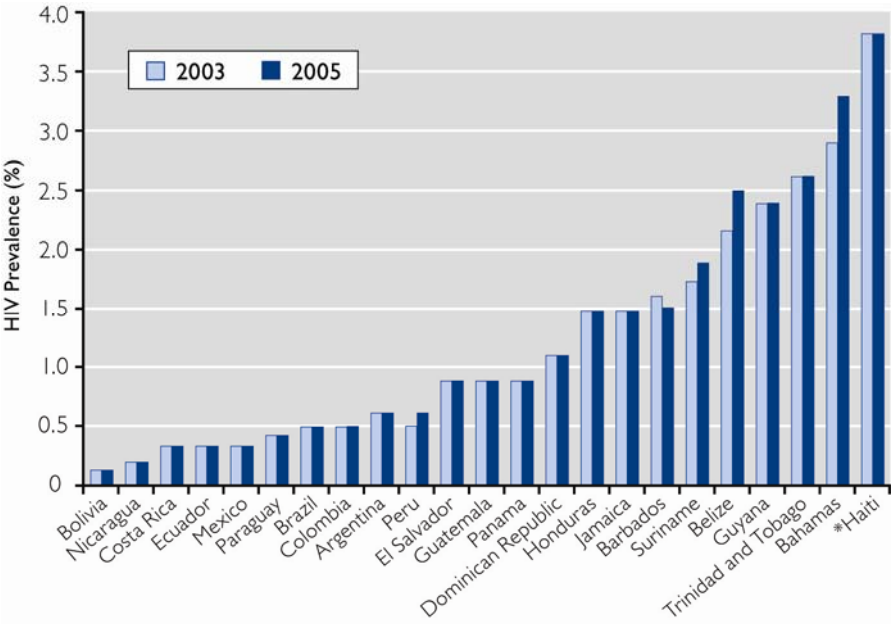
HIV/AIDS HEALTH PROFILE

Latin America and the Caribbean

Overall HIV Trends

Most HIV epidemics in the Latin America and Caribbean (LAC) region appear to be stable, although in some Caribbean countries, they appear to be in decline. In 2007, about 69,000 people in LAC countries died of AIDS, and 117,000 were newly infected (UNAIDS, November 2007). The number of people living with HIV/AIDS (PLWHA) in LAC is estimated at 1.8 million (UNAIDS, November 2007). Two-thirds of PLWHA reside in the four largest countries – **Argentina**, **Brazil**, **Colombia**, and **Mexico** – although the Caribbean and Central American subregions have higher prevalence rates, with countries such as **Haiti** and **Belize** having rates in 2005 as high as 3.8 and 2.5 percent, respectively (see figure below). 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 have moved increasingly from marginalized groups toward the general population (UNAIDS, December 2006). HIV prevalence among sex workers is relatively high in Central America and the Caribbean, especially in the **Dominican Republic**, **Jamaica**, **Guyana**, **Honduras**, **Guatemala**, and **El Salvador** (UNAIDS, November 2007). Unprotected sex between men is an important factor in **Bolivia**, **Chile**, **Ecuador**, **Peru**, **El Salvador**, **Guatemala**, **Honduras**, **Mexico**, **Nicaragua**, and **Panama** (UNAIDS, November 2007). Prevalence among men who have sex with men (MSM) may well be underestimated throughout the region because of stigma, the often hidden nature of this behavior, the fact that some MSM also have sex with women, and the small numbers of people engaging in risky behaviors who actually know their status. Between 1986 and 2004,

Trends in HIV Prevalence, 2003–2005



Source: UNAIDS. 2006 Report on the Global AIDS Epidemic. *According to the recent 2005–2006 Survey on Mortality, Morbidity, and Utilization of Services, Haiti's national prevalence rate may be as low as 2.2 percent.

