



# HIV/AIDS HEALTH PROFILE

## Caribbean



### Overall HIV Trends

Outside of sub-Saharan Africa, the Caribbean region has the highest HIV prevalence in the world. There are currently an estimated 240,000 people living with HIV/AIDS (PLWHA), and in 2009, AIDS was the leading cause of death among 25 to 44 year olds in the Caribbean. Women now account for half of all infections, and adolescent women have markedly higher prevalence than their male counterparts. However, some of the variation between young women and men could be because women are more likely to be tested and know their status.

Data indicate the HIV epidemic is a mosaic; a mixed picture of generalized and concentrated epidemics. Substantial differences exist within countries and across the region. National estimated adult HIV burdens vary significantly, from an extremely low prevalence of 0.1 percent in Cuba to a relatively high prevalence of 3.1 percent in the Bahamas. In the Dominican Republic, there is nearly a sevenfold variation in prevalence

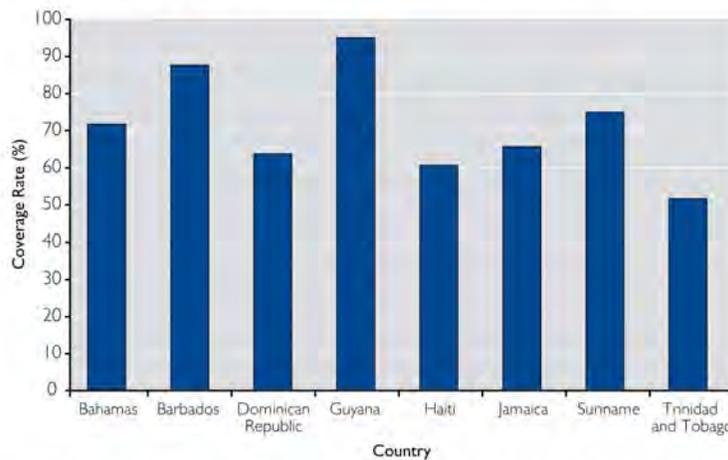
across different parts of the country. Countries supported by the U.S. Agency for International Development (USAID) are indicated in blue on the map.

Whether considered generalized or concentrated, HIV epidemics are disproportionately affecting the most vulnerable population groups across the region. The main route of HIV transmission in the Caribbean is through heterosexual contact. Sex work, including sex tourism, is a primary source of transmission. As more research on most-at-risk populations (MARPs) is conducted, men who have sex with men (MSM) are emerging as another significant route of HIV transmission. Unprotected sex between men is believed to account for about 10 percent of HIV cases in the Caribbean. For many cases of HIV, however, the method of transmission is not reported, making it difficult to ascertain the cause. HIV prevalence among prisoners in six Organization of Eastern Caribbean States (OECS) countries ranged from 2 to 4 percent in 2004 and 2005. Mobile and migrant populations and victims of gender-based violence are vulnerable groups, with higher HIV prevalence relative to the general population. These data paint a diverse picture of the epidemics across the region. However, the availability of quality epidemiological data is limited, which calls into question the true magnitude and characteristics of the epidemic.

The lack of data on the most vulnerable populations, including orphans, MSM, and sex workers, is a major concern among stakeholders and policymakers. Only half of the Caribbean countries submitted data on indicators related to these populations, an indication that policymakers and implementers of health programs lack sufficient information about MARPs and the role they play in the region's HIV epidemics. Much of the lack of data is attributed to the challenge of quantifying such "hidden" populations on small islands, where many of them face stigma and discrimination.

Service delivery data show both successes and challenges that remain. Antiretroviral therapy (ART) coverage has increased substantially. As of December 2009, treatment coverage was 48 percent – higher than the global average for low- and middle-income countries. Programs for the prevention of mother-to-child transmission (PMTCT) have also expanded, and 59 percent of HIV-infected pregnant women in need of treatment were receiving it in December 2009. Unfortunately, prevention services for the most vulnerable populations often reach a very low percentage of MSM, male and female sex workers, and other vulnerable people, according to 2010 United Nations General Assembly Special Session (UNGASS) data.

HIV-Infected People Receiving Treatment in High-Prevalence Countries in the Caribbean, 2009



Source: WHO/UNAIDS/UNICEF *Toward's Universal Access 2010* Data for the Bahamas, Barbados and Trinidad and Tobago are from the 2010 UNGASS reports. Data from Barbados and Trinidad and Tobago are for adults only.

