to discuss the ways in which migration and HIV/AIDS interact in the Caribbean, it is necessary to provide a brief overview of each phenomenon in the region.

2.1 Migration and Mobility in the Caribbean

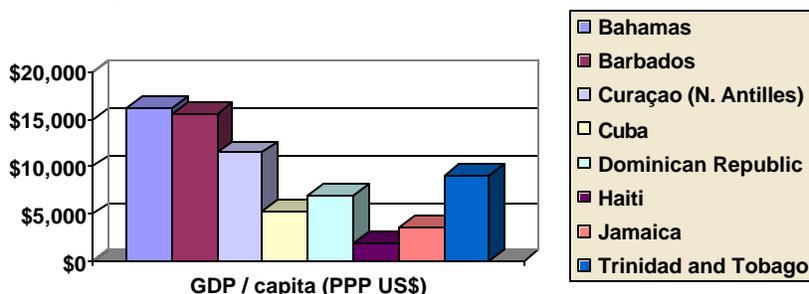
The Caribbean is a region of extensive migration, with a rate of movement in relation to population that may be one of the highest in the world (Marshall 1998, 11). Despite migration being “a way of life” in the Caribbean (Nankoe forthcoming), research on the impact of migration is limited. All states and territories have been affected by inflows and outflows, both historically – through slavery, colonial relationships and industries such as sugar, for example – and currently – via globalization and regular and irregular transnational flows. The cultural histories of Caribbean nations have led to a variety of distinct migratory patterns. The different migration flows are also influenced by the diversity of the region (both culturally and in terms of economic and human development) and by its geographical position.

While other forms of migration occur in the region, there are three primary migration flows in the Caribbean: internal migration (e.g., from a rural area to a city); intra-regional migration (e.g., movement among islands); and outward migration (e.g., movement to Latin America, Europe or North America) (Nankoe forthcoming). Three of the most important factors influencing these flows are socioeconomic inequalities (both within the Caribbean and globally), tourism and human trafficking.

2.1.1 Socioeconomic disparity and labor migration

Migration as a phenomenon is “perceived very positively by Caribbean peoples” and viewed as a strategy for “upward mobility and ‘betterment’” (Marshall 1998, 11). In some cases, “the proximity of wealthier shores within and outside the region” has stimulated migrants to move in search of economic opportunity. A portion of this migration is intra-regional, with some countries acting as “receiving states” and others producing large numbers of economic migrants (IMP 2001b, 1-3). The Caribbean is comprised of high-, middle- and low- income countries; gross domestic product (GDP) per capita ranges from \$1,860 in Haiti to \$16,270 in the Bahamas (see Figure 3).

Figure 3: GDP/capita in Select Caribbean Countries



Source: UNDP Human Development Report 2003

Development indicators also vary widely, with life expectancy ranging from 49 to 77 years, adult literacy rates from 50 to nearly 100 percent, and some countries having significantly more physicians than others (see Figure 4) (UNDP 2003). Such disparities in quality of life and opportunity are important push factors for migration, and lead to movement both within and out of the region.

Figure 4: Caribbean Development Indicators

	Life expectancy at birth (years)	Physicians (per 100,000 people)	Adult literacy rate (% age 15 and above)
Bahamas	67.2	106	95.5
Barbados	76.9	121	99.7
Curaçao (N. Antilles)	75	186	96.8%
Cuba	76.5	590	96.8
Dominican Republic	66.7	216	84.0
Haiti	49.1	25	50.8
Jamaica	75.5	140	87.3
Trinidad and Tobago	71.5	79	98.4

Sources: UNDP *Human Development Report* 2003; *Statistical Review Curaçao*, 1999-2001; Pan American Health Organization online www.paho.org

Intra-Caribbean labor migration will further be facilitated by the Single Market and Economy (CSME) of the Caribbean Community (CARICOM). CARICOM was established by the Treaty of Chaguaramas, signed 4 July 1973, “to provide dynamic leadership and service, in partnership with Community institutions and groups, towards the attainment of a viable, internationally competitive and sustainable Community, with improved quality of life for all.” Current CARICOM members include Antigua and Barbuda, The Bahamas, Barbados, Belize, Dominica, Grenada, Guyana, Haiti, Jamaica, Montserrat, St. Kitts and Nevis, Saint Lucia, St. Vincent and the Grenadines, Suriname, and Trinidad and Tobago. The CSME envisions a Caribbean “without barriers, strengthened by its collective resources and opportunities.” Free movement of persons is not yet a reality in the region, although CARICOM has approved regulations that allow for the free movement of business people, artists, sportspersons, and some categories of students; the movement of other groups has been under discussion for several years. Free trade and free movement of capital are slowly being implemented (CARICOM Secretariat 2003).

In addition to intra-regional migration, labor migrants also travel to non-Caribbean countries in search of economic opportunity. Europe, the United States (US) and Canada are important destinations for this type of migration. Policies based on ties with former colonies and work programs to meet shortages of professionals (such as health workers in the US) have also traditionally influenced these flows.

Labor migration has had both positive and negative effects on the Caribbean. Intra-regional flows have helped support the increasingly important tourism industry that sustains many economies in the region. Migrants who have established themselves in countries outside the region send significant quantities of money to their home countries in the form of remittances, an important contribution to the economy of many Caribbean states. One serious problem related to the migratory outflows of the Caribbean, however, is the departure of professionals, also known as “brain drain.” The loss of professionals to developed countries has been identified as a major challenge for the Caribbean (Nankoe forthcoming). At a recent meeting of the Pan Caribbean Partnership Against AIDS (PANCAP), the migration of skilled labor, particularly medical personnel such as nurses, was discussed as a problem requiring a regional response (Greene 2003). Brain drain not only results in shortages of professionals in certain sectors in the home country, but is also a drain on resources – less wealthy countries educate and train their nationals only to see them migrate elsewhere to put those skills to use. In

the English-speaking Caribbean, the loss of skilled workers has “contributed to a growing sense that West Indians have borne the costs of a part of the US and Canadian skilled labor needs.” In Jamaica and Trinidad, the loss of nurses is creating serious problems (IMP 2001b, 3).

In addition to the loss of professionals, labor migration has other consequences on the region, particularly when the migration is irregular. Many countries in the Caribbean receive boatloads of migrants attempting to illegally enter wealthier neighboring countries. The policies regarding irregular migration differ across the region, but the responsibility to save lives, identify those in need of protection (such as asylum-seekers and the victims of trafficking), while effectively enforcing national migration policies and border control is extremely challenging. Irregular migration is further discussed in section 2.1.3.

2.1.2 Tourism

The largest movement of people in the Caribbean is movement into the region by recreational visitors, more than 20 million people annually according to the Caribbean Tourism Organization (Marshall 1998, 4). The natural beauty of the region has created an industry that sustains many of the Caribbean’s people, contributing half the GDP in some countries (Dixon 2000 as quoted in Nankoe forthcoming). Relative to other regions in the world, the Caribbean has the “highest level of dependence” on the tourism industry (Allen, McLean and Nurse 2004, 15). Labor migration within the region is also linked to the industry, with migrant-receiving countries often being distinguished by economies based on tourism (Marshall 1998, 16). Immigration to such states has actually caused some microstates to experience significant population growth (Marshall 1998, 11). The importance of tourism in the region has also led to a related phenomenon, tourism-oriented prostitution. See section 4.3 for more details.

2.1.3 Human trafficking

The highly mobile Caribbean region is affected not only by regular migration but also by irregular migrant flows, including human smuggling and trafficking. Supplemental to the United Nations (UN) Convention on Transnational Crime, the UN Protocol Against the Smuggling of Migrants by Land, Sea and Air defines smuggling as “the procurement, in order to obtain, directly or indirectly, a financial or other material benefit, or the illegal entry of a person in to a State Party of which the person is not a national or a permanent resident” (UN 2000b).

According to the UN Protocol Against Trafficking in Persons, especially Women and Children, trafficking is defined as:

the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation” (UN 2000a).

Trafficking and smuggling are some of the most serious and urgent challenges facing migration policy-makers and practitioners today. Predominately affecting the most vulnerable (particularly women and children in the case of trafficking), trafficking and smuggling are rooted in the problems of poverty and lack of opportunity, marginalization and violence. Smuggling often occurs as irregular migrants attempt to cross borders otherwise closed to them. Trafficking

occurs for a variety of reasons, including sexual or labor exploitation, forced military conscription, domestic servitude, false adoption, forced marriage and the sale of organs. The consequences of these irregular migration flows are often devastating, both for irregular migrants and for the larger society. Increased irregular migration, the presence of criminal organizations and problems with national security are some of the consequences for countries of origin, transit and destination. Broader implications include the general decline in the health and well-being of communities affected by these activities.

Trafficking and smuggling routes cross the globe, affecting all regions. As a region of origin, transit and destination, the Caribbean is beset by complex irregular migration flows. Smuggling and trafficking occur between and within Caribbean countries, and irregular migration movements link the region to other parts of the world, including Central and South America, Europe and Asia. The USA and Canada are preferred destinations. Though data on the levels of irregular migration is difficult to obtain, Caribbean states are particularly susceptible to irregular migratory movements due to their “exposed geographical positioning” and “porous borders” (IMP 2001b, 2). The pressure these illicit activities place on countries in the region is immense. With limited resources and while facing a range of other political and developmental challenges, countries are confronted with the specific problems associated with smuggling and trafficking – the need to prosecute traffickers, and to identify and assist victims of trafficking while managing borders and preventing illegal movement. At a recent IOM seminar “Mixed Migratory Flows in the Caribbean” held in collaboration with the UN High Commissioner for Refugees, governments commented on the need for better border management and identified irregular migration in the region as a serious problem (IOM 2003).

2.2 HIV/AIDS in the Caribbean

At the Opening Ceremony of the Third Annual Meeting of the Pan Caribbean Partnership Against HIV/AIDS (PANCAP) held in November 2003, Dr. Edward Greene of CARICOM¹ noted that 500,000 people are now infected with HIV in the Caribbean, a full one percent of the population. Regional prevalence is the second highest in the world, and AIDS is beginning to affect infant mortality and life expectancy in some countries (Sullivan 2002, 24). This section provides a brief overview of HIV/AIDS in the Caribbean, including the current dimensions of the epidemic, access to care and treatment, and regional response.

2.2.1 Dimensions of the epidemic

The first HIV/AIDS cases in the Caribbean are believed to have occurred in the early 1980s. Some scholars identify Jamaica as the location of the first known AIDS case in the region (see CAREC 2002), while others have noted even earlier cases in Haiti (see Farmer 1999). Just as during the emergence of the disease in North America, homosexual transmission predominated in the first stages of the epidemic; in the Caribbean, sexual contact with North American men in tourist areas was particularly important (Farmer 1999, 119; Allen, McLean and Nurse 2004, 16). Since 1985, HIV transmission patterns in the Caribbean have been primarily heterosexual (CAREC 2002, vii). More than half of all reported AIDS cases in the region are the result of unprotected heterosexual sex (World Bank 2000, vii). Despite this fact, homosexual and bisexual transmission continue to be significant due to the associated stigma in the region

¹ Assistant Secretary of General, Human and Social Development

(CAREC 2002, vii). In Latin America and the Caribbean, cultural, sociopolitical and religious factors lead to the denial of male-to-male sex, which increases high-risk behaviors and leads to greater vulnerability to HIV infection (UNAIDS, 1999). Homosexual and bisexual transmission have been shown to be well connected to the heterosexual epidemic in countries where homosexuality is not socially accepted, such as much of the Caribbean (CAREC, 2002). All main modes of transmission are present in the most Caribbean countries “amid significant levels of risky behavior – such as early sexual debut, unprotected sex with multiple partners, and the use of unclean drug-injecting equipment” (UNAIDS 2003, 23). In Puerto Rico, injecting drug use is the main driver of the epidemic, an exception in the region. Sex work has also been identified as important in transmission of HIV in the Caribbean (UNAIDS 2003, 23; Kempadoo 1999, 16). Recent statistics are summarized in Figure 5.

Figure 5: Caribbean HIV/AIDS Statistics

	Caribbean Region	Worldwide
Adult Prevalence*	1.9 - 3.1 %	1.1 %
People living with HIV/AIDS	350,000 – 590,000	34 – 46 million
Newly infected with HIV during 2003	45,000 – 80,000	4.2 – 5.8 million
Deaths during 2003	30,000 – 50,000	2.5 – 3.5 million

*The proportion of adults (15-49 years of age) living with HIV/AIDS in 2003, using 2003 population numbers
Source: UNAIDS *AIDS epidemic update: December 2003*

At least one percent of the population is infected with HIV throughout the Caribbean as a whole, and in six countries – Bahamas, Belize, Dominican Republic, Guyana, Haiti, and Trinidad and Tobago – more than 2% of the population is HIV positive (UNAIDS 2003, 23). While the regional prevalence rate in the Caribbean is nearly the worst in the world, national rates vary dramatically. In some parts of Haiti and the Dominican Republic, HIV testing has shown that one in 12 adults between 15 and 49 are living with HIV, while in St. Lucia and the Cayman Islands less than one pregnant woman in 500 have tested positive for HIV (PAHO/UNAIDS 2001, 4). In the English-speaking Caribbean, AIDS is now the leading cause of death among men between the ages of 15 and 44 (WB 2000, 17). Thirty-five percent of adults living with HIV/AIDS in the region are women, and the Caribbean has one of the highest rates of new cases among women in the Americas (WB 2000, 15).

2.2.2 Access to care and treatment

Access to comprehensive care, including treatment with life-extending antiretroviral medications (ARVs), varies greatly in the Caribbean. While some non-governmental organizations do provide ARVs, the supply is uncertain and inadequate for treating all those in need (WB 2000, 32). Overall, access is poor, with AIDS fatality rates between 60% and 85% in many instances (Camara 2003). In some countries only 25% of those who need antiretroviral treatment receive it, while in others more than 60% of those who live with AIDS have access (UNAIDS 2003, 25).

Mother-to-child transmission (MTCT) and access to ARVs to prevent vertical transmission are an important concern in the region; in the English-speaking Caribbean, a child is born with HIV or infected through breast milk every day (PAHO/UNAIDS 2001, 43). In most Caribbean countries coverage of antenatal services is high. More than 75 percent of mothers in

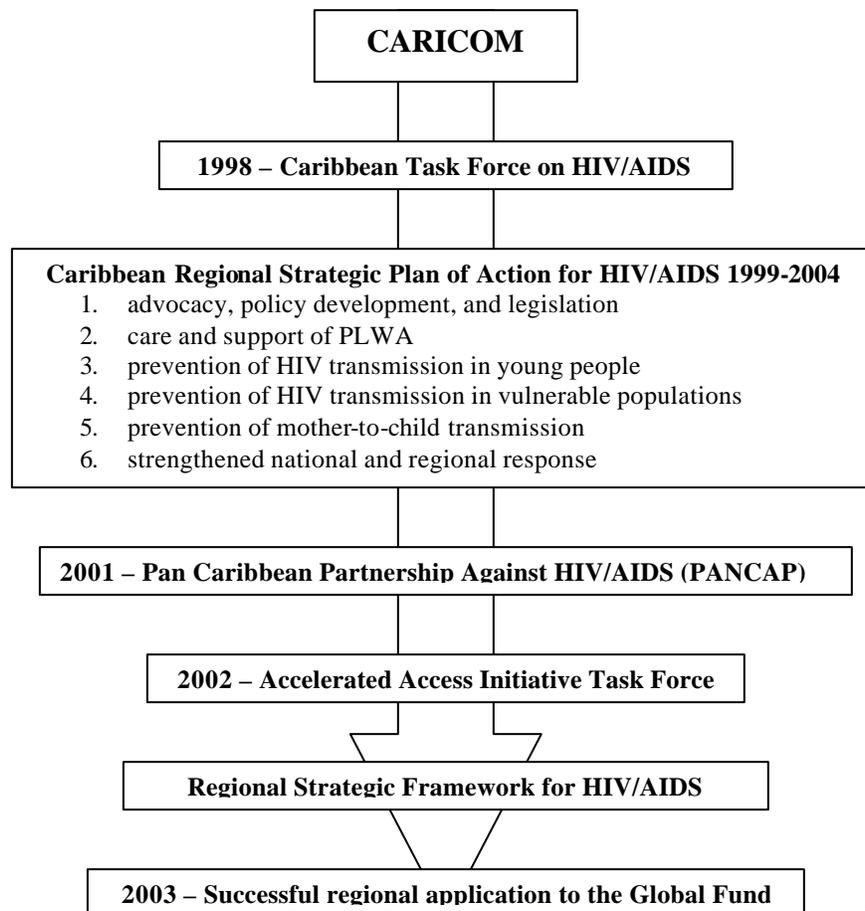
the region are in contact with a clinic before giving birth, and many deliveries occur in hospitals. Haiti is an important exception, where 80 percent of women give birth at home and 30 percent receive no prenatal care (PAHO/UNAIDS 2001, 44).

Widespread stigma associated with AIDS, “its perceived association with homosexuality,” and sexual activity in general have also affected access to voluntary counseling and testing (VCT) and care in the Caribbean (Wolfe 2002, 10). Stigma regarding male-to-male sex has contributed to underreporting and continues to “fuel the silent epidemics” that are underway in the region (UNAIDS 2003, 25). Sex workers are among the vulnerable groups whose access to information and care is limited by stigma in the Caribbean.

2.2.3 Regional response

The response to HIV/AIDS in the Caribbean has increased dramatically over the past five years. A variety of national and regional projects have been implemented, including several successful applications to the Global Fund to Fight AIDS, Tuberculosis and Malaria. The evolution of the regional response to AIDS in the Caribbean under CARICOM is illustrated in Figure 6.

Figure 6: Regional response to HIV/AIDS in the Caribbean



Recognizing the seriousness of the HIV/AIDS epidemic in the region, members of the Caribbean Community established a Caribbean Task Force on HIV/AIDS in 1998. In June 1999, the National AIDS Program Directors met in Antigua to review and approve a draft regional strategic plan (WB 2000, xi). The five-year plan of action was then endorsed by finance ministers at the June 2000 meeting of the Caribbean Group on Cooperation in Economic Development held at the World Bank (Allen, McLean and Nurse 2004, 238). In February 2001, the task force expanded into the Pan Caribbean Partnership Against HIV/AIDS (PANCAP), established by CARICOM heads of state and endorsed by the Nassau Declaration on Health 2001. The partnership is mandated to advocate for HIV/AIDS at the highest levels of government, to coordinate regional response and mobilize both regional and international resources, and to increase country-level resources to address the epidemic (PANCAP online).

Notable among the responses in the Caribbean have been efforts to make antiretroviral medications more accessible. The CARICOM Secretariat initiated the Accelerated Access Initiative (AAI) in 2002 with the establishment of a task force to negotiate with pharmaceutical companies for better prices on ARVs (Brohim 2003, 2). Barbados, the Dominican Republic, Haiti, Jamaica, Trinidad and Tobago were among the participating countries. Negotiations with the companies were conducted by national ministries of health and regional agencies such as CARICOM, with technical support from PAHO. On July 2002, CARICOM and several pharmaceutical countries signed a Memorandum of Understanding during the International Conference on AIDS in Barcelona reducing the price of first-line triple therapy regimen to the price offered to Sub-Saharan Africa, around US\$ 1,100. The negotiated prices will be in effect for one year and are available to government institutions only (PAHO online). Though the negotiations were successful in lowering prices for some countries in the region, “the increasing availability of generic ARVs at even lower prices” has made the generic market increasingly important (Brohim 2003, 4). Countries that continue to purchase non-generic ARVs are paying significantly higher prices than those mainly purchasing generic ARVs (Brohim 2003, 5). The Clinton Foundation recently facilitated and negotiated favorable ARV prices with manufacturer CIPLA for the Bahamas, Grenada and Anguilla (Brohim 2003, 2).

A variety of bilateral donors have funded projects in the region, including Canada, the European Union, France, Germany, Spain, the United Kingdom, and the United States. International agencies have also participated in the response to HIV/AIDS in the region, including the World Bank, the Pan American Health Organization, and multiple United Nations agencies. Regional institutions and networks which are involved in the response to the epidemic include CARICOM, the Caribbean Development Bank, the Caribbean Epidemiology Centre (CAREC), the University of West Indies (UWI), the Caribbean Health Research Council (CHRC), the Caribbean Coalition of National AIDS Programme Coordinators (CCNAPC), networks of people living with HIV/AIDS and many non-governmental organizations (NGOs). PANCAP maintains a matrix of agencies involved in HIV/AIDS activities in the region, which is available, online.² Projects have addressed a variety of topics and issues, such as youth; leadership; social marketing; law, ethics and human rights; access to treatment; nutrition; reproductive health; technical capacity building; and blood safety. In December 2002, Haiti became the first country in the western hemisphere to receive a grant from the Global Fund to Fight AIDS, Tuberculosis and Malaria. In 2003, a regional initiative by PANCAP entitled *Scaling Up the Regional Response to HIV/AIDS through the Pan Caribbean Partnership against*

² See <http://www.caricom.org/pancap/reportslinks.htm>

HIV/AIDS was also approved by the Fund.³ Overall, funding for HIV/AIDS programs in the Caribbean has increased dramatically, from annual resources of approximately US\$ 20 million at the end of 2000 to US\$ 91 million at the end of 2003 (UNAIDS 2003d, 2). This influx of funds is creating both momentum and implementation challenges. As the leading international organization in migration issues, IOM is working with partners in the region to ensure that the needs of mobile populations are an integral part of the response to HIV/AIDS in the Caribbean.

