Toward Universal

to HIV Prevention, Care, and Treatment

// 3 BY 5 REPORT FOR THE AMERICAS

Pan American Health Organization
Regional Office of the World Health Organization

Toward **Universal Access** to HIV Prevention, Care, and Treatment

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“The 3 by 5 Initiative in my view was a remarkable bold plan and had the effect of galvanizing action and serving as a rallying point for many voices and initiatives. One of the main advantages, as seen in your report, was that it served to strengthen not only the delivery of ART, but improved other aspects of the health response such as collection and management of information and prevention”

Sir George Alleyne
Special Envoy of the UN Secretary-General for HIV/AIDS in the Caribbean Region

[i] PREFACE

As governments, organizations, and individuals strive to combat AIDS deaths and the spread of HIV, we must all aim high. The magnitude of the HIV/AIDS epidemic and its potential to spread require high level planning and large scale action. When the World Health Organization and the Joint United Nations Program on HIV/AIDS set the goal to treat three million people with antiretrovirals by 2005, it was with this aim to think big and achieve commensurate gains. In the Americas, the 3 by 5 Initiative was introduced within a context favoring the expansion of antiretroviral treatment and a growing movement toward universal access to prevention, care, and treatment. In the countries of the Region, political will has favored the scaling up of HIV prevention and treatment programs, and governments have benefited from increased support from international development partners.

Looking back over the past two years, significant progress has been made both globally and in the Region. In Latin America and the Caribbean, the 3 by 5 Initiative generated increased financial and technical support to countries from PAHO/WHO in both treatment and prevention. As a result, the Region has seen the expansion of HIV programs, with considerable success in scaling up prevention as well as care and treatment for those in need, increased human resource capacity, and enhanced health sector infrastructure. The Region met and exceeded the goal set by heads of state in the Summit of the Americas in 2004, to treat at least 600,000 people requiring antiretroviral therapy by the end of 2005. At the established deadline, over 680,000 people were receiving antiretroviral medications. The 3 by 5 Initiative was a catalyst for the pooling of technical contributions from across PAHO/WHO at regional, subregional and national levels. It also led the way for the development of the Regional HIV/STI Plan for the Health Sector 2006-2015, released in November 2005.

Despite recent gains, the Region must make even greater progress in order to achieve Goal 6, Target 7 of the UN Millennium Declaration, to halt and reverse the spread of HIV/AIDS by 2015. The 3 by 5 Initiative represents the response of an international sector and national leaders galvanized by AIDS suffering and deaths and committed to achieving large scale, sustainable results. Let us maintain this drive for action and integrate the results-oriented approach of 3 by 5 into our HIV/AIDS efforts in the years ahead. The Regional HIV/STI Plan as well as the recent UN Universal

Access Initiative, coordinated by UNAIDS, provide a solid framework for concerted, harmonized action. With our focus on the well-being of people of the Americas, in particular those affected by HIV, we must build on what we have achieved and continue to break new ground in successfully addressing the challenges ahead.

—Mirta Roses Periago
Director, Pan American Health Organization

[ii] EXECUTIVE SUMMARY

The 3 by 5 Initiative launched by the World Health Organization (WHO) in 2003 aimed to provide antiretroviral therapy to an additional three million people requiring treatment globally. In the Region of the Americas, the Pan American Health Organization (PAHO) included prevention of HIV within 3 by 5 in order to promote a comprehensive care model. The five pillars established for the global 3 by 5 Initiative were adapted to the context and needs of Latin America and the Caribbean, resulting in five strategic orientations guiding the development of the Initiative in the Region:

- Political commitment and leadership, partnerships, and community mobilization
- Health systems/services strengthening, including the adaptation and application of appropriate tools
- Effective, reliable supply of medicines, diagnostics, and other commodities
- Links with health promotion and prevention of STI and HIV/AIDS within health services
- Strategic information and dissemination of lessons learned.

The 3 by 5 target for the Region was to have 600,000 people under treatment by the end of 2005, in line with the goal set by heads of state during the 2004 Summit of the Americas in Nuevo Leon, Mexico. As of December 2005, a total of 680,000 people in the Americas were under antiretroviral therapy, over 300,000 of these in Latin America and the Caribbean. During 2004 and 2005, the health sector expanded significantly in most countries, with major increases in the number of antiretroviral treatment service outlets and advances in access to voluntary counseling and testing and prevention of mother-to-child transmission. Due to subregional negotiations to reduce the cost of medications as well as added support from donors, the price of antiretroviral medicines offered to countries was considerably reduced by the end of 2005.

Implementation of 3 by 5 in the Americas by PAHO/WHO was supported by funding from the Canadian International Development Agency and other develop-

ment partners. PAHO/WHO distributed funds directly to countries and technical staff were recruited at the country, subregional, and regional levels. Thirty-seven countries in the Region developed work plans detailing activities to be undertaken according to the five strategic orientations. During 2004 and 2005, countries initiated a variety of activities to scale up prevention, care, and treatment with technical and financial support from 3 by 5. Most of the resources were used to strengthen health system infrastructure, including human resource capacity and expansion of services. Significant advances were also made in prevention, access to medicines, and strengthening the collection and management of strategic information.

Following the commitments of all countries to universal access to treatment in the Region, many countries began to put supportive policies and programs in place. Strategic plans for national responses to HIV were developed in Guyana and Guatemala, and in many countries, existing national HIV plans were augmented in technical areas including the prevention of mother-to-child transmission and voluntary counseling and testing. In some cases, support from 3 by 5 was used to help countries develop proposals for further funding from major donors, in particular the Global Fund.

Prevention efforts supported by 3 by 5 included a national media campaign addressing homophobia in Mexico, "Know Your Status" campaigns in the Bahamas and Suriname, and a project in Uruguay involving vulnerable groups. The supply of post-exposure treatment kits for health workers and sexual assault victims was expanded in Peru and Costa Rica. In Belize and elsewhere, resources were devoted to improving services for prevention of mother-to-child transmission.

New entry points for HIV care were created in several countries, including in Colombia for reproductive health services, and in Honduras, Nicaragua, and Belize for domestic violence services. New guidelines for the prevention and treatment of STI were implemented in seven countries in the Region. In Cuba, Nicaragua, and Peru, major efforts were initiated to decentralize HIV services.

Virtually all countries in the Region held training workshops for health personnel at all levels, including community health workers, technicians, pharmacists, nurses, and doctors. The workshops were facilitated by Ministries of Health as well as PAHO/WHO staff and in some cases were the result of technical cooperation between countries. Personnel were trained in many aspects of HIV care, including antiretroviral treatment and adherence, prevention, integrated care, voluntary counseling and testing, and prevention of mother-to-child transmission. In response

to the problem of pervasive discrimination against people with HIV in the health sector, sensitization workshops to encourage tolerance and understanding were conducted in several countries.

During 2004 and 2005, countries increasingly utilized regional and subregional mechanisms to obtain antiretroviral medicines and other commodities at reduced prices. Subregional price negotiations with drug companies held in Argentina in 2005 as well as previous subregional negotiations in the Caribbean, Central America, and Andean countries helped to steadily lower the price of antiretroviral medicines. PAHO/WHO's Regional Revolving Fund for Strategic Public Health Supplies (the Strategic Fund) provided assistance to countries for the development of acquisition plans and the improvement of supply and distribution, and for acquiring medicines at the lowest possible prices. As of the end of 2005, thirteen countries were participating in the Strategic Fund. Loans and donations between countries were also instrumental in improving antiretroviral treatment access. Brazil in particular made extensive donations to many countries throughout the Region.

Improving surveillance and the availability of strategic information is key to monitoring progress on HIV programs. Information systems were upgraded in Nicaragua and Venezuela, and bulletins with HIV/AIDS data were created in Argentina and Guatemala. On the US/Mexico border, PAHO/WHO implemented a project to improve surveillance and estimation of HIV prevalence among vulnerable groups.

Despite significant advances, challenges remain that impede the Region's progress toward universal access:

- Strengthening health systems and services to protect achievements and move toward universal access
- Financing and sustainability of programs
- Harmonization and collaboration

The publication of PAHO/WHO's Regional HIV/STI Plan for the Health Sector 2006-2015 paves the way for countries in the Region to take a comprehensive approach to scaling up the response to HIV. During 2005, the Regional Plan was approved by all countries in the Region and activities began at the country level to launch the Plan and integrate its strategies into existing national priorities. Over the next decade, PAHO/WHO will work at all levels to support the rollout of the Regional Plan in countries through advocacy, technical assistance, and financial support.

The use of existing services for HIV can help to maximize resources and reinforce a primary care approach

[1] INTRODUCTION

In 2003, WHO and UNAIDS launched the "3 by 5 Initiative" (3 by 5), which aimed to provide antiretroviral (ARV) treatment to three million people with HIV requiring treatment in low and middle income countries by the end of 2005. Led by ten guiding principles and a five pillar strategy, the WHO initiative ultimately aimed for universal access to ARV for those in need of care.

