

HIV/AIDS in Latin American Countries

The Challenges Ahead

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HIV/AIDS in Latin American Countries

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Preface

Compared with most countries in Africa, and with the nearby islands of the Caribbean, many Latin American countries have not faced a full-scale AIDS epidemic. On average, Latin American countries estimate HIV prevalence among 15- to 49-year-olds at 0.5 percent. Around 130,000 adults and children were newly infected with HIV during 2001, and 80,000 died. Although AIDS accounts for only a fraction of all adult deaths in most Latin American nations, those deaths occur in the most productive years of life. There are worrisome signs in several countries in the Region; the disease appears to be evolving—from affecting virtually only the highest risk groups, such as men who have sex with men (MSM) and injecting drug users (IDUs)—to becoming an increasingly generalized problem. Throughout the Region, many behaviors associated with the spread of HIV/AIDS (young age at first intercourse, violence against women, injecting drug use) are commonplace, and with the exception of a small number of countries, the response to the threat of HIV/AIDS has been slow, small-scale, and largely only supported by external agencies and international programs. If the warning signs are heeded, and appropriate prevention measures are taken in the very near future, Latin America has the opportunity to avoid the sad stories seen in other parts of the world.

Sound and timely policies can limit the current and future impact of HIV/AIDS on Latin American health care systems, economies,

and societies. Good policies are based on understanding the scope and special nature of the HIV/AIDS problem, and confronting it in a way that respects human rights.

This book attempts to present new and updated information about the extent and trends of the HIV/AIDS epidemic in Latin America; to evaluate current national surveillance capacity; to assess national responses of the health sector to the epidemic on a country-by-country basis; to identify key areas in which specific interventions are urgently needed; and to outline the challenges ahead.

Rich in information, and based on both analyses of secondary information and a full set of newly collected country-level data, this book is intended to be the basis for discussions within and across countries, and between countries of the Region and their development partners.

This study was conducted in 2001 and included 17 countries: Argentina, Bolivia, Brazil, Chile, Colombia, Costa Rica, Ecuador, El Salvador, Guatemala, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, República Bolivariana de Venezuela, and Uruguay.

It would be worthwhile for the World Bank, as well as the countries themselves, to conduct a form of self-evaluation in terms of the achievements, obstacles, and challenges ahead; and it would be very useful to make this information available to all actors involved. In the future, this study could become a point of departure for comparing this year's results to others. If the report were to be made publicly available, countries and institutions could use it for their own evaluation.

For purposes of analysis, some countries were aggregated into subregions, according to similarities in socioeconomic level, health system, and epidemiological pattern of the epidemic; geographical proximity; economic, cultural, and political interests; cultural roots; and frequency of internal migrations. Three subregions were analyzed: Central America (Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, and Panama); the Andean Region (Bolivia, Colombia, Ecuador, Peru, and República Bolivariana de Venezuela); and the Southern Cone (Argentina, Chile, Paraguay, and Uruguay).

Brazil and Mexico were analyzed individually. Both countries possess much higher resources; their national programs have reached a

high level of development; and the disease's epidemiological pattern presents some characteristics seen in industrialized countries.

The study uses primary and secondary data. *Primary data* were collected using four survey instruments specifically geared to this study. The surveys were designed to assess surveillance systems and national responses to the epidemic from the health sector. Before distribution to the target group of respondents, the survey instruments were reviewed by experts working in the field who had knowledge of the Latin America region.*

Data on surveillance systems were collected through a self-administered, semi-structured questionnaire applied to those managing national HIV/AIDS surveillance systems in 17 Latin American countries (i.e., technicians from the national AIDS program or from the departments of epidemiology, depending on the countries). The survey instrument included questions assessing the case definition, reporting procedures, type of surveillance, sources of information, and feedback of the surveillance information. All countries surveyed sent in their questionnaires, but the level of completion of the questionnaires was variable.

Data on the institutional capacity to fight the epidemic were collected using three questionnaires. These questionnaires were given to the heads of national HIV/AIDS programs, to key respondents from nongovernmental organizations (NGOs), and to physicians working in the field. Most physician and NGO questionnaires were completed face-to-face by trained interviewers.

