

PART THREE

The Exotic and the Mundane: HIV in Haiti

On one level it has become a commonplace to say that we all inhabit “one world.” There are ecological connections: New York suffers from the Hong Kong flu; the grapevines of Europe are destroyed by American plant lice. There are demographic connections: Jamaicans migrate to London; Chinese migrate to Singapore. There are economic connections: a shutdown of oil wells on the Persian Gulf halts generating plants in Ohio; a balance of payments unfavorable to the United States drains American dollars into bank accounts in Frankfurt or Yokahama; Italians produce Fiat automobiles in the Soviet Union; Japanese build a hydroelectric system in Ceylon. There are political connections: wars begun in Europe unleash reverberations around the globe; American troops intervene on the rim of Asia; Finns guard the border between Israel and Egypt.

Wolf (1982:3)

Although the human immunodeficiency virus cannot be shown to have been present in Haiti before the close of the 1970s, the country is now among those most gravely affected by HIV. As of March 20, 1990, Haiti had reported 2,331 cases of AIDS to the Pan-American Health Organization, making Haiti one of the world's twenty most affected nations. And although no large random surveys have been conducted, several epidemiologic studies of asymptomatic city dwellers reveal HIV seroprevalence rates of between 5 percent and 9 percent. Some Haitian researchers have gone so far as to suggest that HIV-related disorders have recently become the leading cause of death among adults between twenty and forty-nine years of age.

The following chapters will review the epidemiology of AIDS and HIV in Haiti. How did HIV cause such a devastating epidemic in such a short amount of time? What is known about HIV transmission in Haiti? Does it still remain a “mystery”? That such questions are critical is underscored by a February 1990 U.S. Food and Drug Administration (FDA) ruling, which banned all Haitians from donating blood. In response to this ruling, thousands of Haitians brought Miami traffic to a standstill as they shouted “Racists!” in front of FDA headquarters there. The demonstrations culminated in a mammoth rally in New York City. So many marchers—50,000 according to the police, more than twice that according to organizers—crossed the

Brooklyn Bridge that it was closed to traffic for the day.

What, exactly, had prompted the recent FDA ruling? The March 14, 1990, edition of the *New York Times* explained that the decision was based on what was known about HIV transmission in Haiti:

The Centers for Disease Control have stopped publicly specifying that Haitians are at risk for contracting AIDS, but the agency's statistics still carry a category of "pattern II countries," where heterosexual transmission is the primary mode of infection. And these are defined by the World Health Organization as Haiti and sub-Saharan Africa.

In overviews of the world epidemiology of HIV/AIDS, it is often suggested that three general types of epidemiological "patterns" currently exist. Pattern I, to use the terminology of the World Health Organization Global Program on AIDS, is seen in North America and Europe. It is characterized by a preponderance of cases among gay and bisexual men, with variable attack rates among intravenous drug users. Haiti (and sometimes the entire Caribbean) is characterized along with much of Africa as reflecting Pattern II. To cite a recent review:

Pattern II is seen in the Caribbean and in large areas of sub-Saharan Africa, and differs [from Pattern I] in that heterosexual intercourse has been the dominant mode of HIV transmission from the start. Blood transfusion, the reuse of contaminated needles, and intravenous drug use contribute to a variable degree, but homosexuality generally plays a minor role in this pattern. (Osborn 1989:126)

Pattern III is used to describe areas of low incidence of AIDS.

This section, which reviews what is known about HIV transmission in Haiti, will suggest that the World Health Organization (WHO) terminology obscures more than it illuminates, especially in regard to Haiti and much of the Caribbean. In fact, many early assumptions about the Haitian epidemic, and its role in the larger epidemic to the north, have been cast in doubt by careful epidemiological research. Moreover, the course of the American pandemic, including the epidemic in Haiti, has been determined to no small extent by economic and political structures long in place.

A Chronology of the AIDS/HIV Epidemic in Haiti

Most chroniclers of the AIDS pandemic agree that awareness of the new syndrome began in 1980 in California. Several physicians in Los Angeles observed that *Pneumocystis carinii*, a harmless parasite to those with intact immune defenses, had caused pneumonia (P.C.P.) in several young men without recognized states of immunodeficiency. The only epidemiological clue linking the cases was the sexual preference of the men. By June of 1981, the U.S. Centers for Disease Control (CDC), monitoring the distribution of drugs used to treat P.C.P., reported that “in the period from October 1980 to May 1981, five young men, all active homosexuals, were treated for biopsy-confirmed P.C.P. at three different hospitals in Los Angeles.” By the end of the summer, 108 cases of Kaposi's sarcoma and unexplained opportunistic infections had been reported to the CDC. The vast majority of cases were from California and New York. Of those afflicted, 107 were men; over 90 percent of these men stated that they were gay and sexually active.

Alerted to the possibility of an epidemic, North American public health specialists reviewed available documentation and observed that unexpected clusterings of Kaposi's sarcoma and opportunistic infections had begun early in 1977. Haitian physicians began to see similarly puzzling cases of immunosuppression shortly thereafter. The first Haitian case of Kaposi's sarcoma was detected in June 1979, when dermatologist Bernard Liautaud diagnosed the disorder in a twenty-eight-year-old woman from a city in western Haiti. She had been referred to the university hospital for worsening lower-extremity edema and had presented with nodular and papular lesions over her face, trunk, and extremities. Neither demographic variables nor clinical presentation fit the standard description of patients with the sarcoma: before the AIDS pandemic, Kaposi's had been described as a rare and slow-growing malignancy seen largely in elderly men of Eastern European and Mediterranean descent. The tumor behaved quite differently in Dr. Liautaud's patient, in whom it was aggressive and fatal. When he confirmed, later that year, the presence of the cancer in a young Haitian man, Liautaud posed the following question: Was Kaposi's of longstanding and unappreciated importance in Haiti, or was the cancer new to the country? A survey of colleagues led him to conclude that Kaposi's sarcoma was virtually unknown in Haiti. Liautaud and his coworkers reported their

findings to an international medical conference held in Haiti in April 1982 (Liautaud et al. 1983).

The fact that concurrent “outbreaks” of Kaposi's had been reported in California and New York lent credence to the idea that the tumor might be related in some way to an epidemic triggered by an infectious agent, as did the increased incidence of unexplained opportunistic infections.¹ Several such infections, first noted in February 1980, were also presented in the 1982 conference held in Port-au-Prince. These suggestions of immunosuppression were strikingly similar to those recently termed AIDS in the North American medical literature. The conviction that something new and significant was afoot led to the formation in May 1982 of the Haitian Study Group on Kaposi's Sarcoma and Opportunistic Infections (GHESKIO). The study group comprised thirteen physicians and scientists who would eventually treat hundreds with AIDS while conducting important clinical and epidemiological research.

