



The Caribbean Regional Strategic Framework For HIV/AIDS

2002-2006

Pan-Caribbean Partnership
on HIV/AIDS¹

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List of Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ARV	Anti Retroviral Drugs
AZT	Azido-deoxy thymidine
CAFRA	Caribbean Association of Feminist Research and Action
CAREC	Caribbean Epidemiology Centre
CARICOM	Caribbean Community Secretariat
CARIFORUM	Commission of African, Caribbean and Pacific States
CBA	Caribbean Bar Association
CBO	Community-Based Organisation
CCC	Caribbean Council of Churches
CCH	Caribbean Co-operation in Health
CCL	Caribbean Congress of Labour
CCNAPC	Caribbean Consortium of National Aids Programme Coordinators
CDB	Caribbean Development Bank
CDC	Centres for Disease Control
CDDRP	Caribbean Drug Demand Reduction Programme
CEC	Caribbean Employers Confederation
CFY	Caribbean Federation of Youth
CHA	Caribbean Hotel Association
CHRC	Caribbean Health Research Council
CIDA	Canadian International Development Agency
CMA	Caribbean Music Association
COHSOD	CARICOM Ministerial Council on Human and Social Development
CRN+	Caribbean Network of People Living with HIV/AIDS
CRC	Caribbean Red Cross
CSW	Commercial Sex Worker
CTO	Caribbean Tourism Organisation
DFID	British Department for International Development
EC	European Commission
EDF	European Development Fund
EU	European Union
FBOs	Faith-based Organizations
FMU	Fertility Management Unit (UWI)
FTC	French Technical Co-operation
GTZ	German Technical Co-operation
HIV	Human Immuno-deficiency Virus
HFLE	Health and Family Life Education
IDB	Inter-American Development Bank
ILO	International Labour Organisation
IPPF	International Planned Parenthood Federation
LACASO	Latin American and Caribbean Council of AIDS Service Organisations
MSM	Men who have Sex with Men
MTCT	Mother to Child Transmission
NAC	National AIDS Committee
NAP	National AIDS Programme

NGO	Non-Governmental Organisation
OECS	Organisation of Eastern Caribbean States
PAHO	Pan American Health Organisation
PLWHA	People Living with HIV/AIDS
SIDALAC	Regional Initiative on AIDS for Latin America and the Caribbean
STD	Sexually Transmitted Diseases
STI	Sexually Transmitted Infections
TB	Tuberculosis
TCC	Technical Co-operation among Countries
TF	Caribbean Task Force on HIV/AIDS
TG	UN Theme Group on AIDS
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDCP	United Nations Drug Control Programme
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNV	United Nation Volunteer
UWI	University of the West Indies
VCT	Voluntary Counselling and Testing
WAC	World AIDS Campaign
WB	World Bank
WHO	World Health Organisation
WTO	World Tourism Organisation

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Introduction

HIV/AIDS is increasingly recognized as a major development problem in the Caribbean. As both national governments and international donors seek to address its challenges, the importance of coordination at the regional level has been highlighted. The size of the region, its diversity and varying levels of integration, and the multitude of social and economic forces at work in the Caribbean mean that a variety of HIV epidemics are already underway there. These factors present both opportunities and challenges to a regional approach.

The Regional Strategic Framework articulates those specific opportunities and challenges common to most of the countries across the region. Though not a substitute for national level action, the Framework identifies priorities that can be best addressed collectively at a regional level to the benefit of all, while identifying key issues for national level focus that will advance the regional fight against HIV/AIDS.

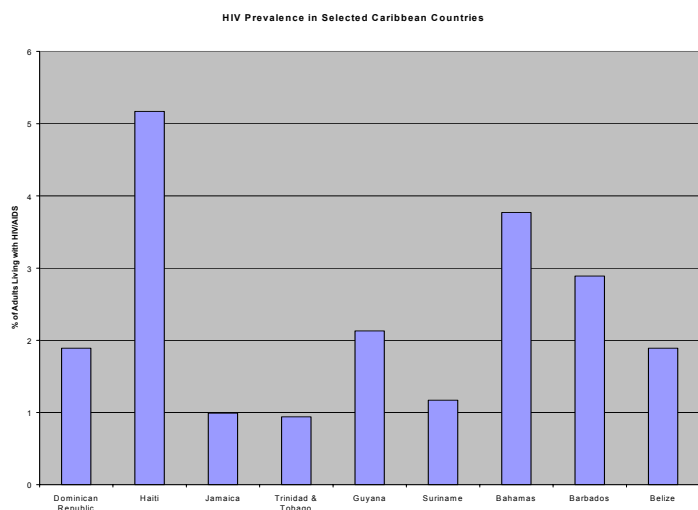
The Framework, which caters to the member states of CARICOM, Cuba, the Dominican Republic, Haiti as well as the Dutch territories and the Netherlands Antilles, was developed with the input of all regional and international players in the area of Health, HIV/AIDS and development (including CARICOM, CAREC, PAHO, CRN+, UNAIDS and its Cosponsors). It will be used by these institutions to develop implementation plans under the political leadership of CARICOM.

The objective of this Regional Framework, and the regional plans of action that flow from it, is to support national efforts to prevent and control the HIV epidemic and mitigate its consequences at national and regional levels. Close collaboration among regional-level organizations and the national programmes will ensure the successful application of the Framework.

HIV/AIDS in the Caribbean

Epidemiology. The Caribbean is heavily affected by HIV/AIDS. AIDS is already the leading cause of death in the 15-44 year age group. With an overall prevalence of approximately 2.11% among adults, the Caribbean is the hardest-hit region in the world outside sub-Saharan Africa. UNAIDS estimates that close to 360,000 people in the region are living with the virus; some put this figure at 500,000. The graph below illustrates the range of levels of infection among the nine most affected countries in the region.

Though none of the countries and territories in this economically, socially, and culturally diverse region have been spared, regional totals of officially



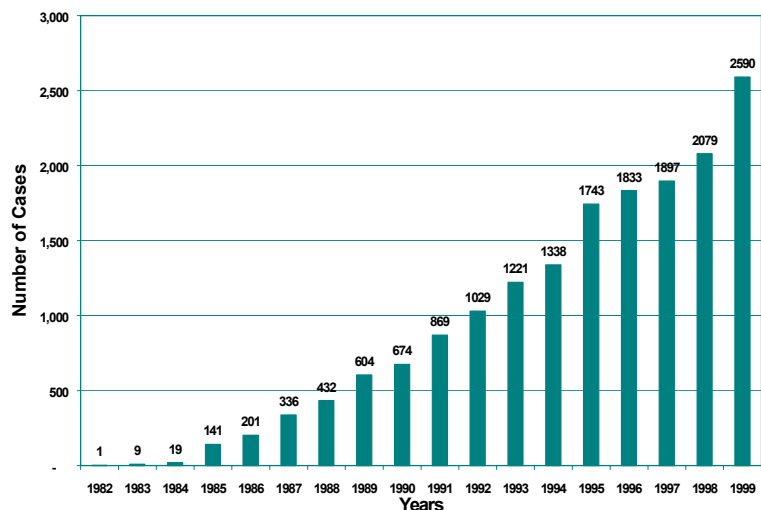
reported cases and estimates of actual cases disguise a wide variation in prevalence among the countries in the region. In some countries such as Cuba, prevalence is still at a very low level. Others face generalized epidemics affecting more than 5% of the adult population. Heavy reliance on AIDS case data, compounded by under-reporting in most countries, (which some estimate to be between 30% and 75% of actual cases), and generally weak HIV surveillance systems, obscure a clear picture of the size of the problem at the regional level, and its variations across the region. Even when under-reporting is taken into consideration, it is clear that the epidemic has worked its way into the general population in at least several countries. In Haiti, government surveys have indicated that up to 12% pregnant women in urban areas and 5% of those in rural areas are living with HIV/AIDS (*Institut Haitien de l'enfance et GHESHIO, 1998*). With a heterosexual epidemic fueled by extreme poverty, Haiti is the most affected country in the world outside of sub-Saharan Africa), and approximately one hundred Haitians die each day due to AIDS.