As the World Health Organization Regional Office for the Americas and with a pre-existing commitment to the expansion of ARV access, the Pan American Health Organization wholeheartedly embraced 3 by 5. The HIV/AIDS epidemic in the Americas is distinct from other areas of the world, as are many of the challenges faced by countries in the Region. In the Western Hemisphere, the epidemic varies by subregion. Within Latin America the epidemic tends to be concentrated among groups such as men who have sex with men, injecting drug users, and commercial sex workers. HIV prevalence is currently increasing among women and youth, and the epidemic is becoming more heterogeneous. In Caribbean countries, where HIV prevalence rates are second highest in the world, the epidemic is generalized.

In response to the needs of the countries in the Region, PAHO/WHO opted for a comprehensive approach to 3 by 5 that included prevention as well as treatment. The Initiative took into account two 2004 Directing Council resolutions: (1) Scaling up treatment within a comprehensive response to HIV/AIDS and (2) Access to medicines.[1] The resolutions urged both Member States and the PAHO Secretariat to intensify actions on these fronts, expanding prevention and treatment programs, prioritizing access to antiretroviral therapy (ART), and collaborating with key partners. The 3 by 5 Initiative also coincided with and was reinforced by the Nuevo Leon Declaration emerging from the 2004 Summit of the Americas, an agreement stating the commitments of all countries to facilitating affordable antiretroviral treatment for all who need it.

The strategic framework for PAHO/WHO's 3 by 5 Initiative was based on WHO's guiding principles and its five pillars, but these were adapted to the specific needs and context of Latin America and the Caribbean. The guiding principles were expanded to include gender sensitivity, resulting in 11 principles. The five pillars were modified to comprise the following five strategic orientations:

1 45th Directing Council Resolutions CD45.R10 and CD45.R7

- Political commitment and leadership, partnerships, and community mobilization
- Health systems/services strengthening, including the adaptation and application of appropriate tools
- Effective, reliable supply of medicines, diagnostics, and other commodities
- Links with health promotion and prevention of STI and HIV/AIDS within health services
- Strategic information and dissemination of lessons learned

These strategic orientations provided a basis for the 3 by 5 work plan and directed PAHO/WHO's distribution of human and financial resources. The prevention and treatment of STI was included in 3 by 5 planning and implementation given that STI are an important underlying risk factor for HIV and an entry point for counseling and testing, and that HIV/STI coinfection rates in the Region are high.

This report discusses the areas of work undertaken as part of 3 by 5 in the Americas and highlights innovative and promising examples of planning and program development in countries. It describes the operational strategy for implementing 3 by 5, the state of ART coverage and related services, progress in prevention and treatment, and challenges for the future. At the official end of the Initiative in 2005, 3 by 5-related activities in countries were only beginning to take shape. Actions stimulated or supported by the Initiative will continue to be implemented as part of wider efforts to scale up the health sector response.

The accomplishments to date of 3 by 5 reflect the dedication of many governments to expanding HIV/STI services and programs, as well as the contributions of partners at national, subregional and international levels. Several countries had been actively promoting universal access prior to 3 by 5. The proactive leadership of Brazil, Argentina, and the Bahamas, among others, paved the way for 3 by 5 in the Region. Support from the Global Fund to fight HIV, Tuberculosis, and Malaria to over 20 countries in the Region was instrumental in expanding treatment and prevention, as were resources from the World Bank, the Clinton Foundation, and, to a lesser extent, grants from the US President's Emergency Fund for AIDS Relief (PEPFAR).

External financing for PAHO/WHO's implementation of 3 by 5 in the Americas came mainly from the Canadian International Development Agency (CIDA). Other partners included the United Kingdom Department for International Development (DFID), the Swedish International Development Cooperation Agency, the Norwe-

gian Agency for International Development, the Spanish Agency for International Cooperation, and UNAIDS. In the Caribbean, a multi-agency partnership supported 3 by 5 activities by providing additional financial and technical assistance for the Special Program on Sexually Transmitted Infections of the Caribbean Epidemiology Center (CAREC). The partnership includes DFID, the US Agency for International Development, CIDA, CDC (US Centers for Disease Control and Prevention), the French Cooperation, the European Union, the World Bank, PANCAP/CARICOM (Pan Caribbean Partnership Against HIV/AIDS / Caribbean Community), and the Global Fund. The total amount of funds for 3 by 5 efforts mobilized in the Region was close to five million dollars. Of this, 68% was distributed directly to countries.

Despite contributions from many fronts and the resulting successes in the Region, large disparities between countries in the response to HIV remain. While some countries have achieved universal access to treatment and widespread prevention, the majority are far behind. All countries have committed to the goal of universal access to prevention and treatment by 2010. Nonetheless, countries with few resources face difficulties due to many competing priorities, and those currently relying on international funding for HIV programs face the challenge of sustaining them over the long term. This illustrates the need for close collaboration among all stakeholders in order to minimize duplication of activities and programs, and for technical cooperation among countries in the Region so that they can learn from one another's successes.

If the future course of the epidemic is to be changed, more people must know their HIV status.

[2] IMPLEMENTING THE 3 BY 5 INITIATIVE IN THE AMERICAS

In preparation for the implementation of 3 by 5, PAHO/WHO conducted several consultations at the subregional level to identify countries' needs in the scaling up process.[2] Using input from these meetings, the strategic orientations and the operational strategy were defined. PAHO classified countries in the Region into four categories using high/low ART coverage and HIV prevalence. The resulting matrix (see text box 1) served as the basis for strategic planning.

The operational strategy for implementing 3 by 5 in the Region was divided into three main lines of action: (1) intensification of support to countries, (2) scaling up PAHO/WHO's response at regional and subregional levels, and (3) mainstreaming HIV within PAHO/WHO. To begin the process, countries in the Region developed individual plans outlining 3 by 5 activities by strategic orientation. PAHO/WHO allocated operational budgets to support the work plans and appointed full time professionals responsible for technical support. Subregional coordinators were appointed in the Andean region, Central America, and the Caribbean to provide additional technical support as well as assistance with monitoring and evaluation.

To scale up PAHO/WHO's response, the HIV/AIDS Unit increased the number of Regional level technical staff and mobilized additional staff within the Organization. An interdisciplinary "Core Team" served to broaden PAHO/WHO's response and help mainstream HIV/AIDS efforts. In January 2005, a Technical Advisory Committee (TAC) consisting of experts from the Region was established to foster accountability, provide additional technical input, and increase linkages with civil society including people with HIV. The TAC has met yearly and participated in the work of the Unit, providing recommendations that have contributed to PAHO/WHO's strategic planning.

2

Consultation meetings were held during 2004 in Central America and the Caribbean, and a Task Force meeting was held in Washington.

Argentina

Mexico

Brasil

Colombia

As homophobia continues to be a major barrier to HIV prevention, several Latin American countries launched mass media campaigns against discrimination of homosexual men.

[3] PREVENTION AND TREATMENT IN THE REGION 2004-2005

Five proxy indicators are used in this report to provide a snapshot of the state of access to prevention and care services in Region.[3] They are the percentage of prenatal services offering prevention of mother-to-child transmission (PMTCT), number of people tested at voluntary counseling and testing (VCT) sites, number of people under ART (total and by sex), percentage of health services with ART outlets, and ARV prices. At the end of December 2005, PAHO/WHO requested data in these areas from countries. Some of the indicators including number of people under ART are collected routinely as part of PAHO/WHO's ongoing surveillance of the epidemic, while others such as percentage of prenatal services offering PMTCT and number of testing and counseling sites are not regularly monitored at the regional level. The data were provided by Ministries of Health, and in most cases were limited to the public sector. However, some countries were able to report data from the private sector as well. Disaggregation of data is becoming more common in countries as surveillance systems improve, but as of 2005, less than half of the 25 countries provided data by age and sex.

The data provided by countries in December 2005 show that, while challenges persist, important progress has been made in the Region in all five proxy indicators.

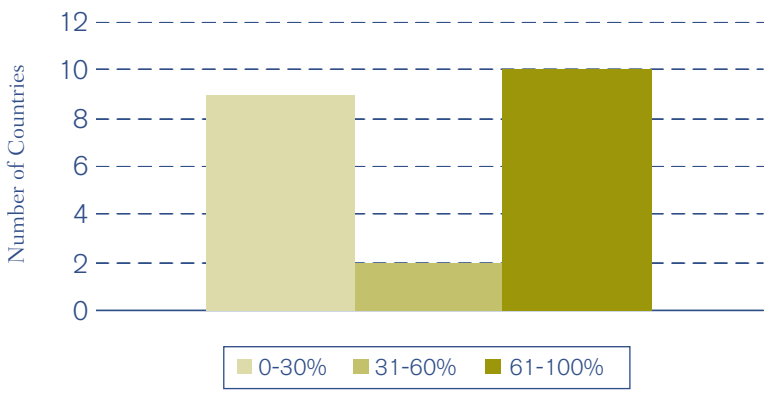
a) Several countries are currently offering PMTCT in 100% of prenatal services.

Prenatal services are a key entry point for HIV care and treatment, and the prevention of mother-to-child transmission has proven to be a cost-effective intervention. If integrated into prenatal care, PMTCT can prevent at least 50% of HIV infections in children, and contributes to the timely identification and referral of women for ART. Currently, several countries in Latin America and the Caribbean are offering PMTCT in 100% of prenatal services; however, there are wide disparities among countries in PMTCT coverage and the level of its integration into primary care. The majority of countries reporting offer PMTCT in less than 60% of prenatal services (see graph 1).

