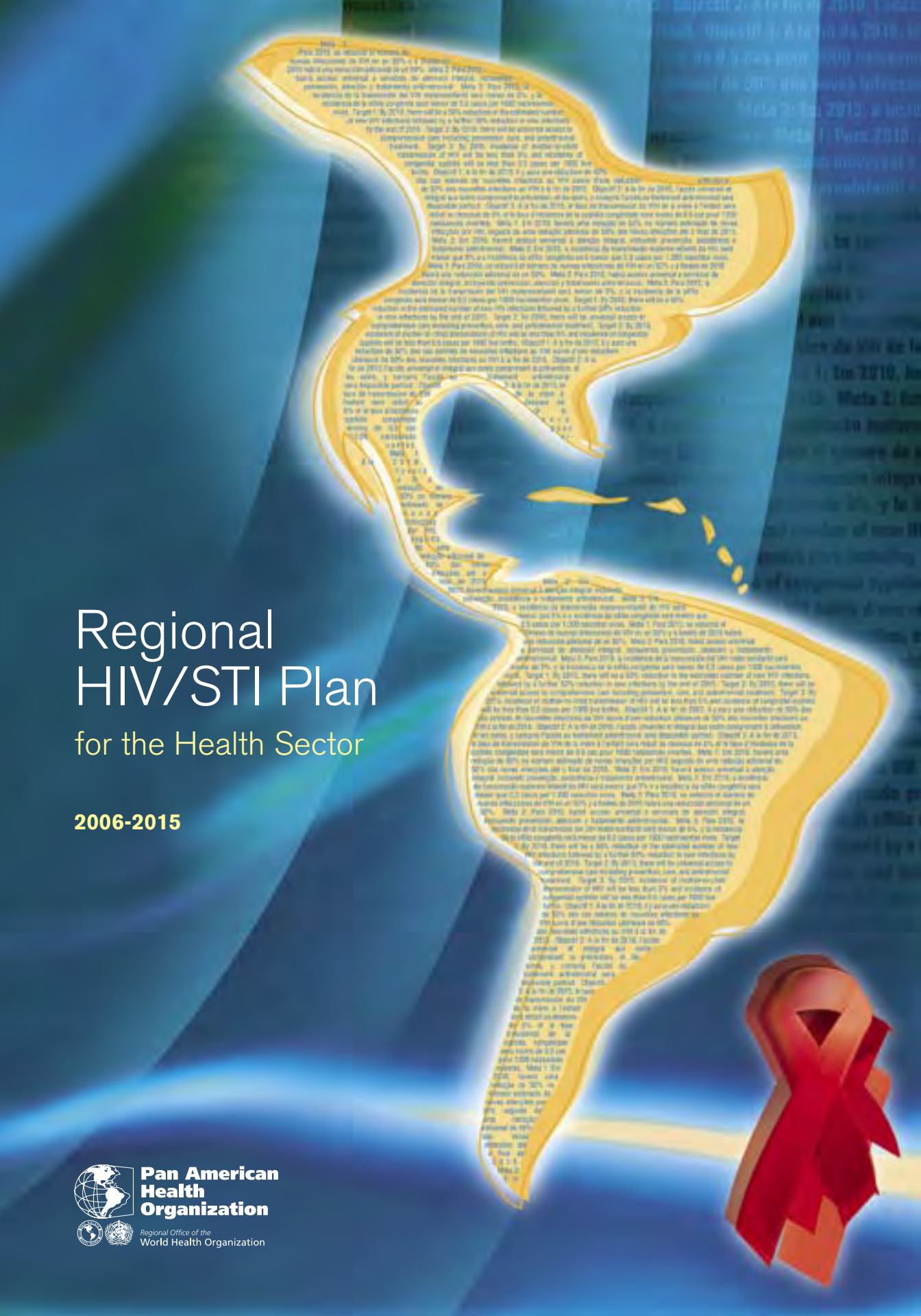

Regional HIV/STI Plan

for the Health Sector

2006-2015

Pan American Health Organization

Regional Office of the World Health Organization

Regional HIV/STI Plan

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NOVEMBER 2005

Pan American Health Organization
Regional Office of the World Health Organization

www.paho.org/aids

Regional HIV/STI Plan
for the Health Sector
2006-2015

VISION

The people of the Americas are empowered to request and obtain equitable and sustainable access to prevention, care, and treatment services, in order to halt and reverse the HIV epidemic and successfully control STI by 2015.

