HIV prevention in the SPOTLIGHT

An analysis from the perspective of the health sector in Latin America and the Caribbean

2017

Pan American Health Organization
World Health Organization
REGIONAL OFFICE FOR THE Americas
UNAIDS

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PREFACE

The countries of Latin America and the Caribbean have committed to ending AIDS by 2030, a clear and at the same time ambitious objective that sets the path to follow in this Region. Ending this epidemic requires special emphasis on HIV prevention, and it is in that context that the Pan American Health Organization is presenting *HIV prevention in the spotlight: An analysis from the perspective of the health sector in Latin America and the Caribbean 2017*, prepared in close collaboration with UNAIDS, with important contributions from civil society.

This report presents the countries' achievements and challenges in HIV prevention and calls on them to renew their commitment and efforts to reduce new HIV infections. It also highlights the progress made toward meeting the targets set by the governments of this Region to end AIDS in the coming years. This edition is particularly timely and relevant, as the number of new HIV cases in Latin America and the Caribbean has remained constant since 2010. We have not seen the decline needed to end the epidemic.

This new edition continues the successful series of in-depth analyses of HIV in Latin America and the Caribbean that began in 2012 with *Antiretroviral treatment in the spotlight*. It addresses different aspects of the HIV response from a public health perspective and provides information to guide governments and partners in the improvement of their efforts. This edition is also presented in support of the *Plan of action for the prevention and control of HIV and sexually transmitted infections 2016-2021,* adopted by the PAHO Member States at the 55th Directing Council of 2016.

The framework for this report is the new "combination HIV prevention" approach, which covers biomedical interventions and the promotion of healthy behaviors, as well as aspects of the enabling environments needed for the implementation of prevention measures.

The analysis and recommendations in this report focus primarily on the health sector and, in particular, the three populations most affected by the HIV epidemic: female sex workers, transgender women, and gay men and other men who have sex with men.

This publication is based on data reported by national programs throughout the Region and information furnished by civil society in more than 12 countries. Various aspects of the health sector response in HIV prevention were examined—such as access by the key populations to HIV testing, antiretroviral treatment, pre- and post-exposure prophylaxis, condoms and lubricants, and barriers to access such as discrimination in health services—in order to evaluate the progress made toward meeting the regional prevention targets.

Furthermore, this report addresses sustainability and warns about the Region's dependence on international funds to advance prevention activities for the key populations and the challenges that this entails. The report also underscores the critical role of civil society in guaranteeing a more effective HIV response, particularly in the area of prevention.

We trust that the information presented in this publication will help all of us, as stakeholders, in our enhanced and coordinated efforts to reduce new HIV infections and end AIDS by 2030.

Dr. Carissa F. Etienne, *Director*
Pan American Health Organization

PREFACE

The world has witnessed decisive changes regarding the status of HIV over the past decade. AIDS-related deaths have been falling, due in large measure to the accessibility and affordability of HIV treatment. The number of new HIV infections has also fallen in many countries around the world. While the reasons for this decline vary widely, antiretroviral treatment is undoubtedly a contributing factor, reducing viral load and, hence, the risk of HIV transmission. This progress has led to discussions on the possibility of ending new HIV infections, something unimaginable just 10 years ago.

We may be able to reduce the number of new HIV infections in the world to fewer than 500,000 by 2020, and to fewer than 200,000 by 2030, which would end the AIDS epidemic as a public health threat. Using 2010 as a baseline, these numbers would signify a 75% reduction in new HIV infections between now and 2020 and a 90% reduction by 2030. Meeting these targets will require specific, high-impact HIV prevention measures, testing, treatment, programs to fight discrimination, and an unbreakable commitment to respect protect, and promote human rights.

Nonetheless, despite these significant global advances, Latin America and the Caribbean have not seen a substantial decline in new infections. In fact, there was an increase in 2015, compared to 2013 and 2014. A high incidence of HIV persists among key populations—especially among MSM and among transgender women. Reducing the incidence of the disease will require strengthening various aspects of HIV prevention and the implementation of combination prevention packages that offer a range of high-impact HIV prevention measures of proven effectiveness that are tailored to local epidemics.

HIV prevention in the spotlight is the product of a multisectoral consultation involving the national AIDS programs of the countries of the region, international cooperation agencies, civil society, and people living with HIV, who have contributed their knowledge and experiences to the discussion. With the valuable information obtained from different sources, this publication presents a joint analysis by PAHO/WHO, UNAIDS, and civil society of the status of HIV prevention efforts and the progress made toward meeting the national and regional prevention targets set by the Latin American and Caribbean countries within the framework of the 2015 Call to Action issued in Rio de Janeiro. It also presents examples of combination HIV prevention measures and

highlights some common challenges, such as inadequate investment and resistance to meeting the specific needs of young adults, adolescents, and key populations in connection with their sexual and reproductive rights, while offering recommendations to address these issues.

The combination prevention approach described herein is fundamental. Countries must recommit to this type of action and seriously examine the importance of targeting interventions to key populations and the need to promote the integration and intensification of HIV prevention programs, while improving their performance and broadening their scope.

A multisectoral commitment, close collaboration with communities, and investment in sustainable prevention are essential if regional agreements are to be transformed into country action. As this publication demonstrates, the prevention targets for implementing the Fast-track Strategy at the regional level can be met if a greater return on each dollar invested can be ensured through efficient investment using a location population approach tailored to the characteristics of each epidemic. Good practices include the successful interventions of the Global Fund to Fight AIDS, Tuberculosis, and Malaria, targeted to the key populations and described in this publication.

Let us not miss this opportunity to end new HIV infections and improve people's lives overall, thereby contributing to the realization of the 2030 Agenda for Sustainable Development. AIDS has not ended, but it *can* end. *HIV prevention in the spotlight* will be an excellent tool for steering us in the right direction.

Dr. César Antonio Núñez, *Director*
Regional Support team for Latin America and the Caribbean UNAIDS

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The Pan American Health Organization (PAHO) and the Joint United Nations Program on HIV/AIDS (UNAIDS) would like to thank the managers, coordinators, and directors of the national HIV/AIDS and STI programs of Latin America and the Caribbean, their teams, and the national representatives of UN agencies and civil society organizations for their collaboration in data collection and active participation in the national consultations.

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ACRONYMS AND ABBREVIATIONS

ART	Antiretroviral treatment
GAM	Global AIDS monitoring
GARPR	Global AIDS Response Progress Reporting
GIPS	Greater involvement of people living with HIV/AIDS
LAC	Latin America and the Caribbean
MSM	Men who have sex with men
NASA	National AIDS spending assessment
PEP	Post-exposure prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PrEP	Pre-exposure prophylaxis
STIs	Sexually transmitted infections
FSW	Female sex worker

EXECUTIVE SUMMARY

The governments of Latin America and the Caribbean (LAC) have made a commitment to putting an end to the AIDS epidemic by 2030. This commitment is aligned with the Political Declaration on HIV and AIDS issued by the United Nations General Assembly in June 2016, with specific targets set in Latin America for 2020 and 2030.

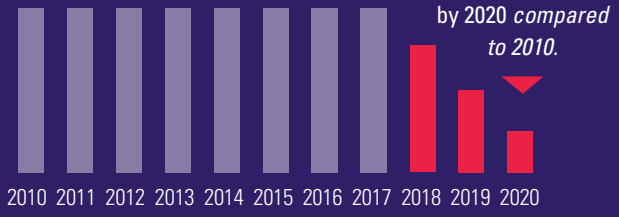
Within this context, the purpose of this publication is to highlight the efforts and challenges to preventing infection with the human immunodeficiency virus (HIV) in LAC through a critical review of the HIV prevention measures adopted by the health sector. The report was prepared with a participatory multisectoral approach involving the compilation of published data and additional data collection through questionnaires and both face-to-face and virtual consultations. The review and recommendations focus on the health sector and three key populations: female sex workers (FSWs), transgender women, and gay men and other men who have sex with men (MSM).

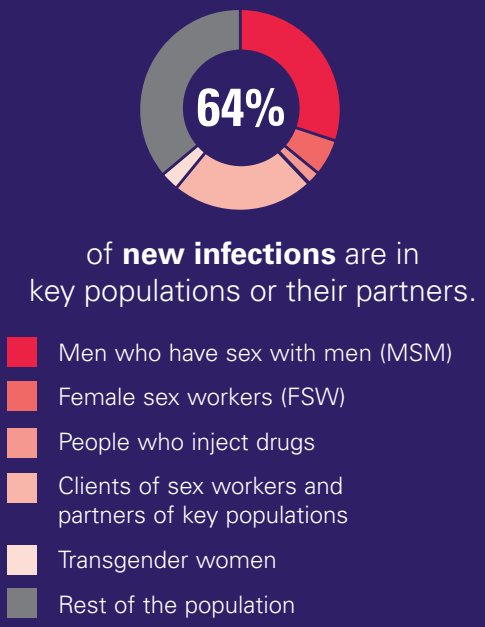
This report is particularly relevant and timely, because the number of new HIV cases in LAC has remained the same as it was in 2010—that is, approximately 120,000 new infections each year—and the number of new infections in adult males is estimated to have increased between 2010 and 2016. Furthermore, in 2016, young men between the ages of 15 and 24 continued to account for one-third of all new HIV infections.

In light of this picture, "combination prevention" is a new approach being promoted

NEW HIV INFECTIONS ARE OFF TARGET

NO CHANGE at 120,000 new infections per year from 2010 to 2016.





to reduce the number of new infections. It combines biomedical and behavioral interventions with interventions that foster an enabling environment to overcome access barriers to health and prevention services.

LAC has made progress in the diagnosis of people with HIV who know their serological status. In 2016, 81% [58%-89%] and 64% [51%-74%] of people with HIV in Latin America and the Caribbean, respectively, knew their serological status. However, delays are still observed in access to diagnosis and health services. An estimated one-third of persons newly diagnosed with HIV were detected late, an indicator that has not improved in the past three years.

Currently, except for the Bahamas, no country offers the complete package of specific interventions for HIV prevention recommended by the World Health Organization (WHO). For example, the data show very limited provision of pre-exposure prophylaxis (PrEP) in LAC, especially for the key populations. Two more countries plan to introduce PrEP in their national public programs in 2017, and seven more are planning pilot projects to implement it.

Every country in LAC offers post-exposure prophylaxis (PEP) that meets two of the three criteria recommended by WHO. Only one-third of the countries also meet the criterion of providing prophylaxis if someone needs it to protect against the risk of transmission during consensual sex.

Nearly all of the countries provide free condoms to young people, MSM, FSWs, and transgender women, and the majority of

the countries report that they also distribute lubricants. The regional median for condom use among MSM in their most recent sexual contact is 63%; among FSWs, 80%; and among transgender women, 88%. There has been no apparent increase compared to the baseline, but there has been an increase in availability of information on transgender women. However, according to the information provided by some key individuals from civil society, the number of condoms and amount of lubricants distributed to the key populations are still insufficient to meet their needs, and it is believed that proper and systematic use of these items may be lower than the data report. Furthermore, the sustainability of this intervention is not guaranteed, since only one-third of the countries report purchasing condoms with their own resources; the remaining countries use resources that come largely from two international donors (the Global Fund to Fight AIDS, Tuberculosis, and Malaria, and PEPFAR).

The diagnosis and treatment of sexually transmitted infections (STI) is an essential aspect of HIV prevention. Data show an increase in STIs in the key populations of some LAC countries. These populations continue to exhibit a high burden of syphilis, which ranges from 1% to 27% in the case of gay men and other MSM, and from 0.5% to 14% in FSWs. In this regard, although 88% of the countries report having STI treatment guides, only slightly more than half of them (59%) follow the WHO recommendations. Furthermore, while the data point to an increase in gonococcal resistance to antimicrobial drugs, only 36% of the countries systematically monitor this resistance to support treatment decisions. Finally, the reporting of active syphilis, which is important for detecting outbreaks and taking steps to combat them, is not compulsory in all the countries (only 89% require it).

The majority of national HIV programs report that training and awareness activities are conducted to attend to key populations. However, the effectiveness of these efforts is not monitored and only rarely is civil society involved in them. Stigma and discrimination continue to fuel the HIV epidemic in LAC, particularly in the key populations.

As part of the targets for eliminating AIDS by 2030, the governments have made several commitments, such as allocating one-quarter of the total HIV budget to prevention and ensuring that at least 30% of service delivery is community-run. However, ensuring the sustainability of the intervention package for the key populations and maintaining a significant level of civil society engagement continues to be difficult, since 82% (27 out of 33) of the countries in LAC depend on international funding to carry out prevention activities in the key populations, and only 60% of the countries (15 out of 25) have resources from their national budget to finance civil society initiatives. Furthermore, service delivery to the key populations, as part of integrated health networks, is limited to a few urban areas, and many countries do not have community-run services.

A significant proportion of people in the key populations have access to prevention services, thanks to financing from the Global Fund and other bilateral cooperation, such as that of the United States. This means that a detailed plan for transitioning toward the national sustainability of HIV prevention in the key populations is necessary and shows the high degree financial dependence of a large number of countries in LAC.

WHY PUBLISH THIS REPORT?

In 2016, the number of new HIV infections in LAC was estimated at roughly 120,000 [98,000-140,000]. Since 2010, the decline in the number of new infections has slowed and, in fact, in 12 countries it is estimated to have increased (*1*). These figures paint a picture in which the commitment to a 75% reduction in new HIV infections by 2020 remains a distant objective.

In order to help countries end the AIDS epidemic by 2030, the Joint United Nations Program on HIV/AIDS (UNAIDS) has developed a strategic framework called the "Fast-track Strategy to End AIDS" (*2*). Implementing this approach implies setting ambitious targets, substantially increasing current investment, and accelerating the delivery of high-impact HIV prevention and treatment services. At the 2016 World Health Assembly, the Member States of WHO approved the *Global health sector strategy on HIV 2016-2021*, which defined how the health sector will contribute to meeting these targets by 2030.

In 2014, the 90-90-90 targets were adopted in LAC to guarantee the continuity of HIV treatment. It was recognized that a greater number of synergistic measures were required to reverse the increase in new HIV infections and the AIDS epidemic by 2030. Thus, in August 2015, at the Second Latin American and Caribbean Forum on the Continuum of HIV Care, held in Rio de Janeiro (Brazil), countries

of the LAC endorsed the conceptual framework for combination prevention and the regional HIV prevention targets (*3*) (*Table 1*).

This publication aims to help the countries of the region rapidly accelerate the improvement and expansion of HIV prevention. It presents a critical analysis of the HIV prevention measures adopted by the health sector to encourage dialogue and national and local decision-making for HIV prevention. The report focuses primarily on three of the region's key populations: gay men and other men who have sex with men (MSM), female sex workers (FSWs), and transgender women.

TABLE 1 Regional HIV prevention targets in Latin America and the Caribbean and situation in 2016

Indicator	Baseline (2010)	Current value (2016)	Targets (2020)	Targets (2030)
Reduction in the estimated number of new HIV infections	120,000	120,000	30,000 (75% reduction)	12,000 (90% reduction)
Reduction in the estimated number of new HIV infections in young adults (aged 15-24)	41,000	39,000	10,000 (75% reduction)	4,000 (90% reduction)
Access to combination prevention packages:[a] percentage of gay men and other MSM, transgender women, and FSWs with access to combination prevention programs	FSW: 76% MSM: 57%	***	90%	95%
Percentage of gay men and other MSM, transgender women, and FSWs tested for HIV in the past 12 months and know the result	FSW: 65% MSM: 46% Transgender women: no data	FSW: 65% MSM: 48% Transgender women: 75%	90%	95%
Percentage of FSWs, gay men and other MSM, and transgender women who report having used condoms with their most recent partner	FSW: 93% MSM: 64% Transgender women: no data	FSW: 80% MSM: 63% Transgender women: 88%	90%	95%
Number of countries that are pilot testing PrEP as an option in a HIV combination prevention package*	2	7 countries with projects planned + 3 with public programs (at the end of 2017)	10	Reset target after PrEP pilot tests

Source: For the 2016 values: UNAIDS, Spectrum estimates corresponding to 2017 (rounded).
Notes: Subregional prevention targets can be consulted in Table 1 of the Annex.
MSM: men who have sex with men. FSW: female sex workers; PrEP: pre-exposure prophylaxis.
a: Appropriate and tailored to the local and cultural context.
*** The GARPR indicator has changed; thus, no country-level information is currently available to measure it.

What is combination HIV prevention?

Combination HIV prevention is an approach initially proposed by the United States in the President's Emergency Plan for AIDS Relief (PEPFAR) and subsequently adopted and expanded in 2009 by the UNAIDS HIV Prevention Reference Group (*4*). Some years later, it was updated in the report *Fast-tracking combination prevention* (*5*).

UNAIDS defines combination prevention programs as rights-, evidence-, and community-based programs that promote a combination of biomedical, behavioral, and structural interventions designed to meet the HIV prevention needs of specific people and communities. Their goal is to reduce the number of new infections through activities with a greater sustained impact. Well-designed combination prevention programs should be tailored to national and local needs, based on epidemiological information. Programs should also concentrate resources on combining activities where they are most needed. Structural interventions make it possible to create an enabling environment for the synergistic preventive action of the biomedical and behavioral components.

The conceptual framework of combination prevention:

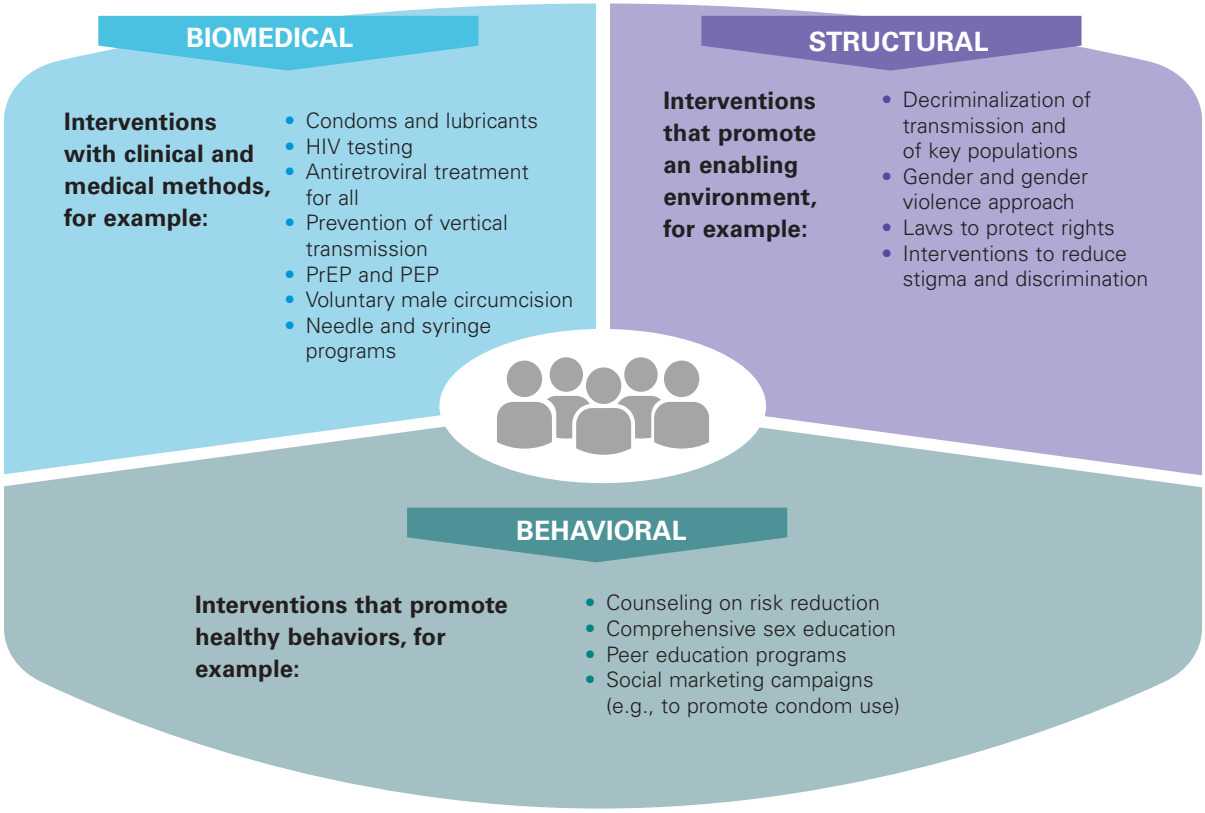
1. consists of a set **of biomedical and structural interventions and others to promote healthy behaviors**
2. is **evidence**- and **human rights–based,** and
3. is focused on **meeting individual and community needs.**

Source: UNAIDS. Combination HIV Prevention: Tailoring and Coordinating Biomedical, Behavioral and Structural Strategies to Reduce New HIV Infections. UNAIDS Discussion Paper. Geneva; 2010.