3

Data compiled by WHO/UNAIDS on the estimated number of people with HIV and number under ART by country are available in the WHO document "Progress on Global Access to HIV Antiretroviral Therapy: A Report on '3 by 5' and Beyond" from March 2006.

GRAPH 1
PERCENTAGE OF PRENATAL SERVICES OFFERING PMTCT IN 21 LAC COUNTRIES



Source: Ministries of Health/PAHO/WHO

b) Voluntary counseling and testing services were expanded in many countries and access improved

Knowing one's HIV status is key for timely access to ART and prevention of further HIV transmission. VCT services were promoted in the Region as a main health intervention to enable people to know their HIV status and make informed decisions about their behavior and general health care. Even though no targets were defined for VCT, many countries expanded their services during the period of the 3 by 5 Initiative. During 2005, close to 772,000 people were tested at VCT sites in 15 countries reporting.[4] In a sub-sample of 11 countries where disaggregation by sex is available,[5] close to 64% of those tested were female. Numbers of people tested vary widely among countries and among subregions. In Anguilla, 650 people were tested, while in the Turks and Caicos the total was 2,800. In Nicaragua, where an estimated 6,400 people were HIV positive in 2003, 200,000 people were tested for HIV during 2005. In Paraguay, the estimated number of people with HIV in 2003 and number of people tested in 2005 were both approximately 15,000. In cases where VCT capacity is low or in the process of expansion, it is of particular importance to focus on increasing the availability of counseling and testing services for at-risk populations and ensure that services are sensitive to their needs.

c) ART coverage increased substantially in the Region and decentralization of services progressed

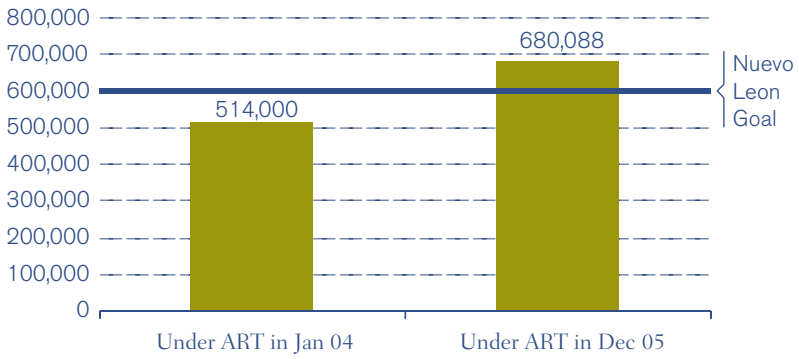
Coverage of ART increased substantially in the Region during the years 2004 and 2005. The goal set in Nuevo Leon in 2004 to treat 600,000 people by the Fourth

4
El Salvador, Turks & Caicos, Paraguay, Belize, Anguilla, Honduras, Peru, Guyana, Guatemala, Venezuela, Nicaragua, Suriname, Haiti, Cuba, Bolivia.

5
Sub-sample includes El Salvador, Turks & Caicos, Belize, Anguilla, Honduras, Peru, Guyana, Venezuela, Nicaragua, Haiti, Cuba.

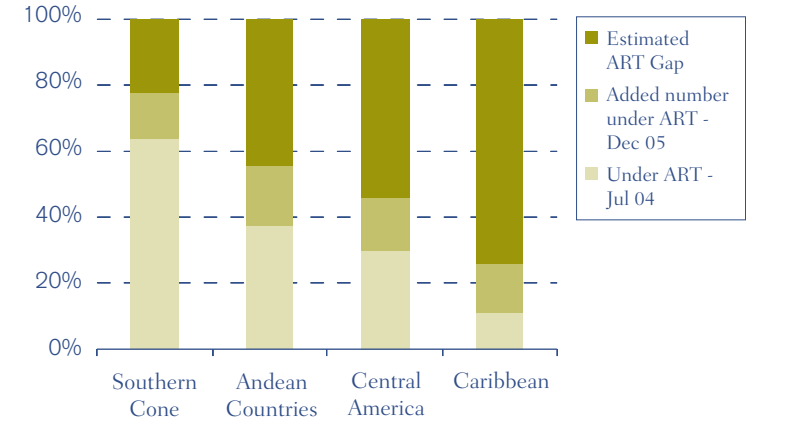
Summit of the Americas in 2005 was met and exceeded, thanks to an extensive mobilization of human and financial resources within countries and from the international sector. That number was also established as the 3 by 5 treatment target for the Americas, making the Region the only one in the developing world to meet the goal. In December 2005, 680,000 people in the Americas[6] were reported under ARV treatment (see graph 2). Of these, close to 46% were in Latin America and the Caribbean.

GRAPH 2
ESTIMATED NUMBER OF PEOPLE UNDER ART IN THE AMERICAS 2004 AND 2005



Source: *Ministries of Health / PAHO/WHO / UNAIDS Estimates*

GRAPH 3
ESTIMATED ART COVERAGE AND GAP BY SUBREGION (EXCLUDING BRAZIL AND MEXICO) 2004-2005



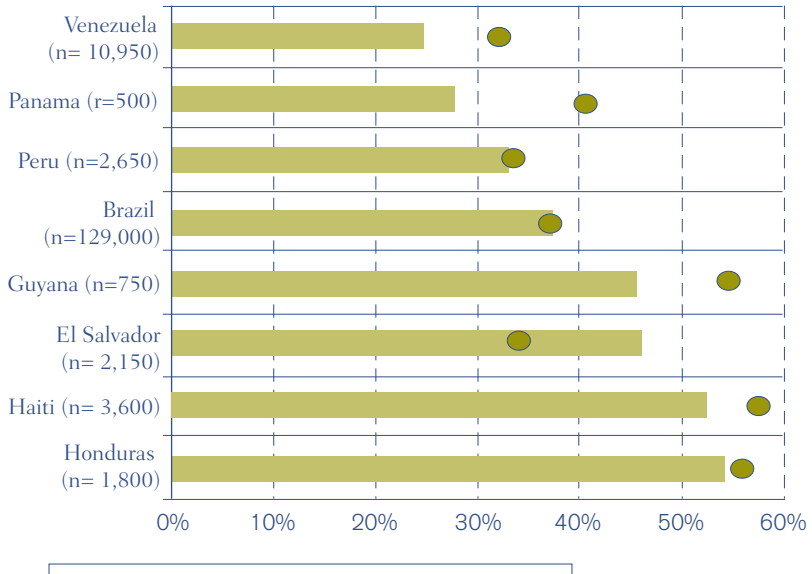
Source: *Ministries of Health / PAHO/WHO / UNAIDS Estimates*

6
Total is likely low due to not all countries reporting. Numbers of people under treatment in the US and Canada are from March 05 and July 04 respectively, and numbers from several Latin American and Caribbean countries date to March or May 05.

In 43 Latin American and Caribbean (LAC) countries, the reported total number of people under ART in December 2005 was 310,000. Though gaps in coverage vary significantly among subregions, all saw increases in the number of people under ART in the 2004-2005 period (see graph 3). Due to their large populations and broad access to ART, Brazil and Mexico represent approximately two-thirds of the total number of people under ART in LAC.

It is difficult to analyze gender and age differences in access to ART or to identify trends because data disaggregated by sex and age were not collected systematically by countries in past years. This is changing, however, and some countries in the Region reported these data to PAHO/WHO in December 2005. In 20 countries reporting,[7] close to 5% (over 11,000) of those taking ART were under the age of 15, and in a subsample of 19 countries[8] in LAC, 36% of those under ART were female. Few countries in the Region have available data to compare the sex distribution in number of people requiring treatment and number of people receiving it. It is possible, however, to compare the sex ratios between number of people with HIV and those receiving treatment in several countries. Graph 4 compares the percentage of women receiving ART versus the expected percentage in nine countries in the Region.

GRAPH 4
PERCENTAGE OF WOMEN AMONG ALL ADULTS RECEIVING ANTIRETROVIRAL THERAPY VERSUS THE EXPECTED PERCENTAGE BASED ON COUNTRY OR SITE REPORTS, 2005



Source: WHO/UNAIDS
a *The expected p;ercentage of women receiving antiretroviral therapy is based on the percentage of people living with HIV/AIDS who are women. Values are sorted in ascending order within each WHO region*

7
El Salvador, Turks & Caicos, Paraguay, Belize, Argentina, Anguilla, Bahamas, Honduras, Peru, Brazil, Guyana, Venezuela, Nicaragua, Trinidad & Tobago, Haiti, Dominican Republic, Cuba, Panama, Bolivia, Ecuador.

8
El Salvador, Turks & Caicos, Paraguay, Belize, Argentina, Anguilla, Bahamas, Honduras, Peru, Chile, Brazil, Guyana, Venezuela, Nicaragua, Suriname, Haiti, Dominican Republic, Cuba, Bolivia.

Though there is not adequate evidence to determine a gender bias in access to ART in the Region at this time, an imbalance in access related to sex exists in several countries.

