

## HIV/AIDS IN THE CARIBBEAN

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The history of HIV in the Caribbean is a reflection of the extent to which the manifestation and progress of any disease is buried in social mores and cultural biases both nationally as well as internationally. The first case of HIV/AIDS in the Caribbean was diagnosed in Haiti in 1981 and Haiti achieved unfortunate prominence because Haiti and Haitians were vilified as being originators of the illness. From 1983 to 1985 the US Centers for Disease Control listed being Haitian or homosexual as constituting risk factors for the disease. The culture of blame and looking for scapegoats has persisted and the stigma against Haiti has been somewhat removed, although that against homosexuals is as virulent as ever in the Caribbean.

The first case of HIV/AIDS in the English-speaking Caribbean was diagnosed in Jamaica in 1982, and in 1982 eight cases were reported in Trinidad and Tobago, all in homosexual or bisexual men. Initially, in line with much of the thinking in the USA, it was believed that this was a homosexual disease, but the further development of the epidemic shows the transmission of the virus to be now firmly through heterosexual intercourse. In 1990 the estimated adult male female ratio was 2 to 1, and in 2007 there was virtual male and female parity.

The number of reported cases rose exponentially in the first years of the epidemic, due in part to better case finding and reporting, and at the end of 2007 UNAIDS estimated that there were 230,000 people living with HIV, of whom 70% were in Haiti and the Dominican Republic. There were around 20,000 new cases in 2007 and some 14,000 deaths from HIV/AIDS. The prevalence rate for the region as a whole is 1.1% of the adult population with wide variation, from 3% in the Bahamas to 0.1% in Cuba. Guyana (2.5%), Suriname (2.4%), Haiti (2.2%), Belize (2.1%), Jamaica (1.6%) and Trinidad and Tobago (1.5%) are still heavily infected. The highest rate is found in the 15–44 age group and AIDS is still the leading cause of death among adults in that age group. The prevalence rate for North America is 0.6% and that for Latin America is 0.5%. The Caribbean region has a prevalence rate second only to that found in Sub-Saharan Africa.

The Caribbean response passed through stages similar to those found elsewhere. There was initially shock and panic with much finger-pointing, followed by a short phase of denial and then the current phase of rational approach to establishing the processes and structures needed to deal with a disease which everyone accepts will be with us for many years to come. In terms of structures, most countries have established national high-level intersectoral committees or commissions to guide the national approach, although the main burden of the response falls on the health sector. The need for a regional approach stimulated the formation of the Pan Caribbean Partnership against HIV (PANCAP), a multilevel, multisectoral partnership that seeks to bring together almost every sector involved or affected by HIV, as well as the 29 countries of the region, to coordinate the regional response as well as the external inflows into the region. There have been a series of Regional Strategic frameworks which have been the blueprints for this regional coordination which seeks to enhance the national response.

The main drivers of the epidemic in the Caribbean are rooted in established social behavior. Gender inequality drives the increasing prevalence rates in young women aided and abetted by the early age of sexual debut in both sexes. Multiple sexual partners are a common phenomenon in both men and women and it is often stated that poverty is another key factor. Stigma and discrimination against persons with HIV prevents many from coming forward to be tested. But perhaps the most patent and pernicious stigma and discrimination is against groups such as men who have sex with men and commercial sex workers. Unfortunately the CARICOM countries are distinguished by being the only ones in the Americas which still have laws that criminalize homosexual practice between consenting males.

In spite of the difficulties there has been significant progress. Perhaps the most significant has been the availability of antiretroviral drugs (ARVs) in all the countries, albeit with different levels of penetration. In Cuba and Barbados there is universal access to ARVs, and death rates are falling; Barbados deaths from AIDS have fallen by around 80% since the introduction of drug therapy. There has been significant reduction in mother-to-child transmission (MTCT); the Bahamas, Barbados, Cuba and Jamaica have achieved over 90% coverage of pregnant mothers. This program has been so successful that PAHO has established the elimination of MTCT as a goal for the Caribbean. Prevalence rates are falling in several countries; for example, the seroprevalence among pregnant women in Guyana has fallen from 3.6% in 2002 to 1.6% in 2007.

Public information is a critical tool in changing the environment that predisposes to the spread of the virus and every country has devoted considerable resources to advertisements and media campaigns. The Caribbean Broadcast Media Partnership is a bold new initiative that unites broadcasters in a coordinated response to the epidemic. It represents a unique framework for sharing information and resources among the region's broadcasters. The private sector is increasingly becoming involved in a structured way. The Caribbean Business Coalition has been formed to facilitate the exchange of practices among businesses about what can be done, especially in relation to rolling out and implementing appropriate work place practices. There is an active association of persons living with HIV that advocates vigorously for its place at the loci of decision making.

But significant challenges remain. The most relevant is the need to focus more aggressively on prevention. More persons are being infected than are being put on therapy and it is clear that the Caribbean cannot treat its way out of the epidemic. In addition, the cost of treating increasing numbers of AIDS patients will put a severe strain on already stretched domestic budgets. The social changes needed are by definition very difficult. There is no evidence that in spite of the vigorous advertising that there has been any change in the practice of multiple sexual partners. Homophobia remains rampant, and the stigma and discrimination against HIV as well as against the vulnerable groups continues; the prospect of change in the legal framework that facilitates the homophobia is currently remote in spite of increasing calls for this to be addressed. There is evidence of increasing condom use by the general public and in some cases by commercial sex workers. There is also no doubt of the political commitment to address the problem, but that commitment is sometimes constrained by the societal attitudes. The monitoring and reporting mechanisms have improved, but still need the attention necessary if there is to be accurate assessment of the progress being made.

There is no doubt about the magnitude of the problem, but optimism comes from the progress that has been made and the demonstrated efforts to mobilize all the Caribbean social partners and their international collaborators to address it.