

HIV/AIDS: HURDLES TO A SUSTAINABLE RESPONSE IN THE CARIBBEAN

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ABSTRACT

In this paper we present empirical evidence on the extent of the HIV/AIDS epidemic, and the danger it poses in terms of projected cost imposition on the countries of the region. We highlight the elements of a regional response approach that is both comprehensive and sustainable and discuss options for mobilizing the resources necessary for effecting such a response. We show that even though a robust regional response in mitigating the threat of HIV/AIDS may be feasible and even not very costly, there remain significant hurdles to its implementation. In this regard, the paper limits itself to a focus on implications of chronic fiscal deficits facing a number of countries in the region. We conclude that the fight against HIV/AIDS is not insurmountable, but it requires strong doses of will to see the big picture, and innovative thinking to rise to the challenge.

Keywords: sustainable development, Caribbean HIV/AIDS response, resource mobilization, fiscal constraints.

1.0 Introduction

The region continues to grapple with its development thrust. As a region, Caribbean countries have envisioned improvements in the quality of life for citizens via reductions in the levels of unemployment, poverty, and functional illiteracy, and via expansion of access to education and health care, and by commitments to increasing productivity and economic growth. They have generally experienced positive gains in health status as indicated by the key mortality and morbidity statistics and are poised to focus on higher-level human development issues such as the quality of the extended years of life. These gains have been recorded even as the region faced and survived a variety of adversities on the economic, social, political and environmental fronts.

This progress is, however, threatened by HIV/AIDS which may decrease the quality of life for all citizens, cause disruptions in economic development, productivity and growth, and affect the population's structure (CCHD, 2006). Prudent economic planning now requires that countries within the region should explicitly take HIV and AIDS into account. High prevalence rates and high levels of growth and development simply do not go together. It is also interesting to note that in the developed countries of Western Europe and in the USA, the adult prevalence rate of HIV/AIDS is just around **0.5%** in most cases - about one fifth of what it is in the Caribbean.

As the countries of the region merge through the processes of the CSME, they have recognized the wisdom of joint efforts to tackle some of the attendant socioeconomic opportunities and threats. A justifiable argument is that the nature of HIV/AIDS dictates that the threat it poses to the sustainable development of individual countries can only worsen within an environment of regionalization and thus should be at the top of the agenda of joint efforts on threats. If such efforts can be shown to be effective and sustainable then mobilizing the necessary resources would be the only remaining effort.

In this paper we present evidence on the extent of the disease and the danger it poses to the countries of the region. We highlight the elements of a regional response approach that is both comprehensive and sustainable and identify the resources necessary for effecting such a response.

We point to and discuss the hurdles that must be overcome for such a response to be successfully implemented, with a special focus on the fiscal challenges faced by countries in the region. On that basis we include some recommendations along with our concluding remarks.

2.0 HIV/AIDS in the 21st Century

As HIV/AIDS enters its third decade, recent research conducted by Bell, Devarajan and Gersbach (2003) suggests that its social, human and economic costs were significantly underestimated. The experiences of countries in the Sub-Saharan region also reveal that the epidemic has grown faster and reached higher levels than had been projected in the worst-case scenario by the World Bank in 1993 (Bonnel, 2000).

HIV/AIDS impacts on economies by negatively interfering with the channels of growth and development. It does so by creating distortions in the various markets and sectors of the economic system, particularly the labour market (DeLong, 1997). Whilst economists differ in both philosophical and methodological approaches to economic growth and development they generally agree on the critical role of accumulation of human and physical capital. Investments in human capital were considered to increase factor productivity because economic growth was not only determined by technical progress or investments in physical capital but also by investments in human capital. (Cobb and Douglas, 1928; Solow, 1957; Mankiw et al, 1992).

Any factor that impacts on investments and the accumulation of human and physical capital impacts directly on the ability of the economy to generate growth. HIV/AIDS is one such factor. The increasing incidence of morbidity and mortality from HIV/AIDS and related complications affects the labour force both quantitatively and

qualitatively. (BER, 2004; Biggs and Shah, 1997; Bloom et al, 2001). This in turn affects the financial resources available for productive investments.

