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Caribbean Crossroads

In June 2000, the heads of state and ministers of finance of the Caribbean nations summoned an urgent conference to assess the devastating effects of HIV/AIDS. The Caribbean Conference on HIV/AIDS, hosted by the government of Barbados on September 11–12 was an historic event. The conference recognized the central role of treatment and not just prevention in response to the epidemic. For the first time, the link was made between the actual economic impact of HIV/AIDS and what it would cost to control the epidemic.

From an epidemiological standpoint, the statistics are chilling. It is estimated that approximately 2 percent of the region's population—more than 500,000 people—are infected with HIV/AIDS. The rate of HIV/AIDS is sharply increasing, particularly among the most productive age groups. Already, it is the chief cause of death for men and women between the ages of 15 and 45. The Caribbean occupies the highest incidence of HIV/AIDS among women in Latin America and the Caribbean. By the year 2020, HIV/AIDS may account for 73.5 percent of deaths in this region.

Of the 12 countries with the highest HIV prevalence in the Americas, 9 are in the Caribbean. The island of Hispaniola, comprising Haiti and the Dominican Republic, accounts for 75 percent of the cases. Puerto Rico, included in the official statistics of the United States and ranking second within the U.S. infection rates, plays a special role in the transmission of the disease because it is a central transportation and commerce hub for the Caribbean.

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The Epidemic under Our Noses

From culture to culture and island to island, HIV/AIDS is enveloped in a dark shroud of irrationality. Professionals working on the issue must wend their way through a labyrinth of stigma, taboo, denial, discrimination, and secrecy. HIV/AIDS is a condition related to sex, blood, death, disease, and forbidden or illegal behavior—men having sex with men, the sex trade (both male and female), drug abuse, and the sexual abuse of children. The fear associated with the disease thwarts efforts to address its causes and find solutions, starting at the level of private, isolated individuals and working all the way up to societal levels. Denial causes communities and nations to refuse to acknowledge the HIV threat. Nevertheless, the causes and consequences of the epidemic will inexorably require them to deal with many controversial issues: religion, human rights, cultural norms governing male and female sexuality, the social and economic status of women, sex workers, migration patterns, inequities in health care and education, and rising drug abuse.

The behavioral dynamics that fuel the epidemic in the Caribbean are linked to the sociocultural contexts of sex and sexuality:

- early initiation of sexual activity (60 percent by the age of 12 years in some countries), exacerbated by social and religious taboos that prevent teaching or discussing safe sex with young people;
- social norms that condone, or even encourage, multiple sexual partners in men of all ages;
- unprotected sexual intercourse due to cultural attitudes and the inaccessibility or unavailability of condoms;
- social and legal repression of same-sex partners, which drives homosexuals underground and results in bisexual relationships that increase the risk of HIV/AIDS transmission to women;
- continued denial by authorities of sexual activity in prisons, including the development of preventative programs;
- new sex trends in the region, often driven by poverty and inequity, such as sex tourism, sex work by school girls, housewives, and children;
- the emotional and socioeconomic dependence of women on men, hampering their ability to negotiate safe sex practices; and
- substance abuse, especially of drugs and alcohol, which impairs judgment and increases high-risk behavior.

Another dynamic surrounds national and institutional capabilities to cope with the epidemic:

- National elections result in a change of government every four to five years, creating discontinuous political commitment.
- Support for the National AIDS Programs in human resources and budget allocations has decreased even as the epidemic increases.
- National policies on testing and reporting of HIV are scarce. This is compounded by the absence of a standardized case definition (underreporting of HIV/AIDS cases can range from 30 percent to 75 percent in some countries).
- There is a lack of sentinel surveillance and behavioral studies that would allow for the determination of HIV sero-prevalence over time, and few targeted prevention programs are in place.
- There is limited or no access to voluntary, confidential counseling and testing (VCT).

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Probably the most important dynamic is the lack of involvement of people living with HIV/AIDS (PLWHA). In the Caribbean, the fatality rates of PLWHA have remained at a constantly high level. Little has been done to help enhance the quality of life of these people. This is due to several reasons: late diagnosis of HIV infection and related conditions; HIV/AIDS testing without consent or withholding results from PLWHA; the absence of policies, skills, and resources to prevent mother-to-child transmission (MTCT) in many countries; the high cost of antiretroviral therapies, limiting accessibility; the inaccessibility of basic medicines to combat opportunistic infection; and the denial or scarcity of medical services to HIV/AIDS patients, due to the fear of health care providers becoming contaminated or due to hospital policies themselves.

