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AIDS in the Caribbean and Central America

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Summary

The AIDS epidemic in the Caribbean and Central America has begun to have negative consequences for economic and social development, and continued increases in infection rates threaten future development prospects. In contrast to other parts of Latin America, the mode of transmission in several Caribbean and Central American countries has been primarily through heterosexual contact, making the disease difficult to contain because it affects the general population. The Caribbean countries with the highest prevalence or infection rates are Haiti, with a rate of 5.6%; Trinidad and Tobago, with a rate of 3.2%; the Bahamas, with a rate of 3%; Guyana, with a rate of 2.5%; and Belize, with a rate of 2.4%. (Belize and Guyana are considered Caribbean nations because of their extensive linkages.) Four other Caribbean countries — the Dominican Republic, Suriname, Barbados, and Jamaica — have rates over 1%. In Central America, Honduras has the highest prevalence rate of 1.8%, while Guatemala has a rate over 1%.

The response to the AIDS epidemic in the Caribbean and Central America has involved a mix of support by governments in the region, bilateral donors (such as the United States, Canada, and European nations), regional and multilateral organizations, and nongovernmental organizations (NGOs). Many countries in the region have national AIDS programs that are supported through these efforts.

The U.S. Agency for International Development (USAID) has been the lead U.S. agency fighting the epidemic abroad since 1986. USAID's funding for HIV/AIDS in Central America and the Caribbean region rose from \$11.2 million in FY2000 to \$33.8 million in FY2003. Because of the inclusion of Guyana and Haiti as focus countries in the President's Emergency Plan for AIDS Relief (PEPFAR), U.S. assistance to the Caribbean and Central America for HIV/AIDS increased to \$47 million in FY2004 and to an estimated \$76 million in FY2005. The FY2006 request is for almost \$91 million, with \$21 million for Guyana and \$47 million for Haiti.

Some Members of Congress have wanted to expand the list of Caribbean countries included as focus countries in PEPFAR. In the 108th Congress, both the House-passed FY2004-FY2005 Foreign Relations Authorization Act, H.R. 1950 (Section 1818), and the Senate Foreign Relations Committee's reported FY2005 Foreign Relations Authorization Act, S. 2144 (Section 2518), would have added 14 Caribbean countries to those targeted for increased HIV/AIDS assistance, but no final action was taken on these measures. In the 109th Congress, S. 600, the Foreign Affairs Authorization Act, FY2006 and FY2007, contains a provision (Section 2516) that would add 14 Caribbean countries to the list of focus countries targeted for increased HIV/AIDS assistance.

This report, which will be updated periodically, examines the characteristics and consequences of the HIV/AIDS epidemic in the Caribbean and Central America and the response to the epidemic in the region. For additional information, see CRS Report RS21181, *HIV/AIDS International Programs: Appropriations, FY2003-FY2006*, and CRS Report RL31712, *The Global Fund to Fight AIDS, Tuberculosis, and Malaria: Background and Current Issues*.

Contents

Characteristics of the Epidemic in the Region	1
Consequences of the Epidemic	4
Response to the Epidemic	5
U.S. Policy	7
Legislative Initiatives	10

List of Tables

Table 1. HIV/AIDS in Latin America and the Caribbean, 2003	2
Table 2. U.S. HIV/AIDS Assistance: CSH and GHAI Funding in Central America and the Caribbean, FY2001-FY2006	9

AIDS in the Caribbean and Central America

Characteristics of the Epidemic in the Region

Although the AIDS epidemic in the broader Latin America and Caribbean region is not as pervasive as in Africa, more than 2 million people were estimated to be living with HIV/AIDS in the region in 2003, including 450,000 in the Caribbean (including Belize, Guyana, and Suriname, which are considered Caribbean nations because of their extensive linkages); 204,000 in Central America; 160,000 in Mexico; and 1.2 million in South America.¹ Moreover, the adult prevalence rate in several countries in the Caribbean and Central America are among the highest outside of sub-Saharan Africa, with 11 countries in these subregions having adult infection rates of 1% or more (see Table 1).