TEXT BOX 1: Epidemiological Characteristics of HIV/AIDS in the Americas

In order to focus on the countries with where HIV/AIDS has the greatest epidemiological impact, PAHO created 4 categories using low/high ART coverage and low/high HIV prevalence. The resulting matrix, from 2004, gives a clear picture of which countries have the greatest unmet need for treatment.

By 2005, five countries had moved from low to high ART coverage, shifting the balance of countries to the high coverage quadrants.

Source: Ministries of Health / PAHO/WHO

The extent to which ART is available from local health services is an area of concern, as services centralized in capital cities make it difficult to successfully treat and monitor those living in other areas. Data from 2005 show that in many countries, even in smaller countries with fewer resources, more ART services exist now than did in previous years. In nine countries of 23 reporting,[9] over 90% of health districts were providing ART. Among the 23 countries, the average percentage of health districts with ART service outlets was 59%. The percentage of health districts with ART service outlets increased in Paraguay from 6% in 2004 to 11% in 2005. In Nicaragua, that figure rose from 3% in 2003 to 29% in 2005, and in Panama from 28% in 2004 to 43% in 2005.[10] While the increase in service outlets marks progress, in many countries it is still not sufficient to reach all who need treatment.

d) The cost of ARV medications was reduced significantly

As a result of partnerships with donors as well as regional and subregional mechanisms, the cost of ARV medications has been reduced significantly in the Region. Consequently, many countries have been able to purchase greater quantities of drugs and offer lower costs to patients. At the end of 2005, the price of ARV medications to governments still varied greatly among countries but was lower than in previous years. The range of prices paid by countries in 2005 for a year's supply of first line ARV for an individual (in USD) was $300 - $1,000+, while in 2003 the range was $1,000 - $1,500. With increasing utilization of the support available in the Region, there is potential for those countries paying higher prices to reduce their costs in future years.

9

El Salvador, Turks & Caicos, Uruguay, Paraguay, Belize, Argentina, Anguilla, Bahamas, Peru, Chile, Brazil, Guyana, Guatemala, Venezuela, Nicaragua, Trinidad & Tobago, Suriname, Haiti, Dominican Republic, Cuba, Panama, Bolivia, Ecuador.

10

Data from Paraguay are from August 2004 and December 2005; in Nicaragua, from December 2003 and December 2005; and in Panama, from December 2004 and December 2005.

Violeta Ross, from Bolivia

In the Americas organized groups of people with HIV have made their voices heard, promoting recognition of the concerns of people with HIV and drawing much needed attention to treatment access

[4] COUNTRY ACTIONS AND PROGRESS

Thirty-seven countries in the Region developed work plans detailing activities to be undertaken with financial and technical support from the 3 by 5 Initiative. Work plans varied in scale and content according to needs and capacities of countries as well as existing priorities. As funds for 3 by 5 only became available in the Region in early 2005, intensified efforts were required to implement the agreed-upon work plans and meet the financial deadlines. Following are descriptions of the main areas, grouped by strategic orientation, in which countries applied 3 by 5 technical and financial support during 2004 and 2005. Text boxes in each section describe PAHO/WHO-led regional and subregional actions to further the goals of the Initiative.

Political commitment and leadership, partnerships, and community mobilization

↳ *Strategic Orientation 1*

High level political commitment to fighting HIV and effective leadership to realize targets are the backbone of a national response to the epidemic. Committed leaders have the power to put into place sound policies based on evidence and supportive legal frameworks with a long-term impact. As the world of HIV/AIDS work is expansive in actors and resources, it falls upon national leaders to streamline diverse agendas, maximizing the contributions of donors and coordinating a focused national response.

In Latin America and the Caribbean, a number of countries have national policies supporting universal access to treatment for people with HIV. Examples include Chile, Cuba, El Salvador, Costa Rica, Colombia, and Guyana. As a result of the growing momentum for universal access in the Region, most countries have now made commitments to put the necessary policies and programs in place, a trend which promises future advances in treatment coverage. In Chile, universal access policies are supported by an ongoing effort to enhance and maintain access. With the support of 3 by 5, a study to assess quality of life for people with HIV was undertaken in the country to evaluate current strategies and improve the treatment program.

Recent national level actions toward scale up in the Region have included the development of many new plans to guide the expansion or improvement of specific technical areas such as ART, VCT, or surveillance, as well as comprehensive plans

detailing the health sector's long-term response to HIV. In both Guyana and Guatemala, the 3 by 5 Initiative supported the development of a 5-year national strategic plan (2006-2010). Guyana held a national workshop in 2005 to obtain the input of multiple stakeholders for the plan's development and to cultivate a multisectoral response. By January 2006, the national strategic plan was in a final stage. In Guatemala, action was taken within the country's health districts to define strategies for local implementation of the new strategic plan.

The work of health authorities in Mexico is another example of high-level political commitment to fighting HIV, especially in the area of prevention. In 2005, a national plan for prevention was developed by the Ministry of Health and funds were requested from the financial sector for its implementation. Recognizing the association between discrimination related to HIV and discrimination related to sexual orientation, authorities in Mexico developed an anti-homophobia campaign, supported in part by 3 by 5, to help reduce the barriers to HIV prevention.

The lack of coordination among agencies is an often-cited challenge to scaling up HIV/AIDS prevention and treatment. In Haiti, where multiple partners are present and PEPFAR and the Global Fund alone invest approximately $65 million yearly in HIV/AIDS activities, coordination is a particularly critical issue. Under the 3 by 5 Initiative, a joint UN group was formed in Haiti to support ongoing activities and identify gaps. The group narrowed their focus to the departmental level and conducted a situation analysis of existing services in two hard-to-reach departments. Results of the analysis were shared widely and the report motivated partners to improve communication and information sharing, and to collaborate in specific areas. The group has since expanded to include non-UN and governmental representatives and joint supervision of other departments has been planned for 2006.

In several cases, funding from 3 by 5 helped countries leverage an expanded pool of resources. Countries used the assistance to develop proposals, fill unforeseen gaps in funded projects, and add technical support. In the case of Paraguay, 3 by 5 funding aided in the development of a technical proposal for the 5th Round of the Global Fund, which will add a considerable boost to the country's resources for HIV/AIDS. The proposal was developed jointly with national stakeholders.

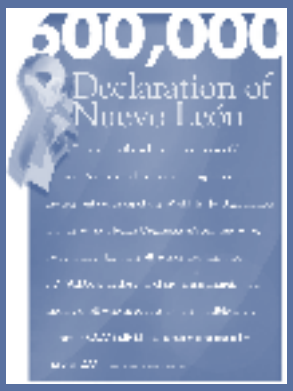
The involvement of people with HIV in planning, program implementation, and evaluation is a key component of the scaling up process. In the Americas, organized groups of people with HIV and their supporters have made their voices heard, promoting

greater recognition of the concerns of people with HIV and drawing much-needed attention to treatment access. People with HIV are now an integral part of international HIV initiatives from design to implementation. To help incorporate the perspectives of people with HIV in regional level health sector decision making, PAHO/WHO has included people with HIV and representatives from advocacy groups in the steering group that guided the development of the Regional HIV/STI Plan and in the HIV/AIDS Technical Advisory Committee.

Empowerment of people with HIV was a cross-cutting element of the 3 by 5 strategy. At the subregional level, CAREC/PAHO, together with partners in the Caribbean, led a project to foster partnerships between health care providers and people with HIV on the island of St. Lucia. The project provided training for people with HIV in St. Lucia and health care providers. In addition, an exchange with Trinidad & Tobago was organized to gain experience from an existing network of health care providers and people with HIV. The project has brought about increased confidentiality in pharmacies, development of a home-based care program for people with HIV, and sensitization training for health workers to reduce stigma and discrimination.

Two projects led by regional NGOs working on behalf of the human rights of people with HIV were supported by 3 by 5 funding. The first, with Agua Buena in Costa Rica, works to improve patient literacy and to provide ongoing information about the rights of people with HIV as well as other current issues. The second, a project with Red La+, collected data from people with HIV, as well as health providers, on access to treatment and stigma and discrimination. RedLa+ plans to use the results to define strategies for action and for political advocacy.

TEXT BOX 2: Addressing HIV/AIDS in Summits of the Americas



During the 2004 Summit of the Americas in Nuevo Leon, Mexico, heads of state of the Americas made the commitment to have at least 600,000 people in the Region under antiretroviral treatment by 2005. This figure represented the number of people estimated by PAHO and countries in the Region to need treatment at the end of 2003. The commitment, known as the Nuevo Leon Declaration, was signed by presidents and prime ministers of 34 countries. PAHO used this opportunity to advocate for treatment access and link the goals of 3 by 5 to existing government commitments. In 2005, during the Summit of the Americas in Mar del Plata, Argentina, governments further committed to strengthening cooperation and exchanges of information in the struggle against HIV/AIDS and fight the stigma, misinformation, and discrimination against people living with HIV/AIDS. The heads of state proposed developing crosscutting strategies, within the framework of WHO and PAHO to combat the disease.

Health systems/services strengthening, including the adaptation and application of appropriate tools

↳ *Strategic Orientation 2*

Strengthening health systems to improve prevention and care for people with HIV is a long-term process, especially in countries with limited human and financial resources. The use of existing services for HIV care can help to maximize resources and reinforce a primary health care approach. Several countries in the Region have used support from 3 by 5 to create additional points of entry for HIV care as well as to improve services for STI.