MISSION

Member States have the capacity to provide and ensure equitable prevention, care, and treatment services for the people of the Americas through the participatory formulation of policies for universal access, progressive and sustained infrastructure development, appropriate resource allocation, and through collaborative efforts to reduce inequities within and among countries.

CONTENTS

ACKNOWLEGEMENTS

This document reflects the input of many people within and outside of PAHO. The HIV/AIDS Unit would like to thank the steering group that oversaw the development of the Plan, whose members from partner organizations include: Lourdes Chamorro (Ministry of Health Spain), Jane Galvao (IPPF), Antonio Gerbase (WHO), Perry Gomez (Ministry of Health Bahamas), Fritz Lherisson (UNAIDS), Ricardo Marins (Ministry of Health Brazil), Ernest Massiah (IDB), Zeidy Mata (Ministry of Health Costa Rica), Mary Mulusa (World Bank), Rodrigo Pascal (Vivo Positivo Chile), and Amrita Paul (CIDA).

PAHO offices and key stakeholders in nineteen countries in the Region (Argentina, Bolivia, Brazil, British Virgin Islands, Chile, Colombia, Costa Rica, Cuba, Dominican Republic, Grenada, Guatemala, Honduras, Nicaragua, Panama, Paraguay, Peru, Suriname, Trinidad & Tobago, and Uruguay) responded to the Unit's request to meet and provide feedback on the concept and design of the Plan. This valuable input contributed to the formation of the present document.

GLOSSARY

ACCESS[1] – The absence of geographic, financial, organizational, and/or structural barriers to participation in the health system and/or receiving health and other social services; it is a determinant of whether people can obtain needed services.

ADEQUATE TRAINING – Training that facilitates competency in a given field and includes, for HIV/AIDS heath care staff, gender sensitivity, human sexuality/sexual health and sensitivity to stigma and discrimination.

COMPREHENSIVE CARE – HIV comprehensive care refers to a combination of services directed at: preventing transmission of HIV as well as the physical and emotional consequences of being infected; preventing the rapid progression of disease and the deterioration of the physical and/or emotional conditions of the infected person; providing care that improves the overall conditions and quality of life and giving access to treatment. For a list of services comprising comprehensive care, see page 35. STI comprehensive care refers to a combination of services directed at improving health-seeking behavior, preventing transmission, providing adequate diagnosis and treatment as well as education, and promoting partner notification.

GENDER – The economic, social and cultural attributes and opportunities associated with being male or female at a particular point in time.

HIV AND AIDS – This Plan uses the term "HIV" to refer to the virus and the epidemic, and uses the expression "people with HIV" to describe those who live with the virus in all stages of the disease. In a time when fewer people develop the clinical manifestations of AIDS, the all-encompassing "HIV" became a more useful and precise term. The Plan uses "AIDS" only when it is necessary to refer to the advanced stage of the HIV disease.

NATIONAL HEALTH AUTHORITY – People who make decisions regarding public health and the administration of national health programs and services.[2]

POSITIVE PREVENTION – Active engagement of people with HIV in the implementation of necessary measures to prevent re-infection and slow down the progression of HIV disease, as well as taking action to prevent the transmission of the infection to others.

SEXUAL HEALTH – A state of physical, emotional, mental and social well-being related to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all people must be respected, protected and fulfilled.[3]

UNIVERSAL ACCESS TO HIV COMPREHENSIVE CARE – The continual availability of comprehensive care services to the public, regardless of legal status or an individual's ability to pay.

[1] *From the PAHO Primary Health Care working document*
[2] *From LACHSR. www.lachsr.org*
[3] *World Health Organization definition*

UNIVERSAL ACCESS TO HIV TREATMENT – A set of conditions in which all people in a country requiring treatment have the right and ability to receive a consistent and life long supply of antiretroviral therapy and other health services to effectively treat HIV/AIDS.

UNIVERSAL COVERAGE – A state in which every HIV positive person is receiving appropriate treatment.

VULNERABLE GROUPS – Segments of the population who due to structural conditions have increased probabilities of being exposed to HIV and of getting infected.