In terms of sheer numbers, Brazil accounts for about one-third of those living with AIDS in Latin America and the Caribbean, but its prevalence rate of 0.7% is low compared to many countries in Central America and the Caribbean. Furthermore, Brazil's active prevention efforts have lowered prevalence among the high risk groups — intravenous drug users and homosexuals — and the government's extensive antiretroviral (ARV) treatment program has lowered death rates.² In contrast, the mode of transmission in several Caribbean and Central American countries has been primarily through heterosexual contact, which makes it difficult to contain the epidemic because it affects the general population.

At year end 2003, the Caribbean countries with the highest prevalence of infection rates were Haiti, with a rate of 5.6%; Trinidad and Tobago, with a rate of 3.2%; the Bahamas, with a rate of 3%; Guyana, with a rate of 2.5%; and Belize, with a rate of 2.4%. Four other countries — the Dominican Republic, Suriname, Barbados, and Jamaica — had rates over 1%. Haiti and the Dominican Republic, with a combined 368,000 adults and children living with HIV/AIDS, account for about 82% of the infected Caribbean population. USAID notes that Haiti's poverty, conflict, and unstable governance have contributed to the rapid spread of AIDS; in some urban areas, HIV infection rates are almost 10%. In the Dominican Republic, while there are indications that the epidemic is stabilizing in Santo Domingo because of effective prevention efforts, there are concerns that this trend is not occurring

¹ Statistics are drawn from: Joint United Nations Program on HIV/AIDS (UNAIDS), *2004 Report on the Global AIDS Epidemic*, June 2004. p. 202.

² UNAIDS, *Report on the Global HIV/AIDS Epidemic 2002*, July 2002; Nevertheless, it should be noted that prevalence rates vary in different parts of the country. In some cities, infection levels above 60% have been reported among injecting drug users. See Joint United Nations Program on HIV/AIDS (UNAIDS), *2004 Report on the Global AIDS Epidemic*, June 2004. p. 36.

elsewhere in the country. Of particular concern is the Dominican Republic, where sugar cane plantation workers have high HIV prevalence rates of 4.9%, HIV prevalence among pregnant women is 2% higher than the national average, and women under 24 years old are twice as likely to be HIV-infected than their male peers.³

Table 1. HIV/AIDS in Latin America and the Caribbean, 2003

Area	Adult Prevalence (%)	Adults/Children Living with HIV/AIDS	AIDS Deaths, (Adults/Children)
Caribbean			
Haiti	5.6	280,000	24,000
Trinidad & Tobago	3.2	29,000	1,900
Bahamas	3.0	5,600	<200
Guyana	2.5	11,000	1,100
Belize	2.4	3,600	<200
Dominican Republic	1.7	88,000	7,900
Suriname	1.7	5,200	<500
Barbados	1.5	2,500	<200
Jamaica	1.2	22,000	900
Cuba	0.1	3,300	<200
Central America			
Honduras	1.8	63,000	4,100
Guatemala	1.1	78,000	5,800
Panama	0.9	16,000	<500
El Salvador	0.7	29,000	2,200
Costa Rica	0.6	12,000	900
Nicaragua	0.2	6,400	<5,00
Mexico	0.3	160,000	5,000
South America			
Argentina	0.7	130,000	1,500
Brazil	0.7	660,000	15,000
Colombia	0.7	190,000	3,600
Venezuela	0.7	110,000	4,100
Paraguay	0.5	15,000	600
Peru	0.5	82,000	4,200
Chile	0.3	26,000	1,400
Ecuador	0.3	21,000	1,700
Uruguay	0.3	6,000	<500
Bolivia	0.1	4,900	<500

Source: UNAIDS, 2004 *Report on the Global HIV/AIDS Epidemic*, June 2004.

³ UNAIDS, *AIDS Epidemic Update*, December 2004, pp. 32 and 34.