3. Methodology

The Baseline Assessment was conducted as the first phase of a more comprehensive IOM project, the *Regional initiative for the Caribbean on HIV/AIDS and mobile populations*. This initial research is being used to design a suitable intervention strategy to address HIV/AIDS and mobile populations in the Caribbean during a future phase of the project. Research was conducted in Barbados, Curaçao (Netherlands Antilles), the Dominican Republic, Jamaica and Trinidad and Tobago. These countries were selected because of their importance as destination countries of regional migrants and tourists as well as their relatively high prevalence rate of HIV/AIDS.⁴

An initial visit was carried out in several of the selected countries to contact local health authorities and institutions to discuss their involvement in the project and to obtain official approval to execute the research. Potential researchers were also identified during these visits. A workshop on migration and HIV/AIDS was then held in Santo Domingo, Dominican Republic from 31 March – 1 April 2003 to jointly define the research methodology and desired outcomes of the research. Participants included country researchers, government representatives, representatives of Ministries of Health, and international partners such as the Caribbean Epidemiology Centre (CAREC) (see Annex A for a list of participants). During the workshop, participants agreed on sex workers and petty traders as target groups for the study. These groups were selected due to their high mobility, potential vulnerability to HIV/AIDS, and the lack of existing information of these populations in the Caribbean.

Researchers in each country compiled and analyzed existing national data on the topics under study, including tourist flows, policies and legislation related to migration and HIV/AIDS. Special attention was paid to the target groups under study. This information was gathered by means of records from the Ministries of Health, Immigration, Labor and Tourism; statistics and migration offices; interviews with key informants and information provided by local and international organizations.

An interview guide was also developed based on existing models for use in surveying the target populations to assess HIV/AIDS knowledge, awareness and skills (see Annex B). The structured questionnaire gathered largely quantitative data, but was supplemented with limited qualitative data through the inclusion of several open-ended questions. Country researchers evaluated the questionnaire in terms of accuracy, flow, applicability to the regional conditions, and ease of administration. The final survey and interview guide was then translated into Spanish and Creole. During the workshop it was agreed to carry out 20 interviews among each target group, including five males in each sample. A coding system and spreadsheet for results were designed and used by all country researchers.

³ Project proposals are available at the Global Fund website, <http://www.theglobalfund.org/en/>

⁴ Though Haiti has the highest HIV/AIDS prevalence rate in the region, it was not included in this study because it is relatively unaffected by immigration and tourism.

The survey was carried out in four of the five selected countries.⁵ Sampling techniques were purposeful, including snowball sampling and site-specific sampling. Data was collapsed into Excel spreadsheets that were coded for analysis using SPSS (Statistical Package for Social Sciences). While petty traders were surveyed in all four countries, limited access to sex workers resulted in surveys being distributed only among two of the selected countries. In some countries, NGO partners with many years of experience working with the target group were able to negotiate safe access. In at least two countries, past and potential raids by immigration authorities made access to sex workers extremely difficult. Final country reports were written according to guidelines developed by project management. Country reports submitted to IOM were analyzed and compiled into a final report. Country reports are available upon request.

⁵ Though Jamaica was initially included in the survey, the contracted researchers failed to fulfill their obligations to the satisfaction of the International Organization for Migration.

PART TWO

4. Main Findings

The research findings as compiled from the country reports are included in the following sections. Section 4.1 describes migration and mobility; section 4.2 gives a summary of HIV/AIDS in each country; and sections 4.3 and 4.4 provide an overview of the results for commercial sex workers and petty traders, respectively. Please see the country reports, available upon request, for more details. In-depth analyses of the crosscutting themes that emerge from this study are included in section 5.

4.1 Migration and Mobility in selected countries

The following section provides a brief overview of migration and mobility in the Baseline Assessment countries. Though a comprehensive analysis of regional migration flows and national migration management systems is beyond the scope of this research, preliminary information about migration patterns, reasons for mobility, related policies and legislation, and concerns has been included. In addition to migrants, other mobile populations, such as tourists, are also addressed due to their importance in the region. Please see Figure 7 and the subsequent country sections for a summary of the results.

Figure 7: Results – Migration and Mobility in Selected Countries

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

Migratory flows in the countries under study reflect the larger characteristics of the region. Most have significant levels of out-migration (both to other parts of the Caribbean and to areas outside the region) as well as complex regional flows. All countries under study have high levels of regional immigrants, with smaller flows from other parts of the world. For those countries with available data, the percentage of the population born in another country ranges from 4-16%; in most cases, the majority come from the region, though South American countries (Venezuela and Colombia in particular) are also important source countries. Economic migrants from the region's poorest states⁶ (such as Haiti, Dominican Republic, Guyana and Grenada) are found in most of the countries under study. Extra-regional migrants are present in the region, some undoubtedly linked to flows associated with tourism and business travel. Interestingly, official data show a variety of source countries. Most countries noted migrants and visitors from the United States, Canada, and the United Kingdom. Additionally, India is a source country for Barbados and Jamaica, the Netherlands for Curaçao, and China for the Dominican Republic and Jamaica.

Tourism was important for all countries. Labor migrants, particularly from the region, were present in all countries. For most countries under study, work permits are required, though researchers noted that irregular migrants often enter as tourists. All countries appear to have some level of irregular migration (smuggling and trafficking). In certain countries trafficking of persons is a serious concern. Other concerns included restricted entry for those who are HIV+, brain drain, and drug trafficking.

4.1.1 Barbados

In Barbados, most immigrants come from the region; 65% of the foreign-born residents are originally from CARICOM countries. The most important source countries are St. Lucia, St. Vincent and Guyana, with extra-regional immigration predominately from the UK, US and India. More than half of the immigrants are female, mostly adults of working age. Tourism is a particularly important short-term flow. In 2002, 89,177 people entered the country as tourists, approximately 7% as business travelers (Interview – Ministry of Barbados, 2003). Barbados continues to attract migrants from less-developed countries in the region. The major underlying causes are the need for cheap and willing labor in the receiving country; the abundant supply of labor created by high unemployment or underemployment together with a shortage of job opportunities in the sending countries; networks of family and friends in the receiving country; and the Caribbean worldview that perceive opportunities abroad as positive.

Immigration policies in Barbados facilitate the circular, short-term movements of migrants such as tourists, petty traders and CSWs. A valid passport is required by all visitors, except nationals of the US and Canada traveling directly to Barbados with acceptable proof of nationality and identity. Visas are not required for nationals of the US, Canada, UK and Commonwealth countries (excluding India and Pakistan) and most western European countries, subject to length of stay. All visitors must have onward or return tickets. Work permits are required for all non-nationals. Work permits are of two types: short-term for six months or less and long-term usually for no more than three years. Short-term migrants sometimes avoid much of this bureaucracy by entering Barbados on a visitor's visa, usually for 28 days. It is possible to apply for an extension of a visitor's visa.

⁶ Based on Human Development rating, *HDR 2003*.

Barbados is a member of CARICOM, and the Prime Minister has accepted special responsibility for efforts towards the establishment of the CARICOM Single Market and Economy (CSME). In 1996, Barbados enacted legislation for free movement of university graduates by the amendment of its Immigration Act. Since then, member states have expanded the categories of persons eligible to move freely and are expected to develop common standards to facilitate this regional movement, though not all member states have taken the necessary steps to make the agreement operational.

4.1.2 Curaçao

Emigration out of the region (primarily to the Netherlands) has greatly affected the Netherlands Antilles. As is the case across the region, inward migration is also very important, particularly from within the Caribbean. The 2001 census indicated that 16% of the population was foreign-born; most had come from Colombia, Dominican Republic, Venezuela and Haiti (Central Bureau of Statistics). Political unrest and social and economic instability represent the main causes for emigration to Curaçao, which, in spite of its problems, still represents a safe haven and a model of economic stability to citizens of surrounding countries (Hillman 2003).

Migration on all islands of the Netherlands Antilles is regulated by the Admission and Deportation Ordinance (Dos Mundos 2003).⁷ Tourists are an important short-term mobile population. Statistics from the Curaçao Tourism Development Bureau indicate 205,943 stay-over arrivals by air and 280,166 arrivals by cruise ship in 2002, an increase over the previous year. The most important source countries for tourists arriving by air included the Netherlands, US, Canada, Venezuela, and Colombia (Curaçao Tourism Development Bureau 2002). In order to be allowed entry a tourist must be able to present a return ticket, financial means, and a visa, if applicable. Tourists may stay for two weeks and can request an extension. Extensions are not easily granted (Dos Mundos 2003). Currently, the immigration office is unable to monitor whether tourists leave Curaçao within the designated time.

Work permits are required on Curaçao. For special work projects, the government allows temporary immigration of skilled labor (Franken 2003). Work permits are also required for commercial sex workers in the state-regulated brothel, "Campo Alegre." Women working at Campo Alegre receive three-month work permits as "employees of Hotel Mirage." Women working in unregulated prostitution in Curaçao often receive work permits as dancers.

Over the last two years drug trafficking has become an increasing problem on Curaçao (Extra, 2003). In addition to drug trafficking, the trafficking and smuggling of humans is also suspected to occur in Curaçao. Yearly an estimated 100 passengers are permitted to pay a small fee to board small vessels bringing fish, fruits and other products to the island, though such entry is illegal. Local NGOs have also noted groups of women arriving in this way (Contrasida 2003).

Following a report by Amnesty International which revealed human rights abuses of irregular immigrants awaiting deportation, a general amnesty was declared from August – December 2001. The only individuals explicitly excluded from the right to apply for general amnesty were sex workers (Extra, 2003). In January 2002, immediately following the amnesty, a Zero Tolerance policy was introduced to combat the presence of remaining irregular immigrants. A special police team was created and places where the presence of irregular residents is

⁷ A new Admission and Deportation Ordinance will be implemented in the near future which differs from the older version in several important ways, including extending state-regulated prostitution and limiting work permits to highly-skilled personnel; please see the country report for more details.

suspected are raided on a regular basis. Irregular or undocumented residents are arrested and deported.

4.1.3 Dominican Republic⁸

Immigration patterns in the Dominican Republic have historic links to the production of sugar and tobacco (Martinez Bretón, 2002) and have often involved regional flows from countries such as Jamaica, Saint Thomas, Antigua, Martinique, and Saint Kitts (Baez Evertsz, 1994). More recently, tourism has stimulated immigration from Europe and North America. Current migration countries of origin include Haiti, the US, Europe, China and Cuba (Caceres Ureña, 2001; Baez Evertsz, 1994; Anuario de Migraciones, 2000). Haitian immigration is of particular importance. IOM estimates that in 2003 there were around 650,000 Haitians living in the country. Approximately 25,000 Haitians cross the border every year; a large number of them return to Haiti after several months or years of work, as Haitian irregular migration is circular. Nearly 12,000 Haitians are deported yearly. In 2000, 75% of immigrants were from Haiti (ENDESA database, 2000). Poverty and poor quality of life, together with geographical proximity, have led to movements from Haiti to the Dominican Republic. Inexpensive and easy border crossings, high demand for cheap labor and an increase in construction and tourism industries in the Dominican Republic in recent decades have also contributed to these flows (Martinez Breton, 2002).

Different administrations have attempted to reduce the irregular Haitian population in the Dominican Republic through massive deportations and repatriations, despite international criticism of human rights abuses. International attention has also been placed on addressing the social and economic situation in Haiti that is creating irregular migration out-flows in the region (ONE-RESPE, 1999). In 1997, the formation of an Inter-Agency Committee for the Protection of Women Migrants (CIPROM) helped initiate a discussion of policies regarding migrant women. Since 2001, CIPROM has taken a leading role in a program to prevent and combat trafficking in persons, in conjunction with the Statue Secretariat for Women and IOM. In 2003 a National Migration Roundtable was created, gathering civil society institutions and international organization such as Catholic Relief Services (CRS) and IOM together to articulate efforts towards new migration policy and legislation. The work of this coalition of government, civil society and international organizations led to a new law on the smuggling and trafficking of persons in the Dominican Republic (No.137-03), which was voted into law in August 2003.

Evidence of human smuggling and trafficking networks exists in both Haiti and the Dominican Republic (Silie, 1999) and the trafficking of Haitian children is a particular problem, sometimes occurring with the consent of the families. It is estimated that in only two locations in the northern part of Haiti, 2,000 to 2,500 children cross the border annually (Plaisance y Pilates). This migration is circular in most cases, with the children staying in the Dominican Republic for 1-5 months and then returning to their families. Some children are thought to travel two or more times per year (Tejeda, Cemephise, and Artola, 2002). The lack of research makes an accurate description of the irregular migration into the country impossible at this time. More studies are urgently needed.

⁸ The country research on the Dominican Republic has been translated from the original Spanish for the purposes of the Baseline Assessment Final Report. Any misrepresentations are unintentional; please see the original country report for more details.

4.1.4 Jamaica

Like much of the Caribbean, Jamaica has been affected by the establishment of migrant communities abroad, large-scale return migration, significant intra-regional migration and irregular transit migration from countries outside the region. Jamaica is both a country of high emigration and a transit point for irregular migrants. Jamaica is the third largest island in the Caribbean Sea with an estimated population of 2,576,200 (Planning Institute of Jamaica 2002) and a net migration rate of -7.52 per 1,000 inhabitants. This last figure almost doubles the net migration rate in the Dominican Republic and triples that of Haiti (Protection Project 2002).

According to the Statistical Institute of Jamaica, approximately 1% of the population is foreign-born. In addition to countries within the region, important source countries include the United States, the United Kingdom, Canada and India. Traditionally, Jamaicans have also immigrated to the United Kingdom, the US and Canada. An estimated 10,000 Jamaicans migrated to the United States annually for agricultural work up until the early 1990s, when other migrant groups (such as Mexicans) began to replace Jamaican farm-workers (IOM 2000, 258). Migration of skilled labor – brain drain – is a serious problem in Jamaica, particularly in the health sector.

Work permits are required for non-nationals seeking to work in Jamaica. Applicants must have a valid passport and documentation of an existing job offer as well as a return ticket and sufficient funds while in the country (Jamaican Consulate online).

Jamaica has the seventh largest natural harbor in the world and has become a leading transportation hub in the region. Tourism is an important flow into Jamaica and is the main industry of the island (Ministry of Health 2002, 6). The Jamaica Tourist Board estimates that 1.3 million tourists entered the country in 2003. Citizens of the US and Canada may enter Jamaica as tourists without applying for a visa, provided they have a valid national passport or other accepted identification document. Members of the British Commonwealth may also enter Jamaica without a visa, with the exception of Nigeria, Pakistan, Sierra Leone and Sri Lanka (Jamaican Consulate online).

Unfortunately, illegal drugs and irregular migration flows are also a problem for Jamaica, which is a major transit point for South American cocaine en route to the United States. Violence related to gang and drug activity is a major concern in Jamaica, in addition to high rates of domestic violence (Ministry of Health 2002, 7). Human trafficking and smuggling are also a concern; in 2000 federal agents broke up a ring that took workers from China through Caribbean countries such as Jamaica, before finally entering the United States. Trafficking related to sex tourism is reported to be a growing industry (US Department of State 2002).

4.1.5 Trinidad and Tobago

The population of Trinidad and Tobago is highly mobile with the characteristic Caribbean pattern of migration for work, vacation, and study (Lee, Ann and Felix, Junior, 1997, p3). Post-independence economic policies actively encourage emigrants, and tourism has attracted visitors from around the globe. Migrant populations include agricultural workers, business travelers, members of the military, students and teachers, tourists, sex workers and petty traders.

Economic prosperity related to oil in Trinidad and Tobago has made it a preferred destination for intra-regional migration flows, particularly from Guyana, Barbados and Grenada.

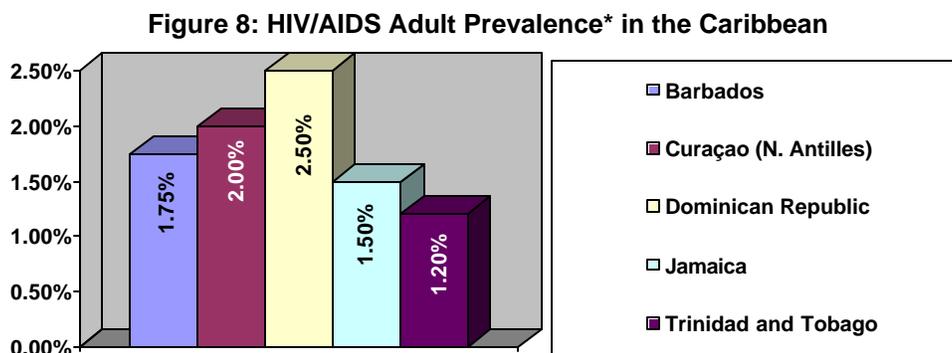
Migration in Trinidad and Tobago (as in much of the Caribbean) is driven in large part by socioeconomic opportunities or the belief in such opportunities. Analysis of the 1990 census data shows that approximately 4% of the population in Trinidad and Tobago is foreign-born. Most come from Grenada and St. Vincent, but a significant proportion (10%) are from Guyana, and qualitative research has shown that there is also a Jamaican community living in Trinidad.

Interviews with immigration officers reveal that there are a number of irregular immigrants, many of whom are Guyanese, who enter Trinidad and Tobago on tourist visas and remain in the country. Many of these immigrants take up employment as petty traders ('higglers'), or are employed as domestic workers. Immigration officers admit to taking a 'soft stance' on the deportation of these irregular immigrants unless specifically called in by community members, or when a crime is committed. This suggests that there may be additional migrants in Trinidad and Tobago that have not been captured by official research.

The move by CARICOM to create a single market economy that includes the free movement of labor has consequences for Trinidad and Tobago as a receiving country of migration flows. For the moment, however, the movement of people across international borders continues to be governed primarily by national laws. National immigration legislation in Trinidad and Tobago bans people suffering from infectious diseases from entering the country. The Minister of Health can authorize entry of such persons subject to certain conditions and must agree to entry for medical treatment. Foreigners requesting a residence permit or wishing to remain for more than one year must undergo an HIV test. Foreigners living with HIV/AIDS may be refused residency.

The perceived negative impacts of intra-regional flows are dealt with by policy-makers through work permit requirements, limitations and constraints regarding the employment of non-nationals, and access to social services. In Trinidad and Tobago migrants are only permitted to work for 30 days without a work permit, and some persons are not permitted to migrate unless they have obtained permission prior to their arrival. There are of course those who migrate both internationally and intra-regionally, but who are not recorded through any of the official statistical agencies. This important form of migration includes informal commercial activities of various types, including the trafficking of drugs and the sex trade.

4.2 HIV/AIDS in selected countries



* The proportion of adults (15-49) living with HIV/AIDS

This section provides a brief description of HIV/AIDS in each of the Baseline Assessment countries, including dimensions of the epidemic, related policies, details about the national

strategic AIDS plan in each country, and concerns raised by the researchers. Country reports with more details are available upon request.

Figure 9: Results – HIV/AIDS in Selected Countries

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

*World Health Report 2003; UN Population Database online

In general, the findings support the regional literature on HIV/AIDS. In all countries under study AIDS first appeared in the early 1980s. Prevalence rates in the countries under study ranged from 1.2% in Trinidad and Tobago to 2.5% in the Dominican Republic (see Figure 8). Total registered cases range from approximately 1,300 to 11,000, though researchers discuss problems with official statistics. Fatality rates were not available for all countries, but the known rates are high: 74% for Barbados and 62% for Jamaica. People living with AIDS (PLWA) in the countries under study are on average between 20-45 years of age. Approximately 40% are women, though data was not available for all countries. In three of the five countries under study researchers noted that younger women are being infected at higher rates than their male counterparts.

Transmission is believed to be primarily through heterosexual sex, but all researchers raised other concerns. Transmission via men-who-have-sex with men was mentioned in all countries as a serious unknown due to the high stigma related to homosexuality. Commercial sex workers were also mentioned as having a role in the spread of the disease, though more research is needed. Only the country report for the Dominican Republic raises injecting drug use as a particular concern for transmission.

All countries have a national AIDS plan (NAP) in place and are actively addressing the issue in collaboration with NGOs, national and international partners, but the level of services and access to those services varies. Most NAPs did not address mobile populations directly. In several cases, mobile populations were indirectly included under vulnerable or high-risk groups.

The health system varies across countries, from universal healthcare including HIV/AIDS services, such as Barbados, to countries whose poorest populations currently do not have access to even primary care, such as the Dominican Republic. Despite these differences, researchers identified access to HIV/AIDS care as a serious problem for migrant populations in all countries. In Barbados, universal care for HIV/AIDS is being implemented, but an ID card is necessary to access these services, for example. In Curaçao, those who do not have health insurance have minimal access to healthcare in general. All countries appear concerned about preventing mother-to-child transmission, and several have been administering ARVs to pregnant women and newborns for many years. Most undocumented migrants, however, do not have access to these services.

Treatment for PLWAs is a goal in many countries, but still a reality for relatively few nationals, let alone migrants. Several researchers mentioned HIV-testing of migrants as a concern: such testing is not necessarily voluntary, support services are not provided, and the human rights of migrants are not protected. Researchers identified gender as an important factor in the AIDS epidemic in the countries under study: gender inequalities and gender violence appear to contribute to the infection rates for women. Finally, stigma and discrimination, both for those living with AIDS and regarding sexuality (homosexuality in particular) was raised as a concern by all researchers. Please see Figure 9 and the country sections for more information.