1 PREFACE

The beginning of the 21st Century may be viewed as a turning point in the history of the HIV epidemic. At this time, with the increasing availability of antiretroviral therapy (ART), the means are at hand to prolong life and alleviate suffering among those infected with HIV. International political commitment to fighting HIV/AIDS is currently at a high pitch. The Development Goal included in the Millennium Declaration targeting the epidemic, together with the establishment of the Global Fund to Fight AIDS, Tuberculosis and Malaria, as well as other partnerships, have prompted action at many levels and have increased resources significantly. Concerted efforts are required to make the most of this auspicious time. Scaling up efforts to provide comprehensive care for HIV/AIDS, including prevention, have a critical place on the public health agenda at national and international levels. Advancements made today can change the map of the epidemic in the near future and beyond.

Progress in HIV/AIDS care and treatment is being made in Latin America and the Caribbean. By the time the Fourth Summit of the Americas is held in November 2005, the target set during the Nuevo Leon Summit, held in Monterrey, Mexico in January 2004, of treating 600,000 individuals by 2005 will be met and exceeded. Nonetheless, achieving universal coverage will require bridging an equity gap between and within countries. Socio-economic, geographic, gender, and stigma-related factors play a large part in determining the fate of an individual with HIV.

The only means to ensure the effective scaling up of efforts to face the HIV epidemic is preventing its growth. Yet, efforts and success in this area are compromised by a lack of evidence-based information about what works and what does not, by the fragmentation of efforts, the lack of continuity and sustained and synergistic actions, and by the persistence of stigma and discrimination. As a Region we must take advantage of current knowledge and lessons learned from interventions, moving from focused and time-bound projects to a scaled up response within a comprehensive national plan.

PAHO has already demonstrated its support for scaling up comprehensive care in the Region, taking extensive actions to implement the 3 by 5 Initiative and providing technical cooperation to support prevention efforts. The Regional HIV/STI Plan for the Health Sector 2006-2015 is a further step to promote effective prevention and care. Stemming from the 2004 Directing Council Resolution CD45.R11 to scale up HIV/AIDS treatment and reinforce prevention activities, and the 2004 Directing Council Resolution CD45.R10 on access to medicines, the Regional Plan was mandated by the Subcommittee on Planning and Programming in 2005. In light of the need to achieve Development Goal 6, to halt and reverse the spread of HIV by 2015, the Regional Plan comes at a critical time. I have no doubt that by promoting true collaboration and coordination between partners and among countries under the leadership role of the national authorities and with full involvement and commitment of every sector and actor of our society, we will be able to curb this epidemic and protect all people.

We are now on the threshold of universal access to treatment and comprehensive care, and have instruments to reach every group with information and communication for behavioral change. We have the tools in hand to open the door and change the face of HIV/AIDS in the Americas. Let us harness the healing power of available knowledge and technologies and make them work for those in our Region who need them most.

MIRTA ROSES PERIAGO
Director, Pan American Health Organization

EXECUTIVE SUMMARY

2

BACKGROUND

HIV in the Americas is a major threat to public health. The numbers of HIV positive people and those dying of AIDS have increased in recent years, and are projected to continue rising in the coming decade. Programs implemented by National AIDS Programs have achieved successes throughout the Region, but their efforts are hampered by lack of infrastructure, lack of political support, and the persistence of stigma and discrimination.

All countries in the Region have committed to international accords regarding HIV/AIDS, including Goal 6 of the UN Millennium Declaration, to halt and begin to reverse the spread of HIV/AIDS, and the Declaration of Commitment of the United Nations General Assembly Special Session on HIV/AIDS (UNGASS). The fulfillment of these goals will require effectively scaling up existing programs and require cooperation between sectors and among countries. PAHO's Regional HIV/STI Plan for the Health Sector 2006-2015 is a tool to assist health sectors in the Americas to more effectively respond to the HIV epidemic and to prevent and control STI. It is meant to be implemented at the national level in all countries of the Region. The Plan focuses on achieving universal access to comprehensive care, including prevention, care, and treatment, and addresses these elements in an integrated manner.