In each country a questionnaire was given to the director of the national HIV/AIDS program. The following topics were covered in the questionnaire: (1) description of the program; (2) multisectoral coordination and legislation; (3) sensitization/prevention interventions directed to the general population and adolescents; (4) interventions targeting high-risk groups; (5) interventions for preventing

*These experts included HIV/AIDS specialists, a former national HIV/AIDS coordinator, a population and health specialist, a demographer, a public health specialist and an epidemiologist. The questionnaires were administered to the target group of respondents, preceded by a letter presenting the study and explaining the methodology.

mother-to-child transmission; (6) access to the health system and prevention methods; (7) financing and relations with NGOs; (8) characteristics/coverage of health and social services provided; (9) relations with international agencies; and (10) main problems faced in controlling the epidemic in that country.

NGOs were selected according to the following criteria: years of experience and level of integration in the countries (favoring those with larger history in the fight against HIV/AIDS); whether they were community-based, working with high-risk groups or people living with HIV/AIDS (PLWHA); and implementation of various HIV/AIDS-related activities (prevention, psychological, legal, and social support). Eighty-four NGOs were selected from a pool of more than 900. Among the NGOs surveyed, the average period of working with HIV/AIDS patients is eight years; 60 percent of these NGOs work at the national level, serving over 500,000 people in the Region. In all, 4,000 people work for the NGOs surveyed (this includes full-time and part-time workers and volunteers).

The NGO questionnaire was designed to cover the following aspects: characteristics of the NGO (level of integration, resources, work environment, target populations, involvement in networks, and objectives of the organization); activities over the last year regarding HIV/AIDS, specifying target populations, budget, flow of funds, and coverage and impact of the interventions; level of coordination with governments and national plans; status of the epidemic and those affected from the perspective of the NGO; and main problems and obstacles (present and future) for controlling the epidemic.

Physicians were selected according to the following criteria: significant experience in clinical management of patients with HIV/AIDS, and experience working in large health facilities.

Five physicians were selected from each country; these were recommended by national HIV/AIDS programs and by experts from the Region. Sixty-four (75.3 percent) agreed to contribute information and opinions for this study. The 64 physicians surveyed have, on average, 13 years of experience in the clinical management of patients with HIV/AIDS—more than half (59 percent) in both public and private practice—and serve approximately 50 patients per month.

The physician questionnaire focused on history (years in the current health sector and level of professional experience); conditions under which she/he practices (good-practice protocols, conditions for diagnosing and treating patients); coverage of basic services for diagnosing and treating patients; knowledge of HIV/AIDS in the population; and issues with infrastructure and health care resources for effectively controlling the epidemic.

Secondary data were drawn from national statistics and were complemented by data published by international organizations (WHO/PAHO, UNAIDS, and SIDALAC), and data from studies conducted in the Region and identified through databases, as well as from national strategic plans.

National surveillance systems provided data on incidence and prevalence of HIV and AIDS. From the same sources, the study used data on incidence and prevalence of STIs and HIV in different sentinel populations (blood donors, CSWs, MSM, IDUs, and others).

Certain countries are not included in certain tables and charts, which indicates that the corresponding relevant data were not available.

This document touches upon the broader context in which the response to HIV/AIDS in Latin America is taking place; however, it focuses more specifically on how the health-sector response is seen by different country players. Results and conclusions drawn from this study represent the views and opinions of a group of key respondents selected from the national HIV/AIDS programs, NGOs, and physicians; these were supplemented with information from other sources. Therefore, these views cannot be and were not extrapolated or generalized to the overall national response of a country.



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Executive Summary

Although the risk behaviors and biological markers that fuel the epidemic are widespread, many Latin American countries have not yet faced a full-scale AIDS epidemic. On average, Latin American countries estimate HIV prevalence among 15- to 49-year-olds at 0.5 percent. Around 130,000 adults and children were infected with HIV in 2001, and 80,000 died of AIDS.

HIV/AIDS in Latin America falls within the framework of a low endemic setting. In the majority of the countries, the epidemic is still concentrated in high-risk populations: men who have sex with men (MSM), injecting drug users (IDUs), commercial sex workers (CSWs), prisoners, and people with sexually transmitted infections (STIs). The exceptions are Honduras and southeastern Brazil, where the epidemic has reached the general population. Heterosexual sex is the primary mode of transmission in Central America, with sex between men predominating in South America, and injecting drug use playing a significant role in the Southern Cone. Survey respondents also identified other populations with increased vulnerability in which interventions would be crucial—young people and women. Although the number of men living with AIDS outweighs the number of women in all countries, the gender gap is closing, and in some countries, the effect of AIDS on rural communities is increasing rapidly.

