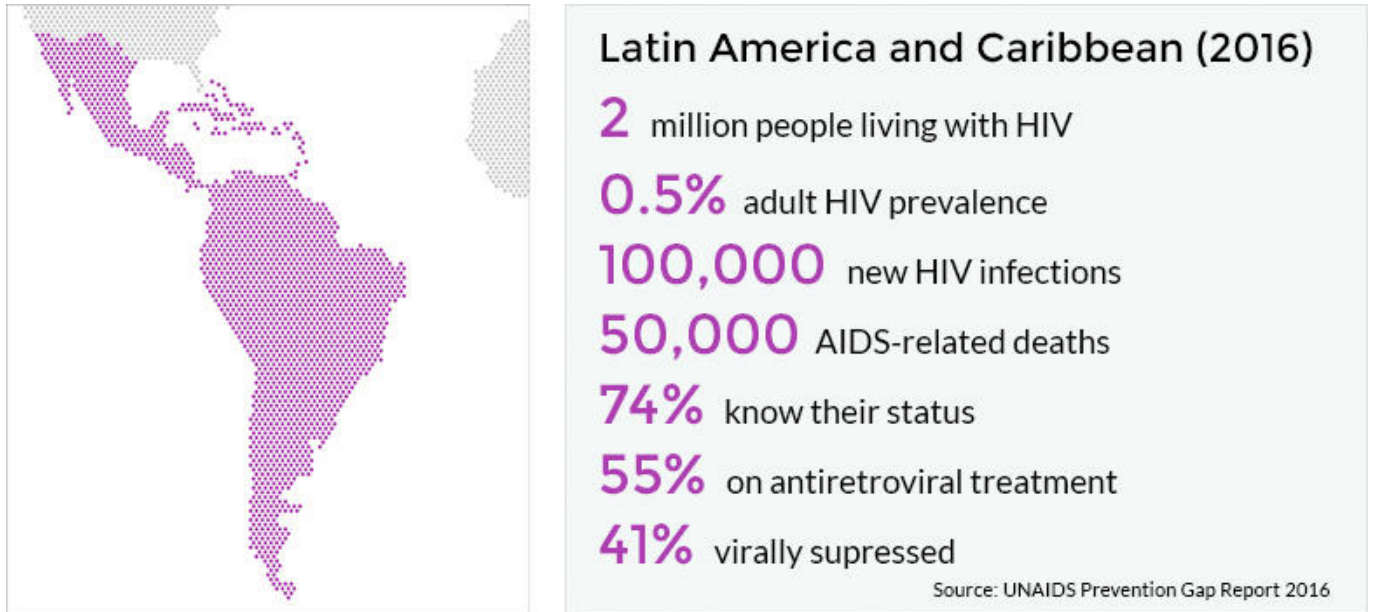


HIV and AIDS in Latin America the Caribbean regional overview

Latin America and Caribbean_23August2016.jpg



In Latin America and the Caribbean, the overall rate of new HIV infections has remained stable between 2010 and 2015. However, this stability masks differences between adults and children and between Latin America and the Caribbean region.¹

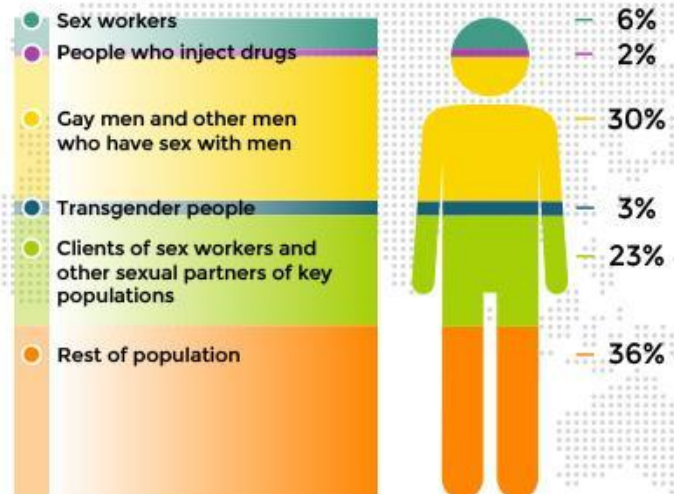
Among adults, a 3% rise in rates of new HIV infections between 2010 and 2015 contrasted sharply with a 20% decline during the previous decade.² In 2015, there were an estimated two million people living with HIV in this region – an infection prevalence of 0.5%. In the same year, there were an estimated 100,000 new HIV infections and 50,000 deaths from AIDS-related illnesses.³