The fact that realistically there is no treatment available for many people leads to a fatalistic attitude. Policymakers exhort people living with HIV/AIDS to "come out," yet the people living with HIV/AIDS say "come out to what?" People shun testing for HIV because the disclosure of their status could lead to stigma, discrimination, and loss of employment. People living with HIV/AIDS stop looking for jobs since many health insurance schemes require an HIV/AIDS test.

Socioeconomic and Demographic Impact

As noted earlier, AIDS is already the leading cause of death in the Caribbean region among those 15–44 years old. The fact that younger age groups are dis-

proportionately affected by this life-threatening disease means that reduced life-expectancy figures can be projected. Furthermore, the expected contributions to national economic and social development of people living with HIV/AIDS becomes smaller and less reliable. This is of particular concern in small countries, for whom the loss of skilled individuals robs them of a resource that is not easily replaced. At the macroeconomic level, the costs associated with this kind of loss include increased absenteeism, higher training costs, foregone income, and resources that would otherwise go into productive activities but need to be shunted into health care.

The fear associated with the disease thwarts efforts to address its causes and find solutions.

Social and economic repercussions are inevitable, as the most economically active population becomes heavily affected by a long-lasting, fatal epidemic. Studies have attempted to project the economic burden over time. Estimates suggest that the direct medical costs and the indirect costs of lost productivity could amount to more than 6 percent of the region's gross domestic product by the end of 2000.

One study, conducted by the University of the West Indies, estimated that by 2005 the gross national product (GNP) of Trinidad and Tobago and Jamaica will be lowered by 4.2 percent and 6.4 percent, respectively. Savings will be reduced by 10.3 percent and 23.5 percent. Investment will also shrink, and employment in key sectors such as agriculture and manufacturing will fall by 20 percent in Trinidad and Tobago and 25 percent in Jamaica. Similar macroeconomic effects are to be expected in other Caribbean countries. Because of HIV's long latency period, the immediate economic consequences may not become palpable for some time.

One of the most important long-term effects of a generalized HIV/AIDS epidemic is its impact on demographic indicators. During the late twentieth century, the average life expectancy in the developing world increased from 40 years to 64 years, narrowing the gap with the industrialized nations. HIV/AIDS has now halted this trend; in some countries it has even reversed it. Indeed, in some nations heavily affected by HIV/AIDS, the average life expectancy has regressed to less than what it was a decade ago. Given current trends, the Caribbean is unlikely to escape such a fate.

In Caribbean Regional Epidemiological Centre (CAREC) member countries, of the English- and Dutch-speaking Caribbean—6.5 million out of the total Caribbean population of 30 million—it is estimated that 6 percent of children with HIV/AIDS are infected via MTCT. CAREC estimates that in

2010, because of AIDS, overall child mortality in the region could increase by 60 percent. This is eroding the gains made in past decades by child survival programs.

A particularly devastating effect concerns the surviving children of parents who are victims of the disease. The Joint United Nations Programme on HIV/AIDS (UNAIDS) estimated that by the end of 1999 the cumulative number of Caribbean children orphaned by HIV/AIDS at age 14 or younger stood at 83,000. This figure is undoubtedly much higher, because the diagnosis and reporting of mortality is usually based on opportunistic infections, especially in countries where it is difficult and expensive to get an HIV/AIDS test.

The Mobile Epidemic

Globalization has placed the Caribbean at the world's doorstep. Over 20 million tourists visit the islands each year. Conversely, globalization also means the Caribbean is just down the block from New York, London, Toronto, or Amsterdam—anywhere in the world where there are opportunities for education, employment, and a better quality of life. And of course, Caribbean emigrants in increasing numbers are returning to their homelands to visit, do business, or retire.

Because mobility is often linked to the increased risk of HIV/AIDS infection, the characteristics of population movements that make up such a distinctive part of Caribbean life call for thoughtful analysis to encourage a focus on care and prevention issues. This focus needs to take account of the general population, tourists, workers in the tourism industry, and other mobile populations such as laborers and commercial sex workers.

