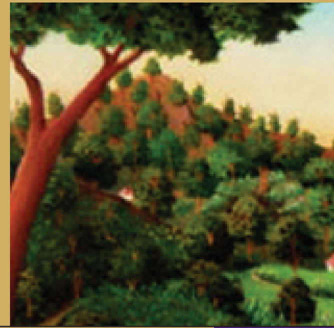
IX. Combating HIV/AIDS, Malaria, and Other Major Diseases



IX. COMBATING HIV/AIDS, MALARIA, AND OTHER MAJOR DISEASES[1]

1. THE MILLENNIUM DEVELOPMENT GOAL FOR HIV/AIDS, MALARIA AND OTHER MAJOR DISEASES

The sixth Millennium Development Goal (MDG) is to combat HIV/AIDS, malaria and other diseases. The target for 2015 is to *halt and begin to reverse the spread of HIV/AIDS and the incidence of malaria and other major diseases*. The UN has suggested that progress toward this target could be measured by indicators such as: i) HIV/AIDS prevalence among 15 to 24 year old pregnant women and ii) condom knowledge and use. The indicators for malaria are i) changes in malaria prevalence and death rates, and ii) the proportion of the population living in risk areas that use effective prevention and treatment measures.

Three questions are important when considering the goals and targets:

- How applicable are they to Latin America and the Caribbean?
- How far is the region from achieving them?
- What challenges must be overcome to meet the MDG?

How Applicable Are the Goals and Targets to Latin America and the Caribbean?

Latin America and the Caribbean have one of the most diverse HIV/AIDS epidemics in the world. Prevalence rates and transmission routes are more varied in Latin America and the Caribbean than in any other region. The overall HIV prevalence rate is 0.6 percent, but this figure obscures the complex dynamics of the many subepidemics that are occurring.

The reduction of HIV/AIDS prevalence among young pregnant women is an appropriate indicator in a generalized epidemic, that is, when HIV/AIDS prevalence is over 5 percent of the population. In a concentrated epidemic, as is the case in most Latin American countries, prevalence among 15 to 24 year olds is low, but it is high in subpopulations. A reduction in subpopulation prevalence levels could have a greater impact on slowing the spread of the disease to the wider population. In Latin America, a more appropriate indicator of progress toward achieving the MDG would be changes in prevalence in the subpopulations most affected by the disease.

The main subpopulations affected by HIV/AIDS in Latin America and the Caribbean are men who have sex with men, commercial sex workers and intravenous drug users. Forty-two percent of all HIV/AIDS cases are among men who have sex with men. However, transmission routes vary significantly across the region. In Central America and the Caribbean over 60 percent of all cases are via heterosexual contact. In the countries of the Southern Cone, close to a third of all cases are among intravenous drug users. The gender profile of persons with AIDS has changed significantly over the past decade; the ratio of male to

1. This chapter was prepared by Ernest Massiah.

female cases has declined considerably. Currently, one out of every three HIV/AIDS cases is female. In the Caribbean, 50 percent of all cases now occur in women, compared to 30 percent in Latin America.

While the average HIV/AIDS prevalence rate appears low, there are signs that the disease is spreading. At the end of 2002, there were 2 million people living with HIV/AIDS in the region. This number is growing by 10 percent a year. Prevalence is rising in vulnerable subpopulations. There are high levels of unprotected sexual activity among 15 to 24 year olds. Additionally, the prevalence of HIV/AIDS in the Caribbean and Central America has increased. Twelve countries now have a prevalence rate of over 1 percent. Limited access to testing and counseling facilities, lack of knowledge, stigma and discrimination, and poor data collection systems, suggest that the existing prevalence figures may be underestimated. In the short term, reductions in prevalence levels may be difficult given the lengthy latency period of the HIV virus.

One of the main lessons learned during the past 20 years is that its impact is greater on the poor and excluded. In the region, individuals are excluded because of their race, ethnicity and gender. Although, few countries collect data on the relationship between poverty, ethnicity, gender and HIV/AIDS, the results of the 1995 and 1998 Demographic and Health Surveys in Guatemala provide an insight into this relationship. Using “no education” as a proxy for poverty, the data suggest that poor and indigenous women have significantly lower usage rates of prevention methods than do other women. The data support other findings on the cumulative disadvantage that confronts excluded groups and the importance of disaggregating average or national statistics so that the conditions of the “average” individual do not hide the reality of the excluded.

The number of AIDS orphans in Latin America and the Caribbean is growing, but it remains relatively small compared to other regions. Most countries have less than 2,000 orphans. Brazil is estimated to have approximately 31,000 AIDS orphans, the largest number in the region. By comparison, there are almost one million orphans in Uganda. In Africa, the number orphans is more sensitive to changes in adult HIV prevalence and mortality than in Latin America and the Caribbean.

Estimates of the number of acute malaria cases vary greatly. The global estimate is close to 500 million. At a minimum, it is estimated that there are 1 million malaria deaths and malaria is a contributing factor in another 2 million deaths. Close to 80 percent of this mortality is reported in Africa. Malaria transmission is reported in 21 Latin American and Caribbean countries. It is estimated that 175 million people in the region live in areas where there is some risk of malaria transmission. Malaria predominates in tropical areas; 91 percent of all cases are in the nine countries that share the Amazon rainforest: Bolivia, Brazil, Colombia, Ecuador, French Guiana, Guyana, Peru, Suriname and Venezuela. Eighty-eight percent of the 68,000 cases reported in Central America in 2002 were in three countries: Honduras, Guatemala and Nicaragua. As seen in table 1, malaria incidence varies widely in the region and progress toward achieving the MDG will depend on targeted actions in selected countries.