In the Caribbean, ongoing stigma and widespread homophobia (which drives people away from HIV services), are significant factors in the spread of HIV.⁴ Sex tourism also is reportedly a factor contributing to rising HIV infection rates in some Caribbean countries. Officials in Trinidad and Tobago have expressed concern about the growth of sex tourism, the so-called “beach bum” phenomenon, and the link to the spread of AIDS.⁵ In Jamaica, the resort town of Montego Bay has the highest HIV infection rates in the country.⁶ In the Dominican Republic, AIDS activists are concerned about child prostitution in resort areas and the spread of HIV.⁷

In Central America, Honduras has the highest prevalence rate of 1.8% (with AIDS related diseases the second leading cause of death in the country), while Guatemala has a rate over 1%.⁸ The epidemic in Central America is concentrated in large urban areas, although some rural areas have been hard hit. In Honduras, the Garifuna community (descendants of freed black slaves and indigenous Caribs from the Caribbean island of St. Vincent) concentrated in northern coastal communities has been especially hard hit by the epidemic, with over 8% of the population infected.⁹

While unprotected heterosexual sex has been the main mode of HIV transmission in most countries in Central America and the Caribbean, sex between men is a major factor in epidemics in both regions. In Costa Rica, for example, men who have sex with men accounted for more than half of AIDS cases. In many cases, men who have sex with men also report having female sexual partners. Bisexuality, therefore, has been a significant bridge for HIV transmission into the wider population in Central America.¹⁰ Other high-risk populations in Central America include commercial sex workers, prisoners, and as noted above, the Garifuna population in Honduras.¹¹

⁴ UNAIDS, *AIDS Epidemic Update*, December 2004, pp. 31 and 35.

⁵ “Sex Tourism Cause of HIV Spread, Says T&T Minister,” *The Weekly Gleaner* (Jamaica), February 19, 2003. The commercial sex industry linked to tourism reportedly is well established in the Caribbean, with increasing male prostitution by so-called “beach boys.” See “The Caribbean Regional Strategic Framework for HIV/AIDS,” Pan Caribbean Partnership on HIV/AIDS and CARICOM, March 2002, p. 7. Also see Annan Boodram, “The Beach Bum Phenomena,” *Caribbean Voice*, August 3, 2002, and Julie Bindel, “The Price of a Holiday Fling,” *Guardian* (London), July 5, 2003.

⁶ “Rising Rate of AIDS in the Caribbean,” *All Things Considered*, *National Public Radio*, July 2, 2003.

⁷ “AIDS Activists Worried Over Child Prostitution in Dominican Republic,” *Boston Haitian Reporter*, January 31, 2003.

⁸ UNAIDS, *AIDS Epidemic Update*, December 2004, p. 59.

⁹ Interview with Dr. Angel Coca, USAID Mission, Tegucigalpa, Honduras, November 27, 2001; UNAIDS, *AIDS Epidemic Update*, December 2004, p. 59.

¹⁰ UNAIDS, *AIDS Epidemic Update*, December 2004, pp. 57-60.

¹¹ World Bank, “HIV/AIDS in Central America: An Overview of the Epidemic and Priorities for Prevention,” October 2003.

Consequences of the Epidemic

The AIDS epidemic in the Caribbean and Central America has begun to have negative consequences for economic and social development in the region. The Pan American Health Organization (PAHO) maintains that the AIDS epidemic threatens to undo many of the health gains made in Latin America and the Caribbean.¹² In the Caribbean, which is the second most affected region in the world, AIDS has become the leading cause of death among adults aged 15-44 years.¹³ Life expectancy and infant mortality have already been affected in some countries. In Haiti, life expectancy is 10 years lower and in Trinidad and Tobago it is 9 years lower than it would be without the epidemic.¹⁴ As the epidemic continues, already-strained health systems will be further burdened with new cases of AIDS. As a result of the epidemic, there are some 250,000 AIDS orphans in the Caribbean (with 200,000 of those in Haiti) and some 73,000 AIDS orphans in Central America.