TEXT BOX 3: PAHO Laboratory Guidelines for Rapid Testing

HIV testing that provides results within the same visit (rapid testing) is a major advance in HIV diagnosis. It has increased the number of people who know their HIV status and helped to form a bridge between VCT and HIV/AIDS prevention, care, and treatment services. In addition, rapid testing decreases reliance on centralized laboratory services and transport systems for obtaining results.

PAHO's rapid testing guidelines describe the process of implementing same visit HIV testing within a country's protocols and outline the operation of a rapid testing site. They are meant to ensure reproducibility and quality of rapid testing in counseling services and include criteria for the selection of test kits and devices. Quality control is a critical issue in rapid testing. In addition to extensive monitoring of the rapid testing process, attention must be paid to kit procurement, selection of the algorithm to be employed, and personnel training.

The process of implementing the guidelines in the Region has not yet begun. A regional meeting is planned for 2006/2007 in which PAHO will work with countries to adapt the guidelines for implementation in same visit centers.

In Colombia, though coverage of HIV testing and care services is low, reproductive health services are accessed by the great majority of the population in need. With this in mind, the Ministry of Health, in alliance with PAHO/WHO and other UN agencies, undertook a pilot project to equip sexual and reproductive health services for HIV diagnosis and care in five cities. The project will provide a trial period for new voluntary counseling and testing guidelines before they are adopted at the national level and will facilitate the introduction of rapid testing in a controlled setting.

In Honduras, Nicaragua, and Belize, a project has been initiated to create HIV entry points within domestic violence services. The project aims to increase access to ART and reinforce prevention among female survivors of sexual and domestic violence while at the same time expanding access to gender-based violence services for women with HIV. As an added benefit, the project will generate core data on the relationship between STI, HIV, and sexual and domestic violence.

In Belize and in Honduras, 3 by 5 support was used to improve STI services. New clinical guidelines were developed for prevention and control of STI, and materials were developed for use in clinics and for outreach services. In El Salvador, a five-year strategic plan for congenital syphilis was developed as part of an initiative to reduce the incidence of syphilis among mothers and infants. National guidelines for the prevention and treatment of congenital syphilis and STI were developed and updated in seven countries in the Region.

To improve HIV/AIDS care at the primary level in Cuba, primary health care personnel in 47 municipalities were trained in HIV and ART. The training focused on care for people under ART and support for adherence to treatment. In both Nicaragua and Peru, efforts are underway to decentralize ARV treatment, supported in part by 3 by 5. Interdisciplinary teams were formed and trained in Nicaragua to run 6 new ARV distribution centers at local levels, while in Peru, technical support was provided to health authorities in a mountain region to institutionalize ARV treatment at a local hospital. In Panama, Venezuela, Ecuador, and Honduras, treatment protocols were reviewed and updated with a public health approach.

Funding from 3 by 5 was utilized in Panama for the purchase of supplies for HIV rapid testing and viral load testing. Health personnel from multiple levels of care in areas of the country with the highest HIV incidence were trained to improve provision of VCT. Similarly, in the Turks & Caicos islands and in Anguilla, health workers were trained in VCT. Though testing is currently available only at the hospital laboratory in Anguilla, the National AIDS Program is working to make all five of the island's health centers VCT sites.

TEXT BOX 4: Improving Blood Safety

As part of the 3 by 5 Initiative, PAHO and United Blood Services worked with blood banks in Latin American countries to improve their capacity to collect blood from volunteer donors. Representatives from seventeen countries in Central and South America were trained to create or strengthen their volunteer donor programs, part of a strategy to move from a "blood replacement system" to an altruistic blood donor system. Studies have demonstrated that altruistic blood donor systems are safer and more efficient, reducing the risk of transmission of infectious diseases such as HIV as well as reducing the cost of blood collection. As a result of this project, participating countries have been able to increase the volume of volunteer blood donations.

Additional funds from 3 by 5 were used to replicate the Latin American experience in Mexican states bordering the US (Baja California, Sonora, Chihuahua, Coahuila, Nuevo León and Tamaulipas). The border project is expected to increase donations from volunteers to the extent that these donations will be responsible for the blood used in 8% of all transfusions.

TEXT BOX 5: CAREC/PAHO Guidelines for the Caribbean: VCT and Care and Treatment

In the Caribbean, the availability of antiretroviral medications increased dramatically (in some instances by 90-95%) during the years 2002 to 2004 as a result of a cost reduction. This expansion was accompanied by other parallel developments including growing political will, increased utilization of countries' financial resources to finance HIV/AIDS programs, and the sourcing of loans and grants.

In early December 2005, CAREC/PAHO hosted two workshops in Trinidad for the development of Caribbean guidelines for VCT as well as guidelines to support HIV care and treatment. Participants were professionals from CAREC/PAHO member countries working in VCT and/or HIV care and treatment delivery.

The VCT guidelines resulting from the first workshop are designed for program managers and VCT providers. They cover operational issues and the implementation of VCT, emphasizing its integration into existing health services. The VCT guidelines include four key areas: policy, program development and management, key elements of service delivery, and protocols and standards for quality service. Also produced in the workshop was a VCT assessment tool to identify VCT program priorities and gaps in the Caribbean.

The second workshop emphasized a public health approach to HIV care, highlighting the need for integration, decentralization of services, standardization, and monitoring and evaluation of programs. Three documents are products of this workshop. The first is an updated version of the Caribbean Clinical Guidelines; the second, aimed at policy makers and program managers, provides operational guidance for a public health approach to scaling up HIV programs in the Caribbean; and the third, A Primary Care Handbook for HIV/AIDS, supports the public health approach and targets health providers. This handbook is based on an adaptation of the WHO HIV/AIDS Integrated Management of Adolescent and Adult Illness (IMAI) guidelines.

Effective, reliable supply of medicines, diagnostics, and other commodities

↳ *Strategic Orientation 3*

In a 2004 Directing Council[11] resolution, PAHO Member States committed to prioritizing access to medicines, developing generic drug policies, and implementing a broad range of cost containment strategies. The resolution specifically cited the application of the TRIPS agreement,[12] which establishes minimum levels of protection that each government has to provide in relation to intellectual property regulation and patenting of medicines, but which also offers flexibilities for developing countries. In response to the needs of countries and in line with the mandates of the Directing Council resolution, PAHO/WHO has intensified efforts for the

11 The PAHO Directing Council is comprised of Ministers of Health and delegates from all PAHO Member States. The Directing Council meets yearly, examines programs and recommendations from PAHO technical units, and produces resolutions for country, subregional, and regional action.

12 The World Trade Organization's Agreement on Trade-Related Aspects of Intellectual Property Rights.

consolidation of the Regional Revolving Fund for Strategic Public Health Supplies. The Strategic Fund is currently providing technical assistance to countries for the development of acquisition plans and the improvement of supply and distribution. In addition, purchases of ARV and other commodities can be facilitated by the Fund. In 2005, six countries purchased through the fund and 10 developed plans. Regional price negotiations in 2005 (see text box 7) also facilitated the purchase of ARV for countries. The negotiations resulted in a significant decrease in price and improved availability of generics.

In addition to these regional mechanisms, many countries in the Region utilized 3 by 5 support to strengthen the health system's infrastructure for providing ARV, including the improvement of supply systems and training of human resources. In Trinidad & Tobago, PAHO/WHO and the Ministry of Health conducted an assessment of the ARV drug supply system in the country's treatment centers. It was determined that an improved ARV management system must be implemented to avoid stock-outs resulting in interrupted treatment. Following the recommendations of the assessment, a workshop for pharmacists in the public and private sectors was planned for 2006. A similar evaluation of the drug supply system was conducted in Guatemala, where an external team assessed acquisition, inventory, and distribution of HIV supplies. A baseline has been established for the development of a new supply and distribution system.

TEXT BOX 6: Intellectual Property Rights, Free Trade Agreements, and Access to Medicines in the Region

Recent Free Trade Agreements (FTAs) in the Region have a led to a changing environment for international trade. In addition to NAFTA and the US-Chilean Agreements, DR-CAFTA (the Dominican Republic and Central American FTA with the US) and the US negotiation with Colombia, Ecuador and Peru led to expectations of future difficulties in implementing flexibilities in trade associated with the WTO TRIPS Agreement. FTAs, which are designed to benefit agriculture and industry, tend to complicate negotiations surrounding access to medicines and create more restrictive conditions.

PAHO/WHO has strongly emphasized the importance of placing access to medicines and trade issues within the health agenda. Recommendations surrounding a public health approach to general trade agreements were generated by PAHO/WHO and distributed to countries in the Region. In addition, PAHO/WHO plans to conduct human resources trainings on the subject of public health and trade agreements jointly with WHO and the Ford Foundation in 2006.

In accordance with the TRIPS Agreement, intellectual property legislation is currently being analyzed in the Region in order to evaluate its impact on public health. Close follow-up of initiatives that affect the use of flexibilities is underway, and includes the participation of countries in the Region and around the world.

Projects to improve treatment through ARV resistance monitoring are also underway in Costa Rica and Honduras. In Costa Rica, with the support of 3 by 5, a hospital

processing over 30,000 HIV tests yearly is working to improve its laboratory capacity and to install the technology to monitor ARV resistance. To date, supplies have been obtained and an additional hospital is planning to monitor ARV treatment as well.

