HIV/AIDS HEALTH PROFILE

Latin America and the Caribbean

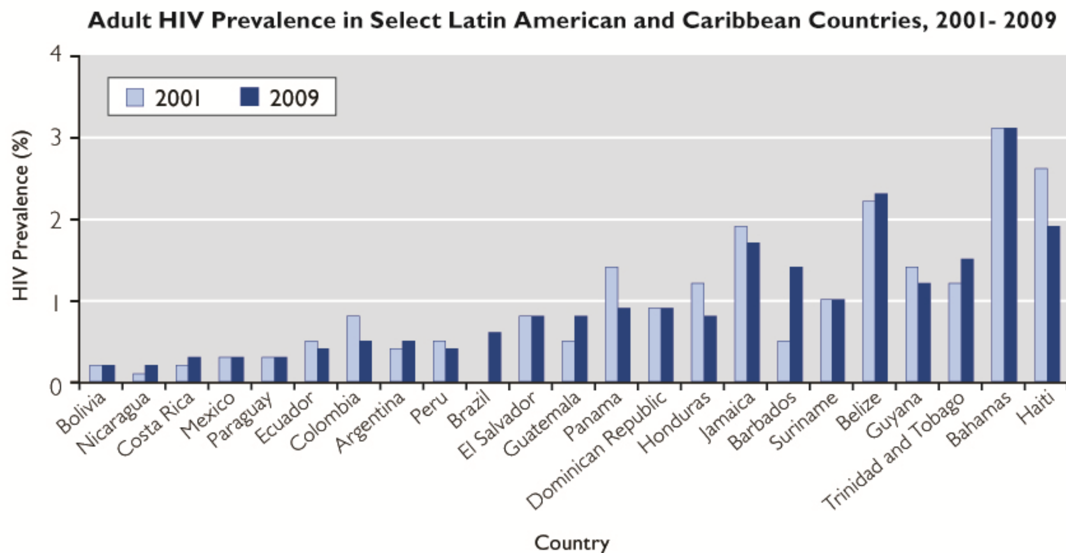
Overall HIV Trends

Most HIV epidemics in the Latin America and the Caribbean (LAC) region appear to be stable, although in some Caribbean countries, they appear to be in decline. In 2009, about 84,400 people in LAC countries died of AIDS, and 123,900 were newly infected (Joint United Nations Program on HIV/AIDS [UNAIDS], 2010). The number of people living with HIV/AIDS (PLWHA) in LAC is estimated at 1.86 million (UNAIDS, 2010). Two-thirds of PLWHA reside in five countries: **Argentina**, **Brazil**, **Colombia**, **Haiti**, and **Mexico**. The Caribbean and Central American subregions have higher prevalence rates than South America, with countries such as **Haiti**, the **Bahamas**, and **Belize** having rates in 2009 as high as 1.9, 3.1, and 2.3 percent, respectively (see figure on next page). With its large population, **Brazil** accounts for about one-third of PLWHA in the region.

The epidemics in LAC are being fueled by varying combinations of unsafe sex (both between men and between men and women) and injecting drug use, but it is important to note that HIV/AIDS transmission patterns appear to have moved increasingly from marginalized groups toward the general population. HIV prevalence among sex workers is relatively high in Central America and the Caribbean, especially in the **Dominican Republic**, **Jamaica**, **Guyana**, **Haiti**, **Honduras**, **Guatemala**, **El Salvador**, and **Suriname** (United Nations General Assembly Special Session [UNGASS] and UNAIDS, 2010). Unprotected sex between men is an important factor in most of the HIV epidemics in the region. In Central and South America, surveys conducted in groups of urban men who have sex with men (MSM) found HIV prevalence of at least 10 percent in 12 out of 14 countries (UNAIDS, 2010). Social stigma keeps these epidemics hidden and many MSM also have sex with women. For example, in Central America, one in five MSM also had sex with at least one woman within the last six months. Injecting drug use is another main mode of transmission in LAC. UNAIDS estimates 2 million people in Central and South America inject drugs and 25 percent may be HIV positive. In older epidemics in South America, heterosexual transmission appears to be increasing (UNAIDS, 2010). This may be due to strong prevention of mother-to-child transmission of HIV (PMTCT) programs, which test pregnant women more often than other high-risk groups. Also, because of the stigma associated with MSM behavior, many hidden MSM do not admit to having homosexual sex. In **Argentina**, injecting drug use is decreasing while unprotected sexual intercourse, mainly between men and women, appeared to account for four out of five new HIV diagnoses during the mid-2000s. In **Peru**, 43 percent of new HIV infections are reported to be heterosexual, mostly through paid or other high-risk sex.