Mortality due to malaria in Latin America and the Caribbean declined from 806 deaths in 1994 to 201 in 1998. The Pan American Health Organization (PAHO) estimated that there were between 200 and 250 deaths in 2002. The region, which uses "case detection" as a morbidity index (cases per 100,000 inhabitants), experienced a decrease in "case detection" in areas ecologically propitious for transmission. The incidence of malaria fell from 418.31 cases per 100,000 inhabitants in 1997 to 404.37 in 1998. Overall, malaria mortality in the region is relatively low. Changes in malaria prevalence rather than changes in morbidity would be a more sensitive indicator of the region's progress toward halting the spread of malaria. There are limited reliable data on the percentage of people in affected areas using preventative methods or receiving treatment.

TABLE 1.
INCIDENCE OF MALARIA AND TUBERCULOSIS, SELECTED COUNTRIES

Country	Incidence of tuberculosis (per 100,000 inhabitants)	Cases identified by DOTS (%)	Incidence of malaria (per 100,000 inhabitants)	Percentage of cases of malaria in the region
Suriname	Not determined	Not determined	440	1.2
Guyana	Not determined	Not determined	231	2.1
Brazil	70	4	59	53.6
Venezuela	42	82	36	2.7
Ecuador	172	26	24	8.6
Guatemala	85	54	22	4.7
Colombia	51	30	21	9.5
Peru	228	95	16	6.1
Bolivia	239	77	11	2.8
Belice	Not determined	Not determined	10	0.2
Nicaragua	88	80	9	2.3
Honduras	92	15	8	3.1
Haiti	361	24	7	1.5
Dominican Rep.	135	7	6	1.0

Source: PAHO/WHO; World Bank; Database on World Development Indicators, 2002.

Globally, tuberculosis kills 1.7 million people a year. In addition, 500,000 people living with AIDS contract tuberculosis as an opportunistic infection. According to WHO, the global tuberculosis mortality rate per 100,000 population is 28 deaths. The mortality rate in Latin America and the Caribbean is 11 deaths per 100,000 persons, or just over double that observed in developed countries. The reduced incidence of tuberculosis and increased use of DOTS are appropriate MDG indicators for the region.

How Far Is the Region from Achieving the MDG on AIDS, Malaria and Tuberculosis?

Progress toward the achievement of the MDG goals for HIV/AIDS, malaria and tuberculosis cannot be examined independently from issues of poverty, social exclusion and development. Income, gender and racial inequalities increase vulnerability to these diseases and affect the coping mechanisms of affected households. Achieving the MDGs for these diseases will require more resources directed at prevention and treatment among the poor and excluded.

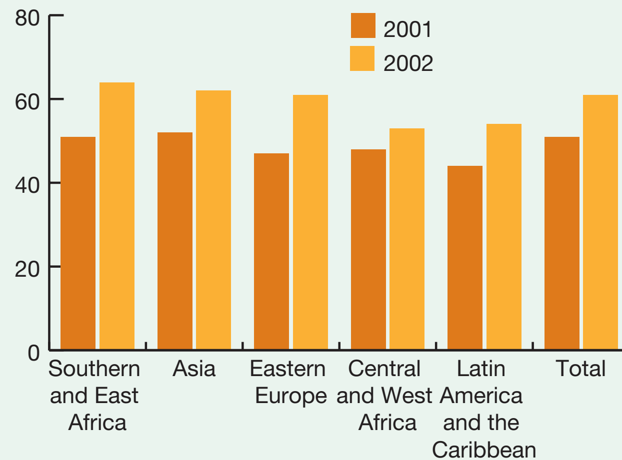
Progress will also require broader social change. The region will have to reassess its moral and legal sanctions on sex and sexuality, particularly as these pertain to young people and women. The societal limitations placed on open social dialogue about sex, the content of mass media messages, the availability of HIV/AIDS services, and the illegal nature of certain sexual behaviors and practices hinder the region's progress toward achieving a reduction in HIV/AIDS incidence.

The MDG for HIV/AIDS and malaria is not quantified. Any reduction or slowing of incidence rates can be interpreted as meeting the goal. HIV incidence rates are increasing in Latin America and the Caribbean. While this in part reflects increased epidemiological surveillance and access to testing and counseling services, it is also an indication of the growing spread of HIV/AIDS. The lack of data makes it difficult to establish a robust quantitative estimate of trends in incidence and prevalence, and progress toward reducing the spread of HIV/AIDS. However, an analysis of AIDS program strength indicators, resource allocation patterns, and data on access to services can provide an indirect indication of the status of programs and their likely impact on the spread of the HIV/AIDS epidemic.

AIDS Program Effort. In September 2003, two years after the United Nations General Assembly Special Session on AIDS (UNGASS), UNAIDS and the United Nations noted that the current pace of country activity on HIV/AIDS was insufficient to meet the 2005 goals agreed to by all nations at the Special Session. The UNGASS goals, which focus on the rapid expansion of HIV prevention, care and impact alleviation programs, are a vital foundation for achieving the MDG. While there has been some concrete progress, the current pace and scope of the global response to HIV/AIDS is insufficient.

Progress toward meeting the HIV/AIDS goal in Latin America and the Caribbean is limited. In 2003 UNAIDS created the AIDS Program Effort Index. The index gives a broad indication of strengths and weaknesses in national responses. Between 2001 and 2003, program effort scores for the region showed slight improvement. Compared to other regions, programs in Latin America and the Caribbean are relatively strong in establishing legal and regulatory frameworks, resources, and care. They are weak in policy formulation, organizational structure, monitoring and evaluation, prevention, human rights, and mitigation. Overall, the region's program effort scores are below the global average and lower than those for regions with emerging epidemics, such as Eastern Europe and Asia (see figure 1). To achieve the MDG, program effort in Latin America and the Caribbean will have to improve in the deficient areas, particularly in two key areas: prevention, and monitoring and evaluation.