In May 1983, the Association Médicale Haitienne (AMH) devoted their annual conference to the subject of AIDS. Research presented there left little doubt that in urban Haiti, at least, a new state of immunodeficiency was striking increasing numbers of young adults, especially men. In the Haitian medical community, few doubted that the patients were ill with AIDS as recently defined by the CDC. There were, by the time of the AMH conference, twenty cases of Kaposi's sarcoma and more than sixty otherwise unexplained opportunistic infections (see [table 2](#)). Using CDC criteria, Haitian researchers diagnosed a total of sixty-one cases of AIDS between June 1979 and October 1982.

Table 2 *AIDS Cases Diagnosed by the Haitian Study Group on Kaposi's Sarcoma and Opportunistic Infections (GHESKIO)*

<i>year</i>	<i>Kaposi's Sarcoma</i>	<i>Oppurtunistic Infection</i>
1979	2	0
1980	2	5
1981	7	9
1982	5	35
1/83–5/83	4	12

SOURCE: Pape et al. (1983)

Despite the obvious parallel—the suggestion in both Haiti and the United States of a new, acquired, and epidemic immunosuppression—there were important disparities between the two epidemics. When compared to cases in the United States, a smaller proportion of Haitians with AIDS had P.C.P., the most common opportunistic infection in North Americans with AIDS. Although the Haitian patients did have mycobacterial infections, they were almost exclusively tuberculosis; *M. avium-intracellulare*, an infection common in North Americans with AIDS, was rare in Haiti. Oroesophageal candidiasis was extremely common in Haitians with AIDS, so much so that it was suggested as an early marker for the syndrome (Guérin et al. 1984: 260). There were also disparities in length of survival after diagnosis: while mean survival after diagnosis was usually greater than a year in the United States, survival was less

than six months in the majority of Haitian patients, and none survived more than twenty-four months. Despite these differences, most researchers were confident that the Haitian and North American epidemics were caused by the same organism.

The research presented in 1983 offered important epidemiologic clues to Haiti's "role" in the larger pandemic. Although the Haitian researchers had initially concluded that "no segment of Haitian society appears to be free of opportunistic infections or Kaposi's sarcoma" (Pape et al. 1983:949), AIDS did not strike randomly. Pape and coworkers found that 74 percent of all men with opportunistic infections lived in greater Port-au-Prince, home to approximately 20 percent of all Haitians. Curiously, 33 percent of all AIDS patients lived in a single suburb, Carrefour. This finding was underscored because several of the patients interviewed by Pape and other researchers reported that they had been remunerated for sex:

The prevalence rate of men with opportunistic infections in Carrefour was significantly higher than that of men in Port-au-Prince ($p < 0.001$ by the chi-square test). This is of interest since Carrefour, a suburb of Port-au-Prince, is recognized as the principal center of male and female prostitution in Haiti. (Pape et al. 1983:948)

These investigations also revealed that only 13 percent of the remaining men with opportunistic infections were from elsewhere in the country. An equal number had been living outside Haiti: two patients lived in New York; one in Miami; one in Belgium; and one in the Bahamas. Five of twenty-one men interviewed by one of the GHESKIO clinicians stated that they were bisexual, as did two patients referred by other Haitian physicians.² Of these seven men, all had lived in Carrefour (four) or the United States (three). Three had had sexual contact with North American men in both Haiti and in the United States, and two others had sexual contact with Haitian men known to have opportunistic infections.³ Furthermore, fully half of the allegedly heterosexual men had either lived or traveled outside of Haiti. Research presented at the 1983 meetings made it clear that none of the Haitians ill with the new syndrome had ever been to Africa.⁴ All denied sexual contact with persons from that continent; most, in fact, had never met an African. But 10 to 15 percent of these patients had traveled to North America or Europe in the five years preceding the onset of their illness, and several more admitted to sexual contact with tourists (Guerin et al. 1984; Johnson and Pape 1989). Other important demographic data offered by the GHESKIO team were high prevalence (71 percent) of venereal disease and histories of blood transfusion (20 percent) in these patients.

Also in 1983, members of the GHESKIO team surveyed the twenty-one dermatologists and pathologists known to be practicing in Haiti, and asked them to provide information about their experience diagnosing and treating Kaposi's sarcoma. Over one thousand biopsy specimens from the Hôpital Albert Schweitzer were also reviewed. The survey revealed that only one case of the disease had been diagnosed in Haiti in 1972, and it had afflicted a man in his sixties. The course of his illness was not known, but it had not aroused suspicions of immunodeficiency. GHESKIO concluded, as had Liautaud, that the new cases of Kaposi's represented an epidemic of recent onset.

In summary, those who attended the AMH conference could draw several important conclusions based on the data presented at these meetings: Haitians with AIDS were then

largely men, though there were increasing numbers of women reporting to the GHESKIO clinic; there was an epicenter of the Haitian epidemic in the city of Carrefour, a center of prostitution bordering the south side of Port-au-Prince; a large percentage of the early cases had been linked to homosexual contact, some of it with North Americans; the rate of transfusion-associated transmission was higher in Haiti than in the United States; although the opportunistic infections were often different from those seen in North Americans with AIDS, the Haitian epidemic was manifestly related to that in the United States; the microbial agent that led to AIDS was probably new to Haiti, as no one could report cases predating the much larger North American epidemic.

Subsequent research, based on the development of assays for antibodies to the newly discovered HIV, also suggested that the virus was new to Haiti. Blood samples drawn from adults during the course of a 1977-1979 outbreak of dengue fever were later tested for antibodies to HIV. Using ELISA (whole virus) and radioimmunoprecipitation assay (RIPA) for antibody to the p24 and gp120 antigens, it was revealed that none of 191 sera tested had antibodies to HIV (Johnson and Pape 1989).⁵ The sole suggestion that AIDS existed in Haiti prior to 1979, the time at which Dr. Liautaud noted the first two cases of Kaposi's sarcoma, were the autopsy records of a previously healthy twenty-year-old man who had died in 1978, two weeks after the sudden onset of generalized seizures. Post-mortem studies at the Hôpital Albert Schweitzer revealed cerebral toxoplasmosis, an opportunistic infection common in persons with AIDS. "These data and studies from Africa," conclude Johnson and Pape (1989:67), "are consistent with the hypothesis that HIV most likely originated in that continent, came to the United States and Europe, and subsequently was introduced into Haiti by either tourists or returning Haitians."

