



**Implementing the Internationally Agreed Goals and Commitments with regard to
Public Health: HIV in Latin America and the Caribbean**

**Background Assessment to the
Economic and Social Council (ECOSOC) Annual Ministerial Review (AMR)¹**

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Table of Contents

Abbreviations and Acronyms	3
Executive Summary	4
1. Halfway between UNGASS (2001) and the Millennium Development Goals (2015): HIV in Latin America and the Caribbean	7
1.1 Latin America	8
1.2 Caribbean	10
1.3 Prevention	11
1.4 Treatment, care and support	16
1.5 Stigma and Discrimination	18
1.6 Institutional Response	21
2. Gaps and Challenges in the Response to HIV	25
2.1 Public perception of development challenges	25
2.2 Under-addressed issues	27
2.3 ‘Scratching the surface’ of integrated development programming	31
2.4 Care, Treatment and Support	32
2.5 Stigma and discrimination	35
2.6 Institutional response	36
3. The Way Forward: Meeting the Internationally Agreed Development Goals (IADGs)	42
3.1 Maintaining Interest in HIV	42
3.2 Maintaining Strategic Investment in HIV	42
4. References	48



ABBREVIATIONS & ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ARV/ART	Antiretroviral Treatment
CAREC	Caribbean Epidemiology Centre
CARICOM	Caribbean Community Secretariat
CRSF	Caribbean Regional Strategic Framework
DU	Drug User
ECLAC	Economic Commission for Latin America and the Caribbean
ECOSOC	Economic and Social Council
EU	European Union
FSW	Female Sex Workers
GDP	Gross Domestic Product
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV	Human Immunodeficiency Virus
IDU	Injecting Drug User
MARP	Most-at-Risk Population
M&E	Monitoring and Evaluation
MOH	Ministry of Health
MSM	Men Who Have Sex with Men
MSW	Male Sex Workers
NAP	National AIDS Program
NGO	Non Governmental Organisation
NSP	National Strategic Plan
OVC	Orphans and Vulnerable Children
OECS	Organisation of Eastern Caribbean States
PAHO	Pan-American Health Organisation
PANCAP	Pan Caribbean Partnership on HIV/AIDS
PASCA	Programa para fortalecer la respuesta en Centro América al VIH
PEPFAR	(US) President's Emergency Plan for AIDS Relief
PLHIV	People living with HIV
STI	Sexually Transmitted Infections
TOR	Terms of Reference
UNAIDS	Joint United Nations Program on HIV/AIDS
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
USAID	United States Agency for International Development
WHO	World Health Organisation



Executive Summary

Countries of Latin America and the Caribbean (LAC) have been faced with a range of co-existing HIV epidemics: from the low level epidemic in Cuba to the generalised epidemics in Haiti and the Bahamas; with predominance of concentrated epidemics throughout the region. While these variances are also noted among in-country responses, significant strides have been made in stabilizing the epidemic in many parts of the region, albeit at high prevalence in some countries; in preventing mother-to-child- transmission of HIV; in the provision of life-saving treatment to those who need it; in attracting international resources; and in mobilizing the highest levels of political commitment. Among these advances, there is still room for improvement.

Across the region, unprotected sex constitutes the main mode of transmission of HIV, with disproportionate impact on most-at-risk groups (men who have sex with men (MSM), sex workers (SW) both male and female, and their clients, and injecting drug users²) and affecting specific vulnerable groups such as women, non injecting drug users, prison populations, migrants, ethnic and indigenous populations and youth. Additionally, transmission from mother child still remains a threat for thousands of children in the region despite the progress made in the recent years. However the impact noted is not matched by comprehensive HIV prevention, care and treatment programmes that reach these groups effectively. Additionally, existing efforts are further undermined by a lack of timely data upon which to design and/or adapt evidence-based programming. Furthermore, persistent social norms, beliefs and legal and policy barriers combine to create highly-stigmatized environments, where discrimination, homophobia and violence against certain groups thrive, augmenting the impact on those already at high risk for HIV infection.

Worldwide, the international community responded convincingly to the need for increased resources to curb the spread of the epidemic, as the period 2001-2007 noted a six-fold increase in funding for low- to middle-income countries. However, the pace of the epidemic and costs associated with mounting an effective response continues to

² Most-at-risk populations are groups of people with higher concentration of behaviors that lead to HIV transmission. These behaviors include high rates of unprotected sexual partnerships, unprotected anal sex with multiple partners, and injecting drugs with shared equipment and drug preparations. Population groups where these behaviors are concentrated include men who have sex with men, female sex workers and their clients, and injecting drug users. These behaviors provide the basis for identifying and prioritizing public health interventions for these populations. Most-at-risk populations are not discrete categories: there are overlapping risk practices of multiple unprotected partnerships, unprotected anal sex, sex work and injecting drug use.

Vulnerable populations are groups that due to biological, environmental or socio-cultural factors have limited or no control over exposure to hazardous or risky situations. These people may not be frequently exposed to risk, but if the exposure occurs they have less power to avoid it or to lessen its damaging effects. Populations vulnerable to HIV include those without information, those without skills or power to negotiate the terms of sexual encounters (notably young and adult women), people with other sexually transmitted infections, those forced to have sexual intercourse or pressed to become sexually active, those who have sex under the influence of alcohol and drugs, adolescent women, and people whose sexual activities are limited by environmental conditions, such as incarcerated individuals and migrants.



outpace the availability of resources³. The Latin America and Caribbean region has benefited significantly from the unprecedented increase in resources made available globally, with significant inputs from international development banks; bilateral agencies such as the United States and the President's Emergency Plan for AIDS Relief (PEPFAR) and multilateral institutions to include the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM). Across the LAC region, increases in national resource allocations provide demonstrable evidence of the growing commitment to meeting internationally agreed development goals.

However, given the present global financial crisis and corresponding vulnerability of the region's economies, ensuring the most effective use of national and international resources is all the more crucial. While maintaining, let alone increasing current levels of 'investment' in the region's HIV response may soon prove to be a challenge, a renewed commitment to reducing the dependence on external resources; to evidenced-based programming; to preventing new infections; to achieving universal access to prevention, care and treatment; and to ensuring maximum effectiveness of available resources is the way to achieving long-term, sustained success.

It is in this context that the present document makes the following recommendations (Box 1) in working towards the achievement of Internationally Agreed Development Goals (IADGs) with respect to HIV in Latin America and the Caribbean.

³ Joint United Nations Programme on HIV/AIDS (UNAIDS). Report on the State of HIV/AIDS Financing, Revised March 2003



Box 1: Policy Directions – Meeting the Internationally Agreed Development Goals, HIV in Latin America and the Caribbean.

Maintaining 'investment' in HIV: The impact of the global financial crisis is being felt globally and all areas of development practice are no exception. In the context of loss of employment, loss of income and the collapse of financial and other institutions, it is even more challenging to maintain interest or priority for HIV, let alone attract increased and/or the same levels of human and financial resources. All sectors must work to decrease the dependence on external resources, as well as ensure that HIV is kept on the development agenda or risk devastating setbacks in the progress made thusfar.

Improved data: Improved surveillance and the availability and strategic use of data are needed across the LAC region to grasp the full scope of the epidemic and respond accurately. This is particularly relevant in areas that are lagging behind, such as effectively reaching MARP and vulnerable populations. While using programme strategies that work globally, the region must produce relevant data to provide an understanding of local dynamics in order to design/adapt targeted interventions. Moreover, relevant and timely data are only effective if they are used strategically to inform programme decisions.

Evaluation for optimal effectiveness of investment: Quite apart from the need for relevant, timely and adequate analysis and use of data, commitment to a long-term-sustained response demands analysis of the allocation and utilization of resources, over and above the achievement of indicators that is currently addressed by current monitoring and evaluation frameworks. Such analysis is critical to maximizing the effectiveness of the resources invested.

Strengthening public health systems: Fragmentation of public health services acts as a barrier to effective HIV programming and service delivery. Vertical HIV programmes, that is, programs that target specific diseases and/or populations, while appropriate for emergency situations, are not sustainable and do not take advantage of synergies with other development issues or available resources. The need for integrated public health systems involves not only the need for more resources, but also the more effective use of existing resources that have been committed; improving management capacity and systems; and integration of HIV specific services and interventions into already existing service delivery mechanisms, moving these services to the most peripheral level of care. Integrated public health systems improve accessibility of services; quality of services; more efficient use and management of resources and increased public confidence.

Addressing stigma and discrimination - social and systemic- from a human rights perspective: After two decades of the epidemic, stigma and discrimination continue to undermine critical progress made in the region in areas such as HIV prevention and care, treatment and support. Stigma and discrimination towards people living with HIV as well as MARP groups are not specific to HIV, but rather form part of social organization processes and are closely linked to values and belief systems. They are often reinforced by institutional structures that mirror the values and beliefs of the majorities or of the sectors that hold social control. As such, an **integrated and consistent approach to social justice and human rights programming** that also addresses public opinion, is critical in addressing HIV-related stigma and discrimination.



Box 1: Policy Directions – Meeting the Internationally Agreed Development Goals, HIV in Latin America and the Caribbean (cont'd)

Impact of the epidemic on women: Available data indicate a significant impact on women, particularly young women, in LAC. Apart from women's biological vulnerability to HIV transmission, this trend is a reflection of other deep-seated development issues such as gender inequality, socioeconomic disparity and a lack of empowerment of women in society. Programmes aimed at comprehensive sexual health education, decreasing risk-taking and vulnerability and improving the quality of life of women must be strengthened in order to impact their vulnerability to HIV.

Impact of the epidemic on MSM and transgender, SW, IDU and clients of SW: Across the region, most-at-risk populations such as MSM, SW and their clients and IDU bear the greatest burden of HIV. However, this is not reflected in available data on these groups, or in targeted programmes that involve these populations and challenge the factors that fuel their risk-taking behaviour. As such, evidence-based programmes that target those most at risk must be scaled up urgently, if the region is to note significant progress towards internationally agreed development goals (IADGs).

Prevention: increasing coverage and comprehensiveness-

- Significant increases will be required in prevention coverage as a key component to reducing infections, particularly among most-at-risk populations, for which prevalence rates are significantly higher across the region, as well as specific vulnerable populations such as prisoners, drug users and women. But prevention programming cannot be undertaken in a vacuum, but rather depend on social and legal infrastructure to work. As such, there is also need for balanced attention to comprehensive prevention, care and treatment programming at the national level that is: i) evidenced-based and ii) addresses the social, infrastructural and legal factors and barriers that underpin risk-taking and vulnerability
- PMTCT: it is important to prioritise the regional initiative for the elimination of vertical transmission of HIV and congenital syphilis.
- Take advantage of opportunities to integrate HIV into sexual and reproductive health education and comprehensive services. This includes strengthening sexual education for young people and adolescents.

Improving and enhancing collaborative responses for HIV/TB co-infection: Greater awareness is needed of the interlinked epidemics of HIV and tuberculosis. Given that tuberculosis (TB) is one of the leading causes of death among people living with HIV globally, there is urgent need for integrated TB and HIV services. Improved collaboration between TB and HIV programmes will lead to more effective prevention and treatment of TB among people living with HIV and to significant public health gains. Necessary collaborative actions include: HIV testing and counseling to all TB patients; screening all PLHIV for TB disease; provision of TB treatment or preventive therapy to all co-infected persons; provision of cotrimoxazole and ARV treatment to all TB patients and; ensuring TB infection control in all health care facilities and high HIV prevalence settings.



1. Halfway between UNGASS (2001) and the Millennium Development Goals (2015): HIV in Latin America and the Caribbean

In June 2001, twenty years after the disease was first detected, the global response to HIV noted a key milestone in the endorsement of the United Nations General Assembly Special Session (UNGASS) Declaration of Commitment on HIV/AIDS. The Declaration marked a critical step in the political momentum to comprehensively address the disease, and in the global recognition of the impact of the epidemic to human development, and set time-bound targets for the response at national, regional and global levels. The United Nations Member States committed to submitting UNGASS country reports every two years against agreed indicators. This document will draw heavily on country reports submitted against these indicators among other data sources and in particular, data as they relate to treatment, care and support, stigma and discrimination and the institutional response to the epidemic in the LAC region.

A number of key global agreements either preceded or would follow, which either focused specifically or included global HIV targets and agreed principles. These include:

- The Millennium Development Goals (MDGs), adopted in 2000, which call for the reversal of the epidemic by 2015; and
- The “3 by 5” Initiative, launched by the WHO and UNAIDS in 2003, which aimed to provide three million people living with HIV in low- and middle-income countries with antiretroviral treatment by the end of 2005.

Critical agreements that followed include broader goals for Universal Access to prevention, care and treatment services as a human right by 2010, which include globally agreed indicators against which governments have agreed to report to the UN Secretary General:

- In 2004 the “Three Ones” principles were adopted in support of multisectoral responses at the national level, which called for one agreed HIV Action Framework; one national HIV Coordinating authority and; one agreed country-level monitoring and evaluation system
- In June 2007 the United States and other G8 nations set ambitious goals to collectively support treatment for a total of 5 million HIV-infected individuals, prevent 24 million new infections, and care for 24 million people, including 10 million orphans and vulnerable children, as well as to cut malaria-related deaths by 50 percent in 30 countries;
- In August 2008, Ministers of Health and Education of LAC signed a Ministerial Declaration in Mexico that outlined efforts and 2015 targets aimed at strengthening comprehensive and multisectoral prevention approaches to sexuality education.



Countries in Latin America and Caribbean are signatory to the above internationally agreed development goals (IADGs). The status of the region's epidemic is summarized in the following section, using, among other data sources, country reports submitted to the 2008 UNGASS on HIV/AIDS.

1.1 Latin America

South America

In a number of **South American** countries, the main mode of HIV transmission according to available information is through unprotected sex, with higher prevalence noted among men who have sex with men (MSM), as well as among sex workers and injecting drug users.