HIV prevalence among adults in the Dominican Republic is estimated at just below 2% in urban areas, meaning that approximately 130,000 people there are living with HIV/AIDS. (*UNAIDS, June 2000*). A recent sentinel survey among pregnant women in one town indicated that 8% were HIV-positive. Among sex workers, HIV prevalence ranges from 1 – 7% in the capital city, and up to eleven percent outside urban areas. In the Bahamas, the adult prevalence rate is 3.6%. (*UNAIDS, June 2000*)

Guyana is also facing a major epidemic. In 1998, 21.5% of patients seeking treatment for sexually transmitted infections were found to be HIV infected. (*UNAIDS, June 2000*) Research indicates that since 1992, prevalence of HIV among pregnant women seeking prenatal care has been consistently over 3%, while figures from 1996 indicate an estimated prevalence of 7.1% (*CAREC-GTZ 1998*). Among blood donors - a population generally thought to represent low risk of infection - HIV prevalence has been recorded at 3.2%, while a study among urban sex workers in 1997 showed a 44% infection rate. (*CAREC Surveillance Report, 1999*)

Data limitations. Most of the data on HIV/AIDS in the Caribbean is based on reporting of AIDS cases in the region, which, though underreported, illustrate an inexorable trend upwards over the past decade, with considerable acceleration in the mid-late 1990s. Between 1988 and 1998, the number of new AIDS cases in CAREC member countries increased by

Reported AIDS Cases in CAREC Member Countries, 1982 - 1999



a factor of five.² While 17,016 cases were reported in CAREC member countries by the end of 1999, the actual number is estimated to be closer to 26,500, based on the evaluations of surveillance systems conducted in each country. When added to the estimates for the non-CAREC members countries, the total rockets to 460,000. The alarming acceleration of the epidemic is highlighted by the fact that more AIDS cases have been reported between 1995 and 1998 than since the beginning of the epidemic in the early 1980s. In 1998, among the CAREC countries, the Bahamas, Turks & Caicos, Barbados, Trinidad and Tobago, St Vincent & the Grenadines, Bermuda, Guyana, Jamaica and Suriname reported the highest numbers of new AIDS cases. Overall, Haiti and the Dominican Republic together account for 85% of the total number of cases in the Caribbean. However, because of their size and tourism dependent economies, the small island nations remain vulnerable to the epidemic.

To exacerbate the difficulties in data collection is the fact that at the national level, data collection responsibilities have been assigned to National AIDS Programmes, most of which are not equipped with the requisite capacity, particularly in the form of trained staff and other resources, to ensure comprehensive and reliable data collection. Reporting is also not compulsory in all instances. Given the social stigma and other difficulties associated with the epidemic, especially evident in small close-knit Caribbean societies, many persons who are infected opt for private forms of treatment and care, often overseas, thereby reducing the likelihood of inclusion in official statistics and follow-up contact investigation. At the legislative level, action needs to be taken to ensure that reporting is undertaken consistently by all sources, that confidentiality is assured and that central systems of data collection are appropriately equipped to manage this process. At the policy level, the introduction of standard methods for reporting and data collection, along with appropriate training and awareness building is now a matter of necessity.

In addition to the collection of data on AIDS cases, there is an urgent need to improve the quality of information and analysis on the prevalence of HIV infection, especially in the most vulnerable populations, and among certain groups in the general population (pregnant women, STI patients). The fact that a standardized AIDS case definition is not used across the Caribbean as a whole (with the exception of CAREC-member countries and Cuba) makes consistent diagnosis and uniform reporting across the region difficult. Very few sentinel surveillance studies of HIV prevalence have been conducted in the region, especially in recent years. Such surveys are needed as they allow for analysis of levels of HIV prevalence over time, especially in vulnerable populations and those that can be viewed as “markers” for the general population. Most countries in the region have yet to develop national policies on testing and reporting of HIV, which impedes the systematic collection of data.

A more intensive effort to assess the actual scale of the epidemic with a broader range of tools will permit analysis of the stage of the epidemic in each country, and the identification of trends within higher risk groups. “Second-generation” epidemiological surveillance, which includes information on prevalence as well as behavioral indicators, is increasingly

² CAREC member countries include Anguilla, Antigua & Barbuda, Bahamas, Barbados, Belize, Bermuda, British Virgin Islands, Cayman Islands, Dominica, Grenada, Guyana, Jamaica, Montserrat, St Kitts & Nevis, St Lucia, St Vincent, Suriname, Trinidad & Tobago, Turks & Caicos.

recognized as an essential part of tracking and predicting the course of the epidemic, as such information helps to target resources on groups facing higher risk of infection. However the second generation surveillance should take into account the need for collecting and analyzing information related to care of PLWHAs and the use of other sources of information such as hospital mortality in the 15-49 age group, HIV/AIDS mortality information, socio-economic markers that can assist in predicting the future of the epidemic.

Heterosexual transmission. The epidemic in the Caribbean region, particularly in the countries already reporting high rates of prevalence, is fueled by heterosexual sex. At the beginning of the epidemic in the region, more men than women were infected, but this is quickly changing. In Haiti and the Dominican Republic, HIV/AIDS affects men and women equally, with a 1:1 male-to-female ratio of infections. In other countries, this ratio is now above 2 to1: 3.6:1 in Dominica, 3.3:1 in Barbados, 2.8:1 in Antigua, and 2.4:1 in Trinidad. In 1985 the ratio for these countries was estimated to be approximately 4:1. Self-reported heterosexual contact is now acknowledged as the main route of HIV transmission and accounts for the majority of HIV infections and AIDS cases in the Caribbean, representing 64% of all AIDS cases in CAREC member countries.

Infection among women and vertical transmission. Of particular concern is the dramatic and constant increase of HIV/AIDS among Caribbean women. The region now has one of the highest rates of new AIDS cases among women in the sub-regions of the Western Hemisphere. Women are at greater risk of contracting HIV in both biological and social terms, as they are both physically more vulnerable and often have little or no power to negotiate safer sex practices with their male partners. As the number of HIV infected women grows, the number of children born with HIV infection also increases. Vertical (mother-to-child) transmission follows the increase in the number of cases among women, and today represents 6% of all reported cases. Though various low-cost, effective treatments are now available for the prevention of transmission from mother to child, in the absence of such intervention, approximately 25-30% of children born to HIV-infected mothers will be infected with the virus. As prevention of transmission from mother to child becomes more economically feasible, reexamination of prevention priorities and allocation of resources at national level will be required.

Male to male transmission. Despite a growing burden of infection among women, there are still strong indications that male-to-male sexual contact is a major route of transmission in the Caribbean. Given the strong homophobic culture that pervades much of the region, this mode of HIV transmission is grossly under-reported, particularly as it relates to bisexuality. The strong stigma and potential discrimination attached to homosexual and bisexual behaviour results in a reluctance to report infection through this type of contact. Approximately twenty per cent of AIDS cases among men are reported to be due to sexual contact with other men, whereas 22% of cases among men are reported as “mode of transmission: unknown.” Most of such “unknown” cases – 80% of which are male --are probably through male-to-male sex, which would attribute more than 40% of all cases among men to be a result of homo-/bi-sexual transmission. Of all heterosexual AIDS cases, men are still the majority (60%), and it is possible that a certain number of them do not report bisexual activity. In total, approximately 50% of cases among men could be related to male-to-male sexual contact.

In terms of epidemiological and behavioral situation, a recent study conducted in Suriname among this group has shown a seroprevalence rate of 18% (UNAIDS, 1998) and a behavioral survey conducted among this group in six OECS countries and Trinidad and Tobago has shown a very high level of risky sexual behaviors (CAREC, Durban, 2000): very low usage of preventative measures towards HIV transmission.

Social and Economic Impact

Estimated costs. AIDS is already the leading cause of death in the Caribbean region among the 15-44 age group. When the most economically active population groups are the most heavily affected by a long-lasting, fatal epidemic, the social and economic repercussions are inevitable. Studies have calculated and projected the economic burden of the epidemic over time, and some estimate that its direct medical costs and the indirect costs of lost productivity could have amounted to more than 6% of the region's GDP by the end of 2000. A study by the University of the West Indies predicted that the total cost of (direct and indirect) of the epidemic in the Caribbean would reach US\$20 MN in 1995 and US\$80 MN in the year 2020. This same study estimated that in Trinidad & Tobago and Jamaica, the GNP will be lowered by 4.2% -6.4%; savings will go down by 10.3% in Trinidad and Tobago and by 23.5% in Jamaica. Investment will also be reduced, as will employment in the key sectors such as agriculture and manufacturing.

The financial and economic burdens are not the only aspects of the epidemic's impact. At the individual level, the terrible burden of illness, stigma and discrimination are real. For households, valuable resources are frequently diverted to care for sick family members, and to replace their foregone income. At the social level, the forces driving the epidemic: poverty, violence, marginalization, are often compounded by rising rates of prevalence. Only frankness, openness and determination to deal with these root causes of the epidemic through adequate policy frameworks and responsible, effective programmes can begin to address them.

Demographic implications. One of the most important long-term effects of a generalized HIV/AIDS epidemic is its impact on demographic indicators. As younger age groups are disproportionately affected by a life-threatening disease, a reduction in life expectancy over time can be projected. As more people are generally expected to live for shorter periods of time, their expected contributions to national economic and social development become smaller and less reliable. This is of particular concern in small countries that lose large numbers of skilled individuals that are not easily replaced. At the macro level, costs associated with this kind of loss such as increased absenteeism, higher training costs, income foregone, and resources that would otherwise go into productive activities is redirected into health care, time spent caring for sick family members, etc.