In the Caribbean, new HIV infections among adults rose by 9% between 2010 and 2015, reversing gains made in the previous decade. In 2015, the annual number of new HIV infections in the Caribbean was estimated at 9,000.⁴ Despite its small population size, the Caribbean has the second-highest HIV prevalence globally after [sub-Saharan Africa](#).⁵

Key affected populations in Latin America and the Caribbean

Though HIV prevalence is generally low, prevalence among [key affected populations](#), such as men who have sex with men and transgender women, is particularly high. ⁶ These key populations and their sexual partners accounted for nearly two-thirds of new infections in 2014. Young people in the Caribbean are also disproportionately vulnerable to HIV.⁷

Latin America and the Caribbean



Men who have sex with men in Latin America and the Caribbean

[Men who have sex with men](#) (sometimes referred to as MSM) are the group most affected by HIV in Latin America and the Caribbean. In 2014, men who have sex with men accounted for nearly a third of new HIV infections in the region.⁸ However, HIV prevalence among this group varies greatly between countries. For example, it is as high as 25.4% in Bolivia, falling to 1.8% in Cuba.⁹

There are many reasons for high levels of HIV transmission among this group. In 2014, only 51% of men who have sex with men were reported to have access to HIV services, a level which had remained largely unchanged for several years.¹⁰ Moreover, HIV testing in the last 12 months among men who have sex with men varied enormously from country to country, ranging from 5% to 70%. This suggests large differences in access to testing services between countries in the region.¹¹

Homophobia and the 'machismo' (strong/aggressive masculinity) culture are common throughout the region and sex between men is highly stigmatised. As a result, large numbers of men who have sex with men do not identify as homosexual (or bisexual) and have sex with women as well as men, forming a 'bridge' population.^{12 13}

As one civil society worker explains, men who have sex with men are often hesitant to reveal how they became infected with HIV. Many are mistakenly classed as heterosexual:

Unless he's a total queen, a man will always be [counted as] heterosexual. Plus, people don't want to be recognised [as homosexual].

- Ruben Mayorga, civil society worker, Guatemala City ¹⁴

Transgender women in Latin America and the Caribbean

Transgender women are highly affected by HIV in Latin America and the Caribbean. HIV prevalence among this group is thought to be 49 times higher than the general population.¹⁵

In countries where data are collected on this key population, transgender women have some of the

highest HIV prevalence rates. Country level data collected between 2011 and 2015 also show much higher HIV prevalence among transgender women sex workers compared to male and female sex workers.¹⁶

For example, HIV prevalence among transgender women who participate in sex work is 32% in Ecuador and Panama, and between 20-30% in Argentina, Bolivia, El Salvador, Honduras, Paraguay, Peru and Uruguay.¹⁷

Research has shown that 44-70% of transgender women have felt the need to leave, or were thrown out of their homes.¹⁸ One study from Mexico indicated that 11.4% of transgender women living with HIV were excluded from family activities.¹⁹

Moreover, transgender people have fewer educational and social opportunities, often resorting to sex work for an income.²⁰

Transgender people also face high rates of violence. Between 2008 and 2016 more than 1,800 murders of transgender people were reported in Central and South America. The highest number of these murders occurred in Brazil, where 938 were reported.²¹ Stigma and violence are barriers to HIV services.