By the year 2006, 23% of reported AIDS cases in Latin America were categorized to have resulted from unprotected anal intercourse between men^{4 5}. In the same year across the Region, the ratio of male: female reported HIV infection stands at 2–3:1. In Brazil, what began as a disease among MSM spread to injecting drug users (IDU), increasingly affecting lower risk sexual partners of IDU and reaching out into the general population. Brazil then noted a growing epidemic among women, who become infected as a result of unprotected sex with a male partner who may have engaged in unprotected sex with another man or through non-sterile injecting equipment. High prevalence among MSM contribute significantly to the country epidemics, with prevalence as high as: 14% in Buenos Aires (Argentina) in 2000-2001 sentinel surveillance reports; 22% in Uruguay (Montevideo); 22% in La Paz (Bolivia); and between 18% to 22% in Peru in studies conducted between 1996 and 2002⁶. While undoubtedly, stigma and discrimination have hampered efforts at reaching this populations through prevention, care and treatment interventions, countries such as Chile have recognised that much more research is needed on the MSM population in order to deliver effective programmes, while Bolivia notes low health service coverage in studies conducted in 2005 (less than 3% of MSM had access to services to help prevent HIV and other sexually transmitted infections, as compared to 30% service coverage for sex workers). The vulnerability of women whose partners engage in bisexual activity is also noted throughout Latin America in countries including Brazil, Chile and Peru, Guatemala, Nicaragua and Honduras to name a few.⁷.

⁴ It is important to underscore that the sexual behaviors and practices that are associated to official data are obtained through self-report. This becomes particularly relevant in countries identified as having a "heterosexual epidemic" and yet the male to female ratio of infection seems to disagree with this.

⁵ Pan American Health Organization, World Health Organization, UNAIDS (2007). *HIV and AIDS in the Americas. 2007. Report: The evolving epidemic, response and challenges ahead*. Washington, United States, PAHO, September 2007.

⁶ Joint United Nations Programme on HIV/AIDS (UNAIDS)/ World Health Organisation (WHO) (2007). *Latin America AIDS Epidemic Update Regional Summary 2007*

⁷ Ibid.



Additionally, unprotected paid sex between men, as well as paid heterosexual sex, plays a significant role in HIV transmission. In Paraguay, prevalence rates of 11% among male sex workers and 1.8% to 2.6% among female sex workers in 2006 indicates this. High syphilis rates, 13% among male sex workers and 19% among female sex workers, point to low levels of condom use and poor access to sexual health services. Also indicative of poor access to sexual health services, high prevalence of other sexually transmitted infections was also noted in El Salvador (15% of female sex workers were infected with syphilis and 11% with gonorrhoea), Guatemala (12% syphilis and 11% gonorrhoea prevalence) and Nicaragua (8% syphilis and 9% gonorrhoea prevalence).

HIV transmission through injecting drug use appears to be decreasing in countries such as Brazil and Argentina, where in the case of Brazil, harm reduction programmes appear to have yielded some success, combined with the trend to move from injecting to inhaling drugs, as is also the case in Argentina. Harm reduction programming is challenged in Argentina though, as injecting drug use is a hidden practice, making outreach difficult. However, in Uruguay, it is suspected that up to 18% of infections are a result of injecting drug use. A similar trend is noted in Asunción, Paraguay, where as many as 12% of injecting drug users tested positive for HIV.

Central America

In **Central America**, the response to the epidemic suffers from inadequate surveillance systems and relevant data⁸. Available data indicates that main modes of transmission are unprotected sex between men and unprotected paid sex. The epidemic is marked by hidden epidemics of men who have sex with men (MSM) in Belize, Costa Rica, El Salvador, Guatemala, Nicaragua and Panama, and Honduras, which all experience high prevalence rates⁹. In a 2002 study, when compared to adult prevalence rates, prevalence among MSM was as much as seven times higher in Honduras, ten times higher in Guatemala and Panama, 22 times higher in El Salvador and 38 higher in Nicaragua. High levels of knowledge of HIV prevention even among MSM are contradicted and undermined by myths and misinformation about transmission. This is exacerbated by low levels of condom use among MSM and male sex workers (MSW) in Guatemala and Nicaragua. HIV prevalence is also significant among female sex workers in Honduras (10%), Guatemala (4%) and El Salvador (3%). Migration also represents a vulnerability factor in the Central American epidemic, where both legal and illegal migration creates opportunities for sexual exploitation of both men and women.

Given the impact on the MSM population coupled with the hidden nature of sex between men, the region also suspects an increasing vulnerability of women whose partners

⁸ Joint United Nations Programme on HIV/AIDS (UNAIDS)/ World Health Organisation (WHO) (2007). *Latin America AIDS Epidemic Update Regional Summary 2007*.

⁹ Soto,RJ et al (2007). *Sentinel Surveillance of sexually transmitted infection/HIV and risk behaviours in vulnerable populations in five Central American countries*. *Journal of Acquired Immune Deficiency Syndrome*. 46, 101-11. As referenced in UNAIDS/WHO 2007.



engage in unprotected sex with other men. Additionally, high prevalence rates for other STIs indicate an urgent need for strengthened access to basic sexual health services for men and women.

The HIV epidemic in Mexico is concentrated among men who have sex with men with a male: female case ratio of 5:1¹⁰, sex workers and their clients, and injecting drug users. Mexico has an estimated 200,000 PLHIV, of whom 125,000 are MSM. Transmission among men who have sex with men accounts for 57% of HIV infections and prevalence rates are as high as 20% in Guadalajara, compared to adult prevalence in the general population of 0.3%. Prevalence rates among IDU in border cities such as Tijuana and Ciudad Juarez range from 2% to 4% and as much as 85% of injecting drug users report using non-sterile syringes¹¹. High prevalence rates are also noted among female sex workers who are injecting drug users.

1.2 Caribbean

Adult HIV prevalence in the Caribbean is estimated at 1.1% (1.0% - 1.2%), double that of Latin America (0.5%) and almost double the rate of North America (0.6%). The sub-region therefore bears the greatest burden of the disease in the Americas, with Haiti and the Dominican Republic accounting for approximately 70% of the estimated 230,000 persons living with HIV in the Caribbean.¹²

Approximately 20,000 new infections occurred in the Caribbean in 2007. Put in perspective, this represents almost 1% of the total global HIV infections for the same year. As can be expected, epidemics vary from country to country, as do prevalence rates, where the Bahamas notes the highest prevalence rate at 3%, while Cuba has the lowest at 0.2%. Apart from the Bahamas and Haiti with generalised epidemics, HIV prevalence in the general population continues to be high in many countries such as Guyana at 2.5%, Suriname at 2.4%, Belize (2.1%), Jamaica (1.6%), Trinidad and Tobago (1.5%), Barbados (1.2%) and the Dominican Republic (1.1%).

The main mode of HIV transmission is unprotected sex. There are a number of areas of special concern among the trends in the Caribbean epidemic. One of them is the impact among women, and more specifically, the significant impact on young women. UNAIDS/WHO estimate that the percentage of women living with HIV increased by almost 40% over the two decades and now leveling off in the past five years to 48%.¹³

¹⁰ WHO/UNAIDS/UNDP (2009). Prevention and treatment of HIV and other sexually transmitted infections among men who have sex with men and transgender populations. Report on a technical consultation 15-17 September, 2008. Geneva, Switzerland.

¹¹ White EF et al (2007). Prevalence of hepatitis C virus and HIV infection among injecting drug users in two Mexican cities bordering the US *Salud Publica Mexico*, 49(3): 169-172. As referenced in UNAIDS/WHO 2007.

¹² UNAIDS, Caribbean Regional Support Team (CAR-RST). Keeping Score II: A Progress Report towards Universal Access to HIV Prevention, Treatment, Care and Support in the Caribbean. Vol. 2. 2008b

¹³ While present analysis of the impact on women is limited as it does not examine conditions in five-year periods, the 40% increase over the 17 years is still instructive.



This underscores the need to clearly identify and address the factors that underpin women's socioeconomic vulnerability to infection, while acknowledging their biological vulnerability, but also gains increased significance considering that 50% of Caribbean households are female-headed¹⁴.

An estimated 800,000 live births take place in the Caribbean annually. While the Caribbean region has an estimated 0.9 – 1.2% adult HIV prevalence, mother-to-child transmission of HIV constitutes an estimated 8-10% of all HIV transmissions in the Caribbean (UNAIDS, 2008). The estimated HIV prevalence among pregnant women in the Caribbean is 1.1%. Without intervention an estimated 2200 – 3000 children will be born with HIV infection in the Caribbean each year.

Also worth noting is the disproportionate impact of the epidemic among most-at-risk populations, MSM and sex workers and their clients, while noting the paucity of available data on clients of sex workers. The impact is also noted on vulnerable groups such as prisoners and crack cocaine users. Injecting drug use is not a significant mode of HIV transmission in the Caribbean region. For the period 2005 - 2007, prevalence rates among MSM in five Caribbean countries ranged from 6.70% (Suriname) to as high as 21% in Guyana. Similarly, some of the highest prevalence rates among female sex workers ranged from 2.7% in the Dominican Republic to 26.6% in Guyana. The high prevalence in the above-mentioned groups also impacts the epidemic in the general population. These data signal the urgent action required in reaching these groups through prevention, care and treatment interventions in order to achieve universal access. It has been widely recognised that outreach to MARP in particular, is made difficult by social taboos, stigma and institutional mechanisms that drive these groups underground. The fact that sex between men and sex work is illegal in the English-speaking Caribbean (with the exception of the Bahamas) reinforces the social stigma that weighs heavily on these groups, and impedes disclosure and health-seeking behaviour.

1.3 Prevention

Prevention of HIV infection is a critical component halting and even of reversing the HIV epidemic. The world's inadequacy to significantly avert the impact of HIV-related morbidity and mortality by investment in prevention and health care systems in the early years, particularly in low- to middle-income countries becomes evident in the prevalence and estimated incidence figures we currently are faced with. For that reason, communities, countries and global actors must be relentless in ensuring that targets are met to avert further disaster in the next ten to twenty year period. UNAIDS estimates that a comprehensive, scaled-up, HIV prevention response would avert more than half of all new infections that are projected to occur between 2005 and 2015. Taking the Caribbean as an example where for every five people put on antiretroviral treatment in

¹⁴ Report of the Caribbean Technical Expert Group Meeting on HIV Prevention and Gender, (2004) as cited in UNAIDS 2008b.



2007, ten were newly infected¹⁵, unless new infections can be prevented, future treatment and other costs will continue to mount.

It goes without saying therefore, that significant increases will be required in prevention coverage as a key component in the achievement of universal access goals. In the absence of effective preventive approaches and strategies at the national level it is practically impossible to have sustainable and efficient treatment and care programs. . A key unpinning factor of all prevention programming is the selection of relevant prevention strategies and approaches according to national conditions. Evidence of the socio-economic and behavioural contexts that in turn inform prevention programming is pivotal for undertaking optimally effective prevention efforts. While the extent to which informed research guides prevention programmes in the LAC region differs from one country to another, the above data clearly point to a persistent failure to reach many people at high risk of exposure to HIV, including men who have sex with men, sex workers and injecting drug users. As a result, while recognising the multifaceted nature of prevention efforts that is necessary in reducing the number of new HIV infections for the LAC region, namely among young people, in-and out-of-school youth, workplace interventions, women and other general population-based interventions, the present document will focus on populations most at risk of infection that are of particular relevance for the region.

The relevance of most-at-risk populations to the region is that in certain groups there may be a concentration of risk behaviours that facilitate efficient HIV transmission that would in turn then drive the majority of new infections. Behaviours that put people at greater risk of HIV infection include high rates of unprotected sexual partnerships, unprotected anal sex with multiple partners, and injecting drugs with shared equipment and drug preparations. Thus, population groups where these behaviours are concentrated include:

- Female sex workers (FSWs);
- Clients of FSWs;
- Injecting drug users (IDUs); and
- Men who have sex with men (MSM).

These behaviours provide the basis for prioritizing interventions to those populations thought to be at highest risk of acquiring and transmitting HIV, in which human rights and non-discrimination elements must be essential components of these interventions. This focus is clear in low-level and concentrated epidemic settings, but it is also well documented that there are countries with high prevalence epidemics where there is also a need for prevention, care and treatment interventions among people who are engaging in these most-at-risk behaviours.

¹⁵ UNAIDS (CAR-RST) 2008b.



Throughout the region, though some improvements have been noted, national reporting on UNGASS indicators demonstrates that prevention service delivery for populations most at risk is inconsistent and highly variable within and between regions. Although significant percentages of these populations can correctly identify the means to prevent sexual HIV transmission, many lack access to essential prevention services, such as condoms and sterile needles.

Prevention programmes will not be optimally effective unless they are supported by effective initiatives to address the social factors that increase vulnerability and risk-taking behaviour, including gender inequality, lower access to health care services, HIV stigma and discrimination, concealment of issues related to sexuality and sexual health, and the social marginalization of the populations most at risk of HIV exposure. This is further undermined in LAC by laws and policies that act as barriers to access prevention and other services, as is the case with the criminalization of sex work in many countries of Latin America and in the Caribbean and additionally, the criminalization of sex between men in the Caribbean, as well as homophobic attitudes of the society at large. As is explored in further detail in the present document, repealing these legal barriers, as part of comprehensive rights-based and social justice programming is a critical enabler for effective scale-up of prevention programmes and promoting access to prevention services.