The research conducted in the first years of the Haitian epidemic also spoke to many of the speculations of North American researchers. Was AIDS caused by "an epidemic Haitian virus," as had been suggested? Had overworked or undertrained Haitian physicians merely overlooked the disease, as others seemed to imply?⁶ Was AIDS caused by an African virus brought to the United States by Haitians?⁷ Was AIDS caused by an organism endemic among isolated, superstitious peasants who transmitted the organism through some bizarre voodoo practice? While some of the Haitian researchers felt that these questions had been answered by their research, which had been published in refereed, international journals, their contributions did little to dampen the apparently self-sustaining "exotic theories" that continued to influence popular opinion in the United States and elsewhere.

HIV in Haiti: The Dimensions of the Problem

How far has HIV spread in Haiti? Given the natural history of HIV infection, this question is best answered not by the epidemiology of AIDS, but through the study of HIV seroprevalence in asymptomatic populations. Researchers in Haiti have studied seroprevalence of HIV using both ELISA and RIPA (p24, gpl20). During 1986 and 1987, sera from several cohorts of healthy adults were analyzed for antibodies to HIV (see [table 3](#)). In a group of individuals working in hotels catering to tourists, HIV seroprevalence was 12 percent. Among urban factory workers, 5 percent were found to have antibodies to HIV. In both series, *rates were comparable for men and women*, which suggested to many observers that the high attack rate in Haitian men would slowly give way to a pattern like that seen in parts of Central Africa, where men and women are equally affected. The highest rates observed were in female Haitian prostitutes (53 percent), underlining for some their role in the transmission of HIV. Few observed that high rates of seroprevalence among prostitutes might simply reflect “occupational risk”—an increased likelihood of coming into contact with a seropositive man—which proved nothing about their role in propagating the virus.

In a group of 502 mothers of children hospitalized with diarrhea and in a group of 190 urban adults with a comparable socioeconomic background, the seroprevalence rates were 12 percent and 13 percent, respectively. All 57 health workers involved in the care of AIDS patients were seronegative, corroborating data suggesting that HIV is not easily spread by nonsexual contact. Overall, GHESKIO researchers found that approximately 9 percent of 912 healthy urban adults (medical workers, college graduates, factory or hotel workers, mothers of sick infants, and other adults) were seropositive for HIV.

Table 3 HIV Seroprevalence Among Healthy Adults in Haiti
(1986–1987)

Category	N	Mean Age (Years)	% HIV (+)
<i>Urban Haiti (Port-au-Prince)</i>			
Hotel Workers	25	45	12.0
Factory Workers	84	30	5.0
Pregnant Women (1986)	1,240	29	8.4
Mothers of Sick Infants	502	29	12.0
Other Adults:			
High SES	54	35	0.0
Low SES	190	33	13.0
Medical Workers	57	40	0.0
Total	2,152	37	9.0
<i>Rural Haiti</i>			
Mothers of Sick Infants	97	25	3.0
Pregnant Women	117	27	3.0
Blood Donors	245	32	4.0
Other Adults (rural village)	191	29	1.0
Total	650	30	3.0

SOURCE: Pape and Johnson (1988b)

A group of researchers based in Cité Soleil, a slum on the northern fringes of Port-au-Prince, reported that 8.4 percent of 1,240 healthy women receiving prenatal care in 1986 were seropositive for HIV (Halsey et al. 1987). In 1987, 9.9 percent of 2,009 “sexually active women” in Cité Soleil were HIV-positive; in 1989, 10.5 percent of 1,074 such women were found to have been exposed to HIV (Brutus 1989b; seropositivity in Cité Soleil was confirmed by Western blot). In Gonaïves, the third largest Haitian city, 9 percent of 1,795 patients reporting to a clinic that serves a predominantly low-income clientele were found to be seropositive in 1988 (Brutus 1989a).

Other investigations confirmed the impression of high rates of seroprevalence among people living in or near the capital. Pape and coworkers also tested sera collected for other diagnostic tests and found that of 1,037 adults phlebotomized during the first six months of 1986 by three commercial laboratories in Port-au-Prince, 8 percent were seropositive for HIV antibodies (Johnson and Pape 1989). The health status of these persons is not known, but since none of the three laboratories performed HIV serology at the time of phlebotomy, the sera had not been collected to diagnose HIV infection. These samples represented about 10 percent of the total number of persons bled by the three laboratories during that period.

In compiling all available data from seroprevalence studies of healthy urban adults, one is led to conclude that a substantial fraction of urban Haitians have been exposed to HIV. In contrast, the seroprevalence rate concurrently averaged 3 percent in rural areas. The seroprevalence rate in 97 mothers of children hospitalized in the university hospital with dehydration was 3 percent; 4 percent of 245 unscreened rural blood donors had antibodies to HIV. In an area even more distant from urban centers, 1 percent of 191 adults who came for immunizations were seropositive.

What of seroprevalence among children? The GHESKIO team studied three groups of children: offspring of a parent with AIDS; children hospitalized in Port-au-Prince with diarrheal disease; and healthy, age-matched controls from the same neighborhoods as the

hospitalized children. Their findings, summarized in [table 4](#), suggest that pediatric infection with HIV is perinatal: rates are highest in the children of parents with AIDS, especially those less than one year old, when maternal antibodies may give “false” positive antibody tests. Further, the children of a seropositive father and a seronegative mother were all seronegative, also strongly suggesting vertical transmission. Disturbingly, the rates of seropositivity were identical for the children of parents with AIDS and the children hospitalized with diarrhea: 6.5 percent in both groups, and three times greater than in controls. This suggests that, in Port-au-Prince at least, pediatric infection with HIV may be leading to significant morbidity (for example, diarrheal disease) even before pediatric AIDS may be diagnosed. The relative contribution of HIV versus that of other pathogens is difficult to assess in Haiti, where infant death due to diarrheal disease has long been commonplace.

In summary, large numbers of Haitians have been exposed to HIV. The speed of spread has been great indeed: sera stored between 1977 and 1979 were found to be free of HIV. Since then, the only areas without a single seropositive adult have been small cohorts of rural Haitians. The exception has been a group of health care workers and adults from relatively privileged backgrounds, which has led some observers to question the conclusion, advanced early in the epidemic, that Haitians from all economic backgrounds were equally vulnerable to AIDS. As Johnson and Pape (1989:70) have recently concluded, “Collectively, these data indicate that HIV infection is widespread and more prevalent in urban areas and in lower socioeconomic groups.” It is precisely this group—poor city dwellers—who were most at risk during the early years of the epidemic. They remain more vulnerable than their wealthy counterparts to HIV infection and to virtually every other infectious disease known in Haiti.

