

National Strategic Prevention Plan

HIV/AIDS/STDs

2003 - 2008

**Island Territory of
Curaçao**

Netherlands Antilles

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1. Introduction

Purpose

Compared to Europe, Latin America and the USA, the Caribbean region, of which Curaçao is part, shows a disproportional high number of Human Immunodeficiency Virus (HIV) -infected persons. For this reason UNAIDS proposed to develop country-specific strategic plans to control the infection rate and to reduce the spread of Acquired Immunodeficiency Syndrome (AIDS),

This plan addresses the island of Curaçao, one of the five islands of the Netherlands Antilles. The number of HIV-infected people or people having a sexually transmitted disease (STD) is an increasing problem for the island. Since 1985, 1233 persons infected with HIV have been registered. Because of the strong relationship between STD and HIV infections in terms of sexual behavior, the present document addresses both.

This plan will cover the period 2003-2008. It is part of a joint plan for the entire Netherlands Antilles. Priority areas have been identified, which are the focus of attention of governmental agencies and non-governmental organizations (NGOs). The plan serves a framework on which individual projects can be based, and upon which technical and financial resources can be mobilized.

Input for the plan

The Temporary Committee 'National Strategic Plan HIV/AIDS/STD Prevention' for Curaçao was installed to give feedback on the draft during the formulation process. The committee is composed from experts from the field of health care on Curaçao. After this strategic plan is adopted by the Executive Council and the Government, the temporary committee will be transformed into a permanent advisory board. In keeping with the need for multi-sectoral response, the Committee must also be expanded to include persons from other key sectors and groups such as youth, faith-based organizations and ministries.

Furthermore, several meetings were organized with stakeholders, experts from the field of health care, prevention and social services. The involvement of these groups is a necessary condition for creating a basis on which the plans can be successfully implemented. The following groups were involved: religious groups, immigrants, youth groups, legal experts, prevention workers, health care workers, NGO's representing vulnerable groups, such as prostitutes, private and public insurance companies, and the educational system.

Representatives of prisons and homosexuals did not participate because of the sensitivity of their positions. Contact has been established with both groups, and discussions have already been held with the prison representatives.

Apart from the expert consultations, this strategic plan is based on previously conducted research and documents by experts from national and international organizations such as UNDP, UNAIDS, WHO, from medical specialists and representatives of interest groups.

Notably, the plan was also developed closely following outcomes of a wider sub-regional initiative between Aruba and the Netherlands Antilles, with technical and financial support from UNDP. This sub-regional planning initiative resulted in the preparation of a Sub-regional Framework for HIV/AIDS in Aruba and the Netherlands Antilles and a corresponding funding proposal to the submitted to the EU.

General administrative characteristics of Curaçao

The Netherlands Antilles consists of five islands: Curaçao, Bonaire, Saba, Sint Eustatius, and Sint Maarten. Curaçao is the largest one. While the official language is Dutch, most inhabitants use Papiamentu.

Within the Kingdom of the Netherlands, the Netherlands Antilles is an autonomous territory. The islands are responsible for their own political affairs and administration, with the exception of a few areas. The Netherlands Antilles has a parliamentary democracy and there are two levels of government: the central government, with a parliament on Curaçao composed of representatives of all the islands, and the local government of each island, consisting of a legislative island council and an executive council.

Since the beginning of the 1990s, the economic situation has deteriorated. According to the Department of Economic Affairs, the unemployment rate for Curaçao for 1999 and 2000 was about 14%. In 2001, it was 16.4%. The main economic sectors are trade and business and financial services.

Population

The 2001 census has estimated the population on Curaçao to be 130,627. Most people living on Curaçao are of Dutch nationality (93.3%). About 1,6% are of Dominican nationality and 1,1% has the Colombian nationality.

Because of the economic situation, net migration has shown a growth since 1994. In 1999 the population growth rate for Curaçao amounted to -3.1%. In the year 2000, almost 13,900 people emigrated. In that same period, about 3,908 persons immigrated to Curaçao. However, a considerable number of people are illegal and therefore not registered at the time of the census. The situation since then has somewhat changed as a general amnesty has been issued for illegal immigrants.

2. HIV-infection and STDs on Curaçao: a situation analysis

Over two decades of the HIV/AIDS epidemic have pointed to a strong relationship between STDs and HIV-infection. Individuals who have one or more STDs are vulnerable for HIV infection as they often show the same high-risk sexual behavior. In addition, some STDs increase the risk of HIV-infection.

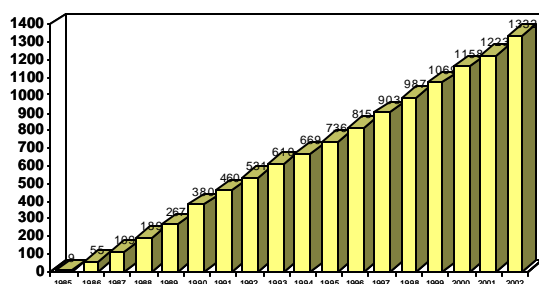
The following data on AIDS, HIV and STDs on Curaçao, provided by the GGD Curaçao, Department of Epidemically & Research, is available.

AIDS: The current number of AIDS cases on Curaçao (and in the Netherlands Antilles) is unknown. Attempts have been made by the Department of Public Health and Environmental Hygiene to register the cases, but so far this has been unsuccessful. On Curaçao, AIDS was the principal cause of death in the age group 25–44 years in the period 1991–1993. At that time, it accounted for 14% of deaths in that age group.