27 percent of the HIV/AIDS cases in **Argentina**, **Uruguay**, **Paraguay**, and **Chile** were attributed to injecting drug use, and over the same time period in **Brazil**, 16 percent of cases were transmitted through injecting drug use (USAID, 2006). However, HIV prevalence in Brazil among injecting drug users (IDUs) is declining in some cities as a result of harm reduction programs, mortality among IDUs, and a change from injecting to inhaling drugs (UNAIDS and WHO, 2006). In Argentina and Uruguay, the epidemics are driven mainly by unprotected heterosexual intercourse (UNAIDS, November 2007).

The figure on the previous page shows trends in HIV/AIDS prevalence in the LAC region between 2003 and 2005. In most countries, the prevalence rate showed little change or was in decline, although in a few it continued to rise. Increases were particularly notable in **Peru**, **Belize**, the **Bahamas**, and **Suriname**. **Haiti** remains one of the region's high-prevalence countries, with 3.8 percent of the adult population HIV-positive (UNAIDS, 2006) (although a more recent population-based survey suggests that the national HIV prevalence rate could be significantly lower).

The Caribbean's status as the second-highest HIV prevalence region in the world masks substantial differences in the extent and intensity of its epidemics. Two countries, **Haiti** and the **Dominican Republic**, have nearly three-quarters of all the infections in the Caribbean, but national HIV prevalence is high (between 1 and 3.8 percent) throughout the subregion (UNAIDS, December 2006, November 2007). New infections remain stable in the Dominican Republic. A sentinel surveillance study in 2006 reported that prevalence among commercial sex workers (CSWs) ranged from 2.4 to 6.5 percent and averaged 4.1 percent. In some sites, prevalence among CSWs is declining and equals that of pregnant women. In Haiti, HIV prevalence among pregnant women attending antenatal clinics declined from 5.9 percent in 1996 to 3.1 percent in 2004 (UNAIDS, November 2007). In 2006, sentinel surveillance results among pregnant women suggested a stabilization of HIV prevalence, and modeling of Haiti's epidemic suggests that the declining trends are due to mortality and an increase in protective behaviors. Behavioral surveys demonstrate a 20 percent decline in the mean number of sex partners between 1994 and 2000, while condom use increased among nonregular partners (UNAIDS, November 2007). However, localized trends suggest the need to protect against a resurgent epidemic. HIV prevalence among pregnant women in rural areas has not decreased, and only 16 percent of women and 31 percent of men in rural areas used a condom the last time they had casual sex (UNAIDS, December 2006). The epidemics in the Caribbean are fueled by multiple sexual partners, a thriving sex industry, and MSM. A 2005–2006 behavioral surveillance survey from six eastern Caribbean countries found that 31 to 46 percent of the surveyed population aged 15 to 24 had multiple sexual partners within the last 12 months. New infections among women are surpassing those among men. Young women in particular face considerably higher odds of becoming infected than young men (UNAIDS, 2005); their higher risk is exacerbated by cross-generational sex and the "sugar daddy" phenomenon (i.e., reliance of younger women on older men for material needs, often basic, in exchange for sex). In Haiti, new data from the Ministry of Public Health and Population show that in some areas, the prevalence rate of HIV infection among young women is twice that of young men.

The LAC region has made considerable progress in providing antiretroviral therapy (ART). According to the April 2007 WHO/UNAIDS/UNICEF progress report *Towards Universal Access,* the number of people receiving ART in LAC steadily increased from 210,000 in 2003 to 355,000 in 2007. There are considerable variations across countries, but the overall coverage of 72 percent appears to be approaching universal access.

HIV/AIDS-tuberculosis (TB) co-infection is a problem in many parts of LAC. In certain countries and provinces where TB incidence is high, there is a need to coordinate HIV/AIDS and TB services. In some areas, people dying from HIV/AIDS are succumbing to TB. In the states of Rio de Janeiro and Sao Paulo, **Brazil**, HIV-TB co-infection runs as high as 25 percent in the major cities. The **Dominican Republic** has one of the highest TB incidence rates in the Americas, at 91 cases per 100,000 population. Although data on co-infection are limited, it is estimated that 6 to 11 percent of TB patients in the Dominican Republic are also infected with HIV. Therefore, the Dominican Republic represents a case where there is the potential for a burgeoning epidemic of TB along with HIV.

