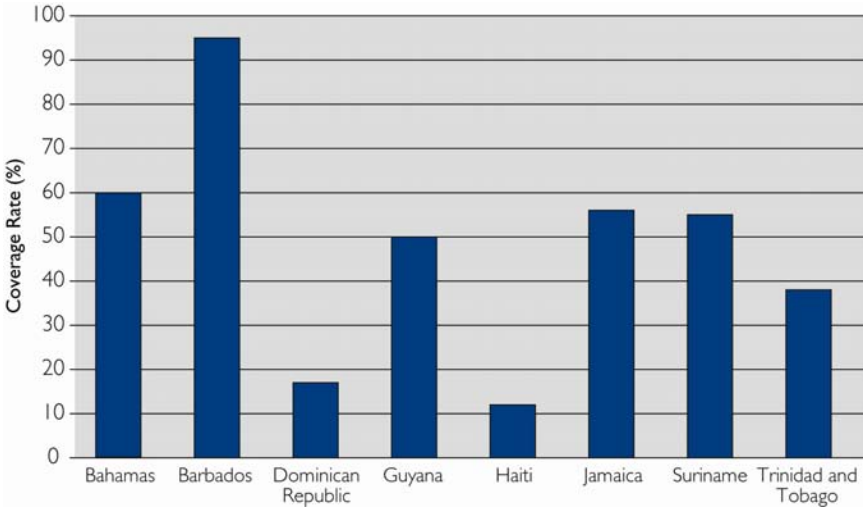
HIV/AIDS HEALTH PROFILE

Caribbean

Overall HIV Trends

Outside of sub-Saharan Africa, the Caribbean has the highest HIV prevalence in the world. In 2006, AIDS was one of the region's leading causes of death among adults aged 15 to 44, claiming the lives of an estimated 19,000 people. That year alone, approximately 27,000 people were newly infected with HIV, according to UNAIDS. The number of people living with HIV/AIDS (PLWHA) in the Caribbean is estimated to be 250,000. Nearly three-quarters of them are from two countries: the Dominican Republic and Haiti. National adult HIV prevalence rates are high throughout the region: 1 to 2 percent in Barbados, the Dominican Republic, Jamaica, and Suriname, and 2 to 4 percent in the Bahamas, Guyana, Haiti, and Trinidad and Tobago. The Caribbean epidemic is fueled by a culture in which men are encouraged to have multiple sexual partners, by a thriving sex industry, and by men having sex with men. A 2005–2006 behavioral surveillance survey (BSS) from six eastern Caribbean countries found that 31 to 46 percent of the surveyed population aged 15 to 24 years had multiple sexual partners in the last 12 months. Prevalence among men who have sex with men (MSM) may be underestimated because of the stigma attached to sexual relations between men, the often hidden nature of this behavior, and the fact that some MSM also have sex with women. Given the poor quality of epidemiological data in the region, the HIV status of most people is not known, and the true magnitude of the epidemic is thus not known. Young women have considerably higher odds of becoming infected than young men (UNAIDS, 2005), in part because of cross-generational sex and the "sugar daddy" phenomenon of young women relying on older men for material, often basic, needs in exchange for sex. New infections among women are surpassing those among men, but whether this is because women are more likely to be HIV-infected or are more likely to be tested, and therefore know their status, remains unclear.

HIV-Infected Men and Women Receiving Treatment in High-Prevalence Countries in the Caribbean, 2006-2007



Source: UNAIDS Web site 2007
Data from the Bahamas are from Ministry of Health 2006 and include children in the treatment rate

Region-Specific Factors

There are a number of important factors driving the epidemic that are unique to the Caribbean. While stigma and discrimination (S&D) related to HIV/AIDS and the practices that make people more vulnerable to infection are not unique to the Caribbean, they are especially acute in small societies and are important in the Caribbean as factors that prevent many people from getting tested. Due to the small size of many islands and the lack of confidentiality policies and practices, a person walking into a facility often fears being observed by a neighbor or a friend or having health practitioners talk about them outside the clinic. Thus, many people travel to other islands for HIV testing, care, and treatment. Addressing S&D will require a comprehensive multisectoral response that includes changing social and cultural beliefs and behaviors and modifying policies at the societal, governmental, employer, and educational levels.