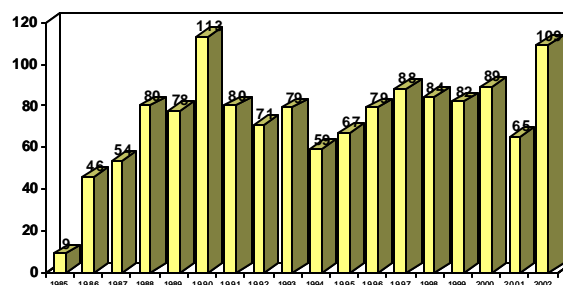
HIV: For the period 1985–2002, the cumulative total of cases of individuals infected with HIV in the Netherlands Antilles is 1.332, and for Curaçao 866. On Curaçao, 57% of the HIV-infected population is male and 43% is female. The majority of individuals infected with HIV in the Netherlands Antilles is between 25 and 44 years of age (874 persons).

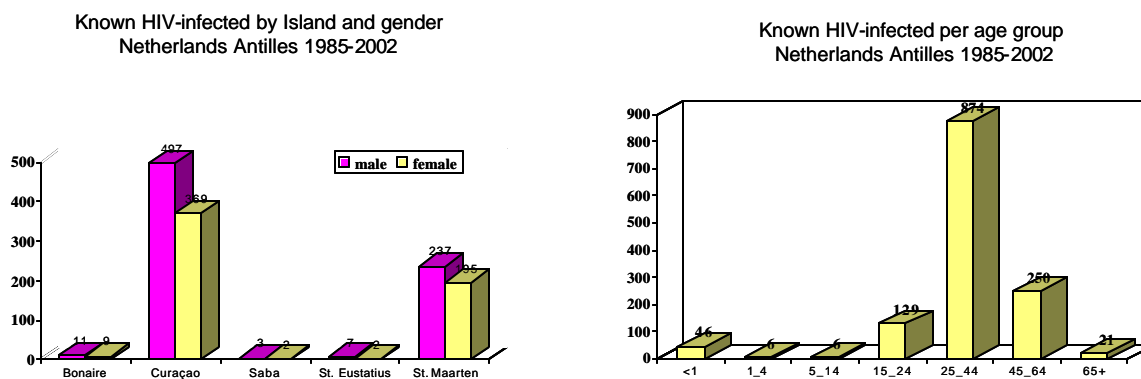
The following figures, provided by the GGD Curacao, illustrate the known.

**Cumulative known HIV-infections
Netherlands Antilles 1985-2002**



**Registered new HIV-infections per year
Netherlands Antilles 1985-2002**





STDs: Data provided by the GGD Rotterdam (The Netherlands) showed that in 1992 on the Netherlands Antilles 34% of the respondents report having experienced STDs, compared to 9% of the Dutch population living in the Netherlands. This was confirmed by a Dutch study of 2001, which reported that women from the Antilles have a disproportional high risk of being infected with chlamydia.¹

Data collection and its limitations

As the above shows, data on AIDS, HIV and STD-infected persons is very limited as information systems are not reliable and are further challenged by migration.

The main registration system for *HIV infection* uses two sources. Since 1985, HIV-1 and HIV-2 infections are registered at the department of immunology of the recently privatized Analytic Diagnostic Centre (ADC, the former state laboratory). However, only those people are registered that are tested positive at one of ADC's laboratories. The second source is the registration at the Sint Elisabeth Hospital (SEHOS). Since 1995, SEHOS has registered HIV-1 and HIV-2 infections when people are tested at the Red Cross Blood Bank Curaçao laboratory facilities. With the introduction of HAART a new registration method of HIV can be developed, as HIV-infected persons have to go to the SEHOS to receive their triple therapy.

In the past, the main method of registration of AIDS cases was conducted by the AZT-register of the pharmacy of the SEHOS. This was unreliable as also HIV-infected – but without having developed AIDS - people received AZT, some people imported AZT themselves and some people having AIDS did not use AZT. Since 1996, the reliability of this source has been further compromised as other pharmacies also started distributing AZT.

Another way to register AIDS cases is looking at the number of people who have died from AIDS. Those known have died from AIDS are registered at the VOMIL, using the I.C.D.-9 code. This method is not very reliable because AIDS being the underlying cause of death is not always recorded.

¹ Women's Network Phase (2001).

A medical specialist treating most of the AIDS patients on the island has conducted another counting effort. However, as other doctors also treat patients this method is unreliable.

For STD, no registration method has been developed, other than those resulting in the data mentioned above.

In sum, the registration and analysis of the data on HIV-infection and AIDS has several limitations:

- Only the number of people having positive HIV-test outcomes is registered. However, no information is collected about the number of people requesting a test;
- Because the registration of HIV-infected persons takes place at two locations, double counting cannot be excluded. While this could be prevented by using the regular system of identification numbers, this in turn would compromise privacy;
- The registration of those who have died is not linked to the registration of those who are infected. Again, this is because no identification numbers are used. In addition, the death certificates do not always make the exact cause of death explicit.
- The registration of the number of people having AIDS suffers from differences in definition (when does a person become an AIDS patient?). In addition, using those who receive treatment as the basis to count AIDS patients is flawed as also HIV-infected persons not having AIDS receive treatment;
- Some people are tested on HIV outside the Antilles, and hence, are not registered.²

Current test methods and modern treatment

The methods used for general testing for HIV-1 and HIV-2 consist of a serological screening (ELISA by Biomerieux or AXSYM by Abbot). When people are tested positive this serological screening result needs to be confirmed by a Western Blot Analysis (Liatek, Biomerieux). For blood donations the Red Cross Blood Bank Curaçao performs next to serological testing also nucleic acid testing on each individual donation (NASBA, Biomerieux).