Table 4 *Prevalence of HIV Antibody in Haitian Children*

<i>Age</i>	Children of AIDS Parents		Children Hospitalized with Diarrhea		Controls	
	<i>N</i>	<i>HIV+ (%)</i>	<i>N</i>	<i>HIV+ (%)</i>	<i>N</i>	<i>HIV+ (%)</i>
<1	96	28	260	8	119	3
1-4	252	3	52	2	41	2
4-10	218	2	5	0	7	0
>10	43	0	0	—	0	—
Total	609	6.5	317	6.5	167	2

SOURCE: Pape and Johnson (1988a)

Haiti and the “Accepted Risk Factors”

In Haiti, the epidemiological questions posed were the same as those in other areas facing the AIDS pandemic: Who is at risk for acquiring HIV infection? How is the virus transmitted? Specifically, what behaviors or preexisting conditions might be associated with seropositivity or HIV disease? What was the extent of infection in groups engaging in high-risk behaviors? A good deal of evidence suggests that answers to these questions have changed over the years. Initial research conducted among Haitian-Americans with AIDS identified none of the “accepted risk factors”—that is, homosexuality, bisexuality, IV drug use, a history of transfusion, or hemophilia—in the vast majority of Haitians with AIDS. In Haiti, however, certain risk factors often were identified, although the factors deemed important have changed over the years.

Spurred on in large part by calls for careful research that would answer questions raised at the 1983 AMH conference, the GHESKIO investigators began to gather much more information from each new patient in an effort to identify activities or events that may have exposed that patient to HIV. Unfortunately, questions pertaining to sexual history were not standardized, and little effort was made to gather ethnographic data that might complement information garnered in the clinic. Dr. Pape developed a standardized questionnaire, which he and the GHESKIO physicians administered beginning in July 1983. They discovered that, in the majority of cases presenting at this time, “accepted risk factors” could be identified. Data on the first thirty-four patients so evaluated were presented at a Washington conference the following summer (see [table 5](#)).

The most striking revelation, considering reports about Haitians with AIDS in the United States, was that fully 50 percent of the men interviewed had a history of sexual relations with men. None of them, however, was exclusively homosexual:

The fact that all the male AIDS patients who have had sex with men are bisexual would also provide greater opportunity for heterosexual transmission of AIDS in Haiti. This also may contribute to the finding that 21 percent of our Haitian AIDS patients are women, as compared with only 7 percent in the United States (Pape et al. 1986:7).

Pape and his team further showed that fully half the women in the study had received a blood transfusion in the five years prior to onset of symptoms, and also observed that Haitian women

are more likely to receive blood—often in the course of childbirth—than are Haitian men.

Did these data, which clearly demonstrated “accepted risk factors” in a majority of those studied, suggest that transmission in Haiti was through the same mechanisms as those elucidated in the United States? To determine the significance of presumed risk factors, a case-control study was initiated at the same time. The research design was ambitious:

Each of the most recent 36 AIDS patients was asked to provide three “healthy” persons to serve as controls. The controls included a sibling of the same sex closest in age to the patient, a friend of the same sex who shared social activities, and a current or recent sexual partner. (Pape et al. 1986)

Despite the audacity of this request, Pape's patients complied by recruiting twenty siblings, twenty friends, and twenty sexual partners. Interestingly, all the patients provided “current or recent sexual partners” of the opposite sex, including the men who had histories of homosexual contact. Among the risk factors studied were transfusion, the use of parenteral medications, and frequency of “heterosexual promiscuity” (arbitrarily defined as greater than twelve different partners during the six months preceding onset of their illness).

Early in the epidemic, it was noted that another potential mode of transmission of HIV is through the use of contaminated needles. In Haiti, intramuscular injections may be given by either medical personnel or, in areas without access to medical facilities, by those known to be *pikiris*, “injectionists.” Disposable needles and syringes, not readily available in Haiti, are frequently reused without sterilization. Pape and colleagues found that, during the five-year period before the onset of AIDS symptoms, parenteral medications were received by 83 percent of male and 88 percent of female AIDS patients (Pape et al. 1985). Although the figure is by itself suggestive, injections were also reported by greater than 67 percent of controls (seronegative siblings and friends), suggesting that other factors were involved in HIV transmission.

Table 5 *Risk Factors in 34 Patients*

	<i>Males (n = 26)</i>	<i>Females (n = 8)</i>
Bisexual	13 (50%)	0
Blood transfusion	3 (11%)	4 (50%)
IV drug abuse	1 (4%)	0
Spouse with AIDS	0	1(12%)
None apparent	9 (35%)	3 (38%)

SOURCE: Pape et al. (1986)

With homosexual contact already a documented risk factor, it was hypothesized that one of the additional factors may be the number of opposite-sex partners. The female siblings and

friends had a mean of one sex partner per year during the five years preceding the study and an HIV seroprevalence rate of 9 percent. Male siblings and friends, in contrast, had six or seven opposite sex partners annually and a seroprevalence of 22 percent. Although the numbers are small and the sample not random, these figures corroborate the initial impressions of those studying the epidemic: urban Haitian men were noted to have significantly more sexual partners than did urban women, suggesting a greater role for men in the spread of HIV. The predominantly male role would be further amplified if the viral agent were more easily transmitted from male to female.

An analogous mode of transmission has been described for HTLV-1, a retrovirus related to HIV, for which female-to-male transmission is thought to occur rarely, if at all (see Kajiyama et al. 1986, and Murphy et al. 1989). There are other reasons to believe that HIV is more efficiently transmitted from men to women. Some are intuitive: HIV is concentrated in seminal fluid, but often difficult to isolate in vaginal secretions. In comparing male ejaculate to vaginal secretions, it is important to note that inoculum size is of course different by several orders of magnitude. Data from the United States also suggest that HIV is inefficiently transmitted from women to men: in two studies of women whose date of transfusion-associated HIV infection could be ascertained, from 0 to 7 percent of their spouses or regular sexual partners showed evidence of HIV infection (Peterman et al. 1988).¹

Based on the case-control study initiated in 1983, the GHESKIO team initially concluded that “accepted risk factors” were present in approximately two-thirds of Haitians diagnosed with AIDS. This figure was compared to those published in reports from the United States, where only 6 percent of Haitian-Americans with AIDS “were bisexual” and only 1 percent used intravenous drugs. As Pape et al. (1986:6) later observed, “The disparity in the data from the United States and Haiti may be attributable, in part, to a greater willingness of Haitians to provide reliable responses to personal questions in their native country and language.”