HIV prevention and most-at-risk groups

Despite high levels of knowledge of HIV transmission among MSM in countries such as Guatemala and Nicaragua, myths, low levels of condom use and limited access to condoms undermine this knowledge. In Mexico, less than 25% of MSM have access to condoms¹⁶, while in Cuba just over 50% of MSM report using a condom at last sex¹⁷. Only three Caribbean countries (Guyana, Cuba and the Bahamas) reported on the percentage of MSM that are reached by HIV prevention programmes. This is a clear indication of deficiencies in prevention coverage, as well as a significant barrier to achieving universal access to prevention. Cuba noted 56% of MSM reached through HIV prevention, the Bahamas 46%, and Guyana 17%. Significant deficiencies are also noted in country reports on the percentage of men who have sex with men who correctly identify ways of preventing the sexual transmission of HIV and who reject misconceptions about HIV transmission. While over 60% of Caribbean countries did not report on this indicator, those that reported noted that myths still dominate knowledge of HIV transmission. These myths should be understood fully and addressed through targeted prevention efforts. Additionally, the paucity of data on size, knowledge and practices of transgender populations throughout the LAC region further underscores the need for targeted research and appropriate prevention interventions.

¹⁶ Joint United Nations Programme on HIV/AIDS (UNAIDS) 2008(a). 2008 Report on the Global AIDS Epidemic. P.110

¹⁷ Joint United Nations Programme on HIV/AIDS (UNAIDS) 2008(a). 2008 Report on the Global AIDS Epidemic. P.110



Similar data limitations on size as well as obtaining data that is truly representative of country situations are also noted for MSM populations in LAC. Even with these data limitations, higher percentages of MSM were reported to have been reached through prevention activities in some countries in Latin America, with Mexico reporting 54.9% MSM reached; 44.5% in Peru; 72.67% (under 25 years) and 79.01% (over 25 years) in Guatemala. While there was no national level data on the percentage of MSM reached for Colombia and Brazil, in the case of Brazil, studies are being conducted to assess knowledge, attitudes and practices for MSM, SW and IDUs. Similarly, higher percentages were noted for MSM correctly identifying ways of preventing HIV transmission. 2004 studies in Brazil noted that 66.7% of MSM correctly identified ways of preventing HIV transmission, while the 2008 reports cited 87.1% in Colombia among MSM over 18 years old and 65.5% in Mexico. The disparity between the reach of prevention programmes and knowledge was noted in data reported for Guatemala and Peru. In the case of Guatemala, while 72.67% (under 25 years) and 79.01% (over 25 years) of MSM were reached with prevention, only 30.62% (under 25 years) and 36.21% (over 25 years) MSM correctly identified ways of preventing HIV transmission. The disparity while less dramatic for Peru, still demonstrated relatively low levels of knowledge of prevention of HIV transmission with 40.2% of MSM correctly identifying ways of HIV prevention.

Prevention among sex workers is challenged not only by factors such as social stigma, legal barriers to access and migration, but also by the very complexity that exists in the definition of sex work. While grouping together male, female and transgenders, this population also encompasses persons who may not self-identify as sex workers, engaging in transactional sex in exchange for a particular gain or commodity. The overlap between sex work and drug use is yet another dynamic that adds to the complexity of required prevention interventions. In a study of the relationship between IDU and sex work in the Mexican cities of Tijuana and Ciudad Juarez, it emerged that among female sex workers (FSWs) who injected drugs over the period of one month, 52.6% reported using a non-sterile needle, 73.7% reported passing their needles to someone else and 70.3% had shared injection apparatus. HIV prevalence among FSW-IDUs of 12% was more than twice of FSWs who did not inject drugs (5%)¹⁸.

Given this complexity, it is often the case that HIV impacts sex workers differently even within a single large country, as a result of factors such as migration, poverty and urban conditions. In Mexico, prevalence rates among female sex workers (FSW) at the border areas were higher than that of the south and noted for transactional sex and drug use. In the south the epidemic was driven by homosexual and bisexual transmission, as well as unprotected heterosexual intercourse.¹⁹ Such differences make it difficult to generalize

¹⁸ Strathdee, S.A., Lozada, R. Semple, S. J., Orosovich, P., PU, >., Staines-Orozco, H., Fraga-Vallejo, M., Amaro, H., Delatorre, A., Magis-Rodriguez, C. & Patterson, T. L. *Sex Transm Dis*, 35, 263-8. 2008.

¹⁹ Herrera, C., Campero, L. (2002) La vulnerabilidad e invisibilidad de las mujeres ante el VIH/SIDA: constantes y cambios en el tema. *Salud Publica Mex*, 44, 554-564. Izazola-Licea, J.A., Avila-Figueroa, C., Gomez-Fraga, S. (2006) Mexico. In Beck, E. J., Mays, N. Whiteside, A.W., Zuniga, J.M. (Ed.) *The HIV Pandemic, Local and Global Implications*. Oxford, Oxford University Press.



trends, even within one country, let alone across regions. This underscores the need for evidence-based prevention and for targeted interventions that are not only specific to an at-risk group, but are also informed by specificities of geographic location. While there is value in ‘borrowing’ strategies for reaching various groups, it is critical that the data are available to understand the local dynamics and make programme adjustments to address local contexts. Hence it is important to note that while there are broad strategies that are proven to work such as community empowerment that combine the environments in which sex workers live and work²⁰, one size does not fit all and adaptation to a local context is critical.

As previously noted, IDUs are also at significant risk of HIV infection. In Latin America, the greatest impact of HIV on injecting drug users was noted in Argentina, Brazil, Mexico, Paraguay and Uruguay. In Uruguay, it is suspected that up to 18% of infections are a result of injecting drug use, and a similar trend is noted in Asunción, Paraguay, where as many as 12% of IDUs tested positive for HIV. Puerto Rico and Bermuda are the only two countries in the Caribbean that note significant injecting drug use. In the rest of the Caribbean, although data is limited, prevalence as high as 18% were noted among crack cocaine users, mainly in Jamaica, Trinidad and Tobago and St. Lucia.²¹

In Latin America, harm reduction programmes exist in a number of countries to include Argentina, Brazil, Mexico and Uruguay²², although the adoption of these programmes often lacks attention to substitution treatment for drug dependence, signaling the need for scale-up of comprehensive harm reduction. Similar scale-up of research on and programming for drug users is also needed in the Caribbean, to include the overlap with risky behaviours including sex work and sex between men.

If the above components of prevention programming continue to go under-served, efforts at reaching Universal Access Goals of 2010 and the Millennium Development goals will continue to fall short.

HIV prevention and vulnerability

While the present document focuses the discussion of HIV prevention on that among MARP groups and does not seek to exhaustively present prevention in the context of social and environmental vulnerability, a number of priorities are worthy of note. HIV prevention programmes must also address vulnerability to HIV infection such as is

9 &10 As cited in Bastos, F. I., Angulo-Arreola, A. & Malta, M. Sex Work and HIV/AIDS in Latin America and the Caribbean: Challenges and the Ongoing Response

²⁰ UNAIDS 2008a.

²¹ UNAIDS (CAR-RST) 2008b.

²² Harm reduction refers to a programme for HIV prevention for injecting drug users that involves: access to substitution treatment for drug dependence; access to sterile needles and syringes; and linkages with other services to include HIV testing, counseling and antiretroviral treatment. UNAIDS 2008a.



presented by young people and young women in particular, prisoners, migrants, and indigenous groups.

In LAC, children under the age of 15 accounted for about 55,000 and young people 15-24 years of age 400,000 of the estimated 1.9 million (1.7-2.3 million) people living with HIV in 2007. Young people in the region remain vulnerable to HIV and lack the skills, support or the means to adopt healthy behaviours. In Latin America and the Caribbean, only 4% of out-of-school youth have access to prevention services. In some countries in the Caribbean the number of female adolescents between the ages of 15-19 living with HIV/AIDS has been found to be up to five times higher than the number of adolescent males of the same age group. An estimated 7,500 (5,800-10,000) children were newly infected with HIV in 2007 in the region. In addition to their own infection, children and adolescents are also impacted by the epidemic through the death of parents and caregivers. But children orphaned by AIDS are not the only children affected by the epidemic. Particularly in the LAC region, many more children live with parents who are chronically ill, and often suffer discrimination and isolation. Stigma and discrimination against children affected by AIDS continue to be major obstacles and must be addressed in all aspects of the response to the epidemic.

Additionally, the issue of migration both legal and illegal, is of significance, both as a stand-alone issue and to the extent to which it overlaps sex work and increased risk-taking. Poverty often drives people either knowingly to undertake sex work in different geographic areas, or unknowingly, through human trafficking and multitude of other forms of sexual exploitation. One study noting an increase in migration for sex tourism by women from Latin America to Europe's sex industry, documented some 118 sex workers from Colombia and the Dominican Republic living in southern Italy. While seroprevalence rates for this particular group was low, reportedly due to consistent condom use by clients, the extent of the practice and potential for HIV transmission is noted²³. There is also a long history of migration throughout the Americas and also from the LAC region to the United States. Migration was a key driving factor for example in the HIV epidemic in Mexico and in recent studies, migrant Mexican workers practiced more risk-taking behaviours including multiple sex partners and drug use, than did non-migrants for the same period.²⁴ While country situations vary widely throughout LAC, migration trends need to be fully understood and addressed through targeted HIV prevention initiatives.

²³ Nigro, L., LaRocca, L., Celesia, B.M., Montineri, A., Sjoberg, J., Caltabiano, E. & Fatuzzo, F. (2006) Prevalence of HIV and other sexually transmitted diseases among Colombian and Dominican female sex workers living in Catania, Eastern Sicily. *J Immigr Minor Health*, 8, 319-23. As cited in Bastos, F. I., Angulo-Arreola, A. & Malta, M. Sex Work and HIV/AIDS in Latin America and the Caribbean: Challenges and the Ongoing Response. PAHO/WHO 2009 Draft document.

²⁴ Jesus M. Garcia-Calleja, MD, MPH, Carlos del Rio, MD, PhD, and Yves Souteyrand, PhD. HIV Infection in the Americas: Improving Strategic Information to Improve Response. *J Acquir Immune Defic Syndr* _ Volume 51, Supplement 1, May 1, 2009. www.jaids.com



Prevention of Mother to Child Transmission of HIV (PMTCT)

Despite the progress achieved in recent years on prevention of mother to child transmission of HIV, to date in LAC, only half of pregnant women are tested for HIV. From the estimated 36,000 pregnant women in Latin America and the Caribbean living with HIV who need ARV to prevent transmission to their newborns, only an estimated 36% received ARV for PMTCT in 2007²⁵.

Many pregnant women diagnosed with HIV do not have access to essential care and treatment, including antiretroviral therapy for their own health, to further reduce HIV transmission and prevent orphaning. Far too few pregnant women in LAC know their HIV status. Addressing mothers' needs for diagnosis and treatment will improve not only their own overall health but their children's survival. The high antenatal coverage in the Caribbean forms a solid basis and an underutilized opportunity for accelerated expansion of services for prevention of mother-to-child transmission of HIV and syphilis. This underscores the need to prioritise the regional initiative for the elimination of vertical transmission of HIV and congenital syphilis.

1.4 Treatment, care and support

Agreements such as the 'Three Ones' and the 3 by 5 Initiative have prompted greater cohesion in funding approaches and efforts to provide antiretroviral treatment to three million people by 2005. As part of scale-up in treatment access around the world, the Latin America and Caribbean region has also achieved exceptional increases in treatment coverage over the last five years. Between 2006 and 2007, the LAC region achieved a moderate increase in treatment coverage of 13%. Notably, the fact that a number of countries in the region have already achieved high coverage rates would limit the extent to which large increases in coverage would be captured in the period of one year. One might argue that with an overall regional treatment coverage rate of 62% (51% - 70%) the 80% coverage target of 2010 may be easily attainable. However, broad coverage rates mask significantly lower country coverage rates and challenges faced at the country level to meeting IADG goals.

By the end of 2007, 360,000 (320,000 – 400,000) people were receiving antiretroviral treatment in Latin America. The region noted average antiretroviral treatment coverage rate of 64%. Within the LAC region, there are significant country by country differences in coverage levels. Countries such as Brazil, Mexico, Argentina and Costa Rica began making treatment available at a relatively early stage of the epidemic (early to mid-nineties) and have now attained or are close to achieving the 2010 universal access treatment goals of 80% treatment coverage. As such, the region presents great diversity

²⁵ UNICEF, 'Children and AIDS, second Stocktaking Report', UNICEF, New York, April 2008, p. 41.



of treatment contexts, where some countries such as Brazil, having already attained Universal Access goals and are now dealing with the effects of a mature post-HAART epidemic: emergence of chronic viral hepatitis, HIV-associated cancers and other long term non-AIDS related complications, multi-drug resistance and prevention fatigue. At the same time, the pre-HAART scenario is also present, with a high incidence and prevalence of major AIDS-associated opportunistic infections, as a result of late diagnosis, and the consequent missed opportunities for timely ART initiation²⁶.

The Caribbean has noted significant progress in the provision of care treatment and support and improving the quality of life of persons living with HIV. The simple fact that the number of people receiving treatment increased from 4,000 in 2003 to 30,000 (25,000 – 35,000) in 2007 is testimony to that. However, there is no room for complacency even as the region averaged 43% treatment coverage by the end of 2007. Notwithstanding high treatment coverage levels in Cuba (95%), the highest in the Caribbean, among low- to middle-income countries, only two other countries were able to report coverage exceeding 50% (Barbados (73%) and Trinidad and Tobago (58%)). It should be noted that there are difficulties with the data analysis instruments that make the capture of information in small population settings difficult. As such, country data reported for many small island Caribbean states do not permit a full comparative regional analysis in 2008²⁷. Notwithstanding this fact, a review of data reported on UNGASS Indicator #4²⁸ reveals that for the most part, and with the exception of a few countries, the sub-region is still in the early to mid-point stages of meeting the targets of universal access to treatment for those who need it by 2010.