## Environmental and Social Influences in the Caribbean

There are a number of environmental and social influences that shape the epidemic in the Caribbean. Stigma and discrimination is widely associated with HIV/AIDS in the region. A predominant view is that HIV/AIDS is a punishment for immoral behavior. Many people avoid being tested or disclosing their HIV-positive status for fear of losing family, friends, jobs, housing, or social status. While some countries have attempted to pass laws to protect PLWHA, many still have provisions that reinforce prejudices, such as laws prohibiting sodomy and sex work. Countries that do have progressive policies are struggling to enforce human and civil rights protections, and many marginalized groups refuse to come forward when their rights are violated out of fear of retaliation or further discrimination. A series of HIV Service Provision Assessments showed refusal of services to known positive persons remains a reality in the region, but regional partners are working to address the issue. Fear of stigma may also drive MSM to seek out female partners to hide their sexual orientation, and this may be accelerating heterosexual transmission.

Gender discrimination also contributes to the spread of HIV. Traditional gender roles in many Caribbean countries imply that women should be submissive, allowing men to make decisions about engaging in sex. This limits women's ability to negotiate condom use and makes them vulnerable to sexual assault. At the same time, young men are also pressured to prove their masculinity by engaging in sex at an early age, having multiple sex partners and using physical force against women. Higher rates of new infections are increasingly being reported among young women compared to men of the same age cohort. This may be due to strong PMTCT programs, which test pregnant women, and to particular high-risk behaviors among young women, such as transactional sex and cross-generational relationships.

Migration contributes to the HIV epidemic in the region in multiple ways. Since tourism drives the economies of many countries, workers migrate to tourist areas. In such areas, many workers engage in transactional sex, sex work, or other high-risk behaviors that increase their vulnerability to HIV. Language and legal barriers make it difficult for migrants in many countries to gain access to services, particularly to HIV testing and treatment services. In addition, outreach to migrant populations is difficult.

Countries in the region have made great strides in responding to the HIV epidemic; proximity, interdependence, and migration have led to increased cooperation and collaboration among countries to meet HIV/AIDS needs. HIV/AIDS programs have received support from multiple development partners, including the U.S. Government (USG) and the Global Fund to Fight AIDS, Tuberculosis and Malaria. However, given the economic development in the region and wealth classification that ranks most of the countries as upper-middle income, donor funding will likely be reduced in the future.

HIV Estimates in Select High-Prevalence Caribbean Countries				
<b>Bahamas</b>			<b>Barbados</b>	
Total Population	310,000		Total Population	286,000
Estimated Number of Adults and Children Living with HIV/AIDS	6,600		Estimated Number of Adults and Children Living with HIV/AIDS	2,100
Adult HIV Prevalence	3.1%		Adult HIV Prevalence	1.4%
HIV in Most-at-Risk Populations MSM (2009)	25.6%			
<b>Dominican Republic</b>			<b>Guyana</b>	
Total Population	9.8 million		Total Population	748,000
Estimated Number of Adults and Children Living with HIV/AIDS	57,000		Estimated Number of Adults and Children Living with HIV/AIDS	5,900
Adult HIV Prevalence	0.9%		Adult HIV Prevalence	1.2%
HIV in Most-at-Risk Populations FSWs (2008)	4.8%		HIV in Most-at-Risk Populations FSWs (2009)	16.6 %
MSM (2008)	6.1%		MSM (2009)	19.4 %
IDUs (2008)	8.0%			
Sugar Cane Workers (2007)	3.2–4.7%			
<b>Haiti</b>			<b>Jamaica</b>	
Total Population	10.1 million		Total Population	2.9 million
Estimated Number of Adults and Children Living with HIV/AIDS	120,000		Estimated Number of Adults and Children Living with HIV/AIDS	32,000
Adult HIV Prevalence	1.9%		Adult HIV Prevalence	1.7%
HIV in Most-at-Risk Populations FSWs (in Port-au-Prince) (2009)	5.3%		HIV in Most-at-Risk Populations FSWs (2009)	4.9%
			MSM (2008)	32%
<b>Suriname</b>			<b>Trinidad and Tobago</b>	
Total Population	487,000		Total Population	1.2 million
Estimated Number of Adults and Children Living with HIV/AIDS	3,700		Estimated Number of Adults and Children Living with HIV/AIDS	15,000
Adult HIV Prevalence	1.0%		Adult HIV Prevalence	1.5%
HIV in Most-at-Risk Populations Street Sex Workers (2005)	24.1%		HIV in Most-at-Risk Populations MSM (2004)	20.4%
MSM (2005)	6.7%			