It is well documented that HIV/AIDS is highly concentrated in the age group 15-44 years (UNAIDS, 2001, 2004). Productivity tends to fall as infected persons work fewer hours and with decreased effort. When death results, organizations lose employees with critical skills and incur costs for training replacement workers¹. Thus, any gains achieved through specialization and division of labour can be undermined by HIV/AIDS (Whiteside et al, 2001; Husain and Badcock-Walters, 2002).

The actual extent of the impacts has been the subject of debate. Projected results derived from the economic models used are conflicting due to their methodologies and underlying assumptions. These fall into two groups. One group employs the indicative approach and infers the impact based on a range of information about the disease, namely the concentration of people living with HIV/AIDS (PLWHAs) in the productive age group, the cost of treatment, and the probable effects of the disease on individuals (UNDP, 1992; Lyons, 1993). For the second group, conclusions are based on the use of empirical information and results generated by economic models adapted to calculate the impact of HIV/AIDS on the economy. Among these models are WEFA² time series as used by ING Barings (2000), Computable General Equilibrium by Arndt and Lewis (2000), and Cross-Country Regressions in Bonnel (2000).

Arndt and Lewis (2000) use similar epidemiological inputs and assumptions as ING Barings but arrive at more pessimistic results. They, however, introduce the added assumption that the epidemic will cause total factor productivity to decline over and above the loss of *labour* productivity, exacerbating the negative macroeconomic impact. They also assume that borrowing by governments to finance their increased

¹ One author describes this as "running Adam Smith in reverse". Adam Smith argued that economic growth creates avenues for specialization and division of labour. HIV/AIDS has the potential to cause employers to reverse this process since employees represent a stock of technical know-how and experience, which can be lost from unexpected deaths due to HIV/AIDS

² Wharton Econometric Forecasting Associates.

HIV/AIDS related spending will crowd out private investments, thereby lowering longer term growth. More recent research such as Bell et al (2003) and McPherson (2003), confirms that the long-run effect of HIV/AIDS is indeed much larger than suggested by earlier investigations, and argue for more emphasis on the formation and accumulation of human capital as this is the engine of growth in the economy and is a function of inter-generational transfer of knowledge and expertise. HIV/AIDS destroys this transfer mechanism but the full extent of the impact becomes apparent only after long lags.

Some projections estimate that almost 20% of the labour force has been decimated prior to 2005 and will rise to 30% by 2020. One study has painted a rather grim picture of labour force losses in a few high-prevalence countries in Southern Africa. These are portrayed in Table 1 below.

Table 1
Southern Africa: Labour Force Losses due to HIV/AIDS (%)

	By 2005	By 2020
Botswana	-17.2	-30.8
Lesotho	-4.8	-10.6
Malawi	-10.7	-16.0
Mozambique	-9.0	-24.9
Namibia	-12.8	-35.1
South Africa	-10.8	-24.9
Tanzania	-9.1	-14.6
Zimbabwe	-19.7	-29.4

Source: Husain and Badcock-Walters (2002)

3.0 The Nature and Dimension of the Caribbean Epidemic

By the end of 2006, approximately 250,000 persons were living with HIV/AIDS in this region, with new infections approximating 27,000 in that same year. (UNAIDS, 2007; CAREC, 2007). By the end of 2006 overall prevalence ranged from below 1% to just over 4% of the population in the English-speaking Caribbean. On the surface, it might seem that the aggregate numbers provide no basis for alarm. After all, more than 97% of the region's population is still virus-free. However, there are three aspects of the data that put a completely different perspective on the foregoing information: (i) the region is now essentially facing a generalized epidemic; (ii) new cases are increasing exponentially; and (iii) there is reason to believe that existing estimates are seriously understating the true dimension of the epidemic. These are amplified below.

