More than 440,000 [270,000–780,000] people are living with HIV in the Caribbean, including the 53,000 [27,000–140,000] people who acquired the virus in 2004. An estimated 36,000 [24,000–61,000] people died of AIDS in the same year. Among young people 15–24 years of age, an estimated 3.1% [1.6–8.3%] of women and 1.7% [0.9–4.6%] of men were living with HIV at the end of 2004. In the Caribbean Community (CARICOM) region 370,000 [210,000–710,000] people are living with HIV, including the 48,000 [22,000–140,000] people who acquired the virus in 2004. More than 29,000 [17,000–54,000] people died of AIDS in the past year*.

With average adult HIV prevalence of 2.3%, the Caribbean is the second-most affected region in the world. In five countries (the Bahamas, Belize, Guyana, Haiti and Trinidad and Tobago), national prevalence exceeds 2%. Overall, the highest HIV-infection levels among women in the Americas are in Caribbean countries and AIDS has become the leading cause of death in the Caribbean among adults aged 15–44 years (Caribbean Epidemiology Centre, PAHO, WHO, 2004). Life expectancy at birth in 2010 is projected to be 10 years less in Haiti and in Trinidad and Tobago nine years less than it would have been without AIDS (see Figure 13) (Stanecki, 2004). Several countries and territories with economies that are dependent on tourism rank among those most heavily affected by the epidemic in this region, including the Bahamas, Barbados, Bermuda, Dominican Republic, Jamaica, and Trinidad and Tobago. Yet most countries in the region have limited capacity to track the evolution of their epidemics, and are relying on data and systems that do not necessarily match the realities they are facing.

Unlike in Latin America, HIV transmission in the Caribbean is occurring largely through heterosexual intercourse (almost two thirds of all AIDS cases to date are attributed to this mode of transmission), although sex between men, which is heavily stigmatized, and in some places illegal, remains a significant—but still neglected—aspect of the epidemics. HIV transmission through injecting drug use remains rare, with the significant exception of Bermuda, where it accounts for a

* CARICOM comprises: Antigua and Barbuda, the Bahamas, Barbados, Belize, Dominica, Grenada, Guyana, Haiti, Jamaica, Montserrat, Saint Lucia, St. Kitts and Nevis, St. Vincent and the Grenadines, Suriname, Trinidad and Tobago.
large share (43%) of AIDS cases, and **Puerto Rico**, where more than half of all infections in 2002 were associated with injecting drug use and about one quarter were heterosexually transmitted (Caribbean Epidemiology Centre, 2003; UNAIDS, 2004). As the epidemics in this region evolve, more women are being affected, and the number of new HIV infections among them now outstrips that among men. Latest estimates suggest that roughly as many women as men are now living with HIV in this region. According to a population-based survey carried out in 2002, women younger than 24 years in the **Dominican Republic** were almost twice as likely to be HIV-infected compared with their male peers (MAP, 2003). In **Jamaica** teenage girls are 2.5 times more likely than boys in the same age group (10–19 years) to be infected—due partly to the fact that some girls have sexual relationships with older men who are more likely to be HIV-infected, a trend that has also been documented in several other countries. **Haiti** continues to have the largest number of people living with HIV in the Caribbean: some 280,000 [120,000–600,000] at the end of 2003 (UNAIDS, 2004). The most recent sentinel surveillance studies suggest a decline in HIV prevalence. The latest data suggest that median HIV prevalence among women (15–49 years) attending antenatal clinics has fallen from 4.5% in 1996 to 2.8% in 2003-2004 in consistently reporting sites (Ministère de la Santé publique et de la population Haiti et al., 2004). HIV prevalence among pregnant women aged 15–24 years appears to have declined by a similar magnitude as among women of all ages in the same period—from 3.6% to 2.8%. The decline in the youngest age group is usually considered to indicate a decline in incidence. The decline in the older age group of similar magnitude is not easily explained. Increased donor support of HIV surveillance in Haiti in 2003-2004 may have enhanced the quality of surveillance data, making it difficult to compare the latest information with that obtained in earlier surveillance rounds. Further investigation combining trends in prevalence data with trends in behavioural data is needed to examine the reasons for the observed decline in Haiti’s HIV prevalence.

The latest round of HIV surveillance among pregnant women shows HIV prevalence varying between 1.8% and almost 7% in different parts of Haiti. Poorer, less educated women are more
likely to be HIV-infected than their better-off counterparts. Recent behavioural surveillance has shown that a significant proportion of the country’s largely young population (about 60% of which is under 24 years) is sexually active and having unprotected sex. In a 2001 survey, almost half the young women (and more than half the men) said they had become sexually active before their 18th birthday and 18% of urban women in their late teens (15–19 years) had been pregnant at least once. Although general AIDS knowledge is widespread, misconceptions about the virus continue to circulate, particularly among women—an indication that there is still considerable room to expand and improve prevention efforts.