Children receiving antiretroviral therapy

Lack of data is particularly remarkable regarding children. Nevertheless it is estimated that 55,000 children under 15 years of age are living with HIV in the region²⁹ and only 16,500 are receiving ARV treatment³⁰; without treatment half of the children born with HIV will die before their second birthday.³¹ Access to antiretroviral treatment in developed countries has made HIV infection in children a chronic illness associated with a prolonged lifespan and a good quality of life. Without treatment, however, about one third of children who get HIV from their mother die in their first year of life, and 50% die before their second birthday. HIV infection progresses more aggressively in infants than in adults. Early HIV diagnosis and treatment are key to dramatically improve the survival

²⁶ Calleja, T., Vitori, M., & Fitzgerald, D. *Antiretroviral Therapy in the Latin America and Caribbean region: and overview and challenges for the future*. Prepared for PAHO/WHO Draft document.

²⁷ Data presented by Antigua & Barbuda, Aruba, Dominica, Grenada, St. Kitts & Nevis, St. Lucia, St. Vincent and the Grenadines and the Turks and Caicos Islands were not captured using UNICEF/UNAIDS/WHO methodologies and as such do not facilitate harmonisation and full regional analysis.

²⁸ Indicator 4: Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy

²⁹ UNICEF, UNAIDS, WHO and UNFPA, "Children and AIDS: Third Stocktaking Report," New York, Dec 2008

³⁰ UNICEF, 'Children and AIDS, second Stocktaking Report', UNICEF, New York, April 2008, p. 43

³¹ UNICEF, UNAIDS, WHO and UNFPA, "Children and AIDS: Third Stocktaking Report," New York, Dec 2008



rates of children with HIV. As many children in LAC still lack access to antiretroviral therapy (ART), in 2007 alone, an estimated 4,300 (3,200-5,500) children under the age of 15 died of AIDS-related illnesses in the region. Most of these children could have been saved by timely administration of ART. Although the region has seen great advances in the expansion of care and treatment for adults (62% of adults in Latin America in need of treatment received ART in 2007), children continue to fall behind in access to treatment and care - even though HIV progresses more rapidly and aggressively in children than in adults. Children born to HIV positive women are being lost to follow-up after birth due to inadequate tracking systems. The lack of routine testing of sick children of unknown HIV status is also preventing children living with HIV from being identified and to receive the proper care and support. Still there is reason for optimism, as in 2007 in LAC, 16,571 children with HIV received antiretroviral treatment, compared with 10,628 in 2005 - an increase of 56%.

HIV/TB Co-Infection

Although preventable and curable, tuberculosis (TB) is one of the leading causes of death among people living with HIV globally. In the Americas the estimated HIV prevalence in incident TB cases was 11.3% for 2007, representing the second highest rate in the world after Africa. For many years efforts to tackle TB and HIV have been largely separate, despite the overlapping epidemiology. There is need for increased awareness of the interlinked epidemics and the need for integrated HIV and TB services. The international community recommends a number of collaborative HIV/TB initiatives that have been initiated in countries of the Americas to include: the establishment of mechanisms for collaboration; decreasing the burden of TB among PLHIV; and decreasing the burden of HIV among TB patients. However, greater efforts and commitment are needed to fully improve collaboration between TB and HIV programs. This will contribute significantly to more effective prevention and treatment of TB among people living with HIV and vice versa and to tangible public health gains.

1.5 Stigma and Discrimination

HIV-related stigma and discrimination has had crippling effect on the global epidemic and the ability of the world's countries to access all sectors of its populations through prevention, care, treatment and support interventions. While UNAIDS (2003) defines HIV-related stigma as: "...a 'process of devaluation' of people either living with or associated with HIV", discrimination refers to action based on stigma. HIV-related discrimination follows stigma, and is the unfair and unjust treatment of an individual based on his or her real or perceived HIV status (UNAIDS, 2003). Discrimination does not only exist in social spaces such as family and community environments, but is often entrenched in institutional mechanisms, such as the legal system or workplace environments. This is manifested in laws and policies that criminalize consenting acts on



the basis of sexual identity, in workplace settings that negatively treat persons living with HIV and even in negative treatment in health care settings. The Commission on Human Rights (now Human Rights Council), has confirmed that discrimination on the basis of “other status”, includes health status, including HIV. As such, it is appropriate to address stigma and discrimination within the broader context of human rights and social justice programming in order to achieve sustained progress in this regard.

All of the of the 16 Caribbean and approximately 90% of the 19 Latin American countries that provided reports for the 2008 UNGASS, identified the existence of programmes designed to change societal attitudes of stigmatization associated with HIV only, using indicators for reduction of HIV-related stigma and discrimination. However, just over 55% of Caribbean countries and approximately 35% of Latin American countries report the use of indicators for the reduction of stigma and discrimination³². Clearly, without indicators to track these programmes, progress in addressing stigma and discrimination will be difficult if not impossible to monitor.

One example of a country-level tool is a mechanism created by the Brazilian government in 2007 that facilitates confidential reporting of violation of laws prohibiting HIV-based discrimination. Additionally, a People Living with HIV Stigma Index, developed through a partnership between the International Planned Parenthood Federation (IPPF), UNAIDS, the Global Network of People Living with HIV (GNP+) and the International Community of Women living with HIV (ICW), is being implemented in the Dominican Republic. Such tools are critical not only in providing invaluable feedback on the success of initiatives, but also in lending credibility and inspiring confidence in the process through the active involvement of the communities at risk.

LAC response

Across the LAC region, a number of country-level initiatives are being undertaken to address stigma and discrimination. In 2004 for example, Brazil launched an initiative entitled “Brazil without homophobia” to address stigma and discrimination against people who engage in same sex activity. The initiative, which involves civil society as well as government sectors, includes addressing HIV and STI transmission among MSM and transgenders, as well as the first National Gay, Lesbian, Bisexual, Transvestite and Transsexual Conference, to promote a national dialogue on homophobia and HIV to be convened by the President. A key feature of the initiative is a number of clear targets to be achieved by 2011. It is this type of programme, i.e. measurable, led at the highest levels, that involves civil society and tackles the most locally relevant and socially sensitive yet harmful dynamics with tangible programme activities, which is needed across the region if sustained success is to be registered in this persistent driver of the epidemic. Most notably, initiatives such as this one are further facilitated by an active social movement and a protective legislative environment. Other programmes to address

³² Joint United Nations Programme on HIV/AIDS (UNAIDS) 2008(a). 2008 Report on the Global AIDS Epidemic.



homophobia have been undertaken in Mexico and Colombia. In 2009, the Caribbean will take advantage of regional scope to address stigma and discrimination in a number of selected countries as part of a single regional initiative. The initiative involves the set up of a stigma unit that in an initial phase will conduct in-country assessments to better understand the dynamics of HIV stigma and discrimination in the national contexts, as well as pilot a number of evidence-based programmes, including the strengthening of existing strategies.

The UNAIDS (2008) Global AIDS Report identifies a number of programme components that are critical in adequately addressing HIV-related stigma and discrimination: preventing HIV-based discrimination; promoting HIV knowledge and awareness, tolerance, and compassion; increasing involvement and visibility of people living with HIV; scaling up treatment; prohibiting discrimination against populations most at risk; empowering the community among populations most at risk.³³

A country's legal environment is a pivotal factor in promoting or fueling stigma and discrimination. While all countries in Latin America have responded emphatically to the call for reducing stigma and discrimination by repealing laws that criminalize consensual same sex relations and enacted anti-discrimination laws to protect persons living with HIV, sex between men is still illegal throughout the English-speaking Caribbean. The combination of deep-seated stigma, resulting discrimination, homophobia and a legal system that criminalizes sex between men make it difficult, if not impossible, for affected populations to enjoy their human rights, including the right to access health care. The fear of stigma and discrimination makes it difficult for those most at risk to access testing and treatment services, as well as disclose their status to their partners. This undermines all aspects of HIV programming particularly that which aims to impact persons living with HIV and groups that are most at risk. Failure to address all and not selected components of human rights and social justice programming, will result in continued and possibly deepened impact on not only these populations, but on country responses as a whole.

Additionally, it should be noted that the enactment of laws is only as effective as its enforcement. The Peruvian government has responded in this regard by addressing the strengthening of reporting and redress of violations of its human rights laws. Efforts include identifying the drivers of stigma and discrimination against men who have sex with men, sex workers and prisoners and capacity building for ombudsperson offices³⁴.

³³ UNAIDS (2008a)

³⁴ Ibid.



1.6 Institutional Response

In any discussion of progress with respect to the institutional response to HIV, the ‘Three Ones’ Principles (see Box 2) provide the core elements of a sound institutional base upon which to build a response.

The LAC region has noted an overall high level of government commitment and leadership in responding to the HIV epidemic, notwithstanding variances in country responses to different components of the response. Multiple examples exist of government, civil society and regional leadership such as: the Government of Barbados demonstrating extensive multisectoral involvement; the Government of Brazil in its early decisions to provide universal access to treatment; the Horizontal Technical Cooperation Group (HTCG) and; coordination of the Caribbean regional response led by the Pan Caribbean Partnership on HIV/AIDS (PANCAP).

Box 2: The ‘Three Ones’ Principles

In April 2004, UNAIDS, the World Bank, and the U.K. Department for International Development (DFID), organized an international conference in Washington for major donors and national partners to consider and adopt key principles for supporting coordinated country-driven action against HIV. This resulted in the adoption of the “Three Ones” principles in support multisectoral national responses in host nations:

- One agreed HIV Action Framework, that provides the basis for coordinating the work of all partners;
- One national HIV coordinating authority, with a broad-based multi-sector mandate; and
- One agreed country-level monitoring and evaluation system.

Moving away from mandating that all contributors do the same things in the same ways, the Three Ones promote complementary and efficient action in support of host nations and locally defined priorities.

Source: UNAIDS. Need for Concerted Action on AIDS Responses: Country Specific Findings. 2004

Countries of the LAC region have all embraced the ‘Three Ones’ principles in the production of a single National HIV Framework that articulates programme priorities and activities across sectors. Across the region, high-level leadership at the country and regional levels have attracted national as well as international attention to the region’s epidemic, mobilizing both financial and technical support to regional and in-country programmes. Many countries have elevated HIV coordinating bodies to the highest level of authority, in many cases reporting directly to the Office of the Head of



State/Government, although some countries in the Caribbean are indicating a tendency to move programmes back into health ministries, presumably in response to increasing pressure from a limited human resource base.

Latin America and the Caribbean: selected Institutional Responses to HIV

- **The Government of Barbados:** demonstrating broad-based multisectoral involvement; with as many as nine different line ministries that have established core HIV working groups with corresponding budgetary allocations for HIV-related activities.
- **The Government of Brazil:** through its early commitment to the provision of care and treatment to people living with HIV Brazil was the first developing country to achieve universal access to HIV treatment via its national health system. Pivotal in this achievement has been the capacity of the country to produce its own HIV medicines in public, as well as private, pharmaceutical manufacturing facilities. As a result, the life expectancy of HIV patients has increased dramatically.

Strong and consistent high-level political support has resulted in regulatory policies as well as clear and well-established allocation of financial resources at national, state and local levels. This strong political commitment is evident in a highly qualified technical management structure within the Ministry of Health charged with coordination and management of the HIV response, in which HIV NGOs have played an essential role in advocacy and policy development and programme implementation. A strong and active National Business Council on AIDS has been in place since 1998.

- **The Horizontal Technical Cooperation Group (HTCG):** The HTCG is a network of Government and civil society leaders from Latin American and the Caribbean that organizes a bi annual initiative called the FORO. The forum is an important space to bring together government and civil society leaders, people living with HIV, representatives of the most-at-risk populations and researchers of Latin America and the Caribbean, as well as international agencies. The initiative is aimed at strengthening the national and regional response to the HIV epidemics in the region through an exchange of experiences and discussion of the challenges and opportunities in community and public health approaches. The FORO's organizing committee also includes key representatives of the regional civil society networks.



Latin America and the Caribbean: selected Institutional Responses to HIV (cont'd)

- **The Pan Caribbean Partnership on HIV/AIDS (PANCAP):** Governed by a Regional Strategic Framework on HIV/AIDS, PANCAP is the embodiment of the 'Three Ones' Principles, a multisectoral, multilevel partnership as it brings together 29 member Governments and country programmes, regional organisations from key sectors (health, education, tourism, development among others), organisations of people living with and affected by HIV, civil society actors (including the business community and faith-based leadership), UN agencies, and the donor community for regional coordination of the response to include resource mobilisation and monitoring and evaluation.

PANCAP's formal establishment in 2001 under the region's highest policy-making body, the Caribbean Community (CARICOM), builds on a regional response that began in the 1980's. The overarching goal is to "curtail the spread of HIV/AIDS and to reduce sharply the impact of AIDS on human suffering and on the development of the human, social and economic capital of the region." PANCAP functions as a network that encourages individual comparative advantage, while fostering an environment of harmonized and coordinated programme implementation.¹

- **The 'Mexico Declaration' (2008):** in a key step towards strengthened multisectoral approaches to HIV prevention, Ministers of Health and Education of Latin America and the Caribbean signed a Ministerial Declaration in Mexico (August 2008) at the XVII International AIDS Conference. The Declaration is aimed at strengthening prevention efforts through education and comprehensive multi-sectoral approaches to sexuality education including curricula development/revision; improved access to information and services; and improved public communication in collaboration with mass media and civil society. The Declaration sets out 2015 targets for reducing by 75% the number of schools that do not provide comprehensive sexuality education of schools administered by the Ministry of Education and reducing by 50%, the number of adolescents and young people who are not covered by health services that appropriately attend to their sexual and reproductive health needs.