In terms of therapy, Highly Active Antiretroviral Therapy (HAART), also called triple therapy, is available for HIV patients since 1996. This therapy is based on a combination of three anti-viral medications, which cut back the HIV-virus concentration to non-measurable levels. This does not

² Lourents, N. et al. (1998).

mean that the virus has been eradicated; it remains present in the secluded areas like lymph nodes. However, long-term survival can be ensured. If patients are compliant in using their medicines, it will reduce the risk of dying of AIDS significantly. However, if a patient fails to take 5% or more of his/her medication, there is a serious danger for the virus becoming resistant and leading to full-blown AIDS.³

Modes of transmission

The modes of transmission are sexual transmission, transmission from mothers to children (vertical transmission), blood transfusion, and transmission through drug use.⁴

Research suggested that on Curaçao the main mode of transmission is *sexual*. For every four man, there are three women infected. This is consistent with the pattern in the whole Caribbean region. However, there are (yet unpublished) indications for skewed men to women infection rate, which could indicate a rise of the use of prostitution, homo- and/or bi-sexual transmission.

Vertical transmission is now rare because of intensive treatment before, during and after delivery. According to the GGD Curacao, over the last few years, not more than five new-borns were infected. The infection was the result of the fact that the HIV-positive mothers were not attending antenatal care.

The risk of acquiring the infection from a *blood transfusion* is minimal as the Red Cross Blood Bank screens all donated blood for HIV. Since the beginning of the epidemic HIV-contamination through blood transfusion has been reduced considerably. A strict voluntary donor policy is in place and with the newest testing techniques (e.g. NAT testing) the window period has been brought back to 10 days. This means a reduction of the chance of contamination with 50%.⁵

The most frequently used *drugs* are marijuana and cocaine. Intra-venous drug use is rare, and therefore illegal drug use does not pose a similar HIV/AIDS problem on Curaçao as it does elsewhere. However, increasingly the indirect relationship between drugs-use and HIV-infection poses a problem as more and more commercial sex work occurs as a way to earn money to buy drugs.

³ Winkel, C. (2000).

⁴ Lourents, N. et. al. (1998).

⁵ Duits, A. (2000)

3. Underlying factors

There are a number of factors that directly and indirectly contribute to the occurrence of STDs, HIV and AIDS on Curacao. Discussed will be the economic factors, social and cultural factors, political factors and legal factors.

Economic factors

Migration

A large number of immigrants enter Curacao because of the relatively favorable economic situation compared to neighboring countries. These immigrants may work as artisans, but may also work as commercial sex workers.

Many of the immigrants that enter Curaçao originate from countries where a relatively high number of the population is HIV positive. According to the Census 2001, the second largest group of immigrants comes from the Dominican Republic and Colombia.⁶ It is unlikely that illegal immigrants will be reached by the medical services of the island. Unfortunately, no data is available on the occurrence of STD and HIV among the populations migrating to Curaçao.

Prostitution

Incitation to prostitution is illegal, but those who are prosecuted are more often the prostitutes themselves than the owners of the establishments where the prostitution takes place. However, in order to avoid any risks many establishment-owners will not acknowledge that prostitution actually takes place. This makes AIDS prevention at the locations themselves extremely difficult. The only 'tolerated' brothel is Campo Allegre. It has been appointed as the official place where prostitution is tolerated, although by law the owners of this brothel are liable to prosecution.

It is thought that this policy of toleration concerning Campo Allegre is outdated, as the largest group of prostitutes works outside the regulated area. The current unclear status of most prostitutes is likely to propagate the transmission of STDs and HIV and leads to a criminalization of the sector. The increased propagation is the result of the fact that the prostitutes are less reached by prevention and promotional activities, and will have less access to treatment. Legal experts have advised to legalize prostitution, or at least tolerate it on a larger scale, to enable a better control of the situation. This control could address all kinds of issues, such as health and criminal activities.

To facilitate the formulation of a strategy on the prevention of HIV/AIDS for illegal commercial sex workers (CSW) Contrasida conducted a research in 1999.⁷ This research showed that women

⁶ The largest group originates from the Netherlands.

⁷ Faas, L. (2000).

working in this sector were mainly originating from countries such as the Dominican Republic, Colombia, Venezuela and a few from Brazil. The CSW meet their clients in all kinds of establishments, such as bars and fast-food joints. Contrasida calculated that in general 1500 women are working in the trade. These women are replaced every few months, which makes the total number of girls working on the island 6000 annually. Half of this 6000 is entering the country as a result of trade in women.