Affected communities should be fully involved in these programs, mobilizing community, private sector, and government resources to achieve the necessary participation, coverage, and continuity (*Table 2*).

In this context, WHO has recommended some essential health sector interventions for the HIV response targeted to the key populations, known as the "**comprehensive package of interventions for key populations**" (*Table 3*).

TABLE 2 The three areas addressed in combination prevention



Source: Adapted from the International HIV/AIDS Alliance. *An advocacy brief for community-led organisations: Advancing combination HIV prevention;* 2016. Available from: http://www.aidsalliance.org/assets/000/002/472/web_AllianceUnaids_Comb_prevention_original.pdf?1459762561.

TABLE 3 Comprehensive package of HIV prevention interventions for key populations according to the World Health Organization, 2016

Essential health sector interventions	Essential strategies for an enabling environment
1. comprehensive condom and lubricant programs	1. supportive legislation, policy, and financial commitment, including the decriminalization of behaviors of key populations
2. harm reduction interventions for substance use	2. addressing stigma and discrimination
3. behavioral interventions	3. community empowerment
4. HIV testing and counseling	4. addressing violence against people from key populations
5. HIV treatment and care	
6. prevention and management of coinfections and other comorbidities, including viral hepatitis, TB, and mental health conditions	
7. sexual and reproductive health interventions	

Source: WHO. *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations. 2016 update.* Geneva; 2016.

METHODOLOGY

For the analysis in this report, the indicators listed below have been selected, using the combination prevention approach and essential health sector interventions for HIV prevention as a framework, with emphasis on the key populations, regional prevention targets, and the indicators reported at the international level (GARPR/GAM):

1) estimated number of new infections in 2010 and 2016;
2) access by MSM, FSWs, and transgender women to HIV testing;
3) distribution of condoms and lubricants and condom use by MSM, FSWs, and transgender women;
4) HIV policies and prevention services;
5) civil society financing of the AIDS response and HIV prevention;
6) situation with respect to PrEP, PEP, the provision of antiretroviral treatment (ART) to all people diagnosed with HIV; the distribution of condoms; nationwide diagnosis, treatment, and monitoring of STIs.

In addition to these indicators, given the great importance of the structural component of combination prevention, a brief analysis is included of this component in LAC, focusing on a review of laws, policies, and practices, the reduction of stigma and discrimination, community empowerment, and violence prevention.

Information sources

The main source of quantitative information was the 2017 country reports for global AIDS monitoring (GAM).

Other sources of information include

1. Estimates of new infections in 2017, calculated using the UNAIDS Spectrum system.
2. Country reports in response to the HIV prevention questionnaire: 28 national programs completed a questionnaire on health sector HIV prevention interventions, with support from the PAHO and UNAIDS focal points.
3. Twelve in-person and virtual national consultations with representatives of national and civil society HIV programs: their purpose was to consider the quantitative information and analyze qualitative aspects of the response, such as significant civil society involvement, the characteristics of the services, structural barriers, and how to improve the supply and demand for services. Prior to the consultations, every participating country received a fact sheet summarizing the data collected from the GAM.
4. Information on prevention interventions and their coverage in projects of the Global Fund to Fight AIDS, Tuberculosis, and Malaria.
5. Other relevant publications and reports, such as the 2017 PAHO/WHO survey on LGBT people entitled *Addressing the causes of disparities in health service access and utilization for lesbian, gay, bisexual and trans (LGBT) persons. Assessing the health situation and access to care for LGBT people in the Americas.*

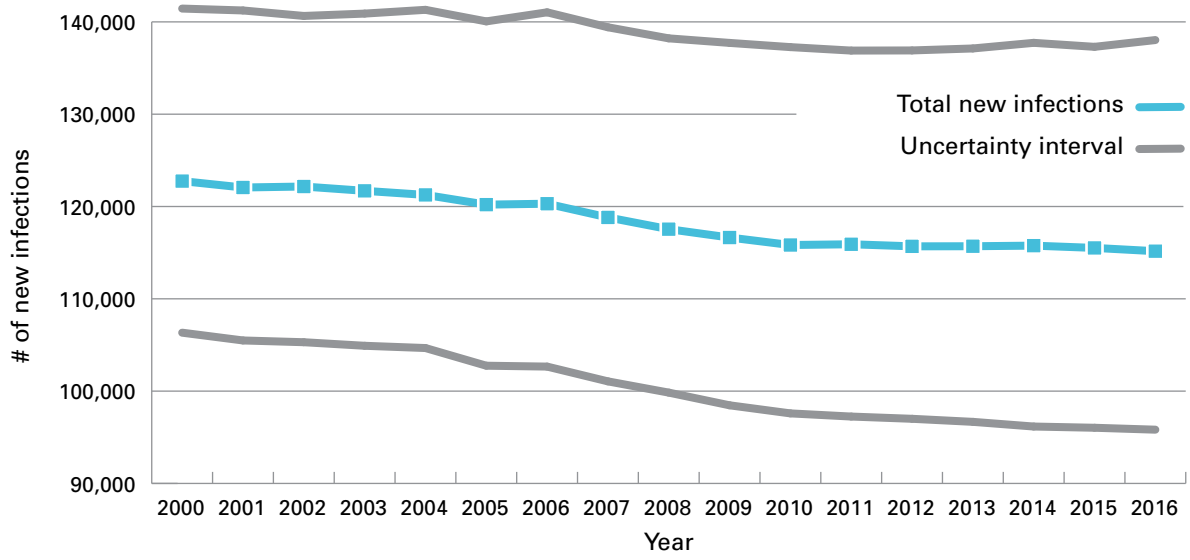
RESULTS

The number of new HIV infections did not decline

An estimated **120,000** [98,000-140,000] new HIV infections were observed in LAC in 2016, a figure similar to that of 2010.

New HIV infections in Latin America and the Caribbean have trended downward in the past 16 years. Nevertheless, new infections have plateaued since 2010 (with 120,000 new infections that year), although there was a slight decline in 2015 and 2016 (*Figure 1*). This suggests that LAC is off track in meeting the established global and regional targets of a 75% reduction in new HIV infections by 2020 (*Table 1*).

FIGURE 1 Trend in estimated new HIV infections in Latin America and the Caribbean, 2000-2016



Source: UNAIDS. Spectrum estimates; 2017.
Note: Estimates have been rounded.

Few countries have seen a clear decrease in new infections since 2010 (e.g., Colombia, El Salvador, and Nicaragua), while in most countries the trend is steady or even increasing (*Table 4*).

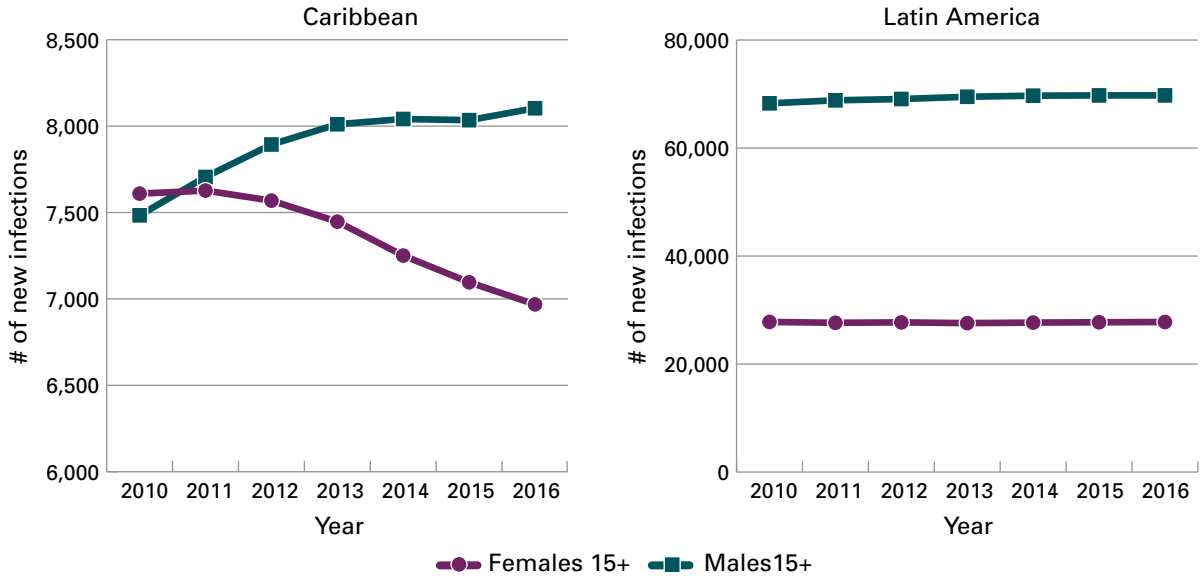
Among males over the age of 15, there was an increase in new infections in the Caribbean from 2010 to 2016 (an 8% increase), while the trend in Latin America was relatively stable (a 2% increase) (*Figure 2*). In contrast, among females

TABLE 4 Classification of countries by trends in new HIV infections, Latin America and the Caribbean, 2010-2016

Decrease greater than 10%	Less than 10% change		Increase greater than 10%
	Small decrease	Small increase	
Colombia	Barbados	Argentina	Chile
Dominican Republic	Mexico	Belize	Costa Rica
El Salvador		Brazil	Cuba
Haiti		Panama	Guatemala
Nicaragua		Paraguay	Guyana
Trinidad and Tobago			Honduras
			Suriname

Source: UNAIDS Spectrum estimates, 2017.

FIGURE 2 Distribution of estimated new HIV infections among adults (15+) in the Caribbean by sex and year, 2010-2016



Source: UNAIDS Spectrum estimates, 2017.

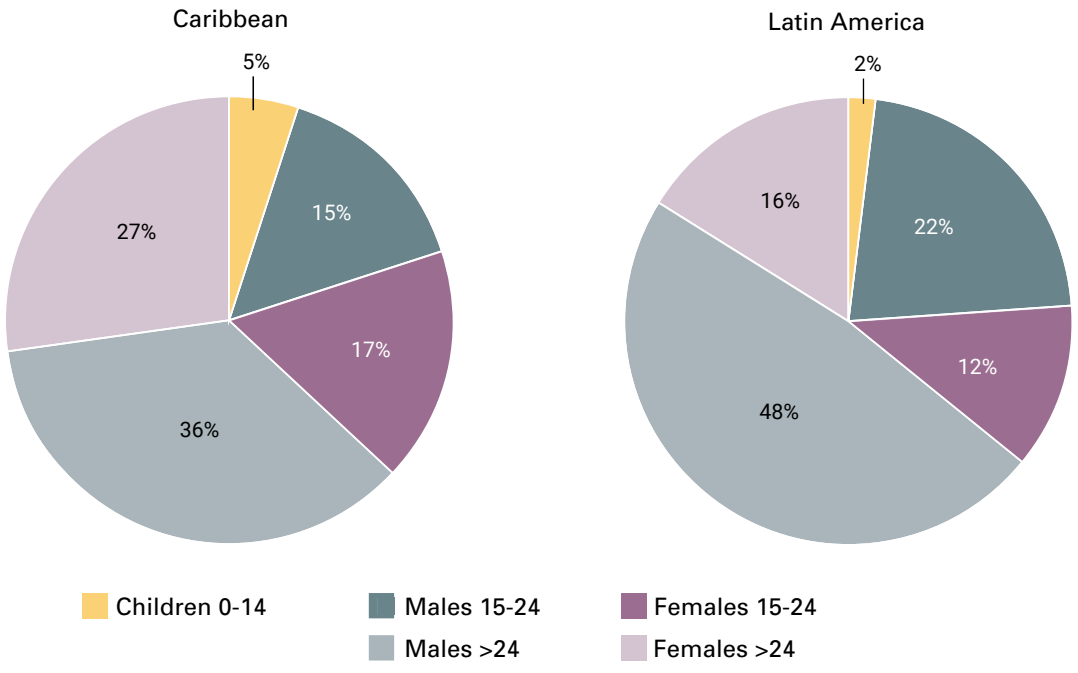
Males over the age of 15 accounted for 70% of all new infections in Latin America and 51% in the Caribbean.

in the same age group, the data show a decline in new infections in the Caribbean (an 8% decline) during the same period.

In 2016, in Latin America, males over the age of 15 accounted for 70% of all new infections in Latin America and 51% in the Caribbean. Notably, Haiti is the only Caribbean country with more new infections in females than males (28% more).

Males and females aged 15-24 accounted for one-third of the total estimated population with new HIV infections in both Latin America and the Caribbean in 2016 (*Figure 3*). In this age

FIGURE 3 Distribution of new HIV infections by age group in Latin America and the Caribbean, 2016



Source: UNAIDS Spectrum estimates, 2017.

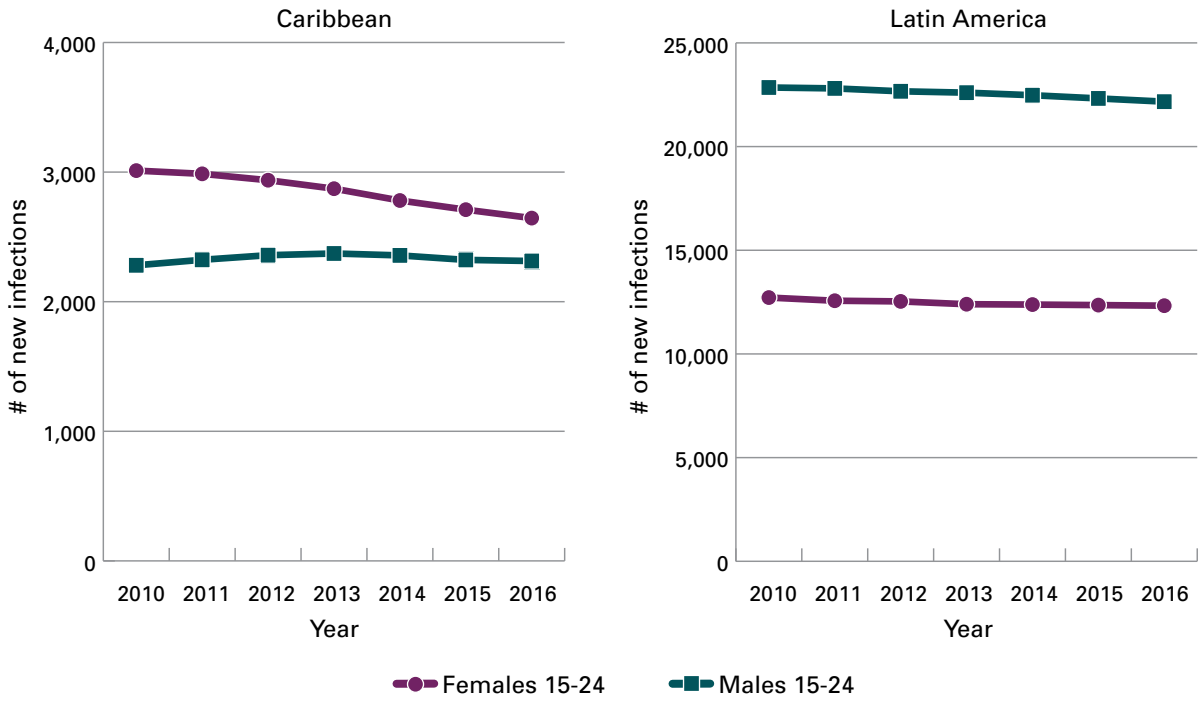
group, females accounted for a high percentage of the new infections in the Caribbean, while males had two-thirds of the new infections in Latin America.

New HIV infections in young people have not fallen at the desired rate

The regional target is a 75% reduction in new infections in young people by 2020. In the past six years, there has been a 5% decrease in new HIV infections among those aged 15-24 (3% in males and 5% in females) (*Table 1*).

The number of new infections in young women aged 15-24 in the Caribbean fell by 10% from 2010 to 2016. Among males in the same age group, new infections in that period remained stable (increasing by around 1%) (*Figure 4*).

FIGURE 4 Estimated new infections in young people aged 15-24 in Latin America and the Caribbean, 2010-2016



Source: UNAIDS Spectrum estimates, 2017.

A complete set of recommended prevention interventions is not offered

In order to meet the HIV prevention needs of individuals and communities, governments should take full advantage of high-impact interventions supported by evidence and based on the essential rights and needs of each community. They should offer a range of services that individuals will use as their particular needs and situation dictate. These interventions, focused on the aforementioned key populations,[a] include:

1. HIV testing and counseling
2. STI diagnosis and treatment
3. PrEP
4. PEP
5. Distribution of condoms and lubricants
6. ART for all (regardless of their CD4 count or the clinical stage of the infection)[b]
7. Peer-led community outreach activities
8. Sexual health information and education

National programs and civil society organizations offer a variety of interventions that are not necessarily standard. The percentage of countries indicating that they have policies for public delivery of these interventions is high in the case of HIV testing and counseling, STI diagnosis and treatment, sex education, and the distribution of condoms. However, public policies are deficient with respect to other services, such as PEP for the key populations, and PrEP and ART for all, regardless of the CD4 count (*Table 5*).

With the exception of the Bahamas, no country in LAC offers all the recommended interventions to all the key populations, although Brazil is expected to have all the combination prevention interventions by the end of 2017 with the start of its PrEP program in the public health sector. In addition, Barbados is launching an initially small-scale public PrEP program, and the Bahamas has plans to further expand PrEP. The existence of public policies that offer the combination prevention interventions and other related services is the first step toward ensuring access (later chapters examine service coverage and access barriers).

a The key populations considered in this publication are female sex workers, gay men and other men who have sex with men, and transgender women.

b WHO recommends antiretroviral treatment (ART) for all adults with HIV, regardless of their clinical status or CD4 count (strong recommendation, medium-quality evidence). Offering treatment to all based on this recommendation is what we call "ART for all" in this report.

TABLE 5 Percentage of countries with public policies for delivery of the HIV prevention services recommended by WHO, by key population and selected services

Service or intervention	MSM (%)	FSW (%)	Transgender women (%)
HIV testing and counseling	100	97	94
STI diagnosis and treatment	90	91	84
PrEP	6	6	6
PEP	39	39	39
Condoms	100	96	81
Lubricants	89	89	83
Antiretroviral treatment (ART) for all	45	45	45
Peer-led community outreach activities	89	86	83
Sexual health information and education	100	96	91

Source: PAHO. Country responses to the HIV Prevention Survey, May 2017.
Note: Percentages based on the response of 31 or 33 countries as of July 2017.
ART: antiretroviral treatment; MSM: men who have sex with men; PrEP: pre-exposure prophylaxis; PEP: post-exposure prophylaxis; FSW: female sex workers.

Peer-led community outreach activities. The majority of countries offer peer-led community outreach interventions, as well as sexual health information and education. The peer-led community outreach interventions are provided largely by nongovernmental organizations that work with the key populations inside and outside the health services.

ESSENTIAL INTERVENTIONS

of the health sector for the prevention of HIV infection

HIV testing and counseling. Nearly all LAC countries offer HIV testing specifically to the key populations. However, some countries lack specific services for these groups. For example, Saint Vincent and the Grenadines does not have interventions with testing that specifically target FSWs or transgender women, and Haiti does not offer testing to transgender women (these services are part of the packages of services for MSM).[c] With regard to HIV self-testing, 5 out of 32 countries (19%) indicated that these tests are available on the market. Brazil, however, is the most advanced in implementing this approach in their national policy and plans. Furthermore, throughout LAC, these tests are financed entirely by the user (out-of-pocket expenditure).

STI diagnosis and treatment. A high percentage of countries have public policies that promote these services. However, quantitative and qualitative data and field studies show that not all of them follow the WHO recommendations on systematic STI screening in the key populations. For example, missed opportunities and lack of integrated services have been observed, since 35% of the countries (10/26) report that testing for syphilis and other STIs is not offered when HIV testing is offered to key populations.

PrEP. The provision of PrEP to key populations is very limited. The regional PrEP target is 10 pilot projects by 2020. That target will soon be exceeded, since by the end of 2017, three countries plan to include or expand its use in their national programs (the latter, in the case of the Bahamas), and seven more are planning pilot projects to provide it (see section on PrEP further on). The regional target will be reviewed before 2020 and a more ambitious target will be set, based on the progress in LAC and the WHO recommendations in this regard.

PEP. All the countries offer PEP: a) in cases of work-related or occupational injuries involving a source who is HIV-positive or whose HIV status is unknown, and b) in cases of sexual assault. WHO (*6*) also recommends that PEP be offered in the case of risk from consensual sex with an HIV-positive sex partner or one whose HIV status is unknown; however, only 39% of the countries offer PEP in this latter case.