The first figure (see next page) shows trends in HIV/AIDS prevalence in the LAC region between 2001 and 2009. In most countries, the prevalence rate was less than 1 percent and showed little change or was in decline, although in a few it continued to rise. Increases were particularly notable in **Barbados** and **Trinidad and Tobago**. The **Bahamas** remains one of the region's high-prevalence countries, with 3.1 percent of the adult population HIV positive (UNAIDS, 2010).

Outside of sub-Saharan Africa, the Caribbean subregion has the highest HIV prevalence in the world. National estimated adult HIV burdens vary significantly, from an extremely low prevalence of 0.1 percent in **Cuba** to a relatively high prevalence of 3.1 percent in the **Bahamas**. Substantial differences also exist within countries. In the **Dominican Republic**, there is nearly a sevenfold variation in prevalence across different parts of the country. Whether considered generalized or concentrated, HIV epidemics are disproportionately affecting the most vulnerable population groups across the region. The main route of HIV transmission in the Caribbean is reported to be through heterosexual contact. Sex work, including sex tourism, is a primary source of transmission. As more research on most-at-risk populations (MARPs) is conducted, MSM are emerging as another significant route of HIV transmission. Unprotected sex between



Source: UNAIDS 2010 Report on the Global AIDS Epidemic Data for Brazil are from the 2010 UNGASS report.
No trend data are available for Brazil.

men is believed to account for about 10 percent of HIV cases in the Caribbean. For many HIV cases, however, the method of transmission is not reported, making it difficult to ascertain the cause. HIV prevalence among prisoners in six Organization of Eastern Caribbean States (OECS) countries ranged from 2 to 4 percent in 2004 and 2005. Mobile and migrant populations and victims of gender-based violence are vulnerable groups, with higher HIV prevalence than the general population.

The LAC region has made considerable progress in providing antiretroviral therapy (ART). According to the 2010 World Health Organization (WHO)/UNAIDS/UNICEF progress report *Towards Universal Access,* the number of people receiving ART in LAC steadily increased from 210,000 in 2003 to 478,000 in 2009. ART coverage reached 50 percent, the highest level of any world region in 2009. The estimate of people in need of therapy is based on the 2010 WHO guidelines for initiating ART in patients with CD4 counts at or below 350 cells/mm^3 rather than the 2006 guidelines of CD4 counts below 200 cells/mm^3. Although the current trend is still positive, under the 2006 guidelines, LAC coverage would have reached 67 percent at the end of 2009.

