



# HIV/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 in several countries, and continued increases in HIV infection rates threaten future development prospects. In contrast to other parts of Latin America, the mode of HIV 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 countries with the highest prevalence or infection rates are Belize, the Bahamas, Guyana, Haiti, and Trinidad and Tobago, with rates between 2% and 4%; and Barbados, the Dominican Republic, Honduras, Jamaica, and Suriname, with rates between 1% and 2%.

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 HIV/AIDS programs that are supported through these efforts.

U.S. government funding for HIV/AIDS in the Caribbean and Central America has increased significantly in recent years. Aid to the 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 region for HIV/AIDS increased from \$47 million in FY2004 to an estimated \$139 million in FY2008. For FY2009, the Administration requested almost \$139 million in HIV assistance for the Caribbean and Central America, with \$92 million for Haiti and \$20 million for Guyana.

In the 110<sup>th</sup> Congress, H.R. 848 (Fortuño), introduced February 6, 2007, would add 14 Caribbean countries to the list of focus countries under PEPAR. 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 second session of the 110<sup>th</sup> Congress, the language of H.R. 848 was included in PEPFAR reauthorization legislation, H.R. 5501 (Berman), approved by the House on April 2, 2008. The Senate version of the PEPFAR reauthorization, S. 2731 (Biden), which was reported by the Senate Committee on Foreign Relations on April 15, 2008, does not have a similar provision expanding the list of Caribbean countries that are focus countries.

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. Also see CRS Report RL33485, *U.S. International HIV/AIDS, Tuberculosis, and Malaria Spending: FY2004-FY2008*, by (name redacted); CRS Report RL33396, *The Global Fund to Fight AIDS, Tuberculosis, and Malaria: Progress Report and Issues for Congress*, by (name redacted); and CRS Report RL33771, *Trends in U.S. Global AIDS Spending: FY2000-FY2008*, by (name redacted).

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## Characteristics of the Epidemic in the Region<sup>1</sup>

Although the AIDS epidemic in the broader Latin America and Caribbean region is not as pervasive as in Africa, over 1.8 million people were estimated to be living with HIV in the region in 2007, including 230,000 in the Caribbean and 1.6 million in Latin America. Moreover, the adult prevalence rate in several countries in the Caribbean and Central America are among the highest outside of sub-Saharan Africa.

In terms of sheer numbers, Brazil accounts for about one-third of those living with HIV in Latin America, but its prevalence rate of 0.5% (2005)<sup>2</sup> 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.<sup>3</sup> In contrast, the mode of transmission in several Caribbean and Central American countries has been primarily through unprotected heterosexual contact, which has made it more difficult to contain the epidemic because it affects the general population.

The estimated adult infection rate in the Caribbean was 1.0% in 2007, with the epidemic claiming an estimated 11,000 lives during the year and 19,000 lives in 2006. An estimated 17,000 adults and children in the region became infected in 2007. AIDS remains one of the leading cause of death among adults in the Caribbean aged 15-44 years. The Caribbean countries with the highest prevalence or infection rates in 2006 were Haiti, the Bahamas, Belize, Guyana, and Trinidad and Tobago, with rates between 2% and 4%; and Barbados, the Dominican Republic, Jamaica, and Suriname, with rates between 1% and 2%.<sup>4</sup>

Haiti and the Dominican Republic account for three-quarters of the region's infected population. The U.S. Agency for International Development (USAID) notes that Haiti's poverty, conflict, and unstable governance have contributed to the rapid spread of AIDS over the years. In both countries, however, there are indications that the epidemic could be reaching a turning point because of prevention efforts. Nevertheless, trends in both countries suggest the need to protect against a resurgence of the epidemic. In Haiti, there are been declining infection levels in Port-au-Prince and other cities, and the declines appear to be associated with some protective behavioral changes (an increase in condom use and a drop in the number of sexual partners) although AIDS mortality has also been a factor. In the Dominican Republic, where there has been a large increase in the use of condoms by commercial sex workers, the epidemic appears to have stabilized.<sup>5</sup> However, workers on sugar cane plantations (bateyes) continue to have high prevalence rates, with rates up to 12% found among males aged 40-44.<sup>6</sup>

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<sup>1</sup> Unless noted otherwise, HIV/AIDS statistics and prevalence rates in this section are drawn from the Joint United Nations Program on HIV/AIDS (UNAIDS), *AIDS Epidemic Update*, December 2007.