Sex workers in Latin America and the Caribbean

In 2013, 6.1% of female sex workers in Latin America were thought to be living with HIV. Male sex workers tend to be much more affected by HIV than female sex workers. For example, in the same year, 69% of male sex workers in Suriname were estimated to be living with HIV, compared to just 4% of female sex workers.²²

Testing coverage among sex workers was higher among female sex workers (ranging from 39% to 98%) than among male sex workers (ranging from 17% to 70%). Condom use during their last transactional sex ranged from 57% in Belize to greater than 95% in Panama and Antigua and Barbuda.²³

In the Caribbean in particular, and across the region, sex workers experience a range of human rights violations and social injustices, including the denial of access to healthcare, poor working conditions, violence and harassment by law enforcement. Sex workers are also frequently marginalised by social and religious institutions and subject to discrimination. For these reasons, many people who engage in sex work do so covertly.

These factors are significant barriers to HIV prevention and successful service delivery for sex workers.²⁴

Violence is a major barrier to HIV prevention for sex workers. One study of female sex workers in Argentina reported that 24.1% had received sexual abuse; 34.7% reported rejection experiences; 21.9% reported having been beaten; while 45.4% reported having been arrested because of their sex work activity. Higher levels of inconsistent condom use were also reported among those who experienced sexual abuse, rejection and police detention.²⁵

People who inject drugs in Latin America and the Caribbean

There are an estimated 721,000 [people who inject drugs](#) (sometimes referred to as PWID) in Latin America and the Caribbean. HIV prevalence among this group averages 2% but varies significantly between countries.²⁶

Reliable data for HIV prevalence among drug users are extremely limited. For example, the latest figures from Brazil are from 2009, when HIV prevalence among people who inject drugs was at 5.9%.²⁷

In Puerto Rico, where poor access to sterile injecting material has been identified as a significant

contributor to the HIV epidemic, 51% of people who died while living with HIV between 1981 and 2013 acquired the infection via unsafe injection practices.²⁸

Across the region, the popularity of injecting drugs has declined and been replaced by people who favour smoking or inhaling drugs.²⁹ It is now widely acknowledged that drug use in the region mainly comprises the non-injecting of cocaine and its derivatives.³⁰

One systematic review of key affected populations in Brazil detected an HIV prevalence of 23.1% among people who use drugs.³¹ Another study, from Montevideo in Uruguay, found an increase in HIV risk among cocaine smokers, with an estimated 6.3% HIV prevalence rate.³² This is due mainly to the fact that any form of drug use impairs a person's ability to engage in safer sex behaviours.

Young people in Latin America and the Caribbean

Young people in Latin America and the Caribbean, especially those who are also members of key populations, are disproportionately at risk of HIV infection. One factor contributing to this is the barriers young people face to accessing prevention services.

Young women are at particularly high risk. Survey data from Barbados, Belize, Costa Rica, Cuba, the Dominican Republic, El Salvador, Guyana, Panama and Uruguay show that between 5 and 16% of young women aged 15 to 24 report that they became sexually active before the age of 15.³³

Sexual activity at a younger age has been linked to higher risk of HIV³⁴. Despite these factors, girls in these countries need parental consent or accompaniment to access sexual and reproductive healthcare services.

In nine of 17 countries, minors require parental or guardian consent to take an HIV test and find out the results. A few countries in the Caribbean have developed policies allowing minors to access HIV testing without parental consent, either allowing it at any age (such as in Guyana) or above the age of 14 (as in Trinidad and Tobago).³⁵

In Mexico and Panama, adolescents have to be accompanied by a parent, a legal guardian or other state-recognized individuals responsible for the well-being of adolescents in order to receive their test results. In Paraguay, health staff can request authorisation to conduct an HIV test in the absence of parents or guardians.³⁶

In the Caribbean, the cultural norm of young women having sexual relationships with older men increases their risk of HIV infection. Between 9 and 24% of women aged 15 to 24 years reported having sex with a man at least 10 years older than themselves within the last 12 months. Other risk factors, such as multiple sexual partners and inconsistent condom use, compound the risk of age mixing in these countries.³⁷

HIV prevalence data for young women in this region highlights their vulnerability. In Haiti, for example, HIV prevalence among young women aged 15-19 years is 0.5% - more than double the figure for young men of the same age. Additionally, women aged 20-24 are three times more likely to be HIV-positive than men of the same age.³⁸