[c] Although some countries do not report services for transgender people, this does not necessarily mean that such services do not exist, but rather that the information on this population is subsumed under the MSM category.

Distribution of condoms and lubricants. The majority of countries report that they distribute condoms to all the key populations, with the exception of Belize, Cuba, El Salvador, Haiti, Saint Lucia, and Trinidad and Tobago in the case of transgender women, and Costa Rica in the case of FSWs (as indicated earlier, services for transgender women are provided by the services for MSM). Lubricants are sometimes not distributed; for example, three countries do not provide them with condoms for MSM or transgender women, and two others do not provide them for FSWs. The majority of the countries do not distribute lubricants along with condoms for the general public or young people (30%; 8 of the 26 countries that provided information). Proper and systematic use of condoms and compatible lubricants is recommended for all the key populations (a strong WHO recommendation) (*7*). As indicated further on (in the section on condoms), even where public policies for the distribution of free condoms and lubricants are in place, the supply is often insufficient to meet the needs of the key populations.

Antiretroviral treatment for all. Roughly half the countries (15/33) in LAC report having adopted the WHO recommendation to offer treatment to all HIV-positive people, regardless of their CD4 count, and 39% (13/33) are planning to adopt this therapeutic criterion. Early HIV treatment improves the patient's quality of life and is an opportunity to prevent transmission, since a person with an undetectable viral load has a minimal probability of transmitting the virus (*8*). Nearly 1.2 million people in LAC (162,000 in the Caribbean and over 1 million in Latin America) received ART in 2016, or 100,000 more people than in 2015. In terms of the total population with HIV in 2016, people who received ART accounted for 52% [41%-60%] of the people with HIV in the Caribbean and 58% [42%-72%] of those in Latin America. Nevertheless, it is essential to take into account suppression of the viral load. In 2016, the viral load was eliminated in 81% [64%-94%] and 72% [52%-89%] of the people receiving ART in the Caribbean and Latin America, respectively. While these figures indicate a certain degree of treatment program success, they still represent less than half the population with HIV (34% with suppressed viral load in the Caribbean and 46% in Latin America), which is far from the target of suppressing the community viral load by 72%—the figure required for epidemic control and to meet the 90-90-90 targets.

More people have access to HIV prevention through support from the Global Fund

The Global Fund to Fight AIDS, Tuberculosis, and Malaria finances interventions that are part of the national HIV response in 18 countries in LAC (in 17 of them, targeting one of the key populations). It also provides funds for regional grants, including the one for HIV prevention in the key populations of the eastern Caribbean. In recent years, the Global Fund has recommended that grant applications from countries with concentrated epidemics should focus on effective interventions for prevention in key populations.[d]

All of the 17 countries that have received grants for HIV prevention in the key populations have funds for interventions with MSM; 14 of them have funds for transgender women; and 12, for FSWs. Three countries (Belize, Guyana, and Haiti) do not have HIV prevention programs for transgender women, although this group has access to such interventions through interventions for MSM. Four countries (Belize, Bolivia, Colombia, and Peru) use domestic funds to finance services and interventions for FSWs.

Among other interventions, the Global Fund invests in prevention packages. In all cases and for all population groups, these packages include various quantities of male condoms, which are provided during behavior change communication activities. Four out of five grants also cover lubricants.

In recent grant applications, all of the countries have had to set targets for the population to be reached by the end the grant period. Based on national estimates of the size of each of the key populations, the experience working with the different groups, productive capacity, and the potential for expanding the interventions during the program implementation period, the country concept notes have indicated the number of people from the key populations that can feasibly be reached in the total population (*Table 6* and *Table 2* of the Annex).

With respect to the targets for the percentage of the population that can feasibly be reached,[e] even if all the programs were properly implemented, none of the three subregions would reach 70% of the MSM population with HIV prevention packages. In the case of transgender women and FSW, none of the three subregions would reach, on average, more than 80% of transgender women or FSW with prevention packages (*Figure 5*).

The 17 countries have an estimated population of 1,158,055 MSM feasible to reach with HIV prevention programs, or 68% of the total

[d] All the information analyzed in this section is taken from the Grant Performance Reports that the Global Fund publishes on its website and updates semiannually with the results of the discussion on the monitoring of each of the grants to the countries.

[e] For the 2014-2018 implementation cycle.

TABLE 6 Percentage of the key populations that each country in LAC defines as reachable, target with respect to the estimated total, and target as a percentage of the reachable population

	MSM			Transgender women			FSW		
	Percentage of the estimated total that can feasibly be reached	Target as a percentage of the estimated total	Target as a percentage of the reachable population	Percentage of the estimated total that can feasibly be reached	Target as a percentage of the estimated total	Target as a percentage of the reachable population	Percentage of the estimated total that can feasibly be reached	Target as a percentage of the estimated total	Target as a percentage of the reachable population
Belize	n/d	n/d	27%	n/a	n/a	n/a	n/a	n/a	n/a
Bolivia	89%	31%	36%	143%	80%	56%	n/a	n/a	n/a
Colombia	28%	17%	60%	28%	13%	45%	n/a	n/a	n/a
Costa Rica	87%	23%	26%	n/d	n/d	81%	n/a	n/a	n/a
Cuba	74%	70%	94%	85%	82%	97%	23%	19%	81%
Dominican Republic	106%	64%	61%	44%	38%	87%	100%	61%	61%
Ecuador	68%	64%	95%	156%	144%	92%	n/d	n/d	n/d
El Salvador	31%	26%	82%	100%	77%	77%	30%	24%	80%
Guatemala	91%	16%	18%	101%	77%	76%	72%	44%	61%
Guyana	100%	90%	90%	n/a	n/a	n/a	100%	92%	92%
Haiti	99%	33%	33%	n/a	n/a	n/a	160%	143%	90%
Honduras	100%	70%	70%	100%	70%	70%	100%	60%	60%
Jamaica	80%	42%	53%	n/d	n/d	57%	102%	60%	58%
Nicaragua	75%	60%	80%	79%	57%	73%	84%	70%	83%
Panama	108%	60%	55%	108%	59%	55%	108%	45%	41%
Paraguay	84%	49%	59%	74%	59%	80%	97%	68%	70%
Peru	96%	43%	45%	96%	43%	45%	n/a	n/a	n/a

Notes: 2014-2017 financing cycle.
MSM: men who have sex with men; FSW: female sex workers; n/a: not applicable; n/d: unavailable.

estimated MSM population of 1,712,619.[f] Of these, 448,900, or 38%, had been reached with prevention packages as of December 2016, according to each Global Fund grant. A total of 197,163 (19%) had been offered and given an HIV test.

Of the 78,708 transgender women feasible to reach (83% of the total estimated trans population of 94,522),[g] 33% (25,568) had been reached with prevention packages and 16% with the HIV test in the 14 countries with grants for this group.

Of the 341,016 FSWs feasible to reach in the 12 countries, 216,697 (63%) had access to prevention services and 42% received an HIV test.

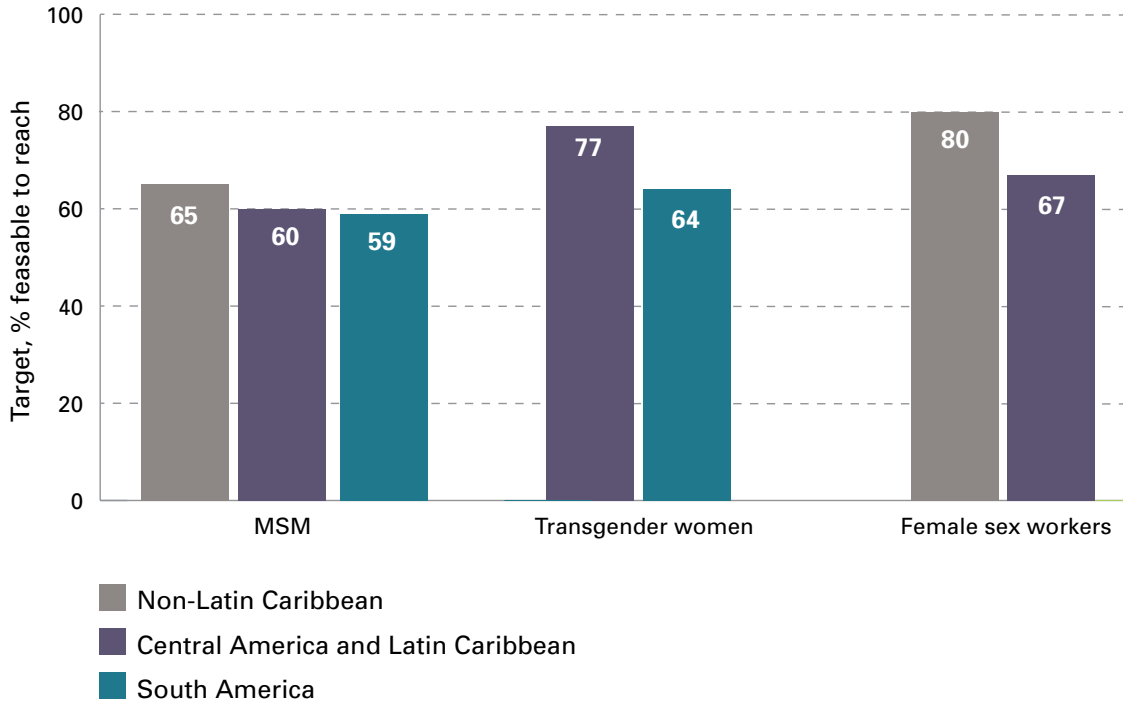
A look at these data by subregion shows that the non-Latin Caribbean countries consider it feasible to reach virtually their entire MSM population with prevention packages, although 39% of this population was set as the target to reach with Global Fund grants. Nevertheless, as of December 2016, 63% of the total had been reached (*Figure 6*).

Similarly, in the case of transgender women (*Figure 7*), the Latin Caribbean and Central American subregions are where the highest

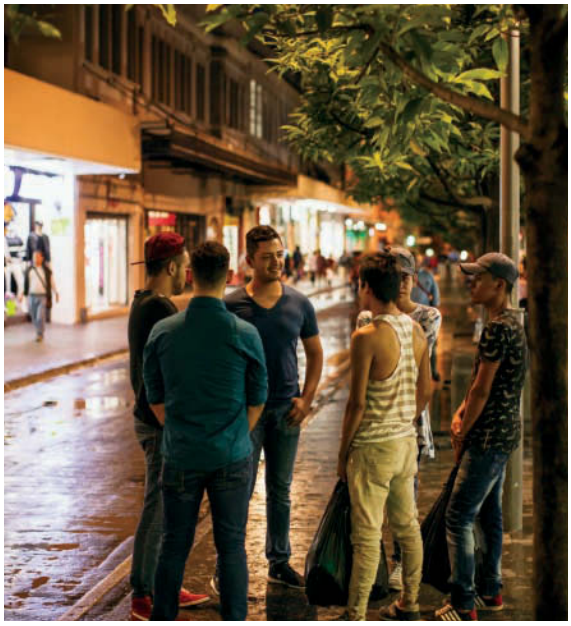
f Belize does not have estimates of the size of its MSM population.

g Costa Rica, Cuba, and Jamaica did not provide an estimate of their transgender population in the 2016 GAM.

FIGURE 5 Target of each key population to be reached, based on those that can be feasibly reached, by subregion, 2014-2018 financing cycle



Note: Only interventions financed by the Global Fund. There are no data for transgender women in the non-Latin Caribbean, because only one country has a specific grant for this group; the rest of the countries include these interventions in those for the MSM population. There is no average for FSWs in South America, because only two countries have a grant for this population and only one has data.



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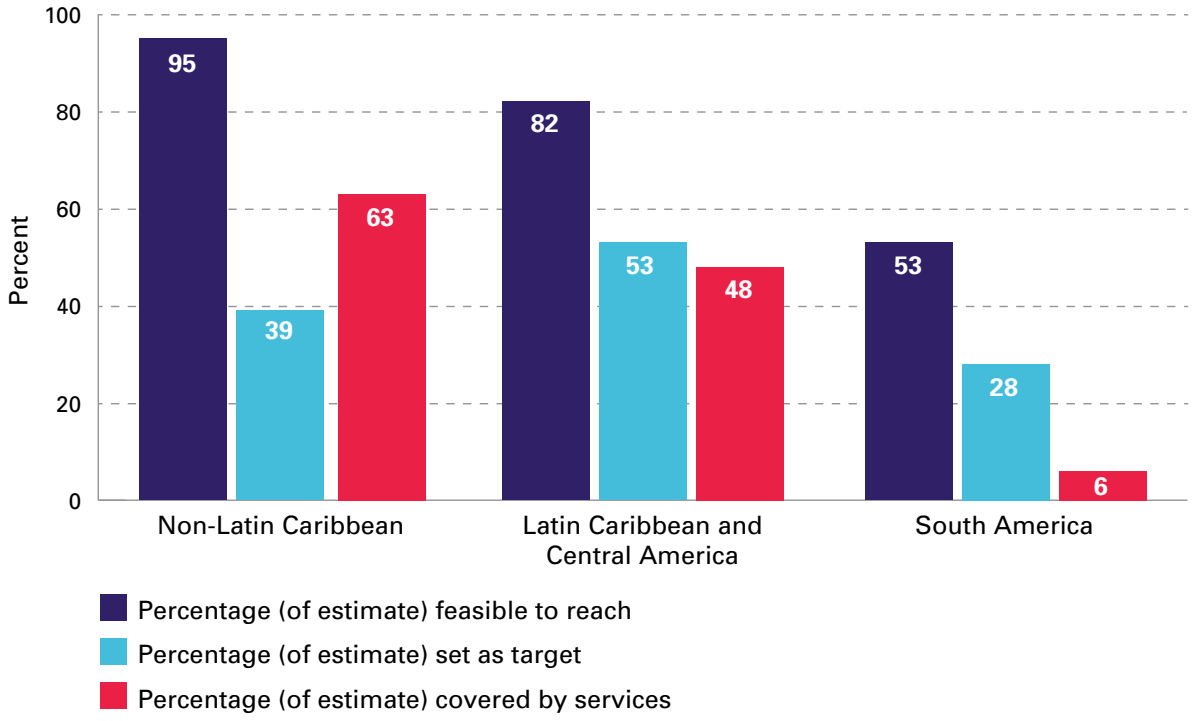
A significant proportion of people access HIV prevention measures thanks to financing from the Global Fund. Planning for a transition to national sustainability of HIV prevention measures is needed in three out of four countries in LAC.

FIGURE 6 MSM prevention services programming cascade, by subregion, 2014-2017 programming cycle



percentage (79%) of the estimated population is feasible to reach with prevention packages. The target was 62% of the total, and as of December 2016, 56% of the total had been reached.

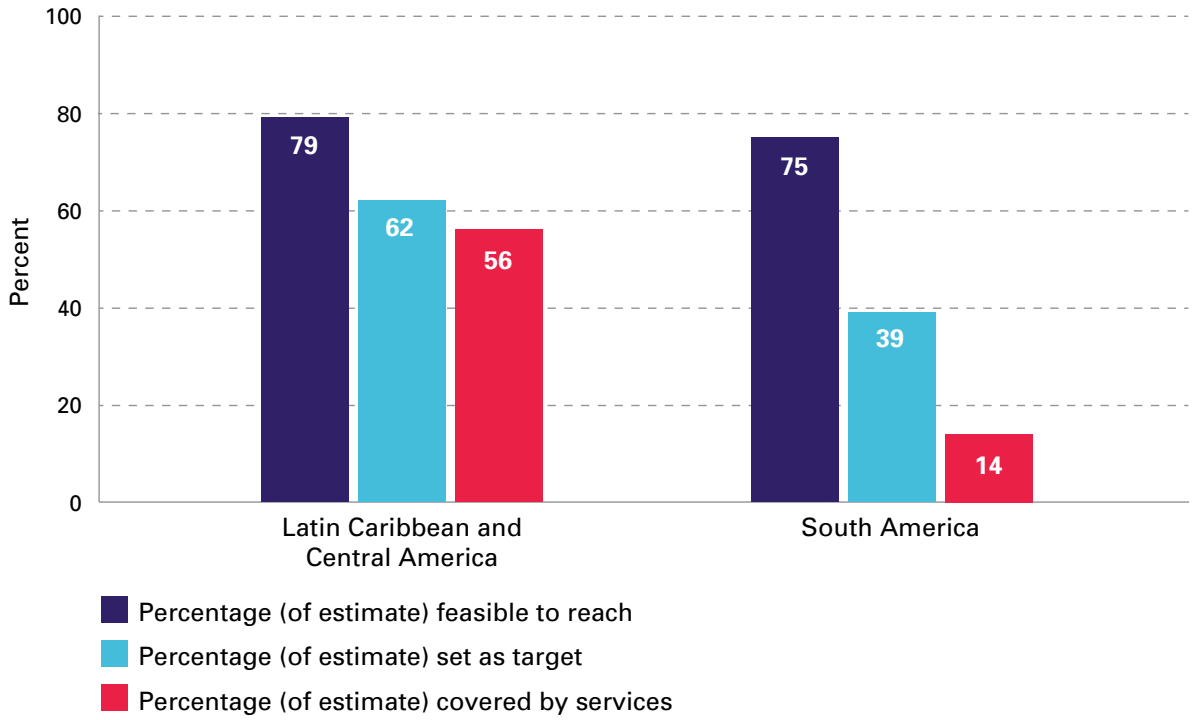
With regard to the FSW population (*Figure 8*), the estimates of population size reported by the non-Latin Caribbean seem conservative, given that the feasibly reachable population indicated in the Global Fund grants exceeds the figure by almost 50%. The target is 124% of the total, and as of December 2016, 132% had been reached.

The prevention service programming cascades (see *Figures 6-8*) reveal variability in the estimates of population size between subregions, the population feasible to reach, the targets, and the coverage achieved by the services. The reasons for these differences may be due to

- weakness in the estimates of population size;
- contributions from other donors or domestic resources to cover the missing percentages of these population groups; and
- differences in the project implementation period, resulting in variations in the coverage achieved.[h]

[h] The new financing model covers a cycle that began in 2014 and concludes in 2018. Since these are three-year programs, the countries are not all in the same implementation cycle, which affects coverage values.

FIGURE 7 Transgender women prevention services programming cascade, by subregion, 2014-2017 programming cycle



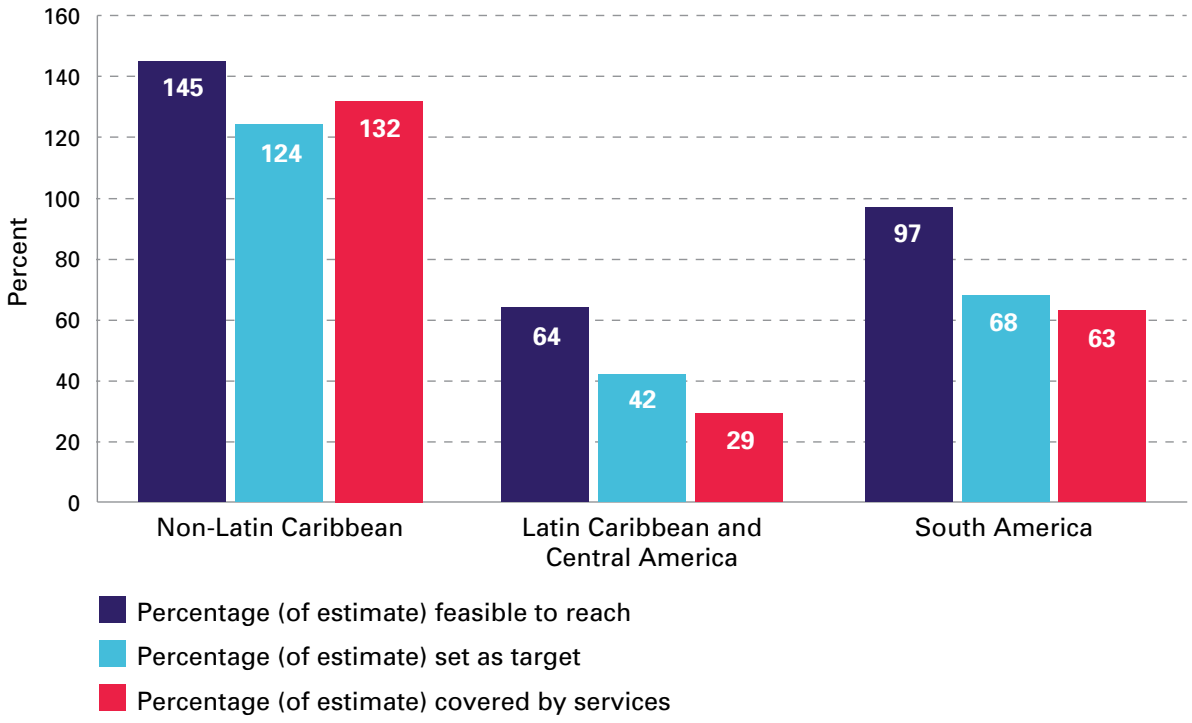
Note: In the non-Latin Caribbean, only Jamaica has individually included it in its grant. Nevertheless, without an estimate of the size of the population, the percentages cannot be calculated.