Other important factors include a cultural double standard and sex tourism. There is a large gap between what the population considers to be the ideal sexual behavior and what is actually practiced. There is stigma associated with multiple partners for women but not for men. Although many young people engage in high-risk behaviors, cultural and religious taboos prevent frank discussions with young people about sex. Sex tourism is also a problem in the Caribbean, where tourism is a major source of income. Overseas tourists seek commercial sex services, exposing islanders to sexually transmitted infections (STIs), including HIV.

The Caribbean's status as the second-most HIV-affected region in the world masks substantial differences in the extent and intensity of the epidemic throughout the region. In urban areas of Haiti, new infections have declined. HIV prevalence in pregnant Haitian women decreased from 5.9 percent in 1996 to 3.1 percent in 2004. However, localized trends suggest there is a need to protect against a resurgent epidemic. Preventive behaviors are still not the norm in Haiti. For example, in Haiti's rural areas, only 16 percent of women and 31 percent of men used a condom the last time they had casual sex (UNAIDS, December 2006). Recent data from Haiti's Ministry of Public Health and Population also indicate that in some areas, the prevalence of HIV infection among young women is twice that of young men.

In the Dominican Republic, the country's epidemic is driven by people who have multiple sex partners, younger women in union with older men, sex workers and their clients, and MSM. According to the latest Dominican Republic Demographic and Health Survey, 29 percent of men had sex with more than one partner in the last 12 months. Women younger than 24 years are also more than twice as likely to be infected as men in the same age group. It is a relatively common practice for young women to establish relationships with older men who are more likely to have acquired HIV. In the Dominican Republic, HIV prevalence among pregnant women was relatively stable for many years. However, 2005 sentinel surveillance data reported HIV prevalence greater than 4.5 percent in pregnant women at two sites. In the 2006 sentinel surveillance of pregnant women of all ages, four sites reported prevalence of 3.4 percent and one reported 5.9 percent. As reported in a recent study, pregnant women ages 25 to 34 had a prevalence rate of more than 8 percent at two sites. The same study reported that prevalence in commercial sex workers ranged from 2.4 to 6.5 percent, with an average of 4.1 percent, and that in STI patients it ranged from 2.5 to 7.2 percent, with an average of 4.4 percent. However, in Santo Domingo, antenatal clinics have noted a decline in HIV prevalence, probably due to a successful prevention campaign. Prevalence in sex workers has also been declining for the last eight years and is reaching the same level as in pregnant women. This may be attributable to the successful implementation of the "100% Condom Strategy" by two nongovernmental organizations (NGOs) in several provinces with major tourist activity. For example, condom use among sex workers increased from 75 to 94 percent in just 12 months in one community project. A 2005 study in three cities, including the capital, Santo Domingo, found that 11 percent of MSM were HIV-positive. Infection levels among sugar cane plantation workers living in communities called *bateyes* average 5 percent, with rates as high as 12 percent in some *bateyes*.

At 3.3 percent, the Bahamas has one of the highest HIV prevalence rates in the region. Nonetheless, HIV infection levels are falling among pregnant women and persons attending STI clinics. The Bahamas has been particularly successful in using antiretroviral treatment (ART) to reduce both mother-to-child AIDS transmission and the number of deaths due to the disease.

In Guyana, the second-poorest country in the Caribbean, AIDS is ranked as one of the leading causes of death among 25- to 34-year-olds. HIV has spread from high-risk populations, mainly commercial sex workers and MSM, to the general population, and the adult HIV prevalence rate is estimated to be 2.5 percent. One study in three regions demonstrated an HIV prevalence rate of 27 percent among sex workers. A BSS of MSM in the Demerara-Mahaica region found that 21 percent of MSM surveyed were HIV-positive.