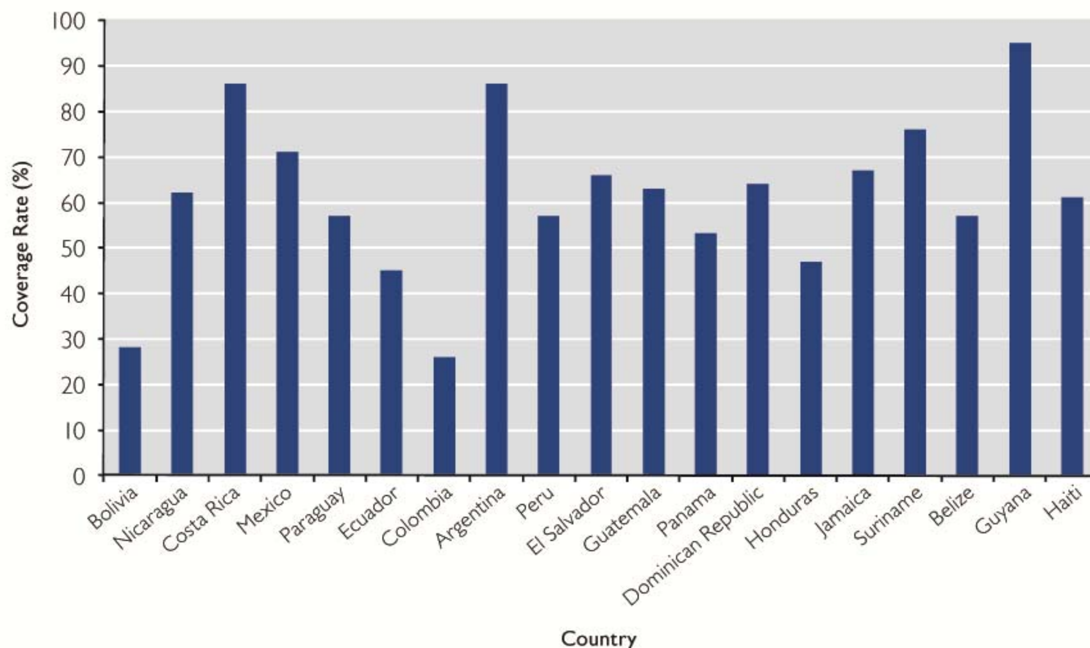
HIV-tuberculosis (TB) co-infection is a major concern in Latin America and the Caribbean, as TB is endemic in the region. According to the 2010 WHO TB report, TB-HIV co-infection in 2008 was high (between 9.4 and 23 percent) in **Brazil**, **Guatemala**, **Jamaica**, **Haiti**, **Honduras**, **El Salvador**, and **Mexico**. HIV-TB co-infection complicates the care and treatment of both diseases, and multidrug-resistant strains of TB are a growing concern.

Economic and Social Impact of HIV/AIDS in Latin America and the Caribbean

Illness, disability, and death associated with HIV/AIDS affect populations at multiple levels and in multiple ways. The vast majority of people who have the disease are between the ages of 15 and 49, and often the under-30 age group is the most affected. This has an impact on the most economically active segment of the population, resulting in possible changes in the demographic structure that pose challenges to support systems for dependent populations, such as children and the elderly. In **Honduras**, nearly 76 percent of HIV cases reported as of December 2009 occurred among people aged 20 to 39. In **El Salvador**, AIDS has grown to be the leading cause of death among young and middle-aged adults, reducing the country's workforce. The cost of addressing HIV can also divert resources away from investments critical to national economic development. The potential loss of productive labor could threaten the economic growth of countries in the region that have more pronounced epidemics.

Although many LAC countries currently have low prevalence rates, this could change due to cross-border migration from higher-prevalence neighboring countries. Migration contributes to the HIV epidemic in the region in multiple ways. Since tourism drives the economies of many countries, workers migrate to tourist areas. In such areas, many workers engage in transactional sex, sex work, or other high-risk behaviors that increase their vulnerability to HIV. Language and legal barriers make it difficult for migrants in many countries to gain access to services, particularly HIV testing and treatment services. In addition, outreach to migrant populations is difficult.

HIV/AIDS stigma and discrimination is widespread in the region. A predominant view is that HIV/AIDS is a punishment for immoral behavior. Many people avoid being tested or disclosing their HIV-positive status for fear of losing family, friends, jobs, housing, or social status. Therefore, accurate national data on prevalence and incidence among PLWHA such



as MSM can be scarce due to the stigma associated both with HIV infection and behaviors within the MSM community. As such, concentrated epidemics among MSM have often been hidden. While some countries have attempted to pass laws to protect PLWHA, many still have provisions that reinforce prejudices, such as laws prohibiting sodomy and sex work. Countries that do have progressive policies are struggling to enforce human and civil rights protections, and many marginalized groups refuse to come forward when their rights are violated out of fear of retaliation or further discrimination. Stigma and discrimination directed toward PLWHA, especially those who belong to marginalized groups, can contribute to further spread of the virus when members of these groups are reluctant to access health services. A series of HIV Service Provision Assessments showed refusal of services to known positive persons remains a reality in the region, but regional partners are working to address the issue. Other forms of stigma may range from gossip and verbal abuse, to violence and physical abuse, and to discrimination by employers, and create a challenge to the success of HIV programs targeting MSM and other MARPs. Fear of stigma may also drive MSM to seek out female partners to hide their sexual orientation, and this may be accelerating heterosexual transmission.