These cascades also reveal the countries' dependence on international funds to offer HIV prevention services to the key populations.

The percentage of people from the three key populations reached with HIV prevention packages in the countries varies widely (see *Figures 6-8*). However, it can be concluded that a very significant proportion of people from the key populations in all the countries have access to HIV prevention measures, thanks to financing from the Global Fund. This situation reveals the need to plan for a transition to national sustainability of HIV prevention measures in three out of four countries in LAC.

Another example of effective services for the key populations are those promoted by the Central American countries with the support of bilateral cooperation from the United States. Thanks to the Sexually Transmitted Infection Surveillance, Prevention, and Control Strategy (known by its Spanish acronym, VICITS), HIV prevention services in the Central American subregion have focused on the needs of the key populations.

FIGURE 8 Sex worker prevention services programming cascade, by subregion, 2014-2017 programming cycle



Experience gained with the implementation of interventions for STI and HIV prevention in the key populations of Central America through the VICITS strategy

The VICITS strategy is a combination prevention strategy for key populations that offers HIV testing, STI diagnosis and treatment, counseling by specialists, the distribution of condoms and lubricants, peer promotion and accompaniment to HIV treatment and other complementary services, and an information system for the surveillance of epidemiological trends. The ministries of health of Guatemala and Honduras were the first to embrace the strategy, implementing it in 2006. The governments of Costa Rica, El Salvador, Nicaragua, and Panama subsequently followed suit, and VICITS is now being implemented in 47 clinics in LAC, which provided services for 22,616 people in 2016. Access to services, especially by MSM and transgender women, has significantly increased: the number of people reached has risen from the 857 in 2011 to 13,359 in 2016.

VICITS has become one of the most effective strategies for reaching people with undiagnosed HIV and ensuring that they receive treatment. A total of 931 MSM and transgender women in Central America received an HIV diagnosis in 2016 through the VICITS strategy (positivity rate: 10%), a percentage substantially higher than the national prevalence, which is no more than 1% in any of the countries where the strategy is being implemented. Connection to HIV treatment through VICITS is also higher. In Guatemala City, for example, 9 out of 10 people diagnosed with HIV in VICITS clinics in 2016 were connected with the health services within an average of three days, a rate that exceeds the national average by almost 30%. In an effort to improve access by the key populations to HIV treatment, at least seven VICITS clinics offer ART (as of July 2017), and several ministries of health are in the process of decentralizing treatment to new VICITS clinics. In addition, the VICITS clinic of the *Amigos contra el Sida* (Friends against AIDS) group in Guatemala City is conducting Central America's first PrEP pilot project, and the Ministry of Health of Panama is developing an additional pilot project to offer PrEP in the country's VICITS clinics, known locally as "friendly clinics."

The VICITS strategy addresses the stigma and discrimination that the key populations face and trains all health personnel to provide compassionate, high-quality services. VICITS clinics build close ties with the key populations' community organizations and appoint peer promoters and navigators to promote visits to clinics and connect people diagnosed with HIV with treatment centers. Furthermore, the ministries of health have partnered with local community organizations to conduct VICITS outreach activities. The purpose of this initiative is to offer services outside the customary clinic hours.

Concerning efforts to achieve sustainability, the strategy currently receives funds from the U.S. government. However, the services are provided mainly in government health clinics, and the health care providers are hired by the ministries of health, which also covers the cost of treatment for STIs and the bulk of laboratory reagents.

The VICITS sentinel surveillance system provides information on current HIV and STI trends, condom use, the number of sex partners, and other behavioral indicators in the key populations. These data help to identify the subgroups at greatest risk of infection, provide the information needed to design specific program interventions, and serve as the foundation for HIV and STI indicators in the key populations. They are also a critical tool for supporting domestic and international resource mobilization efforts for the HIV response in the key populations.

Source: Nasim Farach. Central America Regional Office, Centers for Disease Control and Prevention (CDC).
Note: The findings and conclusions in this box are an intepretation and do not necessarily represent the official position of the CDC.

ACCESS TO HIV TESTING

The LAC countries have made a commitment to improving access to HIVs testing and people's knowledge of their HIV status. Three targets have been set: 1) 90% of people with HIV will know their status by 2020; 2) focus efforts on timely access to HIV testing in the key populations, so that by 2020, more than 90% will have been tested in the past 12 months; and 3) reduce late HIV diagnosis to 10% or less (*9*).

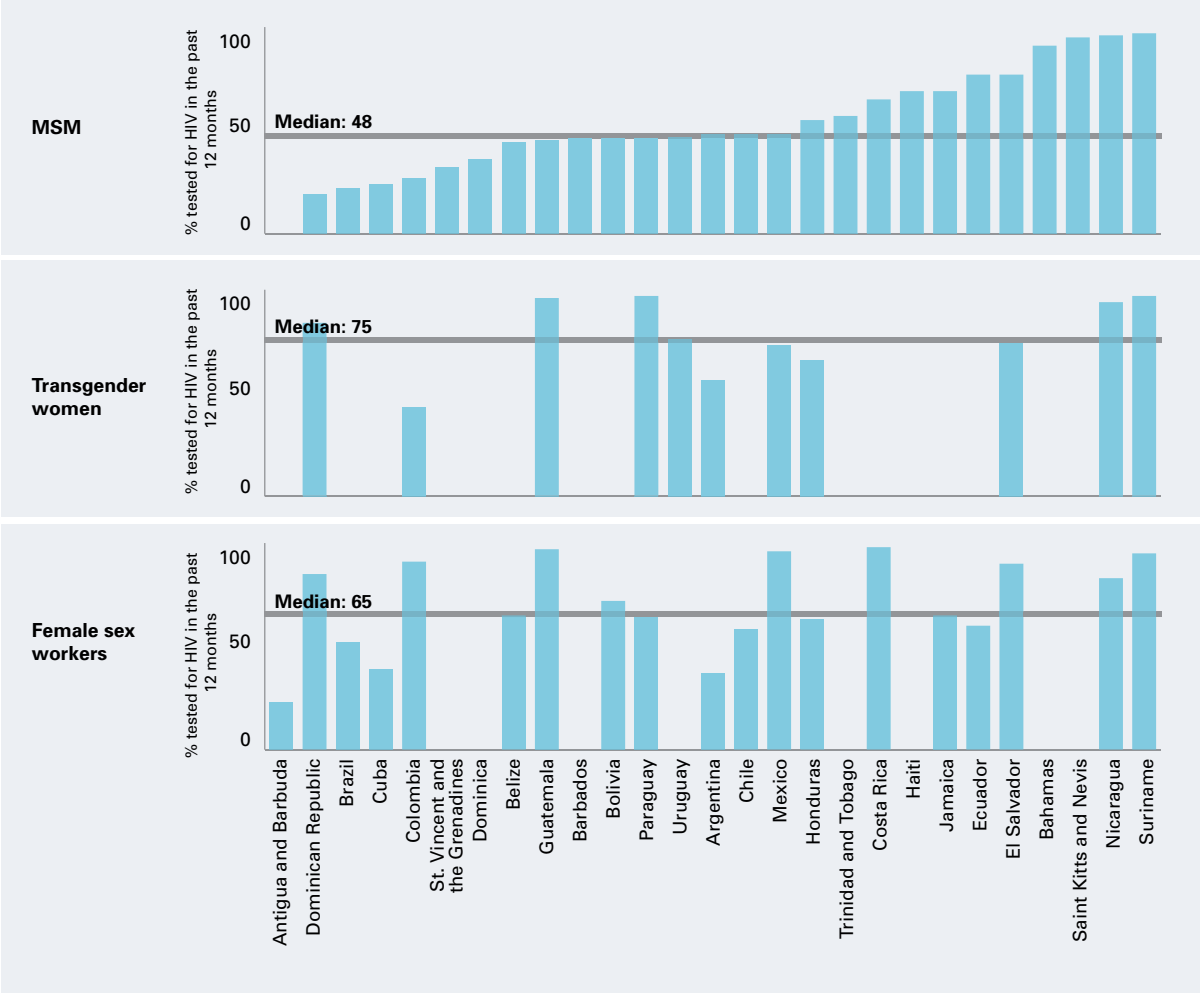
Significant improvements have been made in HIV-positive people's knowledge of their HIV status in LAC. In 2016, an estimated 81% [58%-89%] of people with HIV in Latin America knew their status and 64% [51%-74%] in the Caribbean. In both cases, improvements were observed over the previous year, when 77% and 57% of such people, respectively, knew their status.

The gaps in access to HIV testing among the key populations are still significant. Furthermore, many countries do not have data on testing for transgender women or FSWs. Some 88% of the countries have at least one figure for this indicator for MSM, 67% for FSWs, and 36% for transgender women. In most of the countries, this target is monitored through behavioral studies in the key populations, from whom data are obtained in some urban centers. Many countries (around one-third, or over 10) have received international financial assistance to conduct these studies.

One out of three diagnoses is late

The median HIV testing coverage in the past 12 months is 48% for MSM (with figures ranging from 5% in Peru to 19% in the Dominican Republic, and up to 95% or more

FIGURE 9 Percentage of men who have sex with men (MSM), female sex workers (FSW), and transgender women who have been tested for HIV in the past 12 months in Latin America and the Caribbean, most recent year available



Source: UNAIDS/WHO, Country reports, Global AIDS Response Progress Reporting, 2011-2016, and PAHO, Country responses to the HIV Prevention Survey, May 2017.
Note: Data from countries with program data, such as Guyana, Panama, and Peru, have not been included.

in Suriname and Saint Kitts and Nevis, according to program data), 65% for FSWs, and 75% for transgender women (with figures ranging from 43% in Colombia to over 95% in Guatemala and Paraguay) (*Figure 9* and *Table 3* of the Annex). The regional analysis of this information has limitations, since some countries (Guyana, Panama, Paraguay, and Peru) use data from the health care services. The results are not always representative of all the key populations, and there may be selection and information biases in the data reported, among other limitations.

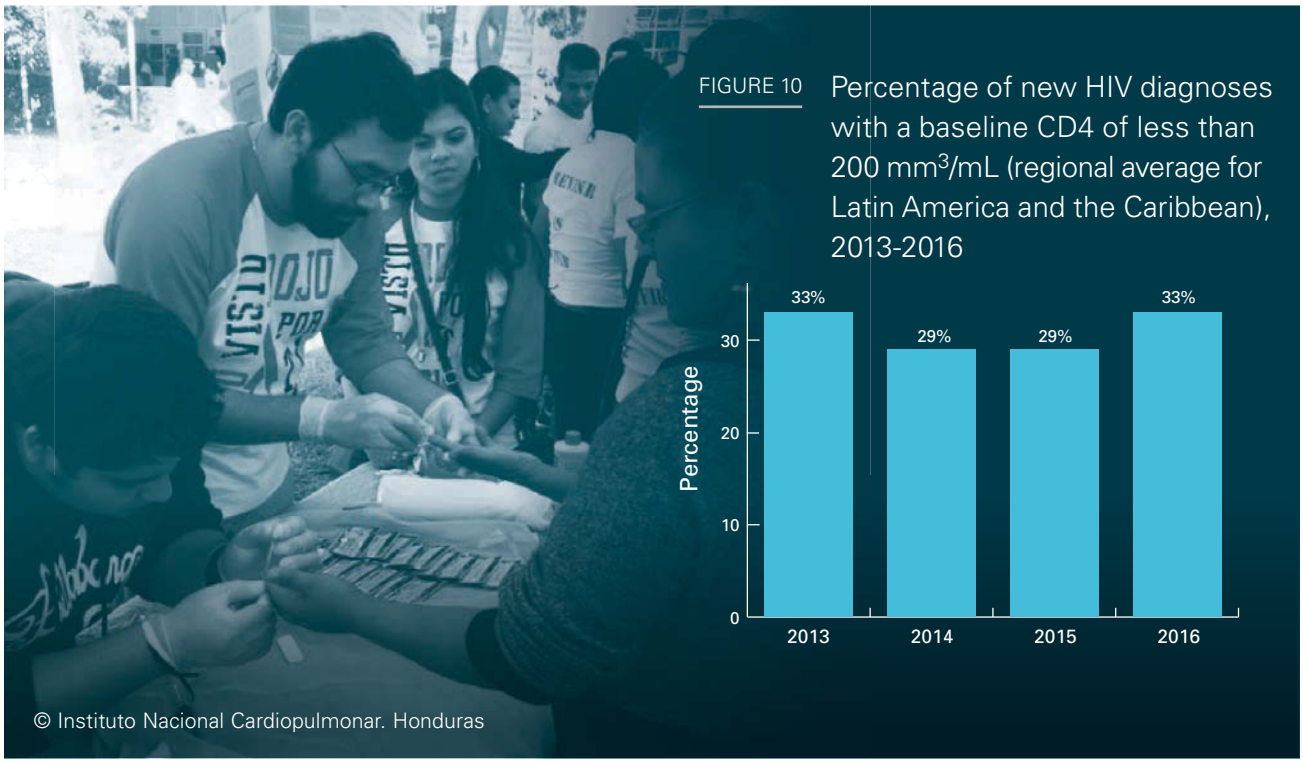
Another indicator for evaluating the degree of access to HIV testing is late diagnosis.[i] In LAC, one-third of cases are diagnosed late. The regional average has not changed substantially in the past four years (*Figure 10*).

Furthermore, in an analysis of the data by country, 59% (13/22) had the same or worse results in 2016, compared with 2015, while 41% (9/22) showed improvements.

Regionally, late diagnosis is more common in men (30% in 2016) than in women (19%). There were no substantial changes in this indicator for men in comparison with 2015. However, an improvement was seen in women (down from 24% in 2015).

In short, these data show that access to testing has improved. However, the gaps are still substantial and access is inadequate. Furthermore, the information systems in many countries do not contain information on testing disaggregated by the key populations. This makes it hard to measure inequities in access and timely

[i] The late diagnosis indicator is the percentage of HIV+ people who have a CD4 count of less than 200 cells/mm^3 in their first CD4 test.



Source: UNAIDS, WHO. Global AIDS Monitoring (GAM) and Country reports, Global AIDS Response Progress Reporting (GARPR), 2014-2016.

Regionally, late diagnosis is more common in men (30% in 2016) than in women (19%).

testing in these populations. The LAC countries face a series of barriers to providing adequate access and testing for the key populations, the most important of which are detailed below.

a. **Up-to-date algorithms and the use of rapid tests to increase access.** Countries such as Chile, Ecuador, Peru, Suriname, and Trinidad and Tobago are modifying their algorithms to optimize the testing process

Steps to overcome access barriers to HIV testing in Latin American and Caribbean countries

- Increase access to rapid tests at the point of care and provide a same-day result.
- Review and update HIV diagnosis algorithms, based on the WHO recommendations.[j]
- Increase the number of civil society-operated testing centers, in which the test is administered by trained non-professional providers, with flexible hours and appropriate locations.
- Evaluate sensitivity training strategies for health sector personnel who provide service for the key populations.
- Lower the age at which young people can obtain an HIV test without the consent of a parent or guardian, based on the Convention on the Rights of the Child.
- Take advantage of the opportunities offered by information and communication technologies to disseminate information about these services, their location, and hours of operation.
- Expand and geographically decentralize testing.
- Promote active involvement by the key populations in the public health services (for example, as peer counselors) as an effective approach that can also facilitate monitoring and provide feedback about the quality of the service (*10*).
- Expand and take advantage of private initiatives to market self-testing and link this with public health activities in HIV prevention and treatment.

Note: Based on the results of the national consultations.

[j] The WHO recommendations are available from: http://www.who.int/hiv/pub/guidelines/hiv-testing-services/en/ and http://www.who.int/hiv/pub/vct/hiv-self-testing-guidelines/en/.

and reduce waiting times to confirm a positive diagnosis. Simplification of the diagnosis algorithms can help yield reliable and timely results.

b. Decentralization of testing and use of diversified strategies to offer the test. Some 68% of the countries report that testing is offered in community centers. Some 43% of the countries (13/30) allow HIV testing to be done by trained individuals who are not health professionals (e.g., Argentina, Dominica, Guatemala, Jamaica, Mexico, and Paraguay). However, in countries that offer testing in community centers, the majority of tests in the country (90%) are done by health centers and only 10% by civil society organizations or private laboratories. That is, the number of tests done by community-based services or civil society organizations

KNOW YOUR STATUS

81%

of people with HIV know that they have it in **Latin America.**

64%

of people with HIV know that they have it in **the Caribbean.**

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is small and is normally in connection with grants from international donors.

c. **Distribution of centers that offer testing.** In the majority of the countries, these centers are concentrated in large cities. This creates problems for people living in communities far from urban centers.

d. **Hours of operation tailored to the needs of key populations.** Some 62% of the countries (16/26) offer services with flexible hours for HIV testing, generally provided by civil society organizations. Flexible hours enable the key populations to get tested at times that are more convenient for them—for example, late afternoons or evenings.

e. **Use of self-testing.** This type of test, which can increase the number of people who know their HIV status, is now on the market in different countries, including the Bahamas, Brazil, El Salvador, Jamaica, Peru, and Trinidad and Tobago. However, no government has yet documented a subsidized cost or using it to expand testing to hard to reach groups or to establish mechanisms to link people with the health services.

f. **Legal barriers.** The age of consent for a young person to seek HIV testing at the health services on his or her own is 18 in 61% of the countries.

g. **Procedures to ensure confidentiality and informed consent.** The written informed consent requirement persists in several countries. This can be a barrier to broadening access to HIV testing. WHO has noted that, in most settings, verbal consent is enough to obtain an HIV test (*11*).

> In the majority of LAC countries, the age of consent is 18 for young people to seek HIV testing on their own.

h. **Stigma and discrimination.** Ninety-two percent (24/26) of the countries provide sensitivity training for health workers involved in HIV screening for key populations. However, civil society organizations in 12 countries that participated in national consultations on HIV prevention reported a lack of sensitivity among these professionals. The factors associated with this situation may be:

- high rotation of human resources
- lack of mechanisms to monitor and evaluate the quality and results of training
- lack of investigation and follow-up of reports of mistreatment or institutional discrimination
- lack of mechanisms to encourage good practices and expand friendly services free of discrimination
- lack of involvement in training by individuals from the key populations.

PREVENTION AND CONTROL OF SEXUALLY TRANSMITTED INFECTIONS

According to WHO estimates (*12*), in 2012, 51 million sexually active people aged 15-49 in the Region of the Americas had an STI, making it one of the regions with the highest burden of disease, along with the African and Western Pacific regions. STIs affect health status because they cause acute disorders such as cervicitis, urethritis, and genital ulcers, in addition to serious complications and sequelae such as ectopic pregnancy, infertility, neurological and cardiovascular disease in adults, neonatal death, premature birth, and blindness or severe disability in infants. They also increase the risk of contracting and transmitting HIV (*7*).

STI diagnosis and treatment is part of the comprehensive package of services provided in combination HIV prevention.

In recent years, the Region has documented outbreaks and increases in the incidence and prevalence of STIs (*13*). Barbados has reported increases in syphilis in 2013 and 2014, again, especially in men (72%)—percentages that stabilized at high rates in 2015 and 2016 (*14*). Sentinel surveillance centers in Guatemala have also reported that positivity for active syphilis in MSM has increased more than 10-fold (from 0.9% in 2014 to 11.6% in 2016). In Mexico, the Institute of Public Health has also reported an increase in syphilis in some states (Yucatán, Campeche, Tabasco, etc.) (*15*). As in some countries outside the Region, there have been outbreaks of hepatitis A among gay men and MSM in Chile and Brazil, as well as the United States (Colorado and Michigan).

MSM and FSWs continue to exhibit a high burden of syphilis, with rates of 1%-27% in the case of gay men and MSM (*Table 4* of the Annex) and 0.5%-14% in FSWs (*Table 5* of the Annex), with figures that are higher and, in some cases, similar to the prevalence in pregnant women (*Table 6* of the Annex).[k] Considering the high vulnerability of the key populations

[k] The prevalence of syphilis in pregnant women receiving prenatal care in countries reporting active syphilis, ranges from 0.0% to 2.9%, with a median regional prevalence of 0.8%.

and their high STI burden, monitoring prevention efforts and their outcomes in these populations should be a priority in LAC.