4.2.1 Barbados

Barbados is among the ten countries in the Commonwealth Caribbean most affected by HIV/AIDS, with an estimated 2.5% of the adult population infected with HIV (CMO's Report 1999). The first AIDS case was reported in 1984; by September 2002 a total of 1,531 cases had been reported, and 1,169 people had died of AIDS, a fatality rate of approximately 74 per cent

(AIDS Information Unit, 2002). Heterosexual transmission dominates in Barbados, with 75% of adults living with AIDS indicating that they had contracted the virus through heterosexual sex (Samiel, 2001). Since testing of blood products began in 1985, there have been no infections via blood transfusion. Mother-to-child transmission (MTCT) has also been greatly curtailed, declining from 27% in 1996 when the MTCT prevention program began, to 5% in 2002. Adults 25-49 are those mainly affected, though younger women are increasingly infected, a phenomenon attributed to age mixing – older men engaging in sex with younger women (AIDS Information Unit, 2002, 5).

Milestones in the response to HIV/AIDS are detailed in the Barbados country report. In summary the response can be characterized as immediate and fairly wide-ranging in the first six years of the epidemic, including testing of blood products, public information dissemination, establishment of an AIDS Management Team and a Counseling Clinic, an AIDS Information Centre with a hotline, a National Advisory Committee on AIDS (NACA), and an NGO AIDS Society of Barbados. The response was focused on the health aspects of the disease, with political leadership from the Ministry of Health. In 1995-6, the government adopted a policy to distribute Zidovudine (AZT) to all HIV-positive pregnant women, greatly reducing the number of children born with HIV. Also in 1995, the NACA committed itself to a multisectoral program involving other ministries of government and civil society. Barbados also participated in a number of regional and international initiatives (see Figure 6), including the formation of the Caribbean Task Force which became the Pan Caribbean Partnership in 2001 and the hosting of a regional conference on HIV/AIDS in 2000. In September 2000 an Expanded National HIV/AIDS Programme, involving multiple ministries committed additional human and financial resources. A National HIV/AIDS Commission was established in May 2001, and in July 2001 the Barbados Government obtained a US\$15.15 million World Bank loan to fight HIV/AIDS.

The HIV/AIDS Prevention and Control Project was officially launched in September 2001 as the result of the development of a National Strategic Plan: an *Action Plan for a Comprehensive Programme on the Management, Prevention and Control of HIV/AIDS 2001-2006*. The priority areas of the plan are listed in the Barbados country report; population mobility is not taken into account. Following the establishment of the National HIV/AIDS Commission (NHAC), a new National Strategic Plan for HIV/AIDS has been developed in which CSWs are defined as one of the vulnerable at-risk groups. As a result, there is now renewed interest in developing systematic programs both with male and female CSWs.

Together with the other member states of the Caribbean Community, and as set out in the 2020 Vision of Rationalized, Shared Services in the Caribbean, Barbados has committed itself to the establishment of a system that would provide universal access to quality healthcare at the national level. The Government of Barbados views healthcare as a fundamental right and aims to provide comprehensive affordable healthcare to all citizens. There are no special services for mobile populations. Services at government facilities are free of cost at the point of delivery, and public health facilities are not allowed to refuse access to anyone, Barbadian or non-Barbadian. Thus, mobile populations are guaranteed access to healthcare in any of the country's public health facilities. However, in reality, free treatment is not guaranteed. Patients are required to present their Barbadian National Identification cards and those without ID cards are required to pay for their treatment. Private health services are also available to those who can afford to pay for them.

4.2.2 Curaçao

HIV/AIDS and other sexually transmitted diseases (STIs) are an increasing problem on Curaçao. According to official government data, 1,332 HIV-infected persons were registered in the Netherlands Antilles between 1985 and 2002. HIV-infections are more prevalent on the islands of Curaçao and St. Maarten. The majority of the registered HIV-infected are between 25 and 44 years of age; 43.4% are female. From 1991-1993 AIDS was the principal cause of death for this age group. Heterosexual transmission is dominant (Lourents 2002; Curaçao Health Service 2003).

Many factors contribute to the spread of HIV/AIDS on Curaçao. The relatively favorable economic situation attracts migrants from lesser-developed islands where the HIV epidemic is well-established. The role of tourism, business travelers and migrants in the incidence of HIV infection is unclear and more research is necessary. Prostitution is considered to play a role in spreading the disease, particularly non-regulated prostitution. Though the extent of trafficking of persons on Curaçao is not clear, there is also a potential link between commercial sex workers (CSWs) and trafficking networks.

Among the general public, knowledge about HIV/AIDS is low. *Macho* mentality and “promiscuous” behavior are explicit components of the Curaçao culture, and the economic dependency of women limits their ability to negotiate safe sex. The current sexual behavior among youth – including sexual intercourse at a young age and erratic use of contraceptives – is also considered an obstacle for HIV/AIDS prevention. On Curaçao homo-, bi- and trans-sexuality are still considered taboo. However male-to-male sexual contact is believed to contribute to the spread of HIV/AIDS. Surrounded by an atmosphere of denial, stigma and secrecy, these types of relationships tend to be characterized by unprotected sex, and most likely contribute to the spread of HIV/AIDS.

In the Netherlands Antilles the central government is engaged in preparation of legislation, supervision and inspection of all public health issues, while the islands maintain a great deal of autonomy in executing their public health policy. Each island has its own Department of Medical and Public Health Services. Both levels lack a complete registration system, resulting in insufficient data on public health. The Department of Healthcare and Environmental Hygiene, together with the AIDS coordinators of the separate islands, are responsible for the development, implementation, monitoring and evaluation of all policies and activities concerning HIV/AIDS. They are severely limited by the fact that the prevention of HIV/AIDS has no political priority (Curaçao Health Services 2003). Although there are many NGOs active in HIV/AIDS in Curaçao, few consider this issue their priority. The Medical and Public Health Services Department of Curaçao has delegated some of the HIV/STI prevention activities to several of these NGOs.

The National Strategic Prevention Plan (NSP) covers the period 2003-2008. The six priority areas identified in the NSP are advocacy, research, policy development and legislation; prevention of HIV/AIDS/STIs; care and support of people infected with HIV/AIDS; prevention of HIV/AIDS/STIs among groups such as sex workers, homosexuals, prisoners and migrants; strengthening response capabilities; and institutional strengthening. Of the priority objectives, several target mobile populations. Special attention is paid to prevention programs for vulnerable groups and in the tourist sector. Support for NGOs concerned with HIV/AIDS

prevention and care for migrants is another priority area. The implementation of a baseline analysis to address issues concerning the migrant population is seen as an urgent need.

Curaçao is fully equipped to perform HIV testing (see country report for details) and testing is routine for pregnant women, hospital patients and as part of the selection procedures of certain employers. Testing is predominantly implemented without informed consent, strict confidentiality or counseling (Curaçao Health Services, NSP 2003). In Curaçao there are 158 patients receiving HAART (highly active anti-retroviral therapy). There is growing awareness among the Curaçao population that life-prolonging HIV treatment is available and covered by most insurance. All known HIV-infected pregnant women with health insurance are treated to prevent vertical transmission (Duits 2003). Due to the actions undertaken to prevent MTCT the number of new HIV infections in children has decreased considerably (Lourents 2002). Despite this, migrant women without health insurance often have no access to prenatal care.

The number of HIV-infected persons covered by private insurance is minimal, so the brunt of the cost is absorbed by social services. These institutions have already indicated that they will eventually not be able to carry these costs. Due to a high GDP, the Netherlands Antilles do not have access to low-cost ARVs as negotiated by PANCAP. The country has lobbied to be included in these programs as many of the PLWA in the Netherlands Antilles are citizens of other CARICOM states. Negotiations are now underway to include the Netherlands Antilles and Aruba (Moerkerk 2003).

4.2.3 Dominican Republic

Since the first known AIDS case in 1983, 6,830 cases have been registered in the Dominican Republic. Nearly 80% of those living with AIDS are between 15-44 years; 63.4% are men. Transmission appears to be predominately through risky sexual behavior (homo-, bi- and heterosexual) (SESPAS /DIGECITSS 2003). In 1987 the government of the Dominican Republic began to respond to the AIDS epidemic through the creation of a program through the Ministry of Health (PROCETS). In 1989 sexually transmitted disease clinics were established in state hospitals, particularly to attend to commercial sex workers. The fact that these clinics were separated from healthcare in general points to the discrimination of CSWs in the country.

The response to HIV/AIDS in the Dominican Republic has had several components, including clinical and epidemiological vigilance; blood banks and laboratories; research; vulnerable groups; and education. In 1991, universal precautions and safe blood handling techniques were introduced at laboratories and blood banks in the country, leading to a reduction in the risk associated with blood transfusions (SESPAS/DIGECITSS 2003). Beginning in 1987, the response to AIDS in the Dominican Republic began to include active NGOs and groups of people living with HIV/AIDS (PLWA), as well as organizations of vulnerable groups such as men who have sex with men and commercial sex workers. Several types of research have been conducted, including epidemiological and behavioral studies.

In 1993, the first National Strategy for AIDS Information, Education and Communication was developed. In 2000, a second version was drafted in cooperation with civil society. In 1999, a National Strategic AIDS Plan was created (PEN) which included several phases and three strategies: political; social mobilization; and prevention and care. One of the most important national organizations is the AIDS network REDOVIH, which works to promote human rights and access to treatment for PLWA in the Dominican Republic. Other local organizations exist, including a network of youth, which formed in 1997. Since 2000, the

organization COPRESIDA has worked to coordinate the AIDS response of the government, civil society, academics, patient groups and those living with the disease. This multisectoral organization is seen as the leading group in the battle against AIDS in the Dominican Republic. Mobile populations are not addressed in the national response to HIV/AIDS, and research is minimal. One of the most important local populations are those who work on sugar plantations, the “bateyes” of the Dominican Republic, many of whom are Haitian.

Funds for AIDS projects in the Dominican Republic have been supplied by the World Bank, the Clinton Foundation, as well as regional funding through the Global Fund. Other funding sources include the European Union, Canada, France, Spain and the United States. USAID has had a presence for 14 years, supporting national strategies and civil society, as well as research. UNAIDS is also an important presence, not only for financing, but for technical advice and coordination.

The National AIDS Plan has components dealing with blood banks and laboratories; information, education and communication; and epidemiological vigilance. Vertical transmission (from mother to child) of HIV is also addressed, as well as treatment of opportunistic infections and care for those living with AIDS. While vulnerable populations are considered in the national plan – including commercial sex workers – mobile populations are not explicitly addressed.

In the Dominican Republic the public health service and social insurance cover 70% of the population. The public sector offers services for those with HIV/AIDS in health centers in Santo Domingo and Santiago. In the Children’s Hospital Robert Read Cabral there is a special program for HIV-positive children. There is a network of laboratories in the country with the capacity to test for HIV.

Much of the migrant population is found in the local slums (bateyes), where access to health services is limited to that provided by NGOs. Most focus on prevention and do not identify mobile populations as an explicit target of their activities.

There are health services on the border with Haiti, where public hospitals offer prenatal services to women and assist in childbirth.

With the new social insurance law (Law 87-00), the country is working to provide universal access to healthcare through social security. The question that many in the Dominican Republic are now asking is whether these services will be available to immigrant populations, such as those from Haiti.

4.2.4 Jamaica

By mid-2002 a total of 6,038 HIV/AIDS cases had been reported in Jamaica. The Ministry of Health estimates that 12,000-15,000 people are living with HIV/AIDS in Jamaica, half unaware of their status. A total of 511 new AIDS cases were reported in Jamaica in the first half of 2002, a slight increase from the previous year. Forty-six percent of the total reported cases were women, an increase of 10% over the year before. According to reported cases, most of those who live with HIV/AIDS are between 20-39 years (Ministry of Health 2002). HIV/AIDS is the leading cause of death for adults aged 30-34 years (Gebre 2000) and the national prevalence rate is estimated at 1.5% (Ministry of Health 2002).

The main mode of transmission is heterosexual sex, driven in particular by early sexual activity, unprotected sex and multiple sexual partnerships. Adolescent girls from 10-14 years and 15-19 years have two to three times higher risk of HIV infection than boys of the same age.

This appears to be as a result of young girls having sexual relations with HIV-infected older men (Ministry of Health 2002).

Children are also affected by HIV/AIDS in Jamaica. Eight percent of reported AIDS cases are children under ten (Gebre 2000). In 1999 HIV/AIDS was the second leading cause of death in children aged 1-4 years. An estimated four HIV-infected children are born weekly in Jamaica. (Ministry of Health 2002)

At a recent conference held by the United Nations Development Programme (UNDP) in Jamaica, stigma was identified as a serious problem (Observer, 19 March 2003). One of the most “insidious” factors in the spread of HIV/AIDS in the Caribbean is “the continued, wide-spread stigmatization of the disease, its perceived association with homosexuality – a topic of taboo and discrimination in much of the Caribbean – and its association with sexual activity” (Wolfe 2002, 10). Stigma and discrimination of those who live with HIV/AIDS is linked closely to prejudice against homosexuals in Jamaica. Homosexuality is punishable by law (UNAIDS 2003c). As in other parts of the world, this has forced homosexual relations underground, leading to unsafe behaviors. One out of fifteen men with AIDS reported having had sex with both men and women (Ministry of Health 2002).

The AIDS response in Jamaica falls under the National AIDS Programme (NAP) in collaboration with focal points from governmental and non-governmental organizations and the National Planning Council (NPC) of the Government of Jamaica (Ministry of Health 2002). The National AIDS Committee (NAC), an NGO with more than 100 member organizations, was established in Jamaica in 1988 (NAC online). NAC reports to the National Planning Council and Cabinet. A National Strategic Plan 2002-2006 was completed and endorsed by the Parliament as a follow-up to the previous 1997-2001 Medium Term Plan. Though links with the tourism industry are mentioned, the plan does not address mobile populations or migrants in general. Further, there is no strategy for injecting drug users (IDU) or men-who-have-sex-with-men (MSM). According to UNAIDS, a National Plan of Action for Orphans and Vulnerable Children has been prepared (UNAIDS 2003c).

In Jamaica, two out of three people living with HIV/AIDS seek medical care at a late stage of the disease, and the case fatality rate for reported cases is 61.6% (Ministry of Health 2002). The Pan American Health Organization has estimated that in Jamaica less than 5% of those who need ARV therapy have access (PAHO online). Access to treatment with life-extending ARVs in Jamaica is “is limited primarily to those who can afford to pay . . . The CD4 counts are performed once a year and are met through out-of-pocket expenses” (Brohim 2003, 5-6). According to UNAIDS, 45% of HIV+ pregnant women receive a complete course of ARVs to reduce mother-to-child transmission (UNAIDS 2003c).

4.2.5 Trinidad and Tobago

The first AIDS case in Trinidad and Tobago was reported in 1983; by 2003 nearly 11,000 had been diagnosed with HIV/AIDS. The percentage of women infected has increased to 37% in 2000. The high female-to-male ratio of infections among the younger age group seems to suggest that younger girls may be having relations with older men. Higher HIV/AIDS prevalence rates are also recorded among groups such as men who have sex with men (MSM), commercial sex workers (CSWs), and injecting drug users (Bartholomew 1987).

An analysis of the response to HIV/AIDS in Trinidad and Tobago was conducted in 2001 which identified factors behind the epidemic including multiple partnering; abuse of alcohol,

drugs and other illegal substances; violence against women and between men; inconsistent use of condoms; gender inequalities; regional and extra-regional migration; an environment in which homosexuality remains illegal; early initiation in sexual practices; and commercial sex work related to tourism (University of West Indies 2001). The Ministry of Health responded to the epidemic in the 1980s and 1990s. In 1987, the Cabinet of Trinidad and Tobago created the *National AIDS Committee* (NAC), which is composed mainly of health experts and is responsible for policy formulation, program monitoring and evaluation.

The delivery of HIV/AIDS services has been fragmented. Vertical services are provided as part of the response of the Ministry of Health through locations such as the Queen's Park Counseling Center and Clinic and public health laboratories. Activities include surveillance, laboratory services, screening, counseling and care, but continue to be plagued by a lack of resources. Co-existing is the decentralized response of the Regional Health Authorities (RHAs) which provide services at health centers and hospitals. The Regional Health Authorities have responded only through the treatment of opportunistic infections.

A number of regional and international agencies have also responded to the epidemic. The Caribbean Epidemiology Center (CAREC) led the response from the very early stages of the epidemic, with the other organizations joining the fight within the last few years. A critical output has been the convening of a UNAIDS theme group, a structure that facilitates the UN's response to the epidemic in Trinidad and Tobago. This group also includes other stakeholders actively involved in the area of HIV/AIDS. NGO response can be classified by those organizations dealing specifically with HIV and those whose interventions contribute indirectly towards reducing the impact of the epidemic (more details in the country report, available upon request).

Trinidad and Tobago's National Strategic Plan for HIV/AIDS was completed in 2002 after several National Stakeholders Consultations. Five broad strategic areas were identified including prevention; treatment, care and support; advocacy and human rights; surveillance and research; program management, coordination and evaluation. The five priority areas are also to be implemented under a new expanded organizational structure called the National AIDS Coordinating Commission (NACC). This structure is to be housed under the Office of the Prime Minister and is not yet fully operationalized. Population mobility is not addressed explicitly in the National Strategic Plan. However, factors that increase vulnerability of mobile groups are mentioned and some identified high-risk groups are mobile populations.

At present, Trinidad and Tobago is implementing a health sector reform program. As part of this initiative, a shift is planned from reliance on secondary level services (hospital care) to primary level community services, with a particular focus on management of chronic diseases. Inadequate capacity of the public health system to deal with HIV/AIDS is one of the leading factors fuelling the epidemic in Trinidad and Tobago. Among the key issues are lack of access to appropriate care and treatment; lack of appropriate standards for care, treatment and support of PLWA; and lack of integration of HIV/AIDS/STI services with other programs.

Mobile populations can access basic services provided for the national population. HIV/AIDS patients who require hospitalization are admitted to the general medical ward, several of which have a few beds designated for HIV/AIDS patients. The results of tests requested for patients who present with suspected HIV/AIDS-related diseases take between 2-8 weeks. Consequently, many clinical decisions are made in the absence of this information. In an environment that still discriminates against PLWA, persons are presenting to healthcare facilities in advanced stages of the disease. As a result, the survival time of persons who have tested HIV-

positive at healthcare facilities is significantly shorter than in other countries. External migrants have been known to access healthcare at public facilities for opportunistic infections, but cannot access treatment unless a formal arrangement has been made to this end.

4.3 Sex workers in selected countries

The following section provides a brief overview of commercial sex workers, mobility, and HIV/AIDS in the countries included in the Baseline Assessment. In addition to the research conducted by each national researcher, surveys were carried out with a small group of CSWs in the Dominican Republic and Curaçao. Survey results are included in the respective country sections below.

Figure 10: Sex Workers in Selected Countries

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

In general, sex workers appear to be extremely mobile, coming from a variety of source countries. Most appear to come from within the region, though Colombia and Venezuela are repeatedly mentioned. In some cases, the migration of CSWs appears to reflect general migration and mobility patterns previously discussed, but in general, more source countries can be identified for CSWs than for the general population. It is also important to note that many of the CSWs appear to enter as tourists. Settings for CSW varied from escort services and highly organized settings (such as the state-run camp in Curaçao) to group apartments. Most researchers identified the important links between tourism and CSW; the crew of ships in the local port were also mentioned. For the countries included in the small survey, it is interesting to note that the interviewees had often worked in other parts of the region and beyond, demonstrating the mobility of the target group. In all countries prostitution is illegal, but in Curaçao the state manages a camp of foreign sex workers (see summary below). As CSWs sometimes entered as tourists and overstayed their visas, CSWs were often targeted by police and immigration officials as irregular immigrants. Researchers noted human rights violations and lack of access to healthcare due to irregular status. Mandatory HIV testing was a concern in at least one country and trafficking of persons for sexual exploitation was raised as a serious concern in several of the country studies. See Figure 10 and the country sections for more information.

4.3.1 Barbados

Though very little research exists on commercial sex work in Barbados, personal conversations and observation suggest that the non-Barbadian CSWs are extremely mobile, moving between and within countries. It is known that members of the crews of cruise ships frequent the bars and clubs of Bridgetown to utilize the services of female CSWs. The number of CSWs on the island varies depending on the time of year, increasing during holidays and festivals. Very little information is available on their duration of stay or the nature of their movements, but immigration rules would suggest that most stay less than one month in order to take advantage of the 28-day visa. Commercial sex work is illegal in Barbados and some club-based female CSWs are foreigners who have overstayed their visitor visas, thus occasioning police and immigration raids. No studies exist which could indicate whether smuggling or trafficking is taking place, or give other insight into the type of migration patterns associated with CSW on the island.

According to existing information, CSWs working out of clubs are primarily from Trinidad, Guyana, St. Vincent and St. Lucia while women working the streets are mainly Barbadians but also include women from Guyana, St. Vincent and the Grenadines, St. Lucia and Grenada. Personal communication also suggests the presence of CSWs from Haiti, Belize, Dominican Republic and Antigua and Barbuda. Most are between the ages of 20 and 40 years. Clients include local men, the crews of ships berthed in the Barbadian port, as well as tourists.

In addition to the female commercial sex workers, there exists a male CSW trade comprised of Barbadian males (“beach boys”) whose clients are foreign females (mainly tourists). While police and immigration authorities clearly target female CSWs, the level of harassment of male sex workers is much lower, perhaps because beach boys are not perceived, nor do they perceive themselves, as prostitutes, though they receive material compensation for the social or sexual services they render to women. Young Barbadian men, between the ages of

eighteen to thirty-five, “hustle” female tourists of varying ages, in exchange for economic goods and services, which range from brand name clothes to airline tickets (Phillips, p183-84).