Health systems. High prevalence of HIV and AIDS in any group means that more people become sick, and demand health care services. The slow medical progression of the HIV infection means that people become gradually sicker over long periods of time, needing more and more health care. Obviously the direct costs of this medical care grow over time. For example, in 1996, the Jamaican national AIDS programme estimated that it spent J\$50

million on prevention, treatment and hospitalizations of AIDS patients. This figure does not include the cost of antiretroviral drugs. In 1998, the Kingstown General Hospital of St Vincent and the Grenadines estimated that 38% of hospital admissions were related to HIV/AIDS. The average length of stay and related costs are also on the rise. Between 1996 and 1998, Barbados estimated that Bds\$3-5 million were spent on treatment of opportunistic infections, while Bds\$300,000 was spent on drugs to prevent mother to child transmission in the same period. Also to be considered is the time that family members must spend caring for sick relatives, which otherwise might have been spent on more productive activities. Time and resources invested in care for HIV and AIDS patients gradually can also affect other programmes and draw down resources for other health activities. The crisis is further exacerbated by aspects of public sector reform being pursued under the influence of the Breton Woods Institutions. Health Sector reform has typically included decentralization without appropriate resource allocation to meet new regional and local responsibilities. Further, cost recovery policies have meant that poorer people often have been placed beyond the coverage of health care that is required to prevent HIV infection and spread.

Impact on the labour force and on strategic sectors. Given that it affects young adults and people in their prime working ages (20-54) – the HIV/AIDS epidemic has a strong impact on the labour force. The HIV/AIDS epidemic will increase the prevalence of poverty and inequities because of its impact on both individuals and economies. From the individual's perspective HIV/AIDS implies absenteeism, fewer working days, limited opportunity for better-paid work and a shorter working life. This personal impact should be considered in conjunction with the economic effect on family members and communities. The impact on businesses will include loss of profit and productivity due to workforce morbidity, increased absenteeism due to sick leave or caring for a family member, increased staff turn-over due to premature loss of services of experienced staff, lower productivity of new employees and investments in their training. HIV/AIDS also impacts on the loss of staff morale (fear of discrimination, loss of colleagues, worries) as well as on the employee benefits due to growing demands for medical care from workplace health services, early retirement, premature payments from pension funds due to early deaths, increased costs of insurance premiums. The development of strong workplace-based HIV prevention and care programmes with full involvement of employers' and workers' organizations is key for the region.

Some key sectors in national economies are more heavily affected by the HIV/AIDS epidemic than others. Though in most countries poverty is clearly a factor that creates a context of risk and forces many into high-risk behaviours, in other countries, the reverse may be true – disposable income, especially outside the family and community setting -- can also equal risk. A cash income (usually available to skilled workers holding professional jobs) allows some to engage in similarly high-risk behaviours: travel away from home, multiple sexual partners, commercial sex, drug and alcohol use, etc. Evidence suggests that this is the case, for example, in some African countries where key sectors of the labour force - such as mid-level managers, mine workers, transport & tourism workers, teachers, military personnel and others are disproportionately affected and thus creating major losses for the national economy.

Issues

Mobility and tourism. As one of the most popular tourist destinations in the world, the Caribbean region is uniquely exposed to various health threats. In addition to receiving more than 20 million visitors from abroad each year, Caribbean people themselves are in general very mobile, travelling from island to island and outside the region for work, study and family reasons. Because mobility is often linked to increased risk of HIV infection, the characteristics of the population movements that make up such an important part of Caribbean life need particular attention. These magnified risks are mainly due to complex behavioural reasons that sometimes link a person's tendency to change residence with risky sexual behaviour. In the Caribbean, HIV/AIDS is often associated with migration to and from the highly affected countries. Political instability and huge socioeconomic inequalities between neighbouring countries are important impulses for migration. Flows of migrants in the Caribbean include sex workers, tourists, business travellers, petty traders, casual laborers and others. Of note in the region is the fact that the major migration streams (into the region, within it, and away from it) are increasingly dominated by females, a feature that differs significantly from historical patterns of Caribbean migration. The predominance of one sex in a migration stream indicates that immigrants are not moving with spouses or families. This presents opportunities for high risk behaviours, such as multiple sexual partners, the likelihood of engaging in or purchasing commercial sex, and increased use of alcohol and drugs, the abuse of which can impair judgement and free up inhibitions that otherwise might offer protection from undue HIV risk.

The sex industry. An important feature of heavily touristed areas and highly mobile populations is the increased presence of a commercial sex industry. Sex workers are generally defined as women or men who provide sex for material benefit. Commercial sex work is widespread, well entrenched and increasing throughout the region, and takes place under a variety of circumstances. It is linked to tourism in the islands; it follows mining villages and trading patterns in a variety of industries. There are short-term as well as fixed brothel workers, and mobile sex workers; they are single and married, women and men. Male prostitution in the form of "beach boys" is increasing across the Caribbean.

In many cases, economic hardship is the single most important reason given by sex workers for going into sex work. Economic difficulties in the region and the rigors of structural adjustment over the last two and a half decades have resulted in a dramatic rise in the number of women and men seeking work in a market that is less than accommodating. Alcohol and substance abuse are related issues, as drinking makes it easier for some women and men to carry on their trade. Though sex work is seen as a viable economic endeavor by those in the trade, it remains marginalized in all societies and illegal in most. The absence of any regulation in the sex trade industry means that social and health services are rarely responsive to the particular needs of this group. Given their marginalized status and the illegal nature of their work it is very difficult for women to seek protection from coercive or physically abusive clients, bar owners and other exploitative adults. The police are often seen as part of the marginalizing or exploiting forces of the society and provide no help in case of physical abuse. The vulnerability of sex workers, as well as the role they play in the overall transmission dynamic of the epidemic in the region requires special attention and adequate policy frameworks.

Emerging sexual patterns. New sexual patterns in the region are also emerging, often driven by economic circumstances. Sex tourism has grown, and increasingly new groups are being pulled into commercial and-or “transactional” sex (sex for food, sex for school fees, etc): they include schoolgirls, housewives and children. As such, new groups are being exposed to new risks, and merit specific analysis and targeted interventions.

As mentioned above, homosexuality and bisexuality continue to be highly stigmatized in most Caribbean societies. Though clearly a major determinant in the spread of HIV in the region, very few prevention campaigns have addressed the specific issues related to homosexuality and bisexuality in the region. Stigma has driven many gay men to adopt a bisexual lifestyle where underground homosexuality co-exists with socially accepted, visible heterosexual lifestyles, making it very difficult to reach this vulnerable group with messages it can readily identify as relevant. Stigma means that the social context of the homosexual community in much of the Caribbean is dominated by lack of trust and open communication, poor dissemination of information and unsafe sex practices. This impacts on the wider community through the bridge of bisexual practices in which risk of HIV is not openly acknowledged.

Challenges

Today, in most of the Caribbean, the level of information on HIV-AIDS is high. Information and education campaigns in most countries, led by national AIDS programmes, that have been established and supported since the beginning of the epidemic, have resulted in widespread awareness of HIV and its prevention. A wide range of Caribbean governments, regional and international agencies, including the United Nations System, bilateral cooperation agencies, and national and international non-governmental organizations (NGOs) have expressed strong commitment to address the various aspects of the epidemic in the Region. Actions taken by these partners under the leadership of national governments have included advocacy and social mobilization, regional and national policy development, the establishment of HIV prevention and drug control activities and programmes, and the development of mass media campaigns, prevention programmes and services for young people. As the epidemic continues to evolve, complex issues related to access to care, policies and coordination will present additional challenges.

Contributing social and behavioral norms. As in other regions, features of the Caribbean social context influence the course of the epidemic. Many men and women have multiple sex partners; social and cultural norms condone and even encourage this. Gender roles and socialization contribute to poor communication among partners on sexual needs and concerns, coupled with and compounded by women’s emotional and socio-economic dependence on men, which limits women's ability to negotiate safer sex practices. These factors are often compounded by high levels of sexual violence in some Caribbean societies. This burden, including domestic violence, disproportionately affects women and is largely unrecognized and reinforced by inadequacy of social and legal sanctions. The media, the courts, the school system and faith-based organizations, all key organs of consciousness formation, need to be mobilized to change the manner in which children, particularly boys, are raised and subsequently behave in adulthood.

Further, sexual activity among youth often begins at much earlier ages than is commonly believed by parents, teachers, and other adults. Social "taboos" prevent teaching or discussing sex with young people and denies incorporation of sex education into school curricula. Heavy stigma surrounding same-sex relationships means both individual and societal denial of actual risk; many men who have sex with men also have sexual relationships with women, thereby increasing the risk of transmission to women and children. Although condoms are now more widely available, their limited acceptability restricts their use. Widespread use and abuse of alcohol and other substances, especially among young people, often act as a dis-inhibiting factor and facilitate sexual violence and other high-risk behaviors. In order to be successful, prevention programmes will have to acknowledge and address these factors in a realistic way.