**Jamaica**, where an estimated 22,000 [11,000–41,000] people were living with HIV at the end of 2003, has the second-highest annual number of AIDS cases and deaths in the region, after Haiti (UNAIDS, 2004). While a handful of other islands in the region appear to be making incremental inroads against the epidemic by expanding access to antiretroviral treatment (see below), in Jamaica at least 900 AIDS cases have been reported there each year since 1999 and the disease has been claiming between 590 and 690 lives annually over the same period—more than double the numbers just four years earlier (Caribbean Epidemiology Centre, 2004). The most recent round of HIV surveillance indicates that the HIV epidemic is not abating either. HIV prevalence among pregnant women attending antenatal clinics stood at 1.4% nationally in 2002, but was as high as 2.7% and 1.9% in the parishes of St. James and of Kingston and St. Andrews, respectively. High HIV prevalence found among patients at sexually transmitted infection clinics in 2002 seemed to confirm earlier warnings of widespread unprotected sex; almost 8% of men attending these clinics were HIV-positive, as were almost 5% of women (Ministry of Health Jamaica, 2003). In the late 1990s, a study among male adolescents and young adults in Jamaica found that fully 9% had reported symptoms of sexually transmitted infections in the previous year, a clear indication of unprotected sex (Norman and Uche, 2002). There is no evidence to date that these patterns have altered significantly.

Meanwhile, in both the **Bahamas** and **Barbados**, there are indications that stronger prevention efforts since the late 1990s could be forcing HIV-infection levels lower. In the Bahamas (see Figure 14), where an estimated 5000 people were living with HIV at the end of 2003, HIV prevalence among pregnant women fell from 4.8% in 1993 and 3.6% in 1996 to 3% in the latest round of HIV surveillance in 2002. A similar downward trend in HIV levels has been observed among patients at sexually transmitted infection clinics (Department of Public Health Bahamas, 2004). The decline in the annual number of reported AIDS cases (from 320 in 2000 to 164 in 2003) and AIDS deaths (from 272 in 2000 to 185 in 2003) probably reflects this steady drop in prevalence, along with the expansion of antiretroviral treatment access since the turn of the century (Caribbean Epidemiology Centre, PAHO, WHO, 2003).

**Barbados** has a smaller epidemic but there, too, a decline in HIV levels is being observed, with new HIV diagnoses among pregnant women dropping substantially between 1999 and 2003, from 0.7% to 0.3% (Kumar and Singh, 2004). Mother-to-child transmission of HIV has also been reduced since the expansion of voluntary counselling and testing services, and the provision of antiretroviral prevention regimes. The rate of mother-to-child transmission declined by 69% between September 2000 and December 2002 (St John et al., 2003). In addition, the introduction in 2001 of antiretroviral treatment for people living with HIV has reversed the trend of AIDS mortality in the island nation. The annual number of AIDS deaths decreased from 114 in 1998 to 50 in 2003, while hospital admissions for treatment of opportunistic infections fell by 42% in the same period. In **Bermuda**, meanwhile, the number of AIDS cases decreased by almost half (19 to 11) between
At an estimated 2.5% at the end of 2003, HIV prevalence in **Guyana** was the second-highest in the region. There has been a steep rise in the numbers of HIV cases reported since the mid-1990s. According to the Ministry of Health, officially reported cases probably represent less than one third of the actual number of people living with HIV. Meanwhile, fewer than one fifth of people infected with HIV—the majority of them aged between 20 and 34 years—are aware of their serostatus. Most infections are occurring through heterosexual intercourse. One recent study among miners in the country’s Amazon region has revealed an exceptionally high HIV prevalence of 6.5%. The miners, all young men, divide their lives between six to eight week work shifts and two weeks of rest at their homes near the coast. The danger of infected miners transmitting HIV to their regular partners at home or to casual partners near the mine seems substantial (Palmer et al., 2002).

The **Dominican Republic**, which shares Hispaniola Island with Haiti, still faces a serious epidemic with HIV prevalence among pregnant women higher than 2% nationally. In the capital Santo Domingo, HIV prevalence among 15–24 year-old pregnant women—which can offer a hint of recent infection rates—has declined from around 3% in 1995 to below 1% in 2003 (UNAIDS, 2004). This might be due to prevention efforts aimed at encouraging people to adopt safer sexual behaviours. However, the same trend is not apparent elsewhere in the country. Of particular concern is the unusually high HIV prevalence (4.9%) that has been detected among sugar cane plantation workers (MAP, 2003).

**Cuba** has been an exception in this region, with very low HIV prevalence, possibly due, in part, to a policy of quarantining HIV-infected people as a preventive measure during the 1980s. Cuba subsequently abandoned that policy. Meanwhile, universal free access to antiretroviral therapy has kept the number of AIDS cases and deaths very low.

**In the Bahamas and Barbados, there are signs that stronger prevention efforts could be nudging HIV-infection levels lower.**
low. Though still small in scale, the country’s HIV epidemic is now growing, however. A sharp increase in newly reported HIV cases has occurred since the late 1990s, with the annual number of reported new cases growing almost five-fold between 1995 and 2000. However, Cuba’s epidemic remains small, in contrast to much of the Caribbean. Most new HIV transmission is occurring during sex between men (Caribbean Epidemiology Centre, 2003).

The lack of good quality HIV-surveillance data in most Caribbean countries is hampering the ability to design and run potentially effective prevention programmes, and will almost certainly undermine efforts to expand access to antiretroviral treatment. But social, not just technical, challenges will need to be confronted if the countries of this region are to bring their epidemics under control. Widespread homophobia is providing an ideal climate for the spread of HIV by driving men who have sex with men further away from the information, services, and security they need if they are to protect themselves against HIV. Meanwhile, the unequal social and economic status of women and men is acting as a powerful dynamic in epidemics that are growing amid ongoing stigma, misconceptions and denial.