The link between tourism, sex work and the epidemic appears to be recognized, together with the need to protect an industry that is one of the lynchpins of the economy of Barbados, while at the same time protecting the people of Barbados from any associated risks. In October 1997, the Ministry of Health began to implement the project “STI/HIV Prevention among Club-based Female Sex Workers” in collaboration with the AIDS Society of Barbados (ASOB). This project made some progress in establishing contact with the CSWs and the managers of bars and clubs in the Nelson Street area of Bridgetown, but came to an abrupt end as the result of raids by the immigration authorities. Eighteen women were taken into custody by immigration officials.

On the initiative of the National Advisory Commission on AIDS (NACA), an exploratory study of beach boys in Barbados was conducted in 1997. It was found that these men engage mainly in transactional sex, and that the use of condoms among them was low. The researcher also found that, although they had very little knowledge of HIV/AIDS, there was a desire to be educated about it (Moseley 1997, 6). Following this study, the Ministry of Health and Education and the National AIDS Program prepared a project with a peer-based approach. An initial feasibility assessment, however, revealed that most participants felt such a project would not be successful and could name no one willing to work as a peer educator (Marshall and Moseley 1999).

In 2002, the Ministry of Health and Education, together with the Ministry of Tourism and the National HIV/AIDS Commission, began a project entitled “STI/HIV Prevention among Male and Female Sex Workers in Barbados.” Its aim is to reduce the incidence and prevalence of STIs and HIV/AIDS among CSWs, both male and female. The project is underway, beginning with the mapping of CSWs and their clients, in order to identify the scope of activities. Some of the targeted CSWs are mobile.

4.3.2 Curaçao

In the Netherlands Antilles, incitation to prostitution is illegal (Article 259 Criminal Code), but prostitution is not. The government has designated an official zone where prostitution is allowed, known as Campo Alegre, where only non-Antillean women are allowed to work (Contrasida, Dos Mundos 2003). Women working at Campo Alegre receive three-month work permits as “employees of Hotel Mirage.” In other clubs where prostitution occurs, women receive permits as dancers, which are not registered in the Netherlands Antilles Aliens Registration System (NAVAS). The reason for this is not clear but suggests the government’s reluctance to admit that prostitution takes place in these clubs. A direct result of non-registration is that the government is unable to tell how many women on Curaçao are employed as “dancers” annually (Contrasida; Dos Mundos).

In 2002 the government approved 1,246 three-month work permits for Campo Alegre for women from the Dominican Republic, Colombia and Venezuela. Women are required to present proof of their HIV status when they arrive and are re-tested in a clinic operated by the Medical and Public Health Services Department. Those found positive for HIV or Hepatitis lose their contracts, their files are turned over to the police department, and they are deported if they remain on the island. Women who fear they may be infected will thus avoid Campo Alegre.

CSWs working in non-regulated prostitution tend to come from the same source countries, Dominican Republic, Colombia, Venezuela, and to a lesser extent, Brazil (Faas L &

Frank Francisca 2000). On a yearly basis 6,000 women are active in non-regulated prostitution in Curaçao. Clandestine prostitution sites include brothels and hotels, snack bars, bars, dance/strip clubs, apartments rented by groups of CSWs, ships in dry-dock, and parking lots. There is also small group of about 20 male CSWs (Contrasida 2003). Most CSWs enter Curaçao as tourists. Tourists are allowed to stay for two weeks. Women from countries where an entry visa is required (Dominican Republic and Colombia) often overstay, even at the risk of deportation. Approximately one third of the Campo Alegre sex workers leave before their work permit expires. An estimated 12% begin working in non-regulated prostitution (Faas and Francisca 2000). Reasons for migrating to Curaçao for sex work seem to be based on financial need. CSWs from the Dominican Republic are often young heads-of-household supporting several children. Colombian women cite the civil war and the loss of male providers as a factor. Other reasons include tuition fees and emergency medical bills for family members. In 2000, proceeds from clandestine prostitution were estimated to be at least US\$ 9 million or US\$ 1,600 per CSW. More than 50% of these proceeds are remitted to families (Contrasida 2002).

The overriding atmosphere of is one of verbal and physical abuse. Due to their irregular status and fear of deportation, most women are not willing to press charges against their assailants (Faas and Francisca 2000). Despite the risks, most women prefer to work outside Campo Alegre. All women who work in the camp are listed with the police department, which monitors their whereabouts. Room and board is also very expensive in Campo Alegre, an average of US\$ 42 per day compared to US\$ 8 in other settings, while earnings are about the same (US\$ 27). Women are not allowed to leave between 6.00 PM and 6.00 AM, which many experience as semi-incarceration (Faas and Francisca 2000).

Trafficking of persons is a serious concern on Curaçao. The Netherlands Antilles has been openly accused of trafficking. This happened for the first time in 1997 by the Social Economic Counsel of the United Nations in the context of a report that implicitly referred to the conditions under which women arrived at Campo Alegre (UNESCO Human Rights Commission 1997). In un-regulated prostitution trafficking of women is thought to be the rule rather than the exception. It is estimated that each year 3000 women are trafficked to Curaçao, 50% of all women working in non-regulated prostitution. Women in this situation arrive with high debts: sex traders/ intermediaries pay for transport, passport, ticket, start-up money, and return deposit. As security for the debt, the sex trader/ intermediary usually require the women to hand over their passports and/or tickets, creating a situation known as sex slavery (Faas in Francisca 2000). Women who are indebted are also more likely to practice better-paid, unsafe sex, increasing their vulnerability to HIV infection. Trafficking of women is a criminal act according to Article 260 of the Netherlands Antilles' Criminal Code. Despite this provision, there has yet to be a successful prosecution of a trafficker on Curaçao. In 1996 five Colombian women took their employer to court on grounds of coercion. They were recruited in Colombia by a female intermediary to go to Curaçao to work as waitresses in the hotel industry. The women declared in court that they were misled and ended up working in a nightclub, having to provide sexual services to clients against their will. They won the case (Interview Franken 2003).

According to interviews conducted by the national research, there are indications that trafficking of children also takes place on Curaçao (Interview Franken 2003). Apparently, one can approach certain brothel owners to "order a child." This child, usually an 8 to 12 year old girl from the Dominican Republic, is then flown to Curaçao, and handed over to a client. This appears to happen with the full cooperation of the family. After one week the girl is returned to the brothel owner and flown back to the Dominican Republic. Considerable amounts of money

are involved, an average of US\$ 2200 per child. To cover the costs, sexual acts with the child are put on video and sold with profit on the black market. Trafficking of children to Curaçao takes place when the clients are known to have more income, around Christmas and Carnival (Interview Franken 2003).

There have also been reports of women who marry Antilleans and are then forced to live under servitude conditions (Franken 2003). The general amnesty seems to have worsened this situation, as 15% of all general amnesty applicants lacked a steady job or income (Curaçao Police Department 2003). Most were women whose partner signed the letter of guarantee obliging him to financially provide for her, often resulting in dependency and abuse. Indeed, the Bureau of Women Affairs registered a rise in cases of emotional and physical abuse against migrant women since the declaration of the general amnesty (Bureau Vrouwezaken Curaçao 2003).

Coercion and abuse against labor migrants has also been documented on Curaçao. Immigrants from India, Indonesia and Bangladesh who were hired as temporary laborers for the building of the new electricity plant found working and living conditions to be very different from what was promised. They were given no days off, and received only one meal a day. Wages were not paid in time and less than agreed upon; the costs of the plane ticket were deducted from their salaries. A Curaçao citizen helped more than 300 of these laborers take their case to court, where they won their case (Interview Franken 2003).

Survey Results

A total of 25 commercial sex workers were surveyed in Curaçao, from five different prostitution settings (none worked at Campo Alegre). The results generally reflect the literature as described above. Figure 11 provides a summary of the survey findings.

Most CSWs were women between 20-39 years of age and came from Colombia and the Dominican Republic. CSWs from the Dominican Republic were younger than those from Colombia. Most interviewees had some secondary education (76%), and 16% had attended university or vocational training. Most interviewees were responsible for large families; more than half had 3-5 people benefiting from their earnings, and 24% supported 6-8 dependents. The surveyed CSWs tended to travel once a year to Curaçao for sex work, staying for several months at a time. A full 80% indicated that someone encouraged them to come, and 60% had help with travel and work arrangements. Of these, 50% felt that they had been trafficked; all were female CSWs and all suffered from abuse, extortion, and physical threats by the trafficker/intermediary. None have dared to press charges out of fear of deportation. One quarter of the CSWs surveyed had also worked in Europe; other countries mentioned were Venezuela, Panama, and Aruba. Most frequent destinations in Europe were the Netherlands, Germany, Italy and Spain. Only 64% of interviewees were comfortable stating that they are sex workers. Male CSWs in particular were unwilling to characterize themselves as sex workers and denied sexual activity. Only through conversations during the informal lunch was it confirmed that they indeed do sell sex to Antillean women and mature Dutch female tourists. Some mentioned male clients.⁹

All CSWs had heard of AIDS, and 72% personally knew someone who had died of AIDS. Interviewees had heard about HIV/AIDS through leaflets or brochures (80%) or through

⁹ Due to recent raids by the immigration authorities of Curaçao targeting foreign sex workers, the researcher arranged to hold an informal gathering for male sex workers in order to have a safe setting in which to follow-up the questionnaires. A local HIV/AIDS NGO offered free medical exams in addition to the snacks that were available.

workshops (68%). All were aware that HIV can be transmitted through sexual contact without a condom, though 20% still think HIV can be transmitted by a toilet seat and 12% by sharing a cup. Three-quarters of the CSWs surveyed indicated a “good chance” that they themselves might be infected, though nearly all had made changes in their sexual behavior to avoid infection, and most had been tested for HIV.

Figure 11: Survey Results – Sex Workers on Curaçao

N=25

Source countries	Colombia Dominican Republic
Age	< 20 (4%) 20-29 (44%) 30-39 (44%) 40+ (8%)
Sex	Female (80%) Male (20%)
Education	Some primary school (8%) Some secondary school (76%) Some vocational / university (16%)
Average visits per year	1 (80%) 2-4 (16%) 8+ (4%)
Average length of stay	3-4 months (12%) 7 months + (8%)
Have also worked in:	Aruba Europe Panama Venezuela
Number of dependents	0-2 (12%) 3-5 (52%) 6-8 (24%) 9+ (12%)
Has heard of AIDS	100%
Knew someone who died of AIDS	72%
How can you get AIDS?	Drinking from the same cup (12%) Using same toilet (20%) Having sex without a condom (100%)
Someone can be infected and look healthy	Yes (84%)
AIDS can be treated	Yes (96%)
Have ever used a condom	100%
Number of partners during past month	1-10 (60%) 11-20 (28%) 21-30 (4%) 41+ (8%)
Usually uses a condom with sexual partners	Always (76%) Almost always (12%) Sometimes (8%) Never (4%)
Reason for not always using a condom	Only have 1 partner (4%) My partner doesn't want to use condoms (4%)
Condoms prevent HIV/AIDS if	They are not damaged (100%) You use them only once (100%) They are not older than the expiration date (100%)
Has had an HIV test	68%
Volunteered to take the test	52%
Concerns	Mandatory HIV testing High knowledge but low condom use Trafficking

Nearly all indicated protecting themselves by using a condom (96%), though a significant group indicated they had unprotected sex with one person who is faithful. More than half indicated 1-10 sexual partners during the past month; almost a third noted 11-20; 8% indicated 41 or more. Though all stated they had used condoms in the past, only 8% indicated they used a condom the last time they had sex.

All CSWs are of the opinion that PLWA are normal people who merit love and care and 92% thought that they should be allowed to work. Sixty-eight percent of all CSWs stated to have undergone testing for HIV antibodies and 94% were informed about the results. Seventy-six percent underwent HIV antibody testing on a voluntary basis; 24% stated that in their case HIV antibody testing was mandatory in the context of a job application.

4.3.3 Dominican Republic

Very little is known about commercial sex workers in the Dominican Republic. Newspapers contain information on young European and Dominican “escorts” (Marte Perez, 2002) and some cases of sexual exploitation of foreign girls have been reported (Pesquiera, 2001). There are no known studies of migrant commercial sex workers in the Dominican Republic, though there is evidence of foreign sex workers in the country. Smuggling networks have been found for other types of migrant workers, particularly Haitians (Silie 1999). Haitian immigrants in the Dominican Republic suffer racial discrimination, are often extremely poor, and usually do not speak Spanish well. These factors contribute to a marginalized position within the country. Many women are reportedly raped when attempting to cross the border. Their names are not listed among the official immigrants, and they are denied shelter. Many turn to commercial sex work in order to survive (Pantelon 2000). Another risk factor is the tendency for commercial sex to be linked to trafficking and smuggling of persons. Very little data exists, but studies have identified trafficking networks of Haitian children (Tejeda 2002). It is probable that some of these children are forced into the sex industry in the Dominican Republic.

Survey results

A total of 20 commercial sex workers were surveyed in the Dominican Republic. All commercial sex workers interviewed were Haitian, the largest immigrant group in the Dominican Republic. Figure 12 provides a summary of the survey findings.

All commercial sex workers interviewed were quite young. Most were younger than 30. Slightly more than half (60%) had attended some secondary school while 5% could not read or write. As in other countries under study, most interviewees supported dependents. Sixty percent had 0-3 people benefiting from their salaries; 40% had 3-5 dependents. Only slightly more than half (55%) recognized themselves as sex workers, though this may have been related to fears of police action. None of the male CSWs interviewed considered themselves to be sex workers.

The CSWs interviewed had varying levels of mobility. Ten percent were highly mobile, traveling between Haiti and the Dominican Republic twice weekly, and 30% made an average of 8 or more trips to the Dominican Republic annually. Ten percent had become firmly established in the Dominican Republic and did not travel. Thirty-five percent of those interviewed were in the Dominican Republic for the first time. Forty percent were returning. Only three respondents had worked in other countries (Puerto Rico, Panama and the Bahamas). The length of stay

varied widely. Some interviewees stayed only days in the Dominican Republic (20%) while other stayed nearly half a year (15%).

Figure 12: Survey Results – Sex Workers in Dominican Republic

N=20

Source countries	Haiti*
Age	< 20 (20%) 20-29 (60%) 30-39 (20%)
Sex	Female (75%) Male (25%)
Education	Illiterate (5%) Some primary school (35%) Some secondary school (60%)
Average visits per year	1 (40%) 2-4 (25%) 8+ (30%)
Average length of stay	Days (20%) 1-2 months (10%) 3-4 months (5%) 5-6 months (15%) 7 months + (10%)
Have also worked in:	Bahamas Panama Puerto Rico
Number of dependents	0-2 (60%) 3-5 (40%)
Have heard of AIDS	95%
Knew someone who died of AIDS	60%
How can you get AIDS?	Drinking from the same cup (15%) Using same toilet (20%) Having sex without a condom (75%) Touching someone's hand (10%)
Someone can be infected and look healthy	Yes (65%)
AIDS can be treated	Yes (5%)
Have ever used a condom	85%
Number of partners during past month	1-10 (45%) "don't remember" (40%)
Usually uses a condom with sexual partners	Always (55%) Almost always (20%) Sometimes (10%)
Reason for not always using a condom	Only have 1 partner (20%) Only have sex with people who look okay (10%) I am okay (20%) Don't know how to use condoms (5%) Condoms make sex less enjoyable (5%)
Condoms prevent HIV/AIDS if	They are not damaged (90%) You use them only once (90%) They are not older than the expiration date (80%) You use them more than once (35%) You put them on halfway (30%)
Has had an HIV test	55%
Volunteered to take the test	50%
Concerns	Young group Low level of knowledge about HIV transmission and prevention Low condom use Extremely low awareness of treatment Trafficking Stigma/discrimination of PLWA

*Only Haitians were surveyed

Almost all of the respondents had heard of HIV/AIDS, and 60% had personally known someone who died of AIDS. Respondents had heard about AIDS in various ways, including on the radio and television (89%), posters (63%), and by word of mouth. Female sex workers had heard more about HIV/AIDS and had a slightly higher level of knowledge. Significantly, 74% of all CSWs interviewed believe that AIDS *cannot* be treated. Only 5% stated that it could (interestingly, all were male CSWs).

Despite fairly high awareness of the existence of HIV/AIDS, knowledge about transmission and prevention was mixed. Seventy-nine percent believe AIDS can be passed from person to person. All respondents knew that unprotected sex puts one at risk for HIV infection. Fifteen percent stated that drinking from the same glass could put one at risk, and ten percent believed touching someone's hand could transmit AIDS. Twenty percent believed that using the same toilet could transmit AIDS.

Only 55% stated they always use a condom, though 85% had used a condom at least once. A full 30% stated that a condom works if on halfway and 35% stated condoms can be used repeatedly. Many stated that having sex with only one person is a good way to prevent HIV infection, though 45% percent had had 1-10 partners in the past month.

Most respondents recognized common high-risk groups including drug users, sex workers and men who have sex with men. Slightly more than half believed they were at moderate risk to contract HIV. Eighty-nine percent stated they had made changes to their sexual behavior to prevent infection. Sixteen percent stated that someone who is cursed is likely to have HIV/AIDS. A significant number of respondents (40%) believed that those who live with HIV/AIDS are not good people, should not be allowed to work, and may be cursed or witches ("brujos"). Only 55% stated that people with AIDS are like other people.

Slightly more than half those interviewed had been tested for HIV. Of those, eighty-two percent knew their results and 91% were tested voluntarily. Many of those interviewed made arrangements to work through a third party.

4.3.4 Jamaica

The Jamaica Ministry of Health estimates that 19.4% of all HIV/AIDS cases involve commercial sex workers or their clients (2002, 10). Prevalence rates are over 9% in commercial sex workers (CSWs) (Gebre 2000) and some studies estimate as high as 20% (Ministry of Health 2002, 7). In Jamaica, foreign sex workers appear to come from the Dominican Republic, China, Cuba, Russia and Venezuela. Commercial sex workers come into contact with clients in a variety of ways, including gaming rooms at hotels, nightclubs and bars. The growing tourist sector and poor economic conditions in Jamaica have facilitated both male and female sex work. Commercial sex work related to tourism often involves internal migration to coincide with the season (Campbell, Perkins and Mohammed 2001, 125, 149-150.) Of particular concern are high numbers of children who appear to be involved in sexual exploitation related to tourism (Bureau of Women's Affairs, 2004). Though little information is available, some scholars point to links between commercial sex work and trafficking of persons in Jamaica, including the internal trafficking of minors for sexual exploitation (Bureau of Women's Affairs 2004).

4.3.5 Trinidad and Tobago

Prostitution is illegal in Trinidad and Tobago and few studies exist of commercial sex workers and HIV/AIDS. Foreign sex workers seem to operate as highly paid CSWs serving a very elite clientele. This made accessing these migrants extremely difficult. Key informant interviews were however conducted with researchers who have worked with this group in the past, as well as with a now retired CSW and manager of her own escort service.

Commercial sex work in Trinidad and Tobago is facilitated in a variety of ways, from street “hustlers” to well-organized networks that include hotels, nightclubs, fashion houses and escort services. There has been a recent increase in the popularity of the more organized type of arrangement, where there is reported to be a significant foreign clientele, including Taiwanese, European and North American hotel guests and “yachties.” A study has recently been completed by UNAIDS and the Caribbean Association for Feminist Research and Action (CAFRA) and includes the mapping of the activities of CSWs together with qualitative research interventions. CAREC has also done some work on CSWs in relation to HIV, in large part concentrated in other countries in the region.

The migratory patterns of CSWs in the Trinidad and Tobago context must be assessed in terms of internal and external migratory patterns. With respect to the former, the movement is inter-island, towards urban centers and away from rural areas. The local CSWs are in areas such as the Capital city, Port of Spain, San Fernando, Chaguanas, Arima and Curepe. The areas immediately surrounding the booming petrochemical sites such as the Point Lisas Industrial Estate have also been identified as areas where a high level of CSW activity is likely to take place.

Commercial sex workers appear to be very mobile. The local CSWs tend to be mobile within the country, while the foreign CSWs are often engaged in intra-regional and extra-regional travel. Foreign CSWs come from Venezuela, Columbia and Cuba. Some commute between their homes and Trinidad regularly, and some are students or tourists who became involved in the business to augment their income. There is significant movement between Suriname, Guyana and Trinidad. A recent study conducted by CAREC estimated that 16% of commercial sex workers in Guyana also plied their trade in Trinidad (CAREC, 2000). Despite tending to be more restrictive in their movement, local CSWs are also known to travel to other islands such as Barbados, Grenada and Guyana.

4.4 Petty traders in selected countries

The following section provides a brief overview of petty traders, mobility, and HIV/AIDS in the countries included in the Baseline Assessment.¹⁰ In addition to the research conducted by each national researcher, surveys were carried out with a small group of petty traders in Barbados, Curaçao, the Dominican Republic and Trinidad and Tobago. Survey results are included in the respective country sections below.

In general, petty traders are extremely mobile, traveling often with stays of short duration. In Curaçao, petty traders average four visits per year, staying an average of two weeks. In the other countries under study, traders entered more frequently, sometimes more than once a week, staying only days at a time. Several researchers noted that petty traders often enter as

¹⁰ Information on Jamaica is not included as no surveys were conducted and no research on petty traders in Jamaica is known to exist.

tourists. Most come from the region; source countries mirror the general migration patterns for the countries under study. Settings for petty trading ranged from economic zones in Curaçao to the border between Haiti and the Dominican Republic. Most traders move their goods by boat, with the exception of those from Guyana, which tend to use air. Traded goods included fruits and vegetables, clothing and textiles, spices and jewelry. In Curaçao, national researchers also noted “suitcase trading” of medicines, condoms and lingerie in the context of commercial sex work. This did not appear to be a trend across the countries under study. In general, petty traders had one sexual partner and some knowledge about HIV/AIDS transmission and prevention. Mandatory HIV testing was a concern in several countries. Interestingly, petty traders in some countries had extremely low knowledge about the existence of HIV/AIDS treatment (traders in the Dominican Republic) while in other countries most petty traders knew that AIDS can be treated (Barbados). Clearly access to treatment ranges greatly across the countries under study. Trafficking in persons did not appear to be a concern for this target group, with the exception of two women from the Dominican Republic on Curaçao. Please see Figure 13 and the country sections below for a summary of this information. Full country reports are available upon request.