In Jamaica, HIV prevalence has stabilized at 1.5 percent. However, the epidemic has spread from traditionally high-risk groups, such as sex workers, to the general population. Two factors contributing to the epidemic are a culture of multiple sex partners and the phenomenon of older men having sex with younger women. A 2004 BSS demonstrated that 89 percent of males and 78 percent of females aged 15 to 24 had participated in risky sex with a nonmarital or noncohabitating partner in the last 12 months. Fifty-six percent of males and 16 percent of females had multiple partners in the last 12 months. New infections among young women are surpassing those among young men. However, surveillance data, as presented by Dr. Peter Figueroa of Jamaica's Ministry of Health at the U.S. Government-sponsored sixth annual Caribbean U.S. Chiefs of Mission Conference on HIV/AIDS held in Jamaica in October 2007, indicate that adolescent females (10 to 19 years old) are 2.7 times more likely to be infected than same-age males. One reason is the relatively common practice of young girls establishing relationships with older men. By virtue of their age, older men are more likely to be infected with HIV than younger men. One study in Jamaica demonstrated that young women in economically desperate circumstances may exchange sex for money, food, or other favors. When the man is significantly older than the woman, this is called the "sugar daddy" phenomenon. HIV infection rates among sex workers are also much higher than among the general population. One study among female sex workers found that 9 percent were HIV-positive. However, according to Jamaica's 2006 UNGASS report, an earlier study found a 20 percent prevalence rate among sex workers in the tourist areas of Montego Bay. Sex workers who were older, less educated, and used crack cocaine (which was also a risk factor for HIV infection among women in Trinidad and Tobago) were more likely to be infected.

Among patients attending STI clinics in Kingston, St. Andrew, and St. James, HIV infection rates are 5 percent.

HIV Estimates in Selected High-Prevalence Caribbean Countries	
Bahamas	
Total Population	305,655
Estimated Number of Adults and Children Living with HIV/AIDS	6,800
Adult HIV Prevalence	3.3%
HIV in Most-at-Risk Populations	
Commercial Sex Workers	-
MSM	-
Barbados	
Total Population	280,946
Estimated Number of Adults and Children Living with HIV/AIDS	2,700
Adult HIV Prevalence	1.5%
HIV in Most-at-Risk Populations	
Commercial Sex Workers	-
MSM	-
Dominican Republic	
Total Population	9,365,818
Estimated Number of Adults and Children Living with HIV/AIDS	66,000
Adult HIV Prevalence	1.1%
HIV in Most-at-Risk Populations	
Commercial Sex Workers	2.4-6.5% (2006)
MSM	11% (2004)
Guyana	
Total Population	769,095
Estimated Number of Adults and Children Living with HIV/AIDS	12,000
Adult HIV Prevalence	2.5%
HIV in Most-at-Risk Populations	
Commercial Sex Workers	26.6% (2004)
MSM	21.3% (2004)
Haiti	
Total Population	8,706,497
Estimated Number of Adults and Children Living with HIV/AIDS	190,000
Adult HIV Prevalence	3.8%
HIV in Most-at-Risk Populations	
Commercial Sex Workers	-
MSM	-
Jamaica	
Total Population	2,780,132
Estimated Number of Adults and Children Living with HIV/AIDS	25,000
Adult HIV Prevalence	1.5%
HIV in Most-at-Risk Populations	
Commercial Sex Workers	9% (2006)
MSM	20-30% (2006)
Suriname	
Total Population	470,784
Estimated Number of Adults and Children Living with HIV/AIDS	5,200
Adult HIV Prevalence	1.9%
HIV in Most-at-Risk Populations	
Commercial Sex Workers	21% (2005)
MSM	-
Trinidad and Tobago	
Total Population	1,056,608
Estimated Number of Adults and Children Living with HIV/AIDS	27,000
Adult HIV Prevalence	2.6%
HIV in Most-at-Risk Populations	
Commercial Sex Workers	-
MSM	-

*Multiple partners and cross-generational sex were not included in this table because HIV prevalence data do not exist for those populations.

Several countries are making progress in providing access to ART. This is especially true in the Bahamas, Barbados, Jamaica, Guyana, and Suriname (see graph). Barbados' balanced approach to prevention and treatment is demonstrating results. HIV infection in young pregnant women fell from 1.1 percent in 2000 to 0.6 percent in 2003. In Barbados, a steep decline in HIV deaths from 34.2 per 100,000 population (older than 16 years) to 17.2 has occurred since the introduction of ART in the late 1990s. Guyana's ART program reached half of the infected population eligible for treatment and may help to reverse the trend of rising deaths due to the disease.