FIGURE 1. CHANGES IN AIDS PROGRAM EFFORT INDEX SCORES (BY REGION, 2001-2003)



Source: UNAIDS, 2003.

Access to Services. The region cannot meet the sixth MDG if the necessary services do not exist. The data on access to the services that are necessary to reduce the spread and impact of HIV/AIDS indicate that they are not available for the majority of people who need them (see box 1). Data from the Demographic and Health Surveys over the last decade show that the median age for girls' first sexual experience ranges between 17 and 19 years. However, for girls with no schooling, it is between 16 and 18 years. The median age for boys' first sexual experience is 16 to 17 years. The lack of behavior change services for youth, whether or not they are in school, means that most young people start their sexual life without the benefit of information and services that could help them adopt safe sex behaviors. Traditionally excluded populations and the poor also have limited access to services, despite the fact that they are among the most vulnerable and affected groups. Data from the 2001 Demographic and Health Survey in Nicaragua show that, overall, 6.6 percent of women had been tested for HIV. However, only 1.6 percent of women with no education had been tested. Global experience has shown that HIV/AIDS crosses social boundaries. Increased incidence in excluded populations eventually affects the wider population. AIDS cannot be controlled if there is not focused attention on prevention and treatment in excluded populations that are most affected by the disease.

BOX 1.
ACCESS TO HIV/AIDS PREVENTION SERVICES IN LATIN AMERICA

- Eleven percent of intravenous drug users have access to harm reduction programs.
- Safe sex behavior change programs reach 1 in 9 men who have sex with men.
- Four percent of out-of-school youth have access to behavior change programs.
- Thirty-eight percent of in-school youth have access to behavior change programs.
- Eighteen percent of people who need treatment for sexually transmitted diseases are able to obtain services.
- Twenty-nine percent of those who want voluntary counseling and testing have access to services.
- Six percent of sex workers and their clients have access to behavior change programs.
- Nineteen percent of mothers have access to programs to prevent mother-to-child transmission of HIV.
- Mass media awareness programs reach fewer than 30 percent of people at risk of AIDS

Source: Access to HIV Prevention: Closing the Gap, Gates Foundation, 2003

Progress in Prevention. Increasing knowledge about HIV/AIDS and how it can be prevented is a precondition for people to be able to protect themselves. While most people in the region have heard about HIV/AIDS, knowledge varies by age group and education level. Poor, rural or indigenous women have lower levels of exposure to information about AIDS, knowledge of how to prevent themselves from being infected, particularly with non-regular partners. In Brazil, an average of 58 percent of all sexually active persons used prevention consistently in the last 6 months; usage rates are lowest in the Northeast, a region with high levels of poverty.

Most Latin American and Caribbean women know about AIDS, that is, they have heard about the disease, but this basic level of knowledge can vary significantly by education level. In Peru, Nicaragua and Bolivia, women with no education and rural women had lower levels of knowledge than did the average woman. Women with no education or those living in rural areas also had less knowledge of how to prevent contracting HIV/AIDS (see table 2). Recent survey data show that between 54 and 12 percent of women with no education don't know how to prevent HIV/AIDS. Among young girls, between 5 and 28 percent don't know how to prevent HIV/AIDS. Approximately 10 to 25 percent of all women believe that a healthy looking person cannot have HIV/AIDS, and between 9 and 50 percent of women with no education hold this belief.

TABLE 2.
FEMALE HIV/AIDS-RELATED KNOWLEDGE, BEHAVIORS AND ATTITUDES (1996-2001, %)

	Knowledge of AIDS			Don't know how to prevent contracting HIV/AIDS			Condom use with non-regular partner		
Country	All	15 to 19 years	No education	All	15 to 19 years	No education	All	15 to 19 years	No education
Bolivia	79	82	30	19	19	54			
Colombia	98	97	91	8	10	25	23	32	0
Dominican Rep.	99	99	96	3	5	12	29	0	0
Haiti	97	96	93	13	19	24	NA	NA	NA
Nicaragua	92	91	76	NA	NA	NA	14	10	4
Peru	87	87	38	24	28	25	17	15	8

Source: Demographic and Health Surveys.

Male HIV/AIDS knowledge and behaviors confirm the limited impact of prevention programs, and the effect of education and age on prevention efforts. While knowledge of HIV/AIDS is high among men, over a third of all men do not think they are at risk for contracting HIV/AIDS, and less than 25 percent of all men have started to use condoms to prevent HIV/AIDS (see table 3).

TABLE 3.
MALE HIV/AIDS-RELATED KNOWLEDGE, BEHAVIORS AND ATTITUDES (%)

	Don't know how to prevent HIV/AIDS			Do not believe they are at risk of getting AIDS			Began to use condoms as result of AIDS		
Country	All men	15 to 19 years	No education	All men	15 to 19 years	No education	All men	15 to 19 years	No education
Bolivia	15	16	62	34	38	35	19	18	8
Dominican Rep.	3	5	11	62	74	73	23	19	12
Haiti	6	7	10	83	93	NA	17	NA	(10*)

** Data for rural populations only.*
Source: Demographic and Health Surveys.

Resource Allocation. Expenditure patterns provide one indication of the effort needed to reach the MDG. A study of HIV/AIDS expenditures in 16 Latin American countries by the SIDALAC project concluded that expenditure on HIV/AIDS prevention was low even though sexual transmission was the main route of infection.