Mobilizing and coordinating an expanded multisectoral response. The experience of many countries around the globe highlights the fact that an effective response to HIV must be based on the involvement of all sectors of society including health, education, social welfare, finance and the highest levels of the executive. High-level support and political commitment is key to the long-term success of any effort. Although some presidents and prime ministers have spoken out publicly on the importance of the epidemic, there remains the need to obtain highly visible, sustained political will, commitment and dynamism and to give unambiguous and personally identifiable leadership at the highest level to the fight against the epidemic in the region.

A key remaining challenge for the region is participatory national strategic planning with the full involvement of all sectors of society - including the health sector and the various other sectoral ministries, as well as the broadest involvement of civil society (not only AIDS-specific NGOs) and the business sector. As the social, economic and political implications of the evolving epidemic become more visible, the responsibilities of the Ministries of Health must accommodate technical demands within the health sector as well as promotion and coordination of other sectors.

Many countries are in the process of developing national strategic plans, and some have completed them, but the process needs to be strengthened in most places. National strategic plans should assess the situation and specific issues of each setting, assess the effectiveness of the response to date and, based on this, determine the priorities for action. A key challenge is the relatively small scale of the interventions that are in place to address the large and complex issues of the epidemic. The effective responses need to be supported and scaled up while new initiatives need to focus on the most critical areas. Given the Caribbean region's social and economic integration at many levels, and challenges presented by differing levels of capacity in some countries, some (but not all) of these issues can be collectively addressed more efficiently through a strong framework for coordination, rather than the simultaneous replication of efforts at each national level. Another key challenge is the sensitization of sectoral ministries other than health and dispelling the myth that the epidemic is a 'health' issue. Failure to see HIV/AIDS as a developmental concern permeates not only governments, but also civil society and the corporate community.

Policy and Programme Development. Very few Caribbean countries have developed national policies and/or legal frameworks that address HIV/AIDS-related human rights.

Policy and program development remain weak for a variety of reasons, including lack of an appreciation of the epidemic's basic causes and consequences, the paucity of reliable data on its size and scope, and projections of its future course. Adequate operational and behavioral research is still needed to inform policy making, and a lack of resources available to national programmes (particularly national resources as opposed to donor funds) highlights the low level of priority given to date to the epidemic. Strategic planning has not yet been consistently undertaken to determine how best to allocate scarce resources, in particular with regard to cost effective interventions.

Prevention. For lack of political commitment, lack of openness regarding sexually sensitive issues and lack of targeted interventions, the speed of behaviour change and increases in condom use have been outpaced by the rate of the spread of the epidemic. Targeted interventions particularly those geared towards vulnerable but hard-to-reach groups, men who have sex with men (MSM), sex workers, mobile populations, young school children and social drop-outs, institutional populations such as prisoners, and uniformed groups, such as the police and the military, are needed. More specific issues such as prevention of mother-to-child transmission and blood safety require technical expertise as well as financial resources. The success of both general and more specific prevention efforts depends also on an “enabling” policy environment that openly acknowledges both the reality of the epidemic and its underlying social and economic causes and consequences. For much of the Caribbean, national leaders have yet to be really mobilized to openly speak about the epidemic, much less introduce policy and legislative frameworks, or commit national resources to the issue. Specific prevention activities, such as blood safety, the prevention of mother to child transmission, and a realistic allocation of resources to prevention among highly vulnerable groups are technical matters as well as ones of policy and legal frameworks.

Meeting the special needs of young people. One of the most important areas of emphasis for prevention efforts must be young people. As a sexually transmitted disease, HIV/AIDS disproportionately affects the younger segments of the population. This is true of the Caribbean region: seventy percent of AIDS cases in the region are diagnosed in the 15 to 44 age group, half in the 25 to 34 age group (which, given the time it takes to progress from HIV infection to a fully diagnosed AIDS case, actually means that most of these infections took place in their teens and early 20's). Given that more than half of the overall Caribbean population is under the age of 24 (roughly 33% is under the age of 15 and another 20% between 15 and 24), these implications hold great significance for the social, economic and political futures of this region.

Early sexual initiation usually brings with it high risk of HIV infection. A recent survey conducted among adolescent youth in four English-speaking Caribbean countries showed that among those who reported being sexually active, more than 40% said their sexual debut had started before the age of 10. An additional 20% said it had started at age 11 or 12 (*PAHO, Adolescent Health Survey, 1998*). This information surprises many adults, including parents and teachers who sometimes resist providing young people with information on sex and reproductive health at such early ages. Many life skills programmes and other reproductive health programmes aimed at young people focus on older youths; however, this evidence – not unique to the Caribbean - points towards the need to provide this information at a much earlier age.

The special risks for young girls. As in other parts of the world, young girls in the Caribbean are at particularly high risk of becoming infected at very young ages, especially by older men who are much more likely to be HIV infected than their younger counterparts. In some countries, these ratios are reported to be as high as 7:1 in the 10 to 19 age group (CAREC, 1997). This phenomenon is a reflection of the social conditions prevailing in many countries of the Caribbean, the peer pressures on young girls to have early sex and the hidden story of coercive sex, rape, incest, domestic violence, and predatory "sugar daddies" that young girls must cope with. Many older men increasingly seek younger girls for sex in the belief that they are more likely to be HIV-free, or, on a more sinister note, with the mistaken belief that sex with virgins is somehow a cure for HIV/AIDS.

Young people, especially girls, are also exposed to sexual abuse and sexual exploitation, often associated with poverty and dysfunctional families. Children subjected to sexual abuse in childhood are typically robbed of self-esteem and of a feeling of control over their lives, which increases their risks of substance abuse and involvement in sex work later in life. In general, violence against women as well as sexual abuse of young men and children are increasing in the region. Surveys indicate that some 21% of boys and 18% of girls may have been sexually abused before age 16, and 1% of men and 6% of women are sexually abused as young adults (UNFPA). Sex tourism with minors, often perceived as a problem of tourist destinations outside of the Caribbean, is also on the rise in the region with countries such as Belize, Dominican Republic and Haiti. Though deeply troubling, these issues require policy makers to confront the reality faced by young people in the region and take measures to protect them.

The need to expand care, treatment and support. Improving access and quality of care for the growing number of people living with HIV/AIDS in the Caribbean must be a priority. Health services are already struggling to respond to the growing population of persons with HIV/AIDS requiring care, support and treatment. Indeed, although the average progression from HIV infection to AIDS is similar to that observed in other regions, the mortality of AIDS patients in the Caribbean is reported at a higher level - 65% - indicating clear gaps in the care spectrum. Although some countries are exploring ways in which to improve access to the most advanced treatments, including anti-retroviral, most governments find the high costs of these treatments prohibitive. A regional strategy to facilitate access to new highly effective therapy and supporting diagnostic and monitoring facilities has not yet materialized. Other problems include insuring health workers' ability to provide timely diagnosis of HIV infection and related conditions. Such diagnosis through counseling, testing, and improved health worker training, provides important opportunities to improve nutrition, psychological support, prevention and treatment of subsequent opportunistic infections in HIV-positive people. Access to knowledge of one's status, and adequate support to deal with it, can also help prevent unwitting transmission of HIV to others. Sometimes this access is limited not by lack of facilities but by fear of stigma and discrimination, including fear of being identified as a member of a "high risk group," the fear of being tested without consent if presenting to a health facility, and limited confidentiality. Therefore, programmes aimed at strengthening the capacity of health services must include not only better access to medications, but improved quality and privacy of services.

Stigma. As in many other parts of the world, the introduction of HIV/AIDS in the Caribbean was coupled with a general reaction of fear and prejudice in most societies. This

often resulted in marginalization, stigma and outright discrimination and violation of the human rights of people infected and living with HIV/AIDS. People living with HIV/AIDS continue to be stigmatized and shunned by their communities thus many still choose not to disclose their HIV status for fear of being rejected by their communities and families, losing their jobs, their housing and social status. While there is a gradually expanding movement of PLWHAs organizing themselves and articulating their own care and support needs, their organisations require support to be effectively included in policy and programme development.

Opportunities for a Regional Response

In spite of the deeply rooted social and economic issues driving the epidemic, and the considerable spread of HIV already witnessed in the region, opportunities do exist for concerted regional action. A Pan-Caribbean Partnership for HIV/AIDS was launched in February, 2001. Many, but not all of these partners are described briefly in Annex 2. Regional institutions such as CARICOM, CAREC, UWI, the regional development banks, the UN system and others representing or associated with Caribbean countries are relevant to the response and have yet to be optimally enlisted. An increasing number of HIV/AIDS specific organizations and those having HIV/AIDS components, networks of people living with HIV/AIDS, NGOs and community-based organizations (CBOs) are now active, some on a regional scale. The international support available to the region, though limited, has facilitated advocacy, policy development and targeted interventions. Recently UN agencies within the Theme Group mechanism and long standing bilateral partners including CIDA, GTZ, FTC, DFID, and the EC have been active in the region and are increasingly committed to strengthening the regional capacity to provide direction and leadership for a concerted response. The Global Fund for HIV/AIDS, TB and Malaria is an additional resource that can be tapped by Caribbean countries. Structured National AIDS Programs also exist across the region and are being encouraged to develop horizontal linkages for the exchange of information and collaborative efforts through various horizontal (“south to south”) cooperation mechanisms.