3.1 Small Island States Facing a Generalized Epidemic

According to UNAIDS, an epidemic is said to be *generalized* when the prevalence rate is more than 1%, with certain subgroups having rates as high as 5%. Most of the countries in the CAREC study had prevalence rates greater than 1%. Specific population subgroups have recorded prevalence rates in excess of 5% while others have reached double-digits. The latest available estimates suggest prevalence rates of 30.0%, 40% and 18% among men who have sex with men in Jamaica, Trinidad and Tobago and Suriname respectively.³ In Guyana, the rate among female commercial sex workers was an estimated 31% in 2000 while the corresponding rate for male miners in that country was 6% in 2001. The rates among pregnant women were 1.4% in Jamaica and Trinidad and Tobago, 3% in the Bahamas and 5% in Guyana in 2002 (CAREC, 2004).

³ Data are for the following years: Jamaica 1996, Trinidad and Tobago 1983 and Suriname 1998.

It is reasonable to expect that a generalized epidemic fuelled by a virus for which there is no cure is one with the potential to severely reduce, and probably annihilate, small communities and the population of small countries. The fact that the rate in the Caribbean is more than twice the “generalized” threshold, together with the fact that among some subgroups rates far exceeding 5% have been found, means that there is really no room for complacency.⁴

3.2 Exponential Rate of Growth and Distribution in New Cases

The second reason why the region needs to see beyond the “low” rates in the Caribbean is related to the pace at which the epidemic has progressed. The data show that both the trend in the total number of HIV positive cases as well as the trend in the new cases has been increasing exponentially.⁵ The same is true for AIDS. At the end of 2003 the estimated percentage of the population living with HIV/AIDS was generally over 1% in most countries, with a low average of 0.19% in Dominica and a high average of 4.08% in Guyana. With a few exceptions, the larger Caribbean countries have the highest rates.

Additionally, from a gender perspective we make the disturbing observation in some countries that although the male-female distribution of HIV positive cases was about 66:34 for the period 1982 to 2002, “...*the acceleration of new cases observed among the female population was at a much faster rate than among the male population.*”^{6,7} The age distribution is also reason for concern. Globally the age group that is most susceptible to acquiring the disease is 15-49 years. The Caribbean is no exception. This group contains the potentially most productive persons in society both in terms of economic and biological productivity.

⁴ Health Economics Unit. 2001a. ; Yearwood, Cumberbatch and Beharry (2004),

⁵ CAREC. 2004.

⁶ Yearwood et al. (2003).

⁷ CAREC. 2004.

3.3 Possibility of Understated Estimates

The third reason why we cannot afford to be lulled by the 2.7% average rate is the fact that there is good reason to believe that this figure may be seriously underestimating the true dimension of the epidemic. An early study took the position that in many developing countries the surveillance systems were not capturing more than one-tenth of the total number of cases of HIV/AIDS. A subsequent study in 1997 estimated the surveillance error to be between 45 and 50 percent in Trinidad and Tobago (Lee et al, 1997). The point is that we need to take the official HIV prevalence numbers with a 'grain of salt.'

The fact is that the epidemic seems to have the potential to unravel all development progress gained in this region over the last four decades, and in so doing, effect such a systematic dismantling of all our key social institutions as to make the prospect of recovery remote. The data provided by UNAIDS put the matter very starkly: it would seem that while in the first decade of its history the epidemic caused about 1.5 million deaths, in the second decade of its visitation it caused around 15 million deaths – ten times the rate of the first decade. CAREC's data for the Caribbean portray a similar pattern – with close to 1,300 deaths in the first decade and more than 8,000 deaths in the second decade. The obvious question is what are the prospects for the third decade? UNAIDS has estimated that the third decade may be twice as unfortunate as the second since the first five years of the decade are likely to see the same number of deaths as the entire previous decade.

4.0 The Response: Elements and Hurdles

4.1 Elements of the Response

Because HIV/AIDS is an infectious disease with chronic implications, the response to the crisis necessitates a comprehensive and sustainable approach – comprehensive in the sense that it will have to address all the dimensions of the epidemic, and sustainable in that it will

be essential to support the necessary behaviour modifications over an extended period of time. The elements of a comprehensive, effective plan have been well articulated at the global and regional levels by UNAIDS (2003) and PANCAP (2002) respectively.