SIDALAC also reviewed public sector expenditures for HIV/AIDS prevention in the population groups most affected by the epidemic. In the nine Latin American countries for which data were obtained, on average, the proportion of the prevention budget spent on the most vulnerable and affected populations was 1 percent for intravenous drug users, 12 percent for commercial sex workers and 7 percent for men who have sex with men. These proportions contrasted sharply with the high HIV/AIDS prevalence rates and vulnerability in these groups. In some of the countries these populations accounted for over 50 percent of all HIV/AIDS cases.

Malaria Prevalence. In 2002, eight hundred and eighty-five thousand malaria cases were reported in the endemic countries, this is the lowest figure since 1993. While it might appear that the region is achieving progress in malaria eradication, cases rates have risen and fallen over the decade. It is difficult to discern trends that help measure progress toward achieving the MDG. Overall, malaria eradication efforts in the last decade have not been successful. The region has taken a step forward by establishing the Roll Back Malaria Initiative in the rainforest region of South America, which is the area most affected by malaria. However, implementation has been slow and there are insufficient data available to confirm the effectiveness of the interventions undertaken. Unlike HIV/AIDS, there is a lack of information on effectiveness and resource needs for malaria programs. Data on the effectiveness of regional tuberculosis prevention and treatment programs are also limited.

The data available suggests that the region is not fully prepared to address the challenges posed by the MDGs. Essential services are not available, expenditure patterns do not follow epidemiological priorities, programs are not targeted to the most affected and vulnerable populations, and data collection systems are very weak so that progress toward achieving the MDGs is hard to ascertain.

Isolated interventions with subpopulations have been successful in Latin America and the Caribbean. At the national level, the Brazilian AIDS program has produced dramatic changes in sexual behavior and changed the global debate on access to treatment. Yet, the region has not been able to mobilize the resources and sustained commitment that are required to reduce the spread of HIV/AIDS. The programmatic inputs required are not in place. Nor is the social context conducive to the development of comprehensive programs. Most countries still have taboos against the discussion of sex and many effective interventions are viewed as supportive of illegal, morally ambiguous or promiscuous sexual behaviors. Without political support, better targeted programs, and more efficient resource allocation the region will not meet the MDG for HIV/AIDS by 2015.

2. HIV/AIDS, MALARIA, POVERTY AND SOCIAL EXCLUSION IN LATIN AMERICA AND THE CARIBBEAN

HIV/AIDS and malaria in Latin America and the Caribbean must be looked at in the context of the region's growing poverty, high levels of income inequality, and social exclusion. These factors help illustrate the limitations of a purely public health approach and identify the broader developmental response required to address the spread of these diseases.

The relationship between poverty and AIDS can be looked at from two perspectives. On one hand, how poverty influences vulnerability to AIDS and coping capacities, and on the other, by examining how HIV/AIDS can exacerbate poverty. Poverty is associated with low levels of financial resources, education, literacy, labor force participation, and with poor health status. The social exclusion of the poor makes it difficult for interventions to reach them, particularly programs that address sensitive aspects of sex and sexuality. Even if interventions are culturally appropriate, the poor and excluded rarely have either the incentives or resources to adopt the recommended behaviors. HIV/AIDS treatment relies heavily on access to and utilization of health services. In Latin America and the Caribbean, access to services varies widely particularly in poor or rural areas. The poor are less likely to have access to HIV/AIDS counseling and testing services and facilities that can monitor antiretroviral treatment.

Poverty, and the absence of employment opportunities have led to large national, regional and international migrations. Mobile populations tend to be young and more likely to engage in high-risk sexual behaviors. Poor female migrants may be forced to engage in transactional sex as a survival strategy for themselves and their dependents. In these situations they are often unable to negotiate the terms of the sexual interaction. These behaviors, in part, account for the high infection rates among young women.

The impact of HIV/AIDS is greater among poor households and deepens their poverty. While the impact of HIV/AIDS on the household is similar to those of other long term, terminal illnesses, there are important differences. HIV infection clusters in families with both parents becoming infected. Husbands infect many monogamous women. When both parents have HIV/AIDS the family's capacity to cope with the psychosocial and economic consequences of the disease is reduced. Poor families have limited capacity to absorb the costs of HIV/AIDS. These costs include the loss of savings, the costs of antiretroviral medications and of other drugs to treat opportunistic infections, the time and transport costs associated with increased medical visits, reduced household income through illness and time caring for the sick, loss of employment from illness and job discrimination, and funeral costs. AIDS wrecks or destroys the mechanisms that generate and foster human capital development in subsequent generations. When one or both parents die when a child is young, the intergenerational transfer of knowledge is weakened, family resources are depleted, and the loss of income and lifetime resources may prevent or reduce the child's ability to secure an education.

In Latin America and the Caribbean, poverty and health are closely linked to issues of inequality and social exclusion. There are 180 million people in the region living below the poverty line, 70 percent of them live in the five largest middle-income countries. In terms of income distribution, the region is one of the most inequitable in the world. As more data become available, an increasingly visible feature of poverty in Latin America is its ethnic and racial origins. In approximately two-thirds of the countries in Latin America, Afro-Latinos or indigenous people comprise between 5 and 71 percent of the total population. These populations have higher poverty levels and worse health indicators than the rest of the population.

HIV prevalence among ethnic or racial minorities is politically sensitive and very few countries in the region collect data on prevalence in these populations or its determinants. A recent report from PAHO/WHO and UNAIDS (2001) notes the lack of data but suggests that there may be a rapid rise in HIV/AIDS cases among ethnic minorities. Data from PAHO/WHO suggest that there is a high incidence of malaria among indigenous populations living in rural and heavily forested areas. One ethnic minority that has been studied extensively is the Garifuna in Honduras. They have one of the highest HIV/AIDS prevalence rates in the region, 8 percent, compared to a national prevalence rate of less than 1 percent. The groups most likely to be affected by the disease are those least equipped to deal with its impact; namely, ethnic minorities, the poor and traditionally excluded groups, such as men who have sex with men, commercial sex workers and intravenous drug users.