Gender discrimination also contributes to the spread of HIV. Traditional gender roles in many LAC countries imply that women should be submissive, allowing men to make decisions about engaging in sex. This limits women's ability to negotiate condom use and makes them vulnerable to sexual assault. At the same time, young men are also pressured to prove their masculinity by engaging in sex at an early age, having multiple sex partners, and sometimes using physical force against women. Higher rates of new infections are increasingly being reported among young women, compared with men of the same age cohort. This may be due to strong PMTCT programs, which test pregnant women, and to particular high-risk behaviors among young women, such as unprotected transactional sex and cross-generational relationships.

A persistent challenge in LAC is the hardship families and individuals face in purchasing antiretroviral drugs (ARVs). The high price of ARV cocktails can deplete family resources for those caring for an HIV-positive family member or deter PLWHA from seeking treatment. While prices were cut nearly in half in 2003 (five major pharmaceutical companies committed to reducing the cost of ARVs in **Costa Rica**, **Guatemala**, **Honduras**, **El Salvador**, **Nicaragua**, and **Panama**), treatment often remains unaffordable for PLWHA in the region. Social security systems and health insurance coverage are limited in many LAC countries, including **Guatemala**, **El Salvador**, and **Panama**. **Costa Rica** is one of the few Central American countries with a public social welfare system that covers health costs for ART. Even in those countries with stronger social welfare programs, the systems currently in place are not strong

enough to manage the burden of the disease. For example, the fact that second-line drugs are vastly more expensive mean that, despite very few people taking them, they still account for a large proportion of the overall drug expenditure in some countries. According to a 2007 AIDS journal article titled “TRIPS Post-2005 and Access to New Antiretroviral Treatments in Southern Countries,” the Brazilian Ministry of Health was spending 80 percent of its national budget expenditure for ART procurement on imported patented drugs. Inadequate supply chain systems in many countries lead to stockouts of ARVs, resulting in the need for much more expensive second-line treatments.

The Global Fund to Fight AIDS, Tuberculosis and Malaria funds ART programs to increase coverage, fostering close collaboration between governments and civil society to work toward sustainability of ART programs. The U.S. Government (USG) provides nearly 30 percent of the Global Fund’s total contributions worldwide.

USAID Regional Support

The U.S. Agency for International Development’s (USAID’s) HIV/AIDS programs in the LAC region are implemented as part of the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR). Launched in 2003, PEPFAR is the USG initiative to support partner nations around the world in responding to HIV/AIDS. Through PEPFAR, the USG has committed approximately $32 billion worldwide to bilateral HIV/AIDS programs and the Global Fund through fiscal year 2010. PEPFAR is the cornerstone of the President’s Global Health Initiative (GHI), which supports partner countries in improving and expanding access to health services. Building on the successes of PEPFAR, GHI supports partner countries in improving health outcomes through strengthened health systems, with a particular focus on improving the health of women, newborns, and children.