The patterns that emerged in the first case-control cohort were soon shown to be shifting. Indeed, the Haitian epidemic was changing. Most striking was the changing incidence of opportunistic infections versus Kaposi's sarcoma in Haitians with AIDS. The percentage of AIDS patients with Kaposi's decreased from 15 percent of cases occurring before and in 1984 to 5 percent in cases between 1986 and 1988 ([table 6](#)).

In addition to changing clinical features, there were important shifts in sex distribution of persons with AIDS. An overwhelming majority of the early patients had been men, but the proportion of women among the GHESKIO patients was increasing with each passing year (see [table 7](#)).

Not only were sex differences in the incidence of AIDS diminishing, but “accepted risk factors” were denied by more and more patients. Such risk factors were found in only 20 percent of the first Haitian cohort (before 1983) because, it was hypothesized, a standardized approach to these questions had not been applied. In a second cohort (1983-84), risk factors could be identified in a majority of patients. Of the men, 50 percent had histories of sexual contact with both men and women. In contrast, only 11 percent of the 170 male and female AIDS patients who presented in or after 1986 reported either bisexuality, blood transfusions, or IV drug abuse.

The changing significance of these risk factors was suggested by the case-control study, in

which a total of 384 persons with AIDS, of whom 278 were male and 106 were female, had been evaluated, as were 174 of their heterosexual sex partners, and 224 of their siblings and friends (table 8). Among the sex-matched siblings, none of whom had been transfused and all of whom denied bisexuality, 17 percent were seropositive. Sex differences in this group were not striking: 19 percent of the brothers were seropositive, as were 14 percent of the sisters. Among 108 of the patients' sex-matched friends, it was discovered that, while none of the women screened were seropositive, fully 26 percent of the men were. All but 5 percent of the male friends screened denied homosexuality or bisexuality; all of those who had same-sex sexual relations were seropositive. Blood transfusion seemed to be less important as a mode of transmission as the epidemic progressed: 2 percent of male and 3 percent of female respondents had received transfusion during the preceding five years, and none of them was seropositive.

Table 6 *AIDS Cases Diagnosed by the Haitian Study Group on Kaposi's Sarcoma and Opportunistic Infections (GHESKIO)*

<i>Year</i>	<i>Kaposi's Sarcoma</i>	<i>Opportunistic Infection</i>	<i>Total</i>
1979	2	0	2
1980	2	5	7
1981	7	9	16
1982	5	35	40
1983	8	53	61
1984	11	103	114
1985	8	136	144
1986	10	160	170
1987	8	159	167
Total	61	660	721

SOURCES: Pape et al. (1983, 1985); Johnson and Pape (1989)

Table 7 *Sex Distribution of Patients with AIDS in Haiti*

<i>years</i>	<i>N</i>	<i>Percent Female</i>
1979-1982	10/65	15%
1983-1985	86/319	27
1986-1988	144/458	31

SOURCE: Marie-Marcelle Deschamps, personal communication

Finally, 55 percent of 174 regular sexual partners or spouses of AIDS patients had antibodies to HIV: 61 percent of male partners and 54 percent of female partners. Only 3 percent and 6 percent of the male and female partners, respectively, had received a transfusion, and neither bisexuality nor IV drug use was reported by either group. HIV infection among the regular sexual partners of Haitians with AIDS underlined the disturbing suggestion that AIDS was becoming "just another" sexually transmitted disease, yet there were still no data to suggest efficient female-to-male transmission of the virus.

Table 8 Risk Factors in 559 Haitian AIDS Patients

	1983	1984	1985	1986	1987	All
N	38	104	132	185	100	559
Bisexuality	50%	27%	8%	4%	1%	13%
Transfusion	23	12	8	7	10	10
IVDA	1	1	1	0	1	1
Heterosexual	5	6	14	16	15	13
Undetermined	21	54	69	73	73	64

SOURCE: Pape and Johnson (1988a:37)

In summary, then, there has been a marked decrease in the relative number of Haitians with AIDS reporting a history of transfusion or same-sex contact.² Among patients who have recently visited the GHESKIO clinic, there has been a marked increase in the proportion having a spouse or regular sexual partner with AIDS, having a history of prostitution, or denying all the “accepted risk factors.” When data from all three “phases” of the epidemic are considered together, it appears that, at the outset of the epidemic, “accepted risk factors” could be identified for only 20 percent of Haitians with AIDS. A couple of years later, risk factors were identified in a majority of Haitians with AIDS, but by 1986 the number of patients with such risk factors began to decrease. The shape of this curve, which suggests a rise and fall of the importance of bisexual contact, is in all probability an artifact of research design. It is far more likely that preliminary low rates of detection of bisexual contact (and perhaps transfusion) were due to the stigma attached to homosexuality and to the nonstandardized approaches in collecting these data.³

A more probable curve would be one that reveals a high prevalence, among the first Haitians with AIDS, of “accepted risk factors,” that is, the “North American/European” risk factors identified by the CDC. Of all of these factors, bisexual activity was by far the most significant in Haiti. With the passage of time, however, it has become increasingly clear that HIV is heterosexually transmitted, especially from men to women. By 1988, heterosexual transmission was presumed in 16 percent of patients who were female prostitutes or in those who had a spouse with AIDS; it is a probable source of infection in the patients denying all other “accepted risk factors.” By 1986, these patients represented more than 70 percent of Haitian AIDS cases (see [table 8](#)). Additional evidence for heterosexual transmission of HIV is the finding that more than half of 139 Haitian prostitutes in the Port-au-Prince area were seropositive: the rate of seropositivity among sex workers increased from 49 percent in 1985 to 66 percent in 1986 (Pape and Johnson 1988a: 36).

The data from Haiti do not offer strong support for *efficient* female-to-male transmission, although it is clearly not trivial: if bisexuality is decreasingly common and yet HIV seropositivity continues to increase among heterosexual men, women are necessarily a source as well as a “sink” for infection. The conclusions that may be drawn from these studies are important: HIV is heterosexually transmitted, but it is much more efficiently transmitted from male to female than vice versa.⁴ At this writing, heterosexual transmission is thought to account for the majority of Haitian AIDS cases, and cases associated with perinatal transmission are increasing at a rate greater than that of the epidemic in general. In Haiti, AIDS is afflicting increasing numbers of women—especially poor women.