Cooperation among countries has been instrumental in improving governments' access to ARV medications in the Region. The achievements of the 2005 price negotiations were the result of a collaborative effort involving 11 Latin American governments working toward the same end. On a smaller scale, agreements have been made at the subregional level and between individual countries to obtain ARV medication and cover stock-outs. Brazil, which itself produces many of the antiretroviral medicines distributed by the country's public health system, offers free treatment to many people in countries in the Region as well as in Africa. Brazil donated supplies of ARV to El Salvador, the Dominican Republic and Colombia for 100 people in each country, and provides universal access to ARV in Bolivia, Paraguay, and Nica-

TEXT BOX 7: ARV Price Negotiations

The price of antiretroviral medications is one of the main obstacles to accessing treatment for HIV. Even in industrialized countries, the yearly cost of these medications exceeds the average annual earnings of the population. In order to increase access to these essential drugs, negotiations were held between 11 Latin American governments and 26 pharmaceutical companies in Buenos Aires in August 2005. Ministries of Health, supported by PAHO/WHO, UNAIDS, NGOs, and six organizations of people with HIV, negotiated a 15-55% price reduction for the treatment regimens most commonly used in the Region. A basic treatment regiment (AZT+3TC+NVP) which formerly cost US$350 per year was reduced to US$241. The cost of one of the most complex therapies (D4T+DDI+LPV/rtv) was reduced by 55%, from US$2,489 to a future price of US$1,123. As a result of the negotiations, countries will be able to cut spending on antiretrovirals by 9-66%, enabling an increase in investment in other aspects of care and helping the Region move closer to the goal of universal access.

The 2005 price negotiations follow similar meetings in 2002 and 2003. Subregional negotiations for the expansion of access to antiretrovirals took place in the Caribbean (June, 2002) and Central America (January, 2003). Following these, the Organismo Andino de Salud, PAHO/WHO, and others coordinated a meeting between 10 Latin American Health Ministers and eight laboratories in Lima, Peru in June of 2003.

Participating in all rounds of negotiations were producers of patented innovative as well as generic drugs and producers of diagnostic and monitoring reagents. According to a 2004 impact assessment, the first round of negotiations was a political and social success, resulting in improved drug access for the period 2003-2004. Lower drug prices due to the 2005 negotiations will likely result in even higher coverage numbers for the Region.

ragua. In addition, Peru agreed in 2005 to loan large quantities of ARV medications to Honduras. Facilitated by PAHO/WHO, the six month loan represents a major increase in the supply of drugs available to people with HIV/AIDS in Honduras.

TEXT BOX 8: PAHO Strategic Fund

PAHO/WHO's Regional Revolving Fund for Strategic Public Health Supplies (Strategic Fund) was created in 2000 to help countries obtain and manage essential medications. The Fund provides technical cooperation to ensure efficiency in the procurement process and adherence to high quality standards. By purchasing supplies and medications in large volumes directly from manufacturers, the Fund is able to negotiate lower prices for countries. Support is also provided to Global Fund recipients to help them comply with the Global Fund's administrative requirements.

Though active in several areas including antimalarials and insecticides, the Strategic Fund has been instrumental in helping countries to obtain antiretroviral medications and has collaborated with projects supported by the 3 by 5 Initiative. PAHO/WHO staff working with the Fund and 3 by 5 have held workshops to increase countries' capacity for programming and planning for procurement of antiretrovirals.

The first subregional meeting of the Strategic Fund was held in Honduras in July 2005. Central American countries and the Dominican Republic met to examine the challenges to ensuring access to medicines. As a result of the meeting, actions were identified to assist Ministries of Health, Social Security Agencies, and Global Fund projects with procurement planning. The most significant medication acquisitions resulting from the Fund have been in those countries participating in the subregional meeting. These countries, along with Brazil and Haiti, have purchased antiretroviral medications totaling $10 million during the 9 months following the subregional consultation.

Currently, the Strategic Fund is incorporating second line tuberculosis medicines in the list of products it makes available. The Fund continues to expand, and PAHO/WHO promotes greater use of it among Member States. With the membership of Suriname and Belize, the Fund now operates in 16 countries.

Links with health promotion and prevention of STI and HIV/AIDS within health services

↳ *Strategic Orientation 4*

Access to HIV prevention services is less easy to define than access to treatment, but many of the barriers are the same: cost, stigma, lack of information, and geography. Health sector programs must overcome these obstacles to provide information as well as condoms or other preventive devices such as microbicides and post-exposure prophylaxis. In many parts of Latin America and the Caribbean, efforts to promote

TEXT BOX 9: Promoting Harm Reduction

Injecting drug use (IDU) is a major mode of transmission of HIV in Latin America's Southern Cone. The epidemic tends to be concentrated in urban areas of Chile, Argentina, and Uruguay, and the border areas of Paraguay. In some areas of Brazil, drug injectors comprise half of all AIDS cases, though the contribution of injecting drug use to HIV transmission is declining. Brazil is home to 80% of total global number of injecting drug users under ART.

PAHO has developed several lines of activities at the country and regional levels to respond to the high rates of IDU transmission in the Region. In Paraguay, a PAHO-supported project funded by Canada and Spain worked to increase drug users' access to health services, helping them to seek voluntary counseling and testing and/or care and treatment. Workshops emphasizing harm reduction were held for both for health professionals and for IDU community leaders, and debate panels were organized in 3 cities to discuss the problem of drug dependency and HIV. In addition, equipment and technical support were provided to mental health and addiction treatment clinics, and educational materials were designed for the use of organizations and IDU community leaders. As part of PAHO/WHO's programming in harm reduction and with the support of the Spanish Agency for International Cooperation, several instruments were produced including a manual for health professionals.

prevention are hindered by a lack of access to target populations living in rural or remote areas and to vulnerable groups, while those in need of services do not seek them due to lack of information or fear. Prevention of mother-to-child transmission has become more available in recent years, but countries still face difficulties in scaling up these programs and integrating them into prenatal care. In many countries, projects supported by 3 by 5 have sought to expand the reach of prevention information and services.

In El Salvador, community health workers form the link between health services and people living in rural areas. As part of an effort to intensify prevention, all community health workers were retrained in HIV/AIDS and provided with materials for use in community education. In both the Bahamas and Suriname, Ministries of Health, with the support of PAHO/WHO, developed and aired a "Know Your Status" campaign for radio and television to extend the message promoting prevention and testing throughout both countries. Suriname's campaign resulted in a dramatic increase in demand for testing. While fulfilling the goals of the campaign, the increased demand required an expansion of testing services as those existing in the country were flooded beyond capacity. In Bolivia, people with HIV and men who have sex with men (MSM) were mobilized to promote voluntary testing among MSM in four cities to address the problem of low attendance to clinics serving the MSM population.

A project in Uruguay supported in part by 3 by 5 took a comprehensive approach to HIV prevention among vulnerable groups. "Proyecto Rivera" consisted of training an

interdisciplinary team in health education and harm reduction and then conducting interventions targeted at injecting drug users, sex workers, and prisoners. The team worked with policymakers and communities, identifying and training health promoters among sex workers and within prisons, conducting workshops, and distributing condoms. In three areas of the Dominican Republic, including the border region, groups of youth leaders were trained as peer health promoters. The youth prevention project aims to fill the gap in areas where young people's access to services is limited.

In several cases, 3 by 5 support has been used to expand the use of post-exposure prophylaxis (PEP) to prevent transmission to health workers exposed to HIV. In Peru, post-exposure treatment kits were acquired for use in the country's main health services. And in Costa Rica, a protocol was developed for the use of PEP with victims of sexual assault.

TEXT BOX 10: PAHO Youth-Centered Counseling Model

HIV infection is increasing among young people in the Region, and there is a growing need to effectively reach this vulnerable group. PAHO/WHO's new Youth-Centered Counseling model, a product of the collaboration between the Child and Adolescent Health and HIV/AIDS teams, is a tool for health and human service providers (clinicians, social workers, counselors, and teachers) who work with young people. It contains detailed actions and guidelines for providing counseling that is responsive, friendly, and accessible to young people. As human service providers come into contact with youth on a regular basis, they have many opportunities to make a positive impact on their sexual health through the provision of individualized counseling and support.

PAHO/WHO's counseling model takes a science-based approach, applying a developmental perspective to multiple counseling and behavior change theories. To test the model's utility and applicability to Latin America, a pilot training workshop was held in Honduras with 20 health service providers and heads of adolescent health programs from Central American countries. Feedback and lessons learned from the workshop were incorporated into the model, and it is currently being published as a manual in book format as well as a CD-ROM. While the book includes guidelines, strategies, and the theoretical underpinnings of counseling practices, the accompanying CD-ROM serves both for self learning and as an instrument for teaching the material in a group setting. By the end of 2005 the model had been implemented in Panama, Nicaragua, Guatemala, El Salvador, Belize, Peru, and Argentina.