HIV testing and counselling in Latin America and the Caribbean

Data on HIV testing coverage is very limited for Latin America and the Caribbean. An estimated 77% of people living with HIV in Latin America knew their status in 2015. While in the Caribbean, an estimated 62% had been diagnosed.³⁹

In 2012, an estimated 36 per 1,000 people were tested across Latin America and the Caribbean, second only to sub-Saharan Africa.⁴⁰

Case study: Self-testing in Brazil

In 2015, Brazil began providing self-testing kits to the general population. These kits were made available free of charge from pharmacies, medication distribution centres, health services and government health programmes, as well as through the mail. The oral self-testing kits featured clear instructions and a telephone helpline.

From January 2015 to March 2016, more than 4,000 HIV tests were performed by four testing units in Curitiba, Brazil. More than 72,000 people accessed the online platform “A Hora e Agora” and around 2,900 self-testing HIV kits were distributed.⁴¹

Late HIV diagnosis is a serious issue in Latin America. In at least half of the countries in this region, 38% of people had a CD4 count under 200 when they were tested for the first time.⁴² Research suggests that HIV testing and knowledge of status was particularly low among key populations, who are most at risk.⁴³

Antiretroviral treatment in Latin America and the Caribbean

Access to antiretroviral treatment (ART) across Latin America and the Caribbean is uneven. Treatment coverage was 56% among all people living with HIV in Latin America in 2015⁴⁴ compared to 34% in 2011⁴⁵

Latin America has the highest total spend on ART among low- and middle-income countries, with Argentina, Brazil, Chile, Cuba, Guyana and Mexico providing universal access to HIV treatment.⁴⁶ However, treatment coverage varies greatly by country. For example, over half of all people living with HIV were accessing ART in Argentina (64%), Chile (87%), Costa Rica (56%), and Mexico (59%). By contrast, treatment coverage is just 29% in Bolivia.⁴⁷

Stock-outs of antiretroviral drugs are a major obstacle to treatment in this region. While efforts have been made to decrease the likelihood of this happening, 10 countries reported at least one stock-out in the previous 12 months when an analysis took place in 2012.⁴⁸

In the Caribbean, access to ART has increased from 20% in 2010 to 50% in 2015.⁴⁹ However, key populations often face barriers to accessing treatment. For example, research from Puerto Rico found that people who inject drugs constitute the highest percentage of the population living with HIV who did not have access to treatment for their condition (between 41% and 53%). This was despite the fact they had the highest retention rate once they initiated treatment.⁵⁰

HIV prevention programmes in Latin America and the Caribbean

Some HIV prevention interventions in the region have been enormously successful, and have helped to reduce HIV incidence among certain groups in particular areas.

Prevention of mother-to-child transmission (PMTCT)

New HIV infections among children declined across Latin American and the Caribbean by more than 50%, down from an estimated 4,700 in 2010 to 2,100 in 2015. Progress was greatest in the Caribbean, where new infections among children plummeted from an estimated 2,300 in 2010, to 400 in 2015.⁵¹

Across the region, 88% of pregnant women needing ART had access to it.⁵² However, coverage of antiretroviral treatment to [prevent mother-to-child transmission of HIV](#) (PMTCT) varies by country, with some making huge progress in recent years. For example, coverage in Mexico increased from 34% in 2010 to 76% in 2015. In the same period, coverage in Bolivia increased from 39% to 76%.⁵³

However some countries continue to lag behind. PMTCT coverage is 13% in Guatemala, 41% in Costa Rica, and 43% in Venezuela . [54](#) Difficulties in reaching those belonging to key affected populations, such as indigenous people, sex workers and young women, contribute to these low coverage rates.[55](#)

Harm reduction

Access to [harm reduction programmes](#) across Latin America and the Caribbean is extremely limited.