People with multiple partners and cross-generational sex partners are not included in this table because HIV prevalence data do not exist for these populations. Sources: U.S. Census Bureau, UNAIDS, Dominican Republic BSS 2008 and DHS, Haitian Institute of Statistics and Information, and UNGASS

## Country-Specific Situation

While epidemics across the Caribbean have many similarities, they also have unique attributes and challenges. With 1.9 percent of adults estimated to be HIV positive, **Haiti** has one of the highest prevalence rates and, in terms of number of PLWHA, the largest epidemic in the Caribbean. In the general population, the burden of HIV prevalence varies markedly from region to region. A 2007 study reported by the Joint United Nations Program on HIV/AIDS (UNAIDS) in 2010 found 12 percent of pregnant women using antenatal facilities in one of Haiti's cities tested HIV positive, compared with less than 1 percent in the west of the country. In terms of MARPs, positive developments are taking place, with 90 percent of female sex workers (FSWs) reporting use of a condom with their most recent client and 73 percent of MSM reporting use of a condom at their last intercourse.

**Guyana** has a lower estimated adult HIV prevalence rate than **Haiti**, and the number of PLWHA is significantly smaller. Due to scaled-up treatment, the numbers of AIDS cases and deaths from AIDS have declined over the past decade, while the number of testing sites has nearly tripled. The primary mode of transmission remains heterosexual contact. The 2009 Guyana Demographic and Health Survey (DHS) found 97 percent of women and men had heard of AIDS and 81 percent of women and 84 percent of men knew using condoms every time during sexual intercourse can reduce the risk of HIV. Despite this, levels of reported condom use remain low. The epidemic was still markedly high among MSM (19.4 percent) and FSWs (16.6 percent) in 2009.

After **Haiti**, the **Dominican Republic** has the largest number of PLWHA in the Caribbean. Three main groups contribute to the epidemic: MARPs, women with four or fewer years of formal education, and residents of *bateyes* (sugar cane plantations). Poorly educated women and *batey* residents are 8.3 percent and 1.1 percent of the

general population, respectively, yet represent 23.7 percent and 4.5 percent, respectively, of the PLWHA population. The Dominican Republic's epidemic is also driven by sex workers and their clients and partners, MSM, and injecting drug users (IDUs). According to the 2008 Behavioral Surveillance Survey (BSS), HIV prevalence was 4.8 percent among female sex workers, 6.1 percent among MSM, and 8 percent among IDUs.

At 3.1 percent, the **Bahamas** has one of the highest estimated adult HIV prevalence rates in the region. AIDS remains the leading cause of death in the 15 to 49 age group. Nonetheless, HIV infection levels are falling among pregnant women and persons attending sexually transmitted infection clinics. The Bahamas has been particularly successful in using ART for PMTCT to reduce both mother-to-child HIV transmission and the number of deaths due to disease. A 2009 survey of MSM demonstrated an estimated prevalence rate of 25.6 percent (UNGASS, 2010).

In **Jamaica**, adult HIV prevalence has stabilized at approximately 1.7 percent. HIV is now present in all of Jamaica's parishes, with the three most urbanized parishes having the majority of cases. The results of the Jamaica 2008 Knowledge, Attitudes, and Behavior (KABP) survey indicated multiple partnerships are one of the main risk factors fueling Jamaica's epidemic, with 76 percent of males 15 to 24 years of age reporting multiple partnerships in the previous 12 months. The KABP data showed transactional sex was common among sexually active respondents (37 percent) and 27 percent of the total population aged 15 to 49 was engaged in transactional sex. HIV prevalence among MSM and sex workers is much higher than among the general population. Despite some progress in reducing stigma and discrimination, same-sex behavior remains illegal, and many MSM hide their sexual orientation and behavior. A 2008 UNAIDS study indicated 32 percent of MSM were HIV positive. A 2009 UNAIDS study of FSWs showed an HIV prevalence of 4.9 percent.

Since the early 1990s AIDS has been the leading cause of death in those aged 15 to 49 in **Barbados**, and data indicate men and women have been equally affected since 2005, except for adults in the 15 to 29 age group. The epidemic has evolved from being mainly concentrated and driven by sexual networks of MSM to increasingly being driven by heterosexual transmission. Since 1984, 60 percent of the cumulative HIV diagnoses in the country have been in males, a figure mirrored in new cases diagnosed in 2007. In 2007, 80 percent of cases diagnosed were within the 20 to 49 age group. Key populations estimated to be at higher risk are youth, MSM, and sex workers, although risky behaviors have reportedly decreased in these populations over the past five years, while recent surveys indicate increasing risky sexual practices among the general population.