In low endemic settings, the main priority is the highest risk groups, and activities to address HIV/AIDS should be focused on

(1) strengthening efforts to prevent new infections in these populations, and (2) providing care and support strategies, which in turn create incentives for early detection of infection and/or risky behavior.

Epidemiological surveillance plays a key role in the control of the epidemic through the measurement of frequency, distribution, and evolution of HIV/AIDS among populations; identification of high-risk groups; and evaluation of the effectiveness of prevention efforts.

In Latin America, epidemiological surveillance of HIV/AIDS at the national level began in the 1980s. Since then, allocation of resources and personnel has steadily increased, leading to well-established surveillance systems based on AIDS cases notification. Presently, in every Latin American country, the reporting of AIDS cases is mandatory. However there are persistent high levels of underreporting and delays in reporting. The epidemic in Latin America is likely to include around 30 percent more cases of AIDS and 40 percent more cases of HIV than currently estimated.

Since the late 1980s, Latin American countries have demonstrated the capacity to confront the HIV/AIDS epidemic, developing new structures and the groundwork needed for community responses.

At the global level, there have been continuous efforts to mobilize political leadership at the highest levels of national, regional, and global governance. At the country level, much has been achieved. By the end of 2001, almost all countries in Latin America had their national strategic frameworks finalized or were in the process of completion. In most cases, the plans were developed with participation from a broad range of stakeholders (including various government ministries, civil society, associations of people living with HIV/AIDS, bilateral and multilateral partners), and they now serve as the common reference for action. The national strategic plan process also resulted in a clear shift in the perception of the epidemic from a health-only issue to a broader social and developmental approach.

Latin America has an excellent basis for effective interventions with multilateral and/or bilateral organizations. The resources infrastructure and professionals are in place to implement a variety of interventions, evaluate their impact, and sustain them over time.

However, the capacity to respond has been limited by political, technical, and social problems. The challenge ahead is to tackle some of the chronic problems that affect the national response.

Results from this study bring to light many aspects of the health sector response to the HIV epidemic that could be improved and they provide feasible prioritized solutions. The study unravels the gains from an expanded response by engaging much more closely the community and social movements around HIV/AIDS.

In terms of the health sector, this study identified several key problems and offered possible solutions.

Prevention

Key Problems

In the national response there are insufficient interventions targeting high-risk groups, worsened by a substantial lack of information on the magnitude and trend of the epidemic. These include MSM, CSWs, IDUs, and other groups such as prisoners. Health and sexual education programs for adolescents and young people are widespread but the skills to prevent HIV infection in these groups may be lacking from its content. Levels of multisectoral coordination are unequal among countries in the Region. Although there are structures in place to foster multisectoral coordination in almost all countries, the level of true collaboration is still low, lacking resources and adequate coverage for coordinated execution of interventions. At the same time, there is limited coordination between NGOs and governments in interventions for specific populations. NGOs are much more likely to have access to marginal populations, or those that lack health services, yet governments and most NGOs dedicate the majority of their efforts to groups with “variable risk” for infection (i.e. the general population, young people, women, etc.). A stronger and continuous involvement from civil society needs to be ensured, since it may be the only way to expand the response to AIDS in the near future.

How to Address them?

- Enhance approaches that focus on social mobilization and on building up of community responses.
- Improve multisectoral coordination.
- Intensify interventions for high-risk groups, where HIV infection reaches the highest levels.
- Promote gender policies that strengthen and build equitable relationships.

Access to Health and Social Services

Key Problems

In Latin America, a substantial number of people infected with HIV do not have access to adequate and comprehensive health care. The reasons for this are diverse, including limited access to services and below-quality standards. Insufficient medical training is one of the main deficiencies impacting health care, along with lack of appropriate clinical management guidelines. Finally, access to new anti-retroviral therapies is hindered due to cost and health infrastructure.