The profile of the clandestine sex-worker on Curaçao is as follows: between 17- 28 years old, originating from a country that is characterized by economic and/or political unrest, has a low level of education and is not knowledgeable about HIV and STD's, pregnancy and adequate use of preventive methods. She typically gave birth to her first child at a very young age and she usually comes from a country with a high level of HIV-infections. 30% of the CSW say they always use a condom in their sexual contacts. 15% said that they have safe sex about half of the time and 10% say they never to use a condom. The main reasons provided for not using a condom is because clients refuse to use a condom.

That the use of the protective measures is low is illustrated by the fact that there is a high incidence of STDs among CSW. A sample among 150 women showed that 18% carried one or more STD's. The low use is also confirmed by the fact that 30% become pregnant within first months of arrival.

Commercial sex workers have very little to negotiate safe sex depends, as this ability is influenced by a number of factors, such as nationality and background, the age, location of the prostitution site, the conditions under which she arrived on Curaçao and the type of prostitution setting at which she is employed.

Insurance

HIV-infected people will not be accepted as new clients of private insurance companies. The situation where people are excluded does not stimulate people to have them selves tested for HIV. If legally staying on the island, those people who are refused by private insurance companies will be insured through public insurance (SVB/BZV). In case someone is already insured, the private insurance companies have a provision to take care of the costs. The SVB/BZV has not build up such a provision.

Social and cultural factors

Knowledge and sexual behavior

Knowledge about STD, HIV and AIDS and the use of condoms among the general public is at a low level. In the past, teachers, health professionals or parents rarely distributed information on sexuality, conception, pregnancy, contraception, and disease. The main sources of information are friends and the media. While with the introduction of a new school system sexual education is increasingly discussed, it may take a while to close the knowledge gap. Low levels of knowledge combined with a low availability of condoms contribute to low use and inhibit prevention of disease and pregnancy.

A central characteristic of sexual behavior on Curacao is the macho mentality. This results in promiscuous behavior of men. However, exact figures are unknown but it is generally accepted both men and women are leading a sexually active life, often involving more than one partner. This promiscuity, accompanied with machismo, is a serious obstacle for STD, HIV and AIDS prevention. The present sexual norms are such an explicit part of the Curaçao culture that behavioral change will be hard to bring about.

When young women are asked why they not use contraceptive protection, they give the following answers: the sexual interaction was unplanned and spontaneous; they have a desire to please their partners who do not want to use anything; they fear that contraception discloses sexual activity; and they fear that using contraceptives gives a man the impression that a girl is “easy to get”. Even when condoms are available everywhere, using condoms is inhibited by culture. However, research has shown that once people have multiple sexual contacts they tend to use condoms more often.⁸

Knowledge and sexual behavior among the youth

The most comprehensive recent source for information about sexual behavior of youth is the 1992 research by Tineke Alberts, “Je lust en je leven”.

Although sex is discussed extensively among young people, these discussion take mainly place in a jokingly atmosphere. Within a relationship, meaningful conversations about sex are rare. The sexual education programs at schools often focus on knowledge and do not discuss the emotional and attitude sides. Also, the age at which children receive sexual education is 12 years of age, which is too high. Negotiating safe sex is one of the issues that escapes the knowledge domain and is part of the emotional and attitude domain. In addition, there is much focused on girls, while boys should also take the responsibility to have a healthy lifestyle. Within the dominant culture on Curacao it is not common for man and women, or parents and children, to discuss the emotions, norms and values connected to sex. Some of the reasons why this is the case is

⁸ Alberts, T. (1992).

because parents have not acquired the tools to start such a discussion, and because religious believes hamper such a discussion.

The importance of all the above increases if one considers that the first sexual experiences take place at a younger age than before.⁹ Sexual experiences often start with multiple partners and much of the activity is risky – contraceptive use is often erratic and unwanted pregnancies are frequent. Abortion is formally illegal on Curaçao but is offered at a large scale; it is assumed that about 1/3 of all the pregnancies are terminated. Abortion often functions as a 'contraceptive'. In spite of these abortions, teenage motherhood remains quite high; 7% of all the girls between 15-19 years have children and often this situation is passed on to the next generation.¹⁰

That in 10 years time no major changes have taken place concerning the above has been confirmed by a recent research of the Task Force for the Antillean Youth.¹¹ This study amongst youngsters, which also briefly addresses sexuality, has shown that that in the age group 12-15 years 12% has had sexual intercourse. In the age category 16-18 years old this is 63%, and between 19-24 years old this is 87%. Males are sexually active at a younger age than females. According to about 27% of the students, being sexually active means being socially accepted.

The majority of the group studies say that they use a condom on the first times they go to bed with someone. 66 of the 650 youngsters questioned answered that do not use condom the first times. Together these 66 youngsters form a 10% risk-group in comparison to the total population. As contraceptive devices is being used beside the condoms for men and women: the pill, injected pill (30% together) and also spiral, periodical abstention and interrupted coitus.

When they have a relatively serious partner about 33% of the respondents do not use any contraceptive devices. Half of the respondents have a serious relationship. 60% of respondents who have a sexual relationship have check-ups for venereal diseases. However, 14% say they do not warn the partner(s) that they are found infected.

The current sexual behavior, including the use of contraceptives, of a large part of the population is a serious obstacle for the prevention of AIDS. Nevertheless, if a serious attempt is made future generations may become more aware of the risks they are taking. Special attention should be paid to the youth. This includes the need for more recent data about the sexual behavior of youth and adults.

⁹ Alberts, T. (1992).

¹⁰ Taskforce Antilliaanse Jongeren (1997).