STRATEGIC PLANNING FOR 2015

A situation analysis of HIV/AIDS/STI in the Region was conducted by PAHO and projections were used to determine several scenarios for the likely future of the epidemic. The scenarios point to the need for a scaled up, comprehensive response from health sectors to keep the epidemic from increasing dramatically in coming years. Based on this need, PAHO developed five critical lines of action that constitute the elements of the Regional Plan. Each critical line of action includes specific strategies to be undertaken by health authorities, targets to be achieved by 2010 or 2015, and milestones. The critical lines of action are:

1_Strengthening health sector leadership and stewardship and fostering the engagement of civil society
2_Designing and implementing effective, sustainable HIV/AIDS/STI programs, and building human resource capacity
3_Strengthening, expanding, and reorienting heath services
4_Improving access to medicines, diagnostics, and other commodities
5_Improving information and knowledge management, including surveillance, monitoring and evaluation, and dissemination.

The targets included in the Plan are directed toward achieving the overall goal of universal access to comprehensive care. An evaluation of needs at the country level will be necessary to determine which targets are most relevant for each country and how the Regional Plan will link to existing plans. PAHO will offer technical support for Regional Plan's implementation. Together with the HIV/AIDS Technical Advisory Committee, PAHO will monitor progress and challenges and provide an annual venue for sharing information and experiences.

3 INTRODUCTION

HIV in the Americas has no one face. Like Proteus in Greek mythology, it is opportunistic in its choice of host. HIV reaches a young girl, a migrant worker, a gay man, a mother, a child.

There are currently between 3 and 5 million people with HIV in the Americas and the spread of the epidemic is increasing. Despite considerable progress in the Region, AIDS continues to threaten the social and economic fabric of society. The data show that HIV is affecting primarily the poor and vulnerable, and that increasingly the burden is falling upon women and youth. There is ample recognition that the risk of HIV is closely intertwined with gender inequality, marginalization, and poverty. High levels of stigma and discrimination throughout the Region and, until recently, the lack of widely available treatment have limited the number of people who have been tested for HIV and as a result, many people who are at high risk of infection still do not know their status.

Over twenty years after the appearance of HIV in the Americas, countries have recognized the need for a more targeted, multisectoral response, and they have committed to scaling up the fight against HIV. If the Region is to meet these commitments, a long term strategy needs to be defined. Countries in Latin America and the Caribbean will need to work quickly and effectively, focusing efforts to maximize available resources and expertise. The Region must seize the moment in recognition of the resources and opportunities that are now at hand. PAHO, through its country offices, centers, and sub-Regional and Regional mechanisms, is intensifying its support to National AIDS Programs to assist them in meeting this challenge through the development of the Regional HIV/STI Plan for the Health Sector 2006-2015.

The development of the Regional Plan has been a participatory process, involving a wide range of PAHO programs and partners as well as Member States. A steering group, consisting of people with HIV, Ministries of Health, development partners, and members of PAHOs Technical Advisory Committee on HIV/AIDS/STI, met on June 3 and September 13, 2005 to conceptualize and guide the process. To obtain external perspectives on PAHO's comparative advantage and on PAHO's future technical support to the Region, development partners were consulted and their input is reflected in this document.

The HIV/AIDS Unit (Family and Community Health Area) led the process and convened working groups with representatives from other Units including: Communicable Diseases; Essential Medicines, Vaccines, and Health Technologies; Child and Adolescent Health; Gender, Ethnicity and Health; Technology and Health Services Delivery; Project Support; Human Resources Development; Immunizations; External Relations and Partnerships. In addition, PAHO's country office staff throughout the Region gathered information through the use of a questionnaire and consultations with national stakeholders on the need for a Regional Plan and how the Plan could assist countries in enhancing their response to HIV/STI. The results of these discussions were used to define the critical lines of action, strategies, targets, and milestones included in this Plan.