Response to STIs in Latin America and the Caribbean

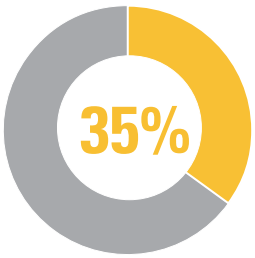
Latin America and the Caribbean are facing a resurgence of STIs in some population groups and an increase in gonococcal resistance to antimicrobial drugs (*16*). In response to the STI epidemics, the LAC countries have approved the *Plan of action for the prevention and control of HIV and sexually transmitted infections 2016-2021* (*17*), which is aligned with the *Global health sector strategy for sexually transmitted infections 2016-2021,* whose goal is to end STI epidemics as major public health concerns (*18*).

In recent years, great strides have been made in the STI response—for example, screening of pregnant women for syphilis and improved surveillance of congenital syphilis. There is a firm political commitment to achieve the dual elimination of mother-to-child transmission of HIV and syphilis (*19*), and to provide greater access to vaccination against the human papillomavirus. Almost 60% (16/27) of the LAC countries have national STI prevention and treatment strategies or plans, but fewer than half of them (11/27) indicate that they are consistent with the targets of the global strategy (to reduce the incidence of syphilis and gonorrhea by 90% by 2030, eliminate congenital syphilis, and guarantee over 90% HPV vaccination coverage). Only 63% of the countries (17/27) report having strategies to actively search for the contacts of people with an STI, although all of them (100%) report offering HIV screening and distributing condoms in STI treatment centers (*Figure 11*).

Furthermore, 88% (25/27) of the countries indicate that they have STI treatment guidelines, although only a little more than half (59%, or 16 out of 27) are consistent with WHO recommendations. In fact, only a minority (four countries) have updated their guidelines in the past two years, and more than half have not done so for over five years. In the absence of up-to-date national guidelines, health care providers sometimes follow the international recommendations of WHO or the CDC.

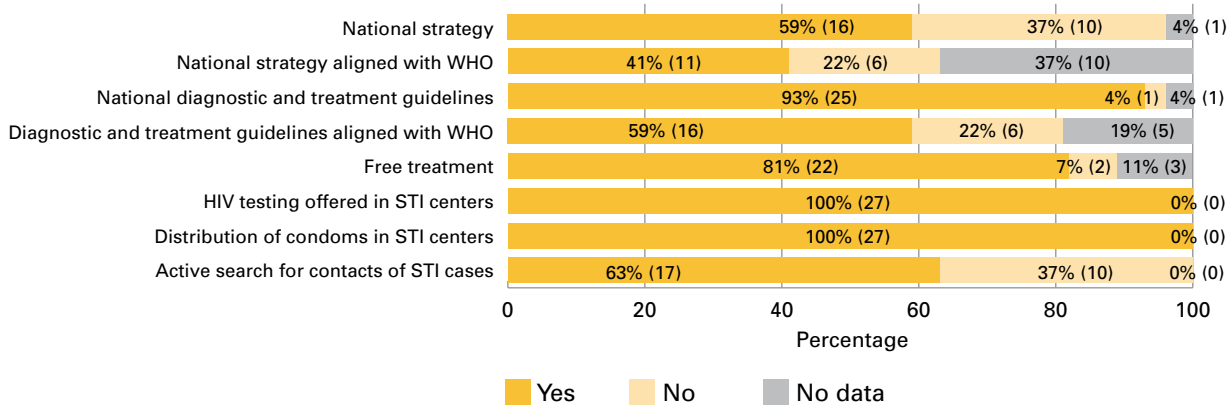
Rapid test for screening and diagnosis of syphilis

Some 66% of the countries (20/30) use rapid syphilis tests to screen and diagnose pregnant women, and 42% (13/31) report using them with the key populations (*Table 7* of the Annex).



of countries
do not test for syphilis when testing for HIV
among key populations.

FIGURE 11 Response to sexually transmitted infections in Latin America and the Caribbean, 2016, by percentage and number of countries



Source: PAHO. Country responses to HIV Prevention Survey, May 2017.
Notes: National strategy = national STI strategy.
National diagnostic and treatment guidelines= national guideline for the diagnosis and treatment of STIs.
Free treatment = Treatment of STIs in the public health services is free of charge.
The number of countries and territories in parentheses.

Surveillance of STIs in LAC countries

There are few data on STIs in LAC. Surveillance of these infections and response monitoring are inadequate, and even when surveillance systems are in place, they are sometimes characterized by deficient data and limited analysis and dissemination of the information.

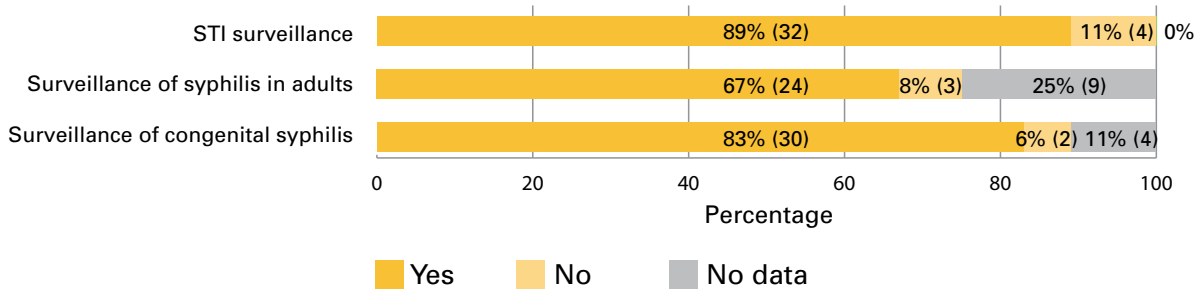
Some 89% (32/36) of LAC countries report having some type of STI surveillance, and 88% (22/25) have designated active syphilis as a reportable event. Reporting syphilis in adults makes it possible to detect outbreaks and adopt effective targeted prevention and control measures. Congenital syphilis is reportable in the majority of the countries (94%, 30/32); only Haiti and Bolivia do not require reporting of congenital syphilis cases (*Figure 12* and *Table 8* of the Annex).

The essential WHO recommendations for STI surveillance are based on four elements:

1. case reporting;
2. prevalence studies;
3. syndrome etiology studies; and
4. surveillance of gonococcal resistance to antimicrobial drugs.

Their purpose is to describe the epidemic, identify and quantify the most affected populations, improve program management and decision-making, and improve the quality of care and treatment (*20*).

FIGURE 12 Percentage and number of countries in Latin America and the Caribbean with surveillance of sexually transmitted infections, 2016, number of countries and territories



Source: PAHO. Country responses to the HIV Prevention Survey, May 2017; UNAIDS/WHO, Country reports, Global AIDS Response Progress Reporting 2016; PAHO, E*limination of mother-to-child transmission of HIV and syphilis in the Americas*, Washington, D.C., PAHO; 2016.
Note: The number of countries and territories in parentheses.

TABLE 7 Surveillance of gonococcal resistance to antimicrobial drugs in Latin America and the Caribbean, by country, 2016

Countries with systematic antimicrobial resistance surveillance	Countries without systematic antimicrobial resistance surveillance	
	Countries with limited data on antimicrobial resistance	Countries lacking data on systematic antimicrobial resistance surveillance
Argentina	Bolivia	Antigua and Barbuda
Barbados	Ecuador	Bahamas
Brazil	Panama	Belize
Chile	Venezuela	Costa Rica
Colombia		Dominica
Cuba		Ecuador
Dominican Republic		Grenada
El Salvador		Guatemala
Paraguay		Guyana
Peru		Haiti
Suriname		Honduras
Uruguay		Jamaica
		Mexico
		Nicaragua
		Panama
		Saint Kitts and Nevis
		Saint Lucia

Source: PAHO. Data from the Latin American AMR Surveillance Network, 2009-2015.
PAHO. Country responses to the HIV Prevention Survey, May 2017.

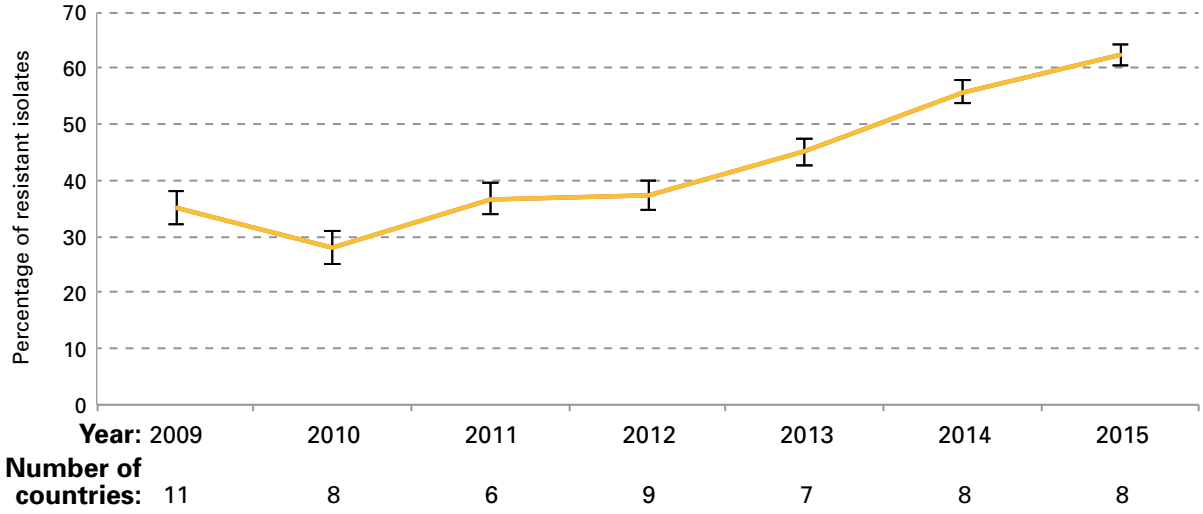
Treatment of gonococcal infection and antimicrobial resistance (AMR)

Of all the STIs, gonorrhea is the most antibiotic-resistant. This resistance has rapidly increased in recent years, reducing treatment options, and it varies with the different strains of *Neisseria gonorrhoeae*, making local surveillance essential to drafting guidelines for proper treatment. Cases of multi-drug-resistant *N. gonorrhoeae* have recently been detected that are unresponsive to monotherapy with broad-spectrum cephalosporins. WHO has published gonorrhea treatment recommendations suggesting that the choice of treatment in each country be determined by the local resistance data obtained through systematic resistance monitoring (*21*).

In LAC, 36% of the countries that provided information (12/33) conduct systematic surveillance of gonococcal resistance to antimicrobial drugs (*Table 7*). Furthermore, according to the country data reported through the Latin American AMR Surveillance Network (ReLAVRA), ciprofloxacin resistance has steadily grown, with isolates increasing from 35% in 2009 to 62% in 2015 (*Figure 13*). Moreover, reduced sensitivity to broad spectrum cephalosporins and macrolides is beginning to emerge (*Figure 14*).

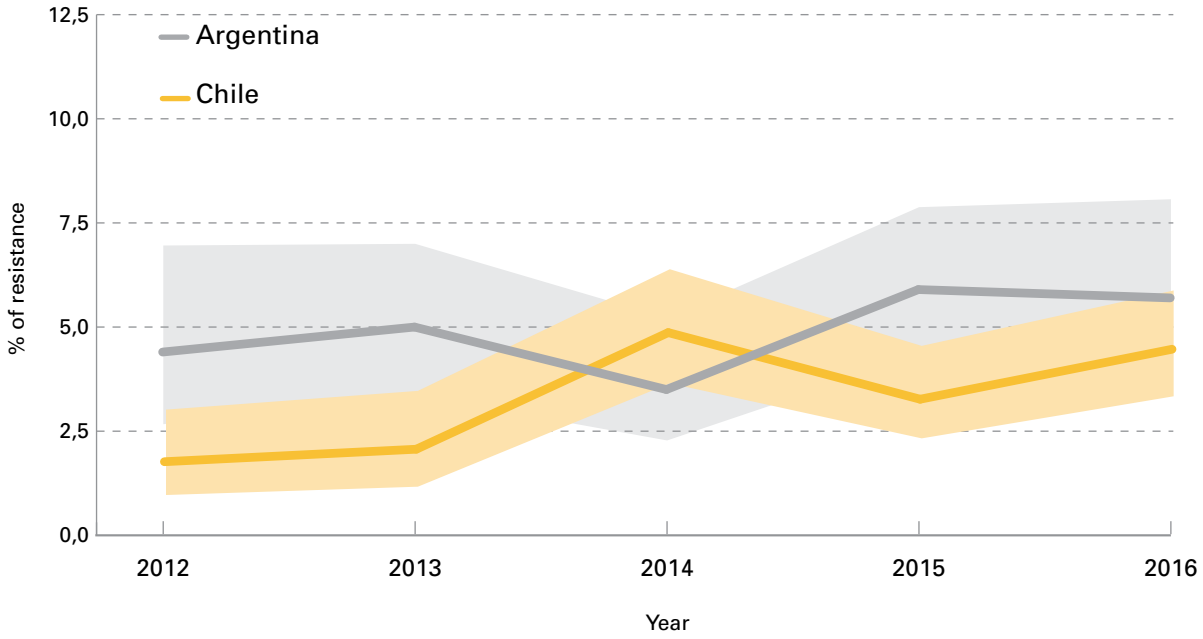
With regard to gonorrhea treatment guidelines, only 8% of the countries (2/24) report the use of ceftriaxone plus azithromycin, as recommended in the WHO guidelines; more than half (67%, 16/24) report the use of ceftriaxone or ciprofloxacin as the treatment of choice (*Table 8* and *Figure 15*).

FIGURE 13 Percentage of ciprofloxacin resistance in *Neisseria gonorrhoeae* isolates, Latin America and the Caribbean, 2009-2015



Source: PAHO. Data from the Latin American AMR Surveillance Network, 2009-2015.

FIGURE 14 Percentage of azithromycin resistance in *Neisseria gonorrhoeae* isolates, Argentina and Chile, 2012-2016



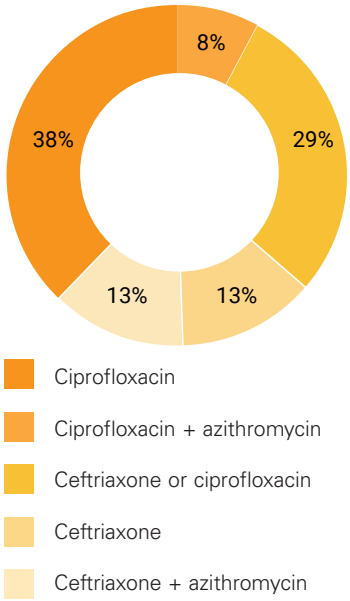
Source: PAHO. Data from the Latin American AMR Surveillance Network, 2009-2015.

TABLE 8 Drugs for gonorrhea treatment indicated in treatment guidelines of Latin American and Caribbean countries

Antibiotic	Number of countries indicating it as the treatment of choice
Ceftriaxone	9
Ceftriaxone + azithromycin	2
Ceftriaxone or ciprofloxacin	7
Ciprofloxacin	3
Ciprofloxacin + azithromycin	3

Source: PAHO. Country responses to the HIV Prevention Survey, May 2017.

FIGURE 15 Percentage of countries by treatment plan indicated for gonorrhea, Latin America and the Caribbean, 2016



PRE-EXPOSURE PROPHYLAXIS (PrEP)

Pre-exposure prophylaxis or PrEP is the use of antiretroviral drugs for HIV prevention in seronegative people. WHO currently recommends the use of regimens that include oral tenofovir (e.g., tenofovir and emtricitabine), a drug widely used throughout the world for HIV treatment.

WHO (*22, 23*) recommends offering PrEP to people at high risk of contracting HIV as an additional intervention from the package of combination prevention interventions. This is a strong recommendation based on high-quality evidence.

Clinical trials and acceptability studies throughout the world show:

- high effectiveness of PrEP in preventing sexual transmission of HIV in different populations;
- high degree of acceptance among potential users, especially if prophylaxis is subsidized or affordable;
- low impact of PrEP in terms of emergence and transmission of resistant viruses in the population (risk of resistance is higher in people who begin PrEP during the window period or acute infection period);
- as yet inconclusive data on increase in risky behavior among users (greater number of sexual encounters without use of condoms); i.e., risk compensation effect has not been demonstrated; and
- greater connection of PrEP users who exhibit high-risk behaviors with HIV and STI prevention services: increase in HIV and STI testing and greater access to

PrEP is the use of antiretroviral drugs for HIV prevention in seronegative people.

prevention measures (use of condoms and lubricants, behavioral management/risk reduction methodologies, sexual health services, etc.).

In July 2017, WHO published a tool (*24*) for implementing PrEP programs with suggestions for the introduction and use of PrEP based on the available evidence and experience. This document includes information not only for clinicians, but for educators and activists, counselors, opinion-makers, pharmacists, regulatory agencies, planners and evaluators, HIV test providers, and PrEP users themselves.

Basic clinical elements for PrEP (WHO, 2017)

Indications for PrEP (by history over the past 6 months):
HIV-negative **and**
Sexual partner with HIV who is not virally supressed, **or**
Sexually active in a high HIV incidence/prevalence population **and** any of the following:

- Vaginal or anal sexual intercourse without condoms with more than one partner
- A sexual partner with one or more HIV risk factors
- A history of a sexually transmitted infection (STI) by lab testing or self-report or syndromic STI treatment
- Use of post-exposure prophylaxis (PEP)
- Requesting PrEP.

Contraindications:
HIV-positive
Estimated creatinine clearance <60 ml/min.
Signs/symptoms of acute HIV infection, probable recent exposure to HIV.
Allergy or contraindication to any medicine in the PrEP regimen.

Rx: for example, TDF 300 mg + FTC 200 mg PO daily.

Counselling: Link tablet use with a daily routine.
Develop a plan for contraception or safer conception and for STI prevention.

Follow-up:
Among other aspects:
Every 3 months: HIV test, check STIs, assess PrEP indications and use.
Every 6 months: creatinine clearance.

Source: WHO implementation tool for pre-exposure prophilaxis (PrEP) of HIV infection. Module 1: Clinical. 2017.

PrEP in Latin America and the Caribbean

The use of PrEP as an intervention in HIV prevention packages is considered critical to the prevention response in LAC. Thus, having PrEP pilot projects in the countries is a first step, which is why it was set as a regional target in 2015 (see *Table 1*).

PrEP implementation has been slow (*25*) but is occurring in pilot demonstration projects for its adoption. It is also being offered in the public health services of the Bahamas and will soon be available in Brazil and Barbados (*Table 9*). The target of 10 projects is about to be reached. Seven countries are already planning public PrEP programs or projects with various modalities and sources of financing.

Barriers to implementation of PrEP in public health services in Latin America and the Caribbean

Barrier	What is being done?
A high degree of ignorance about PrEP among the various actors in national and civil society programs.	Networks of experts are conducting online sessions on PrEP for different audiences to disseminate the new WHO recommendations and information about implementation experiences. This is done through the NEMUS platform and regional PAHO meetings. Individuals from civil society have developed an online PrEP literacy project called *Quiero Prep* [*I Want Prep*].[I]
Bias or moral judgments about the use of PrEP and its impact with respect to risk compensation and the incidence of STIs.	Global and regional efforts are underway to document the impact of PrEP on the incidence of STIs (medium- and long-term), including the potential reduction in these infections through the early detection and treatment of STIs in people undergoing regular monitoring
Budget gaps in national programs (for example, in the provision of antiretrovirals), which could delay implementation of this intervention.	The governments, with support from their partners, are taking action to lower costs, for example: • Access to WHO prequalified generics through the PAHO Strategic Fund, which could lower the cost of the drugs to less than US$8 per month per user. • Inclusion of PrEP in the prevention services for key populations, which lowers the cost to the health system.

Source: PAHO. Key informants at 12 national meetings on prevention, 2017.

[I] *Quiero PrEP* is available online at https://www.quieroprep.org.