Monitoring and Evaluation Systems

In 2008, all Caribbean countries reported on UNGASS core indicators. Reports were also received from nearly all countries in Latin America. Having emerged as the region with the highest reporting rates is a good indication of increased commitment to improvements in the availability and quality of data³⁵. However, there are still significant gaps in the completeness of many country reports and large variances exist from country to country. One example lies in reports received from the Caribbean, where levels of reporting in small island states started as low as 27% in Aruba, the Turks and Caicos Islands and Dominica to as much as 77% in St. Lucia. Among the ten larger Caribbean countries, reporting on all indicators ranged from 45% in Belize to 95% in Cuba, with all

³⁵ UNAIDS (2008a)



of these countries (with the exception of Belize) reporting on 50% or more of the twenty-two (22) UNGASS indicators³⁶.

In almost all country environments in the LAC region, gaps in the availability of accurate surveillance data as well as timely, context-specific data on affected populations represent an impediment to effective programming. Notably, less than 50% of Caribbean countries reported on UNGASS indicators that relate to vulnerable populations to include orphans and vulnerable children; men who have sex with men; male and female sex workers. While few Latin American countries submitted data on orphans and vulnerable children, data on men who have sex with men (as per Section 1.3) and male and female sex workers were much more readily available.

Monitoring and evaluation frameworks are articulated as part of national plans to address HIV throughout LAC. Financing for monitoring and evaluation activity varies throughout the region, but is mainly derived from a combination of national and international funding. The extent to which the region's countries are dependent on international funding is an issue for early consideration, as end of project cycles and possible reduction in funding raises concerns about sustainability of this critical programme component that underpins the accuracy and effectiveness of the region's response. At the global level only one in 10 countries report financing of HIV monitoring and evaluation exclusively through domestic funding. In the LAC region, Guyana indicates considerable progress in monitoring and evaluation, but several donor-funded projects with monitoring and evaluation components are not linked to the national monitoring and evaluation plan (Guyana UNGASS Country Progress Report 2008)³⁷.

While monitoring and evaluation of HIV programmes is undertaken against agreed indicators, current frameworks do not routinely analyze the efficacy in utilization of resources. This is particularly relevant not only as a principle of sound programme execution and maintaining accountability, but particularly given the global recognition that the epidemic continues to outpace the availability of resources at the global level³⁸. In-depth understanding of resource utilization is a necessary step to maximizing the effective use of these resources. In this regard, the global financial crisis and the corresponding limitations to the availability of increased resources present an opportunity to renew regional commitment to efficient resource utilization and to invest in its routine analysis in an effort to build a sustained long-term response.

³⁶UNAIDS, Caribbean Regional Support Team (CAR-RST) (2008b). Keeping Score II: A Progress Report towards Universal Access to HIV Prevention, Treatment, Care and Support in the Caribbean. Vol. 2. 2008.

³⁷UNAIDS (2008a)

³⁸Joint United Nations Programme on HIV/AIDS (UNAIDS). Report on the State of HIV/AIDS Financing, Revised March 2003.



2. Gaps and challenges in the response to HIV

2.1 Public Perception of Developmental Challenges

Even before considering detailed analysis of gaps and challenges in addressing HIV, events such as the global economic crisis have already had repercussions in all facets of development practice in both developing and developed countries. The AIDS response is no exception.

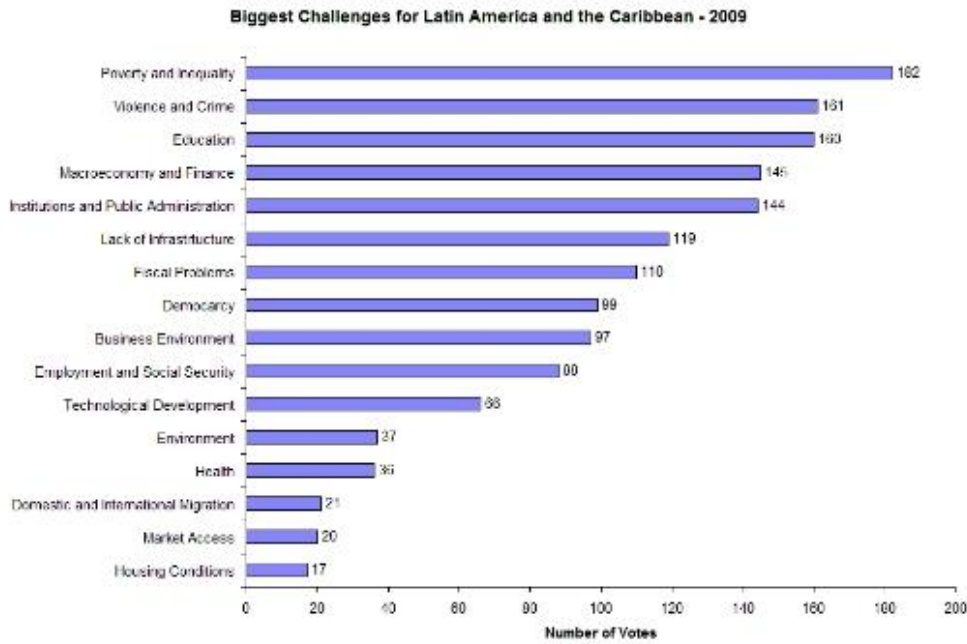
In the context of the tangible and already devastating impact of the global economic downturn, such as loss of employment, failing financial institutions and decreased levels of development assistance, the issue of HIV is at risk of being de-prioritized in the LAC region, even though key investments are now needed to broaden the scope and strengthen many aspects of the response.

In assessing public perception of developmental challenges, the Inter-American Development Bank (IADB) surveyed 317 leaders/key people in government, the private sector, non-profit organisations, media and academia in 26 member countries across LAC³⁹, in an effort to gauge public perception of the challenges facing the region's economies. The responses (Graphs 1 and 2) reveal a number of new challenges to investment in the HIV response.

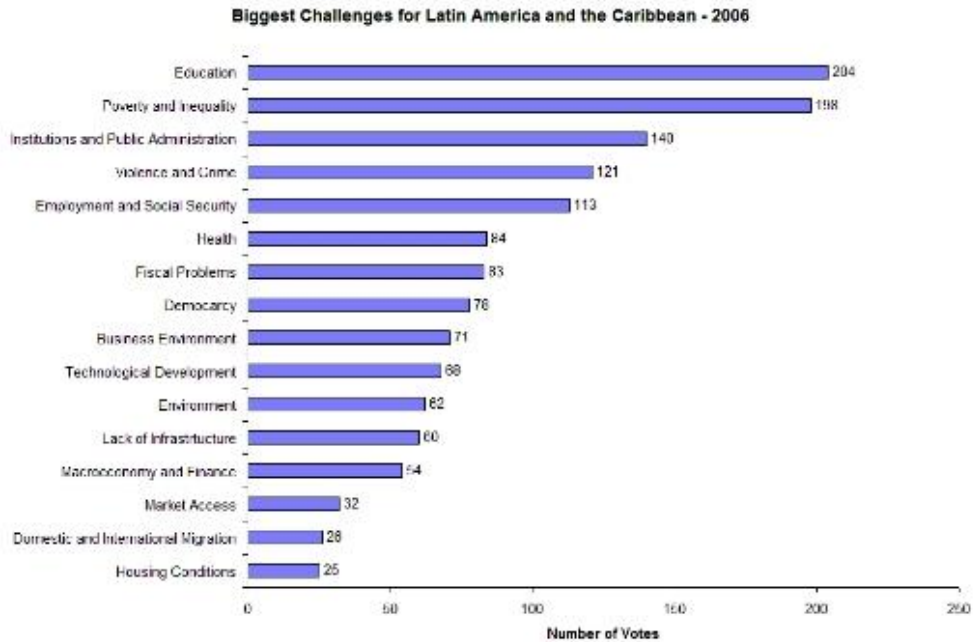
Nearly half the leaders surveyed predicted an increased dependence on funding from international institutions. This lies in stark contrast to the trend of reduced funding levels from many international institutions in the face of the global financial crisis.

Notably, the survey also highlighted a shift in perception of what will be the most significant development challenges for the LAC region. The economy and financial institutions emerged among the top concerns (having not even appeared among the top 10 concerns in a similar 2006 survey). At the top of public concern were issues such as poverty and inequality and violence and crime. Notably, only 18% of leaders surveyed rated health as a priority concern, down from 32.30% in the 2006 survey. These perceptions have the potential not only to influence the national and regional development agendas, but also general public opinion and priority-setting.

³⁹ Inter-American Development Bank (IADB). *Latin America and Caribbean see Slower Growth in next Four Years*. <http://www.iadb.org/research>. March 2009.



Graph 1. Source: IADB (March 2009)⁴⁰



Graph 2. Source: IADB (March 2009)

⁴⁰ Inter-American Development Bank (IADB). *Latin America and Caribbean see Slower Growth in next Four Years*. <http://www.iadb.org/research>. 2009



Even at a time when increased dependence on international funding may be predicted, reduced funding may be the reality. As outlined in the 2008-2017 Health Agenda for the Americas (PAHO 2007), official development aid for LAC had already declined from 10% of the global total in the 1990's to 8% in 2004. Regrettably, future trends may be in rationalizing support to health in the region, by either suspending support and/or focusing support on a limited number of the region's countries⁴¹.

2.2 Under-addressed issues

Quality and availability of relevant data

In line with global trends, national systems for monitoring and evaluation within LAC overall have undergone significant strengthening. This is evident not only in the increased numbers of UNGASS country reports received, but also increases in the numbers of LAC countries that possess basic elements of monitoring and evaluation systems⁴².

However, reporting against the UNGASS and Universal Access, although improved, is not without notable gaps. Garcia-Calleja et al⁴³ note that while efforts are underway to strengthen surveillance systems, many countries are still far behind. The authors further point out that while Latin American countries have accessed technical resources from the international community and financial resources such as that of the Global Fund, only a few consolidated surveillance systems are capable of reliable estimates of HIV prevalence, new infections and can provide information on distribution and trends. The example of Central America is provided, where regional data, apart from ad hoc studies, originates from the Programa para fortalecer la respuesta en Centro America al VIH (PASCA), a project funded by USAID between 2001 and 2002.

An example of this is minimal reporting by Caribbean countries on indicators that addressed most at risk populations such as MSM; and male and female SW and in the case of both Latin America and the Caribbean, limited reporting on vulnerable populations such as orphans and vulnerable children. Given that MSM and SW note some of the highest prevalence rates in the region, it means that these countries are at best responding without relevant or timely data and/or at worst, not meaningfully addressing

⁴¹ Pan American Health Organisation (PAHO). *Health Agenda for the Americas (2008-2017)*. Presented by the Ministers of Health of the Americas in Panama City, June 2007.

⁴² UNAIDS 2008a, p.22

⁴³ Jesus M. Garcia-Calleja, MD, MPH, Carlos del Rio, MD, PhD, and Yves Souteyrand, PhD. HIV Infection in the Americas: Improving Strategic Information to Improve Response. *J Acquir Immune Defic Syndr* _ Volume 51, Supplement 1, May 1, 2009. www.jaids.com



key components of the epidemic. Moreover, improved UNGASS reporting does not always translate to relevant, specific and timely localized data that would facilitate the adaptation of international strategies, protocols and ongoing programme adjustments that are critical in responding to an ever changing development challenge.

Gaps in UNGASS country reporting are further exacerbated by a lack of informed and context-specific research in order to understand the dynamics of the epidemic within a particular community or social setting. This is especially applicable in the areas where the response continues to struggle such as that of prevention, care and treatment among those populations most at risk of infection (men who have sex with men, male and female sex workers and injecting drug users) and vulnerable populations such as prison populations, drug users and young people.

An additional gap is the existence of data on how HIV impacts and is impacted by other development challenges. It is only through integrated analysis, programming and measurement that we can hope to meet the MDGs and understand the full scope of development challenges in order to respond effectively.

There is also need for efficient second generation surveillance systems, that which includes HIV and STI surveillance and also are able to monitor risk behaviours, to warn of or explain changes in levels of infection. Additionally, in many cases much of the HIV-related measurement in a country is lost because there are gaps in coherent M&E systems. Relevant, up-to-date data to understand and respond effectively to the epidemic should aim to capture: characteristics of and impact on populations affected; needs of those affected; timely and accurate epidemiological and sentinel surveillance data; and programme evaluation to learn from initiatives that worked and did not work and make adjustments.

HIV, social vulnerability and risk-taking behaviours

Across the region, a number of sub-populations are particularly affected by HIV, mainly as a result of social and systemic conditions that fuel vulnerability to infection, or risk-taking behaviours and practices. Issues of vulnerability and risk, while interrelated are defined separately for the purposes of programme intervention. As a result, vulnerable populations are considered groups that due to biological, environmental or socio-cultural factors have limited or no control over exposure to hazardous or risky situations and are without skills or power to negotiate the terms of sexual encounters. Included in this grouping are women, people with other sexually transmitted infections, those who have sex under the influence of alcohol and drugs, young people and adolescent women in particular, and people whose sexual activities are limited by environmental conditions, such as incarcerated individuals and migrants. Most-at-risk populations are groups of people with higher concentration of behaviors that lead to HIV transmission. These behaviors include high rates of unprotected sexual partnerships, unprotected anal sex with



multiple partners and injecting drugs with shared equipment and drug preparations and include populations such as MSM, FSW and their clients, and IDUs.

While outreach to and targeted programming for vulnerable and most-at-risk populations have improved, persistently high prevalence rates among those at risk and growing impact on those that are particularly vulnerable, demonstrate that these populations continue to be under-served through access to information and services; targeted programming and; protective national legal and policy environments.

- **Women and HIV:** Reports throughout the region point out that women, and more specifically young women, are impacted by the epidemic, with a corresponding risk of new infections in children. Gender inequity and in particular, specific issues such as a lack of empowerment of women and the corresponding inability to negotiate safe sex practices and/or avoid sexual exploitation, are a key contributor to higher risk of HIV infection among women. Additionally, other issues such as higher biological male to female risk of transmission, poverty, machismo, homophobia (leading men to conceal socially rejected issues around sexuality), harmful gender norms and persistent myths that fuel greater exposure of young girls to HIV infection deepen this vulnerability.