To foster a holistic response, the Regional Plan coordinates with other PAHO initiatives and plans including the Primary Health Care Initiative, the Regional Plan for Human Resources 2006-2015, the Strategic Plan of the Regional Tuberculosis Program 2005-2015, the Global Safe Blood Initiative and Plan of Action for 2005-2010, Regional and Global Syphilis Plans and PAHO's 2003 Family and Health Resolution. Therefore, some of the targets are shared with other PAHO programs, and the strategies are congruent and complementary. They have also taken into account the Three Ones, UNGASS, and recommendations of the Global Task Force on Prevention.[4]

The Regional HIV/STI Plan for the Health Sector 2006-2015 is a tool to assist health services and systems in the Americas to more effectively respond to the HIV epidemic and to prevent and control STI. It is meant to strengthen national plans in all countries of the Region. The ten year length of the Plan encourages international and national planners to consider the long-term impact and sustainability of programs, and view the trajectory of the disease in relation to other long-term economic and human development goals. The Regional Plan will be a valuable resource to improve institutional coordination and build social and economic capital to halt the spread of HIV now and for years to come.

The Plan begins with a situation analysis to provide a basis for the proposed targets and strategies. This includes current epidemiological data and future estimated trends as well as the state of HIV/STI efforts in the Region. Five critical lines of action are then presented with accompanying strategies, targets, and milestones. The role of PAHO's Secretariat in supporting the Plan, including mechanisms for its oversight and management, is presented in the following section, and next steps are briefly summarized at the end of the document.

[4] *The Global Task Force on Prevention is part of the Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors*

POLICY POSITIONS 4

The Regional HIV/STI Plan for the Health Sector supports the implementation of the following national level policies:

1_Universal access to comprehensive care for HIV/AIDS/STI that includes the continuum of care from prevention to treatment, including ART and necessary commodities, free of cost at the point of service delivery.

2_Evidence-based health promotion and HIV/STI prevention programs for and with members of affected groups including youth and children, men who have sex with men, women, injecting drug users, sex workers, Indigenous populations, migrants, and other relevant populations whose quality of life can be improved by reducing their vulnerability and eliminating risk.

3_Gender-sensitive policies and programs focusing on the mitigation of inequalities that arise from the different roles of women and men, the unequal power relationships between them, and the consequences of these inequalities for women and men's lives, health, and well-being.

4_Revitalized commitment to STI prevention and control, recognizing that the presence of STI plays an important role in HIV transmission.

5_Understanding health as a human right and addressing the broader social and political determinants of health. This approach should manifest itself in programs and policies reflecting the values of equity, excellence, solidarity, respect, integrity, efficiency, participation and autonomy.

SITUATION ANALYSIS

5

THE STATE OF THE HIV/AIDS/STI EPIDEMIC IN THE REGION

HIV/AIDS/STI epidemiological overview

Between 3 and 5 million people were living with HIV in the Americas at the end of 2004.[5] Of these, approximately 2 million people were living in Latin America and the Caribbean. The epidemic is currently increasing; at least an estimated 380,000 people were newly infected with the virus during 2004. The Caribbean has the second highest prevalence rate in the world, with adult rates of 2-3%, and some countries in Central America are already beyond the 1% threshold of a generalized epidemic. Globally, half of those infected with HIV are young people between the ages of 15 and 24.

The epidemic is generalized in the Caribbean while in most parts of Latin America it is concentrated in certain geographical areas and among various population groups. This is changing, however, as mobility and migration increase throughout the Region. To date, most infections are due to unprotected sexual intercourse. In several Southern Cone countries, injecting drug use is the major driving factor behind transmission.

HIV infection among women in the Region is a growing concern. The highest levels of HIV among women in the Americas are in the Caribbean countries. According to the Inter-American Development Bank, between 30% and 70% of women in the Region have unstable or insecure occupations and those who are employed still earn significantly less than men. Between 12% and 54% of women with no education and 5-28% of all girls do not know how to prevent HIV infection, while 10-25% of all women believe a "healthy" looking person cannot have HIV/AIDS.

In both Canada and the United States, the number of AIDS deaths has declined somewhat in recent years. In the US, the number of new infections remained stable (close to 43,000) between 2003 and 2005, but in Canada the number of new HIV infections has grown. From the beginning of the reporting of HIV cases in November 1985 to the end of 2004, a cumulative total of 57,674 cases of HIV were reported in Canada[6] *(see graph 1)*. In the last five years, there has been a 20% increase in reported HIV cases, from 2,111 in 2000 to 2,529 in 2004 and more and more young people are being affected.

A strong national response in preventing mother-to-child transmission has reduced HIV incidence among children in Canada and the scaling up of care and treatment has resulted in a declining trend in AIDS mortality, as illustrated by a 92% reduction in AIDS mortality between 1995 (1,500 deaths) and 2003 (124 deaths).