TABLE 9 PrEP in public health services in Latin America and the Caribbean, 2017

Country	Area	Financing	Type of intervention, study, or program	Situation in August 2017
Bahamas	National	Ministry of Health	Program for distributing PrEP to serodiscordant couples and MSM in the public sector	*Implemented* Scope limited for the time being
Barbados Brazil	National	Ministry of Health	Program for distributing PrEP to the high-risk population in the public sector	*In planning* for the second half of 2017
Brazil Chile Dominican Republic Guatemala Haiti Jamaica Mexico Paraguay Peru	Local	UNITAID financing (ImPrEP Project) (Brazil, Mexico, Peru) International donors (PEPFAR, Global Fund, etc.) (Dominican Republic, Guatemala Haiti, Jamaica, Paraguay) or Ministry of Health (Chile)	Demonstration projects	*In planning* for the second half of 2017 (ImPrEP Project) or the first quarter of 2018
Ecuador Dominican Republic Guatemala Paraguay	Local	User-financed	Initiative of civil society organizations in community centers	*In planning* In Ecuador. *Implemented* in Guatemala, the Dominican Republic, and Paraguay
Argentina Barbados Chile Peru*	Local	User-financed	Private physicians' offices	*Implemented*
Costa Rica Grenada Guatemala Saint Lucia Suriname	National	Ministry of Health	Provided only to serodiscordant couples	*Implemented*

Source: PAHO. Direct information from the countries to PAHO. PrEP Network.
Notes: * There may be more countries where PrEP can be obtained by prescription from private physicians.
Dates in the table are approximate.

Several key informants have indicated that the number people who use PrEP outside the health sector has increased, a phenomenon known as "PrEP in the wild." These users purchase the PrEP drugs in pharmacies and drugstores inside and outside the country or on the Internet, or else they obtain them through friends in social settings and self-administer them. This type of access does not guarantee compliance with the recommendations regarding interventions, including, for example, providing information about their use, helping the patient continue treatment, monitoring side effects, and going for regular HIV and STI testing. Moreover, it does not enable national programs to monitor its use and outcomes. Other users obtain PrEP by prescription from a private physician, making it difficult to ensure the quality of care and adherence to national protocols and guidelines, which in many cases are still lacking.

POST-EXPOSURE PROPHYLAXIS (PEP)

What is PEP?

Post-exposure prophylaxis (PEP) is the short-term use of antiretrovirals to reduce the probability of contracting HIV after potential exposure, either occupational (through a work related accident) or non-occupational (for example, during unprotected sex, rape, or the use of contaminated injection supplies). It should be administered within 72 hours of exposure.

All the countries provide PEP, either in primary care centers or emergency services for occupational exposure and rape. Some 39% (11/28) of the countries have adopted the WHO recommendation to provide PEP in cases of risk from unprotected sex (e.g., ruptured condom). Forty-two percent of the countries (11/26) stated their intention to increase the use of PEP, expanding the prescription criteria or the number of centers that offer it.

The most important measures for taking full advantage of PEP as a combination prevention strategy are as follows:

39% of LAC countries have adopted the WHO recommendation to provide PEP in cases of risk from unprotected sex

- Consider PEP an additional intervention of a combination prevention package that can be used to identify people in need of HIV prevention services and connect them with care. For example, a history of using PEP due to high-risk sex is a criterion for offering PrEP, according to the WHO recommendations.

Specific indications when offering post-exposure prophylaxis, based on WHO recommendations

Post-exposure prophylaxis should be offered and begun as soon as possible for people exposed to the risk of HIV transmission—ideally within 72 hours of exposure.

Whenever possible, eligibility for PEP should be assessed on the basis of the HIV status of the source. This can include consideration of HIV prevalence, the individual's history, and local epidemiological patterns. PEP should be prescribed with the informed consent of the patient, who should be apprised of its risks and benefits through a dialogue that includes information about its potential side effects and the importance of strict adherence to the treatment for the 28 days of PEP.

Exposures that do not require PEP include:

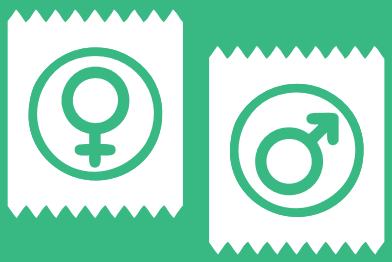
- When the person exposed is already HIV-positive.
- When the source of the exposure is HIV-negative.
- When the exposure is to bodily liquids that do not pose a significant risk, such as tears, saliva not spotted with blood, urine, and sweat.

Source: WHO. Guidelines on post-exposure prophylaxis for HIV and the use of co-trimoxazole prophylaxis for HIV-related infections among adults, adolescents and children. Recommendations for a public health approach - December 2014.

- Increase the availability of PEP in smaller health centers and centers far from major cities.
- Improve knowledge about PEP among non-specialist health workers and key populations.
- Eliminate or reduce red tape to facilitate the provision of PEP within 72 hours of exposure (some countries require a police report or review by a medical examiner to offer PEP).
- Expand the criteria for prescribing PEP, based on the WHO guidelines.

Countries that offer PEP for **consensual high-risk sex**

USE OF CONDOMS AND LUBRICANTS



Condom use is critical for an effective integrated and sustainable approach to HIV prevention, and promoting it should remain a priority. The countries have made a commitment to promoting condom use to ensure that by 2020, 90% of FSWs report having used a condom with their most recent client. In the case of MSM and transgender women, the target is for 90% of them to have used one in their most recent anal sex with a male partner.

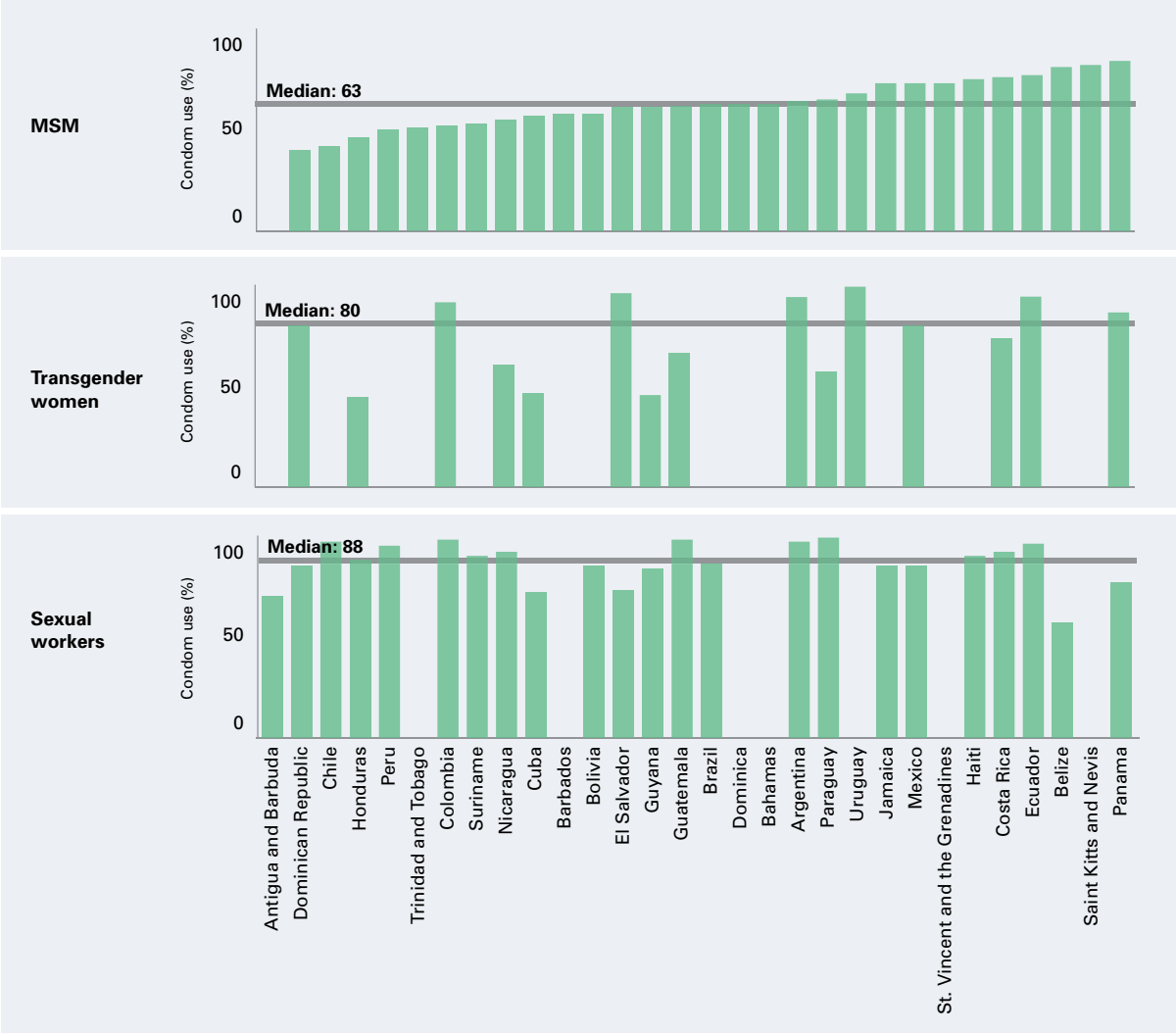
According to the latest available data in LAC, the regional median for condom use among MSM in their most recent sexual encounter is 63%; among FSWs, 80%; and among transgender women, 88%.

These data may include biases related to the representativeness of the study sample, differing definitions, the fact that the studies are often conducted in just a few urban areas (such as capital cities), a very lengthy interval between the years they were conducted, the methodology used in reporting the data, or other aspects related to the measurement indicator itself.

If data on the key populations seen in the services are used, the fact that these populations sometimes use these services to obtain condoms would make the result abnormally high due to selection bias. This indicator measures condom use in an individual's most recent sexual encounter and is a proxy or indirect indicator of systematic use. However, it can overestimate systematic and timely use (*Figure 16* and *Table 9* of the Annex).

One-third of LAC countries reported procuring condoms with domestic resources.

FIGURE 16 FSWs who report having used a condom with their most recent client, and MSM and transgender women who report having used one in their most recent anal sex with a male partner (%), most recent year available



In the key populations, it is essential to increase the availability, access, affordability, and use of the necessary number of male and female condoms and compatible lubricants through targeted distribution that supports proper and systematic use. Another priority is to promote access to condoms and lubricants by people who lack the resources to purchase them (*7*).

According to the representatives of civil society organizations, in many countries the number of condoms distributed to MSM, FSWs, and transgender women is considered inadequate.

All LAC countries report providing free condoms (29/29) to MSM, and 28 out of 29 also provide them to FSWs. In the case of transgender women, 24 out of 28 countries report that they have distribution targeted specifically to this group. All the countries that provided information distribute free condoms to young people. However, according to the representatives of civil society organizations, in many countries the number of condoms distributed to MSM, FSWs, and transgender women is considered inadequate. The calculations for estimating the number of condoms and lubricants that should be procured are sometimes not tailored to the needs of the key populations or do not follow proven standard methodologies for this purpose.

The majority of the countries (25/28) report distributing lubricants. Colombia, Paraguay, and Venezuela do not distribute them to the key populations. In many countries, they are provided only by Global Fund projects, and eight countries (of the 26 that provided information) indicate that they do not distribute lubricants to young people.

One-third of the LAC countries (8/28) reported procuring the condoms with domestic resources. The rest provide condoms and lubricants with resources from the Global Fund or the U.S. government, primarily for those

distributed to the key populations, as part of a prevention package.

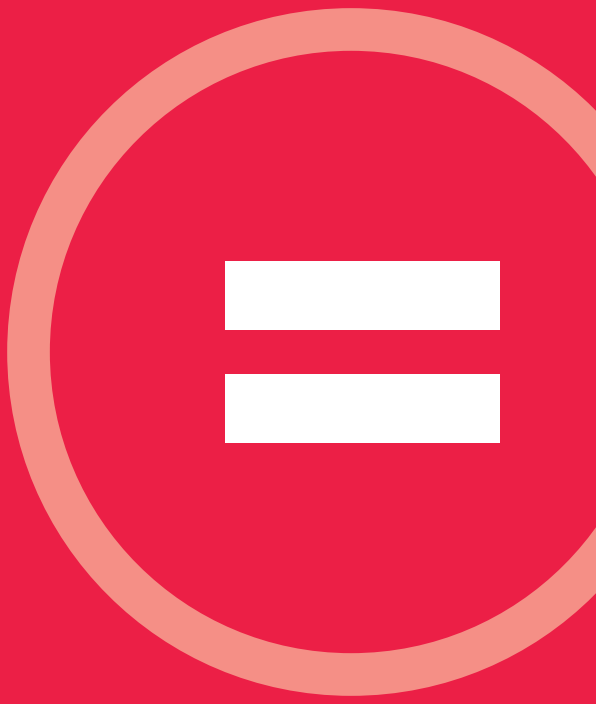
Condoms are distributed mainly by the public health system as supplies for sexual and reproductive health programs. A smaller percentage (2%-35%) of condoms are distributed to the key populations by civil society organizations.

There are wide gaps in condom access and use, especially among the MSM population. This indicates the need to address the barriers to proper and systematic condom use and to offer complementary HIV prevention measures, such as PrEP.

Results of national consultation on barriers to condom access and use

- **Bureaucratic red tape hinders distribution:** In some countries, condoms must be distributed by a health worker following the presentation of a prescription, completing forms or using a book of coupons. Furthermore, the supply is sometimes restricted to certain health centers.
- **Continuous access:** Users must go to a center or organization every month to obtain a specific quota of condoms.
- **Lack of confidentiality:** The control, audit, monitoring, and evaluation methodologies of the many programs for distributing condoms and lubricants require users to provide their personal information.
- **The quantities distributed are not consistent with the needs of the key populations.**
- **Quality of the condoms distributed:** The condoms distributed by the ministries of health are sometimes of inferior quality.
- **Failure to provide lubricants.**
- **Failure to perceive risk and lack of knowledge among some key subpopulations.**

OVERCOMING STRUCTURAL BARRIERS



The HIV epidemic, particularly in the key populations, is exacerbated by stigma and discrimination, gender-based inequality, violence, lack of community empowerment, human rights violations, and laws and policies that criminalize different groups of people based on their sexual orientation or gender identity (*7*). These factors hinder adequate access to health services, the way in which the services are provided, and the effectiveness of the services. Vulnerability to HIV is heightened if people are unaware of the available HIV prevention services or how to exercise their human rights.

The HIV response should consider the political, geographical, cultural, and social context that affects the risk of infection with the virus and access to services. The structural barriers (*26*) that hinder access to these services have been identified in the majority of the countries and can be summarized as:

- criminalization of behaviors that define the key populations (homoaffective practices, sex trade, illegal drug use, etc.)
- criminalization of HIV transmission, nondisclosure, and exposure
- legal frameworks and discriminatory practices
- ignorance of rights, national laws, and international treaties
- stigma and discrimination
- gender violence, including violence that occurs in institutional settings.

A series of critical environment facilitators have been identified to address and overcome most of these structural barriers:

- review of laws, policies, and practices
- reduction of stigma and discrimination
- community empowerment
- violence prevention

Effective implementation of critical facilitators requires collaboration among different sectors, including health, justice, housing, welfare, labor, and other sectors. It is also necessary for multiple stakeholders to work with the government, including civil society, the private sector, and people with HIV.

Review of laws, policies, and practices

According to the GAM country reports, 10 countries (Bahamas, Bolivia, Colombia, Cuba, Dominican Republic, El Salvador, Mexico, Panama, Suriname, and Venezuela) report the existence of laws that criminalize transmission, nondisclosure, and HIV exposure. Seven more (Belize, Costa Rica, Grenada, Guatemala, Honduras, Jamaica, and Peru) do not have a specific law criminalizing HIV but have enacted other criminal legislation on HIV transmission, nondisclosure, and exposure.

Five countries (Antigua and Barbuda, Dominica, Grenada, Jamaica, and Saint Lucia)

Example of civil society empowerment and good practices to address stigma and discrimination against the key populations

RedTraSex is a network of local and national sex workers' organizations that operates in 15 Latin American and Caribbean countries. In 2012, the network launched an HIV prevention program for FSWs through interventions for national defense workers. The program focused on three main activities:

- Capacity building for promoting the rights of FSWs and access to quality health services (including the design of policies, a review of the legal framework, and the participation of FSWs in national and regional policy debates to fight stigma and discrimination).
- Implementation of activities to reduce violence and discrimination.
- Institutional capacity building.

RedTraSex has reached 17,306 FSWs through this methodology and held sensitivity training for 1,259 health workers in 14 countries. It has also produced a guide for health systems on good practices with FSWs. FSWs have participated to a greater extent in parliamentary debates. The principal changes brought about by these interventions are greater visibility of the problems facing FSWs (at the national and regional levels through their participation in the Organization of American States), improvements in the quality of care provided to them in health facilities, and the agreements signed with formal health systems.

Source: UNAIDS. Communities Deliver; 2015. Available from: http://www.unaids.org/sites/default/files/media_asset/UNAIDS_JC2725_CommunitiesDeliver_en.pdf.

report that MSM run the risk of prosecution and prison. Civil society organizations in nine countries have reported cases of people who have been arrested or prosecuted in the past three years because they had sex with people of the same sex.

Six countries report that sex work is considered criminal behavior (Antigua and Barbuda, Bahamas, Barbados, Dominica, Grenada, and Jamaica) and four describe the partial criminalization of sex work (Bolivia, Costa Rica, Mexico, and Suriname). Civil society organizations in 15 countries report that female and male sex workers have been arrested or prosecuted for their sex work in the past three years.

Although no government reports the criminalization of transgender people, in the GAM reports, civil society organizations in nine countries (Antigua and Barbuda, Argentina,

Costa Rica, the Dominican Republic, Honduras, Mexico, Paraguay, Peru, and Venezuela) state that in the past three years, transgender people have been arrested or prosecuted for activities related to their gender identity.

Of the 24 countries that provided information, 10 (Brazil, Colombia, Costa Rica, Dominica, Haiti, Honduras, Panama, Saint Lucia, Saint Vincent and the Grenadines, and Trinidad and Tobago) described access barriers to justice facing key populations and people with HIV. Some examples include barriers erected by the judicial system itself, which does not guarantee confidentiality; lack of trust in the judicial system; lack of sensitivity on the part of justice officials; and ignorance of judicial procedures.

- Community empowerment and *greater involvement of people living with HIV* (GIPS) (*27*) are guiding principles for HIV programs and activities. GIPS is a principle aimed at enabling people with HIV to exercise their human rights and responsibilities, including the right to health and to participate in decisions that affect their life. Similarly, community empowerment is a social process that enables the key populations to address the structural limitations to health, human rights, and well-being to promote change, improving their health and well-being and increasing their access to health services.[m] Community empowerment broadens the scope and improves the effectiveness of services for the key populations (*28*).

One of the commitments assumed as part of the follow-up to the U.N. Political Declaration on HIV/AIDS in 2016 (*29*) was to empower people living with HIV, at risk of contracting it, or affected by it to know their rights and have access to justice and legal services in order to prevent and report human rights violations. In the past two years, 17 countries have reported having extensive training and capacity-building programs for people with HIV and the key populations to educate them and make them aware of their rights.

Addressing stigma and discrimination in the health services[n]

The goals established in the WHO Global Health Sector Strategy on HIV/AIDS 2016-2021:

- End policies and practices that reinforce stigma and discrimination (especially in health care settings), particularly for people living with HIV and key populations.
- Create institutional and community environments that make it safe for people to access HIV services without fear of discrimination, involving communities in the planning and delivery of services.

In this regard, the Joint United Nations Statement on Ending Discrimination in Health Care Settings demonstrates the commitment of

[m] Community empowerment is the individual and collective ownership of programs in order to achieve the most effective HIV responses and take concrete action to address social and cultural barriers to their broader health and human rights (WHO. Implementing comprehensive HIV/STI programmes with sex workers: practical approaches from collaborative interventions. Geneva; 2015. Available from: http://www.who.int/hiv/pub/sti/sex_worker_implementation/en).

[n] Definition of discrimination: Any action or omission by an individual or institution (for example, in the health sector) that produces and reproduces inequalities in access to resources and services (*Diccionario de la lengua española*. 23rd edition. Madrid, Spain).

Factors affecting institutional discrimination in the health sector and substandard practices in interactions with key populations in Latin America and the Caribbean

Discrimination and poor practices

Denial of services: Situations have been reported in which health professionals have refused service to individuals or have unjustifiably referred them to another department.

Disrespect: Disrespectful behavior, abuse, dehumanized care, or a hostile attitude among health workers—for example, the use of insensitive language, referring to trans people as male, or joking about them with colleagues.

Failure to offer specific and comprehensive services: Some health professionals focus only on offering HIV and STI testing to these populations, without considering other sexual or mental health issues.

Violation of confidentiality, anonymity, and consent: Some coercive situations in HIV testing were mentioned, along with services that cannot guarantee user anonymity or confidentiality.

Failure to follow regulations or protocols: Many countries in LAC have adequate protocols, procedures, and algorithms to guide interventions with the key populations; however, it has been reported that some health workers do not follow them.