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 part of a population, resulting in possible changes in the demographic structure that pose challenges to support systems for dependent populations such as children and the elderly.

HIV/AIDS epidemics cut the supply of labor and threaten the livelihoods of many workers. According to a 2004 report from the International Labour Organization (ILO), from 1990 to 2010, **Haiti** could lose more than 10 percent of its labor force to HIV/AIDS if the availability of ART is inadequate. The loss of skilled and experienced workers causes productivity to fall and

business costs to increase, and tax revenues, market demand, and investment are also undermined. Studies suggest, however, that a company's investment in prevention, medical care for opportunistic infections such as TB, and treatment of sexually transmitted infections (STIs) reduces personnel turnover rates and labor costs. Preliminary research shows that the cost of providing treatment and care to keep employees in the workforce is often less than the cost of replacing workers lost to HIV/AIDS, even for small businesses. Volkswagen in Brazil reports that its AIDS care program has reduced costs to the company from between $1,500 to $2,000 per affected employee per month to $300 (*Action Against AIDS in the Workplace*, UNAIDS, August 2005). VARIG, the largest airline company in Latin America, realized that the nature of its work placed the company's employees in situations that could lead to risk-taking behavior. In 1986, the company introduced an AIDS program to respond to the health and social needs of its employees and "fulfill a social responsibility role by contributing to national and international efforts to control the impact of HIV/AIDS." VARIG's 2003 budget for prevention activities and medication was approximately $5 per employee per year. Employees and their families have free access to voluntary counseling and testing (VCT) and ART. VARIG extends its program beyond the workplace by providing free cargo handling for selected drugs that are not available in Brazil and sponsoring annual campaigns on World AIDS Day. Also in Brazil, Nestlé (the world's largest food company with more than 254,000 employees worldwide) is seeing the results of its long-standing HIV/AIDS program. Its focus on prevention through behavior change has resulted in a reduction of more than 50 percent of workers reporting high-risk behavior. Other key components of Nestlé's policy include nondiscrimination against PLWHA, confidentiality, and disclosure. Benefits include VCT, care, support, and treatment for employees, spouses, and their children. Business coalitions to fight HIV/AIDS are engaged in similar efforts in Mexico, Jamaica, and other Caribbean countries.

The economic and social effects of HIV/AIDS are felt from the family level, where families experience the death and incapacity of loved ones and providers must cope with the burden of caring for the sick and dying, to businesses, schools, hospitals, and other institutions that suffer the loss of valuable personnel and declines in productivity. In many cases, the impact of the epidemics on families, communities, and countries has feedback effects that influence the epidemics' future course; for example, poverty and the breakdown of social and economic systems impair community systems that could help stem the spread of infection. Food security is threatened by the effects on food production and the reduced ability of households to afford a nutritious diet. School enrollments decline, and the payoffs of investments in education are undercut by high death rates among young adults.

The economic costs of addressing HIV/AIDS and its effects, both in the health sector and other economic sectors, divert resources from other important needs and from investments critical to economic development. A study by CAREC and the University of the West Indies Health Economic Unit, for example, estimated that Jamaica's gross domestic product could be 6.4 percent lower by 2005 due to HIV/AIDS. According to ILO's model, income in eight LAC countries would have grown by 0.5 percent more per year without the HIV/AIDS epidemics (2004). A study sponsored by the World Economic Forum, Harvard School of Public Health, and UNAIDS *Business and HIV/AIDS: Commitment and Action: A Global Review of the Business Response to HIV/AIDS (2004–2005)*, found that, overall, 16 percent of the nearly 9,000 business leaders surveyed from 104 countries judged HIV/AIDS a serious business threat. Moreover, 35 percent of respondents in Latin America and 67 percent in the Caribbean expected some impact of HIV/AIDS on their companies in the next five years.

Finally, HIV/AIDS has orphaned many children who are now raised by grandparents, live in orphanages, or live in households headed by other children. As parents die, the effects on children cannot be overstated. Many children orphaned by HIV/AIDS lose their childhood and are forced by circumstances to become producers of income and food or caregivers for sick family members. They often drop out of school and suffer their own increased health problems related to increased poverty and inadequate nutrition, housing, clothing, and basic care and affection.