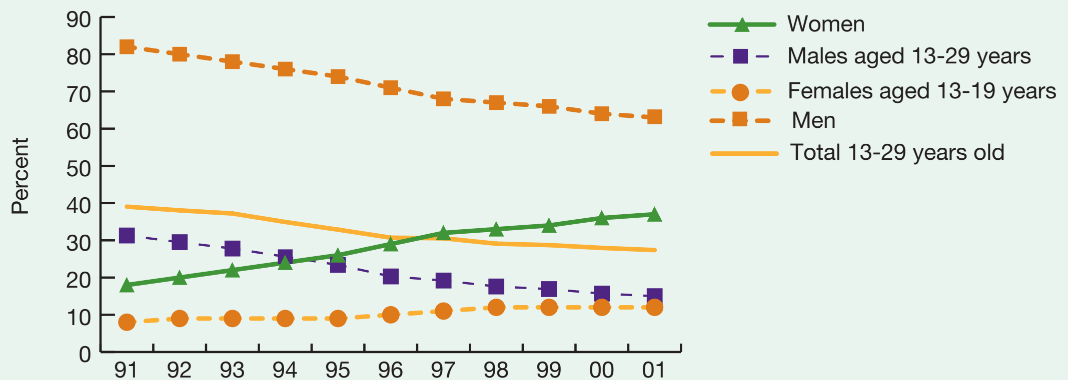
3. HIV/AIDS AND GENDER

Gender inequality is an important determinant of the spread of HIV/AIDS and reflects a complex and interwoven set of cultural and economic factors. In Latin America and the Caribbean, cultural prescriptions for masculinity and male sexuality and for femininity and female sexuality influence both men's and women's vulnerability to HIV/AIDS by affecting what women and men know, their sexual communication and behavior within relationships, and their ability to access resources and services when infected or affected by HIV/AIDS. Women are supposed to be ignorant of sex; this makes it difficult for them to take a proactive role in negotiating safe sex and seeking counseling or testing services. Women are also more vulnerable to physical violence. Fear of violence limits women's ability to discuss fidelity and the adoption of safe sex behaviors with their partners, their ability to leave high-risk relationships, and their utilization of HIV/AIDS counseling and testing services. It can also restrict their willingness to tell their partners if they have HIV/AIDS. On the other hand, men's assumed sexual knowledge and experience and peer pressure to prove their manhood makes it less likely, particularly among young men, that they will seek out information or adopt safe sex behaviors. Multiple partners, a characteristic of male sexuality, increases men's risk of contracting HIV/AIDS, and is a serious challenge to prevention messages that advocate fidelity, abstinence, and partner reduction.

Gender inequalities increase women's economic vulnerability and dependence and facilitate the spread of HIV/AIDS. While in the region, women's economic status has improved and their participation in the labor market has increased, between 30 to 70 percent of women have insecure jobs in the informal sector and female formal sector workers earn less than men. Job insecurity and low incomes increase the likelihood of multiple partners, transactional sex, and relationships in which the power to negotiate safe sex is limited. Approximately one-quarter of all households are female headed, single mothers and female heads of household are vulnerable to HIV infection and less able to cope with the economic and psychological impact of the disease. Gender, ethnicity and socioeconomic status cannot be looked at separately: unemployment, large wage gaps, and occupational segregation are more common for indigenous, or Afro-Latin women. These women are at greater risk of contracting HIV/AIDS. A more in-depth discussion of gender and its effect on reproductive health behaviors and development can be found in the chapters on gender and maternal health.

Gender, HIV/AIDS and Youth. In Brazil, as in many parts of Latin America and the Caribbean, the incidence of HIV among women is increasing at a faster rate than for men. Data from Brazil on trends in HIV incidence from 1991 to 2001 illustrate the progress that has been made in reducing the incidence of HIV/AIDS in Brazil, and how far the region will have to go to meet the MDG if gender inequities are not addressed. Over the last decade, HIV/AIDS incidence declined among 13 to 29 year olds from 39 percent to 27 percent. But, it increased from 8 percent to 12 percent among women in that age group and declined from 31 percent to 15 percent among young men (see figure 2).

FIGURE 2. REPORTED HIV CASES IN BRAZIL, BY GENDER (1991-2001)



Source: National Program on Sexually Transmitted Diseases and AIDS, Brazil

4. CHALLENGES

Political Leadership. The main lesson learned after 20 years in the fight to control AIDS is that political support is the single most important element of a successful response. Financial and human resource constraints reflect budgetary restrictions and the extent to which policymakers are committed to giving AIDS programs high visibility. Because the disease is associated with shame, and legal and moral sanctions against sexual behaviors, it can be difficult for policymakers to discuss HIV/AIDS issues, especially prevention among young women, a key MDG target population. Sustained public dialogue helps break the stigma and silence surrounding HIV/AIDS and empowers people to adopt safer behaviors and to seek treatment.

AIDS is transforming the nature of the dialogue policymakers have with their constituents not only on how health systems are organized but also on hitherto personal aspects of sexual and social behavior. AIDS presents an enormous political challenge because it threatens to transform the way people think about the role of government and its accountability and, change the way they view their societies' commitment to equality for women and excluded populations.