<sup>2</sup> UNAIDS, "Epidemiological Factsheets on HIV/AIDS and Sexually Transmitted Infections: Brazil, 2006 Update," December 2006.

<sup>3</sup> 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.

<sup>4</sup> UNAIDS, *AIDS Epidemic Update*, December 2006.

<sup>5</sup> UNAIDS, *AIDS Epidemic Update*, December 2007, p. 27.

<sup>6</sup> UNAIDS, *AIDS Epidemic Update*, December 2006. pp. 44-45; Tim Collie, "'To Stay Alive,' Bateyes, Labor Camps for Old Sugar Plantations in the Dominican Republic, Have the Highest HIV Infection Rates in the Caribbean," *South* (continued...)

In Central America, Honduras has the highest prevalence rate of 1.5% (with AIDS related diseases the second leading cause of death in the country), while El Salvador, Guatemala, and Panama have rates just under 1%.<sup>7</sup> 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% and 14% of the population infected.<sup>8</sup>

Although 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 factor in epidemics in both regions. In Belize, Costa Rica, El Salvador, Guatemala, Nicaragua, and Panama, high HIV infection rates are found among men who have sex with men.<sup>9</sup> In many cases, men who have sex with men also report having female sexual partners. In Central America, bisexuality has been a significant bridge for HIV transmission into the wider population in Central America.<sup>10</sup> High prevalence rates have also been found among female sex workers in El Salvador, Honduras, and Guatemala. In Honduras, however, recent studies have shown that increased condom use by sex workers and men who have sex with men has reduced prevalence rates in the major cities of Tegucigalpa and San Pedro Sula.

In the Caribbean, stigma and widespread homophobia (which drives people away from HIV services), have been significant factors in the spread of HIV.<sup>11</sup> Although the share of HIV infections in the Caribbean attributed to sex between men is about 12%, homophobia and stigma could hide a higher percentage.<sup>12</sup> In recent years, human rights organizations have criticized Jamaica for pervasive homophobia and targeted violence against gay men that has also carried over to violence against people living with HIV and organizations providing HIV/AIDS education and services.<sup>13</sup> In June 2004, Jamaica's leading gay rights activist, Brian Williamson, was murdered, while in November 2005, Steve Harvey, a noted Jamaican AIDS activist, was murdered in what some news reports have characterized as a hate crime. UNAIDS condemned the murder and called on the Jamaican government to address homophobia and other causes of stigma and discrimination that are fueling the spread of HIV.<sup>14</sup> In September 2006, the Jamaican government launched an anti-stigma media campaign to combat discrimination associated with those infected with HIV.<sup>15</sup>

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*Florida Sun-Sentinel*, December 3, 2006.

<sup>7</sup> UNAIDS, *AIDS Epidemic Update*, December 2006, p. 48.

<sup>8</sup> Interview with Dr. Angel Coca, USAID Mission, Tegucigalpa, Honduras, November 27, 2001; UNAIDS, *AIDS Epidemic Update*, December 2006, p. 51.

<sup>9</sup> UNAIDS, *AIDS Epidemic Update*, December 2007, p. 32.

<sup>10</sup> UNAIDS, *AIDS Epidemic Update*, December 2004, pp. 57-60.

<sup>11</sup> UNAIDS, *AIDS Epidemic Update*, December 2004, pp. 31 and 35.

<sup>12</sup> UNAIDS, "Caribbean Fact Sheet," November 21, 2005.

<sup>13</sup> *Hated to Death: Homophobia, Violence, and Jamaica's HIV/AIDS Epidemic*, Human Rights Watch, 2004.

<sup>14</sup> "UNAIDS Condemns Killing of AIDS Activist in Jamaica," Press Statement, UNAIDS, December 7, 2005.