Partnering for Success: USAID and the U.S. President's Emergency Plan for AIDS Relief

The United States Agency for International Development (USAID) programs in LAC are implemented in partnership with the U.S. President's Emergency Plan for AIDS Relief (Emergency Plan/PEPFAR). The Emergency Plan is the largest commitment ever by any nation for an international health initiative dedicated to a single disease. To date, the U.S. has committed $18.8 billion to the fight against the global HIV/AIDS pandemic, exceeding its original commitment of $15 billion over five years.

Reauthorized on July 30, 2008, the U.S. is continuing its commitment to global AIDS in the amount of $39 billion for HIV/AIDS bilateral programs and contributions to the Global Fund to Fight AIDS, Tuberculosis and Malaria. Working in partnership with host nations, the initiative will support antiretroviral treatment for at least 3 million people, prevention of 12 million new HIV infections, and care and support for 12 million people, including 5 million orphans and vulnerable children.

The Emergency Plan encompasses all U.S. Government (USG) international HIV/AIDS activities, including those implemented by USAID. Under the Emergency Plan in LAC, USAID's staff of foreign service officers, trained physicians, epidemiologists, and public health advisers work with host governments, nongovernmental organizations (NGOs), and the private sector to provide training, technical assistance, and supplies – including pharmaceuticals – to prevent and reduce the transmission of HIV/AIDS and provide care and treatment to PLWHA. In fiscal year 2008, USAID will continue efforts to prevent the spread of HIV/AIDS using several interventions:

- The ABC approach to preventing sexual transmission of HIV – Abstinence, Be faithful, correct and consistent use of Condoms
- Prevention of mother-to-child HIV transmission (PMTCT)
- VCT services
- Injection safety and ensuring the safety of blood supplies
- Provision of therapy for concurrent illnesses and opportunistic infections, as well as palliative care
- Nutritional therapy
- Support for OVC
- Strengthening the supply chain for critical commodities
- Strategic information including public health evaluations and health and behavioral studies

A proposal has been made to extend the Emergency Plan for another five years and $50 billion dollars. There appears to be bipartisan support for this effort, and it is expected that the expanded PEPFAR program will continue through 2013.

USAID is uniquely positioned to support multisectoral responses to HIV/AIDS that address the widespread impact of HIV/AIDS outside the health sector. In particular, USAID is supporting cross-sector programs in areas such as agriculture, education, democracy, and trade that link to HIV/AIDS and mutually support the objective of reducing the impact of the pandemic on nations, communities, families, and individuals. Under the Emergency Plan, USAID also supports a number of international partnerships; provides monetary and technical support to the Global Fund to Fight AIDS, Tuberculosis and Malaria and its grantees in LAC; and works with local coordinating committees of the Global Fund to improve implementation of its programs and their complement to USG programs. Finally, USAID supports targeted research, development, and dissemination of new technologies and new packaging and distribution mechanisms for antiretroviral drugs.

USAID Support in Latin America and the Caribbean

USAID plays a lead role in coordinating the activities of several USG agencies in the region in support of PEPFAR, including the U.S. Centers for Disease Control and Prevention (CDC), the Peace Corps, the U.S. Department of Labor, and the U.S. Department of Defense. In LAC, USAID and PEPFAR place special emphasis on two focus countries – **Guyana** and **Haiti**. In addition, HIV/AIDS programs are also implemented in a number of other countries, including **Belize**, **Bolivia**, **Brazil**, the **Dominican Republic**, **El Salvador**, **Guatemala**, **Honduras**, **Jamaica**, **Mexico**, **Nicaragua**, **Peru**, and **Panama**. In addition, USAID's Caribbean Regional Program covers **Trinidad and Tobago**, **Suriname**, **St. Kitts and Nevis**, **St. Lucia**, **St. Vincent and the Grenadines**, **Grenada**, **Antigua and Barbuda**, **Dominica**, and **Barbados**. In the Caribbean, USAID is also an active member of the Pan Caribbean Partnership on HIV/AIDS, providing support on both a bilateral and regional basis, including increasing the capacity of NGOs and community organizations to deliver HIV/AIDS prevention and care programs and improving governments' capacity to implement an effective response.