Many governments fear that the HIV/AIDS epidemic will hinder the development of their tourism industries and refuse even to discuss it. The belief that discussion of HIV/AIDS will turn away tourists has been proven through research to be unfounded. Countries that have adopted stringent HIV/AIDS awareness campaigns, such as Thailand, have in fact experienced an increase in tourism. Now that tourism is taking priority over trade, a public debate on HIV/AIDS is crucial.

A key feature of heavily touristed areas and highly mobile populations is the increased presence of a commercial sex industry. Economic hardship is usually the single most important reason given by sex workers for going into the trade. Economic difficulties in the region and the rigors of structural adjustment over the last two-and-a-half decades have led to a dramatic rise in the number of women and men seeking work in a market that exists both inter-island and overseas. The lack of regulation in the sex trade means that

social and health services are rarely responsive to the particular needs of this group. Given their marginalized status and the usually illegal nature of their work, it is very difficult for women and young boys to seek protection from coercive or physically abusive clients.

New sexual patterns are also emerging. Increasingly, new groups are being pulled into commercial and/or transactional sex (sex for food, sex for school fees, sex for shelter); this includes schoolgirls, housewives, and children of both sexes. In the Dominican Republic alone, the United Nations Children's Fund (UNICEF) is working with 50,000 child prostitutes living in the streets. The vulnerability of sex workers, as well as the role they play in the overall transmission of the epidemic in the region, requires specially targeted interventions and policy frameworks.

Exploitation, as in other parts of the world, is pervasive, covert, and rots individual self-esteem. Young girls are, as ever, vulnerable to the chasm of coercive sex, rape, incest, domestic violence, and predatory "sugar daddies." Many older men increasingly seek younger girls for sex in the belief that they are more likely to be HIV-free. On a more sinister note, in some areas there is also a mistaken belief that sex with virgins is somehow a cure for HIV/AIDS. These issues are inextricably linked to the spread of HIV/AIDS; any expanded response to the epidemic must take them into account.

Crafting a Regional Response

National, regional, and multilateral institutions have made some progress in crafting a Caribbean response to this challenge. The overarching framework for the effort is provided by the Caribbean Community (CARICOM), which comprises all territories and independent states of the Caribbean with the exception of Cuba. CARICOM's Council of Human and Social Development is responsible for issues related to HIV/AIDS. UNAIDS, which comprises seven UN agencies, was created in 1995 to strengthen and support the response to the HIV/AIDS epidemic. UNAIDS covers the 24 countries of the English-, Spanish-, French-, and Dutch-speaking Caribbean and works at regional and national levels in the areas of advocacy, prevention strategies, and national multisectoral strategic planning and in getting people living with HIV/AIDS more actively involved in the issue. CAREC was established in 1975 and serves 21 member countries in the Caribbean. CAREC's Special Program on Sexually Transmitted Diseases focuses on HIV/AIDS through behavioral studies as well as improved surveillance diagnosis and treatment capabilities. CAREC has been particularly active in the areas of advocacy, policy planning, and capacity building. The Caribbean Network of People Living with HIV/AIDS (CRN+) is a regional voice for

networks of people living with HIV/AIDS in the pan-Caribbean. This engages people with the disease more actively in national and regional fora and seeks to overcome the stigma and discrimination that exists. Given the challenges that lay ahead for the region, CARICOM, UNAIDS, and the European Union convened a Caribbean Consultation Meeting in June 1998 which led to the creation of the Caribbean Task Force on HIV/AIDS. The Task Force is made up of individuals from UN agencies, CARICOM, CAREC, National AIDS Programs, and key regional partners.[1] After exhaustive consultations with national ministers of health, the Task Force produced the Regional Strategic Plan (RSP) to combat the spread of the virus.

AIDS is already the leading cause of death among those aged 15-44 in the Caribbean.

The RSP framework identifies priority areas at the regional level, focusing on promoting a strengthened, effective, and coordinated regional response to the epidemic. The plan is also aimed at expanding multisectoral HIV/AIDS programs at the national level. The priority areas that correspond to the challenges faced by the region include

- advocacy, policy development, and legislation;
- support for people living with HIV/AIDS;
- prevention of HIV transmission, with a focus on young people;
- prevention of HIV transmission particularly among vulnerable groups, including men who have sex with men, sex workers, prisoners, uniformed populations, mobile populations, and workplace interventions;
- prevention of MTCT of HIV; and
- strengthening national and regional response capacity.