The process of identifying priorities for regional action must also involve a close look at the experience to date and existing capacities at national level. This is particularly important in the Caribbean given the huge diversity in terms of the the scale of the epidemics and the varying levels of capacity to respond. Although all of the Caribbean countries have established broad based multisectoral national AIDS committees and have taken some measures to control the AIDS epidemic, the scope and effectiveness of this response has varied considerably. Many of the countries in the region are simply too small to develop alone the capacity needed to respond to the HIV epidemic in the region. As a long term problem, HIV/AIDS demands a sustained response from qualified health care and other personnel, which many countries lack, placing too many demands on too few qualified and informed individuals. In other countries, especially the larger ones, a serious lack of infrastructure, poverty, aspects of macroeconomic structural adjustment, political instability and large size have presented major obstacles.

Given the historical, social and economic factors that serve as linkages throughout the Caribbean region, as well as the population movements within it, HIV must be considered as

a regional issue. If some countries cannot or do not mount an effective response, it is inevitable that the consequences will be felt in other countries as well. As noted often, HIV is a problem that transcends national boundaries; in fact, given the specific needs of people living with HIV and the unique stigma that surrounds the disease, HIV positive people may be even more inclined to leave countries with inadequate responses in search of adequate and confidential support elsewhere. Therefore, strengthening regional networks and institutions and acknowledging the linkages that the HIV/AIDS epidemic creates and reinforces among the countries of the region would enable all countries in the region -- even the smallest -- to benefit. Opportunities to make HIV a priority development issue exist. A basis for this was laid with the Nassau Declaration (2001) that “the health of the Region is the wealth of the Region”. Concerted action can also be facilitated by the move towards the Common Market and Economy. By maximizing the potential of existing regional institutions that can highlight HIV issues over party politics, points of shared interests, shared vulnerabilities and shared responsibilities can be identified.

National Level Action

Throughout the Caribbean, several governments have led the national process of preparing strategic action plans. In varying degrees, these processes have involved a broad range of national interest groups and stakeholders, often working in partnership with government and international development groups. The present state of preparation of national strategic action plans, with the establishment of identifiable implementation mechanisms in many instances, vary across the region. While some countries have just begun the preparation and consultation process, others have completed this process and are at a progressive stage of implementation, or have prepared draft documents under active discussion and refinement.

What is clear however, is that care has to be taken to elaborate a Regional Strategic Framework consistent with established national strategic priorities and interests; whether these are fully outlined national strategic plans or articulated in varying forms of draft documents and policy statements. The priority areas as expressed in this Regional Strategic Framework are intrinsically linked to such national actions. The Regional Strategic Framework derives its importance and validity from national policy goals and objectives, and in this way relies on the effective pursuit of national goals and priorities for achieving the objectives set out herein. Further detailed action to fulfill these objectives, are to be undertaken in the context of specific regional and national strategic plans. The Framework therefore exists as a broad presentation of issues, policies and actions that feed into processes of elaborating and/or implementing national strategic approaches aimed at combating the HIV/AIDS epidemic in the Caribbean.

The Regional Strategic Framework

The Caribbean is intensifying its regional response to the challenges of HIV/AIDS. Alarming statistics and increased awareness among regional leaders of the epidemic’s human, social and economic implications have given the impulse to the development of a coordinated multi-sectoral expanded response. An important expression of this sense of urgency was the formation of the Caribbean Task Force on HIV/AIDS following a major pan-Caribbean consultation on HIV in 1998. Under the leadership of the Caribbean

Community Secretariat (CARICOM), and comprised of the major regional institutions, governments, national programme managers, donors, UN agencies, and people living with HIV/AIDS – all from virtually every country and territory in the region -- the Task Force initiated the process that led to the emergence of the Pan Caribbean Partnership on HIV/AIDS which further developed the present Regional Strategic Framework.

The overall intention of the Framework is to provide a basis for reducing the spread and impact of HIV/AIDS in the Caribbean. The framework identifies areas for priority action at the regional level, which are focused on promoting a strengthened, effective and coordinated regional response to the epidemic, and supporting expanded multi-sectoral HIV/AIDS programmes at the national level. The Regional Strategic Framework is based largely on the efforts of these groups to coordinate and prioritize HIV/AIDS work in the Caribbean region. The priority areas correspond to the challenges described in the previous sections, and are as follows:

- Advocacy, policy development and legislation
- Care, treatment and support of people living with HIV/AIDS
- Prevention of HIV transmission, with a focus on young people
- Prevention of HIV transmission among especially vulnerable groups:-
 - Men who have sex with men (MSM)
 - Sex workers
 - Prisoners
 - Uniformed populations (military and police)
 - Mobile populations
 - People in the Workplace
- Prevention of mother to child transmission of HIV
- Strengthening national and regional response capability
- Resource Mobilization

Linkages with existing programmes and activities. Successful pursuit of the objectives of the Regional Strategic Framework will require the support of a variety of players that operate regionally. Each lead partner must identify and undertake strategic actions to strengthen existing programmes and activities at the regional level. Among others, examples of these activities include UNICEF's Multi-Island Plan (MIP) developed for the Eastern Caribbean, the Health and Family Life Education programme, UNDCP's drug control plan, CAREC's Strategic Plan (2001-2005), and various activities undertaken by UNAIDS and PAHO. Several bilateral donors are already supporting important HIV/AIDS activities at the national level, particularly in the larger islands. The Framework builds on the recommendations of various regional workshops, conferences, and follow-up meetings to major world conferences, including the World Summit on Children, the Social Development Summit, the Fourth World Conference on Women (Beijing), the International Conference on Population and Development, and the UN General Assembly Special Session on HIV/AIDS. Various international and regional instruments have also been consulted throughout the process of its development, including the Convention on the Rights of the Child, the Convention on the Elimination of All Forms of Discrimination Against Women, the Millennium Decade Goals, the Belize Commitment, the Regional Plan of Action on Poverty Eradication, the ILO code of practice on HIV/AIDS and the world of work, the

Platform for Action on HIV/AIDS and the world of work in the Caribbean Sub-Region, the CARICOM Ministers of Health and Education policies concerning the Health and Family Life Education (HFLE) project, the Caribbean Health Promotion Charter. The Caribbean Cooperation in Health II (CCH II) priorities and key indicators have been fully considered to ensure compatibility.

Resource mobilization. These existing programmes and planned projects provide a basis for the resources required to implement actions embraced by the Regional Strategic Framework. However, important gaps remain, and as various donors and partners consider options and means of supporting an expanded regional response, it is important that new activities are coordinated with the framework. In collaboration with the Pan-Caribbean Partnership, the CARICOM Secretariat retains the responsibility to mobilize additional resources in support of the regional strategy; these include multilateral and bilateral co-operation agreements, the private sector, and other mechanisms.

Support for key components of the Regional Strategic Framework is already being realized. The European Union is funding a large-scale regional programme for strengthening the regional capacity to address the HIV epidemic in the Caribbean through the stronger involvement of key regional institutions, including CARICOM, CAREC, PAHO, CHRC, UWI, UNAIDS and the Caribbean Network of People Living with HIV/AIDS (CRN+). This is a fundamental input to the implementation of activities within the Regional Strategic Framework as it will help strengthen regional institutional capacity to plan and coordinate an effective response, particularly in the most affected countries. Anticipated outputs include:

- An increased pool of appropriately skilled personnel able to contribute to effective policy development and implementation of programmes;
- Increased regional awareness of the benefits, costs and operational feasibility of interventions to reduce mother-to-child transmission of HIV;
- An expanded and effective regional network of people living with HIV/AIDS, advocating for improved care and support, and contributing to national policy development;
- Improved regional capacity to design, implement and evaluate interventions to reduce high risk behaviour related to the spread of STI/HIV infection;
- More comprehensive and accurate information on the course, consequences and costs of the epidemic through improved surveillance, monitoring and evaluation of national control programmes and through operational research.

These outputs are already reflected in the current framework, and should be seen as integral support to other regional efforts. Support from other bilateral and multilateral partners for other priority activities is also currently under negotiation.

Implementation. The pursuit of the objectives of the Regional Framework will fall to the Pan-Caribbean Partnership on HIV/AIDS under the overall leadership of the Caribbean Community Secretariat (CARICOM), specifically its Human and Social Development Directorate. While not a substitute for national level action, the Framework is intended to facilitate the identification of activities that will guide decision-making at both regional and national levels. Most of the actions to achieve the objectives of the Framework will be

implemented at regional level; however, given the high level of integration among the countries and the similar features of the epidemic being confronted in the region, many national programmes will look to the Regional Framework for both guidance and support. The priorities it identifies are those that are most effectively addressed from the regional level, and in the recognition that at national level, while priorities may be similar, they may have different features and orders of priority within country.