An evaluation of the national program to prevent mother-to-child transmission is currently underway in Belize. The country defined PMTCT as a priority area in its National Strategy in 1999, and at that time implemented a PMTCT program. A partnership with the Bahamas provided technical support to train Belizean health professionals, develop guidelines, and manage programs. Currently, Belize is undertaking an evaluation of PMTCT services with the support of 3 by 5. The project will assess supplies, equipment, and training in order to update guidelines to incorporate currently available therapies.

TEXT BOX 11: Know Your Status Workshops

Know Your Status (KYS) campaigns aim to increase demand for HIV diagnosis and treatment from both vulnerable groups and the general population. A new strategy in HIV prevention, KYS campaigns have been successful in several countries in the Region, and are a promising strategy for increasing HIV awareness.

In April 2005, the government of Suriname, with support from CAREC/PAHO and PAHO/WHO, held a workshop in Paramarimbo on developing "Know Your Status" campaigns in the Caribbean. Objectives of the meeting were to identify obstacles to voluntary counseling and testing, find opportunities for KYS campaigns, define a complementary communication agenda for prevention and care, and examine the draft WHO guidelines for KYS.

Representatives from nine countries attended the training, which included lessons learned and outcomes from countries that had already conducted the campaigns. A person with HIV representing the NGO CRN+ in Trinidad & Tobago was in attendance as well. Recommendations emerging from the workshop included policy-related justifications for carrying out KYS campaigns and their potential benefits to prevention and care.

Strategic information and dissemination of lessons learned

↳ *Strategic Orientation 5*

The area of strategic information is of key importance to monitoring and evaluation and measuring the success of HIV efforts. Actions to strengthen surveillance, monitoring, and evaluation systems and to train personnel are underway in some places, but there is still a need in the Region to collect information on a regular basis and make accurate, disaggregated data available publicly. Some examples of strategic information efforts in the Region are in the areas of patient tracking and the collection and dissemination of HIV/AIDS information.

A project to improve surveillance of ART is ongoing in Nicaragua with support from 3 by 5 and the assistance of the Dominican Republic. The Ministry of Health in the Dominican Republic provided technical assistance for the introduction of a new information system (SIAI) to monitor patients under ART in three distribution centers in Nicaragua. The SIAI system has proven successful in the Dominican Republic and is expected to improve information management in Nicaragua. Hospital personnel in the pilot sites were trained to use the system and as a result have access to information on individual treatment regimens, patient histories, and adherence. The system also allows for improved collection of HIV surveillance data at the national level.

Venezuela's surveillance of HIV care and treatment was improved with 3 by 5 funding as well. In 2005, the country's National AIDS Program implemented a new information system to monitor care and improve patient follow-up. Using data from the system, a centralized team will be able to track cases, monitor therapies, and assist physicians with treatment.

Three by Five funds have also been used to improve surveillance along the US-Mexico border, an area where migration, sex tourism, and intravenous drug use pose a high risk for HIV transmission. With the support of PAHO/WHO, new methodologies are being developed to estimate HIV/AIDS prevalence among high risk groups.

In Argentina, a monthly electronic bulletin was created to systematically distribute HIV/AIDS information among interest groups including health professionals. Toward the same end, and also supported by 3 by 5, a bulletin with HIV/AIDS surveillance information in Guatemala was created and is now in print.

In the Caribbean, several steps were taken as part of 3 by 5 to improve information management and dissemination. CAREC/PAHO established a listserv connecting care and treatment focal points at Ministries of Health in all Caribbean countries. The listserv allows for regular communication in regard to national HIV/AIDS programs, including ARV stock management and the transfer of patient information. The Caribbean health Research Council, in collaboration with UNAIDS and CAREC/PAHO, developed a framework for monitoring and evaluation of national HIV/AIDS plans including outcomes of HIV/AIDS care and treatment

TEXT BOX 12: ARV Resistance

Resistance to ARV can be defined as the ability of HIV to transform itself and become less and less sensitive to antiretroviral drugs. ARV resistance (HIVDR) is virtually inevitable, as treatment is long-term and HIV has a high rate of mutation. However, it is possible to reduce the rate of emergence and spread of HIVDR and limit its public health consequences. Some important steps to take include appropriate prescribing and usage of ARV medications, ensuring adherence, reducing HIV transmission, and close monitoring of patients taking ARV.

There is currently very little information available about HIVDR prevalence from developing countries. The WHO-led surveillance and monitoring network HIVResNet was created to address the lack of information on HIV resistant strains circulating in developing countries. Preparatory work for the establishment of a regional HIVResNet for the Americas has started in collaboration with CDC and Health Canada and has begun by focusing preliminarily on Brazil, Mexico, Argentina, Honduras, and Caribbean countries. Guidelines for laboratories and HIVDR monitoring as well as templates for the development of national action plans are currently available in the Region. A pilot study testing the protocol for HIVDR was completed in Mexico in 2005 and other countries in the Region are currently moving to apply the protocol to their own settings.

TEXT BOX 13: PAHO/WHO's Support of Monitoring & Evaluation in the Region

The nature of PAHO/WHO's support to countries in the area of monitoring and evaluation has changed over time. Initially, PAHO/WHO worked with countries to develop the monitoring components of projects and programs, but in recent years the focus has shifted to measuring outcomes and impacts as governments are increasingly accountable for results and need to demonstrate transparency. PAHO/WHO has worked extensively on the harmonization of global methodologies and tools, in line with the "Three Ones," to develop a common monitoring and evaluation framework. The Organization led the process to reach consensus on monitoring and evaluation of care and treatment indicators for Latin America and the Caribbean.

Capacity building efforts at the national level led by PAHO/WHO, in collaboration with the CDC and other agencies, include guideline development, assessments of National AIDS Programs, and training. Over 30 countries in the Region have participated in PAHO/WHO-led national, subregional, and regional workshops on monitoring and evaluation of care and treatment.

Reliable data is a key element of the universal access agenda and an intensified focus on this area will be essential to moving the agenda forward. Improved monitoring and evaluation and ARV resistance surveillance are emerging challenges in countries and will be a priority for PAHO/WHO's technical cooperation in the coming years.

Technical Cooperation Between Countries

Technical cooperation from countries in the Region has been an important source of assistance for many National AIDS Programs. Brazil in particular has been very active in providing assistance to other countries in the Region, both through ARV donations and technical support. Through a project facilitated by PAHO/WHO and with the financial support of DFID, professionals from Bolivia and Honduras traveled to Brazil to study the country's successful integrated care system as well as epidemiological surveillance, integration of civil society, and monitoring and evaluation, with the objective of replicating Brazil's successful experiences in their own countries.

In 2005, Brazil offered a package of services and goods to a visiting CARICOM/PANCAP mission led by the Prime Minister of St. Kitts and Nevis. The package includes training for professionals, assistance with infrastructure development, and the provision of first line treatment to 500 people in the Eastern Caribbean States over five years.

In 2004, care and treatment staff from the Suriname AIDS Treatment Group visited Cange in rural Haiti to experience first hand its decentralized model of care. The

visitors learned about Haiti's simplified approach, based on three essential elements. The first is a strategy with four pillars, including integration of HIV into primary health care, women and children's health, control of tuberculosis and diagnosis and treatment of STIs. Second is the establishment of a model of care and treatment based in the community, and third is the reinforcement of public health infrastructure. To assist patients with their treatment regimens, the NGO Partners in Health which works extensively in Haiti emphasizes the importance of "accompanateurs" or community health workers.

Human Resources Capacity Building

↳ *A cross-cutting topic*

In many parts of the Region, a scarcity of qualified human resources in the public health sector severely limits countries' ability to scale up prevention and treatment services. Higher salaries and better benefits in the private and non profit sectors make it difficult for Ministries of Health to acquire and retain staff. This is especially true in respect to HIV/AIDS. In some countries, new funding sources for scale up have exacerbated the problem, depleting key staff at all levels of ministries. This phenomenon debilitates the public health system and presents difficulties for the decentralization of services, negatively impacting the provision of treatment for those patients most in need.

Discrimination against people with HIV in health services is widespread in the Region, and can be so extreme as to violate human rights and result in the denial of care. Often, existing health providers are not adequately trained to provide comprehensive care and treatment for people with HIV. For example, providers may not be prepared to work with the vulnerable populations most affected by the epidemic, including MSM, sex workers, adolescents, and marginalized populations. Not only is there a need for increased technical capacity of human resources, but also for increased tolerance and ability to address taboo subjects, and an understanding of human sexuality.

HIV/AIDS prevention, care, and treatment need to be incorporated into education programs for all health-related fields. In-service training and continuing education can help to keep existing professionals up to date on HIV information and create a forum for discussion of critical issues. Close collaboration with professional associations and organizations of people with HIV are also essential as these partnerships can encourage positive policy changes, motivate health professionals, and increase tolerance and understanding.

TEXT BOX 14: Cara a Cara / Face to Face

"Cara a Cara" or Face to Face is a seminar for health professionals and community leaders that was developed jointly by PAHO/WHO and the Program on Human Sexuality at the University of Minnesota. It focuses on promotion of sexual health among men who have sex with men (MSM) and emphasizes strategies for prevention of HIV/STI. During the 5-day seminar, participants learn about theories and models of human sexuality and determinants of risk behaviors, and delve into topics of intimacy and sexual orientation. Participants explore their own values and attitudes toward sexuality and how these views facilitate or hinder their work in promoting sexual health and fostering behavior change.