<sup>15</sup> "Jamaica Launches HIV Anti-Stigma Campaign," *BBC Monitoring America*, September 16, 2006.

## 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. In 2001, the Pan American Health Organization (PAHO) maintained that the AIDS epidemic threatened to undo many of the health gains made in Latin America and the Caribbean.<sup>16</sup> In the Caribbean, which is the second most affected region in the world, AIDS is one of the leading causes of death among adults aged 15-44 years. Life expectancy and infant mortality have already been affected in some countries. UNAIDS reported in 2004 that in Haiti, life expectancy was 10 years lower than it would be without the epidemic.<sup>17</sup> In 2006, it reported that life expectancy in the Dominican Republic was estimated to be three years lower than without the AIDS epidemic and that AIDS mortality in Trinidad and Tobago would reduce the country's overall population by 2010.<sup>18</sup> As the epidemic has continued, already-strained health systems in the region have been further burdened with new cases of AIDS. As a result of the epidemic, there are reportedly some 250,000 AIDS orphans in the Caribbean (with 200,000 of those in Haiti) and some 73,000 AIDS orphans in Central America.<sup>19</sup>

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.<sup>20</sup> 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."<sup>21</sup> A 2004 report by the Pan Caribbean Partnership Against HIV/AIDS maintained that the epidemic is taking its greatest toll on younger people who traditionally have been the most productive human resources.<sup>22</sup>

The U.S. government has viewed the HIV/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. Under Secretary of State for Global Affairs Paula Dobriansky warned in 2002 that the disease was spreading in regions close to home, particularly Central America and the Caribbean.<sup>23</sup> Scott Evertz, former Director of the White House Office of AIDS Policy, warned

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<sup>16</sup> Pan American Health Organization, "AIDS Threatens to Undo Health Gains," September 7, 2001.

<sup>17</sup> Ibid.

<sup>18</sup> UNAIDS, *Report on the Global AIDS Epidemic 2006*, May 2006, p. 83.

<sup>19</sup> UNAIDS and UNICEF, *Children on the Brink 2002, A Joint Report on Orphan Estimates and Program Strategies*, July 2002.

<sup>20</sup> "Caribbean Leaders Call AIDS 'Single Biggest Threat' to Development, Announce Push for Low-Cost Antiretrovirals," *Kaiser Daily HIV/AIDS Report*, July 8, 2003

<sup>21</sup> World Bank, *HIV/AIDS in the Caribbean: Issues and Options*, March 2001, p. xii.

<sup>22</sup> UNAIDS and Caribbean Community (CARICOM), *A Study of the Pan Caribbean Partnership Against HIV/AIDS (PANCAP)*, December 2004.

<sup>23</sup> Senate Foreign Relations Committee, Testimony by Paula Dobriansky, February 13, 2002, Federal Document Clearing House.

in 2002 that AIDS problems abroad could jeopardize the health of Americans, and described the Caribbean as “our third border.”<sup>24</sup> USAID Assistant Administrator for Latin America and the Caribbean Adolfo Franco testified in 2005 that migration from the region can contribute to the risk of HIV in the United States, citing statistics that Caribbean immigrants account for 46% of all immigrants testing HIV positive in New York City.<sup>25</sup>

## Response to the Epidemic

The response to the HIV/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.

The World Bank has provided significant support to combat HIV/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 the Bahamas, Belize, Guatemala, Guyana, Haiti, Honduras, Jamaica, Nicaragua, Suriname, 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 \$484 million or almost 10% of disbursed funding worldwide going to this region as of early 2008. 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 multi-country programs for CARICOM, the Caribbean Regional Network of People Living with HIV/AIDS (CRN+), 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 RL33396, *The Global Fund to Fight AIDS, Tuberculosis, and Malaria: Progress Report and Issues for Congress*, by (name redacted).)

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,

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<sup>24</sup> William Gibson, “AIDS Crisis Spurs U.S. Into Action; Disease Damaging World Economies, Leaders Determine.” *Sun-Sentinel*, June 23, 2002.