¹¹ Taskforce Antilliaanse Jongeren (2000).

Single headed households

Although the GDP of the Netherlands Antilles (and Curaçao) ranks amongst the highest in the Caribbean basin, there is sizeable poverty. In addition, the phenomena of 'shifting' or 'visiting' father occurs frequently. Keeping a man in a long-term relationship may require a strategy. Such strategy may include getting a child from a man as this more or less forces the father to contribute to the household. In this context of economic dependency, women have limited power to negotiate the use of condoms. In addition, the instability of the relationship increases the chances to become infected.¹²

HIV in the prison

Those detained in prison have no right to sustain sexual relations with their partner, as in some countries prisons provide during visiting hours. Until now, this has also resulted in disregarding the existence of sexual relations in prison. However, the prison is currently developing a policy to deal with this issue. While there will be no attempts to change the policy on visiting partners, policy is being developed in prisons to deal with these issues and to make condoms available.

All new inmates are tested on HIV and Hepatitis B. They are provided with information material in several languages. However, this material is still incomprehensible by most of the inmates. HIV-positive inmates are preferably placed in a single cell, but in case this is not possible, they will share their cell with others. Currently, the prison has no infection disease policy or condom policy, but as mentioned, it is being developed.

Religion

80% of the population of Curaçao is catholic. To the disappointment of many, the Catholic Church lacks an active approach towards discussing sexuality and the prevention of STDs.

Sexual Diversity

On Curaçao, as all over the Caribbean, sexual diversity (homo-, bi- and transsexuality) is still considered a taboo. Although Curaçao has no anti-sodomy laws, a non-heterosexual sexual preference or identity is at best considered a weakness, and in the worst case an abomination and a shame. Still, local psychologists and Indise/Orguyo, the local organisation for acceptance of sexual diversity and gay and lesbian emancipation, estimate that more than 50% of the male population engages more than once in male to male sexual contact. Among youngsters about 11% males and 8% females question their sexuality.¹³ This attitude is not related to the general western definitions of homo- and bisexuality, as most men who engage in this behavior have more frequent heterosexual relationships and will generally not define themselves as bi-sexual.

¹² Alberts, T. (1992).

¹³ Taskforce Antilliaanse Jongeren (2000).

Because the general atmosphere of denial and secrecy around these relationships, they have a tendency to be characterized by unprotected promiscuous sex.¹⁴

The same atmosphere of denial, secrecy and shame makes it very difficult for prevention campaigns geared towards the general population and socially accepted sexual behavior, to have an effect on these men. Because of the scope of this behavioral pattern, it cannot be disregarded, and alternative campaigns should be designed and executed to promote AIDS/HIV consciousness and safer sex practices among these groups. Also emancipation-oriented campaigns on sexual diversity should be actively supported to create more tolerance, openness and acceptance as preconditions for more successful prevention campaigns.

Political factors

The prevention of STDs, HIV and AIDS has currently no political priority. However, political commitment and prioritization is not only important for the allocation of funding, it is equally important to convince the population of Curaçao of the threat of the HIV/AIDS epidemic.

Legal factors

Prostitution

Section 259 of the criminal codes reads that he who deliberately brings about or encourages vice of others with a third party as a profession or as a custom, will be punished with imprisonment of at the most 15 years or a fine of at the most a thousand guilders. As mentioned before, this section leads to a situation in which illegal brothels are operative but are outside the control of the authorities. Therefore, it would be advisable to eliminate the brothel ban, or at least eliminate prosecution. In addition, a system of working permits should be developed for prostitutes and the Department of Health Care.

Trade in women

Trade in women is illegal under Antillean law. However, it seldom comes to prosecution. As a result, illegal prostitution is widespread. Women that enter the country illegally often have gone into debt to pay for their passport and tickets. This debt makes them vulnerable to agree to unsafe sex as this is better paid. Therefore, they have a higher chance of becoming infected by a STD or HIV.¹⁵ Experts, however, see no option to deal with phenomenon because of the lack of legal means and because of the high interests involved.

¹⁴ Alberts, T. (1992).

¹⁵ Report of the Symposium "AIDS Policy: Take your Responsibility (2000)".

Testing

Women who come to work in the brothel Campo Alegre are tested for HIV, against all international rules. When positive they are sent to their home country. This gives a false sense of security as being in the serological window phase could imply infection potential for those remaining on the island.

4. Additional focusing points on dealing with AIDS

The above section suggests many points that should be the focus of this plan. However, there are more points that need attention, even though they are not directly related to the spread of the disease. These are the following.

Publicity and educational material

While studies on the subject are not available, experts indicate that both quality and quantity of current educational material is insufficient. The distribution of the currently available information too scattered and conducted without co-ordination. The political interest is very limited, and therefore the government is currently not performing a co-ordinating role. Besides that, the information that is around is not target-specific. Related to this is the lack of educational material at schools, and material to reach dropouts.

Central registration

Central registration is needed to improve understanding of the modes of transmission amongst the different risks groups. This can also be used for evaluation of the current and future educational and publicity campaigns.

Research

The economic and demographic aspects of HIV and AIDS need to be studied to understand the effects.

Discontinuity of care

Groups such as the homeless, drug addicts, the socially excluded and prostitutes are affected by a discontinuity of care. After a patient is discharged from the hospital they have no place to go until they have to be hospitalized again. The only form of care comes from family, and this is not available in all cases. It has been suggested to establish new organizations for this purpose, and to provide necessary information to those who are working at already operating organizations about how to offer aid to these groups.