The Caribbean Regional Strategic Plan of Action for HIV/AIDS details six priority areas as follows: advocacy, policy development and legislation; 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; workplace interventions; prevention of mother to child transmission of HIV; strengthening national and regional response capability. These key elements have been largely adopted and/or adapted at the various national levels as attested to by the national strategic plans for HIV/AIDS.

4.2 Hurdles to the Response

4.2.1 *The Impact*

The sheer magnitude of the impact of HIV/AIDS could in itself act as an obstacle to a sustainable response. The evidence suggests that the HIV/AIDS tentacles show a decided tendency to extend throughout the economy. Figure 1 captures the many channels of the impact. A country's GDP growth is impacted on by the quantity and quality of the society's pool of human resources. Growth creates the potential for economic and human development. In the presence of HIV/AIDS, it is the same resource pool with the potential for development that is diverted into the fight against HIV/AIDS—educators, health personnel, management personnel and similar workers.

According to Figure 1, HIV/AIDS strikes at the heart of the society's development. While the disease delivers a frontal attack upon the society, it simultaneously undermines the society's capability for future resistance against it. In this regard, it may be argued that HIV/AIDS is an "intelligent" epidemic. The broken arrow to the right of the diagram portrays this "intelligence".

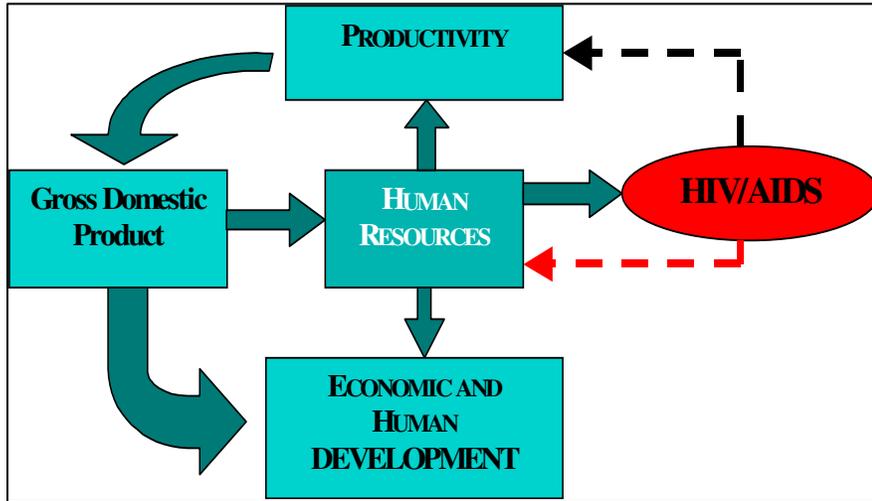


Figure 1
The Link between HIV/AIDS, Productivity and Development

The most recent estimates of the economic impact of HIV/AIDS in the Caribbean were conducted for Guyana and Suriname. The key results are summarized in Table 2.

Table 2
Projected Impact of HIV/AIDS in Suriname and Guyana by 2015

Variables	Extent of Impact: By 2015 (%)	
	Suriname	Guyana
GDP	-1.18	-2.73
Savings	-1.34	-2.81
Investment	-1.47	-3.74
Employment	-0.02	-0.02
Labour Supply	-0.02	-0.01

Sources: McLean (2004); Laptiste (2004)

These are not unreasonable estimates given what is currently known of the evolution of the disease in other territories. In the most extreme cases the productivity impact will come from the exit of experienced workers from the labour force either through an advanced stage of illness or through death.