Needle and syringe programmes (NSPs)

Only eight countries provide [needle and syringe programmes](#) (NSPs): Argentina, Brazil, Colombia, Dominican Republic, Mexico, Paraguay, Puerto Rico and Uruguay. In some cases, coverage of NSP services is believed to have declined due the reduction in the number of people who inject drugs, such as in Argentina, Brazil and Uruguay.[56](#)

In Colombia, support from Open Society Foundations helped establish a syringe programme in Pereira and Dos Quebradas in 2014, with 818 people who inject drugs registered in the programme. Further NSPs have since been developed by NGOs with support from the Ministries of Justice and have begun operating in Bogotá and Cali

However, the services available for people who inject drugs remain limited, and are often unavailable outside of city centres.[57](#) The cessation of Global Fund support has had a big impact on NSP provision in Mexico. NGOs in Tijuana and Cd. Juarez report that distribution of needles and syringes per person who injects drugs fell by between 60% to 90% following cessation.

Funding cuts also meant that outreach was reduced, requiring people who inject drugs to attend NGO offices, rather than receiving sterile injecting equipment wherever they are. Even the limited level of existing harm reduction services has relied partly on commodities donated by organisations which ceased operations following the withdrawal of the Global Fund.[58](#)

Opioid substitution therapy (OST)

OST services in Latin America and the Caribbean are only available in Argentina, Brazil, Colombia, Mexico and Puerto Rico.[59](#) In Colombia, OST sites operate in seven cities: Bogotá, Medellín, Cali, Pereira, Armenia, Cúcuta and Bucaramanga. However, the number of sites in each city is unknown, as is the number of people using them.[60](#)

There are plans to make OST available for people who use heroin in the Dominican Republic with support from consultants from the school of public health of Puerto Rico. However, this programme is not yet operating.[61](#)

Reducing HIV-related stigma and discrimination

Some Latin American countries have taken steps to address the problem of [HIV-related stigma and discrimination](#). For example, Peru, Columbia, Brazil and Mexico launched action plans to raise awareness among health providers and government officials of the importance of non-discrimination on the basis of sex, race, religion, sexual orientation and HIV status.[62](#)

At a community level, one study from Chile showed how peer education can improve HIV-related knowledge, attitudes and behaviours among community clinic health workers. Three months after the intervention, healthcare workers had higher knowledge of HIV transmission and were more accepting of people living with HIV. They were also more likely to engage in safer sex themselves. [63](#)

Another study from Peru has shown how engaging community leaders with HIV interventions can reduce community-level HIV stigma. Intervention participants reported lower levels of stigma after two years. This suggests that normalising HIV prevention behaviours and HIV communications can

reduce HIV-related stigma and change community norms.⁶⁴

Social protection

HIV can push people and families into poverty by reducing household capacity and increasing medical costs. In response to this, some countries in Latin America have introduced social protection measures to mitigate against the negative impacts suffered by those affected by HIV.⁶⁵

For example, the Ecuadorean government implemented a policy where caregivers for children under the age of 14 living with HIV receive a monthly cash transfer. In the first year of the scheme, 500 caregivers were set to receive the cash transfer.⁶⁶

In Uruguay, the 'Social Card' is a social protection programme targeting transgender women. Cardholders receive \$30 a month to buy food and cleaning products. The initiative reaches 1,000 people, the majority of whom belong to the transgender community. ⁶⁷

Barriers to HIV prevention in Latin America

Social barriers

Discrimination against key populations and HIV stigma continue to proliferate through many societies in the region and discriminatory practices are widespread in health and other social services.

Key populations and women living with HIV are subject to practices such as forced sterilisation and denial of health services. Discriminatory and punitive laws and policies further limit access to services.⁶⁸ Many people remain ignorant and fearful of HIV and AIDS.

[His family] fed him in the same plate ever, and like that, he had his own cup, glass, fork, knife, spoon, you get the idea, he was isolated by his own family. His razors where always trashed, and his tooth brush too, also, no one was ever taking care of his pills...One week before he died, in the middle of a discussion because of he having AIDS he was thrown out of his house by his older sister... he died alone.