There are general deficiencies, such as the need to strengthen resources infrastructure, especially the network of HIV diagnostic laboratories, labs for determining CD4 levels* and viral load[†], as well as infrastructure needed for diagnosis and follow-up for coinciding infections and other disease processes associated with HIV. According to national programs, the network of laboratories is insufficient, especially in Central America and the Andean Region (although this

***CD4** count refers to a measure of “helper” T cells that help B cells produce antibodies. The number of CD4 cells is an important measure of an individual’s immune system capabilities.

[†]**Viral load** test is a measure of the amount of HIV in the blood to determine how far infection has progressed.

is characteristic of all Latin America). Access to services is limited by the payment required.

Substantial numbers of people are unaware that they are infected by HIV. Barriers that prevent greater coverage and have implications for supply and demand (such as discrimination, confidentiality, etc.) prevent people from coming early to the services. There is also the need to pay more attention to those interventions for decreasing mother-to-child transmission of HIV in health centers.

How to Address them?

- Improve health and social services through multisectoral collaboration.
- Promote HIV testing, especially among high-risk populations.
- Offer HIV testing to all pregnant women.
- Strengthen health infrastructure and laboratory networks.
- Train physicians and nurses in clinical management and treatment of HIV and other STIs.

Human Rights

Key Problems

Lack of information, stigmatization, homophobia, and social prejudices regarding sexual orientation or behavior prevent access to prevention and clinical care in Latin America. These are some of the obstacles that people at high-risk or who are infected face when trying to access services. These also hinder access of people living with HIV and AIDS (PLWHA), which impedes fair and equitable treatment.

How to Address them?

- Fight against ignorance and promote human rights.
- Preserve the right to access health, social, and psychological care.

- Promote programs addressing the issue of schooling for HIV-positive children.
- Promote the right to work and integration or re-integration in the workforce.
- Involve PLWHA in all strategies for prevention and control of the epidemic.

National Capacity: Structure and Management

Key Problems

The multiplicity of health problems affecting Latin America and the health sector reforms are part of the circumstances that have prevented Latin America from giving a more articulated response to the epidemic. Most of the countries have multisectoral plans with the participation of multi-partners; however, the actual functionality and capacity for a collaborative response has been mediated by the technical and political capacity of national programs and by limited resources available for HIV/AIDS control. Stronger involvement from civil society, communities, and associations of PLWHA is critical to the response to AIDS in the Region.

Surveillance systems in Latin America need to be strengthened to provide accurate data for decision making. Availability of systematized information on the incidence of newly diagnosed HIV infections and sentinel surveillance coverage (especially among the most affected groups) is scarce throughout the Region. Registries of AIDS cases, which have the greatest tradition and permanence, show high levels of under-reporting in certain subregions, especially Central America. Currently, these systems don't provide a clear picture of the magnitude and trends of the epidemic, and they are also weak in capturing the early signs of alarm given by the dissemination of the epidemic. These systems should include a behavioral component.

How to Address them?

- Consolidate multisectoral responses to the epidemic, and bring national strategic plans into a reality.
- Strengthen epidemiological surveillance systems.
- Establish guidelines for prevention interventions and consolidate the interventions that have been most cost-effective.
- Blood safety policies should be revised to achieve universal testing of donated blood and acceptance of only voluntary, altruistic, non-remunerated donations.
- Provide continuous capacity-building of human resources.
- Increase available resources.
- Overcome cultural, social, and religious factors that obstruct good technical proposals or government decisions.
- Encourage and support NGO networks.
- Increase synergy and coordination among different actors in the Region.



Abbreviations and Acronyms

AIDS	Acquired immune deficiency syndrome
ARV	Antiretrovirals
CDC	Centers for Disease Control and Prevention
CSW	Commercial sex worker
HAART	Highly active antiretroviral therapy
HIV	Human immunodeficiency virus
IBRD	International Bank for Reconstruction and Development
IDUs	Injecting drug users
IFA	Immuno-florescence assay
INH	Isoniazide
MoH	Ministry of Health
MSM	Men who have sex with men
NGOs	Nongovernmental organizations
PAHO	Pan American Health Organization
PLWHA	People living with HIV/AIDS
STIs	Sexually transmitted infections
UNAIDS	Joint United Nations HIV/AIDS Program
WB	Western blot
WHO	World Health Organization