According to the World Bank, continued increases in HIV prevalence in the Caribbean will negatively affect economic growth. The epidemic, according to the Bank, will have a negative impact on such economic sectors as agriculture, tourism, lumber production, finance, and trade because of lost productivity of economically active adults with the disease. In particular, the labor market in the region will be dealt a shock because of deaths from AIDS. The Prime Minister of St. Kitts and Nevis, Denzil Douglas, maintains that the epidemic threatens to cripple the labor force just as the region needs to become more competitive in world markets amid the momentum toward hemispheric free trade.¹⁵ Looking ahead, the World Bank warned in 2001 that “what happened in Africa in less than two decades could now happen in the Caribbean if action is not taken while the epidemic is in the early stages.”¹⁶

The U.S. government views the AIDS epidemic not only as a humanitarian crisis, but also as a national security issue because of its negative impact on economic development and political stability abroad. In February 2002, State Department Under Secretary of State for Global Affairs Paula Dobriansky warned that the disease was spreading in regions close to home, particularly Central America and the Caribbean.¹⁷ In June 2002, Scott Evertz, then Director of the White House Office of AIDS Policy, reportedly warned that AIDS problems abroad could jeopardize the health of Americans, and described the Caribbean as “our third border.”¹⁸

¹² Pan American Health Organization, “AIDS Threatens to Undo Health Gains,” September 7, 2001.

¹³ UNAIDS, *AIDS Epidemic Update*, December 2004, p. 31.

¹⁴ Ibid.

¹⁵ “Caribbean Leaders Call AIDS ‘Single Biggest Threat’ to Development, Announce Push for Low-Cost Antiretrovirals”, *Kaiser Daily HIV/AIDS Report*, July 8, 2003

¹⁶ World Bank, *HIV/AIDS in the Caribbean: Issues and Options*, March 2001, p.xii.

¹⁷ Senate Foreign Relations Committee, Testimony by Paula Dobriansky, February 13, 2002, Federal Document Clearing House.

¹⁸ William Gibson, “AIDS Crisis Spurs U.S. Into Action; Disease Damaging World (continued...) ”

Response to the Epidemic

The response to the AIDS epidemic in the Caribbean and Central America has involved a mix of support by governments in the region, bilateral donors (such as the United States, Canada, and European nations), regional and multilateral organizations, and nongovernmental organizations (NGOs). Many countries in the region have national AIDS programs that are supported through these bilateral, regional, and multilateral programs.¹⁹

The World Bank has provided significant support to combat AIDS in Latin America and the Caribbean, with Brazil becoming the first country in the region to receive such assistance. In June 2001, the Bank approved a \$155 million lending program for the Caribbean to help countries finance their national HIV/AIDS prevention and control projects. Under this program, the Bank has approved loans to Barbados (2001), the Dominican Republic (2001), Jamaica (2002), Grenada (2002), St. Kitts & Nevis (2003), Trinidad & Tobago (2003), the Caribbean Community's (CARICOM) Pan Caribbean Partnership Against HIV/AIDS (PANCAP) (2004), Guyana (2004), St. Lucia (2004), and St. Vincent (2004). In March 2005, the World Bank approved an \$8 million Central America regional project to manage and control the epidemic.

The Inter-American Development Bank has supported HIV/AIDS activities in such countries as Haiti, Honduras, the Bahamas, Jamaica, Guatemala, Nicaragua, and a regional program through CARICOM. Moreover, its assistance to support health infrastructure in the region has been important for HIV/AIDS treatment and care programs.

The Global Fund to Fight AIDS, Tuberculosis, and Malaria has begun funding programs throughout Latin America and the Caribbean, with about \$159 million, or 12% of disbursed funding, going to this region as of mid-July 2005. Beneficiaries in Central America and the Caribbean include Belize, Costa Rica, Cuba, the Dominican Republic, El Salvador, Guatemala, Guyana, Haiti, Honduras, Jamaica, Nicaragua, Panama, and Suriname as well as regional programs for CARICOM and the Organization of Eastern Caribbean States (OECS). (See the Global Fund's website at [<http://www.theglobalfund.org/en/>]. For more on the Global Fund, see CRS Report RL31712, *The Global Fund to Fight AIDS, Tuberculosis, and Malaria: Background and Current Issues*.)