However, ART is expensive and access in the Caribbean is highly uneven, with some of the worst-affected countries – such as Haiti and the Dominican Republic – having the lowest rates of ART coverage, at less than 20 percent. Lower prices from pharmaceutical companies and assistance from donors have been especially important in providing HIV treatment in the region. The Global Fund to Fight AIDS, Tuberculosis and Malaria[1] funds ART for the Organization of Eastern Caribbean States (OECS) countries, and Brazil provides free ART to 500 persons living with AIDS in the Caribbean Community and Common Market (CARICOM) countries. Even while access to ART has increased appreciably, there is still a need to scale up prevention efforts to stop new infections from occurring.

Economic and Social Impact of HIV/AIDS in the Caribbean Region

HIV infections are increasingly affecting the younger and most economically productive segments of society. If unchecked, the epidemic could impact national economies, as evidenced by high-level epidemics in sub-Saharan Africa. The 20- to 49-year age group is most affected in the Caribbean, accounting for more than 65 percent of positive cases annually. Younger women are particularly affected. In Haiti, AIDS is the leading cause of death among adults aged 15 to 44. In the Dominican Republic, life expectancy is estimated to be three years shorter than it would be in the absence of AIDS (UNAIDS, 2006), and AIDS is reported to be the principal cause of death in women of reproductive age. HIV/AIDS changes a population's demographic structure and poses a challenge to the systems for supporting dependent populations such as children and the elderly. In Trinidad and Tobago, where the population is already decreasing due to out-migration, AIDS is expected to further reduce population size by 2010.

The economic and social effects of HIV/AIDS are felt from the family level, where families experience incapacity and death of loved ones and providers must cope with the burden of caring for the sick and dying, to businesses, schools, hospitals, and other institutions that suffer the loss of valuable personnel and declines in productivity. Dr. Denzil Douglas, Chairman of the Pan Caribbean Partnership Against HIV/AIDS (PANCAP), presented data at the World Bank conference "Accelerating the Response to HIV/AIDS in the Caribbean" that predicted that the gross domestic product in some Caribbean countries could be reduced by as much as 4 percent because of the disease. The economic costs of addressing HIV and its effects, both in the health and economic sectors, divert resources away from other important investments that are critical to economic development. In many cases, the impact of the epidemic on families, communities, and countries affects the epidemic's future course. For example, HIV/AIDS can contribute to poverty and the breakdown of social and economic systems, which in turn can facilitate the spread of the infection.

Finally, HIV/AIDS has orphaned an estimated 250,000 children in the Caribbean, many of whom will lose their childhoods and be forced by circumstances to become producers of income and food or caregivers for sick family members. They suffer their own increased health problems related to increased poverty and inadequate nutrition, housing, education, clothing, and basic care and affection.

National/Regional Response

Although small in absolute number of cases when compared with other global "hot spots," the Caribbean's fragile small-island economies and second-highest regional HIV prevalence rate in the world make it a high-profile region in the global fight against AIDS. The high levels of intraregional mobility and interdependence make regional coordination an important part of addressing common concerns in the response to HIV/AIDS, which is easily transmitted across borders.

Most Caribbean countries have taken measures to control the epidemic. By the end of 2006, 21 Caribbean countries had national strategic plans on HIV/AIDS. However, the national health care infrastructure in many countries is not adequately equipped to address the individual and societal challenges posed by the epidemic, including S&D; the cost of prevention, treatment, care, and support services; income and job losses; reduced tourism revenue; and diminished labor productivity in key sectors due to illness and the reduced life expectancy of young people.

[1] The United States Government provides one-third of the funding for the Global Fund.