In **Suriname**, the current estimate is 1.0 percent adult prevalence in the 15 to 49 age group. The gender distribution of new HIV-positive cases has shifted over the years, and since 2004, females account for a larger proportion of reported HIV infections, particularly in the 15 to 19 and 20 to 24 age groups. This may be due to a strong PMTCT program, which includes the testing of pregnant women. Overall, the highest registered prevalence is in the 15 to 49 age group, with 60 to 80 percent of annual new cases. The MARPs identified in Suriname are sex workers and MSM. Seroprevalence surveys, conducted in the capital city, Paramaribo, found estimated prevalence rates of 24.1 percent among street sex workers in 2005, and 6.7 percent among MSM.

By 2009, 20,255 HIV-positive cases; 6,208 AIDS cases; and 3,845 deaths due to AIDS had been reported in **Trinidad and Tobago**. The main mode of transmission is heterosexual. The majority of new HIV-positive cases occur among women aged 20 to 24, while the largest number of new cases among males was found in the 45 to 49 age group. It must be noted, however, that more women are being tested through the PMTCT program. A survey among MSM indicated an estimated 20.4 percent HIV prevalence; 25 percent of the MSM respondents also reported regularly having sex with women.

The OECS countries (**Antigua and Barbuda, Dominica, Grenada, St. Kitts and Nevis, St. Lucia, and St. Vincent and the Grenadines**) have smaller total populations and lower HIV prevalence rates that range from an estimated 0.2 to 0.9 percent. In **St. Lucia**, crack cocaine usage is emerging as a major factor in the epidemic, as crack users tend to engage in risky behavior to obtain it or while under the influence of the drug. The smaller OECS countries have limited capacity for development of socially and technologically complex programs like those needed for a comprehensive response to HIV. This is due to a variety of issues, including human resource constraints, civil society organizational capacity, and stigma and discrimination – challenges that are often insurmountable without technical assistance.

## 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 make it a high-profile region in the global fight against AIDS. The high levels of intra-regional mobility and interdependence make regional coordination an important part of addressing common concerns in the response to HIV/AIDS.

Most Caribbean countries have taken measures to control the epidemic. By the end of 2006, 21 Caribbean countries had national strategic plans (NSPs) on HIV/AIDS. Most NSPs in the Caribbean embrace a comprehensive approach, which includes prevention; care; treatment and institutional development; management; and coordination, including monitoring and evaluation. NSPs in the region also embrace implementation strategies that include broad engagement of civil society and key line ministries; however, in many cases, public-private sector engagement is not emphasized.

Although NSPs exist, the national health care infrastructure in many countries is inadequately equipped to address the individual and social challenges posed by the epidemic, including stigma and discrimination; 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.

Aligned with country plans and priorities, activities are supported by a coordinated approach articulated by the Pan Caribbean Partnership Against HIV and AIDS (PANCAP) in the Caribbean Regional Strategic Framework for 2008–2013. This framework identifies the following objectives to reach by 2012: reducing the estimated number of new infections by 25 percent; reducing mortality due to HIV by 25 percent; and reducing the social and economic impact of HIV/AIDS on households by 25 percent. In this framework, specific emphasis is also placed on programs for MARPs and addressing economic and social disparities, such as gender inequities and gender-based violence.

## USAID Regional Support

USAID’s HIV/AIDS programs in the Caribbean are implemented as part of the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR). Launched in 2003, PEPFAR is the USG initiative to support partner nations around the world in responding to HIV/AIDS. Through PEPFAR, the USG has committed approximately \$32 billion to bilateral HIV/AIDS programs and the Global Fund through fiscal year 2010. PEPFAR is the cornerstone of the President’s Global Health Initiative (GHI), which supports partner countries in improving and expanding access to health services. Building on the successes of PEPFAR, GHI supports partner countries in improving health outcomes through strengthened health systems, with a particular focus on improving the health of women, newborns, and children.