<sup>25</sup> U.S. Congress, House of Representatives, Committee on International Relations, Subcommittee on the Western Hemisphere, Hearing, “Policy Overview of the Caribbean Region,” October 19, 2005, p. 15.



and treatment programs in the region vary because of unequal socioeconomic development and high population mobility.<sup>26</sup>

Access to ARV drugs has improved significantly in a number of countries, although universal access to treatment in poorer resource-limited countries 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, the Bahamas, Barbados, Costa Rica, Cuba, and Panama.

According to a joint 2007 report issued by UNAIDS, UNICEF, and the WHO, some 355,000 people were receiving ARV treatment in Latin America and the Caribbean in 2006, or 72% of those needing it. The report also cautioned, however, that coverage declined slightly in the second half of 2006, and suggested that the increase in need is not being matched by an increase in the number of people being treated.<sup>27</sup>

In a number of smaller poorer countries in the region, particularly in the Caribbean and Central America, the percentage of people receiving ARV treatment is much less than the regional average.<sup>28</sup> In Haiti, almost 37% of those needing ARV treatment were receiving in 2006, while in neighboring Dominican Republic 36% of those needing treatment were receiving it. Other countries where less than 50% of those in need of ARV treatment were receiving it include El Salvador, Honduras, and Trinidad and Tobago.

While these numbers are low compared with the regional average, they also reflect a large increase in ARV treatment for these countries. In Haiti, Partners in Health, a non-profit organization affiliated with the Harvard Medical School, initiated a program in 1998 to provide ARV treatment to patients in several impoverished rural villages in the Central Plateau region of the country. The project, which expanded to other parts of Haiti, demonstrated that even in severely impoverished countries with little health infrastructure, there can be sustained treatment for people with HIV.

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. 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 coalition established to involve government, business, and the international community in 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.

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<sup>26</sup> UNAIDS and WHO, *AIDS Epidemic Update*, December 2002, pp. 19-21.

<sup>27</sup> WHO, UNAIDS, and UNICEF, *Toward Universal Access, Progress Report*, April 2007.

<sup>28</sup> International Antiviral Therapy Evaluation Center (IATEC), "Antiretroviral Access Panorama Continues to be Grim for Much of Latin America," *IATEC Update*, June 2005.



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.

## 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), which has been the lead agency fighting the epidemic abroad since 1986. 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 RL33485, *U.S. International HIV/AIDS, Tuberculosis, and Malaria Spending: FY2004-FY2008*, by (name redacted).)

U.S. government funding to combat HIV/AIDS in the Caribbean and Central America has increased in recent years. Foreign aid to the 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 from \$47 million in FY2004 to an estimated \$139 million for FY2008. For FY2009, the Administration requested \$139 million, with \$92 million for Haiti and \$20 million for Guyana through the GHAI account. The balance of the request for other countries is through the Child Survival and Health (CSH) foreign assistance funding account. (See **Table 1**).

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.

**Table 1. U.S. HIV/AIDS Assistance: CSH and GHAI Funding in Central America and the Caribbean, FY2003-FY2008**  
(U.S. \$ millions)

Country	FY2004 <sup>a</sup>	FY2005 <sup>a</sup>	FY2006 <sup>a</sup>	FY2007 <sup>a</sup>	FY2008 (est.) <sup>a</sup>	FY2009 (request)
Belize	—	—	0.2	0.5	—	0.5
Costa Rica	—	—	0.2	0.2	—	0.3

Country	FY2004 <sup>a</sup>	FY2005 <sup>a</sup>	FY2006 <sup>a</sup>	FY2007 <sup>a</sup>	FY2008 (est.) <sup>a</sup>	FY2009 (request)
Dom. Rep.	5.3	5.5	6.1	6.5	5.0	5.8
El Salvador	0.5	0.5	1.1	2.2	2.0	2.2
Guatemala	0.5	0.5	1.3	3.4	3.5	3.5
Guyana	6.8	14.8	18.0	25.3	20.0	20.0
Haiti	18.3	44.1	47.3	77.3	92.0	92.0
Honduras	4.2	5.2	5.2	5.8	5.0	5.0
Jamaica	1.3	1.3	1.5	1.3	1.2	1.2
Nicaragua	0.5	0.5	1.0	2.2	1.5	1.5
Panama	—	—		0.5	—	0.5
Central America Program	5.0	5.4	5.5	1.7	3.4	1.0
Caribbean Regional Program	4.7 <sup>a</sup>	4.7	5.9	6.6	5.7	5.8
<b>Total</b>	<b>47.0</b>	<b>82.5</b>	<b>92.9</b>	<b>133.5</b>	<b>139.3</b>	<b>139.3</b>