The impact on young girls and women in many countries is of particular concern. Sexual abuse and intergenerational sex increase vulnerability of women and girls in the region. In Jamaica for example, with a male to female infection ratio in the 10 to 19 age group of 1:2.84, females in the 10 to 14 age group face twice as much risk as young women in the 15 to 19 age group and three times the risk of infection as males in the same age group⁴⁴. While prevention programmes throughout the region incorporate a number of interventions for young people, HIV programming alone will not overcome the issues around gender inequity that drive increased vulnerability to infection for young women. Comprehensive social development programming that address gender inequity and social vulnerability, including poverty, gender relations; effective child protective services; and public information including the dispelling of myths surrounding HIV infection, are in urgent need of strengthening. Additionally a comprehensive approach to sexual education that integrates HIV, particularly among young people, also provides an opportunity to address this vulnerability. Moreover, the linkage of these issues as part of HIV planning tools, frameworks and monitoring will contribute to more sustained efforts at reducing the impact of the epidemic. Programme gaps such as this highlight the need for comprehensive multisectoral approaches where this type of initiative could conceivably result from partnership with Health and Social and/or Community Development and/of Gender Affairs sectors. Urgent attention is needed to address the greater vulnerability of girls as

⁴⁴ Planning Institute of Jamaica (PIOJ). Vision 2030 – Jamaica – Draft Integrated National Development Plan; Planning for a Secure and Prosperous Future. (January 2009). P67. Available at <http://www.jis.org>.



a result of multiple concurrent partnerships, intergenerational sex, transactional sex and gender-based violence.

Harmful gender norms should also be well-documented and understood in order to be addressed. Social norms that define a more passive role for women in sexual decision-making on issues such as condom use by their male partners expose them to sexual coercion and risky situations, even when basic sexual and reproductive health services are available⁴⁵. These norms also work to increase risk among boys and men, where 'machismo' and expectations for aggression and sexual dominance often translate into multiple unprotected sexual encounters and poor health-seeking behaviour where sexually transmitted infections could be more routinely detected.

A key underpinning factor of HIV and gender programming is that of corresponding budget allocations. The 2008 Global AIDS Report points out that while many national HIV planning processes recognize gender equity as a critical component in HIV programming, this is not matched by concrete budget allocations. Specifically, while 80% of countries include a focus on women in national plans, 52% set out specific budget allocations to the issue. The proportions of countries with reported budgets for including women as a specific component are approximately 67% for the Caribbean, and approximately 52% for Latin America, indicating gaps in resource allocations that clearly need to be addressed if tangible programmes are to be undertaken.

- **Addressing the vulnerability factors of other groups such as prisoners, drug users and young people** also require allocation of resources across sectors, as well as more data informed programming. As discussed in section 1.4, there is also need for integrated TB and HIV services.
- **Men who have sex with men (MSM) and transgenders, Sex workers (SW) and injecting drug users (IDUs):** The high prevalence rates previously noted among most-at-risk groups in LAC are the result of not one, but a complex combination of social, institutional and legal barriers that: fuel social marginalization; drive the epidemic underground; limit health-seeking behaviour and socialization; and bar access to effective prevention, care and treatment services. As will be explored in later sections, all of the above drivers that fuel risk-taking behavior must be addressed in order to curb the spread of the epidemic among these populations most at risk. Programmes aimed at addressing discrimination must first practice non-discrimination in the allocation of resources to invest in: informed research to understand local contexts; empowerment of those most at risk; social change communication; law reform; human rights

⁴⁵ UNAIDS 2008a.



education; widespread access to prevention services and basic sexual health services; and protection against sexual violence.

While recognising that these initiatives are not an immediate process, there is an urgent need to scale-up community empowerment among populations most at risk in many countries of LAC. The building of social support networks or social capital is a key tenant to overcoming social marginalization and building community empowerment and meaningful engagement. Merson (2008)⁴⁶ points to the fact that strong community mobilization was intrinsic to the national response in nearly all countries where the epidemic has been reversed. It is this engagement that unpins the design of relevant prevention and outreach strategies and facilitates the effective uptake of services.

2.3 ‘Scratching the surface’ of integrated development programming

In addition to the issues presented above, other challenges are evident when examining global development progress towards the MDG targets. The interconnectedness among MDGs is clear, where high poverty levels for example, create a clear tendency to the adoption of survival techniques and risk-taking and in turn, a vulnerability to HIV transmission. However, it is not always evident that the correlation of development issues finds its way into cohesive, multisectoral development programming and measurement.

An issue that underpins the success of adherence to treatment, for example, is that of adequate nutrition. By extension, levels of undernourishment in a given country and/or community, particularly as it impacted persons living with HIV, would be of concern. While data does not cross-reference recipients of ART with persons who are defined as undernourished, levels of undernourishment are a potentially significant factor in undermining treatment gains as adequate nutrition plays a critical role in treatment adherence. In a 2007 report (ECLAC 2007), five LAC countries (Chile, Cuba, Ecuador, Guyana and Peru) have already met 2015 targets for reducing undernourishment, and nine others have made progress in reducing undernourishment by up to 60% of 1990-1992 levels (Argentina, Bolivia, Brazil, Colombia, Costa Rica, Haiti, Jamaica, Paraguay, Uruguay). However, six countries (Dominican Republic, El Salvador, Honduras, Nicaragua, Suriname and Trinidad and Tobago), while having made some progress, are not likely to reach 2015 targets. Moreover with undernourishment increasing in Venezuela, Panama and Guatemala, these countries while less likely to meet 2015 targets. Expanding this type of analysis to poverty levels, or any of the other MDGs, it is clear that these development challenges have a clear and bidirectional impact on the

⁴⁶ Merson, M.H. et al. (in press). The History and Challenge of HIV Prevention. *Lancet*. As referenced in UNAIDS (2008a).



attainment of their respective goals. Present limited research and data on the ways and extent to which HIV impacts and is affected by other development concerns, means that current gains and future efforts may be undermined, and that the region cannot respond to the epidemic in the broader development context.

Bastos et al⁴⁷ point out that in the LAC context of limited infrastructure and non-integrated health programmes, public health systems need to fully integrate support services and understand the interconnections that underpin risk and HIV infection. An example that is discussed by the afore-mentioned authors, is that of commercial sex work, drug use and the opportunities provided by a well-established sex tourism industry. Each if these issues alone, let alone taken together, constitute vulnerability to HIV infection. Failure to routinely integrate strategies and services to address these undeniably interconnected issues represents a lost opportunity to impact a number of public health and social development challenges including HIV.

2.4 Care, treatment and support

Despite the unprecedented increases previously noted in the provision of antiretroviral treatment and related services, the Latin America and Caribbean region falls short of the needs for treatment⁴⁸. This is exacerbated by a number of persistent as well as emerging challenges that impact the provision of adequate and quality care, treatment and support services.

Lack of integration into primary health care services

One such challenge lies in the lost opportunities for enrolment and retention of those persons in need of treatment, as a result of centralized service provision and a lack of integration of treatment programmes, into a comprehensive public health system. This is a direct consequence of fragmented public health systems, an issue that is explored in

⁴⁷ Bastos, Francisco I., Alexandra Angulo-Arreola & Monica Malta. Oswaldo Cruz Foundation (Fiocruz), RJ, Brazil; 2. Fulbright Scholar, RJ, Brazil. *Sex work and HIV/AIDS in Latin America and the Caribbean: Challenges and the ongoing response*. Prepared for PAHO/WHO Draft document.

⁴⁸ Antiretroviral therapy coverage measures the proportion of people who need antiretroviral therapy that have access to it. The numerator (the number of people receiving antiretroviral therapy) is derived from national programme reporting systems, aggregated from health facilities or other service delivery sites. The denominator (the total number of people who need antiretroviral therapy) is generated using a standardized statistical modeling approach (3). Estimating the number of people who need antiretroviral therapy raises some definition and measurement issues, which in turn influence estimates of coverage. To estimate the number of people who need antiretroviral therapy in a country, WHO and UNAIDS use statistical modeling methods that include all people who meet treatment initiation criteria, whether or not these people know their HIV status and their eligibility for antiretroviral therapy. Hence the number of people who need antiretroviral therapy in a country includes:

- the people currently receiving antiretroviral therapy;
- the people who know they are HIV-positive and are eligible for antiretroviral therapy but do not have access to it;
- the people who do not know their HIV status but meet criteria for initiating treatment.

World Health Organisation (WHO)/UNAIDS/UNICEF 2008. *Towards Universal Access. Scaling up Priority HIV/AIDS interventions in the health sector. Progress Report 2008.*



detail in later on. There is increasing evidence⁴⁹ that the integration of HIV care into primary health settings, with a wide range of HIV services including counseling by adherence counselors, greatly improves not only enrolment numbers, but also retention of individuals to strengthen adherence. However integration of treatment into primary health care sites is not without its challenges and limitations. Adequate human resource capacity, particularly in technical areas such as clinical management, laboratory support and procurement and supply management to name a few, are often in short supply, particularly in resource-constrained settings. Ironically this constraint acts as a justification for the integration of treatment services into primary health care sites, since, subject to adequate training and identification of relevant resources, the provision of comprehensive services represents a more effective use of scarce human resources across health services.

Lack of integration of community care/support services

In addition to the above, there are also missed opportunities for HIV treatment programmes that fail to include community care and support services and social networks. Given the hidden nature of many of the populations at increased risk of HIV infection across the LAC region (MSM, SW, IDUs) it stands to reason that the linkage of informal social support and community based networks to treatment systems are a key point of interface with many of the most vulnerable populations. While there have been excellent documented and undocumented examples of community-based care and support initiatives across the region, the extent to which these form part of or are even captured by national treatment systems varies widely.

Geographic centralization of treatment sites

Another challenge is that of centralization of treatment sites in urban areas. This is even more of a challenge for rural populations with generalised epidemics in low-to middle-income countries such as those of LAC, where transportation costs pose an additional barrier to access.

Equity in treatment access

Given the disproportionate impact of the epidemic on most-at-risk groups, equitable treatment access is a concern. Women do not appear to be disadvantaged in terms of access to treatment, representing 36% and 32% respectively of those persons receiving treatment in LAC. However, the same is not the case for at risk groups such as MSM, IDUs, crack cocaine users and SW. Available data on the levels of access to treatment by these populations is limited and does not permit analysis of this dynamic. This is a clear gap in available data and also in the provision of treatment programmes, particularly in a

⁴⁹ World Health Organisation (WHO)/UNAIDS/UNICEF 2008. Towards Universal Access. Scaling up Priority HIV/AIDS interventions in the health sector. Progress Report 2008



region that notes such a disproportionate impact on MSM, IDU, crack cocaine users and SW.

Additionally, enrolment of children in treatment programmes has historically lagged behind. Challenges in treating children living with HIV have been compounded by difficulties associated with diagnosing HIV in infants. As antiretroviral formulations for children and improved paediatric diagnostic strategies have been developed, advances in children's access to HIV treatment have been observed. Nevertheless the social and economic disparities in the region lead to high levels of vulnerability in marginalized and historically excluded populations such as indigenous and afro-descendent children.

Gaps in coverage

In many countries in the Latin America and Caribbean region, coverage levels, while significantly increased, are still well behind the 2010 80% target. High prevalence rates among key populations such as MSM, IDU, and SW across the LAC region and recognised gaps in up to date data on these populations clearly play a role in the difficulties in broadening treatment coverage to those who need it. Moreover, for pregnant women, arguably a more socially accessible group and not subject to the high levels of stigma experienced by the afore-mentioned populations, the gaps in coverage are instructive (later examined in detail in Section 2.6.3). With 52% of pregnant women undergoing HIV testing in LAC in 2007, approximately 36,000 tested positive⁵⁰. However only 36% received antiretroviral treatment. This is clearly a missed opportunity to retain these individuals as part of comprehensive care and treatment programmes.

Treatment costs

At the global level, once prohibitive treatment costs have been driven downward as a result of pressure on pharmaceutical companies through advocacy and pricing negotiations supported by international organisations. In early 2000, with the support of international organisations such as UNAIDS, the Caribbean negotiated reduced pricing on first-line therapies. The LAC region has noted a number of other innovative approaches enhancing a country's ability to provide life-saving treatment to those who need it. In Brazil for example, national savings were estimated at approximately US\$ 1 billion between 2001 and 2005 as a result of its domestic generic manufacture of eight antiretroviral drugs and its negotiation of price reductions from manufacturers⁵¹.

While most countries in LAC are receiving first-line therapies, countries such as Brazil and Argentina are now facing the challenges of the provision of second-line therapies to significant proportions of persons receiving treatment. Second-line regimens are

⁵⁰ Castro, A. (2009) Ph.D., MPH, Harvard Medical School. Prevention of Mother-to-Child Transmission of HIV and Syphilis in Latin America and the Caribbean. Prepared for PAHO/WHO Draft document.

⁵¹ Nunn AS et al. (2007). Evolution of Antiretroviral Drug Costs in Brazil in the Context of Free and Universal Access to AIDS Treatment. *PLoS Med* 4:e305. As referenced in UNAIDS (2008a)



significantly more expensive than first-line regimens in low- and middle-income countries. In 2007, the average cost of the most commonly used second-line treatment was US \$1,214 in low-income countries and US\$ 3,306 in middle-income countries. This is further complicated by the fact that the prices paid from country to country vary significantly. A WHO (2008)⁵² progress report notes that while South Africa pays an average price of US\$ 1,600 for a particular second-line therapy, El Salvador pays US\$ 3,448 per person per year for the same regimen. This underscores the need for continued effective price negotiation, that has already been undertaken in the region, since responding to the changing dynamics and needs of treatment and sustaining the supply of antiretroviral drugs is critical to maintaining effective treatment programmes.