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

- In collaboration with the Health Resources and Services Administration and CDC, USAID has provided substantial technical and financial assistance toward the establishment of six training centers, known as CHART (Caribbean HIV/AIDS Regional Training), in **Jamaica**, the **Bahamas**, **Barbados**, **Haiti** (2), and **Trinidad and Tobago**, providing training to health professionals in more than 30 countries in the region. In 2006, 691 HIV/AIDS service providers were trained; they in turn provided services in 315 VCT sites and 46 ART clinics where more than 7,000 HIV-positive patients received treatment.
- In **Bolivia**, USAID strengthened the national HIV/AIDS prevention program by conducting a research study on hard-to-reach groups to develop prevention messages; developed a manual for HIV/AIDS VCT; and opened VCT sites in five NGO health service delivery centers with high-risk populations. To expand access to VCT, especially for at-risk populations, 90 health providers received training in VCT in 2006.
- In **Brazil**, USAID is supporting prevention projects developed by Brazilian NGOs to improve the quality of life for PLWHA. Activities are geared toward focusing on overall quality of life issues that have been identified as high priorities by PLWHA, such as treatment adherence, nutritional literacy, income generation, job skills training, and improving linkages to other social movements. USAID in collaboration with CDC supported the completion of a TB-HIV co-morbidity study.

- In the **Dominican Republic**, USAID reached more than 250,000 adolescents and youth with abstinence and being faithful messages through the annual youth and adolescent song contest; reached 117,000 people with testing and counseling services; supported PMTCT services in 82 facilities for almost 72,000 women and their babies; provided direct support to six outpatient clinics; supported treatment for 11,552 HIV-positive patients; and supported 7,669 OVC through 18 community- and home-based care programs for children and families affected by HIV/AIDS.
- In **Guyana**, USAID supported prevention programs emphasizing abstinence and being faithful for 33,900 people annually and reached 28,300 people with counseling and testing services. PMTCT services have reached nearly national coverage, and USAID has significantly strengthened a joint partner procurement and supply chain system.
- In **Haiti**, USAID supported prevention programs emphasizing abstinence and being faithful for 345,700 people; counseling and testing for 128,600 people; palliative care and support for 38,700 people; and program assistance for 20,000 OVC.
- In **Mexico**, USAID supported the launch of a successful HIV/AIDS business council (known as CONAES) dedicated to the elimination of job-based discrimination. CONAES has 30 member companies from a diverse range of Mexican and multilateral businesses. Since 2004, CONAES has had a direct impact on 150,000 Mexican workers and an indirect impact on an estimated 560,000 family members. Private companies contributed more than $400,000 of their own resources, and in December 2006, CONAES became completely self-sustaining through member contributions.
- In **Peru**, USAID conducted a number of activities aimed at reducing stigma and discrimination (S&D), including training health professionals; developing and testing a monitoring system to include S&D as a criterion for quality of care; successfully promoting the inclusion of HIV/AIDS-related S&D on the agenda of the Peruvian ombudsman; and producing guidelines to decrease S&D in families of PLWHA. USAID reached 65,200 individuals through a communication program to prevent HIV/AIDS; trained 187 health professionals in VCT; and completed two baseline surveys on knowledge of STIs and HIV/AIDS and safer sexual behaviors among MSM, sex workers, and PLWHA.
- In **Suriname**, USAID launched a media campaign that significantly increased HIV/AIDS counseling and testing between December 2005 and August 2006. Client satisfaction has improved and staff workload has decreased since the implementation of same-visit testing and results.

Important Links and Contacts

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For more information, see USAID HIV/AIDS Web site *http://www.usaid.gov/our_work/global_health/aids*
Caribbean Regional Program Web site *http://www.usaid.gov/our_work/global_health/aids/Countries/lac/caribbeanregion.html*
Central America Regional Program Web site *http://www.usaid.gov/our_work/global_health/aids/Countries/lac/caregion.html*

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