**Sources:** U.S. Agency for International Development, website at [http://www.usaid.gov/our\\_work/global\\_health/aids/Funding/FactSheets/lac.html](http://www.usaid.gov/our_work/global_health/aids/Funding/FactSheets/lac.html); U.S. Department of State, FY2007, FY2008, and FY2009 Congressional Budget Justification for Foreign Operations.

- a. For FY2004, Guyana, received \$5.1 million in Global HIV/AIDS Initiative (GHA) funding and Haiti received \$13 million in GHA funding. For FY2005-FY2009, all assistance for Guyana and Haiti was GHA funding. The remainder of assistance for all countries and years is 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, as well as small amounts of GHA funding for several countries.

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.<sup>29</sup> 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. USAID has also focused on fighting stigma and discrimination against people living with AIDS in Jamaica. 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, is being scaled up.

<sup>29</sup> U.S. Agency for International Development, Santo Domingo, Program Summary, May 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 and Guyana, and since 2002 it has funded a Caribbean regional program supporting the Caribbean Epidemiology Center (CAREC) based in Trinidad and Tobago. It has plans in 2008 to fund programs in Jamaica and the Dominican Republic. In Central America, the CDC has funded a regional program since 2003, and in 2008 it has plans to fund programs in Honduras and Nicaragua.<sup>30</sup>

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.<sup>31</sup>

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**

For several years, 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.<sup>32</sup> 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.<sup>33</sup> Other Members note that the legislation does not preclude the President from designating additional Caribbean countries.

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<sup>30</sup> See the CDC's website at <http://www.cdc.gov/nchstp/od/gap/>.

<sup>31</sup> 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.

<sup>32</sup> 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.

<sup>33</sup> 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 110<sup>th</sup> Congress, H.R. 848 (Fortuño), introduced February 6, 2007, would add 14 Caribbean countries to those countries targeted as focus countries 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 109<sup>th</sup> Congress, similar language had been included in Section 2516 of S. 600, the Foreign Affairs Authorization Act for FY2006 and FY2007, but final action on the measure was not taken before the end of the Congress. In the 108<sup>th</sup> Congress, similar language was 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.

In the second session of the 110<sup>th</sup> Congress, legislation is being considered to reauthorize U.S. assistance to combat HIV/AIDS worldwide during FY2009-FY2013. In May 2007, the President announced his intention to work with Congress for the reauthorization of PEPFAR, calling for \$30 billion over five years beginning in FY2009. On April 2, 2008, the House approved H.R. 5501 (Berman), a PEPFAR reauthorization bill that authorizes \$50 billion from FY2009 to FY2013 to fight AIDS, tuberculosis, and malaria overseas. Significantly for the Caribbean, Section 102 of the bill would add 14 Caribbean countries as focus countries, the same countries set forth in H.R. 848 noted above. The Senate version of the PEPFAR reauthorization bill, S. 2731 (Biden), reported by the Senate Committee on Foreign Relations on April 15, 2008, would also authorize \$50 billion over FY2009-FY2013, to fight AIDS, TB, and malaria, but would not designate the additional 14 Caribbean countries as focus countries.

Appropriations for HIV/AIDS assistance to the Caribbean and Central America are funded largely through the annual State Department, Foreign Operations, and Related Agencies appropriations measure. For further information, see CRS Report RL33485, *U.S. International HIV/AIDS, Tuberculosis, and Malaria Spending: FY2004-FY2008*, by (name redacted).

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