AIDS in the Caribbean: The “West Atlantic Pandemic”

The history of the Haitian AIDS epidemic is a brief and devastating one. Less than two decades ago, HIV may not have been present in the country. Now, complications of HIV infection are among the leading causes of death in urban Haiti. How are other Caribbean islands affected? Is Haiti, as some believe it to be, an AIDS-ridden pocket in an otherwise low-prevalence region?¹ Answering these questions is no mean task, as Pape and Johnson (1988a: 32) suggest:

First, in many countries there is no registry system for AIDS and it was only in 1984 that most nations started reporting cases to [the Pan American Health Organization]. Secondly, the widely used CDC case definition for AIDS is inappropriate for defining tropical AIDS and requires sophisticated laboratory support that is not readily available in most countries. In our experience in Haiti, the new CDC case definition for AIDS (CDC 1987), which relies more on HIV testing and clinical presentation, should increase the actual number of reported cases by at least 30 per cent.

Ironically, given the extreme poverty of Haiti, Haitians with AIDS stand a better chance of an adequate workup than do the citizens of several other Caribbean nations. Although Haiti has the weakest health infrastructure in the region, it has had the largest number of cases, the greatest amount of international scrutiny as “the source of AIDS,” and has sustained the most substantial economic blows relative to GNP. Perhaps in part as a result of these negative forces, many Haitian physicians and researchers have been involved in the professional response to the epidemic. Haitians publish more HIV-related studies than do researchers in other Caribbean countries, and the GHESKIO-run national laboratories are experienced in diagnosing AIDS and other forms of HIV infection.

Given these limitations, what do we know about the chief characteristics of the Caribbean pandemic? All of what are termed “the Caribbean basin countries” have reported AIDS cases to the Pan American Health Organization (PAHO). Among the islands, Haiti, the Dominican Republic, Trinidad and Tobago, and the Bahamas account for 82 percent of all cases reported to PAHO between the recognized onset of the epidemic and September 1987. Haiti had

reported the largest number of cases in the Caribbean region, which appears to lend credence to the widely shared belief that citizens of that nation are somehow uniquely susceptible to AIDS. When the number of cases is standardized to reflect per capita caseload, however, the uniqueness of Haiti disappears: the attack rate in Haiti is actually lower than that in several other countries in the region (Lange and Jaffe 1987:1410).

During the twelve months preceding September 1987, the number of reported Caribbean cases doubled, with the largest rates of increase in Barbados, Jamaica, Martinique, Guadeloupe, French Guiana, the U.S. Virgin Islands, and Grenada. The epidemic in the Dominican Republic continues to grow: although no cases were reported in 1983, a total of 62 were reported in the subsequent two years. During 1986, the number of Dominican cases more than doubled, and as of the end of 1989, 856 cases had been reported to PAHO.

What is the nature of HIV transmission in these countries? As noted, many public health specialists speak of the entire Caribbean basin as demonstrating “Pattern II,” which differs from Pattern I “in that heterosexual intercourse has been the dominant mode of HIV transmission *from the start*.... Homosexuality generally plays a minor role in this pattern” (Osborn 1989:126; emphasis added). The above review of the data from Haiti suggests that the WHO terminology obscures an accurate understanding of the Haitian AIDS epidemic. First, although “the start” was never accurately documented, it seems clear that same-sex relations between men played a crucial role in the Haitian epidemic; second, the WHO scheme highlights similarities between Haiti and Africa, which would be acceptable if such comparisons did not tend to draw attention away from the history of the Caribbean pandemic, which is in fact, causally speaking, much more intimately related to the North American epidemic. Third, the WHO scheme is static, whereas the Haitian epidemic is rapidly changing. Data from other Caribbean countries suggest that the WHO terminology is equally inappropriate there, and that the patterns seen in Haiti are suggestive of what has occurred in other countries in the region.

[Table 9](#) also presents figures suggesting that homosexual contact has played an important role in other Caribbean islands. But even here finer distinctions may be drawn. “For these homosexuals,” note Pape and Johnson (1988a: 36) in reference to gay men in Jamaica, the Dominican Republic, and Trinidad, “sexual contact with American homosexuals rather than promiscuity per se appeared to be associated with increased risk of infection.” What studies allow such a conclusion? The first case of AIDS in the West Indies was reported on Trinidad in February 1983. Since then, the number of cases has risen steadily, leaving Trinidad with one of the highest attack rates in the Americas. In an important study, Bartholemew and coworkers (1987) compare the epidemiological correlates of infection with two retroviruses: HTLV and HIV. Infection with the former virus, thought to be long endemic in the Caribbean, was significantly associated with age, African descent, number of lifetime sexual partners, and “duration of homosexuality,” that is, length of time as a sexually active gay man. In sharp contrast, “age and race were not associated with HIV seropositivity. The major risk factor for HIV seropositivity was homosexual contact with a partner from a foreign country, primarily the United States. Duration of homosexuality and number of lifetime partners were not significantly associated with HIV seropositivity” (Bartholemew et al. 1987:2606). The same risk factors were documented in Colombia, also a Caribbean-basin country. In Bogota, Merino et al.

(1990:333—334) observe that “significant behavioral risk factors for HIV-1 seropositivity among this sample of Colombian homosexual men included receptive anal intercourse and, for the subgroup reporting receptive roles, contact with foreign visitors.”² The Haitian experience would suggest that Trinidad and Colombia can expect the relative significance of sexual contact with a North American gay man to decrease, as other risk factors—most notably, high numbers of partners—become preeminent.