Lack of compliance to treatment

A serious problem is the lack of compliance to treatment. As mentioned above, a 5% non-compliance already gives rise to a significant resistance of the virus to drugs. This non-compliance not only means that patients may die, but it also may result in the development of resistance of the virus against the treatment. It is necessary to stimulate a maximum of compliance.

Lack of informed consent and violation of privacy

Many who are tested on HIV-antibodies have not been asked to give their permission, neither have they been informed about the possible negative consequences of receiving a positive test

result. In addition, in the past it has occurred that the test results of people have been published in the newspaper. This has created a situation in which people are will not volunteer to be tested. Both practices, however, will belong to the past with the introduction of the new civil code in 2001, gives clear directions on these matters.

On the other hand, medical professionals often believe that under all circumstances they are bound to secrecy. However, the law has formulated the possibility to repeal the protection of privacy of a patient when there is no other way to protect the well being of another person. Those working in the medical profession need to be aware of this possibility.

Intentional infection

Experts have suggested adding an additional text to the civil codes that deals with the punishment of intentional infection of one person to another. Currently, no specific text has been incorporated.

Reporting

The law should adjusted to ensure the obligation to report cases of infectious diseases by doctors ('meldingsplicht').

Illegal immigrants and the right to care

It is considered to be unrealistic to assume that the government can take care of the medical costs of sero-positive illegal immigrants. However, legal experts believe that with the ratification the Convention of the Rights of Children, the government is obliged to provide treatment to protect the unborn child and thus provide treatment to pregnant illegal immigrants.

Legal framework for health care

There is currently no legal framework to regulate the preventive tasks, the registration of data and to ensure quality of the health care sector on the Antilles. Therefore, no control and be exercised and in case of misconduct no disciplinary measures can be taken. This omission needs the attention of a legal expert.

Tourism and other people traveling

The role of tourism in the incidence of HIV infection has not yet been studied. However, as it may be impacting the spread of the disease it is necessary to conduct research in this field, and to expand in the information campaigns to those working in the industries involving tourists and business travelers.

5 Social and Economic costs

Medical care and its costs

Medical care for AIDS patients is for the greater part done by two internists. The number of patients currently on HAART treatment is probably around 150. The monthly costs of treatment per patient are about Nafl. 3000 with approximately Nafl. 2000 additional for care. The total costs of treatment of AIDS patients on the island of Curaçao amounts currently to Nafl. 9,000,000 per year.¹⁶

Besides the above data, there has been no research conducted on the costs of medical care. Therefore, we can only identify the other sources of the costs.

The number of HIV infected persons covered by private insurance schemes is a minority. This implies that most of the costs will be taken by the – financially already ‘overstretched’ - social insurances. Social insurances do have an obligation to accept everybody including HIV infected individuals. During consultations, private insurances have pointed out that it is difficult to make projection for future costs of the AIDS epidemic. Currently they are not formally involved in prevention campaigns, but internally there is willingness to participate in preventive actions.¹⁷

Moreover, doctors spend much time on making sure that people comply with their therapy. Therapy compliance is a general problem, not only for people living in the margins of society but also for educated patients. A 5% non-compliance already gives rise to a significant resistance of the virus to drugs.¹⁸

In case ambulant care is not possible anymore, the patient is admitted in one of the hospitals, usually the main public hospital. In some cases, when long-term medical care is required, the patient is referred to the nursing home Bethesda. However, Bethesda only admits the terminally ill.

The care for marginalized people like illegal immigrants, drug-addicts, homeless people and prostitutes is a major problem. They often do not have access to health insurance schemes and offering a complete and continuous HAART is currently not possible for uninsured people. Follow-up is cumbersome and often these people only return to the care institution to die. Many of the

¹⁶ Lourents, N. et al. (1998), HIV en AIDS op de Nederlandse Antillen.

¹⁷ Symposium AIDS Beleid (2000).

¹⁸ Winkel, C. (2000).

migrants return home. However, if a patient is admitted to the hospital the state has to carry the costs.

Non-medical costs

In spite of the effective treatment, working days will be lost. People always have relapses and days of illness, but also the care is very intensive and many hours are spent in the hospitals and "officina's". As this concerns usually the younger segment of the population the loss of working days and general income can be considerable.

Not only the individual infected with HIV is losing productivity. For households the burden can be considerable, when sick family members have to be attended to or have to be accompanied to the hospital for care or for diagnostically reasons. When a patient dies some family members receive a form of social security. In addition, there are also considerable costs related to psychosocial problems.¹⁹

Often when an employer discovers that one of his employees is infected, the latter faces discharge. This is because the employer does not want to be responsible for the costs associated with the loss of productivity. For the employee this of course means a loss of income, often without social security.

¹⁹ Lourents, N. et al (1998).

6. Response to the epidemic

Activities and organizations

Over the past years a number of activities have been undertaken, amongst which the establishment of new organizations. Although there are many organizations active in fields related to STD, HIV and AIDS, there are only a few focused solely on these diseases. Those still active, or the activities still executed, are the following.