HIV/AIDS Stigma and Discrimination. Stigma and discrimination against those with HIV/AIDS and their families can seriously threaten the effectiveness of prevention and treatment programs. Discrimination in employment, educational establishments, health facilities, and the lack of support from the legal system reduces the likelihood that individuals will seek testing, access treatment, negotiate safer sex and care for family members who have HIV/AIDS. AIDS is still linked to societal perceptions of deviant sexual behavior. The stigma of HIV/AIDS falls hardest on members of vulnerable and excluded groups. They face the combined stigma of the disease and the other characteristics on which their exclusion is based. This contrasts sharply with the notion of the "innocent victim," for example, children born with AIDS. This dichotomy legitimizes the stigmatization and discrimination that restricts program impact.

Gender Inequalities. AIDS is growing rapidly among women in the region. Policymakers need to i) increase the knowledge of young people (particularly girls) about sex, gender roles, and HIV prevention, support, and care; ii) support increased accessibility of female controlled technologies for HIV prevention; iii) develop programs that foster new gender equitable norms of masculinity and femininity; and, iv) address the gender-based factors that restrict women's access to services. At the same time, programs need to directly confront male perceptions of sexuality and sex and their perceived invulnerability to HIV/AIDS.

Migration, HIV/AIDS and Malaria. HIV/AIDS and malaria are not national issues. Their control is a global public good; the benefits of reduced spread accrue to all countries. Migration, development and deforestation affect the spread of malaria. Changes in land use, such as, road building, logging and agricultural and irrigation projects, particularly in the Amazonian

region have helped spread malaria. The movement of populations displaced by armed conflicts, violence and poverty in rural areas has altered its incidence patterns. There is increased incidence of urban endemic malaria, stable malaria patterns in rural areas with and without conflict, and epidemic malaria in receptive zones. The high levels of migration of the poor and of women promote the spread of these diseases. Subregional programs should allow migrants easy access to information and services across the region, facilitate the coordination of surveillance systems, and promote the exchange of data.

Limited Access to Services and Supplies. A key challenge to scaling-up services in a concentrated epidemic is increasing access to excluded and traditionally underserved populations. The public sector is not best equipped to work with excluded populations, and in some cases, for example, programs with intravenous drug users, commercial sex workers, or men who have sex with men, state-funded public health interventions may contravene national law. Innovative partnerships between the public sector and civil society are needed to reach these populations.

Limited Access to Medications. In principle, reductions in the price of antiretroviral (ARV) medications have made treatment more available. Several countries have policies and laws that guarantee antiretroviral therapy for their HIV-positive citizens. At the end of 2002, it was estimated that 196,000 people were receiving antiretroviral treatment in Latin America and the Caribbean. According to WHO, treatment is provided to 53 percent of the people in the region who need it, more than in any other developing country region. The majority of the people receiving ARV treatment are in Brazil. Access to treatment is still limited in most other countries (see table 4). Increased access will require more staff training, improved laboratory support, and better community support systems for patients and their families.

Availability of malaria treatment is a key determinant of the region's progress toward achieving the MDG. Access to malaria treatment per diagnosed case ranges from 0.57 to 241.8 first-line treatments. Up to 1999, effective anti-malarial therapy was available in all countries. Recently, many countries experienced problems with access to drugs to treat resistant strains. The lack of drugs will increase the number of future cases.

Low Prevention Coverage. Access to basic prevention services and knowledge about AIDS are low, particularly among vulnerable populations and young girls. There is a need for more frank discussions of sex and sexuality; increased access to life skills training, including abstinence and partner reduction; and the removal of the social, financial and economic barriers to the adoption of safe sex behaviors.

TABLE 4.
ACCESS TO ANTIRETROVIRAL MEDICATION IN LATIN AMERICA AND THE CARIBBEAN

Country	Eligible Patients Who Receive Antiretroviral (ARV) Therapy (%)
Argentina	91
Barbados	33
Belize	8
Bolivia	6
Brazil	100
Chile	91
Colombia	35
Costa Rica	100
Ecuador	68
Guatemala	46
Mexico	92
Paraguay	50
Peru	19

Sources: Process of joint negotiation for the access to antiviral and reactive drugs in the Andean sub region, Argentina, Mexico and Paraguay, Document Framework, May 2003; Accelerating access initiative, framework document for Central America, January 2003, Progress report on the global response to the HIV/AIDS epidemic, 2003, UNAIDS; UNGASS 2003 Country Reports from Argentina, Belize, Brazil, Guatemala, Mexico, Paraguay, 2003

Lack of Data. Progress toward the achievement of the MDGs cannot be measured without data. Data collection systems for HIV/AIDS, malaria and tuberculosis are weak in Latin America and the Caribbean. Data are collected on an *ad hoc* basis and changes in conceptual approaches between data collection efforts make trend monitoring difficult. Many countries do not have national monitoring and evaluation plans or the budget to conduct these activities. These problems are related to broad questions of data availability and quality, more specifically, data need to be examined to assess whether:

- the indicators are conceptually appropriate for measuring the MDG;
- data are available for all countries or subregions;
- data are valid;
- the indicator's coverage is appropriate for developing regional estimates; and
- the data are reliable over time.

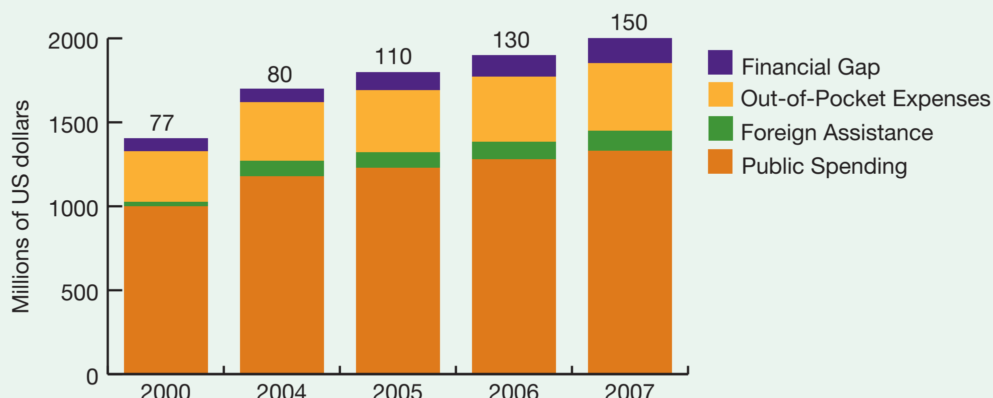
Resource Needs and Allocations. In 2002, the IDB, with UNAIDS and AIDS program representatives from over 20 Latin American and Caribbean countries, undertook a study of the resource needs for HIV/AIDS programs in the region. The study allowed the Bank to identify current resource allocation patterns, the resources needed for an effective response, and the size of the financing gap.