A similar risk factor was also hypothesized for the Dominican Republic, where Haitians, long despised in the neighboring country, have come under even heavier fire as “AIDS carriers.” And yet studies revealed high seroprevalence among homosexual/bisexual male prostitutes living in the tourist areas of the country—10 percent in Santiago and 19 percent in Puerto Plata. “Tourists, and not Haitians, were the most likely source of virus transmission to Dominicans, because contact occurs frequently between tourists (for example, male homosexuals) and Dominicans but rarely between Haitians and Dominicans” (Koenig et al. 1987:634). Further, it seems that the epidemiology of HIV in the Dominican Republic may resemble that in Haiti to an even greater extent than did the Trinidadian epidemiology. Koenig and coworkers underline the role of economically driven prostitution among young Dominican men who consider themselves heterosexual: “Persons who engage in homosexual acts only to earn money usually consider themselves heterosexual. This situation, public health workers have indicated, is particularly prevalent in the tourist areas-with young adolescents. It could explain our finding of three positive serum samples in schoolchildren from Santo Domingo” (Koenig et al. 1987:634).³

Table 9 HIV Seroprevalence in Caribbean Homosexuals or Bisexuals									
	Jamaica			Dominican Republic			Trinidad		
	Year	N	HIV (%)	Year	N	HIV (%)	Year	N	HIV (%)
Homo/ Bisex	'86	125	10	'85	46	17	'83–84	106	40
Controls	'86	4,000	0	'85	306	2.6	'82	983	0.2

SOURCE: Pape and Johnson (1988a)

More recent research in the Puerta Plata area suggests that, although homosexual prostitution has diminished, another form of sexual exchange fostered by economic inequity continues to flourish. Garcia and coworkers have studied the “beach boys” who work the area's tourist hotels:

Beach boys are charming, friendly young heterosexual males who provide escort service to women tourists, most of whom are 30 years old or more. The beach boys are known locally as “Sanky Panky”—a corruption of the term “hanky panky.” Because these men have contact with tourists from different countries and continents, they are often skilled, if not fluent, in English, French, German, and Italian. (Garcia 1991:2)

Although termed “brief holiday romances,” the escort service typically involves “monetary compensation,” and qualitative research allows Garcia (1991:2) to conclude that “beach boys have multiple sexual partners and ply their trade in an area where the prevalence of AIDS is among the highest in the country.”

Epidemiologic reports from other parts of the Caribbean suggest a similar history for other growing island epidemics. Composite data from Surinam and what has been termed the “English-speaking Caribbean,” which includes twenty island nations, show that while 100 percent of those diagnosed with AIDS in 1983 were homosexual or bisexual, the relative significance of same-sex contact as a risk factor for AIDS plunged to 30 percent over the next five years. Blood-transfusion-related AIDS remained low, at less than 5 percent, and pediatric AIDS continued to account for less than 10 percent of diagnosed cases. Cases among those claiming to be exclusively heterosexual and without history of transfusion or intravenous drug use have soared, from less than 10 percent before 1985 to 60 percent in 1988. The male-to-female ratio has declined each year, as more and more women fall ill with AIDS. These trends necessarily imply that the proportion of pediatric cases will also climb (Hospedales 1989).

Caribbean-wide data suggest that many of the factors that have helped to shape the Haitian epidemic have been important throughout the region. Of these factors, the most important have been economically driven and historically given: sufficient data now exist to support the assertion that economically driven male prostitution, catering to a North American clientele, played a major role in the introduction of HIV to Haiti. Why might Haiti have been particularly vulnerable to such commodification of sexuality? In a country as poor as Haiti—“the poorest country in the hemisphere”—AIDS might be thought of as an occupational hazard for workers in the tourist industry. A similar observation may be made about several other Caribbean nations.

Throughout the earlier half of this century, tourists’ attitudes toward Haiti are nicely summarized by Carpenter (1930:326), whose Anglo-American guide book to the Caribbean qualifies Haiti as “a deplorable and almost unbelievable mixture of barbaric customs and African traditions.” Later, in a slightly different era, Haiti’s “exoticism” could be peddled as an attraction.⁴ Tourism truly began in 1949, when Port-au-Prince celebrated the two hundredth anniversary of its founding with the inauguration of the “Cite de Exposition,” a long stretch of modern buildings built on the reclaimed swampy waterfront of the capital. The country counted some 20,000 visitors that year, and slightly fewer in 1950 and 1951. During the next few years, however, approximately 250,000 tourists would spend an average of three days and \$105 in Haiti—bringing in approximately 25 percent of Haiti’s foreign currency (Francisque 1986:139).

There was every sign that the gains in tourism would be steady, but political instability in 1957, followed by the tyrannical rule of François Duvalier, led North American tourists to avoid Haiti for several years.⁵ This was the case even though a number of casinos located in Cuba relocated to Haiti after the overthrow of the Batista dictatorship. After he had silenced domestic opposition, Duvalier attempted to court tourists and their dollars later in the decade. In the same speech in which he welcomed U.S. Vice President Nelson Rockefeller to Haiti and promoted the country as an ideal site for U.S. assembly plants, François Duvalier suggested that “Haiti could be a great land of relaxation for the American middle class—it is close, beautiful, and politically stable” (Trouillot 1990:200).

By 1970, the annual number of visitors was close to 100,000; not counting brief layovers and “afternoon dockings,” the annual tally had risen to 143,538 by 1979. Club Méditerranée opened its doors the following year (Barros 1984:750). It seemed as if tourism had arrived.

Indeed, the industry, it was predicted, would soon supplant coffee and the offshore assembly plants as the capital's chief source of foreign exchange. But the effects of the "AIDS scare" were dramatic and prompt : the Haitian Bureau of Tourism estimated that tourism declined from 75,000 visitors in the winter of 1981-82 to under 10,000 the following year. In 1983-84, during the season following the risk-grouping and spate of articles in the popular press, even fewer tourists came to Haiti. Six hotels folded, and as many more declared themselves on the edge of bankruptcy. Several hotel owners were rumored to be planning a lawsuit against the CDC.⁶

Of course fluctuations in tourism and trade may be attributed to many factors, but there was little doubt in Haiti about the cause of the collapse: Haiti had been accused of "starting the AIDS epidemic." To cite Abbott (1988:255) once again: "AIDS stamped Haiti's international image as political repression and intense poverty never had." "Already suffering from an image problem, Haiti has been made an international pariah by AIDS," concluded one 1983 report. "Boycotted by tourists and investors, it has lost millions of dollars and hundreds of jobs at a time when half the work force is jobless. Even exports are being shunned by some" (Chaze 1983:41).