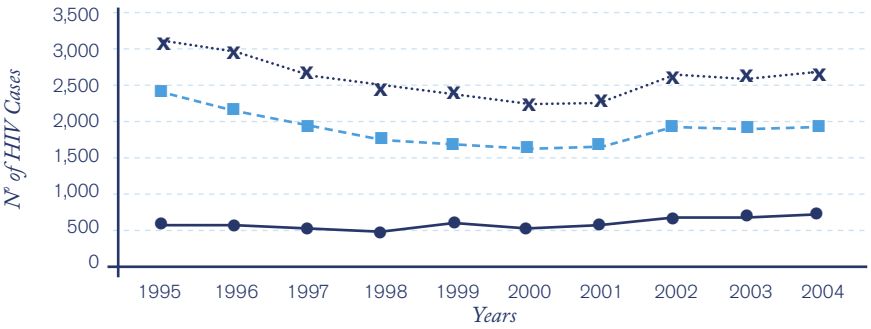
[5] *WHO/UNAIDS, 2004*

[6] *According to the HIV/AIDS surveillance report published in April 2005 by the Public Health Agency of Canada.*

Graph 1_ Reported Cases of HIV in Canada by Year and Sex: 1995-2004

Source: Public Health Agency of Canada 2005

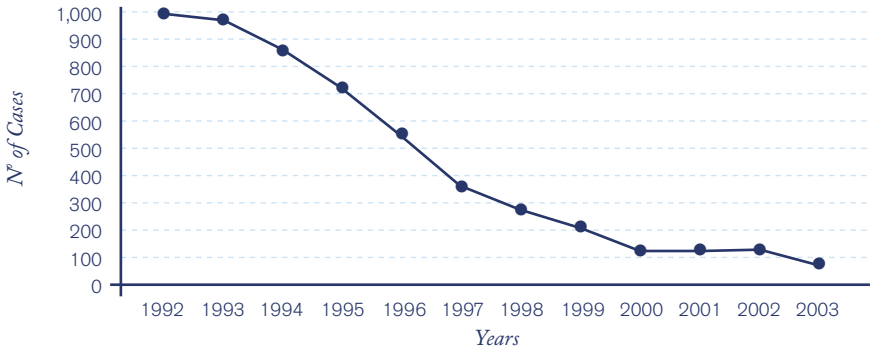
Males ■ /Females ● /Total x



In the United States, an estimated 929,985 cases of AIDS have occurred since the inception of the epidemic in 1981.[7] Among the reported cases of AIDS, the annual incidence rate remained stable between 2002 and 2003. Nationwide, the estimated number of AIDS cases among children has declined from 952 cases in 1992 to 59 in 2003, due to the impact of prevention of mother-to-child transmission programs *(see graph 2)*.

Graph 2_ AIDS Incidence Among Children in the US: 1992-2003

Source: US CDC: HIV/AIDS Surveillance Report. Vol.15. DHHS



[7] *From the CDC HIV/AIDS Surveillance Report (Vol. 15)*

Sexually transmitted infections

While responding to the threat posed by the HIV/AIDS epidemic in the Western Hemisphere, the Region continues to be challenged by the spread of sexually transmitted infections (STI). It is estimated that on annual basis 50 million new cases of STI occur in the Americas. Chlamydia, gonorrhea, syphilis, trichomoniasis, bacterial vaginosis, herpes, human papiloma virus, and chancroid remain public health issues in the Region and are a fuelling factor for the HIV epidemic.

The magnitude of STI in Latin America and the Caribbean can be seen in examples from different countries and different methodologies. In a sentinel site in Chile that held 10,525 STI consultations between 1999 and 2003, 22% of patients were diagnosed with condyloma, 10.4% with latent syphilis and 10.1% with gonorrhea. The same pattern regarding cases of gonorrhea and syphilis was observed among STI patients in Nicaragua during the period 2000 to 2002. In Jamaica, STI screening of 5,183 pregnant women enrolled in a national program aimed at reducing mother to child transmission of HIV in 2002 found that 9.8% were positive for STI. A population-based survey[8] conducted in 2004 among adults in Barbados found that 14.3% of that population was infected by gonorrhea or chlamydia. There was no difference in terms of prevalence between males and females but 25% of younger women (age 18-20) were found to be infected, a higher percentage than those age 21-35. This high prevalence of asymptomatic infection in both males and females in Barbados indicates that routine STI screening is critical for the prevention and control of STI and the HIV epidemic in that country.