- *Lover of an HIV-positive man in Honduras* ⁶⁹

Legal barriers

Punitive laws

Some Latin American countries have passed national drug policy reforms in recent years, shifting away from a punitive approach. Punitive laws are a barrier to HIV prevention and treatment as they often deter people who use from accessing services for fear of punishment and may force people to hide injecting equipment and and engage in unsafe injecting practices.

In 2009 Mexico partially decriminalised the possession of small quantities of drugs such as cocaine and heroin, with users referred to treatment services rather than criminalised. In 2011, Bolivia began allowing indigenous communities to legally cultivate and use coca leaves which had

previously been banned. In 2013, Uruguay became the first country in the world to sanction state controlled sales of cannabis.⁷⁰

Despite this progress, across the region large numbers of people who use drugs are still imprisoned. Around one in five prisoners in the region are detained due to drug-related offences and their numbers have been rising.

In Mexico, for example, the number of people held for drug-related offences increased by 1,200% between 2006 and 2014. This was despite partial decriminalisation in 2011.⁷¹

Most countries in Latin America and the Caribbean lack anti-discrimination laws and legislation on gender identity and sexual orientation.⁷²

As a result, transgender people, in particular, face very high levels of transphobia. Furthermore, the arbitrary detention of transgender women, including torture and inhumane treatment, is not investigated and prosecuted. Transphobia is reported to be widespread among police forces in Guatemala and Honduras.⁷³

Some countries in the region have made significant progress in recognising the rights of LGBTI people. Argentina, Brazil, Chile, Colombia, Costa Rica, Ecuador, Mexico and Uruguay allow marriage or civil unions between people of the same sex.⁷⁴

In contrast, discriminatory laws against sex between men exist in 11 countries in the Caribbean. While seldom enforced, existing legislation has the impact of institutionalising discrimination against men who have sex with men.⁷⁵

Restrictions on entry, stay and residence

The majority of countries in Latin America and the Caribbean have no restrictions on entry, stay and residence for people living with HIV. Nicaragua and Paraguay have restrictions on the permanent stay of people living with HIV who have been in the country longer than three months. In both countries, resident permits are withdrawn in the case of a positive HIV test.⁷⁶

HIV funding in Latin America and the Caribbean

Latin America has shown significant commitment in investing resources in HIV programming with treatment largely funded by domestic sources. In contrast, in the Caribbean, 11 out of 16 countries were highly dependent on external sources.⁷⁷

However, even in countries with high levels of domestic funding, programmes for key affected populations are still mostly funded by donors (two-thirds in 2012).⁷⁸ Sustainability, effectiveness and long-term access to treatment is also dependent on lower antiretroviral drug prices. Currently, middle-income countries in Latin America, such as Brazil and Argentina, are paying higher prices for a number of second- and third-line treatments.⁷⁹

The future of HIV and AIDS in Latin America and the Caribbean

While some countries in Latin America and the Caribbean have made significant progress in tackling the HIV epidemic, particularly in the provision of treatment, this progress has been uneven. Even where treatment is readily available, a number of barriers prevent many groups from accessing the services they need. For example, homophobia and transphobia, which in many cases result in homophobic crimes, need to be addressed by laws and policies that protect the rights of all people.

Sensitisation programmes targeting national uniformed personnel, aimed at reducing stigma and discrimination towards key affected populations and people living with HIV, are also needed in order to reduce hate crimes across the region.

The region has strong inter-institutional and civil society networks. Many of these, along with international organisations and government representatives from across the region, attended the second Latin American and Caribbean Forum on the Continuum of HIV.

This meeting resulted in the Rio Call to Action, which set targets for combination prevention and zero discrimination, along with a number of priorities for achieving these targets.

Those priorities include the following:

- basing all commitments and subsequent actions on respect for - and promotion of - human rights with a gender perspective.
- reducing prejudice, violence, stigma and discrimination associated with HIV or against persons living with HIV and key populations and others left behind by the response. This is to be done through actions such as eliminating legal and political barriers, reducing discrimination in health care settings, addressing the specific needs of women and girls, reducing violence and guaranteeing access to justice.
- strengthening national strategic information systems to ensure appropriate monitoring of progress.⁸⁰

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