Most national-level activities are supported by a coordinated regional approach articulated by PANCAP in the Caribbean Regional Strategic Framework, which was initiated in 1998 by the Caribbean Task Force on HIV/AIDS to scale up the response to the epidemic in the region. The framework, developed under the leadership of CARICOM with input from other regional organizations, national governments, and bilateral and multilateral donors, identifies seven interrelated priorities best addressed at a regional level:

- Advocacy, policy development, and legislation
- Care, treatment, and support of PLWHA
- Prevention of HIV/AIDS transmission among young people
- Prevention of HIV/AIDS among most vulnerable groups (including MSM, sex workers, prisoners, military personnel, and transients)
- Prevention of mother-to-child transmission (PMTCT)
- Strengthening of national and regional response capability
- Resource mobilization

The United States Agency for International Development (USAID) works in collaboration with several regional organizations integral to the region's HIV/AIDS response, including the Caribbean Epidemiology Center (CAREC), the principal technical public health organization for the region, which mainly serves the eastern Caribbean. CAREC is administered by the Pan American Health Organization (PAHO), the regional office of the World Health Organization. Its mission is to improve health status in 21 member countries by advancing technical capacity in epidemiology, laboratory technology, training, and research. PANCAP, PAHO, UNAIDS, and the William J. Clinton Foundation were instrumental in negotiating with pharmaceutical companies to reduce ART prices for 15 Caribbean countries. The Caribbean Coalition of National AIDS Program Coordinators, a peer-based organization dedicated to improving the quality of national AIDS programs, has also emerged as a key coordinating body in the regional fight against HIV/AIDS. UNAIDS is also expanding its Caribbean presence.

USAID Role

USAID programs in the Caribbean region are implemented in partnership with the U.S. President's Emergency Plan for AIDS Relief (Emergency Plan/PEPFAR). The Emergency Plan is the largest commitment ever by any nation for an international health initiative dedicated to a single disease – a five-year, $15 billion, multifaceted approach to combating the disease in more than 114 countries around the world. To date, the U.S. has committed $18.8 billion to the fight against the global HIV/AIDS pandemic, exceeding its original commitment of $15 billion over five years. USAID plays a lead role in helping to coordinate the activities of several U.S. Government agencies in the region, including the Centers for Disease Control and Prevention (CDC), the Peace Corps, the Department of Labor, and the Department of Defense. Haiti and Guyana are two of the 15 focus countries supported by the Emergency Plan. All other Caribbean countries that receive U.S. Government HIV funding through USAID also benefit from Emergency Plan funding as nonfocus countries. USAID also works with the Global Fund, other donors and development banks, UNAIDS, and PAHO, which have brought crucial resources and technical capacity to the region's fight against HIV/AIDS.

USAID is an active member of PANCAP, providing support on both a bilateral and regional basis for increasing the capacity of nongovernmental and community organizations to deliver prevention, care, and treatment programs and for improving the capacity of governments to implement an effective response.

The U.S. Government is the major contributor to the Global Fund and is leveraging Global Fund resources in HIV/AIDS for maximum results in the Caribbean. USAID is coordinating with the Global Fund to scale up the Caribbean regional response to HIV/AIDS through PANCAP, OECS, and the PLWHA organization CRN+.

Bilateral support is provided through USAID Missions in the Dominican Republic, Guyana, Haiti, and Jamaica, while the Barbados-based Caribbean Regional Program provides technical support for selected countries without a bilateral USAID mission (Trinidad and Tobago, Suriname, St. Kitts and Nevis, St. Lucia, St. Vincent and the Grenadines, Grenada, Antigua and Barbuda, Dominica, and Barbados). The 2005–2009 strategy for USAID's Caribbean HIV/AIDS regional program is to build on previous interventions to support national and regional efforts addressing HIV/AIDS issues, primarily expanded HIV prevention, treatment, and care services; improved monitoring of the epidemic; and further prevention of HIV transmission in high-risk groups. USAID focuses on high-risk and vulnerable populations in both high- and low-prevalence countries. Crosscutting themes include reducing S&D, increasing preventive and behavior change efforts, and putting more focus on gender issues that put young women at risk for HIV/AIDS. Specific areas of regional activities include support for PANCAP, CAREC, nongovernmental networks, and the Caribbean Regional HIV/AIDS Training (CHART) network of centers to train health care professionals to provide quality HIV/AIDS services.

USAID Regional Support

Caribbean Epidemiology Center (CAREC)

USAID provides support to CAREC to prevent the spread of HIV and to minimize the impact of AIDS by strengthening national and regional capacity in the areas of research; by improving diagnosis, care, and treatment for TB/HIV programs; and by providing information to target behavior change interventions at groups most likely to acquire and spread HIV. From 2003 to 2007, USAID provided financial resources and worked in collaboration with CAREC to execute and publish BSSs in **Antigua and Barbuda**, **Dominica**, **Grenada**, **St. Kitts and Nevis**, **St. Lucia**, and **St. Vincent and the Grenadines**. These surveys provide information on critical gaps in HIV/AIDS services and on high-risk behaviors driving the epidemic.