- AIDS Stichting Nederlandse Antillen (ASNA): Its main goal is to provide information about to prevent the further spread of HIV infections.
- Fundashon Contrasida Caribbean: This Foundation is focusing on sex workers. Their main activities have been the establishment of a telephone help line for sex workers on Curaçao and offering a contraceptive package free of charge consisting of several different CC's including condoms and emergency contraception pills. Contrasida also offers diagnosis and treatment of the STDs and legal support in cases of abuses. Since 2002 it offers low-cost obstetric care for migrant women.
- Indise/Orguyo: a local organization for acceptance of sexual diversity and gay and lesbian emancipation.
- AIDS Telephone Line: This Island initiative enable people to request information about HIV and AIDS. Currently, the line operates on a low level.

The terminated activities or those organizations that have terminated their activities are the following.

- Halfway the 1980s the National AIDS Committee (NAC) was established. Its main purposes were to advise the minister of Public Health and Environmental Affairs, to analyze the epidemiological issues related to HIV, to research and study the development of HIV-infections, and to co-ordinate the joint activities of the islands.
- Island Working Group: The purpose of this Working Groups was to offer information to the public, and to organize activities to create awareness amongst the general public and specific risks groups. The Working Group has terminated its activities because of the lack of funds.

- Apoyo HIV/AIDS Antiyano (AHAN); Being part of the homosexual movement of Curaçao, this organization is concerned with providing information, especially directed towards youth. Apoyo has also stopped its activities.²⁰
- Stichting Le Beau: This Foundation is concerned with the establishment of a buddy project to guide HIV-infected and AIDS patients and to defend their interests.
- KURIAKE: A foundation for the care of children affected by HIV with the name KURIAKE has been established. Because of the lack of financial input, initial enthusiasm waned. Apart from that, with the changing dynamics of the epidemic because of the treatment, there were fewer children to care for.

Lessons learned

As the above list shows, many of the organizations' activities show overlap. This is still an area for concern. It means a lack of co-operation and co-ordination that tend to result in a duplication of activities. In addition, the voluntary nature of the work of some of the organizations makes it difficult to maintain continuity. This is closely related to the lack of funds. Finally, the government has not yet prioritized STDs, HIV and AIDS within the health care system. Moreover, the government should adjust the law that requires an obligation to report cases of infectious diseases by doctors (meldingsplicht), and enforce it.

²⁰ Regering van de Nederlandse Antillen (1992).

7. Priority areas and strategic objectives

In co-operation with the stakeholders, several priority areas with strategic objectives have been identified.

Priority area 1: Advocacy, research and policy development and legislation

1. Having legislation in place that supports effective STD/HIV/AIDS-policy on (1) STD/HIV/AIDS-prevention (2) STD/HIV/AIDS-care (3) human rights and non-discrimination practices;
2. Increase of the awareness of policymakers (government) of the need of a strong STD/HIV/AIDS-policy and having policymakers actively involved in policy development;
3. Having an effective STD/HIV/AIDS-policy and intervention strategies in place.

Priority area 2: Prevention of HIV/AIDS/STDs

1. Establishing a change in sexual behavior and lifestyle that reduces the risk for sexual diseases including STD/HIV/AIDS.

Priority area 3: Care and support of people infected with HIV/AIDS

1. Improving and sustaining adequate care through improvement of (1) counseling services (2) better access to and better control on medication (3) accessibility to basic facilities for HIV/AIDS patients;
2. Increasing the understanding and care of HIV/AIDS of family.

Priority area 4: Prevention of AIDS/STDs among high-risk groups; sex workers, homosexuals, prisoners and immigrants

1. Having effective 'high risk group' policies and intervention strategies in place targeting on (1) prevention of the transmission and (2) care campaign;
2. Improve consciousness and safer sex behavior among the sexually diverse population;
3. Ensure that HIV/AIDS prevention and care needs of prisoners are understood, recognized and addressed.

Priority area 5: Strengthening of response capabilities

1. Improving registration and surveillance.

Priority area 6: Institutional strengthening

1. Improving international collaboration to coordinate actions.

The table in Appendix 3 shows the priority areas, the objectives, activities, indicators and costs. The activities, indicators and costs are tentative. The table includes a financial provision for the employment of a project coordinator, who can conduct a part of the activities. Curacao could finance a part of the costs of the project coordinator, for another part financial support should be sought.

8. Implementation of the program

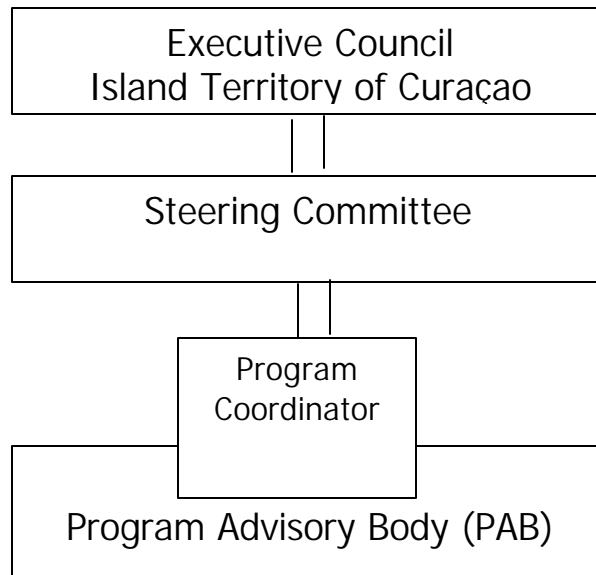
In this chapter the set up is described for the implementation of the program.