Figure 13: Petty Traders in Selected Countries

	Barbados	Curaçao	Dominican Republic	Trinidad and Tobago
Source Countries	Guyana St. Lucia St. Vincent and the Grenadines Trinidad and Tobago	Colombia (CSWs) Dominican Republic Haiti Jamaica Trinidad and Tobago	Haiti	Grenada Guyana St. Vincent
Settings		E-zone, street markets, cruise ships	Along border with Haiti	
Goods traded	Fruit and vegetables Personal and consumer goods Seafood (Guyana) Jewelry (Guyana)	Textiles Liquor Footwear Spices Food Lingerie (CSWs) Condoms (CSWs) Medication (CSWs)		Food Clothing
Migration	Circular, frequent and of short duration (often one day)	Average four visits per year Usually enter as tourists (stay less than two weeks)	Frequent (even several times a week)	Stay rarely exceeds three days Trips back and forth as frequently as weekly
Concerns	Some misinformation about transmission and prevention	Mandatory HIV testing Trafficking (not a generalized problem – DR)	Some misinformation about HIV/AIDS transmission and prevention Extremely low knowledge of AIDS treatment	Some misinformation about HIV/AIDS transmission and prevention\ Mandatory HIV testing

4.4.1 Barbados

There is little data on the trading done by petty traders in Barbados, particularly as it is small (both in volume and value) and is considered informal, despite its importance to the countries of origin and the livelihoods of the traders. There are no known studies of petty trading and HIV/AIDS in Barbados. The movement of petty traders into Barbados appears to mirror the main streams of long-term migrants, coming mainly from St. Lucia, St. Vincent and the Grenadines, Guyana, and to a lesser extent from Trinidad and Tobago. Petty trade movements are determined not only by the immigration policies of Barbados, but also by the nature of the goods being traded and demand in Barbados. Movement is circular, frequent (often weekly) and of short duration (sometimes as short as one day). Traditionally, traders have accompanied their goods on the boats, but for the past twenty or thirty years, traders have been shipping their goods by boat, but traveling by LIAT, the Eastern Caribbean airline. Traders from Guyana have always depended on air transport.

The international vendors in Barbados are mainly female and are of varying socio-economic status. Traded goods include fruit and vegetables and, increasingly, personal and consumer goods. Traditionally, petty traders – also called “hucksters” in Dominica and “traffickers” and “speculators” in St. Vincent – buy produce from farmers in their home countries and transport these goods on small vessels. Petty traders from Guyana have goods such as seafood, mainly shrimp, and jewelry made of Guyanese gold, in addition to fruits and vegetables.

In Bridgetown, there is a dedicated section of the port called the “Shallow Draft” that is used by small vessels. At present, petty traders depend mainly on two boats that make weekly trips between the islands. The goods traded and the volume transported are included in the manifests that are deposited with the Customs Department at the Shallow Draft, but apparently are not officially recorded or reflected in the trading statistics of Barbados. Imported goods include bananas, plantains, ginger, coconuts, mangoes, citrus, avocado pears, plums, mammi apples, and ground provisions like yams, eddoes, dasheen and tannias.

Associations appear to be important to petty traders in the region. The trade used to include the traffickers of St. Vincent and the hucksters of Dominica, many of whom were members of viable and dynamic associations that are recognized and valued by the governments of their countries, associations like the Dominica Hucksters Association of Dominica and the Traffickers Small Business Association of St. Vincent. Petty traders interviewed suggested that the Vincentian association is more or less defunct. In contrast, the Dominican association is still vibrant, but its members no longer travel to Barbados, only to the neighboring French islands, though they do still ship produce to Barbados. In an effort to keep importation costs to a minimum, some traders have banded together. One example is the Caribbean Banana Importers, a group of five traders (two St. Lucians and three Barbadians) who import bananas from St. Lucia to Barbados. The Guyanese movement is by air rather than by sea, and import is individual rather than communal; there does not seem to be an association of Guyanese importers.

Survey results

The petty traders interviewed in Barbados made a distinction between vendors – who primarily sell goods in small stalls – and speculators (St. Vincent) or exporters (St. Lucia and Guyana) who

sell most of their goods to others, though they themselves may sell some of the goods from stalls. Please Figure 14 for a summary of the survey findings.

Figure 14: Survey Results – Petty Traders on Barbados

N=20

Source countries	Guyana St. Lucia St. Vincent and the Grenadines
Age	30-39 (30%) 40+ (70%)
Education	Some primary school (25%) Some secondary school (50%) Some university/vocational (25%)
Average visits per year	1-9 (25%) 10-19 (15%) 20-29 (20%) 40+ (20%)
Average length of stay	<1 week (35%) 1-3 weeks (15%) 1-2 months (15%) 2-4 months (10%)
Have also worked in:	Trinidad Antigua, Dominica, Grenada, St. Vincent (1 resp.)
Number of dependents	0-2 (55%) 3-5 (20%) 6-8 (15%) 9+ (10%)
Have heard of AIDS	100%
Knew someone who died of AIDS	40%
How can you get AIDS?	Drinking from the same cup (5%) Using same toilet (10%) Having sex without a condom (95%) Touching someone's hand (10%)
Someone can be infected and look healthy	Yes (90%)
AIDS can be treated	Yes (90%)
Have ever used a condom	60%
Number of partners during past month	0 (55%) 1 (45%)
Usually uses a condom with sexual partners	Always (5%) Sometimes (10%) Never (30%)
Reason for not always using a condom	Don't have sex (20%) Only have 1 partner (50%) Condoms make sex less enjoyable (10%) My partner doesn't want to use condoms (10%)
Condoms prevent HIV/AIDS if	They are not damaged (85%) You use them only once (80%) They are not older than the expiration date (55%) You use them more than once (15%) You put them on halfway (5%)
Has had an HIV test	25%
Volunteered to take the test	20%
Concerns	Some misinformation about transmission and prevention

The petty traders who were interviewed reflect the source countries mentioned above, Guyana, St. Lucia and St. Vincent and the Grenadines. This petty trader group is a mature one: the majority (70%) are 40 years or more. This maturity is reflected in their marital status: only

40% were single while the others were either married (40%), in common law relationships (10%), or divorced (10%). In terms of education, those interviewed were reasonably well educated: half had some secondary school, and one quarter had attended vocational training or university studies. Slightly more than half the interviewed petty traders had three or more dependents. Ten percent stated they supported nine or more people. The transnational nature of the movement is seen in two respondents who had dependents both in Barbados and in the country of origin.

Most of those interviewed had been trading with Barbados for some time, from 9-33 years. More than half came on their own (were not encouraged to come). Their movements are very frequent and the duration of their stay is short. About half stay less than four weeks and most stated an average stay of two months or less. Only five respondents had been to Barbados less than ten times in the past twelve months. Twenty percent had traveled to Barbados more than twenty times and 20% percent more than forty times in the past year. Four of those included in the sample can be considered “not so mobile” traders as they have homes in Barbados. However, even some of those who are very mobile, coming every week or every month, rent rooms or homes on a long-term basis, and one has even built a home, despite the fact that she has no legal status in Barbados. Eighty percent of the interviewed petty traders had not worked in countries other than Barbados. One had traveled to Trinidad and another had traveled to various countries, but in general the mobility was between Barbados and the country of origin.

All respondents had heard of HIV/AIDS. Similarly, all of the respondents believed that AIDS exists and can be passed from one person to another via “anything that has to do with sex”, but, interestingly, less than half of the sample knew someone with AIDS or who had died of AIDS. Only 5% of respondents weren’t sure whether the virus could be passed by drinking from the same cup, 10% from touching someone’s hand or using the same toilet. Essentially, they said that “they say that you can’t pass it like that” but, to be on the safe side, “I won’t be taking the chance”. Most of them believed that a person can be infected and look healthy and that AIDS can be treated.

The sample was confident in their belief that there was “no chance” of them being infected (80%). Those who felt at risk believed that their partners “could bring it home” without their knowledge. Seventy percent had made changes in their sexual behavior to avoid HIV/AIDS; essentially these changes were not to have sex or to be faithful to one partner. Responses would also suggest that the respondents are practicing their protective behavior: no respondent had had more than one partner in the past month while fourteen respondents had had no sexual partner in the past week.

Forty percent said they had never used a condom. For those in monogamous relationships, condoms are seldom used – only two respondents had used condoms the last time they had sex, even though some of the women acknowledged that their spouses could “bring it home.” On the whole, condoms are not a part of the lives of this petty trader sample.

For the most part, respondents gave humane responses regarding people living with HIV/AIDS. Those who had been tested for HIV were tested while they were pregnant. In Barbados, this test is voluntary, but one respondent said that her test was not – where the test was administered is not known.

In summary, this group does not consider itself at risk. Forty-five percent of the respondents did not want to know more about HIV/AIDS, because they considered more knowledge irrelevant.

4.4.2 Curaçao

No studies of petty traders (known on Curaçao as “higglers”) are available. Limited information was obtained from Curaçao Industrial and International Trade Development Company N.V. (Curinde) that works in the free zones on Curaçao, officially known as economic zones (E-zones). There are four E-zones, two dedicated to service industries and two that are harbor-related, concentrating on the export of goods to Venezuela, Jamaica and Colombia. A considerable number of visitors to E-zone “Koningsplein” are petty traders who come to buy goods wholesale. Information from this E-zone indicates that most come from Jamaica, Haiti, Trinidad and the Dominican Republic. The most important products bought by the petty traders are textiles, liquors and footwear. It is estimated that each trader visits the E-zone about three times per trip, first to get an entry pass, second to purchase goods, and third to pick up the merchandise (Department of Economic Affairs 2002). Most come four times per year. Average spending per visit is estimated to be around US\$ 1,900.

Petty traders are not a uniform group, and distinctions should be made between those coming in as tourists and those residing on Curaçao. Most are women who enter Curaçao as tourists, so their duration of stay is usually no longer than two weeks. Some, especially those from Haiti and Jamaica, bring in goods from their own country (artifacts, spices), which they sell on street markets in Curaçao, or directly to cruise ship tourists. The proceeds from these sales are then used to purchase merchandise from the E-zone, which is transported back home. This group of petty traders can be further divided into those who own a store in their own country and those who purchase for others. While in Curaçao, most stay in low-budget guest houses (Consperanze 2003).

Suitcase trading also occurs on Curaçao, mostly in the context of prostitution. Female vendors from Colombia and the Dominican Republic bring in lingerie, food, condoms and medication. On Curaçao medication cannot be purchased without a prescription, and medication for those without insurance is very costly. Thus, women active in prostitution on Curaçao depend on low-cost medication brought in by suitcase traders. Suitcase traders usually keep stock of a variety of antibiotics and anti-fungal ovules, relevant in the context of sex work. They also provide pregnant sex workers with Cytotec (misoprostol) tablets, normally prescribed to combat stomach ulcers and gastritis, which have abortive qualities if used when pregnant. This is the product most sold by suitcase traders (Dos Mundos 2003).

Survey results

Please see Figure 15 for a summary of the survey results.

Nearly all petty traders interviewed were over 30 years; 45% were 40 years or older. That mature petty traders probably had limited access to education when they were young is proven by the fact that in 23% of all cases education did not surpass primary school level. Sixty-four percent had attended some secondary school. Sixty-four percent of all petty traders were Jamaicans, 14% were from the Dominican Republic, 9% were from Colombia, another 9% were Haitians and 4% were from Trinidad. Most petty traders take care of large families: 86% of all indicated to provide for 3-9 family members.

In general the petty traders were highly mobile. Fifty-nine percent of the respondents had visited Curaçao five times or more during the past year. Only 37% of those interviewed were visiting for the first time.

Figure 15: Survey Results – Petty Traders on Curaçao

N=22

Source countries	Colombia Dominican Republic Haiti Jamaica Trinidad and Tobago
Age	20-29 (14%) 30-39 (41%) 40+ (45%)
Education	Some primary school (23%) Some secondary school (64%) Some university/vocational (14%)
Average visits per year	1-9 (95%) 10-19 (5%)
Average length of stay	<1 week (41%) 1-3 weeks (14%) 1-2 months (9%)
Have also worked in:	Canada Cayman Islands Ecuador Europe Guyana Panama St. Maarten St. Thomas USA
Number of dependents	0-2 (14%) 3-5 (68%) 6-8 (14%) 9+ (5%)
Have heard of AIDS	100%
Knew someone who died of AIDS	55%
How can you get AIDS?	Drinking from the same cup (5%) Using same toilet (9%) Having sex without a condom (100%)
Someone can be infected and look healthy	Yes (91%)
AIDS can be treated	Yes (82%)
Have ever used a condom	100%
Number of partners during past month	0 (27%) 1 (55%) 2 (14%)
Usually uses a condom with sexual partners	Always (41%) Almost always (14%) Sometimes (32%) Never (14%)
Reason for not always using a condom	Don't have sex (9%) Only have 1 partner (36%) Only have sex with people who look okay (5%) I am okay (23%) Condoms make sex less enjoyable (14%) My partner doesn't want to use condoms (14%)
Condoms prevent HIV/AIDS if	They are not damaged (95%) You use them only once (100%) They are not older than the expiration date (95%)
Has had an HIV test	77%
Volunteered to take the test	41%
Concerns	Mandatory HIV testing Trafficking (not a generalized problem – DR)

Most stated an average stay of less than one month while many usually stay less than one week (41%). Those who stayed for longer periods of time were usually petty traders from the Dominican Republic and Colombia who either have a work/residence permit for Curaçao or who choose to stay on the island illegally. All purchase goods on Curaçao and sell against profit in their home country. Fifty-five percent of the interviewees had done business in countries other than their home country or Curaçao. Places most mentioned were the Cayman Islands, Panama, the USA and Canada, all of which are dollar driven economies. Seventy-three percent of the petty traders that were interviewed stated that they were motivated by someone to come to Curaçao. By this they meant that colleagues had informed them that business in Curaçao was good and profitable. Seventy-five percent received some sort of support from the person that motivated them to go to Curaçao, either by providing loans or by arranging the initial business contacts. There was no allusion whatsoever to trafficking of women

The story of the three female petty traders from the Dominican Republic, however, was very different. They stated to have been lured into coming to Curaçao under false pretenses. They were offered a job as live-in domestic worker, but upon arrival in Curaçao the intermediary informed them that there was neither work, nor a place to stay. Only by selling sex could the women obtain the necessary funds to rent a roof over their heads and to pay back the debt to the intermediary. While working as prostitutes each met an Antillean man who became their steady partner. The moment General Amnesty was declared the women signed up for it. This enabled them to leave sex work and move up to become newspaper vendors and, eventually, petty traders.

All of the interviewees had heard of AIDS and 55% personally knew someone who had died of AIDS. This is again indicative of the fact that HIV/AIDS is well established in the Caribbean and Latin American regions and also explains why almost no one doubted that AIDS exists or that it can make people sick. All interviewees are aware that HIV can be transmitted from one person to another when there is sexual contact without a condom with someone who is infected. Only 5% still think that HIV can be transmitted by sharing a cup with someone who has HIV/AIDS and 9% are of the opinion that HIV can be transmitted by a toilet seat. Ninety-one percent thought that a person could be infected with HIV/AIDS and still look healthy. Most (82%) knew that there is treatment for HIV/AIDS.

All stated that AIDS has brought about a change in their sexual behavior. For most this implied having sex with one person who also remains faithful, or to always use a condom when having sex (at least, this is the goal). Interestingly, 9% practiced total abstinence as a viable way to avoid HIV/STI infection. Forty-five percent considered that there is no chance that they are infected with HIV. All of the petty traders with a history of prostitution (23%) thought there was a good chance of their being infected

Most respondents had had less than two sexual partners during the past month. Sixty percent of the male petty traders carried a condom and could show it to the interviewer. Of the 17 female petty traders, 41% carried a condom. These results suggest that there is considerable intention among petty traders to protect themselves from HIV/AIDS and other STIs. The reason most mentioned for not using a condom was that the informant indicated to have only one sexual partner and that this partner doesn't want to use a condom because it makes sex less enjoyable. Especially the female petty traders said that they could agree to have unprotected sex with their steady partner, as long as he uses a condom when he is having a sexual encounter with another woman.

All petty traders were of the opinion that PLWA are normal people who merit love and care, though 41% thought that they should not be allowed to work. Most were of the opinion that PLWA could work only in settings where they would not pose a risk to their surroundings. Seventy-seven percent of the interviewees stated to have undergone testing for HIV antibodies, 100% of which knew the result. Only 41% volunteered for HIV antibody testing; others stated that the test had been mandatory in the context of a job application.

The data from this survey indicate that petty traders who come to Curaçao and who stay for short periods of time have a very limited risk for HIV infection, despite their high levels of mobility. Furthermore, the survey has not been able to corroborate what has been indicated by some informants, namely that well-to-do male petty traders look for sexual services from prostitutes during their stay on Curaçao. In that sense the Curaçao researchers have to conclude that petty traders do not require priority attention for future HIV interventions.

4.4.3 Dominican Republic

Petty traders work in a section of Santo Domingo known as “Little Haiti.” (Baez Evertsz, 1994). Haitian petty traders also work along the border in areas such as Jimaní-Malpassé, Dajabón, Comendador, and Pedernales. Little is known about the migratory movements of petty traders in the Dominican Republic. It appears that merchants move goods back and forth between Haiti and the Dominican Republic, but the link between this trade and migration flows is not clear.

No known studies exist on petty traders and HIV/AIDS in the Dominican Republic. The nature of petty trading in the Dominican Republic, however, is such that it is often carried out in precarious social and economic conditions. In this context there can be risks associated with violence towards marginalized populations, and in some cases, risks having to do with informal trade. It is unclear whether petty traders are more at risk for HIV infection due to their mobility; in the Dominican Republic. The apparent link with informal or irregular trade by Haitian petty traders seems to be a more important factor than mobility in and of itself, but the relationship is unclear.

Survey results

A total of twenty petty traders were surveyed in the Dominican Republic. See Figure 16 below for a summary of the survey results.

The petty traders interviewed ranged in age. Forty percent were younger than 30, while another forty percent were 40 years or more. Education was lower than in other countries under study. Twenty-five percent could not read or write, half had attended some primary school and only twenty-five percent had some secondary education. None had attended vocational training or university studies. Most supported multiple people with their earnings. Only 20% supported less than three persons and 30% stated they supported more than nine dependents. Eighty-five percent had dependents in Haiti, 10% in the Dominican Republic, and 5 % in both countries.

The interviewed traders were highly mobile. Twenty-five percent traveled between the Dominican Republic and Haiti between 1-30 times per year; 25% stated they traveled back and forth “almost daily.” Seventy percent had an average stay of less than two months. All identified themselves as petty traders. Half stated that they had been encouraged to come to the Dominican Republic. Most had never worked outside of Hispaniola. The ten percent who had worked elsewhere had worked in Panama and the Bahamas.

Figure 16: Survey Results – Petty Traders in Dominican Republic

N=20

Source countries	Haiti*
Age	20-29 (40%) 30-39 (20%) 40+ (40%)
Education	Illiterate (25%) Some primary school (50%) Some secondary school (25%)
Average visits per year	1-9 (15%) 10-19 (5%) 20-29 (5%) 30-39 (5%) 40+ (45%)
Average length of stay	<1 week (40%) 1-3 weeks (25%) 1-2 months (5%) 4+ months (15%)
Have also worked in:	Bahamas Panama
Number of dependents	0-2 (20%) 3-5 (35%) 6-8 (15%) 9+ (30%)
Have heard of AIDS	100%
Knew someone who died of AIDS	35%
How can you get AIDS?	Drinking from the same cup (10%) Using same toilet (15%) Having sex without a condom (75%) Touching someone's hand (5%)
Someone can be infected and look healthy	Yes (60%)
AIDS can be treated	Yes (20%)
Have ever used a condom	30%
Number of partners during past month	0 (40%) 1 (55%) 3 (5%)
Usually uses a condom with sexual partners	Always (10%) Almost always (5%) Sometimes (10%) Never (5%)
Reason for not always using a condom	Only have 1 partner (50%) Only have sex with people who look okay (15%) I am okay (5%) Condoms make sex less enjoyable (5%) My partner doesn't want to use condoms (15%)
Condoms prevent HIV/AIDS if	They are not damaged (60%) You use them only once (55%) They are not older than the expiration date (50%) You use them more than once (15%) You put them on halfway (10%)
Has had an HIV test	30%
Volunteered to take the test	25%
Concerns	Extremely low knowledge of AIDS treatment Some misinformation about HIV/AIDS transmission and prevention

*Only Haitians were surveyed

All interviewed petty traders had heard of AIDS. However, 25% doubted its existence and 25% stated it didn't make people sick. Thirty-five percent stated they had personally known

someone who had died of AIDS. Ninety percent of those interviewed had heard something about AIDS on the radio, and 85% on the television. Sixty percent believed that a person with HIV could appear healthy, while 30% stated they could not. Thirty-five percent believed that AIDS cannot be treated and 40% did not know. Sixty percent considered themselves to be at risk of contracting HIV. Eighty-five percent stated they had made changes in their sexual behavior to prevent infection with HIV.

Only thirty percent of the interviewed petty traders had ever used a condom. Only 15% usually use a condom, mostly likely because half stated they have only one partner and 40% indicated that they protect themselves by not having sex. Other stated reasons for not using condoms included the fact that condoms make sex less enjoyable and that their partner didn't want to use condoms.