Partners have identified lead and support implementation roles within the Framework. However, the majority opinion holds that even though bi-lateral and multi-lateral agencies are part of the PCP they normally should not have lead roles in the RSF. It is felt that these lead roles are more appropriately assigned to Caribbean organizations. Further, a lead role does not imply a bureaucratic “gate-keeper” function but more one of mobilizing support, facilitating networking among partners and coordinating all efforts to achieve the particular priority objectives. Where no regional institution currently has the capacity to fully exercise a required lead role, the primary responsibility of any temporary lead partner is to help rapidly develop that capacity: e.g., the Red Cross and UNICEF are thus considered in relation to the CFY for Priority Area 3.

In Annex 1, the lead partner is identified for each priority area. Further, within each priority area a lead partner is assigned responsibility for each output. That partner’s name is shown in Annex 1 above the list of support partners in relation to each output.³ On this basis regional partners need to develop or modify their implementation plans in order to meet the obligations arising from their agreed roles within the Framework.

While the seven priority areas are shown separately in Annex 1, these are not mutually exclusive but rather closely interrelated. Implementation plans will need to reflect this interrelatedness and have gender considerations and participation of PLWHAs fully integrated throughout.

Budget: In the earlier document (the Caribbean Regional Strategic Plan, September 2000) cost estimates were given in Annex 1. Those figures were intended to give an idea of the overall costs by strategic objective over the proposed five-year period. However, recent consultations have indicated that significant revisions of those estimates, which totaled US\$34,574,430, are needed and would be best undertaken by the lead partner for each priority area. Consequently, no figures appear in the revised matrix in Annex 1 of this document.

³ The list of support partners is based on recommendations of key regional partners who were available for consultation during the month of February 2002. The list is meant to be as inclusive as possible so some of the listed organizations have not been consulted on their participation and others with interests may not have been identified.

Priority Areas and Strategic Objectives

Priority 1: *Advocacy, policy development and legislation*

Lead Partner: CARICOM

- To inform and mobilize policy makers at highest levels with more comprehensive information on the course, consequences and costs of the epidemic
- To ensure participation of key economic and social sectors in national and regional dialogue on HIV/AIDS
- To increase quality and coverage of HIV/AIDS issues in the media
- To promote the incorporation of human rights and non-discrimination practices in policy and legislation, in accordance with international guidelines, best practice and commitments
- To mobilize regional opinion leaders on HIV/human rights issues
- To promote awareness at multisectoral level on HIV and human rights issues
- To ensure that national level policy decisions reflect international standards/best practice/consistency with international guidelines
- To increase participation of PLWHAs in policy dialogue
- To ensure inclusion of HIV/AIDS issues in regional health sector reform activities (at national and regional level)
- To expand analysis of the impact of the epidemic on key social and economic sectors
- To ensure that prevention messages are integrated into as many general advocacy opportunities as possible

Priority Area 2: *Care, Treatment and Support for People Living with HIV/AIDS*

Lead Partner: CRN+

- To promote the active formation and participation of networks of people living with HIV/AIDS in programme and policy design, implementation and evaluation (GIPA)
- To develop and promote improved understanding of quality of care issues
- To improve access to basic medication (for the prevention and treatment of opportunistic infections)
- To improve access to antiretrovirals
- To ensure that regional standards for clinical management and care for STI/HIV/AIDS are being met
- To improve understanding and opportunities for regional bulk procurement of test kits and drugs, condoms, etc
- To strengthen and extend counselling and diagnostic facilities
- To identify opportunities for regional participation in international vaccine efforts

Priority Area 3: *Prevention of HIV Transmission, with a focus on young people*

Lead Partners: Red Cross/UNICEF/CFY

- To ensure general access to reliable and accurate information about HIV/AIDS
- To ensure recognition of gender issues within all prevention campaigns

- To improve and support the implementation of Health and Family Life Education Programmes
- To integrate HIV and STI issues into adolescent programmes including reproductive health programmes
- To promote the development of HIV/AIDS prevention programs for young people, including condom distribution
- To advocate for the provision of youth-oriented health services and facilities
- To promote and support innovative peer counselling models for youth, parents and teachers
- To ensure the access of out of school youth to HIV/AIDS prevention and services.

Priority Area 4: *Prevention of HIV transmission among especially vulnerable groups*
Lead Partner: UNAIDS

Men Who Have Sex with Men (MSM)

- To support development of national and regional networks of MSM NGOs and partners addressing HIV prevention and care
- To strengthen understanding of role of MSM and female partners of MSM in regional epidemiology of HIV/STIs and to use information in appropriate prevention and care strategies
- To ensure access to best practice information and adaptation of lessons learned into regionally appropriate use

Sex Workers

- To strengthen understanding of role of sex workers in regional epidemiology of HIV/STIs, and to use information in appropriate prevention and care strategies
- To support development of regional networks of NGOs addressing HIV prevention and care needs of sex workers

Drug and Substance Abusers

- To strengthen understanding of role of substance abuse and drug use in regional epidemiology of HIV/STIs, and to use information in appropriate prevention and care strategies

Prisoners

- To ensure that HIV/STI policies and appropriate prevention strategies and services are available and implemented in the prison system

Uniformed Populations

- To ensure that HIV/STI prevention and care needs of uniformed populations are recognized and addressed with appropriate services

Mobile Populations

- To identify and address policy issues affecting mobile populations at regional level (testing, immigration requirements, employment, insurance, etc)
- To identify opportunities within tourism sector for HIV prevention

People in the Workplace

- To mobilise and support key employers at regional and national level to assess HIV/AIDS in their workplaces and to introduce appropriate prevention and support programmes for employees

Priority Area 5: *Prevention of Mother to Child Transmission*

Lead Partner: CAREC/PAHO

- To develop regional policy and operational guidelines
- To identify and support field training sites/models
- To strengthen primary prevention among women
- To strengthen national capacity in MTCT counseling and psychosocial support

Priority 6: *Strengthen national and regional capacities for analysis, programme design, implementation, management and evaluation*

Lead Partner: UWI

- To build analytical and management capacity in key regional institutions such as CARICOM, CAREC, UNAIDS, UWI, CRN+ and others
- To expand and improve the quality of information available to programme managers and policy makers on the course, causes and consequences of the epidemic at national and regional levels
- To promote information exchange, coordination, and formation of strategic alliances in the region

Priority 7: *Resource Mobilization*

Lead Partner: CARICOM

- To identify resource needs and gaps
- To ensure bilateral/regional access to the Global Fund for HIV/AIDS, TB and Malaria

Annex 2. National and Regional Partners in the Response to Date

Various partners and regional institutions have been identified as having the potential to be key players in the implementation of the strategic framework. First and foremost are members of the Task Force and its associate members. Institutions participating in the EC Project while having a major role to play, will provide the basis for strategic alliances, partnerships and collaborative arrangements with other regional and national agencies and initiatives.

Pan-Caribbean Partnership on HIV/AIDS: Members and Associate Groups

CARICOM: The Caribbean Community (CARICOM) was established in 1973 and comprises all of the independent states and dependencies of the Caribbean, with the exception of Cuba. CARICOM's mission is to provide dynamic leadership and service, in partnership with community institutions and groups, toward the attainment of a viable, internationally competitive and sustainable community, with improved quality of life for all.

CARICOM's objective is to promote regional integration in the Caribbean through economic co-operation, foreign policy co-ordination among independent member states, development of common services and co-operation in health, education, culture, communication, and industrial relations. CARICOM operates through an annual conference of Heads of Governments, an annual meeting of the Community Council of Ministers and four Inter ministerial Councils. One of these, the Council of Human and Social Development (COHSOD) promotes regional co-operation in the area of human development, encompassing health, including matters relating to HIV/AIDS/STI. Regional co-operation relates to matters of policy, programme development, financing and external co-operation. The organs of CARICOM, are serviced by a Secretariat based in Georgetown Guyana, headed by a Secretary General. CARICOM's annual budget is US\$ 7.4 million, 85% of which is contributed by member states and the rest from United Nations and the Inter American Development Bank (IDB).

CAREC: The Caribbean Regional Epidemiological Centre (CAREC) was established in 1975 as a result of a decision of the Regional Ministers of Health. CAREC serves twenty-one (21) member countries in the Caribbean and is administered by the PAHO, regional office for the Americas of WHO. The mission of CAREC is to improve the health status of the Caribbean people. The centre is organised into three divisions (epidemiology, laboratory, and administration), and a number of units and programmes, including the Special Programme on Sexually Transmitted Diseases (SPSTD). The SPSTD aims to reduce the spread and to minimise the impact of HIV/AIDS/STI by behaviour modification and improved surveillance diagnosis and treatment capabilities. To this end CAREC has been particularly active in the area of advocacy, policy planning, capacity building and resource mobilisation. Major intervention areas continue to be young people, communications, MTCT, VCT and networks of PLWHAs.