In 2000, eighteen countries, accounting for 91 percent of the region's population, spent US$1.2 billion on HIV/AIDS. The majority of that spending was for middle-income groups in the upper middle-income countries. Domestic resources financed the majority of this response. International donors provided only 2.1 percent of the resources needed.

The region is facing a financing gap. Lower income countries and those with prevalence rates close to or above 1 percent will need external financial and technical resources. Some of these countries have received assistance from the Global Fund. As of September 2003, the Global Fund had approved grants to 12 countries totaling US$343.7 million over a five-year period (see figure 3).

Preliminary data from the IDB study suggest that the region will need US$1.5 billion in 2005 rising to US$2.0 billion in 2007 to finance an effective response to HIV/AIDS. HIV/AIDS program personnel estimate that 56 percent of these resources will be allocated to prevention, 38 percent to treatment and care, and 6 percent to mitigation. This represents a change from current resource allocation patterns. SIDALAC data on current expenditure patterns for 2002 show that only 25 percent of AIDS spending was on prevention and 75 percent was spent on treatment and care.

FIGURE 3. HIV/AIDS RESOURCE NEEDS AND FINANCING GAPS 2000-2007



Source: Resource Requirements to Fight HIV/AIDS in Latin America and the Caribbean. IDB, 2003

The financing gap for malaria control is even more acute. Program budgets have varied greatly over the last five years and expenditures per person have declined steadily in recent years. In 1999, average expenditure was US$0.45 per person for the 16 countries that provided information on their malaria control budgets to PAHO/WHO. This represents a 31 percent decrease compared to 1996 (US$0.65), a 4.2 percent decrease compared to 1997, but a 7.1 percent increase over funds available in 2000.

5. A GLOBAL EXAMPLE: THE BRAZILIAN AIDS PROGRAM

The Brazilian AIDS program has emerged as a global example. It led the global debate on access to medications, and its integrated approach to prevention, treatment and care changed global thinking on how AIDS programs should be organized. A decade ago, there was widespread skepticism as to whether AIDS programs could succeed in developing countries, and if so, at what cost. One of the main achievements of the Brazilian program, and others in the region (for example, Haiti) has been to demonstrate that it is feasible to provide treatment in impoverished areas and that the poor and excluded can follow treatment regimens. In 1992, the World Bank estimated that that there were 1.2 million cases in Brazil. Today, out of a population of 170 million, there are 597,000 people with AIDS in Brazil.

Achievements. One of the most notable achievements of the program has been the reduction in the price of medications. This has had an epidemiological and economic impact. Brazilian patent law went into effect in 1997, but was not retroactive. At that time, patents did not cover many of the drugs used to combat AIDS and Brazil began producing generics. Brazil produced seven out of the fourteen components of the antiretroviral cocktail, reducing its cost by 75 percent. Having the technology to produce patented antiretroviral medications strengthened the country's negotiating position with drug companies. Negotiations with Merck and Roche laboratories led to price reductions of 40 to 65 percent for three essential components of ARV therapy. The median cost of antiretroviral therapy declined from a high of US$4,860 to US$2,530 between 1996 and 2001, a 48 percent reduction.

The reduction in the price of antiretroviral drugs and free access to treatment had two important impacts. First, since 1999, the percentage of the health budget spent on HIV/AIDS has declined. Expenditures on antiretroviral treatment declined from 3.2 percent in 1999 to 1.87 percent in 2003.[2] In 1996, US$336 million was spent in drugs compared to US$245 million in 2001. Overall, between 1989 and 2002, the AIDS program reduced projected expenditures by US$2.2 billion; local production of antiretroviral drugs led to a “savings” of US$960 million and reductions in mortality and morbidity reduced spending estimates by US$1.23 billion. Second, by increasing access to treatment and supporting an integrated approach, the country averted approximately 58,000 new cases and 90,600 deaths between 1994 and 2002 (see figure 4).

2. In 2003, the 3 antiretroviral medications that had to be imported consumed 63 percent of the budget for AIDS drugs.

BOX 2.
CORE PRINCIPLES OF THE BRAZILIAN AIDS PROGRAM

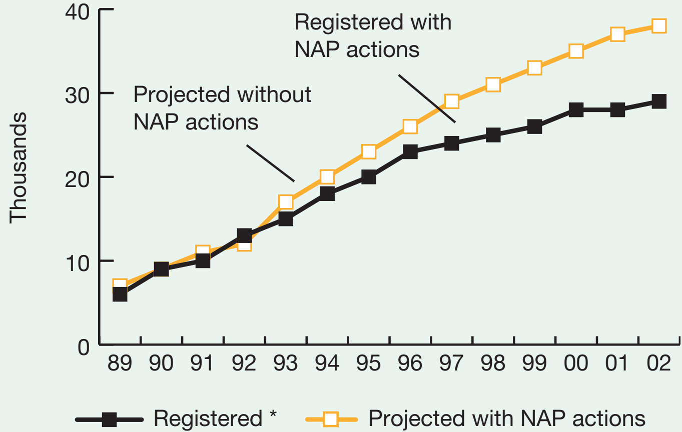
Early and Sustained Political Support. The National Program for Sexually Transmitted Diseases and AIDS was created in 1985. The most striking aspect of the government's response has been its continuity. This has allowed the program to develop consistent positions on core issues (for example, access to medications) and to initiate a frank and open social dialogue on sex and sexuality.