Looking broadly at the entire Latin American and Caribbean region, the commitment to stem the epidemic has grown considerably, and the region has made progress in the treatment and care of people infected with HIV/AIDS. Nevertheless, the quality and scope of surveillance, prevention, and treatment programs in the

¹⁸ (...continued)

Economies, Leaders Determine." *Sun-Sentinel*, June 23, 2002.

¹⁹ For a listing, see Pan Caribbean Partnership Against HIV-AIDS and CARICOM. "Matrix: Activities of Agencies in HIV/AIDS in the Caribbean Region," Guyana, March 2003. The matrix provides information on bilateral, regional, and multilateral HIV/AIDS programs in the Caribbean and originally was prepared by UNAIDS in 2000.

region vary because of unequal socioeconomic development and high population mobility.²⁰

Access to ARV drugs has improved significantly in a number of countries, although in poorer resource-limited countries, universal access to treatment could take years to achieve. Brazil has been a model in the developing world in terms of offering antiretroviral treatment to all people living with HIV, and the survival rate of AIDS patients in the country has risen significantly because of this. AIDS mortality has also declined in other countries providing universal coverage for ARV treatment, including Argentina, Barbados, Costa Rica, El Salvador, and Panama. Other countries like Honduras, Guyana, and Peru have been scaling up access to ARV treatment, while other countries like Guatemala, Nicaragua, Bolivia, and Ecuador have lagged behind in providing ARV treatment to people living with AIDS. According to the World Health Organization, out of a total of 465,000 people needing ARV treatment in Latin America and the Caribbean, an estimated 290,000, or 62%, were receiving it.²¹ Some observers caution that treatment is concentrated in the larger countries of the region, but that in many smaller poorer countries, the percentage of people receiving ARV treatment is much less.²²

In Haiti, an estimated 42,500 people needed ARV treatment in 2004, while as of March 2005, only about 4,000 people, or 9%, were receiving it.²³ Funding from the Global Fund will reportedly allow Haiti to expand programs for ARV treatment to 30% of those in need by 2007. Partners in Health, a non-profit organization affiliated with the Harvard Medical School, has provided HIV screening and counseling since 1988, and is now providing ARV treatment to patients in several impoverished rural villages in the Central Plateau region of the country.²⁴ The project demonstrates that even in severely impoverished countries with little health infrastructure, there can be sustained treatment for people with AIDS.

Regional and multilateral institutions in the Caribbean support a regional approach in dealing with the epidemic in part because governments are either too small or too poor to respond adequately. The minimal infrastructure, weak institutional capacity and poverty have hampered efforts to respond to the epidemic in several countries. In order to overcome these difficulties, the Caribbean Community (CARICOM) has coordinated a regional approach to combat AIDS. In 1998, the CARICOM Secretariat chaired a Caribbean Task Force on HIV/AIDS that developed a strategic plan for the region. In February 2001, CARICOM launched the Pan Caribbean Partnership Against HIV/AIDS (PANCAP), a new coalition established to involve government, business, and the international community in

²⁰ UNAIDS and WHO, *AIDS Epidemic Update*, December 2002, pp. 19-21.

²¹ UNAIDS and WHO, *Progress on Global Access to HIV Antiretroviral Therapy*, June 2005, p. 13.

²² International Antiviral Therapy Evaluation Center (IATEC), "Antiretroviral Access Panorama Continues to be Grim for Much of Latin America," *IATEC Update*, June 2005.

²³ World Health Organization, "Haiti: Summary Country Profile for HIV/AIDS Treatment Scale-up," June 2005.

²⁴ See the Partners in Health website at [<http://www.pih.org/wherewework/haiti/index.html>]

support of the strategic plan to combat AIDS. In 2002, CARICOM and the Partnership developed a 2002-2006 strategic framework and a plan of action to respond to the epidemic. The Pan American Health Organization and its Caribbean Epidemiology Center (CAREC) have provided technical assistance to help implement the strategic plan, and donors have included UNAIDS and the World Bank and bilateral donors such as the United States.