First a preliminary organizational structure is proposed, which can be used for further discussion. The main responsibilities and the accountability of the different bodies are also described in this chapter.

The chapter finishes with a description of the focus and main activities in the start up year 2003-2004.

Organizational structure

The organizational structure is comprised of three bodies: the steering committee, the program coordinator, and the program advisory body.



The responsibilities under the proposed framework can be described as follows:

Responsibilities under the proposed framework	
Structure	Responsibilities
Steering Committee HIV/AIDS (SC), headed by the Deputy of Health of the Executive Council of the Island Territory of Curaçao	<ul style="list-style-type: none"> • Approval of strategic plan adjustments • Monitoring the implementation of the strategic plan • Identifying potential funding organizations and promote the strategic plan for getting financing • Approval of annual programs • Earmarking of financial means for approved projects as mentioned in the yearly program • Reporting on the progress of the implementation of the strategic policy plan to the Executive Council • Financial reporting on the programs to the Executive Council
Program coordinator (PC)	<p>Supports the steering committee with the following tasks:</p> <ul style="list-style-type: none"> • Development and adjustment of strategic plan • Coordinating the implementation of the strategic plan • Formulation of yearly program including priority setting and budgeting • Advising the steering committee • Monitoring of the execution of approved projects • Defining standards and procedures for the formulation and approval of project proposals • Supporting the formulation of project proposals • Financial monitoring of the projects • Administration/reporting • Communicating the advise of PAB to the SC • Conducting certain project activities • Informing the PAB regarding decision-making of SC
Program Advisory Body (PAB)	<ul style="list-style-type: none"> • Advising the SC (through the PC) on priorities • Advising the PC on project proposals • Mobilize persons needed for the formulation and implementation of projects • Send in proposals in the PAB for approval (according to standards and procedures)

Accountability

The Steering Committee (SC) has the final responsibility concerning the execution of the strategic plan and is supported by the Program Coordinator (PC) and (Program Advisory Board) PAB.

Steering Committee

The SC is the paramount decision making body and is directly accountable to external finances concerning the allocation of funds in the light of the execution of the program. The SC consists of 6 representatives of governmental and nongovernmental organizations. The SC informs the Executive Council of the Island Territory of Curacao regarding the implementation of the strategic plan on a regular basis.

The executive council of the island territory of Curacao appoints the Deputy of Health as chairman of the SC and four highly qualified persons with substantial knowledge and managerial experience of either health policy or finance.

In addition the temporary committee will appoint two other persons working with NGOs covering the interests of the following groups²¹:

- Vulnerable groups (sex workers, homo- and bisexuals, persons addicted to drugs)
- Persons Living With HIV/Aids
- Youth

Program Coordinator

The PC is directly accountable to the SC and as such reports to the SC. He or she is responsible for the day-to-day management and implementation of the program.

An important task of the PC is to take an advisory seat in the PAB and to communicate the progress, obstacles, areas of support and future actions to the SC. He or she will not be part of the actual decision making process of the PAB, as this will act as an independent advisory body. The advice which is mutually agreed upon by the PAB, will be communicated by the PC to the SC.

Program Advisory Board

The PAB consists of representatives of the principal stakeholders of the strategic plan. It has an advisory position towards both the PC and the SC. Those included are representatives of youth, faith-based organizations, ministries, social services, immigrants, legal services, health care, commercial sex workers, private and public insurance companies, people living with HIV/AIDS and the educational system. Its members were also part of the temporary committee. The PC is the chairperson of the PAB.

²¹ The PAB will appoint any new future member representing the NGO's in the steering committee whenever relevant.

The members of the PAB have the following tasks:

- Mobilize persons needed for the formulation and implementation of projects
- Send in proposals in the PAB for approval (according to standards and procedures)
- Advising the SC.

Communication between SC, PC and PAB will be based as much as possible on the formal structure. Transparency of the decision making process and the development of trustful and effective systems of communication will be key elements of the communication policy.

Implementation program 2003 and further

The first year activities are focused on the setting up of the organization, starting up the most urgent research activities and further policy development:

- a. Setting up the organization;
- b. Funding;
- c. Starting up research;
- d. Updating the strategic plan;
- e. Formulation of Plan 2004 (including priority setting and financial programming);
- f. Preparing of implementation of first set of programs.

The programming is divided among the following areas:

1. Institutional strengthening
2. Policy development
 - Research
 - Legislation
 - Information and communication to stakeholders
3. Strengthening of response capabilities
4. Prevention
 - Information and communication programs to target groups
 - Training programs for target groups
 - Research

The second year of implementation of the strategic plan will focus on starting up the execution of the different programs and further policy development.

Appendix 1 Strategic objectives, indicators and costs

Appendix 2 Cumulative known HIV-infected Antilles 1985-2001

Cumulative known HIV-infected Netherlands Antilles 1985-2002 by agegroup per gender			
agegroup	Male	Female	total
<1	26	20	46
1-4	4	2	6
5-14	3	3	6
15-24	57	72	129
25-44	487	387	874
45-64	166	84	250
65+	12	9	21
Total	755	577	1332
Epidemiology & Research Unit Medical and Public Health Service of Curaçao, Neth Ant.			

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Appendix 4 Members of the Temporary Committee

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