In June 2010, the USG signed a five-year Partnership Framework with 12 countries (**Antigua and Barbuda, the Bahamas, Barbados, Belize, Dominica, Grenada, Jamaica, St. Kitts and Nevis, St. Lucia, St. Vincent and the Grenadines, Suriname, and Trinidad and Tobago**) and two regional organizations (PANCAP and OECS/HIV/AIDS Project Unit). The USG Regional Partnership Framework shares the fundamental priorities of the PANCAP Caribbean Regional Strategic Framework and describes a shared vision by the region, with specific emphasis on bolstering the region’s HIV prevention services and resources; improving national and regional capacity for surveillance and monitoring and evaluation; strengthening national and regional laboratory diagnostic and monitoring capacity; and strengthening health systems and supporting the capacity of national governments to implement effective, sustainable national HIV/AIDS programs.

USAID/Barbados-Eastern Caribbean’s (USAID/B-EC) program supports the strengthening of managerial, technical, and administrative capacities of nongovernmental organizations (NGOs) involved in HIV/AIDS prevention activities and is a technical partner with national governments in strengthening the financial capacity of health systems and in private sector engagement. USAID/B-EC works with local partners to provide prevention, health care services and support to sex workers and their clients, MSM, migrant workers, serodiscordant couples, and PLWHA. Small grants and technical support provided to NGOs and community- and faith-based organizations improve the quality of program delivery while enhancing linkages with national AIDS programs, thus enabling greater achievement of results and the sustainability of efforts.

USAID regional and bilateral offices also coordinate with other USG agencies in the region, including the U.S. Centers for Disease Control and Prevention; the Peace Corps; the Departments of Defense, Health and Human Services, Health Resources and Services Administration, and the State Department. USAID also works with the Global Fund, the Pan American Health Organization, UNAIDS, World Bank, and other donors and development banks, which have brought crucial resources and technical capacity to the region.

## USAID Bilateral and Regional Support in the Caribbean Region

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**).

Examples of USAID bilateral country support in 2009 include:

- In **Haiti**, 1.3 million people received messages to increase awareness and knowledge and promote behavior change. More than 56,000 orphans and vulnerable children (OVC) received supplemental food, health care, legal and social services, and school scholarships. Linkages with economic growth programs supported cash-for-work infrastructure projects in which 65 percent of workers were PLWHA and which provided 1,388 short-term jobs and 10,788 person-days of employment.
- In the **Dominican Republic**, more than 77,200 adolescents and youth received abstinence and “be faithful” messages through life skills programs in schools. More than 67,000 pregnant women received HIV counseling, testing, and test results for PMTCT. More than 31,600 adults infected with HIV received palliative care in 2009, and more than 77 million condoms were distributed from 2003 to 2009. USAID-supplied Pante brand condoms, which constituted 62 percent of condoms available in high-risk zones.
- In **Jamaica**, USAID supported workplace policy development with 10 companies, and 549 staff received training in reducing HIV-related stigma and discrimination.
- In **Guyana** more than 23,000 people, including 10,500 pregnant women, received HIV counseling and testing services and received their results. Outreach and sensitization activities reached more than 27,000 with abstinence and “be faithful” messages. Continued scale-up of ART programs provided more than 2,850 people living with HIV with ART, and an additional 4,100 HIV-positive individuals (including people with tuberculosis-HIV co-infection) and 1,331 OVC received care and support services. Additionally, 744 health care workers of various categories were trained in safe injection practices and methods.

### Important Links

USAID/Barbados – Eastern Caribbean  
U.S. Embassy Complex  
Wildey, St. Michael, Barbados  
Tel.: 246-227-4118  
Fax: 246-228-8589

USAID/Dominican Republic  
Leopoldo Navarro #12  
Santo Domingo, Dominican Republic  
Tel.: 809-221-1000  
Fax: 809-221-0444  
Web site: <http://www.usaid.gov/dr>

USAID/Guyana  
Department of State  
Washington, DC 20521-3170  
Tel.: 592-22-57315  
Fax: 592-22-57316

USAID/Haiti  
17 Blvd. Harry Truman  
Port-au-Prince, Haiti  
Tel.: 509-229-3084  
Fax: 509-229-3200  
Web site: <http://www.usaid.gov/ht/>

USAID/Jamaica  
142 Old Hope Road  
Kingston 6  
Jamaica, W.I.  
Tel.: 876-702-6445  
Fax: 876-702-6385

USAID’s HIV/AIDS Web site for the Caribbean:

[http://www.usaid.gov/our\\_work/global\\_health/aids/Countries/lac/caribbeanregion.html](http://www.usaid.gov/our_work/global_health/aids/Countries/lac/caribbeanregion.html).

For more information on USAID’s HIV/AIDS programs see: [http://www.usaid.gov/our\\_work/global\\_health/aids](http://www.usaid.gov/our_work/global_health/aids).