In the United States, cases of primary and secondary syphilis declined between 1990 and 2000. [9] However, cases of syphilis increased during the period 2000-2002 and continued to increase from 2002 (6,862 cases) until the end of 2003 (7,177 cases). Men who have sex with men were particularly affected by this increase. Although African Americans were found to be the most affected overall, the syphilis rate among this group is declining. Syphilis has increased among other ethnic groups in the US, especially in the Hispanic population.

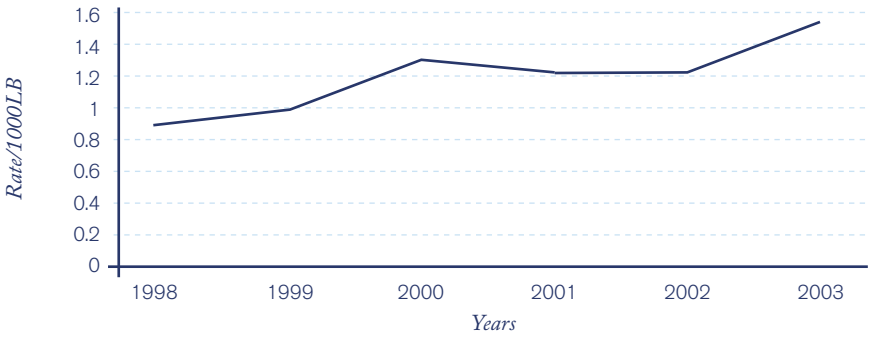
In Latin America and the Caribbean, 330,000 pregnant women are diagnosed with syphilis every year but are not treated adequately. This results in 110,000 infants being born with congenital syphilis yearly. Among these, only of 15,570 cases of congenital syphilis were reported from 11 Latin American and Caribbean countries in 2003. In countries where cases of congenital syphilis are reported annually, an increasing trend is being observed in Costa Rica where the fatality rate increased from 2.35% in 1995 to 3.3% in 2000, in Venezuela where cases increased from 50 in 2000 to 135 in 2002, and in Brazil, where the rate of congenital syphilis per 1000 live births increased from 0.9 in 1998 to 1.5 in 2003 *(see graph 3).*

[8] *OP Adams et al, CHRC-2005*

[9] *Syphilis Surveillance Report (2004)*

Graph 3_Brazil Congenital Syphilis Rate per 1,000 Live Births : 1998-2003

Source: Ministry of Health-AIDST Bulletin, 2004



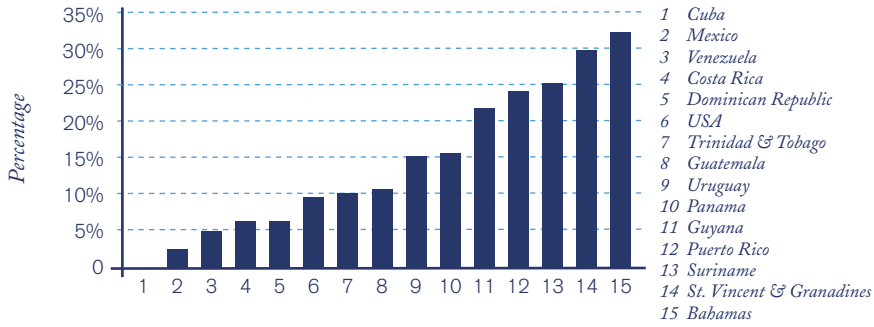
HIV coinfection

HIV prevalence among STI patients is a good indicator of the potential transmission of HIV. Surveys conducted in some Caribbean countries found that STI patients are seriously affected by the HIV epidemic. In several instances, HIV prevalence rates are 2 to 6 times higher in STI patients than in the general population. The high co-infection rates underscore the need for the promotion of a double screening policy: Every STI patient should be offered an HIV test and every female patient with HIV should be screened for STI including HPV because of its dangerous association with HIV, and Candida albicans because it is a common opportunistic infection.