Tourism and poverty did bring something of lasting significance, however: institutionalized prostitution. As one physician-author put it, "This country had—as far as promiscuity was concerned—replaced Cuba" (Météllus 1987:90). And as Haiti became poorer, both men's and women's bodies became cheaper. Although there have been no quantitative studies of Haitian urban prostitution, it was clear that a substantial sector of the trade catered to tourists, and especially North Americans. Some portion of the tourist industry catered specifically to a gay clientele:

During the past five years Haiti, especially Port-au-Prince, has become a very popular holiday resort for Americans who are homosexual. There are also Haitians who are homosexual, and homosexual prostitution is becoming increasingly common.... For the young Haitian male between the ages of fifteen and thirty there is no likelihood of escaping the despair that abounds in Port-au-Prince. As elsewhere, those with money can purchase whatever they want. (Greco 1983:516)

Although not all gay sex was prostitution, the deepening poverty of Haiti helped to ensure that money played an inordinant role in even "voluntary" same-sex relations: "With the help of money," writes d'Adesky, "what existed as gay life in Haiti in the '60s and '70s flowed like a dream." In a report recently filed in *The Advocate*, d'Adesky writes of "hotels that catered to a gay clientele," of "discreet fucking rooms" in tourist hotels, and of slum houses that "would be emptied for a price and arrangements made." She continues by citing a North American participant in Haiti's "once-flourishing gay subculture."

"There was a gay life that was very gala and that involved various sectors of society," said AIDS activist Stephen Machon, a former resident of Haiti who saw the tail end of what some call Haiti's gay golden period. "There would be the gay guys and the working boys and the tourists, of course, and the parties would be just fabulous. Some of it took place in the streets,

but a lot went on behind the courtyard walls. You could lead a very flamboyant life-style within certain limitations, and it was wonderful.” (d’Adesky 1991:31)

During the AMH-sponsored conference in 1983, one Haitian-American researcher read aloud from the pages of the 1983 *Spartacus International Gay Guide*, in which Haiti was enthusiastically recommended to the gay tourist: handsome men with “a great ability to satisfy” are readily available, but “there is no free sex in Haiti, except with other gay tourists you may come across. Your partners will expect to be paid for their services but the charges are nominal.” Another advertisement, which ran in *The Advocate*, assured the prospective tourist that Haiti is “a place where all your fantasies come true” (Moore and LeBaron 1986:82).

It was not long before interviews with Haitians with AIDS revealed their sexual contact with gay men from North America. In a key paper published in 1984, Guerin and coworkers from Haiti, North America, and Canada stated that “17 percent of our patients had sexual contact with [North] American tourists” (Guerin et al. 1984:256). Murray and Payne (1988:25-26) question the relevance of gay tourism in the Haitian AIDS epidemic: “Insofar as gay travel can be estimated from gay guidebooks, Haiti was one of the least-favored destinations in the Caribbean for gay travelers during the 1970s and the less-favored half of the island of Hispaniola.”⁷ His assessment is based only on “frequency of listing in gay guidebooks,” surely a less significant indicator of the relevance of such tourism than the cluster studies which revealed direct sexual contact between Haitian men and North American gay tourists. It is important to note that the introduction of an epidemic of sexually transmitted disease need not involve some critical mass of sexual contact, but requires only that the infectious agent be introduced into a sexually active population (in this case, Haitian men). The Guerin et al. (1984) study makes this clear. Interestingly, Murray and Payne cite, an American journalist’s interview with Guerin and not the research published in *the Annals of the New York Academy of Science*: “At the Haitian end of the hypothesized transmission vector, Dr. Jean-Michel Guerin of GHESKIO told [journalist Anne-Christine] d’Adesky that ‘all his patients—without exception—had denied having sex with tourists.’” Yet the *Annals* article, which brought together the research of ten physicians representing research centers in Haiti, the United States, and Canada, clearly specifies which patients acknowledge sexual relations with gay tourists from North America.⁸

The existence of tourism, some of it gay, does not of course prove that such commerce was “the cause” of the Haitian AIDS epidemic, nor is it my intention to argue that it does. Such commerce does, however, throw into relief the ties between Haiti and nearby North America, ties not mentioned in early discussions of AIDS among Haitians, which often posited “isolated Haiti” as the *source* of the pandemic. In fact, a review of even the scholarly literature on Haiti would leave the impression that the country is the most “isolated” or “insular” of Caribbean countries. In an assessment resonant with the U.S. medical community’s AIDS-related speculations, the author of one standard text remarks that “Haiti in 1950 was in general what it had been in 1900: a preindustrial society inhabited by ignorant, diseased peasants oblivious to the outside world” (Langley 1989:175). A more attentive study of Haiti’s economy reveals that the nation has long been closely tied to the United States. In fact, Haiti plays an interesting role in what Orlando Patterson has termed the “West Atlantic system,” an economic network

encompassing much of the Caribbean basin and centered in the United States:

Originally a region of diverse cultures and economies operating within the framework of several imperial systems, the West Atlantic region has emerged over the centuries as a single environment in which the dualistic United States center is asymmetrically linked to dualistic peripheral units. Unlike other peripheral systems of states—those of the Pacific, for example—the West Atlantic periphery has become more and more uniform, under the direct and immediate influence of the all-powerful center, in cultural, political and economic terms. Further, unlike other peripheral states in their relation to their centers, the West Atlantic system has a physical nexus in the metropolis at the tip of Florida. (Patterson 1987:258)

The Caribbean nations with high attack rates of AIDS are all part of the West Atlantic system. A relation between the degree of “insertion” in this network and prevalence of AIDS is suggested by the following exercise. Excluding Puerto Rico, which is not an independent country, the five Caribbean basin nations with the largest number of cases by 1986 were as follows: the Dominican Republic, the Bahamas, Trinidad/Tobago, Mexico, and Haiti. In terms of trade, which are the five countries most dependent upon the United States? Export indices offer a convenient marker of involvement in the West Atlantic system. In both 1983 and 1977, the years for which such data are available, the same five countries were’ most linked to the United States economically—and they are precisely those countries with the largest number of AIDS cases.⁹ And the country with the most cases, Haiti, was also the country most fully dependent on U.S. exports. In all the Caribbean basin, only Puerto Rico is more economically dependent on the United States. And only Puerto Rico has reported more cases of AIDS to the Pan American Health Organization.

To understand the West Atlantic AIDS pandemic, a historical understanding of the worldwide spread of HIV is crucial. The thesis that evolving economic forces run parallel to the lineaments of the American epidemics is confirmed by comparing Haiti with a neighboring island, Cuba, the sole country in the region not enmeshed in the West Atlantic system. In Haiti, as we have seen, several epidemiological studies of asymptomatic city dwellers reveal HIV seroprevalence rates of approximately 9 percent. In 1986 in Cuba, only 0.01 percent of 1,000,000 persons tested were found to have antibodies to HIV (Liautaud, Pape, and Pamphile 1988:690). Had the pandemic begun a few decades earlier, the epidemiology of HIV infection in the Caribbean might well have been different. Havana, once the “tropical playground of the Americas,” might have been as much an epicenter of the pandemic as Carrefour.