Prejudice or moralizing: Some service users from these groups are subjected to lectures that morally judge their behavior and practices.

User ignorance of regulations and practices: The key populations agree that ignorance of their rights and local regulations is a barrier to exercising their rights in the health services.

Lack of friendly sexual health services with flexible hours of operation.

Note: Factors indicated by participants in the national consultations on HIV prevention in May-June 2017.

UN entities to working together to help Member States adopt coordinated multisectoral measures to eliminate discrimination in health care settings.

According to representatives of the key populations, health services are not welcoming and in some cases, abusive, which explains why the demand among these groups is very low. This unfriendly attitude is one of the main barriers to timely access to HIV and STI diagnosis and treatment in the key populations. These informants also identify the main facilitators of discrimination in the health sector as the lack of sensitivity training for health professionals; ignorance among health professionals and users about rights and current laws and regulations; inconvenient hours of operation; the institutional

Participants' recommendations in national consultations to improve services for the key populations and make them user-friendly

- Ensure integrated health services and include task shifting among providers.
- Create flexible program hours with regular and reliable services tailored to the users.
- Strategically locate services where the key populations are concentrated or in places that they frequent.
- Involve the community and, above all, the key populations, in the development, promotion, delivery, monitoring, and evaluation of the services.
- Train staff to work with different key populations at all levels of the health services and monitor and evaluate sensitivity training.
- Adopt measures to ensure that law enforcement activities do not interfere with access to HIV services.
- Promote public-private services connected with community services for care of the key populations.
- Promote the creation of observatories and ombudsmen in health districts.
- Inform the key populations about their rights and the remedies available to them when those rights are violated. Widely disseminate information on the complaint and grievance mechanisms available inside and outside the health center.

behavior of health center professionals and authorities; bias among professionals; difficulty lodging complaints and grievances; and, in some cases, the failure to recognize civil society organizations as key partners in improving services.

A number of civil society organizations in 25 LAC countries reported having a mechanism for reporting discrimination and human rights violations in health care settings, such as reporting procedures, compensation mechanisms, and grievance procedures or systems to protect and respect patient privacy or confidentiality.

A full 97% of the countries reported having sensitivity training for health workers who offer HIV testing to people in the key populations. However, given the way it is carried out, many stakeholders and studies question the effectiveness of these interventions in eliminating stigma and discrimination in the health services against

Types of discrimination against FSWs and recommendations to address stigma and discrimination against them in the health services

According to the RedTraSex study in LAC (*33*), 75% of FSWs obtain care through the public health system, where they have encountered the following types of discrimination:

- Hostile treatment, unjustifiable delays in care, and being treated as infectious agents of HIV and STI.
- Value judgments that include the use of disparaging, humiliating, or prejudiced language, and the equating of sex work with crime.
- Health services centered on gynecological and STI monitoring, neglecting other aspects of comprehensive health care or aspects associated with the particular working conditions of FSWs.
- Violation of the right to privacy and confidentiality.
- Hours of operation not compatible with sex work.

The general recommendations formulated by FSWs are the following (*34*):

1. Promote greater access to consultations, better hours of operation, and access to the diagnosis and treatment of gynecological emergencies.
2. Respect the decisions of each sex worker, steering clear of value judgments about the profession.
3. Provide ample and complete information to let them make their own decisions about their body and their sexual and reproductive health.

the key populations (*30-32*). Based on the comments of consultation participants, these training activities are neither monitored nor evaluated, and high staff turnover means that many health workers do not receive any training. The participants considered the strategy of hiring peer counselors and community navigators to be successful, as these individuals improve knowledge and understanding of the needs of each population and provide ongoing sensitivity training and interventions that actively involve the key populations and people living with HIV in the design, implementation, and evaluation of health services. For example, the sensitivity training conducted by organizations of the key populations, such as RedTraSex, have been successful in reducing discrimination in the health services. In addition, the programs need policies and codes of conduct to discourage stigma and discrimination. Government and

civil society representatives described protocols, resolutions, and standards for preventing and penalizing discrimination. However, many health professionals, center administrators, and users were unaware of their existence or how to apply them.

End violence against the key populations

Violence against the key populations heightens the risk of HIV and STI[o] exposure (*35*). Multiple structural factors influence the vulnerability to violence, including discriminatory laws, institutional repression, cultural and social norms that legalize stigma and discrimination, as well as their coexistence with the activities of groups operating outside the law (for example, gangs in Central America). There are high rates of reported verbal and physical violence against FSWs and transgender women that sometimes result in death (*36*), as well as high rates of homophobic violence. For example, according to the Observatory of Murdered Trans People, 2,016 transgender people were murdered in the period 2008-2015, 1,573 (78%) of them in LAC (*37*). This reflects the gravity of the violence and crimes against trans people, which are correlated with the prevalence of HIV, late diagnosis of HIV, and the high level of mortality in this population.

Civil society organizations and national programs are working to reduce violence against the key populations and create an enabling environment that promotes physical, sexual, and emotional well-being, in addition to safety. There is an inherent constraint, however: health programs and services fall under the ministries of health, while uniformed personnel and programs to fight organized crime are under another portfolio. The directors and technical personnel of the programs consulted agree that lack of coordination among ministries and programs is a major constraint.

The critical facilitators for mitigating violence include: 1) mechanisms for documenting and monitoring violence; 2) training people in the key populations, people with HIV, and other stakeholders to understand human rights; and 3) strengthening intersectoral efforts to promote responsibility among law enforcement personnel to prevent violence and human rights violations.

As part of the efforts to prevent institutional violence in the health sector, it will be necessary to review policies and procedures for the application of standards, provide sensitivity training for professionals, train the key populations, and create human rights oversight mechanisms.

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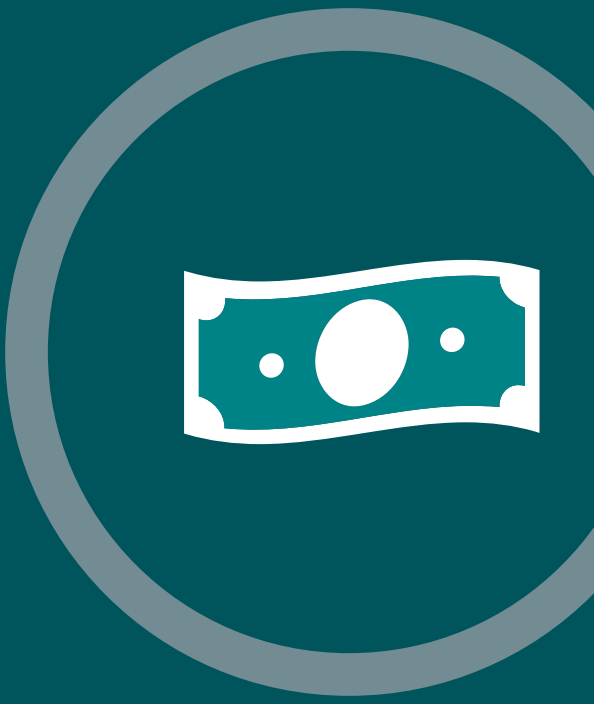
[o] The Inter-American Commission on Human Rights (IACHR), the Inter-American Commission of Women (CIM), UNAIDS, and PAHO call on OAS Member States to eradicate stigma and discrimination surrounding HIV in the Americas (December 2012). Available from: http://onusidalac.org/1/index.php/sala-de-prensa-onusida/item/1883-la-cidh-la-cim-onusida-y-la-ops-llaman-a-los-estados-miembros-de-la-oea-a-erradicar-el-estigmatization-y-la-discriminacion-en-relacion-con-el-vih-en-las-americas.

FINANCING AND SUSTAINABILITY OF HIV PREVENTION



The global targets in HIV prevention include allocating one-quarter of the HIV budget to prevention and ensuring that at least 30% of the services are community-operated by 2030.

Based on the data from 33 countries, UNAIDS estimates that LAC investment in the HIV response in 2013 was US$ 3 billion (*38*). Some 88% of the HIV expenditure was financed with domestic sources and 12% by international sources. In addition, 23% (US$ 690 million) of the expenditure allocated to the HIV response that year was devoted to prevention.[p] According to the data from the 23 countries that reported preventive expenditure targeted to the key populations, 7% of the expenditure on prevention in 2014 was allocated to programs for these populations (US$ 44 million of the US$ 639 million for prevention) (*38*).

With regard to the sustainability of the prevention response, 68% of the countries (17/25)[q] have a dedicated budget line for this purpose in their HIV budget. However, 82% (27/33) depend on external funds for prevention, and only six countries finance 100% of their prevention activities with domestic funds (*Table 10*). This dependency is seen primarily in prevention for the key populations; the figure ranges from 5% in the Bahamas to more than 95% in Haiti, but in more than half the countries it is estimated at less than one-third of the total prevention funds.

Hence, we can see that we are faced with a dual challenge: first, reaffirming the political will to allocate domestic funds to financing in this area, and second, determining the real needs in order to increase the allocation for prevention in the key populations.

In 2014, funding for prevention activities in LAC was distributed among the key populations as follows: 6% for FSWs, 30% for MSM, 23% for the partners and clients of the key

[p] Considering only public funds, the percentage of the total allocated to HIV prevention is 20% and 28% in Latin America and the Caribbean, respectively.

[q] According to information based on LAC country responses to the HIV Prevention Survey, May 2017.

populations, 3% for transgender women, 2% for drug users, and 36% for the general population. The GARPR reports of several countries have indicated very little or no spending on prevention programs for the key populations. Some countries have difficulty quantifying the expenditure allocated to these populations and, based on the conclusions of studies in several of them (for example, GOALS and other similar studies), the proportion of the expenditure allocated to the key populations must be increased to ensure a greater reduction in new infections (*39-43*).

- The funds currently allocated are inadequate, since: 1) the comprehensive service packages offered are incomplete; except for the Bahamas and, very soon, Brazil and Barbados, no country offers a

TABLE 10 Dependency of LAC countries on external funds for HIV prevention, July 2017

● Percentage of national financing

COUNTRIES WITH 100% DOMESTIC FINANCING

ARGENTINA	●●●●●●●●●●●●●●●●●●●●
BRAZIL	●●●●●●●●●●●●●●●●●●●●
CHILE	●●●●●●●●●●●●●●●●●●●●
MEXICO	●●●●●●●●●●●●●●●●●●●●
URUGUAY	●●●●●●●●●●●●●●●●●●●●
VENEZUELA	●●●●●●●●●●●●●●●●●●●●

COUNTRIES WITH EXTERNAL FUNDING

BAHAMAS	●●●●●●●●●●●●●●●●●●●○
COSTA RICA	●●●●●●●●●●●○○○○○○○○○
DOMINICA	●●●●●●●●●●●●●○○○○○○
EL SALVADOR	●●●●●●●●●●●●●●●●●●○○
GUATEMALA	●●●●●●●●●●●●●○○○○○○
HAITI	●○○○○○○○○○○○○○○○○○○
HONDURAS	●●●●●●●●●●●●●○○○○○○
NICARAGUA	●●●●●●●●●●●●●○○○○○○
PANAMA	●●●●●●●●●●●●●●●●●●○○
PARAGUAY	●●●●●●●●●●●●●○○○○○○
SAINT LUCIA	●●●●●●●●●●●●●○○○○○○
SURINAME	●●●●●●●●●●●●●○○○○○○

COUNTRIES WITH EXTERNAL FUNDING BUT LACKING INFORMATION ON THE PERCENTAGE OF DEPENDANCY

ANTIGUA AND BARBUDA
BARBADOS
BELIZE
BOLIVIA
COLOMBIA
CUBA
DOMINICAN REPUBLIC
ECUADOR
GRENADA
GUYANA
JAMAICA
PERU
SAINT KITTS AND NEVIS
SAINT VINCENT AND THE GRENADINES
TRINIDAD AND TOBAGO

Source: PAHO. Country responses to the questionnaires on HIV prevention, 2017. Global Fund Concept Notes and PEPFAR reports.

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complete package of services or subsidized self-testing under the national program; and 2) service coverage for the key populations is inadequate.

- It is not known what magnitude of expenditure is required to meet these needs at both the regional and country levels.

The countries also need to improve their information on the financing of HIV prevention—for example, by institutionalizing the development of national health accounts, using the methodology recommended by WHO (*44*) and considering systematic NASA exercises[r] (at a cost of roughly US$ 5,000) or similar

The current amount allocated to HIV prevention in key populations is insufficient; there are interventions that are not offered or if offered, the coverage is low.

[r] NASA: National AIDS Spending Assessment. For more information, visit: http://www.unaids.org/en/resources/documents/2009/20090630_20090916_nasa_classifications_edition_en.pdf.

studies, whose low cost will enable them to monitor expenditures on prevention activities in key populations.

Furthermore, 60% of the countries (15/25) report that they have domestic resources to fund civil society interventions. In some countries, however, these funds take the form of supplies, and the amount of the financing has not been quantified.

In conclusion, in LAC, there is a high level of dependence on external funds for prevention activities targeted to the key populations, and inadequate funding for civil society organizations, which are the most effective entities for reaching these populations. Some informants from the key populations in countries with 100% domestic financing stress the inadequacy of domestic financial support to civil society organizations for HIV prevention activities in these groups. Governments should create lines and mechanisms for funding civil society with domestic sources to support HIV prevention interventions, and countries that already have them should increase the funding, establishing fair and transparent mechanisms for the selection of service providers.

CONCLUSIONS AND RECOMMENDATIONS

This report analyzes the elements that show the main persisting gaps in HIV prevention in LAC. Use of the combination prevention approach can help LAC make progress toward meeting the 2020 and 2030 targets. However, given that two years after the LAC countries embraced the regional prevention targets, the number of new HIV infections has still not fallen, this report issues guidelines for reorganizing efforts and heightening their impact to achieve the sustainability of the outcomes. The following are the main areas where efforts should be focused in LAC:

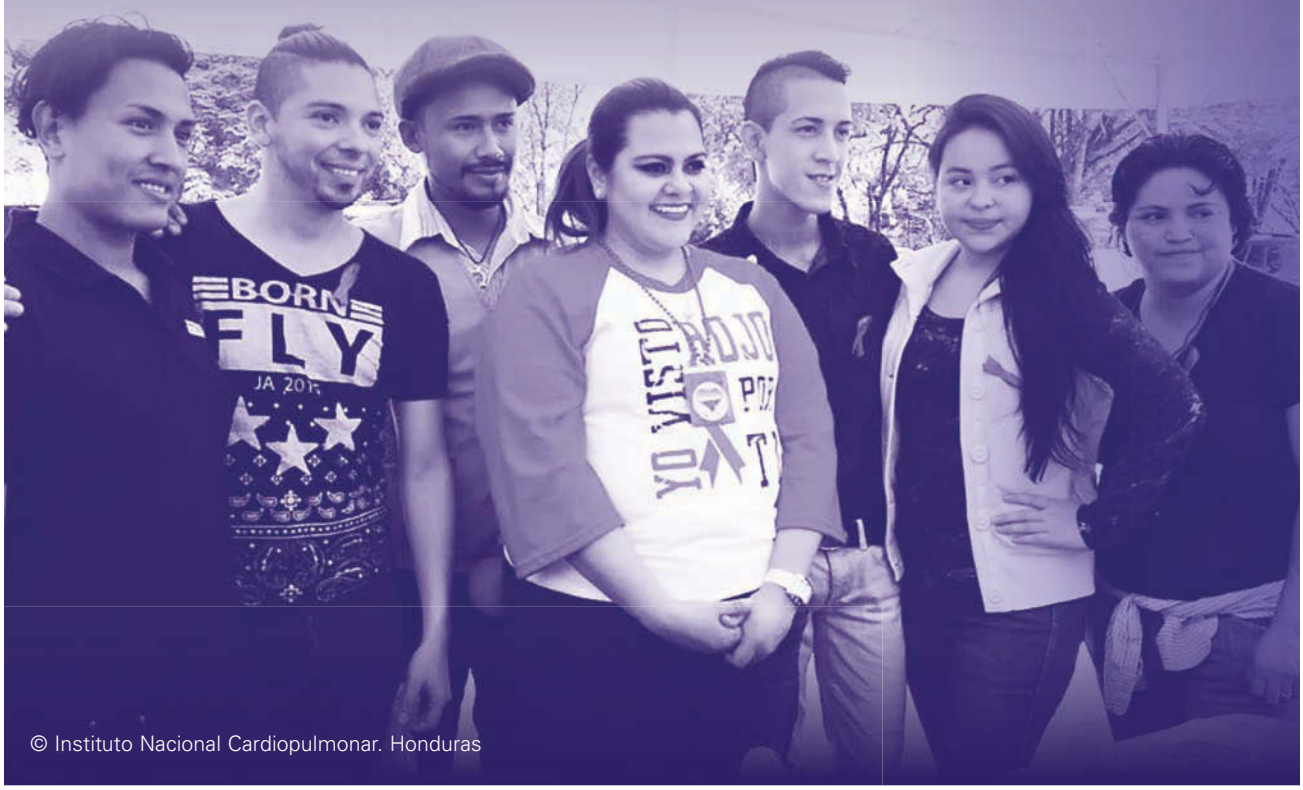
- There is a dual gap in LAC: first, in delivery of the complete set of prevention interventions of proven efficacy, resulting in a loss of synergy for achieving a greater reduction in transmission of the infection; and second, in service coverage, since in the few cases where a complete package of services is provided, coverage is very limited; thus, the good practices of the interventions have had very little impact on the course of the epidemic.
- The combination prevention approach is only rarely incorporated into the work of institutions or civil society. Training and dialogue on this approach should be promoted to determine how to apply it through interventions tailored to national realities.

- The services or interventions are often provided in isolation and are fragmented. There are many opportunities for improvement in this regard: when providing services, greater advantage should be taken of the opportunity to address prevention needs, considering a broader range of available interventions.
- Progress has been made in improving access to HIV testing, and more people with HIV are aware of their diagnosis. However, a high percentage of people with HIV still receive a late diagnosis. Efforts should be made to continue expanding the measures adopted to increase HIV testing in the key populations, addressing legal, technological, service delivery, and other barriers.
- Despite the clear, evidence-based recommendations of WHO, even with significant information from studies in LAC on interventions such as PrEP, self-testing, and PEP, countries have been slow to adopt these new combination prevention tools. Greater political commitment, implementation facilitated by more structured dialogue, and collaboration between government institutions and civil society organizations are urgently needed to fast track the expansion of prevention services for the key populations.
- Even in countries dependent on external financing, most prevention measures (prevention of mother-to-child transmission, blood safety, STI treatment, etc.) are financed with government resources. However, prevention interventions and services for the key populations are highly dependent on external funds.
- The cost of meeting the prevention targets in LAC is unknown, and so is the investment gap. There are no accurate country estimates of the cost of covering all prevention needs, nor of how many services civil society provides for the key populations. Systematic NASA studies and the dissemination of study findings should be increased, both as a reporting mechanism and in order to monitor gaps and progress toward meeting commitments.
- In order to improve the performance of the health services and boost their efficiency, their fragmentation must be addressed, promoting integrated health services networks and services focused on the needs of the key populations and taking advantage of the social engagement and support of civil society organizations.
- A lack of data and analysis of the key indicators associated with HIV prevention in the key populations has been detected, revealing a weakness in strategic information systems on the outcomes and impact of programs geared mainly to these populations.
- Although we have certain good practices and have made progress in addressing stigma and discrimination in the health services, the strategies employed should be reviewed to increase their effectiveness, involving people from the key populations in finding solutions to this problem.

There is a strong leadership by governments and civil society to end AIDS in LAC, but much remains to be done to improve the situation of the key populations and the quality of care in health centers. These are

the pillars for mounting an integrated HIV and STI response in the coming years, which will require more and better information, as well as an increase in technical and financial resources. The conditions are ripe for implementing the combination prevention approach. We hope this report will serve as a catalyst for creating the mechanisms and structures recommended by the new Global HIV Prevention Coalition in its fast-track action plan to reach the targets for 2020 in this next phase of the response to the HIV epidemic.

Use of the combination prevention approach can help LAC make progress toward meeting the 2020 and 2030 targets.



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ANNEX

TABLE 1 HIV prevention targets for the subregion

Targets	Baseline (%)	Target 2020 (%)	Target 2030 (%)	Subregion
Percentage of people aged 15-24 that correctly identify HIV prevention methods and know the main misconceptions about HIV transmission	41	90	–	South America and the Caribbean
Access to combination prevention packages*: percentage of drug users offered combination prevention programs	–	90	95	South America
Percentage of drug users tested for HIV in the past 12 months and who know the result	–	90	95	South America
Percentage of drug users who report using a condom in their most recent sexual encounter	–	90	95	South America
Percentage of people aged 15-24 with more than one sex partner in the past 12 months who used a condom in their most recent sexual encounter	–	90	95	The Caribbean
Percentage of financing devoted to HIV prevention in key populations	7	25	25	South America and the Caribbean

Source: PAHO/UNAIDS. Regional prevention targets. Second Latin American and Caribbean Forum on the Continuum of HIV Care. Rio de Janeiro; 2015.