The potential impact on the region's labour force is cause for concern. Starting with a crude regional estimate of a 3.13%⁸ loss overall by 2010 and applying similar rates of loss of 0.8% per annum—as in the Southern African cases⁹—we arrive at a crude estimate of 11% loss in the region's labour force by 2020, all else being equal. Alternatively, we could take an extremely conservative starting estimate of 1.57% which is one half of the average used by Camara et al (2001). We further assume that the difference in the two regions' rates of erosion in the labour force

⁸ This incorporates the higher rates of 5.2 percent and 7.3 percent impacts on labour supply in Trinidad and Tobago and Jamaica (2001) and conservatively holds these results to 2010.

⁹ See Table 1 on Page 5

would follow patterns in diversion of adult prevalence rates, placing the Caribbean's erosion rates at approximately one-tenth of the Southern African rate—0.08% per annum—with corresponding overall loss in the labour force of 2.37% by 2020.

The economic significance of these data is that HIV/AIDS would lead to new factor combinations which are not induced by the technology itself or by the cost of the factors. In other words, in the presence of HIV/AIDS, the basic guidelines for arriving at efficient factor combinations are rendered powerless and production may well be guided by criteria other than economic efficiency.

4.2.2 The Cost and Capacity of Responding

A second hurdle to the response is the quantity of resources required to mount a comprehensive, effective, and sustainable response. The pharmaceutical cost alone (of mounting a comprehensive response) is likely to be much greater than what most Caribbean countries are currently spending on all other diseases combined. Table 3 summarizes the cost of HIV/AIDS intervention programmes for countries in the region.

The costs are derived employing a generalized model, which is basically an adaptation of the FGI's¹⁰ Resource Allocation Model, which calculates the resources required based on the HIV/AIDS response programmes at the national level. The stylized models are further adaptations which take into account country-specific details. We arrive at a year 2000 estimate of US\$ 49.8 billion for the combined national income of the countries of the wider Caribbean – CARICOM/CARIFORUM members and CARICOM Associates, that is, excluding Aruba, Cuba,

¹⁰ The Futures Group International (FGI) provides technical and logistical assistance to initiatives in Africa, Asia, Europe and Eurasia, Latin America and the Caribbean, and the Middle East. While its scope is not limited to HIV, it has earned a reputation for its work in the area of HIV/AIDS software applications.

Puerto Rico and the USVI. When the latter four countries are included the figure jumps to US\$ 98.4 billion.¹¹

Table 3
HIV/AIDS Response Programme Costs: December 2003

Country	Adult Prevalence (As per Model)	Cost of HIV/AIDS Intervention Programmes		
		HEU/World Bank ¹	Stylised Model ²	Adjusted Estimates ³
	(%)	(US \$m)		
Anguilla	0.80	0.70		1.03
Antigua & Barbuda	1.30	6.91		10.19
British Virgin	0.70	1.42		2.09
Dominica	0.40	2.64	4.35	4.35
Grenada	0.80	5.66		8.35
Montserrat	0.50	0.65		0.96
St Kitts and Nevis	1.00	3.18	7.11	7.11
St Lucia	0.70	7.61		11.22
St Vincent	0.50	4.62		6.81
Bahamas	4.13	81.04		119.53
Bermuda	0.60	3.51		5.18
Cayman	0.10	0.64		0.94
Turks & Caicos	9.00	8.13		11.99
Haiti	5.17	2,304.11		3,398.56

¹¹ The CARICOM/CARIFORUM countries include Antigua/Barbuda, Bahamas, Barbados, Belize, Dominica, Dominican Republic, Grenada, Guyana, Haiti, Jamaica, Montserrat, St. Kitts/Nevis, St. Lucia, St. Vincent & the Grenadines, Suriname, and Trinidad and Tobago. The CARICOM Associates include Anguilla, Bermuda, British Virgin Islands and Turks and Caicos.