2.5 Stigma and Discrimination

The Secretary General of the United Nations, Ban Ki Moon, in an address to the International Aids Conference in Mexico City on 3 August 2008, is quoted as saying:

“ ... In most countries, discrimination remains legal against women, men who have sex with men, sex workers, drug users and ethnic minorities. This must change. ... [I]n countries with legal protection and protection of human rights for these people ..., there are fewer deaths. Not only is it unethical not to protect these groups: it makes no sense from a public health perspective. It hurts us all.”

Source: (UNAIDS 2009⁵³)

In the past year, law reform in Nicaragua and Panama has meant that there are now no countries in Latin America which criminalize sex between men. While these developments in the legislative framework are pivotal, the reality is often far from ideal as strong social attitudes that value ‘machismo’ still thrive and often drive homophobia, and violence, particularly towards men who have sex with men and transgender individuals. Even as the region with the highest number of laws against discrimination based on sexual identity, it is estimated that someone is killed every two to three days as a result of sexual identity⁵⁴. The English-speaking Caribbean is still dealing with the challenge of legislative systems that criminalize sex between men.

Throughout the region, the gaps in comprehensively addressing stigma and discrimination are significant. In Latin America, efforts at battling homophobia will be bolstered by consistent reporting of human rights infringements; enforcement of anti-

⁵² World Health Organisation (WHO)/UNAIDS/UNICEF 2008. Towards Universal Access. Scaling up Priority HIV/AIDS interventions in the health sector. Progress Report 2008

⁵³ Joint United Nations Programme on HIV/AIDS (UNAIDS) (2009). UN Guidance Note on HIV and Sex Work. February 2009. p.3.

⁵⁴ Joint United Nations Programme on HIV/AIDS (UNAIDS) 2009. HIV prevention hampered by homophobia. 13 January 2009. Available at <http://www.unaids.org>.



discrimination laws already in existence; in addition to persistent efforts to address homophobia and harmful public perceptions around sexuality and sexual orientation.

In the Caribbean, while regional strategy-setting and high level discourse on the importance of addressing stigma and discrimination has been strengthened, as well as regional and national communication campaigns, tackling the legislative environment with respect to the decriminalization of homosexuality and the establishment and enforcement of anti-discrimination laws particularly for affected populations (MSM, SW) is the most critical obstacle in making progress in this regard.

These broad challenges with respect to both sub-regions underscore the need for a human rights-based approach to addressing stigma and discrimination. A human rights-based approach allows for addressing a number of challenges as the benefits of the approach include:

- taking action not based on social norms, but rather on internationally agreed human rights principles and recognized entitlements;
- prioritizes the empowerment of all people to know and claim their human rights through a number of supportive interventions including law reform, human rights education, social mobilization and civil society support;
- affords an integral focus on those populations disproportionately impacted by the epidemic (such as women, men who have sex with men, intravenous drug users, crack cocaine users, sex workers, mobile populations and indigenous groups);
- calls for meaningful involvement of affected persons in all aspects of programming including accountability mechanisms; and
- integrating human rights standards into HIV programming, it strengthens the correlation with other development concerns.

2.6 Institutional Response

Despite the unprecedented and demonstrable government and civil society leadership demonstrated in key aspects of the LAC response to HIV, a number of challenges persist. While all countries of the LAC region have developed or are reviewing national HIV plans, the extent to which multisectoral involvement is backed by budget allocations from sectors varies widely from country to country. Additionally, most plans fail to include strategies that address broader development drivers of the epidemic including poverty and gender equity. This would create opportunities for a full understanding of how these issues impact the epidemic and vice versa and facilitate more broad-based development programming towards achievement of IADGs.



Monitoring and evaluation

By 2008, the LAC region had accounted for the highest numbers of countries that reported on the 25 core UNGASS indicators, with all Caribbean countries reporting back on some indicators, while 90% of Latin American countries submitted reports. This can be attributed to a number of factors including strengthening of monitoring and evaluation systems; increased government commitment and ownership of global HIV commitments⁵⁵. A detailed look at country-level reporting however, reveals wide variances as well as a number of trends in need of attention.

In the case of the Caribbean, 13 of the 18 countries submitted reports that covered 50% and above of core indicators, with the remaining five countries reporting on as low as 27% of indicators and up to 45%. The most notable reporting gaps were on issues relating to populations most at risk such as MSM and SW⁵⁶. The lack of data on the impact of and on these vulnerable populations is cause for concern as it severely limits full understanding of the factors that underpin the Caribbean epidemic. It goes without saying that there are severe implications of planning without adequate data such as inefficient use of resources and programme delivery that misses the mark and allows the epidemic to escalate.

Availability of resources

A key facilitator to effective national and regional responses to HIV is undoubtedly that of resources, both human and financial. The region has made significant progress in the development and training of local technical expertise to address all aspects of the epidemic and benefited from regional, bilateral and multilateral partnerships in filling human resource gaps. However, taking the health sector as an example, the sector is challenged by scarcity and sub-optimal distribution of personnel (particularly between urban and rural locations); stretched resources to respond to the range of health needs (25 health workers per 10,000 population in the LAC region⁵⁷); migration of skilled professionals and; emigration.

The LAC region has been able to attract significant levels of international loan and grant resources from a variety of sources to include the World Bank, the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), and a host of other philanthropic, bilateral and multilateral arrangements. However these funding streams are time-bound and factors such as the global financial crisis seriously call into question the availability of these funds for future programme periods.

⁵⁵ UNAIDS 2008. The Global HIV Challenge. 2008 Report on the Global AIDS Epidemic. P.13.

⁵⁶ UNAIDS, Caribbean Regional Support Team (CAR-RST) 2008. Keeping Score II: A Progress Report towards Universal Access to HIV Prevention, Treatment, Care and Support in the Caribbean. Vol. 2. 2008. p.36.

⁵⁷ Health Agenda for the Americas 2008-2017. Presented by Ministers of Health of the Americas in Panama City June 2007.



The allocation of financial resources to HIV at the national level has long been used as a benchmark for strong country-level commitment and leadership. While levels of domestic expenditure vary widely throughout the region, with Brazil leading the region in absolute terms⁵⁸, increased domestic financial investments in HIV is a sound strategy at sustaining long-term impact, particularly in the context of vulnerability that may be created by over-dependence on external resources.

Integrated Public Health Delivery Systems

WHO Director-General Dr. Margaret Chan is quoted as saying:

*“The world has never possessed such a sophisticated arsenal of interventions and technologies for curing disease and prolonging life. The reality is straightforward. The power of existing interventions is not matched by the power of health systems to deliver them to those in greatest need, in an integral manner, and on an adequate scale.”*¹

Source: PAHO/WHO 2008⁵⁹

A key challenge to HIV programming and service delivery and to the achievement of national and international development goals, has been that of fragmentation of the public health services. Strategic investments in integrating public health systems involve not only the need for more resources, but also the more effective use of existing resources that have been committed. As the examples presented in the LAC region will show, fragmentation leads to: services that are difficult to access; poor quality services; inefficient use of resources; increased production costs; and low public confidence in the system.

Strengthening health care delivery systems has been recognised as a priority for LAC countries. Most recently in June 2007, Ministers and Secretaries in Health of the Americas came together to set out their commitment and approaches to the improvement of health and development in the region. Among the commitments, the Declaration pointed out that *“Strengthening referral and cross-referral systems and improving health information systems at the national and local levels will facilitate the delivery of services in a comprehensive and timely manner.”*⁶⁰

The health systems in LAC are further undermined by: low levels of health expenditure in the region and/or; high dependence on external resources; scarce distribution of health care personnel; and limited informed research that supports policy design, all conditions

⁵⁸ UNAIDS (2008a)

⁵⁹ Pan American Health Organisation/World Health Organisation (PAHO/WHO). *Renewing Primary Health Care in the Americas. Integrated Delivery Networks: Concepts, Policy Options, and Road Map for Implementation in the Americas.* (November, 2008) p.8.

⁶⁰ Health Agenda for the Americas 2008-2017. Presented by Ministers of Health of the Americas in Panama City June 2007. Paragraph 49. Pg 15.



adding to the vulnerability of the sector and the challenge of effective service delivery. Additionally, in focusing on financial and organizational issues as part of the health sector reform process of LAC in the 1990s, key elements of public health, such as coordination and management of a network of services were under-addressed.⁶¹

Fragmentation in health care systems is often the result of a number of factors to include the development of specialized systems; resource (human and financial) constraints and even vertical programmes, that is, programs that target specific diseases and/or populations. While vertical programmes do have their benefits in the provision of services to targeted groups in emergency or epidemic situations, failure to manage these epidemics with a long-term vision and systems may erode hard-won gains. In the case of HIV, this would translate in a missed opportunity to address many of the root causes of the epidemic; duplication of efforts and resources and; unproductive competition for resources with other programmes. While the reality of donor preference to fund specific HIV-related programmes must be recognised, advocacy efforts and effective planning processes must ensure that there is adequate investment in integrated and effective public health care delivery systems, as a facilitator to effective uptake and delivery. Undoubtedly, the establishment of parallel infrastructure may be faster and possibly less expensive in the short term. However in the long-term, an integrated system will result in greater efficiency and sustainability, while the investments to strengthen this system may also benefit other health services⁶² and human development challenges.

Countries of LAC have seen first hand that in the absence of adequate supporting infrastructure, the scale up of specific programmes, such as that of HIV, results in an overload of already stretched human resources⁶³, with the additional risk of impacting negatively on other human development programs: either drawing away valuable and necessary human resources from other services; affecting the quality of services delivered; or posing additional stresses that cause much needed human resources to emigrate to wealthier countries⁶⁴.

The value of the system-wide approach to tackling HIV was the rationale behind Round nine (9) of the call for proposals of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM)⁶⁵. The Fund recognised the integration of health services as key to scaling up sustainable responses, avoiding duplication of resources in resource-constrained settings, even overcoming stigma associated with accessing services from an 'HIV-related' facility and moreover, improving health and development outcomes across the board.

⁶¹ Ibid. Para 28. Pg. 9.

⁶² Physicians for Human Rights (PHR), Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). *Guide to Using Round 9 of the Global Fund to Fight AIDS, Tuberculosis and Malaria to Support Health Systems Strengthening. Updated from March 2007, Guide developed for Round 7.* October 2008.

⁶³ UNAIDS-CRST (2008).

⁶⁴ Health Agenda for the Americas 2008-2017. Presented by Ministers of Health of the Americas in Panama City June 2007.

⁶⁵ Physicians for Human Rights (PHR), Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). *Guide to Using Round 9 of the Global Fund to Fight AIDS, Tuberculosis and Malaria to Support Health Systems Strengthening. Updated from March 2007, Guide developed for Round 7.* October 2008.



Studies conducted in the Dominican Republic⁶⁶ and evidence from other countries in LAC clearly illustrate how fragmented public health systems and services undermine coverage efforts and cause the inefficient use of valuable resources and lost opportunities to impact other development challenges:

The Health System and HIV: the example of the Dominican Republic

In the Dominican Republic, early attention to targeted prevention among populations most at risk (men who have sex with men and sex workers) by PROCETS⁶⁷ influenced early legislative review in the approval of the Law on AIDS (Law 55-93) in 1993. This law mandated comprehensive health care for people living with HIV. Later attention during the period 2000-2003, to the scope of comprehensive care came when HAART was included, as were protocols for PMTCT and VCT for most at risk groups and the integration and/or participation of non-governmental organisations in the health system response.

Further updating of the health system's response in 2004-2006 deepened the focus on specific populations at risk to include persons living in 'bateyes', MSM (including transgender populations), young people, migrants, children and adolescents, persons with disabilities and sex workers. Key to this stage of updating the health system response was the involvement of NGO interest groups for each of the above populations. Yet further efforts at expanding access to services included the expansion of comprehensive care units (CCU) in hospitals and primary health care settings featuring an active 'watch dog' role of the NGO community as well as that of counselors in the CCUs; and the decentralization of services in Regional and Provincial Health Directorates with the integration of HIV care into all services provided by health care sites, relevant to capacity. Undoubtedly, the system has noted positive changes to include an increase in the number of qualifying health facilities from 22 to 122; an increase in HIV test coverage from 23% in 2002 to 35% in 2005, then 39% in 2006; and an increase in proportion of pregnant women captured by services from 29.6% in 2004 to 40.6% in 2006. However, even with the above initiatives aimed at integration of HIV into the health system, a number of gaps emerged:

- Only 33% of persons in need of HAART are receiving treatment.
- Scale up of PMTCT was still insufficient as evidenced by the fact that only 9% of pregnant women with HIV were being captured by the health system by October 2006. Included in this gap were children born to mothers with HIV, the so-called preventable cases.

⁶⁶ Pan American Health Organisation (PAHO)/UNICEF 2008. Evaluation of the National Health System Response to HIV in the Dominican Republic. 2008.

⁶⁷ PROCETS, the Programa de Control y Prevención de las Infecciones de Transmisión Sexual (ITS) y SIDA was the national body charged with management of the national response at the time. PROCETS was subsequently transitioned to the Directorate General for the Control of Sexually Transmitted Infections and AIDS (DIGECITSS)



- In fact, preventable cases alone for the period 2004-2006 are estimated to cost the health system between US\$ 13.5m to US\$44.5 million, representing the cost of HAART in now needing to provide treatment.
- Duplication of efforts between two key coordinating entities in the health systems response (COPRESIDA⁶⁸ and DIGECITSS), largely related to the demands of rapid expansion of care and other services to persons living with HIV, coupled with the need for accountability to external donor funding. The demand for rapid scale-up of service provision, as well as accountability for external resources in this case exceeding the pace and structure of integration of HIV programming into the health system, still therefore producing duplication.
- Vertical planning processes for HIV to include a national strategic planning process that while multisectoral in development is not integrated into the health system's planning process.
- Centralized management and planning including the availability and use of data that does not facilitate district or localized understanding of and planning for the epidemic.