* Appropriate and tailored to the local and cultural context.

TABLE 2

Programming cascade by key group and country, Latin America and the Caribbean, most recent year available

The data on the size of each key population reported by the countries, the number of populations that the country considered reachable when preparing its concept note, and the goal for each population indicated in the concept note.

	MSM			Transgender women			FSW		
	Size	Reachable population	Prevention target	Size	Reachable population	Prevention target	Size	Reachable population	Prevention target
Belize	n/d	2,618	700	n/a	n/a	n/a	n/a	n/a	n/a
Bolivia	29,490	26,134	9,282	833	1,188	670	n/a	n/a	n/a
Colombia	545,042	154,499	92,699	24,891	6,923	3,115	n/a	n/a	n/a
Costa Rica	33,208	28,988	7,563	n/d	578	468	n/a	n/a	n/a
Cuba	257,921	191,131	180,205	3,544	3,002	2,915	89,008	20,877	16,846
Dominican Republic	124,472	131,997	79,860	8,891	3,900	3,400	97,758	97,758	60,030
Ecuador	47,410	32,138	30,531	4,366	6,820	6,274	n/a	n/a	n/a
El Salvador	54,140	16,932	13,844	2,011	2,011	1,548	44,972	13,305	10,644
Guatemala	124,366	112,738	20,509	4,840	4,891	3,713	36,113	25,846	15,779
Guyana	3,327	3,327	2,994	n/a	n/a	n/a	5,256	5,256	4,836
Haiti	54,700	54,140	17,855	n/a	n/a	n/a	70,302	112,300	100,750
Honduras	40,949	40,949	28,664	2,975	2,975	2,083	22,771	22,771	13,663
Jamaica	33,000	26,358	14,000	n/d	7,006	4,000	18,696	19,157	11,180
Nicaragua	58,072	43,835	35,068	4,837	3,805	2,778	17,622	14,822	12,302
Panama	15,842	17,151	9,443	888	961	525	5,217	5,648	2,332
Paraguay	24,115	20,293	11,935	904	671	537	3,369	3,276	2,293
Peru	266,565	254,827	114,415	35,542	33,977	15,181	n/a	n/a	n/a
Total	**1,712,619**	**1,158,055**	**669,567**	**94,522**	**78,708**	**47,207**	**411,084**	**341,016**	**250,655**

Source: Population size: GAM country reports; 2016.
n/d: unavailable; n/a: not applicable or there is a grant from the Global Fund for these groups.

TABLE 3 Percentage of men who have sex with men (MSM), female sex workers (FSW), and transgender women tested for HIV in the past 12 months in Latin America and Caribbean, most recent year available

Country	MSM	Year, sample, methodology, or study	FSW (%)	Year, sample, methodology, or study	Transgender women (%)	Year, sample, methodology, or study
NORTH AMERICA						
Mexico	48	2013. Sample: 6,617. 24 cities in the 5 regions of the country	96	2013. Sample: 1,034 in Jalisco, State of Mexico, Veracruz	73[b]	2012
CENTRAL AMERICA						
Costa Rica	65	2011	98	2013	–	–
El Salvador	77	2016. Sample: 943. 6 departments. RDS methodology	90	2016. Sample: 800	74	2016, Sample: 222. San Salvador
Guatemala	45[b]	2012. Sample: 443. Guatemala City. RDS methodology	97[b]	2016	96	2013. Sample: 130. RDS
Honduras	55	2012. Sample: 706. Three cities	63[b]	2012	66[b]	2012. RDS methodology
Nicaragua	96	2016. Sample: 1,400. RDS methodology	83	2016. Sample: 1,100	94	2016. Sample: 135. RDS methodology
Panama	79[a]	2016	55[a,b]	2016	60[a]	2016
ANDEAN AREA						
Bolivia (Plurinational State of)	46	2015. Sample: 1,160. 4 cities	72	2010. Sample: 1,990	–	–
Colombia	27[b]	2016. Sample: 2,262. 7 cities.	91	2016. Sample: 2,198, Bogotá DC, Medellín, Barranquilla, Cali, Bucaramanga	43	2016. Sample: 1,008. 4 cities
Ecuador	77[b]	2015	60[b]	2015	–	–
Peru	5[a,c]	2015	35[a]	2015	–	–

Sources: UNAIDS/WHO. Country reports, Global AIDS Response Progress Reporting 2011-2016; other sources of country data are indicated below.
Notes: Data are based on surveys in selected cities, unless otherwise indicated. Different data collection methods (that is, RDS, PLACE, grab sampling), inclusion criteria, and sample sizes were used.
a Data from programs for care to key populations.
b Data reported directly to PAHO.
c Numerator: Data from the testing and counseling service. Denominator: estimate of population size.

TABLE 3 (continued)

Country	MSM	Year, sample, methodology, or study	FSW (%)	Year, sample, methodology, or study	Transgender women (%)	Year, sample, methodology, or study
SOUTHERN CONE AND BRAZIL						
Argentina	48	2014. Sample: 1,015. Metropolitan Buenos Aires. 2010. RDS methodology	37[b]	2014	56[b]	2014
Brazil	22[b]	2010. RDS methodology	52	2016. Sample: 4,245. RDS methodology	–	–
Chile	48	2016 Sample: 375. Metropolitan Santiago. RDS methodology	58	2016. Sample: 370. Time-space sampling Metropolitan Santiago	–	–
Paraguay	46[a]	2014. Sample: 669. Laboratory database	64	2014. Sample: 726	97[b]	2014
Uruguay	47	2013. Sample: 290. 7 cities	33[a]	2013. Monthly health check-up report	76[b]	2013. Sample: 206. National in scope
CARIBBEAN						
Antigua and Barbuda	–	–	23[b]	2014 Sample: 314. RDS methodology	–	–
Bahamas	91	2015. Sample: 103. RDS methodology	–	–	–	–
Barbados	46	2014. Sample: 125	–	–	–	–
Belize	44	2016 Sample: 300	65[b]	2013	–	–
Cuba	24	2015. Sample: 255,699	39	2015 Sample: 33,807	–	–
Dominica	36	2011. Sample: 72	–	–	–	–
Dominican Republic	19	2012. Sample: 1,637	70[a,b,c]	2012 Sample: 1,928	84[b]	2016
Guyana	83[a,b,c]	2016	–	2016	57[a,b,c]	2016
Haiti	69	2016. Sample: 626	65	—	–	–
Jamaica	69	2011	85	2014 Sample 1,009. PLACE method	–	–
Saint Kitts and Nevis	95	2011. Sample: 150	–	–	–	–
Saint Lucia	–	–	–	–	–	–
Saint Vincent and the Grenadines	32	2011. Sample: 74	–	–	–	–
Suriname	97	2011	95	2011. Sample: 164	–	–
Trinidad and Tobago	57	2015 Sample: 246. RDS methodology	–	–	–	–

TABLE 4 Active syphilis prevalence in gay men and other men who have sex with men in Latin America and the Caribbean, 2010-2016

Country	Syphilis prevalence (%)	Denominator	Type of syphilis	Year	Comments
Antigua and Barbuda	10.0	20	n/d	2012	
Argentina	17.7	1,014	Active syphilis	2014	
Bahamas	35.0	103	n/d	2015	
Barbados	13.6	125	n/d	2014	
Bolivia	29.0	107	n/d	2014	
Brazil	8.3	3,096	Rapid test	2009	
Chile	0.8	375	Active syphilis	2015	
Colombia	24.2	232	n/d	2016	
Costa Rica	13.7	300	n/d	2010	
Dominican Republic	12.9	1,636	n/d	2012	
Ecuador	6.2	419	n/d	2012	
El Salvador	8.9	2,071	n/d	2016	Sentinel sites
Guatemala	7.5	730	n/d	2016	
Guyana	1.0	388	Rapid test	2014	
Honduras	4.3	1,596	Active syphilis	2014	Data from VICITS clinics
Mexico	14.1	20,710	Active syphilis	2016	
Nicaragua	2.2	1,400	n/d	2016	
Panama	27.6	674	Active syphilis	2016	Data from VICITS clinics
Paraguay	5.7	3,372	n/d	2016	
Peru	11.1	13,244	Nontreponemal test	2014	
Trinidad and Tobago	21.0	290	n/d	2011	
Uruguay	21.0	290	Rapid test	2013	

Source: UNAIDS/WHO Country reports, Global AIDS Response Progress Reporting 2013-2016; other sources of country data are indicated below: n/d: no available data; VICITS: Sexually Transmitted Infection Surveillance, Prevention, and Control Strategy.

TABLE 5 Active syphilis prevalence in female sex workers, Latin America and the Caribbean, 2010-2016

Country	Syphilis prevalence (%)	Denominator	Type of syphilis	Year of data	Comments
Argentina	14.1	78	Active syphilis	2014	
Belize	0.5	216	n/d	2012	
Bolivia	3	14,332	n/d	2014	
Brazil	8.4	4,173	n/d	2016	
Chile	0.5	5,137	Active syphilis	2016	Data from STI care centers
Colombia	1.5	2,198	Syphilis reported by individual surveyed	2016	Syphilis test was not administered
Costa Rica	4.5	246	Active syphilis	2013	Data from VICITS clinics
Dominican Republic	9.5	1,929	n/d	2012	
El Salvador	3.1	1,929	n/d	2016	
Guatemala	0.5	1,234	n/d	2015	
Guyana	1.6	386	Rapid test	2013	Includes men, women, and transgender
Honduras	10	386	Active syphilis	2016	Data from VICITS clinics
Mexico	1.8	4,874	n/d	2016	
Nicaragua	4.5	134	n/d	2016	
Panama	2.4	415	Active syphilis	2016	Data from VICITS clinics
Paraguay	1.2	2,429	n/d	2016	
Peru	6.1	33,034	Unspecified syphilis	2014	
Trinidad and Tobago	10.8	102	n/d	2011	
Uruguay	8	224	Active syphilis	2016	

Source: UNAIDS/WHO. Country reports, Global AIDS Response Progress Reporting 2016.
Note: n/d: no data.

TABLE 6 Syphilis prevalence in pregnant women in Latin America and the Caribbean, 2015-2016

Country	Syphilis prevalence (%)	Denominator	Type of syphilis	Year of data	Comments
Antigua and Barbuda	0.5	1,042	Active syphilis	2016	
Argentina	1.5		Active syphilis	2015	
Barbados	1.5	1,056	Rapid test	2016	
Bolivia	0.8	5,746	Active syphilis	2016	Prevalence study
Brazil	0.8	33,801	Active syphilis	2011	Prevalence study
Chile	0.2	180,985	Active syphilis	2015	
Colombia	1.5	270,532	Rapid test and VDRL test	2016	
Costa Rica	0.9	52,428	VDRL test	2015	
Cuba	0.5	114,421	Active syphilis	2016	
Dominican Republic	2.0	139,121	VDRL test	2016	
El Salvador	0.3	50,489	VDRL test	2016	
Grenada	1.0	999	VDRL test	2016	
Guatemala	1.1	68,816	Active syphilis	2016	
Haiti	2.8	222,773	Rapid test		
Honduras	0.1	117,536	Rapid test	2016	
Jamaica	1.5	22,166	Rapid test		
Nicaragua	0.1	107,596	Rapid test	2016	Prevalence study
Panama	1.6	50,238	Rapid test	2015	
Paraguay	2.9	90,696	Active syphilis	2016	Prevalence study
Saint Kitts and Nevis	0.0	508	Active syphilis	2016	
Saint Lucia	2.1	1,986	Active syphilis	2016	
Trinidad and Tobago	0.2	12,927	Active syphilis	2016	
Uruguay	0.9	45,097	Rapid test and VDRL test	2016	
Venezuela	2.0	109,949	VDRL test	2016	

Source: UNAIDS/WHO. Country reports, Global AIDS Response Progress Reporting 2016.

TABLE 7 Availability of rapid syphilis tests in Latin America and the Caribbean, 2016

Country	Rapid syphilis test	Rapid test for the key populations	Rapid test for pregnant women
Antigua and Barbuda	Yes	No	Yes
Argentina	No	No	No
Aruba	Yes	No	Yes
Bahamas	Yes	Yes	Yes
Barbados	No	No	No
Belize	No	No	n/d
Brazil	Yes	Yes	Yes
Chile	No	No	No
Colombia	Yes	Yes	Yes
Costa Rica	Yes	No	Yes
Cuba	Yes	Yes	Yes
Dominica	No	No	No
Dominican Republic	Yes	Yes	No
El Salvador	Yes	Yes	Yes
Grenada	Yes	No	Yes
Guatemala	Yes	Yes	Yes
Guyana	Yes	No	Yes
Haiti	Yes	Yes	Yes
Honduras	No	No	No
Jamaica	Yes	No	Yes
Mexico	Yes	Yes	Yes
Montserrat	Yes	No	Yes
Nicaragua	No	No	No
Panama	Yes	Yes	Yes
Paraguay	Yes	Yes	Yes
Peru	Yes	Yes	Yes
Saint Kitts and Nevis	Yes	No	Yes
Saint Lucia	No	No	No
Suriname	No	No	No
Uruguay	Yes	Yes	Yes
Venezuela	No	No	No

Source: PAHO. Country respnses to the HIV Prevention Survey, May 2017.
PAHO. *Elimination of mother-to-child transmission of HIV and syphilis in the Americas.* Washington, D.C., PAHO; 2016.
PAHO. Direct communication with countries.
n/d: Unavailable.

TABLE 8 Epidemiological surveillance of sexually transmitted infections (STI) in Latin America and the Caribbean, by country and territory, 2016

Country	STI surveillance	Reporting of syphilis in adults	Congenital syphilis reporting
Anguilla	No	–	–
Antigua and Barbuda	Yes	Yes	Yes
Argentina	Yes	Yes	Yes
Aruba	No	–	–
Bahamas	Yes	–	Yes
Barbados	Yes	–	Yes
Belize	Yes	Yes	Yes
Bermuda	No	–	–
Bolivia	Yes	Yes	No
Brazil	Yes	Yes	Yes
Chile	Yes	Yes	Yes
Colombia	Yes	No	Yes
Costa Rica	Yes	Yes	Yes
Cuba	Yes	Yes	Yes
Dominica	Yes	–	Yes
Dominican Republic	Yes	Yes	Yes
Ecuador	Yes	Yes	Yes
El Salvador	Yes	Yes	Yes
Grenada	Yes	Yes	Yes
Guatemala	Yes	Yes	Yes
Guyana	Yes	Yes	–
Haiti	Yes	Yes	No
Honduras	Yes	No	Yes
Jamaica	Yes	–	Yes
Mexico	Yes	Yes	Yes
Nicaragua	Yes	Yes	Yes
Panama	Yes	Yes	Yes
Paraguay	Yes	Yes	Yes
Peru	No	No	Yes
Saint Kitts and Nevis	Yes	–	Yes
Saint Vincent and the Grenadines	Yes	Yes	Yes
Saint Lucia	Yes	Yes	Yes
Suriname	Yes	–	–
Trinidad and Tobago	Yes	Yes	–
Uruguay	Yes	Yes	Yes
Venezuela	Yes	No	Yes

Source: PAHO. Country responses to the HIV Prevention Survey, May 2017.
UNAIDS/WHO. Country reports, Global AIDS Response Progress Reporting 2013-2016.
PAHO. *Elimination of mother-to-child transmission of HIV and syphilis in the Americas.* Washington, D.C., PAHO, 2016.

TABLE 9 Percentage of female sex workers (FSW) who report having used a condom with their most recent client, and of men who have sex with men (MSM) and transgender women who report having used a condom in their most recent anal sex with a male partner, most recent year available

Country	MSM (%)	Year, sample, methodology or study, and place	FSW (%)	Year, sample, methodology or study, and place	Transgender women (%	Year, sample, methodology or study, and place
Antigua and Barbuda	81	2013. Sample: 80	70	2014. Sample: 314. RDS	–	–
Argentina	64[b] 37[c]	2014	97[b] 25[c]	2014. Sample: 759	94 36[c]	2014
Bahamas	63[b]	2016. Sample: 103. RDS	–	–	–	–
Barbados	58	2014. Sample: 125	–	–	–	–
Belize	81	2016. Sample: 258	85	2016. Sample: 297. TRaC study	86	2016. Sample: 42. KAP study
Bolivia	58	2015. Sample: 1,160. RDS	96	2010. Sample: 1,990	89	2013. Sample: 415
Brazil	63[b]	2011	86	2013		
Chile	42	2016. Sample: 375. Metropolitan Santiago. RDS	97	2015 Sample: 370. Vibimos. University of Chile. Sampling by time and place	–	–
Colombia	52[b]	2016. Sample: 2,562. 7 cities in Colombia. RDS	98	2016. Sample: 2,598. Bogotá D.C., Medellín, Barranquilla, Cali, Bucaramanga	92[b]	2013. Sample: 368
Costa Rica	76	2016. Sample: 734. Greater metropolitan area. RDS	92	2016. Sample: 612. TRAC study	74	2016 Sample: 57. Greater metropolitan area. TRAC study
Cuba	57	2015 Sample: 69,412	72	2015. Sample: 33,807	47	2016. Sample: 1 517
Dominica	63	2011. Sample: 57		–	–	–
Dominican Republic	40	2012 Sample: 1,637	85	2012 Sample: 1,929 RDS	80[b]	2016
Ecuador	77	2015. Sample: 625. PLACE	96	2015. Sample: 531. Behavioral survey. PLACE	94	2015. Sample: 331. PLACE
El Salvador	61	2016. Sample: 943	73	2016. Sample: 907	96	2016. Sample: 224
Guatemala	62[b]	2013. Sample: 555. Guatemala City and Coatepeque	98	2013 Sample: 1,216. Guatemala City, Escuintla, Malacatán	66	2013. Sample: 205
Guyana	61[b]	2014. Sample: 545. 9 administrative regions. PLACE	84[b]	2014. Sample: 181. PLACE	46[b]	2014. Sample: 68. PLACE

(continued)

TABLE 9 (continued)

Country	MSM (%)	Year, sample, methodology or study, and place	FSW (%)	Year, sample, methodology or study, and place	Transgender women (%	Year, sample, methodology or study, and place
Haiti	75	2016. Sample: 626	90	2015. Sample: 1,780. RDS	–	–
Honduras	46[a]	2016. Sample: 1,596. VICITS Services	88	2016. Sample: 907. Tegucigalpa, La Ceiba, San Pedro Sula	44[b]	2016. Sample: 90. VICITS services
Jamaica	73	2013. Sample: 453	85	2016. Sample: 1,009. PLACE	–	–
Mexico	73	2013. Sample: 5,729	85	2012. Sample: 633	80 (non-FSW) 95 (FSW)	2012. Sample: 146. Sample: 171
Nicaragua	55	2016. Sample: 1,400	92	2016. Sample: 1,100	60	2016. Sample: 135. RDS
Panama	84[a]	2016. Sample: 2,056. VICITS services	77	2016. Sample: 708. VICITS services	86[b]	2016. Sample: 70. VICITS services
Paraguay	65	2014 Sample: 617	99	2014 Sample: 726	57[b,c] 94 with client	2014 Sample: 170
Peru	50	2011. Sample: 1,571	95	2013. Sample: 770	73	2013
Saint Kitts and Nevis	82	2011. Sample: 150	–	–	–	–
Saint Vincent and the Grenadines	73	2011. Sample: 45	–	–	–	–
Suriname	53	2011. Sample: 319	90[a]	2012	–	–
Trinidad and Tobago	51	2015. Sample: 246	–	–	–	–
Uruguay	68	2013. Sample: 290. Montevideo, Canelones, Maldonado, Colonia, Rivera, Cerro Largo, Artigas	–	–	99	2013. Sample: 113. Montevideo, Canelones, Maldonado, Colonia, Rivera, Cerro Largo, Artigas

Sources: UNAIDS/WHO. Country reports, Global AIDS Response Progress Reporting 2011-2016; other country data sources are indicated in the table:

a Data from programs for care to the key populations.

b Data reported directly to PAHO.

c Condom use with a steady partner.

Notes: Data are based on surveys in selected cities, unless otherwise indicated. Different data collection methods (that is, RDS, PLACE, grab sampling), inclusion criteria, and sample sizes were used.

The percentages have been rounded.

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