Table 3 (Continued)
HIV/AIDS Response Programme Costs: December 2003

Country	Adult Prevalence (As per Model)	Cost of HIV/AIDS Intervention Programmes		
		HEU/ World Bank ¹	Stylised Model ²	Adjusted Estimates ³
	(%)	(US \$m)		
Dominican Republic	2.80	1,381.26		2,037.36
Netherlands Antilles	0.90	12.95		19.10
Aruba	0.80	4.92		7.26
Guyana	5.00	241.64		356.42
Suriname	0.90	26.39		38.93
Barbados	1.17	23.18		34.19
Belize	2.01	27.64		40.77
Jamaica	2.00	306.30		451.79
Trinidad & Tobago	2.05	167.15	90.33	90.33
Cuba	0.03	122.58		180.81

Notes:

- 1 Costs estimated by the World Bank/HEU in 2001 for a one year-period using the FGI resource allocation model. High Cost includes the high cost scenario for activities in Prevention, Care, Advocacy, Research and Capacity Building.
- 2 Adjustments were made to the HEU/World Bank model using country-specific information with respect to scope and costs of activities for a five-year period.
- 3 Based on the costs generated by the Stylised HEU model, the HEU/World Bank 2001 estimates (for a five year period) were adjusted by a factor of 0.295

There are essentially *four* potential sources of financing for the HIV/AIDS response: domestic fiscal revenues; domestic private incomes; external bilateral assistance; and external multilateral assistance. The first two sources would obviously depend on the national income of the respective countries. The annual cost of mounting a full-scale

response to the epidemic in the wider CARICOM/CARIFORUM region (that is, excluding Puerto Rico and Aruba) would be between US\$ 275 million and US\$ 550 million, depending on assumptions made about the cost of anti-retroviral (ARV) drugs.¹² Using the lower estimate, this cost, as seen against the estimated annual combined national income of close to US\$ 50 billion, is significantly less than one percent of the region's combined income. There is therefore a strong *prima facie* case for advocating the financial feasibility of the response to HIV/AIDS. However, there are three sobering considerations which dampen what would otherwise be very good news for the region in respect of the national income potential to contribute to the fight against HIV/AIDS. The following sub-sections provide further details.

4.3 Income Inequality Across and Within Countries of the Region

The first consideration is the extent of the *income inequality across the region*. For seventeen countries in the region – CARICOM/CARIFORUM members and CARICOM Associates—the average per capita income in 2000 was US\$7,800. When the Bahamas, Bermuda and Cayman Islands are omitted the average plummets to just around US\$4,000. Clearly the need here is for consideration of linking the financing of HIV/AIDS to the resource pooling mechanisms being currently considered in the Caribbean. Given the reality of high levels of migration across the region it is important that no one national programme be under-financed since this could impose additional burdens elsewhere in the region.

The second cause for caution is the even greater *income inequality within countries*. Ramsaran (1999) gives us a Gini coefficient range between 0.3 and 0.6 with most countries above 0.45. The point here is that HIV/AIDS raises the significance of the national efforts being made to provide universal access to quality health services and to other social services. These domestic financing reforms are now made even more

¹² HEU and World Bank presentations at Sept 2000 Meeting in Barbados.

imperative in the midst of HIV/AIDS. The laudable goal of universal ARV treatment for all who need it becomes a real possibility only if access to such treatment is assured through some mechanism of social financing, i.e. public revenues.

4.4 Fiscal Deficits: Difficulty in Mobilizing Resources

Given the obvious role of the public sector in a successful response to HIV/AIDS, the third cause for caution is the *near intractability of resource mobilization* in many countries of the region. The evidence shows that nearly all the countries in the region currently experience a significant fiscal deficit.¹³ In itself this would rule out public revenues as a strong platform for mobilizing the financial resources required. What is true, however, is that the fiscal deficits in some of these countries may be less a reflection of limited resources and more a reflection of warranted fiscal reform. The point here is that fiscal reform in the Caribbean will bring with it a greater capability to respond to the HIV/AIDS epidemic. As we reduce fiscal slippage, for example, making revenue collection systems more efficient, or as we modernize our expenditure management systems to make better use of resources, the fiscal deficits in all our countries will be reduced and HIV/AIDS funding requirements will seem more within our reach.