Other country examples in the Latin America and Caribbean region also demonstrate the lost opportunities and coverage gaps as a result of a fragmented health system. Complicated, time-consuming processes that demand burdensome visits to multiple service points are documented in many country settings, each site presenting its own challenges. In Brazil despite increased access to PMTCT, there are still missed opportunities to diagnose and treat women during pregnancy: where in a 2002 National Sentinel Surveillance Study revealed that while 52% pregnant women were tested for HIV and were notified of their result, only 27% received care⁶⁹. These missed opportunities are not uncommon across the region. Failure to provide HIV and syphilis testing as routine procedures to pregnant women, delays in obtaining test results, subsequent gaps in follow-up prophylaxis and treatment, and failure to follow up with children exposed to HIV or syphilis and their mothers unfortunately exist.

Despite scale-up of PMTCT programmes in many countries, prenatal care is still not being fully utilized as an entry point to HIV diagnosis. This is evident in the extent to which health facilities at country level offer PMTCT services. Among the Latin America and Caribbean countries that report on PMTCT, nine countries offered prevention of Mother to Child Transmission of HIV in less than 30% of facilities, one country offered PMTCT at between 31-60% of facilities and ten countries in over 61% of facilities⁷⁰. The missed opportunities presented by prenatal care are all the more evident considering

⁶⁸ COPRESIDA. In 2001 the Presidential Council on AIDS (Presidential Decree 32-01) was created as a multisectoral body to include civil society, charged with the development of national strategies and policy.

⁶⁹ Castro, A. (2009) Ph.D., MPH, Harvard Medical School. Prevention of Mother-to-Child Transmission of HIV and Syphilis in Latin America and the Caribbean. Prepared for PAHO/WHO Draft document.

⁷⁰ Ibid.



that notwithstanding variances across the region⁷¹, it is estimated that in LAC, 86 percent of women are attended at least once during pregnancy by skilled health personnel (doctor, nurse or midwife)⁷².

Additionally, a tendency to focus on preventing transmission of HIV to the child as opposed to additional follow-up with the mother's serostatus is another issue that impacts coverage. Other development challenges can also impact significantly on follow-up with HIV positive mothers where when financial resources are limited, women may not seek prenatal care, testing, and adhere to treatment as they prioritize child care or paid work over health seeking, as was noted in Haiti and in Peru. Efforts to address the gap in PMTCT programmes in the LAC region have recently resulted in a renewed push for an integrated response to eliminating congenital syphilis and vertical transmission of HIV that is unfolding at the time of preparation of this document. Given the missed opportunities in this critical area of HIV programming, this represents a critical area in need of country-level support.

⁷¹ Proportion of women who were never attended during pregnancy is as high as 40 percent in Guatemala, 31 percent in Ecuador and Bolivia, or 30 percent in Costa Rica, while the proportion of women who have at least one prenatal visit is as high as 86 percent in Mexico and Brazil, 91 percent in Colombia, 98 percent in the Dominican Republic and 100 percent in Cuba

⁷² Ibid.



3. The Way Forward: Meeting the Internationally Agreed Development Goals (IADGs)

Given the analysis of the gaps and challenges to the response to HIV in LAC, a number of cross-cutting imperatives are critical to achieving sustained progress towards the internationally agreed development goals (IADGs) and specifically, Universal Access goals of 2010 and the Millennium Development Goals of 2015:

3.1 Maintaining interest in HIV

While human and financial resources are critical enablers to the region's response, there are a number of 'no-cost' and/or 'low cost' initiatives that are critical in maintaining interest in tackling HIV, particularly at a time of seemingly 'competing' or perceived lower level priority. These include:

- Continue to provide community, national and regional leadership and to keep HIV on national and regional agenda;
- Maintain and/or increase, as far as possible, current national investments in HIV (with a focus on integrated development approaches) and actively lobby for the same of international institutions; and
- Invest more actively in non-financial and low-cost options in addressing HIV: stronger and more visible national leadership on difficult challenges such as stigma; facilitate in-country partnerships for pooling resources as an option that many countries have not yet exhausted; build social capital among PLHIV receiving treatment in order to support sustained and increased funding for treatment and care; actively facilitate regional sharing of expertise and contextually appropriate problem-solving.

3.2 Maintaining strategic investment in HIV

In recognition of the realities of a global financial crisis and the fact that the needs of the region's epidemic far outpace the available resources, countries in LAC must make **strategic investments** in their country and sub-regional regional epidemics in order to protect and sustain the hard-won gains over the past two decades. A key underpinning investment is in **reducing the dependence on external resources**, where HIV should be tangibly integrated (with corresponding resource allocation) across sectors, thereby reducing the burden on one sector and maximizing the effectiveness of programme delivery.



Other investments are critical in the areas of:

- ***Relevant research and high quality, timely data***
- ***Maximizing the effectiveness of current and future investments***
- ***Integrated public health systems***
- ***Human rights and social justice programming***
- ***Strengthening programmes to address social vulnerability and risk***
- ***Strengthening prevention coverage***
- ***Strengthening collaborative responses for HIV/TB co-infection***

● ***Improved data***

Whether through public health services, or social service delivery, all aspects of HIV-related programming will continue to be underserved unless policy decisions and programme revisions are based on high quality and timely informed research. Strengthened surveillance systems that routinely capture all those affected by the epidemic including those most at risk (MSM, SW, IDU) and vulnerable (women, prisoners, drug users) is the basic tenant upon which country responses should be based. Surveillance systems should also capture: where new cases are coming from and project where they are likely to arise (to plan the most effective prevention response); whether the epidemic is increasing, stabilizing or decreasing (to monitor overall progress and identify gaps); and profiles and numbers of people living with HIV and AIDS, disaggregated by sex and age (to adequately plan for and provide care and treatment for persons living with HIV and AIDS), if responses are to be effective. Additionally, there is need for full understanding of national and regional epidemics through additional research data on targeted affected populations, as well as thorough examination of HIV vis à vis other development challenges.

● ***Maximizing the effectiveness of current and future investments***

Quite apart from the need for relevant, timely and adequate analysis and use of data, commitment to a long-term, sustained response demands analysis of the allocation and utilization of resources, over and above the achievement of indicators that is currently addressed by current monitoring and evaluation frameworks.

In addition to monitoring against agreed indicators, countries of the Latin America and Caribbean region must seek to expand evaluation routinely to that of resource utilization of HIV programming in order to: maximize the effectiveness of the resources invested as well as; facilitate more long-term planning approaches to and resource mobilisation for HIV, as opposed to medium-term responses.

● ***Strengthening Health Systems***

Given the barrier posed by fragmented public health systems to HIV programming and service delivery, LAC countries must prioritise the following:



- Invest in integrated public health systems for more effective use of scarce resources and to ensure effective delivery. Multisectoral approaches to health communication and health service delivery must be a key component of this integrated approach, as well as the integration of HIV specific services and interventions into already existing service delivery mechanisms, moving these services to the most peripheral level of care.
- Together with the investment in integrated health systems, the decentralization of service delivery points will contribute in the long-term, to the effective scaling up of HIV treatment as well as de-stigmatizing the provision of HIV services by removing the element of 'identifiable' HIV facilities.
- National treatment systems and approaches to consult and integrate community-based care and support services and informal social networks as a means of interface with those populations most at risk of infection.

● ***Human rights and social justice programming***

Recognising that stigma and discrimination are not specific to HIV and recognising that stigma and discrimination represent perhaps the single most devastating barrier to attaining the IADGs, immediate and increased investment is needed in support of human rights and social justice programmes. Well-defined and context-specific programmes in this regard will permit a tangible, action-oriented approach to addressing stigma and discrimination to include repealing laws that deny human rights of groups of individuals most at risk, public health systems review and addressing public opinion, over and above the high-level advocacy and public information campaigns that seem to dominate efforts in many countries in this regard.

As such, related investments are also needed in improving the technical capacity on human rights programming and specifically, moving from conceptual and analytical approaches to practical implementation of rights-based programming.

● ***Strengthening programmes to address social vulnerability and risk:***

- ***Gender inequity*** needs to be addressed across development programming through specific and targeted interventions, and in particular, the empowerment of women (specifically young women), given the impact of the epidemic on women throughout the region.
- ***Vulnerability*** of groups such as prisoners, drug users and young people must be addressed through comprehensive and sustained prevention programmes, rather than ad hoc interventions.
- ***Most-at-risk populations*** such as men who have sex with men, sex workers, and injecting drug users require targeted outreach and interventions including improved access to basic sexual health services, aimed at improving access to information and services and reducing risk-taking behaviour.



● ***Prevention: increasing coverage and comprehensiveness***

Significant increases will be required in prevention coverage as a key component to reducing infections, particularly among most-at-risk populations, for which prevalence rates are significantly higher across the region. But prevention programming cannot be undertaken in a vacuum, but rather depends on social and legal infrastructure to work. As such, there is also need for balanced attention to comprehensive prevention, care and treatment programming at the national level that is: i) evidenced-based and ii) addresses the social, infrastructural and legal factors and barriers that underpin risk-taking and vulnerability.

- PMTCT: it is important to prioritise the regional initiative for the elimination of vertical transmission of HIV and congenital syphilis.
- Take advantage of opportunities to integrate HIV into sexual and reproductive health education and comprehensive services. This includes strengthening sexual education for young people and adolescents.

● ***Improving and enhancing collaborative responses for HIV/TB co-infection***

Greater awareness is needed of the interlinked epidemics of HIV and tuberculosis. Although it is mostly preventable and curable, tuberculosis (TB) is one of the leading causes of death among people living with HIV globally. There is urgent need for integrated TB and HIV services. For many years efforts to tackle TB and HIV have been largely separate, despite the overlapping epidemiology. Improved collaboration between TB and HIV programmes will lead to more effective prevention and treatment of TB among people living with HIV and to significant public health gains. Necessary collaborative actions include: HIV testing and counselling to all TB patients; screening all people living with HIV for TB disease; provision of TB treatment or preventive therapy to all co-infected persons; provision of cotrimoxazole and antiretroviral treatment to all TB patients and; ensuring TB infection control in all health care facilities and high HIV prevalence settings.

In addition to these broad yet essential regional priorities for action, a number of priorities also exist for both Latin America and the Caribbean, as developed in the sections below.

3.3 Latin America

- ***Deepen investment in programmes for those most at risk:*** Scale up financing to invest more in replicating successful localized interventions with most at risk groups, as an integral part of comprehensive strategies. Strengthen active involvement of, outreach to, prevention and accessibility of basic sexual health services to at risk populations such as female sex workers and specifically men



who have sex with men, particularly through paid sex (male sex workers), as well as sex between men who are injecting or inhaling drug users.

- ***Moving from theory to application:*** The fact that Latin America as a region has abolished laws that criminalized sex between men does not translate to the disappearance of homophobia or the availability of national resources to adequately address this and other at risk populations. There is need to comprehensively address homophobia and discrimination through effective reporting of anti-discrimination violations; enforcement of anti-discrimination laws; and social communication initiatives.
- ***Changing dynamics of vulnerability:*** In addition to the vulnerability of women to HIV infection as a result of poverty and inequality, countries of Latin America must strengthen programmes that address the vulnerability of women whose partners are infected through sex with other men and that of young girls suffering from sexual abuse and involved in intergenerational sex.
- ***Addressing data needs:*** As a constant underpinning factor, data on the specific country dynamics of the epidemic, as well as how it is impacted and impacts the wider development context is needed. In addition to data on most at risk populations, Latin American countries must also routinely document and address the needs among indigenous and migratory populations where applicable.

3.4 Caribbean

- ***Insufficient data:*** Despite significant improvements in the reporting abilities of a number of countries, there are still key gaps in data that undermine a full picture to be formed of many national epidemics. The impact of and/or on most at risk populations, other development challenges and legal and illegal migration are but a few of the issues that need to be fully understood and addressed. Urgent investments are needed in creating relevant, accurate and timely data, in order that programmes are targeted and effective.
- ***Availability and use of resources:*** Amidst unprecedented increases in domestic and international funding made available for HIV programming, the needs of the Caribbean epidemic continue to outpace those resources. Additional investments of financial resources are needed in strategic programme areas, as well as investments in the absorptive capacity of national and civil society actors to use available financing most effectively. Moreover, in times of scarcity, the Caribbean must reconsider where the most strategic investments are needed, in areas that persistently drive its epidemic: insufficient and/or outdated data; specific, comprehensive and integrated programmes to address human rights and



social justice and; strengthening of public health delivery systems and infrastructure.

- ***Reaching treatment targets:*** While absolute numbers of persons receiving treatment has increased, treatment coverage is still in danger of missing Universal Access targets in many countries. National programmes need to be strengthened to adequately reach and retain those persons requiring treatment. This includes a fresh look at how to maximize the opportunities for reaching the population as well as maximize resources through integrated public health services.
- ***Imperatives of addressing those most at risk and those most vulnerable:*** Outreach to and access to prevention, care and treatment services among most at risk populations such as MSM, and SW in particular have begun to take shape in a few countries, but most of the region's countries have no data in this regard. Moreover, social and institutional barriers such as stigma, discrimination and the existence of laws that criminalize these behaviours if not addressed will perpetuate and possibly deepen the impact of the epidemic on these groups. Pregnant women and children need to remain as a group of special attention in order to continue progress in access to early diagnosis, care and treatment for mothers and their newborns.

While recognising the significant difficulties in challenging individual and community moral value systems and social norms, not to mention directly addressing issues of political sensitivity, the available data on the staggering impact on MARP groups leave no choice but to face issues such as legalization of sex between men and sex work head on, and make urgent adjustments to legislative and public health systems. The price to be paid for ignoring systemic and/or institutional obstacles is too high.



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