Knowledge about HIV/AIDS was lower than in other groups studied. Only seventy-five percent stated that unprotected sex can lead to transmission of HIV/AIDS. Ten percent believed AIDS can be passed by drinking from the same glass, fifteen percent from using the same toilet and five percent from touching someone's hand. It is interesting to note that the respondents felt that those who have been cursed could be infected (65%).

Interviewees had mixed feelings about people living with HIV/AIDS. Half stated that people with AIDS are not "good people" and "should be punished by God" though 55% indicated that PLWA are like other people.

Thirty percent of the respondents had been HIV tested; twenty-five percent had volunteered to take the test. All indicated that they would like to learn more about HIV/AIDS.

4.4.4 Trinidad and Tobago

There are no known studies of petty traders and HIV/AIDS in Trinidad and Tobago. The petty trader has traditionally not featured among the high-risk groups or engaged in high-risk activities in Trinidad and Tobago. The migration patterns of petty traders are consistent with intra-regional movements of immigrants. It appears as though some enter as tourists. The main countries from which these traders come include Guyana, Grenada and St. Vincent. These traders operate largely as wholesalers, doing bulk purchasing of food and clothing for sale in their countries of origin. The duration of their stay rarely exceeds three days, and trips back and forth are made as frequently as weekly. The Guyanese trader is likely to travel via plane while the mode of travel used by the traders from the Eastern Caribbean States is typically boat.

Survey results

Please see Figure 17 for more details on the survey results.

Ninety percent of the respondents indicated that they worked full time as petty traders. The interviewees were a mature group. All were over 30 and 70% were older than 40. Sixty-five percent has attended some secondary school with 35% indicating that they had some primary level education. Guyana, Grenada and St. Vincent were main source countries. The countries of birth that were identified by the petty traders are consistent with the pattern of migrants traveling to Trinidad and Tobago outlined earlier. Petty traders had worked in a number of other countries in the region and beyond.

Figure 17: Survey Results – Petty Traders on Trinidad and Tobago

N=20

Source countries	Grenada Guyana Nicaragua St. Lucia St. Vincent and the Grenadines
Age	30-39 (20%) 40+ (70%)
Education	Some primary school (35%) Some secondary school (65%)
Average visits per year	1-9 (25%) 10-19 (15%) 20-29 (20%) 40+ (20%)
Average length of stay	<1 week (35%) 1-3 weeks (15%) 1-2 months (15%) 2-4 months (10%)
Have also worked in:	Antigua and Barbuda Barbados Brazil Grenada Guyana St. Maarten Suriname Venezuela
Number of dependents	0-2 (10%) 3-5 (45%) 6-8 (35%) 9+ (10%)
Have heard of AIDS	100%
Knew someone who died of AIDS	60%
How can you get AIDS?	Drinking from the same cup (10%) Using same toilet (25%) Having sex without a condom (100%)
Someone can be infected and look healthy	Yes (100%)
AIDS can be treated	Yes (95%)
Have ever used a condom	70%
Number of partners during past month	0 (10%) 1 (65%)
Usually uses a condom with sexual partners	Always (0%) Almost always (5%) Sometimes (35%) Never (30%)
Reason for not always using a condom	Only have 1 partner (30%)
Condoms prevent HIV/AIDS if	They are not damaged (85%) You use them only once (75%) They are not older than the expiration date (60%) You use them more than once (40%) You put them on halfway (30%)
Has had an HIV test	60%
Volunteered to take the test	25%
Concerns	Some misinformation about HIV/AIDS transmission and prevention\ Mandatory HIV testing

Most respondents had three or more dependents supported by their earnings. Ten percent had nine or more dependents. Petty traders surveyed were highly mobile; most traveled to

Trinidad and Tobago nine or more times per year. Twenty percent reported more than forty visits per year. Average stays were short. Thirty-five percent stayed less than one week. The petty trader operates very much as a wholesaler; they travel to Trinidad to purchase select items in bulk for immediate shipment to their homeland. In some cases the items are sent via boat, in others via plane. In either case the duration of stay in country seldom exceeds three days and is usually one day.

Of the traders interviewed, 60% indicating that they were asked or encouraged to come to the country. In most cases a family member with a family business made this request. Travel and other arrangements were usually taken care of under these circumstances.

All respondents had heard of AIDS and most believed it could be passed from one person to another. Sixty percent indicated that they personally knew someone who had died of HIV/AIDS. Of the respondents surveyed, 90% of them had heard or seen AIDS messages via TV and radio, while 75% and 65% saw messages on the newspapers and posters, respectively. All respondents indicated that one could get AIDS from unprotected sex, while 25% believed that it could be contracted through sharing toilets and 10% from sharing a cup

All of the respondents surveyed believed that PLWA could look healthy. Almost all (95%) believed that HIV/AIDS could be treated. With respect to their chances of being infected, a total of 75% indicated that they had no chance of being infected by the virus. Despite the fact that most of the respondents knew that AIDS could be contracted through unprotected sex, 55% indicated that they had not changed their sexual behavior since the onset of HIV/AIDS. When questioned as to how they protected themselves, 90% said by having one partner, 55% said by using a condom and 30% by not having sex. Only 10% indicated that they asked about the HIV status of their partner.

On the topic of sexual partners, 75% of respondents indicated that they had 1 or 0 sexual partners in the last month. With respect to using condoms during sex, although 70% indicated that they had used condoms before, only 5% indicated that they almost always used one with their sexual partner. In fact 30% indicated that they never used a condom with their sexual partner, as they only had one partner. Most respondents surveyed agreed that condoms could only prevent AIDS if they are not damaged or if they were only used once. However 40% and 30% respectively thought that condoms could still prevent AIDS if they were used more than once or put on only halfway.

The petty traders interviewed largely expressed the view that PLWA are not necessarily bad people, but are like any other people in society. Interestingly, only 45% felt that PLWA should be allowed to work. Only 60% of respondent indicated that they wanted to know more about AIDS, though 95% felt that their families needed to know more. Sixty percent of respondents indicated that they had had an AIDS test, though only 25% volunteered to take the test.

5. Limitations

The current study provides an initial look at mobile populations and HIV/AIDS in the Caribbean. The survey in particular has limited applicability to the region in general due to the small sample size and the lack of information on commercial sex workers. Problems with accessing this population in three of the countries under study led to the inclusion of only two countries in the sex worker survey. The results should be received in this context. In addition to limitations with the survey, data on migration and HIV/AIDS in the region is sometimes imperfect. In the

absence of reliable country statistics, researchers interviewed key informants to gather the necessary information about migration flows and HIV/AIDS. Though this type of data has limitations, at the current time it is the best available information.

6. Conclusions

Analysis of the country reports and survey results on HIV/AIDS and mobile populations in the Caribbean region reveal the following:

***HIV/AIDS is a growing problem in the Caribbean,
made more complex by the high level of population mobility in the region***

Despite gains in the response to HIV/AIDS in the Caribbean over the past five years, the epidemic continues to spread, with alarming prevalence rates in certain countries and among high-risk groups. The generalized nature of the epidemic in some parts of the region calls for an urgent and effective response, lest the situation in sub-Saharan Africa (the only region with worse prevalence rates) replicate itself in the Caribbean. The high mobility rates in the region make responding to HIV/AIDS all the more complex.

***Increased AIDS funding in the Caribbean is creating implementation challenges
Mobile populations must be an integral part of this response***

Though funding for HIV/AIDS in the Caribbean has increased greatly (up to US\$91 million at the end of 2003), health infrastructure and capacity to implement this response is lacking in parts of the region. Basic epidemiological surveillance, for example, is improving but still insufficient. Regional phenomenon, such as population movements, make a coherent and effective response even more challenging. The diversity, geography and high levels of mobility in the Caribbean region require contextually appropriate responses to HIV/AIDS, with mobile populations at the forefront of that response. Based on the results of this study, however, mobile populations have not yet been taken sufficiently into consideration in the region.

***HIV/AIDS testing, care and treatment services are uneven across the Caribbean region
Mobile populations (particularly irregular migrants) have minimal access to AIDS care***

The diversity of the Caribbean is also reflected in different levels of healthcare and capacity to provide HIV/AIDS services. Access to voluntary counseling and testing, treatment for opportunistic diseases, and basic AIDS care is uneven in the region. In some countries HIV tests take weeks or months, for example. Many nationals do not have access to life-saving anti-retroviral medications, though some countries are working to implement universal access to ARVs. Though the focus on preventing mother-to-child transmission of HIV has made some gains, high-risk populations such as men-who-have-sex-with-men and sex workers are still excluded. Stigma and discrimination of these groups and people living with AIDS only add to this problem. Mobile populations, particularly irregular migrants, have minimal access to basic healthcare in the Caribbean, let alone HIV/AIDS services. Though identified as a vulnerable population in some national AIDS plans, in reality mobile populations and migrants have minimal access to HIV/AIDS services. Even countries with a policy of universal healthcare

actually require national ID cards, for example. In some cases, fear of deportation prevents irregular migrants from seeking healthcare even when it is available.

Young women in particular are at risk for HIV-infection in the Caribbean

Several researchers identified the growing phenomenon of increasing HIV-infection among young women and girls, despite lower rates for boys of the same age. Given that the infection rate among women in the Caribbean is growing in general and that the primary mode of HIV transmission is heterosexual sex among young people, young women are an important target group for HIV/AIDS interventions in the region. Researchers also identified relations between young girls and older men as one reason girls are increasingly infected. More information and a targeted response are urgently needed in order to protect young women in the Caribbean from increasing HIV-infection and to ensure that they receive the necessary information to protect themselves from HIV and are included in the response to HIV/AIDS in the region.

Mandatory HIV testing is a problem that needs to be addressed in the region

Several researchers identified mandatory HIV testing in the context of immigration or employment. Access to voluntary counseling and testing is problematic in the region; minimal standards of human rights for those living with HIV/AIDS must be put in place as part of the response to HIV/AIDS in the region.

High mobility does not necessarily lead to vulnerability to HIV infection

High-risk behaviors together with high mobility leads to greater vulnerability to HIV infection

Though the petty traders surveyed were highly mobile (in fact more mobile than the sex workers interviewed) their high mobility did not put them at greater risk for HIV infection. The demographics of the petty traders may have also influenced their low-risk behavior: most were middle-aged women in serious, committed relationships (often married) who intended to protect themselves and did not engage in risky sexual behavior. In the case of the interviewed sex workers, they continued to engage in high-risk behaviors (unprotected sex) despite high levels of knowledge about HIV/AIDS in general. This behavior, together with their mobility, put them at greater risk of HIV infection. These results illustrate that the level of mobility alone does not determine the level of HIV risk. Rather, the circumstances of the movement and the behavior of the group together determine vulnerability to HIV infection.

Irregular migration is a serious problem in the Caribbean

In particular, trafficking in persons may be contributing to the HIV/AIDS epidemic

The current study raises serious concerns about trafficking in persons in the Caribbean. Stories of women lured to work as domestic workers and then forced into prostitution to pay their debts; of foreign children for rent for the night for sexual exploitation; of sex workers who feel they were trafficked – these call for further investigation and an urgent response in the region. The link between trafficking and HIV/AIDS is an important dimension in the region, though the extent of the problem is unknown.

7. Recommendations

After taking into consideration the findings and conclusions of the country research, the researchers recommend the following actions. Please see Figure 17 for possible intervention strategies.

- **Include mobile populations as a primary focus of the AIDS response** in the Caribbean
- **Improve access to healthcare for mobile populations** (in particular HIV/AIDS services), regardless of immigration status
- **Target HIV/AIDS interventions to those mobile populations at higher risk**, either due to high-risk behavior (such as sex workers) or circumstances of movement (such as forced movement)
- **Target young women and girls for HIV/AIDS prevention** activities due to their high risk in the region
- Work with governments in the region on **improved migration management** to prevent irregular migration movements which put mobile populations at higher risk for HIV/AIDS
- Address the **root causes of irregular migration** through empowerment / economic alternative programs among at-risk populations (i.e. micro-credit for young women), and labor migration programs which promote regular migration in the region
- Respond to possible **trafficking of women and children** in the region for sexual exploitation
- Promote the **human rights of migrants** and other vulnerable populations (PLWAs, MSM, young women, etc.) and **fight the stigma and discrimination** that contribute to the AIDS epidemic in the region (i.e. PLWAs, MSM)
- Work with governments to **encourage voluntary HIV counseling and testing** and to discourage mandatory HIV testing for employment or migration.
- Improve **access to life-extending anti-retroviral medications** in the region, for mobile populations and in general; promote prevention through successful and accessible treatment for HIV/AIDS
- **Further study of mobile populations and HIV/AIDS** in the Caribbean region is necessary in order to target interventions to those groups who are at risk. Studies could focus on other mobile (and bridge) populations (such as students or tourists)
- **Further study of trafficking in persons and HIV/AIDS in the Caribbean** in order to better design successful interventions

Figure 17: Intervention Strategies for AIDS and Mobile Populations in the Caribbean

	Information, Education and Awareness-Raising	Policy and Legislation	Direct Services	Further Research
<p>Vulnerability</p> <p>(source, transit and destination countries)</p>	<p><i>AIDS Information and Education Campaigns (at-risk mobile populations)</i></p> <p>IRREGULAR MIGRATION (smuggling, trafficking) Information and Education Campaigns (potential irregular migrants, at-risk groups)</p> <p>HUMAN RIGHTS OF MIGRANTS Information and Education Campaigns (at-risk groups)</p> <p>HUMAN RIGHTS of vulnerable groups (PLWAs, MSM, young women, children) Information and Education Campaigns</p> <p>Hotlines (AIDS, Trafficking)</p>	<p>Counter-trafficking legislation</p> <p>Regular labor migration programs (at-risk populations such as young women)</p> <p>Legal protections for at-risk groups (PLWAs)</p>	<p>Empowerment / micro-credit programs for at-risk groups (young women, marginalized communities)</p> <p>Voluntary HIV counseling and testing (at-risk populations) and ARV treatment (prevention through treatment)</p> <p>Regular labor migration programs for at-risk groups (young women, marginalized communities)</p>	<p>Role of gender and age in the Caribbean in vulnerability to HIV/AIDS (young girls increasingly infected)</p> <p>Stigma and discrimination in the Caribbean – men who have sex with men</p>
<p>Irregular Migration</p> <p>(source, transit and destination countries)</p>	<p>IRREGULAR MIGRATION Information and Education Campaigns (community and policy-makers; the region as a whole)</p> <p>HUMAN RIGHTS OF MIGRANTS Information and Education Campaigns (at-risk groups, community; policy-makers; region as a whole)</p> <p>Hotlines (Trafficking)</p>	<p>Counter-trafficking legislation</p> <p>No mandatory HIV testing for migration or employment</p> <p>Regular labor migration programs (at-risk populations such as young women)</p> <p>Promote better migration management to discourage irregular migration flows</p>	<p>Comprehensive assistance to victims of trafficking</p> <p>Voluntary HIV counseling and testing and ARV treatment (prevention through treatment)</p>	<p>Links between trafficking and AIDS in the Caribbean</p> <p>Role of gender and age in the Caribbean in vulnerability to trafficking in persons</p>
<p>Lack of access to healthcare (comprehensive AIDS care)</p> <p>(source, transit and destination countries)</p>	<p><i>AIDS Information and Education Campaigns (community; policy-makers; the region as a whole)</i></p> <p>HUMAN RIGHTS OF MIGRANTS Information and Education Campaigns</p> <p>Hotlines (AIDS)</p>	<p>Mobile populations included in National AIDS Plans</p> <p>No mandatory HIV testing for immigration or employment</p> <p>Improved access to healthcare and AIDS care for mobile populations (regardless of status)</p>	<p>Comprehensive HIV/AIDS care to at-risk mobile populations (regardless of status) including VCT and ARV treatment</p> <p>Free condom distribution to at-risk populations</p>	<p>Mobility and HIV/AIDS in other countries of the Caribbean</p> <p>Mobility and HIV/AIDS with other mobile groups in the Caribbean (students)</p> <p>Mobility and HIV/AIDS with “bridge populations” in the Caribbean</p>
<p>High-risk behavior</p> <p>(source, transit and destination countries)</p>	<p>AIDS Information and Education Campaigns (at-risk mobile populations; communities; tourism industry)</p> <p>IRREGULAR MIGRATION Information and Education Campaigns (potential victims)</p> <p>Hotlines (AIDS, Trafficking)</p>	<p>No mandatory HIV testing for immigration or employment</p> <p>Improved access to healthcare and HIV/AIDS care for mobile and migrant populations (regardless of status)</p> <p>Regular labor migration programs (at-risk populations such as young women)</p>	<p>Voluntary HIV counseling and testing (at-risk mobile populations) and ARV treatment (prevention through treatment)</p> <p>Voluntary return and reintegration for migrants, victims of trafficking</p> <p>Empowerment / micro-credit programs for at-risk groups (young women, marginalized communities)</p>	<p>Role of gender in the Caribbean in vulnerability to HIV/AIDS (young girls increasingly infected)</p> <p>Stigma and discrimination in the Caribbean – men who have sex with men</p> <p>Links between tourism and HIV/AIDS in the Caribbean</p>

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Annex A

LIST OF PARTICIPANTS

HIV/AIDS AND MOBILE POPULATIONS WORKSHOP 31 MARCH - 1 APRIL 2003

NAME	INSTITUTION	COUNTRY	PHONE	E-ADDRESS
Dawn Marshall	Consultant	Barbados	(246) 425-1485	dawn@sunbeach.net
Nicholas Adomakoh	Ministry of Health	Barbados	(246) 429-5941	nadomakoh@hotmail.com
Lily Faas	Ngo ContraSida Caribbean	Curaçao	00-599-9-56297341	Fax 00-599-9-7470897
Jeannette Eleonora	Public Health Department	Curaçao	011-59994625800	Eleonora-jean@curinjo.an
Marion Schroen	Health Services/ContraSida	Curaçao	563.74.30 947.08.30	scheoerrm@una.net
Raul Boyle	UNAIDS	Haiti	(509) 246-6778	boyles@unaids.org
Raymond Pryce	National Review Organization	Jamaica	(876) 993-5494	rayoflujan@yahoo.com
Elizardo Puello	CASCO	Dominican Republic	(809) 534-9514	casco@codetel.net.do
Tomini Valerio	CASCO	Dominican Republic	(809) 534-9514	casco@codetel.net.do
Ernesto Guerrero	UNAIDS	Dominican Republic	(809) 565-1155	guerreroe@unaids.org
Roger Mclean	University of the West Indies	Trinidad	(868) 662-6555	rmclean@fss.uni.tt
Deanne Samuels	CAREC	Trinidad	868-622-42614618	samuelde@carec.paho.org
Sheila Samiel	Caribbean Epidemiology Centre (CAREC)	Trinidad		Sheilasamiel@yahoo.com
Katja Oppinger	MHS, IOM Geneva	Switzerland	+41227179503	koppinger@iom.int
Berta Fernandez	IOM Regional Office, Washington DC	USA	+1(202) 862 1826	bfernandez@iom.int
Mireille Smit	IOM Santo Domingo	Dominican Republic	(809) 732-7121	iomsantodom@codetel.net.do
Juan Artola	IOM Santo Domingo	Dominican Republic	(809) 732-7121	iomsdomingo@codetel.net.do

Q5	In which country were you born?		
Q6	Which country do you consider home?		
Q7	How many people benefit from /or depend on your income?		
Q8	How many of them are under 15?		
Q9	In which country (countries) do the people you support live?		
Q10	For how many months have you been separated from your family now?		