UNAIDS: The Joint United Nations Programme on HIV/AIDS (UNAIDS) is a co-sponsored programme comprised of seven United Nations agencies (UNDCP, UNDP, UNESCO, UNFPA, UNICEF, WHO, and the World Bank). It brings together the expertise of a range of sectors including health, education, social development, and economics. Its mission is to guide, strengthen and support the expanded response aimed at preventing the transmission of HIV, providing care and support to PLWHAs, reducing the vulnerability of individual and communities and alleviating

the impact of the epidemic.

In the Caribbean, UNAIDS' regional office is located in Port of Spain, Trinidad. The office supports the region's theme groups, advocates and leads the UN co-sponsors response to HIV/AIDS and provides a centre where information on the latest human rights policy and programme developments at global level can be accessed.(e.g. best practices series). Guidance and support is provided to the theme groups in the setting up of technical working groups and focal points. The office works through a broad cross section of partners (UNV, Red Cross, FTC and strategic alliances (e.g. EC, CARICOM).) The office also provides onsite technical support to policy makers, programme managers, and advocates, such as PLWHA s. It funded projects in 18 territories (including Dominican Republic (DR), Cuba and Haiti) for a total of US\$ 3.2 million over the period 1996 - 1999.

Projects funded include advocacy for the expanded response (Eastern Caribbean, Guyana); capacity building for strategic planning; reduction of the impact of HIV/AIDS in PLWHA s and vulnerable populations (CSW, MSM, mobile populations). The office also gives support to programme for young people in information, education for prevention of HIV/AIDS, drama, music, condom social marketing, it gives support to programmes for the prevention of vertical transmission of HIV/AIDS (Belize, Jamaica, DR, Haiti). Other programmes supported by UNAIDS are capacity building, mitigation of socio-economic impact, and AIDS in prisons. Over the period 1999-2000, interventions are being developed within the framework of the Regional Strategic Framework for HIV/AIDS in its six priority areas.

CRN+: The Caribbean Network of People Living With HIV/AIDS (CRN+), established in 1996, is based in Trinidad and Tobago and is a member of the Global Network of HIV positive people (GNP+). Its mission is to advocate for the rights PLWHA, and to provide moral support to and to improve the quality of life of people, who are infected and affected by HIV/AIDS, and to act as a resource for training counsellors and care givers.

UNDP: The United Nations Development Programme (UNDP) is the largest provider of grants for economic and social development and is the main co-ordinator of the UN' s operational activities for development at country level. The overall goal of UNDP is to build capacity for sustainable human development. In working towards this goal, top priority is given to the eradication of poverty. Other areas of focus include employment and sustainable livelihood, the advancement of women, environmental protection and the building of an enabling environment for sustainable development, which includes the promotion of good governance.

UNDP has implemented HIV/AIDS-related activities through a number of mechanisms - country programming, regional and sub regional projects, including those in the Caribbean. The UNDP HIV and Development Programme (HDP) is set up to provide policy guidance to the organisation on HIV/AIDS related institutional and personal issues. The role of HDP is to increase understanding of the social and economic determinants and consequences of the epidemic and to build capacity to respond appropriately. In this context, in the Caribbean, the UNDP is carrying out HIV and Development workshops, designed to increase awareness of the nature of the impact of the epidemic, to promote approaches to strengthen community coping and national responses, and to identify associated policies and programmes. These workshops bring together policy makers from a wide variety of sectors.

WHO/PAHO: Within the context of HIV/AIDS/STI, the World Health Organisation/Pan American Health Organisation (WHO/PAHO), works with numerous partners to strengthen the response of the health sector to the epidemic. As the leading health international agency, through its regional bureau PAHO, WHO provides health sector specific assistance to countries to improve their health policies, planning, and implementation of interventions known to be effective. Efforts are concentrated on strengthening health systems, prevention of infection, provision of care and support and mitigation of the impact of illness on individuals and communities. In the Eastern Caribbean, PAHO/WHO is involved in areas of strengthening national capacity in health planning, gender issues in health (training of trainers); adolescent health (comprehensive adolescent health plan in 4 countries); HFLE; health promotion, nutrition and HIV/AIDS (nutrition training for HIV/AIDS clients); perinatal care (review national breast feeding policies). PAHO/WHO is co-signatory with CARICOM for the implementation and monitoring of CCH-II (q.v.), which has a very comprehensive HIV/AIDS/STI component.

SIDALAC: SIDALAC, initially sponsored by the World Bank is now being incorporated into the technical support efforts of UNAIDS. It focuses on epidemiology; the economic impact of the epidemic, the development of interventions to raise awareness of decision-makers; and the development of innovative interventions in the private sector. The Mexican Health Foundation (FUNSALUD), a private non-profit institution, is the implementing agency of SIDALAC.

Other Regional Actors

CARIFORUM: The Caribbean Forum of African, Caribbean, and Pacific States (CARIFORUM), established in October, 1992, is a grouping of fifteen Caribbean States which are signatories to the Lome Convention. The Secretary General of CARICOM is the Secretary General of CARIFORUM, whose decisions are taken by the annual Council of Ministers (mostly of Foreign Affairs). CARIFORUM's primary objective is to co-ordinate the allocation and monitor disbursement of EDF resources for regional projects in the Caribbean, within the framework of Lome IV Convention.

UWI: The University of the West Indies (UWI) has campuses in Jamaica, Trinidad, and Barbados. UWI provides teaching to over 7, 000 undergraduates and 3, 000 post graduates. A number of special institutes support ongoing service and career training. The UWI Medical School, the Caribbean Institute of Mass Media and Communication (CARIMAC), and the Department of Economics, provide technical and intellectual guidance to the region in their respective fields. With respect to HIV/AIDS, under the proposed EC project, UWI aims to implement a long-term effort to expand skills base. Post graduate research and training in the medical aspects of HIV/AIDS, in prevention approaches, in public health relations, and in economics, will be introduced to the region. The medical school will design and introduce new modules at medical undergraduate and postgraduate level in HIV/AIDS/STI diagnosis and management for both doctors and nurses. The Department of Psychology will develop a new course of behavioural modification for risk reduction. The Department of Economics will expand its teaching a research capacity in health economics. CARIMAC's special course for journalists on HIV/AIDS will be supported. Overall the UWI effort will result in a significant expansion of skills base to address the causes and consequences of HIV/AIDS.

CHRC: The Caribbean Health Research Council (CHRC) was established in 1981 to promote, support, facilitate and co-ordinate research in the Caribbean and advise Caribbean Governments on

health research matters. It promotes the establishment of essential national health research in member countries, and operates a competitive grants award scheme for researchers. It conducts health research training workshops, organises scientific meetings and facilitates collaboration between researchers in the region and internationally. CHRC will conduct an evaluation of the national HIV/AIDS control programmes in the region in order to identify best practices with a view to influencing policy makers. The council will also administer research grants for HIV/AIDS research in the region.

UNESCO: The main objective of the United Nations Educational, Social and Cultural Organisation (UNESCO) is to contribute to peace and security in the world by promoting collaboration among nations through education, science, culture and communication in order to further universal respect for justice, for the rule of law and for human rights and fundamental freedoms, which are affirmed for the peoples of the world, without distinction of race, sex, language or religion, by the Charter of the UN. In the Caribbean, UNESCO has recently organised, in collaboration with CAREC, a young people HIV/AIDS and media forum, the recommendations of which are expected to lay the groundwork for major involvement of the agency in this area. In addition UNESCO is interested in studying the implications of culture for HIV/AIDS and on the other hand in exploring initiatives to use cultures as a vehicle for attitudes and behaviour change.

UNFPA: The UN Fund for Population Activities (UNFPA) is involved in eight main areas, which in order of priority are: family planning, communication and education, basic data collection, population dynamics, formulation and evaluation of population policies and programmes, special programmes and multi-sector activities. UNFPA is embarking on the development of a regional strategic plan for HIV/AIDS.