Successful implementation of the RSP will require the support of a variety of players. To facilitate the plan's realization, key activities identified will strengthen existing programs and activities at the regional level, such as the UNAIDS biannual workplan in collaboration with its cosponsors.

The Sign for Hope

In order to generate the highest political commitment for the RSP, a CARICOM/UNAIDS/World Bank delegation gave the region's heads of state and ministers of finance a presentation on the economic and developmental implications of the HIV/AIDS epidemic at the Caribbean Group for

Cooperation in Economic Development meeting in June 2000. As a result, the prime minister of Barbados convened the Caribbean Conference on HIV/AIDS.

Participants included governments from the English-, Spanish-, French-, and Dutch-speaking countries and territories, representatives of Caribbean regional organizations, UN agencies, multilateral and bilateral agencies, civil society and associations of people living with HIV/AIDS, academic institutions, and the media. Prime ministers from six countries (Barbados, the Bahamas, St Vincent, the Grenadines, St Kitts, and Nevis, as well as the chief minister of Anguilla) attended, as well as ministers of finance, health, population, and/or social development from another 15 countries.

Care and support must be pursued as actively as preventive strategies.

The conference aimed to create a wide-ranging, high-level discussion forum for the issue. In a major development, it also sought to create a common basket for funding so that international, multilateral, and bilateral agencies were not working against each other.

The Caribbean Conference was the first occasion in which, as a region, the taboos of the epidemic were addressed by a clear-sighted, level-headed discussion of how the epidemic is affecting the Caribbean's very existence. It became clear that care and support must be pursued as actively as preventive strategies and that people living with HIV/AIDS are crucial to the success of the response. The conference recognized that, at this stage, the cost of inaction far exceeds the cost of action.

A conservative estimate of the cost for a comprehensive regional response would be approximately $260 million annually. To put matters into perspective, this is more than a tenfold increase on current national and international spending levels in the Caribbean each year. Research remains to be done on the "country accounts," which will gauge the actual spending from national levels to household levels, on HIV/AIDS for specific countries. The conference made clear that the epidemic has spread beyond the scope of the health sector, and that government resources will have to be allocated accordingly for a truly multisectoral response. Mobilizing the required funding will require creative solutions and an increased commitment from governments and the private sector, as well as support from the international community.

Aside from providing a structure for involvement by the donor community, the conference also called for the individual countries to take owner-

ship of the issue by strengthening national AIDS programs and improving the quality of national HIV/AIDS initiatives. Pledges of continued and/or increased support were made by the governments of the Netherlands, Canada, the United States, Germany, the United Kingdom, and France, as well as by the UN system and multilateral agencies (including the European Commission, the Caribbean Development Bank, and the Inter-American Development Bank). The World Bank proposed a lending package of $85–$100 million for HIV/AIDS initiatives in the Caribbean. Although such a gathering was a significant move in support of an effective regional response, the next step is to bring together the partners and the donors in the region to establish clear links between the RSP and implementation at the national level.

Generally speaking, experience with HIV/AIDS has shown that effective public policy measures can be taken to stop the spread of the disease. Like the medications taken for HIV/AIDS itself, an effective public policy response requires a "cocktail" of measures, including

- political leadership to promote policies and programs, backed by structural and financial support;
- full participation of people living with HIV/AIDS in the design and implementation of programs to reduce stigmatization, increase visibility, promote human rights, and improve access to care and support;
- social policies and programs that target vulnerable groups, especially for migrant populations, children, and young people; and
- strengthened regional and national institutions to increase absorptive capacity and provide high-quality technical resources.

Above all, what is needed is honesty and forthrightness: a candid recognition of the problem and an open discussion on how to respond. The Caribbean nations have taken a fundamental step in that direction, but it is a long, difficult road ahead of them. They will need help to stay the course.

Note

1. Other regional partners that make up the task force include the University of the West Indies (UWI), the Caribbean Network of People Living with HIV/AIDS (CRN+), the Caribbean Conference of Churches (CCC), the Caribbean Tourism Organization (CTO), the Caribbean Development Bank (CDB), the Red Cross, SIDALAC, and the International Organization for Migration (IOM).