In 2010, the USG signed Partnership Frameworks with regional and national governments and organizations in Central America and the Caribbean. Partnership Frameworks are designed as five-year joint strategic frameworks to facilitate cooperation among the USG, the partner government, and other civil society partners to combat HIV/AIDS through service delivery, policy reform, and coordinated financial commitments. In March 2010, the USG and the Council of Ministers of Health of Central America signed a Partnership Framework that outlines a jointly developed strategy to support Central America’s regional response to HIV/AIDS. In June 2010, the USG signed a Partnership Framework with 12 Caribbean countries (**Antigua and Barbuda**, the **Bahamas**, **Barbados**, **Belize**, **Dominica**, **Grenada**, **Jamaica**, **St. Kitts and Nevis**, **St. Lucia**, **St. Vincent and the Grenadines**, **Suriname**, and **Trinidad and Tobago**) and two regional organizations (Pan Caribbean Partnership Against HIV and AIDS and the OECS/HIV/AIDS Project Unit). In November 2010, the USG signed a Partnership Framework with the Government of the **Dominican Republic** to support the implementation of the Dominican National Strategic Plan for the Prevention and Control of STIs, HIV, and AIDS, 2007–2015, which is part of the HIV/AIDS national response, and the Health Sector Development Plan.

USAID regional support strengthens countries’ programs and services to prevent MARPs from transmitting or acquiring HIV/AIDS and provide effective care and treatment for persons infected with HIV. With LAC regional funding, USAID held two meetings on HIV prevention with MARPs, one for Latin America in December 2009 and one in March 2011 for Central America. These meetings led to improved comprehensive programming for these groups, including MSM, commercial sex workers, and PLWHA. In preparation for the Caribbean meeting, USAID commissioned a technical brief on hidden MSM in the Caribbean and case studies on program responses to address HIV prevention and service needs of this population in LAC. The LAC regional program also strengthened resources to provide comprehensive HIV care and treatment in six Central American countries through boosting universities’ capacity to provide pre-service education in HIV knowledge, attitudes, and practices, so future health professionals understand and implement preventive practices; providing training in HIV counseling and testing to health faculties and students; and conducting baseline assessments of hospital-based HIV services, followed by in-service training of health care providers to improve quality and performance in delivering those services, with follow-up performance assessments to gauge improvements in each hospital.

USAID bilateral support also focuses on private sector involvement. With USAID support, CONAES, a national business council, was launched in 2004 in **Mexico** to reduce stigma and discrimination in the workplace. By using the media effectively and involving key opinion leaders, the project has dramatically raised the public profile of HIV-related stigma while giving credit to those companies that dedicate resources to reduce it. Since its inception, CONAES has had a direct impact on 150,000 Mexican workers and an indirect impact on an estimated 560,000 family members. In **Panama**, USAID has supported the Panamanian Business Council in HIV/AIDS prevention activities in the workplace since 1999. The Council distributes its HIV/AIDS management manual to human resource managers and provides corresponding training. A similar council was formed in **Guatemala** in December 2007 to develop and improve HIV/AIDS workplace policies and promote voluntary counseling and testing (VCT). The commission integrates reporting on private sector services into the reporting requirements of the public sector. Utilizing best practices developed in **Mexico** and **Guatemala**, USAID supported the creation of additional public-private alliances for HIV workplace policies and education in 2009–2010.

USAID regional and bilateral offices also play a lead role in coordinating activities with several USG agencies in the region, including the U.S. Centers for Disease Control and Prevention; the Peace Corps; and the Departments of Defense, Health and Human Services (Health Resources and Services Administration), and State. USAID also works with the Global Fund, Pan American Health Organization, UNAIDS, World Bank, and other donors and development banks, which have contributed crucial resources and technical capacity in fighting HIV/AIDS. In LAC, USAID and PEPFAR implement HIV/AIDS programs in **Belize**, **Bolivia**, **Brazil**, the **Dominican Republic**, **El Salvador**, **Guatemala**, **Guyana, Haiti**, **Honduras**, **Jamaica**, **Mexico**, **Nicaragua**, **Peru**, and **Panama**. In addition, USAID's Caribbean Regional Program, working with the other USG agencies, multilateral programs, and donors, covers the 12 Caribbean countries under the Partnership Framework.

Examples of recent USAID assistance include the following activities and interventions:

- In **Haiti**, 1.3 million people received messages to increase awareness and knowledge and promote behavior change to prevent HIV/AIDS. More than 56,000 orphans and vulnerable children (OVC) received supplemental food, health care, legal and social services, and school scholarships. Linkages with economic growth programs supported cash-for-work infrastructure projects in which 65 percent of workers were PLWHA and which provided 1,388 short-term jobs and 10,788 person-days of employment.