In Central America, there have been several notable regional efforts, including an initiative to protect vulnerable populations from the epidemic. Various regional meetings have brought together government officials and non-governmental organizations. Central American nations were also successful in negotiating significant price cuts with drug companies for antiretroviral drugs.

Although there have been significant efforts to combat the epidemic in the Caribbean and Central America, the challenges ahead are considerable since the epidemic continues to grow. Overall challenges in the region include continued surveillance of the epidemic, an increase in prevention programs that also focus on marginalized populations that have been overlooked by past efforts to promote safe behavior, and an expansion of therapy to those in greatest need.²⁵ In the Caribbean, the World Bank maintains that concerted action by national governments and regional agencies, in partnership with NGOs and the private sector, and with the assistance of the international community, will help diminish the adverse impact of AIDS. According to the Bank, prevention campaigns need to focus on changing risky behavior; making HIV-testing and condoms more accessible; treating sexually transmitted diseases; and reducing mother-to-child transmission. Moreover, the Bank maintains that care and treatment, which is negligible in most countries in the region, needs to be developed and expanded to serve entire national populations.²⁶

U.S. Policy

Within the federal government, overall U.S. support to combat the HIV/AIDS epidemic in Latin America and the Caribbean is provided through programs administered by several U.S. agencies, including the Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH), the Department of Labor, the Department of State, and the U.S. Agency for International Development (USAID). Most funding for such programs is included in annual appropriations measures for Foreign Operations and for the Departments of Labor, Health and Human Services, and Education. In addition to support provided by U.S. agencies, the United States also provides contributions to multilateral efforts to combat AIDS, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria described above. The United States is also a major financial contributor to such multilateral institutions as the World Bank and the Inter-American Development Bank that fund HIV/AIDS projects in the region. (For more, see CRS Report RS21181, *HIV/AIDS International Programs: Appropriations, FY2003-FY2006*.)

²⁵ Pan American Health Organization, *HIV and AIDS in the Americas: An Epidemic with Many Faces*, 2001, p. 45.

²⁶ World Bank, *HIV/AIDS in the Caribbean: Issues and Options*, pp. xiv, xvii, and 35-38.

The U.S. Agency for International Development has been the lead U.S. agency fighting the epidemic abroad since 1986, including in Latin America and the Caribbean where it has funded a variety of regional and bilateral programs to combat AIDS. USAID's funding for HIV/AIDS in Central America and the Caribbean region rose from \$11.2 million in FY2000 to \$33.8 million in FY2003. Because of the inclusion of Guyana and Haiti in the President's Emergency Plan for AIDS Relief (PEPFAR), largely funded through the Global HIV/AIDS Initiative (GHAI) foreign assistance account, assistance to the region for HIV/AIDS increased to an estimated \$47 million in FY2004 and an estimated \$76 million in FY2005. For FY2006, the Administration requested almost \$91 million in HIV/AIDS assistance for Central America and the Caribbean, with \$21.4 million for Guyana and \$47 million for Haiti funded through the GHAI account. The balance of the request is from the Child Survival and Health (CSH) foreign assistance funding account. (See **Table 2.**)

In the Caribbean, USAID provides HIV/AIDS assistance through both bilateral and regional programs, and is an active member of the Pan Caribbean Partnership Against HIV/AIDS. As part of its Caribbean regional program, USAID has initiated a program focusing on Caribbean countries that do not have a permanent USAID presence: Trinidad and Tobago, Suriname, St. Kitts and Nevis, St. Lucia, St. Vincent and Grenadines, Grenada, Antigua and Barbuda, Dominica, and Barbados. The program, implemented through NGOs, governments, CARICOM, and CAREC, is aimed at expanding education and prevention programs and improving the effectiveness of health delivery programs.