Civil Society Involvement. Civil society was involved from the start of the program in the planning and delivery of interventions. Currently, over 600 NGOs work with the program. Between 1999 and 2000, the government funded 1,780 projects, worth US$33 million, implemented by civil society. Their involvement has had two immediate impacts. First, it has facilitated the development of culturally appropriate interventions, particularly for excluded and vulnerable populations, and second, it has expanded the reach of the national effort.

Integrated Prevention, Treatment and Care Approaches. The Brazilian program saw treatment and prevention as mutually reinforcing. Free and universally available treatment has aided prevention efforts. People feel more confident submitting to voluntary and confidential testing. This has led to earlier detection and treatment of the disease. Patients are in close contact with government and NGO providers and receive a constant flow of information, advice and prevention tools. Treatment reduces viral load, enhances patients' self-esteem and encourages them to avoid infecting their partners. Prior to the introduction of free antiretroviral therapy in 1996, the median survival rate for persons with AIDS was 18 months; it rose to 58 months between 1996 and 2001.

Human Rights. The program's commitment to human rights is reflected in its approach to civil society involvement. The legislation that approved the provision of free ARV therapy took as a central theme the basic human rights of all citizens to health care, including access to medications. A wide range of programs have been launched that address discrimination in the labor market, education sector, and social protection programs.

FIGURE 4. NUMBER OF AIDS CASES (REGISTERED AND ESTIMATED) TAKING INTO ACCOUNT THE ACTIONS OF BRAZIL'S NATIONAL AIDS PROGRAM (NAP), 1989-2002



*Cases estimated after 1998 using actual trends
Source: National AIDS Program, Brazil

6. THE ROLE OF THE INTER-AMERICAN DEVELOPMENT BANK

The Bank has three tools at its disposal to assist the region, its ability to convene conferences and other forums to discuss important issues and reach consensus, its analytical strength, and its lending capability. There is an urgent need to expand the debate on HIV/AIDS to increase political leadership. This dialogue must involve governments, civil society and the networks of persons living with HIV/AIDS. The Bank will continue to use its powers to convene forums to pursue this dialogue. This process is necessary if the region is to address the social and economic issues that limit the effectiveness of its HIV/AIDS initiatives. Second, the Bank's analytical strength will be used to review the social and economic aspects of the epidemic in Latin America and the Caribbean. Studies on gender, resource needs and stigma have helped identify new challenges and programmatic responses. The Bank is a lending institution. The region's HIV/AIDS programs require a strong health infrastructure. The IDB has been the main supporter of health system development in Latin America and the Caribbean. Between 1992 and 2001, the Bank provided loans totaling US$1.7 billion to improve many of the services that are used in the

response to HIV/AIDS, including, for example, epidemiological surveillance, clinic upgrading, training for nurses and doctors, and increasing the availability of service delivery points. Without this support, many countries would present a more limited response to HIV/AIDS. The Global Fund for AIDS, Tuberculosis and Malaria will increase the amount of grant funding available to countries. The Bank will work with the Global Fund to address the implementation challenges and financing gaps.

Reducing the spread of HIV/AIDS and malaria are regional public goods. In a geographically contiguous area, with high levels of mobility and poverty, and with increased willingness to open markets to regional inputs, stemming the spread of these diseases benefits all countries. The region is unlikely to contain these diseases if it does not adopt a regional approach. The Bank can assist the region develop this response. First, it provides an environment of trust for the interaction between countries participating in a complex operation. Second, it has extensive networks with organizations and funders at the international, regional and subregional levels. These organizations can work with the Bank to support the production of regional public goods. Third, the Bank's regional perspective and analytical power make it best placed to research the costs and benefits of regional public goods. The Bank is well placed to identify the aggregate benefits and to approximate the share of these benefits that accrue to each country. This is key information when discussing the financing of regional public goods. Fourth, the Bank can play a role in supporting countries with limited absorptive capacity in the production and consumption of a regional public good. Lastly, the Bank alone or in partnership, can finance regional public goods approaches to help stem the spread of HIV/AIDS and malaria by 2015.

Investment Priorities in Latin America and the Caribbean. An important part of the Bank's analytical role is to assist countries identify priorities. The status of and challenges facing existing programs suggest three priority areas for Bank assistance:

- *Improved Data Collection and Dissemination*. Increased effort is needed to improve the availability and quality of data on the epidemiological and behavioral aspects of these three communicable diseases. This will require support for data collection systems and institutions, training, financing for periodic surveys, and improved methods of information dissemination. Importantly, all data collected must be disaggregated by gender, race, ethnicity and poverty level.

- *Increased Policy Dialogue*. Particularly in the case of HIV/AIDS, stronger, more vocal policy support is needed. Dialogues will help lessen the shame, stigma and gender biases surrounding the disease and those it affects and support the discussion and implementation of more effective responses. Dialogue will also raise the issue of resource needs and allocations and add more transparency to the budgetary process.

- *Increased Access to Services for the Poor and Excluded*. Increasing the quality and availability of services for the poor, in particular poor women and members of excluded groups, will have the greatest impact on the incidence of HIV/AIDS, malaria and tuberculosis. At a minimum, HIV/AIDS services should be more fully integrated into the health system. These services must increase their targeting to vulnerable populations.

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