A special workshop called "Hombre a Hombre" or Man to Man, in which MSM are in attendance, is nested within the larger seminar. This workshop allows for interaction between health workers and the target population, and offers a more concrete opportunity to develop tolerance and understanding through more familiarity with members of the population of MSM. At the end of the 5 day seminar, participants have a clearer idea of their own attitude toward sexuality and MSM, and have developed proposals for work in sexual health promotion and prevention of HIV/STI among this vulnerable population.

Between 2000 and 2004, the "Cara a Cara" seminar was implemented several times in the United States, targeting the Latino population. Participants from countries in the Region attended and became acquainted with the model. At the request of health authorities in Mexico, the seminar was carried out twice in the country. A revised model was utilized which took into account suggestions from participants and learned lessons from previous experiences. During the two seminars in Mexico, participants from all states in the country were trained.

"Cara a Cara" creates a forum for open discussions of sexual orientation, sexual health, and discrimination in settings where such discussion is not a common occurrence, bringing legitimacy and a foundation in evidence to the dialog surrounding these taboo subjects. The seminar is an example of the type of factual and candid discourse that must be present in the health sector in order to address the high levels of stigma and discrimination that hinder an effective response to the HIV epidemic.

In the majority of countries in the Region, support from 3 by 5 was used for training health professionals in technical areas. Workshops were held to disseminate information about new guidelines for care and treatment; multidisciplinary teams of professionals were formed to improve the provision of comprehensive HIV care; and seminars were held to increase tolerance and reduce discrimination within health services. Table 1 contains a list of these programs.

An example of a 3 by 5-supported country effort to improve the technical capacity of human resources is Haiti's adaptation of the WHO Integrated Management of Adolescent and Adult Illness (IMAI) package. IMAI is a set of evidence-based operational guidelines, tools, and training manuals for health care providers as well

TABLE 1
HUMAN RESOURCE CAPACITY BUILDING IN THE REGION
Programs implemented during 2004-2005 as part of the 3 by 5 Initiative

Anguilla	• Training for health professionals on VCT
Bahamas	• Development of curriculum for training health professionals in ART clinical management
Belize	• Training for nurses at the referral hospital in the issue of HIV/AIDS related stigma and discrimination • Training for nurse's aids in HIV/AIDS home and community care • Training for program managers on HIV/AIDS care and treatment • Training for rural public health nurses and lab technicians on rapid testing for seroprevalence among pregnant women
Chile	• Training for the National AIDS Program team on a model of integrated prevention of HIV and STI
Colombia	• Training of HIV advisors at the primary care level in 46 municipalities
Costa Rica	• Trainings for health professionals in HIV care and treatment • Regional trainings in the surveillance protocol
Cuba	• Training for 15 professional, rural HIV/AIDS teams in surveillance, monitoring and evaluation of ART, and adherence • Training for primary care doctors and nurses in comprehensive care for people under ART
Dominican Republic	• Training for over 2,000 health professionals in PMTCT, integrated care for people with HIV and ART adherence, counseling pre and post testing, home care management, STI, and project planning • Formation of youth groups and training of 225 youth health promoters
El Salvador	• Training for all community health workers in HIV/AIDS/STI
Guatemala	• Training for health professionals on all aspects of integrated care, including blood banks, epidemiological surveillance, STI, and IEC • Training for health professionals and activists in areas which will support the implementation of integrated care centers • Training for maternal and child health professionals in new protocols for management of HIV positive pregnant women and administration of ART
Haiti	• Funded training on PMTCT for an NGO
Honduras	• Held workshops with community members and health institutions on sexual abuse and HIV prevention • Training for health personnel on care for people with HIV • Training for hospital personnel on an integrated care strategy
Nicaragua	• Training for health professionals in ART • Creation and training of drug supply teams • Train-the-trainer workshop for health professionals on nutrition for children with HIV • Training for 50 youth leaders in prevention and promotion of behavior change

Panama	• Held 3 workshops for health personnel and managers on the issue of stigma and discrimination in health services • Training for 98 health professionals at three levels of care in VCT
Peru	• Training for health professionals on managing emergencies among people under ART • Informational meeting for members of the Peruvian OBGYN Society on HIV during gestation
Suriname	• Held 20 one-day workshops for hospital staff to increase knowledge to deal with HIV/AIDS patients and reduce fear, stigma, and discrimination • Training for 100 health assistants from the rural areas in new protocols for HIV clinical care • Training for stakeholders in prevention on Epi Info • "Know Your Status" workshop for Caribbean program staff
Trinidad & Tobago	• Training for prison officials in basic knowledge of HIV • Training for STI clinic staff in counseling • Training for pharmacists to improve ARV drug supply system • Training for staff at the country's main STI clinic and HIV testing site in basic management of data, analysis, and reporting of surveillance data
Turks & Caicos	• Training for 30 health care workers on VCT • Initiation of training program for laboratory personnel
Uruguay	• Held 7 workshops to train primary care doctors and other health workers in new guidelines for STI and HIV

as materials for patient education. The package includes key clinical interventions for low resource settings. Haiti's Ministry of Health, PAHO/WHO, and many development partners collaborated to adapt aspects of IMAI, including a module on HIV/TB, a flipchart for patient education, and materials supporting caregivers. Several other countries in the Caribbean have begun reviewing their clinical guidelines with the intent of using the IMAI approach to improve harmonization and promote decentralized, comprehensive services.

[5] 2006 AND BEYOND

The years 2004 and 2005 brought improvements across the spectrum of HIV/AIDS prevention and treatment in the Region, and these achievements laid the foundation for further scale up and ultimately the fulfillment of the universal access goal. The ten-year time period between 2006 and 2015, the target date for the achievement of the Millennium Development Goals, has the potential to bring about dramatic changes in HIV in the Region. But to do this, a concerted effort is required at all levels. The specific areas to be addressed can be grouped into three central challenges:

1. Strengthening health systems and services to protect achievements and move toward universal access

- Integration of prevention, care, and treatment
- Application of prevention interventions based on evidence
- Decentralization of HIV services including diagnosis, care, and treatment
- Human resources capacity building
- Alleviation of stigma and discrimination

2. Financing and sustainability of programs

- Securing financing for the continuation of programs after current grant cycles
- Obtaining adequate amounts of medications and supplies at the best possible prices
- Establishing sustainable systems for the supply of medicines and commodities

3. Harmonization and collaboration

- Maximization of resources by avoiding parallel processes and competition among organizations
- Implementation of "The Three Ones"

THE WAY FORWARD

Achieving universal access in the Region will require work on many fronts; in health, finance, development, education, social welfare, and other sectors. PAHO/WHO's contribution to the universal access agenda specifically focuses on assisting countries in scaling up the health sector response. In light of existing commitments to universal access and the Millennium Development Goals, PAHO/WHO recently published the Regional HIV/STI Plan for the Health Sector 2006-2015. The plan was developed in collaboration with multiple partners in countries and at the international level including Ministries of Health, National AIDS Programs, development partners, people with HIV, and representatives from civil society. Based on an analysis of the state of the epidemic in the Region, the Plan sets overall targets in the areas of reducing new infections and providing universal access to comprehensive care including prevention, care, and treatment.

Five critical lines of action were developed to help countries scale up the response to HIV/AIDS in line with the five strategic orientations of the 3 by 5 Initiative. Each critical line of action includes specific strategies to be undertaken by health authorities and other stakeholders, targets to be achieved by 2010 or 2015, and milestones to mark progress. The critical lines of action are:

- Strengthening health sector leadership and stewardship and fostering the engagement of civil society
- Designing and implementing effective, sustainable HIV/AIDS/STI programs, and building human resource capacity
- Strengthening, expanding, and reorienting heath services
- Improving access to medicines, diagnostics, and other commodities
- Improving information and knowledge management, including surveillance, monitoring and evaluation, and dissemination.

The Plan was launched in November 2005 and the process of integrating the Plan into existing national or subregional plans began in January 2006, at the 2nd meeting of the HIV/AIDS Technical Advisory Committee (TAC). At that time, the Plan was discussed in detail and representatives from National AIDS Programs and PAHO/WHO country offices examined links between national plans and the Regional Plan, existing gaps, and opportunities for scaling up the health sector response in countries. The Regional Plan has also been an important reference document in national, subregional and regional consultations on universal access.

PAHO/WHO has developed a strategy for the rollout of the Plan at national, subregional and regional levels. Major emphasis in 2006-2007 will be given to supporting countries in developing, reviewing, or updating their HIV/STI health sector plans, including the definition of principles, country targets, the package of services to be provided, health care delivery options, and cost. Similar exercises will be conducted at the subregional level to identify areas in need of subregional action such as the issue of universal access for migrant populations.[13]

Following the lines of action in the Regional Plan, PAHO/WHO will take the lead, together with the UNAIDS Secretariat, key UN agencies such as UNICEF and UNFPA, and development partners, to construct a strong regional program for reaching the goals of universal access. It is through collaborative work toward our common objective that the needs of countries will be met and the Region will eventually provide access for all.

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Participating in these exercises will be the subregional organizations RESSCAD, REEMSA, CARICOM, and others.

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