PART TWO: Questions on Migration and Employment

Q11	How often did you come to country X in the last twelve months? <i>If this is the first visit put 1</i>		
Q12	How long have you been in country X for?		
		<i>If it is first visit go to Q14</i>	
Q13	<i>If it is not the first visit ask:</i> How long do you usually stay in country X?		
Q14	What employment/job do you have in country X? <i>Do not prompt</i>	Vendor 1 CSW 2 Waiter/ Waitress 3 Dancer 4 Construction 5 Student 6 Unemployed 7 Other, specify _____	
Q15	Were you encouraged or did someone ask/tell you to come to country X?	Yes 1 No 2 No response 99	
Q16	Did this person arrange the travel and work for you?	Yes 1 No 2 No response 99	
Q17a	How would you rate the living conditions in Country X?	Excellent 1 Good 2 Fair 3 No so good 4 Not at all good 5	
Q17b	How would you rate the working conditions in Country X?	Excellent 1 Good 2 Fair 3 No so good 4 Not at all good 5	
Q18a	<i>If answer to Q17a is not Excellent or Good ask...</i> If you had known about the <u>living</u> conditions in country X before coming, would you have come here?	Yes 1 No 2 No response 99 Don't Know 77	
Q18b	<i>If answer to Q17b is not Excellent or Good ask...</i> If you had known about the <u>working</u> conditions in country X before coming, would you have come here?	Yes 1 No 2 No response 99 Don't Know 77	
Q19	In which other countries have you worked before?		
Q20	Do you have a (girlfriend)/boyfriend in your home country?	Yes 1 No 2 No response 99	
Q 21	Do you have a (girlfriend)/boyfriend in this country ?	Yes 1 No 2 No response 99	

	E) homosexuals ⇒ F) women having sex with women ⇒ G) people who have been cursed ⇒ H) all people ⇒ I) don't know ⇒ J) no response ⇒ K) other, specify ⇒	Yes 1 No 2 Yes 1 No 2	
Q31	Do you believe that a person can be infected with the AIDS virus and still look healthy?	Yes 1 No 2 Don't know 77	
Q32	Do you believe AIDS can be cured?	Yes 1 No 2 Don't know 77	
Q33	Do you believe AIDS can be treated?	Yes 1 No 2 Don't know 77	
Q34	What do you believe are your chances to be infected with HIV?	no chance 1 moderate/medium chance 2 good chance 3 don't know 77 already infected 5	
Q35	If you found out you were infected with HIV who would be the first person(s) you would tell?	a relative 1 a friend 2 your (wife)/ husband 3 your (girlfriend)/boyfriend 4 Doctor 5 Social worker 6 your employer 7 your priest 8 no one _____ 9 other, specify _____	
Q36	Have you made any changes in your sexual behaviour to avoid HIV?	Yes 1 No 2 Don't know 77	
Q37	How do you protect yourself from being infected with HIV/AIDS? Please be sure to indicate multiple answers, should this be the case. <i>Prompt</i> A) Not having sex at all ⇒ B) Only having sex with one person who also remains faithful ⇒ C) Always using a condom when having sex ⇒ D) Asking a person who you will have sex with, whether or not they have HIV/AIDS ⇒ E) Getting protection against HIV/AIDS from a traditional healer ⇒ F) Not ever touching anyone who has HIV/AIDS ⇒ G) Never speaking to anyone who has HIV/AIDS ⇒ H) I don't know ⇒ I) Other, specify ⇒	Yes 1 no 2 Yes 1 no 2	

Sexually Transmitted Illnesses (STIs)

Q38a	For your age would you describe your state of health as:	Very good 1 Fairly good 2 Average 3	
------	--	---	--

		Rather poor 4 Very poor 5	
Q38b	In the past 12 months, have you had any drips or noticed the presence of any yellow substance coming from you (penis)/vagina or noticed any sores in the genital area or have you been told you have a STI?	Yes 1 No 2 No response 99 Don't know 77 <i>If not yes go to Q44</i>	
Q39	Where did you go for help, when you realised that you had such symptoms/illnesses? Please be sure to indicate multiple answers, should this be the case. Do not prompt A) I went to see a traditional healer⇒ B) I went to a clinic/hospital⇒ C) I got medicine at a pharmacy ⇒ D) I went to a private doctor⇒ E) I used medicine, that I made at home⇒ F) I went to a relative or friend for advice⇒ G) I waited for the symptoms to go away on their own⇒ H) To no one⇒ I) Other, specify⇒	Yes 1 No 2 Yes 1 No 2 Yes 1 No 2 Yes 1 No 2 If one of the above was answered "yes" go to Q41 Yes 1 No 2 Yes 1 No 2 Yes 1 No 2 Yes 1 No 2 _____	
Q40	For those who did not seek medical attention ask Why did you not go to a medical facility? Please be sure to indicate multiple answers, should this be the case. A) Too expensive⇒ B) Don't know where to go in country X⇒ C) Language barrier/communication problems in country X⇒ D) Afraid of deportation⇒ E) Too embarrassed⇒ F) Don't believe modern medicine works⇒ G) Other, specify⇒	Yes 1 No 2 Yes 1 No 2 Yes 1 No 2 Yes 1 No 2 Yes 1 No 2 Yes 1 No 2 Yes 1 No 2 _____	
Q41	During the time you had these symptoms/illnesses, did you have sex?	Yes 1 No 2 P Q43 No response 99 Don't recall 88	
Q42	If you had sex during this time, did you use a condom?	Always 1 Sometimes 2 Never 3 No response 99 Don't recall 88	
Q43	During the time you had these symptoms/illnesses, did you tell your sexual partner(s)?	Yes 1 No 2 No response 99 Don't recall 88	

Prevention Skills with regard to HIV/AIDS

Q44	How many sexual partners have you had in the past month? <i>For CSW: this includes clients and boyfriends/(girlfriends)</i> Probe	----- No response 99 Don't recall 88	
Q45a	How many sexual partners have you had in the past week? <i>For CSW: this includes clients and boyfriends/(girlfriends)</i>	----- No response 99 Don't recall 88	
Q45b	During the last 12 months did anyone force you to have sex with them even though you did not want to have sex?	Yes 1 No 2 No response 99	
Q45c	Did you use any drugs in the past 12 months?	Yes 1 No 2 No response 99	
Q45d	In the past 12 months, have you exchanged sex for drugs?	Yes 1 No 2 No response 99	
Q46	Have you ever used a condom? With women probe to make sure they understand they are considered to have used a condom even if it was the partner that actually wore it.	Yes 1 No 2 ⇒ Go to Q 48 No response 99	
Q47	Do you usually use a condom with your sexual partner(s)? Prompt <i>(note: try to find out if condoms are used with clients, with regular partners...)</i>	Always 1 ⇒ Go to Q 50 Almost always 2 Sometimes 3 Never 4	
Q48	For persons who did not always use a condom What are your reasons for not (always) using a condom? Do not prompt		
	A) Never had sex⇒	Yes 1 No 2	
	B) I only have one sexual partner⇒	Yes 1 No 2	
	C) I only have sex with people who look ok⇒	Yes 1 No 2	
	D) I am ok⇒	Yes 1 No 2	
	E) Get more money⇒	Yes 1 No 2	
	F) Condoms are too expensive⇒	Yes 1 No 2	
	G) I don't know how to use condoms ⇒	Yes 1 No 2	
	H) Condoms make sex less enjoyable⇒	Yes 1 No 2	
	I) Don't know where to buy condoms ⇒	Yes 1 No 2	
	J) My sexual partner(s) doesn't want to use condoms ⇒	Yes 1 No 2	
	K) Too embarrassed to buy them⇒	Yes 1 No 2	
	L) Other, specify ⇒	-----	
Q49	The last time you had sex with anyone did you use a condom?	Yes 1 No 2 No response 99 Don't Know 77	
Q50a	Do you have a condom with you now?	Yes 1 No 2 No response 99	
Q50b	If yes, can you show me the condom now?	Showed condom 1	

		Did not show condom No response	2 99	
Q51	Would you refuse to have sex with someone who refuses to use a condom?	Yes No No response Don't Know	1 2 99 77	
Q52	Condoms can prevent HIV/AIDS if... <i>prompted</i> A) ...they are not damaged⇒ B) ...you use them only once⇒ C) ...they are not older than the date on the package⇒ D) ...you use them more than once⇒ E) ...you put them on only half way⇒	Yes Yes Yes Yes Yes	No No No No No	2 2 2 2 2
Q53	Have you or your partner ever used a female condom?	Yes No No response Don't Know	1 2 ⇒ Go to Q 55 99 77	
Q54	Do you want to use the female condom more often?	Yes No No response Don't Know	1 2 99 77	
Q55	Please be sure to indicate yes or no to the following statements. I think that people who have HIV/AIDS.... <i>Prompted</i> A) ...are good⇒ B) ...are bad⇒ C) ...are like any other person⇒ D) ...deserve what they get⇒ E) ...should be punished⇒ F) ...should be punished by God⇒ G) ...should be punished by their ancestors ⇒ H) ...should pay for their sins⇒ I) ...are witches⇒ J) ...are normal people who are sick⇒ K) ...are normal people who need love and care⇒ L) ...should not be allowed to work⇒	Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes	No No No No No No No No No No No No No	2 2 2 2 2 2 2 2 2 2 2 2 2
Q56	Do you want to know more about HIV/AIDS?	Yes No No response Don't Know	1 2 99 77	
Q57	Would you like your family to know more about HIV/AIDS?	Yes No No response Don't Know	1 2 99 77	
Q58a	Have you ever had an HIV test?	Yes No No response	1 2 99	
Q58b	If yes, you don't need to tell me the result, but do you know what the result is?	Yes No No response	1 2 99	

Q58c	Did you volunteer to take the HIV test or were you required to take it?	Yes	1	
		No	2	
		No response	99	

Qualitative questions

Was coming to this country to work or trade worth it to you? Explain:

What are the best things about your work?

What are the worst things about your work?

Does your job expose you to any other types of risk? If yes, what types? By whom?

What type of medical services do you most require?

What do you do when you need to access medical services? Where do you go?

What other type of support services do you need?

What do you do when you need to access these services? Where do you go?

Do you have any recommendations for AIDS prevention for the people who do the same work as you do in this country? For your "clients"?

Do you have any other comments?

Other Key issues for probing: - Trafficking if indicated by answers

Annex C: Results – Sex Workers

Sex Workers - Personal Information

Sex	Curaçao		DR	
	Count	Percentage	Count	Percentage
Female	20	80%	15	75%
Male	5	20%	5	25%

Age	Curaçao		DR	
	Count	Percentage	Count	Percentage
18-19	1	4%		
20- 24	4	16%		
25- 29	7	28%		
30- 34	9	36%		
35- 39	2	8%		
40- 44	1	4%		
45 +	1	4%		
18-22			8	40%
23-27			6	30%
28-32			2	10%
33-37			4	20%

Marital status	Curaçao		DR	
	Count	Percentage	Count	Percentage
Single	17	68%	3	15%
Married	3	12%	1	5%
Common law	1	4%	9	45%
Divorced	1	4%	0	0%
Separated	3	12%	1	5%
Widowed	0	0%	0	0%
Visiting relationship	0	0%	6	30%

Education	Curaçao		DR	
	Count	Percentage	Count	Percentage
Illiterate	0	0%	1	5%
Primary School incomplete	1	4%	3	15%
Primary School complete	1	4%	4	20%
Secondary School incomplete	11	44%	11	55%
Secondary School complete	8	32%	1	5%
College/University not completed	3	12%	0	0%
Vocational	0	0%	0	0%
College/University	1	4%	0	0%

Country of birth	Curaçao		DR	
	Count	Percentage	Count	Percentage
Colombia	20	80%	0	0%
Dominican Republic	4	16%	0	0%
Curacao	1	4%	0	0%
Haiti	0	0%	20	100%

Country considered home	Curaçao		DR	
Curaçao	20	80%	0	0%
Dominican Republic	4	16%	1	5%
Curacao	1	4%	0	0%
Haiti	0	0%	19	95%

# of people benefiting from salary	Curaçao		DR	
0-2	3	12%		
3-5	13	52%		
6-8	6	24%		
9 or more	3	12%		
0			3	15%
1-3			12	60%
4-6			4	20%
no information			1	5%

Number benefiting < 15 years	Curaçao		DR	
0	13	52%	7	35%
1-3	6	24%	12	60%
4-6	5	20%	1	5%
7 or more	1	4%	0	0%

Country of beneficiaries	Curaçao		DR	
Colombia	20	80%	0	0%
Dominican Republic	4	16%	6	30%
Curacao	1	4%	0	0%
Haiti	0	0%	9	45%
Haiti and the DR	0	0%	2	10%

# days separated from family	Curaçao		DR	
only days	2	8%		
1-2 months	3	12%		
3-4 months	10	40%		
5-6 months	4	16%		
7 months or more	6	24%		
1-7 days			2	10%
8 days -1 month			6	30%
1-3 months			3	15%
3-6 months			7	35%
6 months - 1 year			1	5%
year+			1	5%

Sex Workers - Mobility

Visits during last year	Curaçao		DR	
	Count	Percentage	Count	Percentage
one	20	80%	7	35%
2-4	4	16%		
5-7	0	0%		
8 or more	1	4%		
2-17			8	40%
twice per week			2	10%
live in country			2	10%
not specified			1	5%

Duration of stay	Curaçao		DR	
	Count	Percentage	Count	Percentage
only days	2	8%		
1-2 months	2	8%		
3-4 months	11	44%		
5-6 months	4	16%		
7 months or more	6	24%		
< 1 month			2	10%
1-4 years			6	30%
5-8 years			2	10%
9-12 years			2	10%
not specified			8	40%

Average duration of stay	Curaçao		DR	
	Count	Percentage	Count	Percentage
only days	0	0%		
1-2 months	0	0%		
3-4 months	3	12%		
5-6 months	0	0%		
7 months or more	2	8%		
< 2 months			2	10%
2-4 months			2	10%
5-7 months			3	15%
8= months			1	5%
not specified			5	25%

Type of employment	Curaçao		DR	
	Count	Percentage	Count	Percentage
vendor	1	4%	1	5%
CSW	16	64%	11	55%
waiter/waitress	2	8%	0	0%
dancer	4	16%	2	10%
construction	1	4%	1	5%
student	0	0%	0	0%
unemployed	1	4%	3	15%

other	0	0%	2	10%
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Encouraged to come?		Curaçao		DR	
yes	20	80%	12	60%	

Advance travel/work arrangements?		Curaçao		DR	
yes	15	60%	9	45%	

Living conditions in country		Curaçao		DR	
excellent	0	0%	0	0%	
good	5	20%	5	25%	
fair	15	60%	2	10%	
not so good	3	12%	10	50%	
not at all good	2	8%	3	15%	

Working conditions in country		Curaçao		DR	
excellent	1	4%	0	0%	
good	2	8%	3	15%	
fair	14	56%	4	20%	
not so good	5	20%	9	45%	
not at all good	3	12%	4	20%	

Would've come knowing living conditions		Curaçao		DR	
yes	8	32%			

Would've come knowing working conditions		Curaçao		DR	
yes	8	32%			

Other countries where worked		Curaçao		DR	
Aruba	2	8%	0	0%	
Panama	3	12%	0	0%	
Venezuela	3	12%	0	0%	
Europe	6	24%	0	0%	
Puerto Rico	0	0%	1	5%	

Has boy- / girlfriend in home country		Curaçao		DR	
yes	13	52%	8	40%	

Has boy-/ girlfriend in this country		Curaçao		DR	
yes	11	44%	8	40%	

Sex Workers - Health and HIV/AIDS Knowledge and Skills

Heard of AIDS	Curaçao		DR	
yes	25	100%	19	95%

Age when first heard about AIDS	Curaçao		DR	
7-11	1	4%		
12-15	11	44%		
16-19	6	24%		
20-23	5	20%		
24+	2	8%		
10-13			3	15%
14+			4	20%
don't remember			12	60%

AIDS exists	Curaçao		DR	
yes	25	100%	16	80%

AIDS makes people sick	Curaçao		DR	
yes	25	100%	17	85%

Know one person who died of AIDS	Curaçao		DR	
yes	18	72%	12	60%

Has heard about AIDS	Curaçao		DR	
on the radio	2	8%	17	85%
on television	5	20%	17	85%
on posters in the streets	8	32%	12	60%
in advertisements in cinemas	1	4%	8	40%
in leaflets or brochures	20	80%	12	60%
in articles / ads in newspapers	6	24%	10	50%
in workshops	17	68%	10	50%
in conversations with people	1	4%	0	0%

AIDS can be passed from person to person	Curaçao		DR	
yes	25	100%	15	75%

Can get AIDS from	Curaçao		DR	
drinking from the same cup	3	12%	3	15%
using same toilet	5	20%	4	20%
having sex without a condom	25	100%	15	75%
touching someone's hand who has HIV/AIDS	0	0%	2	10%
don't know	1	4%		0%
no response	0	0%		0%
other	10	40%		0%

Can be infected with AIDS	Curaçao		DR	
injected drug users	23	92%	14	70%
persons who have many sexual partners	24	96%	17	85%
sex workers	23	92%		0%
men having sex with men	24	96%	18	90%
homosexuals	23	92%	17	85%
women having sex with women	19	76%	16	80%
people who have been cursed	4	16%	16	80%
all people	14	56%	3	15%
don't know	0	0%	17	85%
no response	0	0%		0%
other	0	0%		0%

Can be infected and still look healthy	Curaçao		DR	
yes	21	84%	13	65%

AIDS can be cured	Curaçao		DR	
yes	4	16%	2	10%

AIDS can be treated	Curaçao		DR	
yes	24	96%	1	5%

Self-denominated likelihood to be infected	Curaçao		DR	
no chance	3	12%	3	15%
moderate/medium chance	3	12%	11	55%
good chance	19	76%	4	20%
don't know	0	0%	1	5%
already infected	0	0%	0	0%

Person to confide in when infected with HIV	Curaçao		DR	
relative	16	64%	3	15%
friend	1	4%	1	5%
spouse	0	0%	0	0%
partner/boyfriend	0	0%	0	0%
doctor	6	24%	10	50%
social worker	0	0%	0	0%
employer	0	0%	0	0%
priest	1	4%	0	0%
no one	1	4%	4	20%
other	0	0%	1	5%

Has made changes in sexual behavior to avoid HIV	Curaçao		DR	
yes	23	92%	17	85%

Protects herself from infection by	Curaçao		DR	
not having sex at all	2	8%	8	40%
only having sex with one person who is faithful	11	44%	13	65%
always using a condom	24	96%	16	80%
asking potential partners if they have HIV/AIDS	0	0%	9	45%
getting protection from a traditional healer	0	0%	4	20%
never touching anyone who has AIDS	1	4%	3	15%
never speaking to anyone who has AIDS	1	4%	5	25%
don't know	0	0%		0%
other	2	8%		0%

Describes state of health as	Curaçao		DR	
very good	11	44%	9	45%
fairly good	11	44%	8	40%
average	3	12%	3	15%
rather poor	0	0%	0	0%
very poor	0	0%	0	0%

In last 12 months has had drips or a yellow substance coming from vagina/penis, sores in genital area, or was told to have an STI	Curaçao		DR	
yes	17	68%	4	20%

When realized had an STI went for help to	Curaçao		DR	
a traditional healer	0	0%		0%
a clinic/hospital	1	6%		0%
a pharmacy (to get medicine)	0	0%		0%
a private doctor	16	94%		0%

Had sex with STI or STI symptoms	Curaçao		DR	
yes	12	48%	2	10%

If so, used condoms	Curaçao		DR	
always	11	92%	1	50%
sometimes	1	8%	0	0%
never	0	0%	1	50%
no response	0	0%	0	0%
don't recall	0	0%	0	0%

Told sexual partner about STI or symptoms	Curaçao		DR	
yes	4	24%	1	50%

Number of sexual partners in past month	Curaçao		DR	
none	0	0%	1	5%
1-10	15	60%	9	45%
11-20	7	28%	0	0%
21-30	1	4%	0	0%
31-40	0	0%	0	0%
41 or more	2	8%	0	0%
don't remember	0	0%	8	40%
no response	0	0%	2	10%

Number of sexual partners in past week	Curaçao		DR	
0	2	8%	1	5%
1-5	17	68%	8	40%
6-10	4	16%	0	0%
11-15	1	4%	0	0%
16+	1	4%	0	0%
don't remember	0	0%	9	45%
no response	0	0%	2	10%

In past 12 months has been forced to have sex	Curaçao		DR	
yes	3	12%	2	10%

In past 12 months has used drugs	Curaçao		DR	
yes	2	8%	2	10%

Exchanged sex for drugs in past 12 months	Curaçao		DR	
yes	0	0%	1	5%

Has ever used a condom	Curaçao		DR	
yes	25	100%	17	85%

Usually uses a condom with sexual partners	Curaçao		DR	
always	19	76%	11	65%
almost always	3	12%	4	24%
sometimes	2	8%	2	12%
never	1	4%	0	0%

Reason for not always using a condom is	Curaçao		DR	
never had sex	0	0%	0	0%
only have one sexual partner	1	4%	3	15%
only have sex with people who look okay	0	0%	1	5%
I am okay	0	0%	3	15%
I get more money	0	0%	0	0%
condoms are too expensive	0	0%	0	0%
I don't know how to use condoms	0	0%	0	0%

condoms make sex less enjoyable	0	0%	1	5%
I don't know where to buy condoms	0	0%	0	0%
my sexual partner(s) doesn't want to use condoms	1	4%	0	0%
I am too embarrassed	0	0%	0	0%
other	4	16%	0	0%

Did use a condom last time having sex	Curaçao		DR	
yes	2	8%	5	25%

Does carry a condom	Curaçao		DR	
yes	21	84%	7	35%

Can show the condom	Curaçao		DR	
yes	21	100%	5	71%

Would refuse to have sex without a condom	Curaçao		DR	
yes	25	100%	12	60%

Condoms prevent HIV/AIDS if	Curaçao		DR	
they are not damaged	25	100%	18	90%
you use them only once	25	100%	18	90%
they are not older than the date on the package	25	100%	16	80%
you use them more than once	0	0%	7	35%
you put them on only halfway	0	0%	6	30%

Has ever used a female condom	Curaçao		DR	
yes	9	36%	8	40%

Wants to use female condom more often	Curaçao		DR	
yes	8	89%	4	50%

Thinks that people who have HIV/AIDS	Curaçao		DR	
are good	23	92%	10	50%
are bad	2	8%	8	40%
are like any other person	22	88%	11	55%
deserve what they get	0	0%	8	40%
should be punished	0	0%	9	45%
should be punished by God	1	4%	9	45%
should be punished by their ancestors	0	0%	10	50%
should pay for their sins	1	4%	8	40%
are witches	0	0%	8	40%
are normal people who are sick	25	100%	12	60%
are normal people who need love and care	25	100%	15	75%
should not be allowed to work	2	8%	8	40%

Wants to know more about HIV/AIDS		Curaçao		DR	
yes	25	100%	19	95%	

Wants family to know more about HIV/AIDS		Curaçao		DR	
yes	25	100%	18	90%	

Has ever had an HIV test		Curaçao		DR	
yes	17	68%	11	55%	

Knows the result		Curaçao		DR	
yes	16	94%	9	82%	

Did volunteer to take the HIV test		Curaçao		DR	
yes	13	76%	10	91%	

Annex D: Results – Petty Traders

Petty Traders - Personal Information

Sex	Barbados		Curaçao		DR		T&T	
Female	16	80%	17	77%	15	75%	14	70%
Male	4	20%	5	23%	5	25%	6	30%