- In the **Dominican Republic**, more than 77,200 adolescents and youth received abstinence and "be faithful" messages through life skills programs in schools. More than 67,000 pregnant women received HIV counseling, testing, and test results via PMTCT programs. More than 31,600 adults infected with HIV received palliative care in 2009, and more than 77 million condoms were distributed from 2003 to 2009. USAID supplied Pante brand condoms, which constituted 62 percent of condoms available in zones where high-risk behaviors are frequently practiced.

- In **Jamaica**, USAID supported workplace policy development with 10 companies via a business council, and 549 staff received training in reducing HIV-related stigma and discrimination.

- In **Guyana**, more than 23,000 people, including 10,500 pregnant women, received HIV counseling and testing services and received their results. Outreach and sensitization activities reached more than 27,000 people with abstinence and "be faithful" messages. Continued scale-up of ART programs provided more than 2,850 PLWHA with ART. An additional 4,100 HIV-positive individuals, including people with HIV-TB co-infection, and 1,331 OVC received care and support services. Additionally, 744 health care workers of various categories were trained in safe injection practices and methods.

- In 2009–2010, USAID provided technical assistance in **Bolivia** to revise HIV diagnostics algorithms that have since been adopted as a national policy. It also helped develop two protocols for AIDS treatment (one for children and one for adults) that subsequently were adopted as national norms.

- USAID's program in **Brazil** uses relationship sites such as Facebook and Orkut, gay virtual meeting sites, and mobile phone messaging to disseminate prevention messages and provide information on the availability of rapid testing and counseling services. People interested in knowing more about testing options are referred to a USAID-funded blog that provides HIV/AIDS information and directions to testing sites. On the day the mobile phone service was inaugurated, the blog had 800 visitors – the average number of individuals previously accessing the site in a month.

- USAID reached 165,000 prevention contacts and increased targeted condom service outlets in **Guatemala** to 23 percent above the goal, demonstrating its commitment to provide condoms to at-risk groups.

- Strengthening the capacity of Ministry of Health personnel and other key stakeholders, USAID in **El Salvador** provided HIV/AIDS prevention and treatment services, including training 633 nurses working in the health network and 3,000 community health promoters. Fifty Ministry of Health health units were accredited as providing quality VCT.

- USAID reached 201,645 members of MARPs through a condom social marketing campaign in **Honduras**, resulting in significant behavior change among beneficiaries. Condom use with an occasional partner rose from 32 percent in 2004 to 98 percent in 2009 in the Garifuna (Afro-Hondurans among those at highest risk of contracting HIV/AIDS) population, and from 79 to 86 percent among PLWHA during the same time period.

- To promote condom availability in **Mexico**, local commercial distribution partners work with USAID to distribute condoms in 61 high-risk locations in three target cities. A variety of behavior change communication strategies are employed with target groups in these cities to promote condom purchase and correct use. A recent

independent study found individuals exposed to these strategies were 19 to 49 percent more likely to carry a condom than those who were not.

- By leveraging local resources, USAID exceeded its targets in **Peru**, reaching 102,780 adolescents with HIV prevention activities and 161,000 individuals in the general population from two hot spot regions (Ucayali and Loreto) (as well as 7 million people through a mass media campaign that included Lima).

Important Links

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USAID's HIV/AIDS Web site for Latin America and the Caribbean:
http://www.usaid.gov/our_work/global_health/aids/Countries/lacin.html.

For more information, see USAID's HIV/AIDS Web site: *http://www.usaid.gov/our_work/global_health/aids*, USAID's HIV/AIDS Web site for the Caribbean Region: *http://www.usaid.gov/our_work/global_health/aids/Countries/lac/caribbeanregion.html,* and USAID's HIV/AIDS Web site for the Central America Region: *http://www.usaid.gov/our_work/global_health/aids/Countries/lac/caregion.html*.

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