USAID Missions in the Dominican Republic, Jamaica, Guyana, and Haiti provide bilateral HIV/AIDS assistance. In the Dominican Republic, USAID funds NGOs that provide prevention information to vulnerable groups, support people with HIV, and work in the policy arena to reduce stigma and discrimination. The Mission also provides assistance for mother-to-child transmission prevention, voluntary counseling and testing, and prepackaged therapy programs. It also collaborates with the Dominican Republic's Presidential HIV/AIDS Council and other donors to promote widespread societal participation in HIV prevention.²⁷ In Jamaica, USAID provides assistance to the Ministry of Health in support of a strategic plan to combat the epidemic, including support to target Jamaica's high-risk adolescent population. In Guyana, USAID supports prevention, treatment, and care activities, including support for voluntary counseling and prevention of mother-to-child transmission. Prevention activities will be scaled up as a result of increased assistance under PEPFAR. In Haiti, USAID has provided support for education and prevention activities aimed at high risk groups, people living with HIV/AIDS, programs to prevent mother-to-child transmission, and the marketing of condoms. As a result of increased assistance under PEPFAR, assistance for prevention, treatment, and care activities, including ARV treatment, will be scaled up.

²⁷ U.S. Agency for International Development, Santo Domingo, Program Summary, May 2005.

Table 2. U.S. HIV/AIDS Assistance: CSH and GHAI Funding in Central America and the Caribbean, FY2001-FY2006
(U.S. \$ millions)

Country	FY2001	FY2002	FY2003	FY2004*	FY2005 (est.)*	FY2006 (req.)*
Dom. Rep.	3.3	4.0	5.3	5.3	5.3	5.3
El Salvador	0.5	0.5	0.5	0.5	0.5	0.5
Guatemala	0.5	0.5	0.5	0.5	0.5	0.5
Guyana	0.8	1.0	4.2	6.8*	13.2*	21.4*
Haiti	4.4	4.0	7.7	18.3*	39.4*	47.0*
Honduras	2.6	3.5	4.2	4.2	5.2	4.2
Jamaica	1.3	1.3	1.3	1.3	1.3	1.3
Nicaragua	0.5	0.5	0.5	0.5	0.5	0.5
Central America Program	3.7	4.0	4.7	5.0	5.4	5.5
Caribbean Regional Program	1.5	5.5	4.9	4.7*	4.7	4.7
Total	19.1	24.8	33.8	47.0	76.0	90.9

* For FY2004, Guyana, received \$5.1 million in Global HIV/AIDS Initiative (GHAI) funding and Haiti received \$13 million in GHAI funding. For FY2005 and FY2006, all assistance for Guyana and Haiti was GHAI funding. The remainder of assistance for all countries and years came largely from the Child Survival and Health (CSH) funding account, with the exception of \$1 million in Economic Support Funds for the Caribbean Regional Program in FY2004.

Sources: U.S. Agency for International Development, website at [http://www.usaid.gov/our_work/global_health/aids/Funding/FactSheets/lac.html]; U.S. Department of State, FY2006 Congressional Budget Justification for Foreign Operations, February 2005.

In Central America, USAID funds HIV activities in Honduras, Guatemala, El Salvador, Nicaragua, Belize, and Panama. In Honduras, which has the largest program, USAID supports both the public and private sector, including support to local NGOs working with populations that have high rates of HIV prevalence and support for the promotion and marketing of condoms. USAID's Central America regional program is involved in prevention activities focused on high-risk groups and mobile populations that cross borders, support for improved public HIV/AIDS programs, and support for comprehensive care for people living with HIV/AIDS. Among its prevention activities, USAID has funded a condom social marketing and behavioral change program focusing on high-risk populations.