Age	Barbados		Curaçao		DR		T&T	
18-19	0	0%	0	0%			0	0%
20- 24	0	0%	2	9%			0	0%
25- 29	0	0%	1	5%			0	0%
30- 34	3	15%	6	27%			2	10%
35- 39	3	15%	3	14%			2	10%
40- 44	4	20%	6	27%			8	40%
45 +	10	50%	4	18%			6	30%
No info	0	0%	0	0%			2	10%
23-27					5	25%		
28-32					3	15%		
33-37					3	15%		
38-42					2	10%		
43-47					1	5%		
48-52					2	10%		
53 +					3	15%		
No info					1	5%		

Marital Status	Barbados		Curaçao		DR		T&T	
Single	8	40%	14	64%	2	10%	9	45%
Married	8	40%	4	18%	6	30%	10	50%
Common law	2	10%	2	9%	7	35%	0	0%
Divorced	2	10%	2	9%	0	0%	0	0%
Separated	0	0%	0	0%	1	5%	1	5%
Widowed	0	0%	0	0%	2	10%	0	0%
Visiting relationship	0	0%	0	0%	2	10%	0	0%

Education	Barbados		Curaçao		DR		T&T	
Illiterate			0	0%	5	25%	0	0%
Primary School incomplete			1	5%	7	35%	0	0%
Primary School complete			4	18%	3	15%	7	35%
Secondary School incomplete			7	32%	4	20%	3	15%
Secondary School complete			7	32%	1	5%	10	50%
College/ University not completed			0	0%	0	0%	0	0%
Vocational			1	5%	0	0%	0	0%
College/ University			2	9%	0	0%	0	0%

Country of birth	Barbados		Curaçao		DR		T&T	
Colombia	0	0%	2	9%	0	0%	0	0%
Dominican Republic	0	0%	3	14%	0	0%	0	0%
Haiti	0	0%	2	9%	20	100%	0	0%
Jamaica	0	0%	14	64%	0	0%	0	0%
Trinidad	0	0%	1	5%	0	0%	0	0%
Grenada	0	0%	0	0%	0	0%	6	30%
Guyana	8	40%	0	0%	0	0%	8	40%
Nicaragua	0	0%	0	0%	0	0%	1	5%
St. Vincent	8	40%	0	0%	0	0%	5	25%
St. Lucia	4	20%	0	0%	0	0%	0	0%

Country considered home	Barbados		Curaçao		DR		T&T	
Curaçao	0	0%	2	9%	0	0%	0	0%
Dominican Republic	0	0%	3	14%	0	0%	0	0%
Haiti	0	0%	2	9%	20	100%	0	0%
Jamaica	0	0%	14	64%	0	0%	0	0%
Trinidad	0	0%	1	5%	0	0%	2	10%
Grenada	0	0%	0	0%	0	0%	6	30%
Guyana	4	20%	0	0%	0	0%	7	35%
Nicaragua	0	0%	0	0%	0	0%	1	5%
St. Vincent	4	20%	0	0%	0	0%	4	20%
St. Lucia	3	15%	0	0%	0	0%	0	0%
Barbados	6	30%	0	0%	0	0%	0	0%
Non-response	3	15%	0	0%	0	0%	0	0%

# of people benefiting from salary	Barbados		Curaçao		DR		T&T	
0-2	11	55%	3	14%			2	10%
3-5	4	20%	15	68%			9	45%
6-8	3	15%	3	14%			7	35%
9 or more	2	10%	1	5%			2	10%
1-3					5	25%		
4-6					7	35%		
7-9					3	15%		
10+					5	25%		

Number benefiting < 15 years	Barbados		Curaçao		DR		T&T	
0	7	35%	13	59%	3	15%	3	15%
1-3	10	50%	5	23%	10	50%	16	80%
4-6	2	10%	4	18%	6	30%	1	5%
7 or more	1	5%	0	0%	1	5%	0	0%

Country of beneficiaries	Barbados		Curaçao		DR		T&T	
Colombia	0	0%	2	9%	0	0%	0	0%
Dominican Republic	0	0%	3	14%	2	10%	0	0%
Haiti	0	0%	2	9%	17	85%	0	0%
Jamaica	0	0%	14	64%	0	0%	0	0%
Trinidad	0	0%	1	5%	0	0%	0	0%

DR and Haiti	0	0%	0	0%	1	5%	0	0%
Grenada	0	0%	0	0%	0	0%	6	30%
Guyana	20	100%	0	0%	0	0%	8	40%
Nicaragua	0	0%	0	0%	0	0%	1	5%
St. Vincent	15	75%	0	0%	0	0%	5	25%
St. Lucia	10	50%	0	0%	0	0%	0	0%
Barbados	20	100%	0	0%	0	0%	0	0%
Barbados and Guyana	5	25%	0	0%	0	0%	0	0%
Barbados and St. Vincent	5	25%	0	0%	0	0%	0	0%

# days separated from family	Barbados	Curaçao	DR	T&T
4-Feb		12	55%	
7-May		1	5%	
15-Dec		3	14%	
28-30		1	5%	
180 +		5	23%	
1-7 days			8	40%
8 days -1 month			6	30%
1-3 months			3	15%
6-12 months			1	5%
1 year +			2	10%
not separated	2	10%		
less than 1 week	6	30%		
1-3 weeks	4	20%		
1-2 months	3	15%		
2-4 months	1	5%		
NA	4	20%		

Petty Traders - Mobility and Work

Visits during last year	Barbados	Curaçao	DR	T&T
one	1	5%	8	36%
2-4			1	5%
5-6			12	55%
8 or more			1	5%
2-17			5	25%
daily			5	25%
twice per week			1	5%
not specified			8	40%
2-9	4	20%		4
10-19	3	15%		3
20-29	4	20%		4
30-39	0	0%		0
40+	4	20%		4
NA	4	20%		4

Duration of stay	Barbados		Curaçao		DR		T&T	
1 day			0	0%				
2-4 days			12	55%				
5-7 days			1	5%				
12-15 days			3	14%				
29-30 days			1	5%				
180+ days			5	23%				
< 1year					3	15%		
1-4 years					3	15%		
5-8 years					2	10%		
9-12 years					3	15%		
13-16 years					4	20%		
not specified					5	25%		
<1 week	7	35%					7	35%
1-3 weeks	3	15%					3	15%
1-2 months	5	25%					5	25%
2-4 months	1	5%					1	5%
40 months +	0	0%					0	0%
NA	4	20%					4	20%

Average duration of stay	Barbados		Curaçao		DR		T&T	
2-4 days			6	27%				
5-7 days			3	14%				
12-15 days			3	14%				
28-30 days			1	5%				
40-42 days			1	5%				
< 2 months					9	45%		
8 months +					1	5%		
not specified					8	40%		
NA					1	5%		
< 1 week	7	35%					7	35%
1-3 weeks	3	15%					3	15%
1-2 months	3	15%					3	15%
2-4 months	2	10%					2	10%
4 months +	0	0%					0	0%
NA	5	25%					5	25%

Type of employment	Barbados		Curaçao		DR		T&T	
vendor	4	20%	22	100%	20	100%	18	90%
CSW	0	0%	0	0%	0	0%	0	0%
waiter/waitress	0	0%	0	0%	0	0%	5	25%
dancer	0	0%	0	0%	0	0%	0	0%
construction	0	0%	0	0%	0	0%	0	0%

student	0	0%	0	0%	0	0%	0	0%
unemployed	1	5%	0	0%	0	0%	0	0%
wholesaler/exporter	11	55%	0	0%	0	0%	0	0%
salesperson	2	10%	0	0%	0	0%	0	0%
farmer	1	5%	0	0%	0	0%	0	0%
domestic	1	5%	0	0%	0	0%	0	0%
other	0	0%	0	0%	0	0%	5	25%

Encouraged to come?	Barbados		Curaçao		DR		T&T	
yes	7	35%	16	73%	10	50%	12	60%

Advance travel/work arrangements?	Barbados		Curaçao		DR		T&T	
yes	3	15%	12	55%	4	20%	12	60%

Living conditions in country	Barbados		Curaçao		DR		T&T	
excellent	1	5%	1	5%	1	5%	5	25%
good	15	75%	6	27%	2	10%	8	40%
fair	2	10%	8	36%	3	15%	7	35%
not so good	1	5%	4	18%	11	55%	0	0%
not at all good	0	0%	3	14%	2	10%	0	0%
don't know	1	5%	0	0%	1	5%	0	0%

Working conditions in country	Barbados		Curaçao		DR		T&T	
excellent	0	0%	1	5%	0	0%	2	10%
good	10	50%	7	32%	3	15%	8	40%
fair	4	20%	6	27%	4	20%	10	50%
not so good	3	15%	5	23%	9	45%	0	0%
not at all good	1	5%	3	14%	3	15%	0	0%
don't know	2	10%	0	0%	1	5%	0	0%

Would've come knowing living conditions	Barbados		Curaçao		DR		T&T	
yes	3	15%	13	59%				

Would've come knowing working conditions	Barbados		Curaçao		DR		T&T	
yes	6	30%	13	59%				

Other countries where worked	Barbados		Curaçao		DR		T&T	
Canada	0	0%	1	5%	0	0%	0	0%
Cayman Islands	0	0%	3	14%	0	0%	0	0%
Ecuador	0	0%	1	5%	0	0%	0	0%
Guyana	0	0%	1	5%	0	0%	3	0%
Panama	0	0%	1	5%	1	5%	0	0%
St. Maarten	0	0%	1	5%	0	0%	1	0%
St. Thomas	0	0%	1	5%	0	0%	0	0%
USA	0	0%	1	5%	0	0%	0	0%
Europe	0	0%	2	9%	0	0%	0	0%

Nassau (Bahamas)	0	0%	0	0%	1	5%	0	0%
Antigua	1	5%	0	0%	0	0%	5	25%
Barbados	0	0%	0	0%	0	0%	3	0%
Grenada	1	5%	0	0%	0	0%	1	5%
Suriname	0	0%	0	0%	0	0%	1	0%
Brazil	0	0%	0	0%	0	0%	1	5%
Venezuela	0	0%	0	0%	0	0%	2	0%
Trinidad	3	15%	0	0%	0	0%	0	0%
St. Vincent	1	5%	0	0%	0	0%	0	0%
Dominica	1	5%	0	0%	0	0%	0	0%

Has boy- / girlfriend in home country	Barbados	Curaçao	DR	T&T				
yes	8	40%	14	64%	2	10%	14	70%

Has boy-/ girlfriend in this country	Barbados	Curaçao	DR	T&T				
yes	8	40%	5	23%	4	20%	1	5%

Petty Traders - Health and HIV/AIDS Knowledge and Skills

heard of AIDS	Barbados	Curaçao	DR	T&T				
yes	20	100%	22	100%	20	100%		

age when first heard about AIDS	Barbados	Curaçao	DR	T&T			
7-11		1	5%			0	0%
12-15		6	27%			2	10%
16-19		5	23%			1	5%
20-23		5	23%			6	30%
24+		5	23%			6	30%
10-13				2	10%		
14+				4	20%		
not specified				14	70%	5	25%
<19	5	25%					
20-24	2	10%					
25-29	3	15%					
30-34	0	0%					
35-39	4	20%					
40-44	1	5%					
45-49	2	10%					
50-55	2	10%					
55-59	0	0%					
60+	0	0%					
can't remember	1	5%					

AIDS exists	Barbados		Curaçao		DR		T&T	
yes	20	100%	21	95%	15	75%	20	100%

AIDS makes people sick	Barbados		Curaçao		DR		T&T	
yes	20	100%	22	100%	15	75%	20	100%

know one person who died of AIDS	Barbados		Curaçao		DR		T&T	
yes	8	40%	12	55%	7	35%	12	60%

has heard about AIDS	Barbados		Curaçao		DR		T&T	
on the radio	14	70%	2	9%	18	90%	18	90%
on television	18	90%	7	32%	17	85%	18	90%
on posters in the streets	11	55%	0	0%	10	50%	13	65%
in advertisements in cinemas	3	15%	1	5%	7	35%	0	0%
in leaflets or brochures	10	50%	3	14%	11	55%	4	20%
in articles / ads in newspapers	14	70%	3	14%	10	50%	15	75%
in workshops	0	0%	0	0%	6	30%	5	25%
in conversations with people	0	0%	1	5%	0	0%	0	0%
in church	1	5%	0	0%	0	0%	0	0%

AIDS can be passed from person to person	Barbados		Curaçao		DR		T&T	
yes	20	100%	22	100%	16	80%	18	90%

can get AIDS from	Barbados		Curaçao		DR		T&T	
drinking from the same cup	1	5%	1	5%	2	10%	2	10%
using same toilet	2	10%	2	9%	3	15%	5	25%
having sex without a condom	19	95%	22	100%	15	75%	20	100%
touching someone's hand who has HIV/AIDS	2	10%	0	0%	1	5%	0	0%
don't know	0	0%	0	0%	0	0%	0	0%
no response	0	0%	0	0%	0	0%	0	0%
other	0	0%	1	5%	0	0%	0	0%

can be infected with AIDS	Barbados		Curaçao		DR		T&T	
injected drug users	19	95%	21	95%	7	35%	20	100%
persons who have many sexual partners	19	95%	22	100%	13	65%	20	100%
sex workers	19	95%	22	100%	18	90%	20	100%
men having sex with men	19	95%	22	100%	15	75%	20	100%
homosexuals	19	95%	22	100%	16	80%	20	100%
women having sex with women	14	70%	18	82%	16	80%	2	10%
people who have been cursed	0	0%	0	0%	3	15%	0	0%
all people	0	0%	16	73%	11	55%	3	15%
don't know	0	0%	0	0%	0	0%	0	0%
no response	0	0%	0	0%	0	0%	0	0%
other	0	0%	0	0%	0	0%	0	0%

can be infected and still look healthy	Barbados		Curaçao		DR		T&T	
yes	18	90%	20	91%	12	60%	20	100%

AIDS can be cured	Barbados		Curaçao		DR		T&T	
yes	4	20%	1	5%	1	5%	4	20%

AIDS can be treated	Barbados		Curaçao		DR		T&T	
yes	18	90%	18	82%	4	20%	19	95%

Self-denominated likelihood to be infected	Barbados		Curaçao		DR		T&T	
no chance	16	80%	10	45%	12	60%	15	75%
moderate/medium chance	0	0%	4	18%	4	20%	0	0%
good chance	0	0%	5	23%	2	10%	0	0%
don't know	4	20%	3	14%	2	10%	4	20%
already infected	0	0%	0	0%	0	0%	0	0%

Person to confide in when infected with HIV	Barbados		Curaçao		DR		T&T	
relative	5	25%	6	27%	3	15%	10	50%
friend	1	5%	0	0%	1	5%	10	50%
spouse	3	15%	5	23%	1	5%	10	50%
partner/boyfriend	4	20%	4	18%	0	0%	20	100%
doctor	4	20%	7	32%	9	45%	30	150%
social worker	0	0%	0	0%	0	0%	0	0%
employer	0	0%	0	0%	1	5%	0	0%
priest	1	5%	0	0%	0	0%	10	50%
no one	0	0%	0	0%	3	15%	0	0%
other	3	15%	0	0%	2	10%	10	50%

Has made changes in sexual behavior to avoid HIV	Barbados		Curaçao		DR		T&T	
yes	14	70%	22	100%	17	85%	8	40%

Protects herself from infection by	Barbados		Curaçao		DR		T&T	
not having sex at all	8	40%	3	14%	8	40%	6	30%
only having sex with one person who is faithful	11	55%	20	91%	16	80%	18	90%
always using a condom	0	0%	19	86%	8	40%	11	55%
asking potential partners if they have HIV/AIDS	0	0%	4	18%	4	20%	2	10%
getting protection from a traditional healer	0	0%	0	0%	3	15%	2	10%
never touching anyone who has AIDS	0	0%	2	9%	3	15%	0	0%
never speaking to anyone who has AIDS	0	0%	2	9%	1	5%	0	0%
don't know	0	0%	0	0%	0	0%	0	0%
other	0	0%	0	0%	0	0%	0	0%

Describes state of health as	Barbados		Curaçao		DR		T&T	
very good	17	85%	16	73%	9	45%	12	60%
fairly good	3	15%	4	18%	8	40%	8	40%
average	0	0%	2	9%	3	15%	0	0%

rather poor	0	0%	0	0%	0	0%	0	0%
very poor	0	0%	0	0%	0	0%	0	0%

Number of sexual partners in past month	Barbados		Curaçao		DR		T&T	
0	11	55%	6	27%	8	40%	2	10%
1	9	45%	12	55%	11	55%	13	65%
2	0	0%	3	14%	0	0%	0	0%
3	0	0%	0	0%	1	5%	0	0%
don't recall	0	0%	1	5%	0	0%	0	0%
no response	0	0%	0	0%	0	0%	5	25%

Number of sexual partners in past week	Barbados		Curaçao		DR		T&T	
0	14	70%	9	41%	9	45%	11	55%
1	6	30%	11	50%	11	55%	8	40%
2	0	0%	1	5%	0	0%	0	0%
don't recall	0	0%	1	5%	0	0%	0	0%
no response	0	0%	0	0%	0	0%	1	5%

In past 12 months has been forced to have sex	Barbados		Curaçao		DR		T&T	
yes	1	5%	3	14%	2	10%		0%

In past 12 months has used drugs	Barbados		Curaçao		DR		T&T	
yes	0	0%	0	0%	0	0%	0	0%

Exchanged sex for drugs in past 12 months	Barbados		Curaçao		DR		T&T	
yes	0	0%	0	0%	0	0%	0	0%

Has ever used a condom	Barbados		Curaçao		DR		T&T	
yes	12	60%	22	100%	6	30%	14	70%

Usually uses a condom with sexual partners	Barbados		Curaçao		DR		T&T	
always	1	5%	9	41%	2	10%	0	0%
almost always	0	0%	3	14%	1	5%	1	5%
sometimes	2	10%	7	32%	2	10%	7	35%
never	6	30%	3	14%	1	5%	6	30%
NA	11	55%	0	0%	0	0%	0	0%

Reason for not always using a condom is	Barbados		Curaçao		DR		T&T	
don't have sex	4	20%	0	0%		0%	0	0%
never had sex	0	0%	2	9%		0%	0	0%
only have one sexual partner	10	50%	8	36%		0%	6	30%
only have sex with people who look okay	0	0%	1	5%		0%	0	0%
I am okay	0	0%	5	23%		0%	0	0%
I get more money	0	0%	0	0%		0%	0	0%
condoms are too expensive	0	0%	0	0%		0%	0	0%
I don't know how to use condoms	0	0%	0	0%		0%	0	0%

condoms make sex less enjoyable	2	10%	3	14%		0%	0	0%
I don't know where to buy condoms	0	0%	0	0%		0%	0	0%
my sexual partner(s) doesn't want to use condoms	2	10%	3	14%		0%	0	0%
I am too embarrassed	0	0%	0	0%		0%	0	0%
other	5	25%	1	5%		0%	0	0%
allergic to condoms	1	5%	0	0%		0%	0	0%

Did use a condom last time having sex	Barbados		Curaçao		DR		T&T	
yes	2	10%	6	27%	2	10%	0	0%

Does carry a condom	Barbados		Curaçao		DR		T&T	
yes	2	10%	10	45%	0	0%	0	0%

Can show the condom	Barbados		Curaçao		DR		T&T	
yes	2	100%	9	90%	0	0%	0	0%

Would refuse to have sex without a condom	Barbados		Curaçao		DR		T&T	
yes	10	50%	20	91%	9	45%	6	30%

Condoms prevent HIV/AIDS if	Barbados		Curaçao		DR		T&T	
they are not damaged	17	85%	21	95%	12	60%	17	85%
you use them only once	16	80%	22	100%	11	55%	15	75%
they are not older than the date on the package	11	55%	21	95%	10	50%	12	60%
you use them more than once	17	85%	0	0%	3	15%	8	40%
you put them on only halfway	15	75%	0	0%	2	10%	6	30%

Has ever used a female condom	Barbados		Curaçao		DR		T&T	
yes	0	0%	4	18%	3	15%	1	5%

Wants to use female condom more often	Barbados		Curaçao		DR		T&T	
yes	0	0%	4	100%	1	33%	0	0%

Thinks that people who have HIV/AIDS	Barbados		Curaçao		DR		T&T	
are good	0	0%	14	64%	9	45%	13	65%
are bad	0	0%	8	36%	9	45%	6	30%
are like any other person	15	75%	20	91%	11	55%	19	95%
deserve what they get	2	10%	1	5%	3	15%	1	5%
should be punished	1	5%	0	0%	10	50%	0	0%
should be punished by God	2	10%	0	0%	10	50%	0	0%
should be punished by their ancestors	0	0%	0	0%	7	35%	0	0%
should pay for their sins	1	5%	0	0%	11	55%	0	0%
are witches	0	0%	0	0%	5	25%	0	0%
are normal people who are sick	15	75%	22	100%	14	70%	19	95%
are normal people who need love and care	15	75%	22	100%	13	65%	0	0%
should not be allowed to work	4	20%	9	41%	9	45%	9	45%

Wants to know more about HIV/AIDS	Barbados		Curaçao		DR		T&T	
yes	11	55%	22	100%	20	100%	12	60%

Wants family to know more about HIV/AIDS	Barbados		Curaçao		DR		T&T	
yes	12	60%	22	100%	20	100%	19	95%

Has ever had an HIV test	Barbados		Curaçao		DR		T&T	
yes	5	25%	17	77%	6	30%	12	60%

Knows the result	Barbados		Curaçao		DR		T&T	
yes	5	100%	17	100%	6	100%	11	92%

Did volunteer to take the HIV test	Barbados		Curaçao		DR		T&T	
yes	4	80%	9	53%	5	83%	5	42%