The reality of fiscal deficits at this time, however, has meant that the region has had to mobilize external assistance and rely more on external financing in the fight against HIV/AIDS. This is not consistent with mainstreaming which is needed for sustainable response programmes. It is reasonable to suppose that given the urgency of the situation this external mobilization could be seen as buying time to put in place more effective domestic resource mobilization measures. For while the combined external assistance may not come near the US\$ 275 million

¹³ UNECLAC, *Fiscal Trends and Policy Issues and Implications for the Caribbean*, 2003. Table 26 on page 38 shows that for all the English-speaking countries, except Trinidad and Tobago, the deficit/GDP ratio for 2002 was negative and that this has been the case for more than a decade for most of the countries.

required annually, external support has served as a catalyst to get the national response kick-started in a number of countries. However, since mainstreaming and sustainability go hand in hand, a note of caution must be sounded. The region has already experienced being on the negative end of the international shifts in foreign direct investment in the past. It will not be surprising if external assistance for HIV/AIDS programmes suffers a similar fate once the epidemic bares its fangs in other more populous regions of the world.

Where external assistance will remain vital to the mainstreaming strategy is in respect of the market mitigation efforts now being mounted, in particular the lowering of the prices of ARV drugs and of the reagents needed for laboratory testing. These two sets of activities, together with the technical support now normally provided by WHO and UNAIDS, have the potential to change the face of national HIV/AIDS programmes, both in terms of access and in terms of the quality of support services provided. This kind of external support can certainly ease the financial strain of the HIV/AIDS programmes in all countries of the region.

4.5 Behavioural Rigidities

The HIV/AIDS epidemic is driven by lifestyle behaviour and by prejudicial reaction. Changes in behaviour represent a significant hurdle that can only be overcome by long term sustainable efforts. Reducing the infection rate requires getting individuals to make better choices and to eliminate stigma and discrimination against PLWHA. This requires an integrated execution involving families, schools, faith-based organizations (FBOs), non-governmental organizations (NGOs), the Government and any other country specific institutions and sectors that may be considered relevant to the response process.

5.0 Conclusion

HIV/AIDS has proven that it has the capacity to dismantle and destroy household structures and relations, communities and communal norms,

decades of growth and development, and/or to act as the proverbial final straw on the camel's back in depressed, underdeveloped economies. Thus, while at the individual/household level it may be expected, and even appropriate, to have what may appear to be non-strategic, ad hoc responses, the same does not hold for a regional and national response.

In this presentation we make the case that for the Caribbean region the rationale for fighting back is twofold. *First*, the epidemiological experience of HIV/AIDS suggests that ***this epidemic has the potential to annihilate the Caribbean***. UNAIDS (2002) has informed us that in two decades the epidemic has claimed more than 20 million lives and could claim another 30 million by the end of the present decade. Any epidemic of this magnitude, resident in a region of 35 million people, poses an extinction threat to that region. Therefore, even as we reckon the economic cost of fighting back, we need to keep in mind that it is our very survival that may be at stake. *Second*, the economic calculations tell us that if the epidemic is not contained, by 2010 it will be destroying our national income base at the rate of around 3% per year. In a region where total health spending is just around 5% of national income, the prospect of losing this portion of our national income through HIV/AIDS is very daunting indeed. What is more, in a region where the spectre of persistent poverty is still very much a reality, we cannot be neutral to an epidemic that will cost us hundreds of millions of dollars.

In summary, faced with an epidemic that promises to become chronic to the region, the financial mainstreaming of the regional response is both a challenge and an opportunity—with support coming from both domestic and external sources. Fortunately, as we have seen, resource availability is not the problem. The challenge is partly one of resource mobilization, especially public resource mobilization.

In relation to the hurdles identified, we put forward the following recommendations. For the financing hurdle, we need to be clear on the differences between immediate and long term response needs. For the latter, fiscal reforms and the introduction of a resource pooling mechanism for the region are crucial. For the human resource hurdle, the combination of universal access to prevention and treatment and a

credible approach to stigma and discrimination is the key here. For the behavioural/managerial hurdle, we need to explore a combination of specific economic incentives with greater support for the work of the FBOs and NGOs.

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