The CDC's Global AIDS Program (GAP) (under the U.S. Department of Health and Human Services) also has collaborative agreements with developing countries that help support research and formulate preventative and care efforts. It is involved in three program elements: primary prevention; surveillance and infrastructure development; and care, support, and treatment. To date in the Caribbean, the CDC has funded programs in Haiti, Guyana, and a Caribbean regional program supporting the Caribbean Epidemiology Center (CAREC) based in Trinidad and Tobago. CDC Caribbean funding for FY2002 amounted to an estimated \$5.5 million, with \$1.2 million for Guyana, \$1.2 million for Haiti, and \$3.1 million for CAREC. For FY2003, CDC funding for the Caribbean amounted to \$4.8 million, with \$1.4 million for Guyana, \$1.6 million for Haiti, and \$1.8 million for the Caribbean regional program.²⁸

NIH has funded international research efforts worldwide focusing on such areas as vaccine research, prevention of disease transmission, research on women and AIDS, prevention and treatment of HIV infection in children, prevention and treatment of opportunistic infections, and capacity building and training of foreign scientists. In the Caribbean and Central America, NIH has funded research studies and/or training programs for most countries in the region.²⁹

The Department of Labor has funded HIV/AIDS workplace education and prevention projects in Belize, the Dominican Republic, Guyana, Haiti, Jamaica, and Trinidad and Tobago.

Legislative Initiatives. Some Members of Congress have wanted to expand the Caribbean countries that would benefit from increased assistance under PEPFAR beyond Haiti and Guyana, arguing that high mobility in the region necessitates a regional approach in combating the epidemic.³⁰ Members and Caribbean leaders have expressed concern that other Caribbean countries will be overlooked. Caribbean officials maintain that targeting specific countries rather than the entire region could be disastrous given the significant travel among Caribbean islands, as well as the annual visits of millions of American tourists.³¹ Other Members note that the legislation does not preclude the President from designating additional Caribbean countries.

²⁸ See the CDC's website at [<http://www.cdc.gov/nchstp/od/gap/>].

²⁹ National Institutes of Health. "Global AIDS Research Initiative and Strategic Plan." December 2000; The Henry J. Kaiser Family Foundation, "Spending on the HIV/AIDS Epidemic," July 2002.

³⁰ David Gonzalez, "As AIDS Ravages Caribbean, Governments Confront Denial," *New York Times*, May 18, 2003; Matthew Hay Brown, "Caribbean Asks U.S. to Widen Plan," *Hartford Courant*, June 5, 2003.

³¹ Michael Smith, "Islanders Decry AIDS Fund Targeting U.S. Plan Leaves Out Most of Caribbean," *Miami Herald*, June 14, 2003; Also see "The Caribbean Regional Strategic Framework for HIV/AIDS," Pan Caribbean Partnership on HIV/AIDS and CARICOM, March 2002, p. 7.

In the 109th Congress, a provision in S. 600 (Section 2516), the Foreign Affairs Authorization Act, FY2006 and FY2007, would add 14 Caribbean countries to those countries targeted for increased HIV/AIDS assistance under PEPFAR. The additional countries are Antigua & Barbuda, Barbados, the Bahamas, Belize, Dominica, Grenada, Jamaica, Montserrat, St. Kitts & Nevis, St. Vincent and the Grenadines, St. Lucia, Suriname, Trinidad & Tobago, and the Dominican Republic. In the 108th Congress, similar provisions were included in both the House-passed FY2004-FY2005 Foreign Relations Authorization Act, H.R. 1950 (Section 1818), and the Senate Foreign Relations Committee's reported FY2005 Foreign Relations Authorization Act, S. 2144 (Section 2518), but no final action was taken on these measures.

Several other legislative initiatives in the 109th Congress have been introduced dealing with AIDS in the Caribbean. H.R. 164 (Millender-McDonald), introduced January 4, 2005, would amend the Foreign Assistance Act of 1961 to provide for the establishment of pediatric centers in certain developing countries, including Guyana, to provide treatment and care for children with HIV/AIDS. S. 350 (Lugar), introduced February 10, 2005, and H.R. 1409 (Lee), introduced March 17, 2005, would amend the Foreign Assistance Act of 1961 to provide assistance for orphans and other vulnerable children in developing countries, including in the Caribbean. H.R. 945 (Lee), introduced February 17, 2005, would provide assistance to combat infectious diseases in Haiti, including HIV/AIDS, and to establish a comprehensive health infrastructure.