Nongovernmental Organization (NGO) Networks

USAID's regional program supports the strengthening of managerial, technical, and administrative capacities of NGOs involved in HIV/AIDS prevention activities and works with national governments in public-private partnerships to develop multiyear HIV prevention plans. USAID supports NGO networks in six countries in the eastern Caribbean that are working with national governments to reduce HIV transmission among high-risk populations. Members of the networks receive training in financial sustainability, governance, income generation, and monitoring and evaluation. In the current strategy, USAID works with local partners to target three population groups: sex workers, MSM, and PLWHA. USAID is shifting its focus from high-risk groups to high-risk behaviors because behavior is what places someone at risk, and it is not always easy to categorize a person into a specific high-risk group. The Agency supported 18 prevention programs in nine countries that targeted behavior change interventions for more than 8,000 people, most of them in hard-to-reach vulnerable populations. Activities included organizing training workshops on education and prevention of HIV/AIDS; interpersonal skills building and behavior change to reduce the likelihood of HIV transmission; and advocacy work with regional bodies to promote the rights and needs of members of key populations.

Regional Training Centers

As governments and NGOs scaled up activities to meet the demand for care, it became apparent that the Caribbean region had a shortage of health care providers trained in HIV/AIDS. To address this need, the regional program collaborated with two other U.S. Government agencies, CDC and the Health Resources and Services Administration, and the University of the West Indies to establish the CHART network of HIV/AIDS training centers in the region. The initiative led to the establishment of six training centers in **Jamaica**, **Bahamas**, **Barbados**, **Haiti** (two centers), and **Trinidad and Tobago** that provide training to health professionals from more than 30 countries. USAID/Barbados contributes to CHART through a five-year cooperative agreement extending through 2009. In 2006, 691 HIV/AIDS service providers were trained and then provided services in 315 voluntary counseling and testing (VCT) sites and 46 ART clinics that treated more than 7,000 patients. The Caribbean program continues to expand the number and quality of VCT trainers in the region. The training program supports service delivery in VCT, PMTCT, and clinical care and treatment. Building on the large network of VCT trainers already developed, USAID conducts refresher courses and technical updates for master and advanced trainers to ensure that their HIV/AIDS-related knowledge, skills, and attitudes comply with standards that are in accord with the latest available evidence.

USAID Country Support in the Caribbean Region

In the Caribbean, USAID also provides direct technical support to individual countries. Examples of USAID country support include the following:

- Supported prevention programs in **Haiti** emphasizing abstinence and being faithful messages for 345,700 people; counseling and testing for 128,600 people; palliative care and support for 38,700 people; and program assistance for 20,000 orphans and vulnerable children (OVC)
- Reached more than 250,000 adolescents and youth in the **Dominican Republic** with abstinence and being faithful messages through the annual youth and adolescent song contest; reached 117,000 people with testing and counseling services; supported PMTCT services in 82 facilities for almost 72,000 women and their babies; provided direct support to six outpatient clinics; supported treatment for 11,552 HIV-positive patients and 7,669 OVC through 18 community- and home-based care programs for children and families affected by HIV/AIDS
- Launched a media campaign in **Suriname** that significantly increased HIV counseling and testing between December 2005 and August 2006. Client satisfaction has improved and staff workload has decreased since the implementation of same-visit testing
- Supported prevention programs in **Guyana** emphasizing abstinence and being faithful messages for 33,900 people and reached 28,300 people with counseling and testing services

Important Links and Contacts

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USAID HIV/AIDS Web site for the Caribbean Regional Program:
http://www.usaid.gov/our_work/global_health/aids/Countries/lac/caribbeanregion.html

For more information, see USAID HIV/AIDS Web site *http://www.usaid.gov/our_work/global_health/aids* and
Latin American and Caribbean HIV/AIDS Initiative Web site *http://www.usaid.gov/our_work/global_health/aids/Countries/lacin.html*

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