ILO: "The International Labour Organization is unique in the UN system with its tripartite structure where employers' and workers' organizations have an equal voice with governments in shaping its policies and programmes. Its ultimate objective is social justice. It promotes decent work for all men and women. As a co-sponsor of UNAIDS, its mandate is prevention and mitigation of the impact of HIV/AIDS in the world of work. The ILO Programme on HIV/AIDS responds to the effects of HIV/AIDS in the world of work and supports the efforts of its tripartite constituents through: research and policy analysis on HIV/AIDS issues in the world of work; fact-finding and programme development; advisory services for governments, employers' and workers' organizations on integrating workplace issues in national AIDS plans, revising labour laws to address HIV/AIDS, development of workplace policies and programmes on HIV/AIDS; technical meetings at global, regional and national levels; development of education and training programmes; and awareness raising and advocacy. The ILO Code of Practice on HIV/AIDS and the World of Work is a major tool for policy and programme development at all levels. Caribbean Governments, employers' and workers' organizations endorsed the effective implementation of the Code in the Caribbean and adopted the Platform for Action on HIV/AIDS and the World of Work in the Caribbean sub-region in May 2002, at a major ILO regional Meeting of its constituents on HIV/AIDS and the world of work. The Platform contains specific commitments to action, which form the basis for the Caribbean strategy in the world of work at the regional, national, community and workplace levels."

ECLAC: The Economic Commission for Latin America and the Caribbean (ECLAC) serves many functions, which include initiating and participating in measures to facilitate concerted action for dealing with urgent economic problems, for raising the level of economic activity and for maintaining and strengthening the economic relations of the Latin American and Caribbean countries both among themselves and with other countries of the world.

IPPF: The objective of the International Planned Parenthood Federation (IPPF) is to promote the concept of the planned family and provide family planning services on the widest possible scale. It also respects the rights of the individual and couple in their free choice of family planning; appreciates the diversity of cultures in which it operates and ensures that its messages and services are socially and culturally acceptable, especially involving indigenous 'grass roots' volunteers in its national associations. IPPF also recognises the independence and sovereignty of nations and seeks to expand government family planning practices and help to improve their quality. The Caribbean Family Planning Association is affiliated to the IPPF and has the potential to play a key role in the region's response to HIV/AIDS e.g. in the area of MTCT.

CARIMAC: CARIMAC is a teaching department of the University of the West Indies, Mona Campus, Jamaica. CARIMAC's overall programme is designed to upgrade academic standards and skills in the field of communication, with the focus on media professionals in the region.

CATIN: CATIN was established in 1996 with resources from the US Centres for Disease Control (CDC), CIDA, and DFID. CATIN's role is to provide critical health information on HIV/AIDS/STIs to member countries and to co-ordinate and promote prevention and control programmes in conjunction with regional National AIDS Programmes (NAPs) within each participating country.

C-FLAG: The general objectives of the C-FLAG network are to formulate human rights advocacy to end all forms of oppression and marginalisation of sexual minorities in the Caribbean; to educate and inform the GAL Caribbean community, in particular, and the Caribbean public, in general, regarding relevant issues; and to promote general health within the GAL community. In this respect one of its principal focus is activities addressing ongoing concerns for HIV/AIDS as a problem among the community.

CBU: The CBU was inaugurated in 1970 to stimulate the flow of broadcast material between radio and television systems in the Caribbean. CBU's mission statement is to provide excellent broadcast services, representation and training in support of the regional integration of a unified Caribbean. CBU has been involved in regional HIV/AIDS initiatives in collaboration with CAREC/PAHO/WHO and UNESCO.

UNICEF: UNICEF is a semi-autonomous agency of the UN that works for sustainable human development the lives of children. A major focus for UNICEF in the Caribbean is the regional health and family life initiative (see HFLE). The project re-orientates and re-designs HFLE programmes at primary and secondary schools (KAP values, skills for healthy life style choices), develops resource materials, advocacy programmes. The latter has for objective to utilise all available fora to bring attention to the situation of HIV/AIDS and its impact on children, with the aim of achieving appropriate

programmatic and legislative reform. Another important focus is MTCT in collaboration with WHO/PAHO/CAREC.

UNDCP: The United Nations Drug Control Programme (UNDCP) is entrusted with the exclusive responsibility for co-ordinating and providing effective leadership for all UN drug control activities. The UNDCP addresses all aspects of the drug problem, including such wide-ranging activities as demand reduction, comprising prevention, treatment and rehabilitation; supply reduction, including alternative development and law enforcement; legislative and institutional advisory services to enhance governments' capacity to implement the international drug control conventions. UNDCP funds a regional drug advocacy programme for the Caribbean (8 territories), the main objective of which is the development of a mass media campaign to target youth and policy makers to raise awareness on drug control programmes in general, and drug abuse in particular. The programme is also funding the establishment of a regional epidemiological surveillance system in six territories. This programme aims at strengthening governments and community groups to respond better to changing drug abuse patterns and trends and the establishment of effective, reliable epidemiological surveillance systems to improve prevention and treatment programmes.

WTO: The World Tourism Organisation (WTO) has put in place an Internet service called "Child Prostitution And Tourism Watch," as an information base for use by organisations or destinations affected by child abuse tourism.

World Bank: The World Bank is active in Latin American and the Caribbean in areas of support to diagnostic, treatment, and prevention programmes. MORE HERE

National Institutions

National AIDS Programmes: National AIDS Programmes (NAPs) have been established in all territories in the region. They are responsible for policy, guidance and execution of government HIV/AIDS efforts, including management, planning, co-ordination of an expanded national response to HIV/AIDS.

RAP PORT: RAP PORT is a division of the National AIDS Programme Unit in the Ministry of Health, Trinidad and Tobago. The centre targets young people from the ages 13 - 25 (as well as assistance to individuals below and above these ages) and provides HIV/AIDS/STI education to young people. The main strategy is to empower young people in order to help them make informed decisions regarding their sexual activities. RAP PORT uses a culturally appropriate medium such as drama and role-plays that would enable young people to change behaviour. RAP PORT attempts to focus on the gap that exists between what young people are taught by parents, church, teachers, about abstinence/delayed sex, and actual practices.

JAS: Jamaica AIDS Support an NGO works to ensure that men who have sex with men are aware of AIDS and safer sexual practices, and are practicing safer sex consistently. The project combines the use of educational out reach activities, informal presentations, and in depth long-term sessions for support groups of MSM. JAS also targets the general public with activities that include education workshops for police, church members and young people. JAS also targets PLWHA facilitating home and hospice care.

Regional Initiatives

HFLE: The Health and Family Life Education (HFLE) initiative brings together CARICOM Ministers of Education and Health, PAHO/WHO, UNFPA, UNICEF, UNDCP, UNDP, UNIFEM, FMU, UWI, and ECLAC. HFLE is implemented through a partnership arrangement, and the programme provides the basis for a proactive rather than crisis approach to reach young people with information in areas such as HIV/AIDS, sexual health, substance abuse, environmental health, safety and nutrition. Students will be empowered with skills, values, attitudes and knowledge and will have the opportunity to enact “real life” situations in the classroom; this approach will promote behaviour change. A single plan of action, entitled “A Strategy For Strengthening HFLE In CARICOM States”, will be implemented by the partner agencies. The new project has 4 major changes: to improve teacher training; to develop comprehensive life skills based teaching materials for HFLE; to strengthen co-ordination among institutions engaged in HFLE in regional and national levels; to raise the status of HFLE at all levels of education.

CCH-II: Caribbean Cooperation in Health Phase II (CCH II), a “new vision for Caribbean health”, is a mechanism through which member states of CARICOM collectively focus action and resources towards the achievements of agreed objectives in priority areas of common concern. It also seeks to identify approaches and activities for joint action and/or Technical Co-operation among Countries (TCC) in support of capacity building. The goal of CCH is to improve and sustain the health of the people of the Caribbean, this goal will result in the following; adding years to life and life to years; increasing equity for health within and among countries; and maintaining universal access to quality care for priority problems.

Eight priority areas have been identified; environmental health; strengthening health systems, chronic non communicable diseases; mental health including substance abuse; family health; prevention and control of communicable diseases; food and nutrition; human resource development. The administrative activities of this new initiative will be managed by a secretariat comprising CARICOM secretariat and PAHO, to be known as the CCH Secretariat. Chief Medical Officers will be responsible for co-ordinating national activities.

The prevention and control of communicable disease component will focus, inter alia, on HIV/AIDS/STI and tuberculosis. The objectives comprise: (1) health information and surveillance systems strengthening; (2) policy, regulations and legislation for effective disease control enacted and enforced; (3) multisectoral collaboration between agencies enhanced in order to minimise risk and impact of communicable diseases; (4) availability and quality of diagnostic, clinical, preventive and support services for HIV/AIDS/STI/TB, and client accessibility to these improved; (5) committed decision makers and key influential persons at all levels actively engaged in support of the prevention and control of HIV/AIDS/STI/TB; (6) individual and communities through education and other strategies adopt preventive behaviour and be empowered as partners in care efforts for AIDS and TB patients; (7) the incidence of STI, TB and the vertical transmission of HIV and syphilis in the Caribbean reduced. Strategies will include review public health policy, reorientation of health services, empowerment of communities, creation of supportive environment, personal health skill development and the building of alliances.

HTCG: The Horizontal Technical Collaboration Group (HTCG), was established by NAP managers in Latin America and the Caribbean to facilitate national strategic planning epidemiological networks, evaluation of interventions, counselling and communications.