In many countries, dual HIV/TB infection has become a serious public health problem. The HIV prevalence among TB patients varied from 0% in Cuba to 31.5% in the Bahamas in 2003 *(see graph 4)*.

Graph 4_HIV prevalence in People with TB: 2003

Source: Ministries of Health, 2004



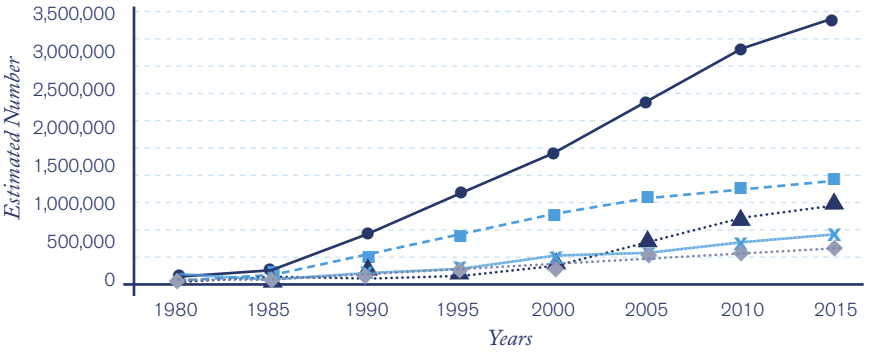
The Future of the HIV Epidemic

The negative impact of the HIV epidemic on demographic trends in the Western Hemisphere has been well documented. If current trends continue, life expectancy will be reduced by at least 10 years by the end of 2010 due to AIDS in hard-hit countries such as Haiti, Guyana, and the Bahamas. Using a moderate case scenario[10], WHO/UNAIDS projections show that there will be 3.3 million people with HIV in Latin America and the Caribbean at the end of 2015 *(see graph 5)*.

Graph 5_Estimated Number of People with HIV (Adults & Children) in Latin America and the Caribbean: 1980-2015 (Middle Scenario)

Source: UNAIDS Reference Group on Estimates, Modeling and Projections

Caribbean ◆ /Southern Cone and Brazil ■ /Andean Area ▲ / Central America and Mexico ✕ /Total ● /

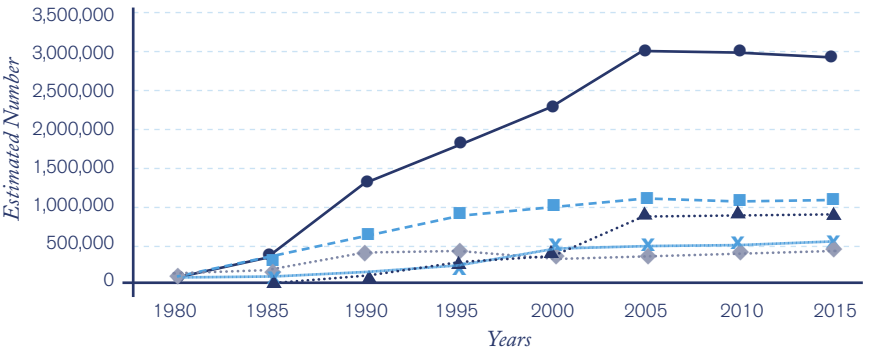


During the next decade, the cumulative total of new HIV infections in Latin America and the Caribbean will be close to 3 million *(see graph 6)*.

Graph 6_Estimated Number of New HIV Infections (Adults & Children) in Latin America and the Caribbean: 1980-2015 (Middle Scenario)

Source: UNAIDS Reference Group on Estimates, Modeling and Projections

Caribbean ◆ /Southern Cone and Brazil ■ /Andean Area ▲ / Central America and Mexico ✕ /Total ● /



[10] *WHO/UNAIDS developed projections based on three scenarios: low, medium, and high. They indicate the progression of the epidemic according to the level of response, with high being rapid progression of the epidemic as a result of inadequate response. For this situation analysis, the moderate scenario was used. The moderate or "middle" scenario is based on assumptions that there will be some scale-up of antiretroviral treatment (less than 60% coverage rate) or some change in prevention efforts (prevention of mother-to-child transmission programs using simple regimens and achieving less than 70% reduction in transmission rate, or successful behavior modification programs impacting vulnerable groups), and utilized the natural dynamics of the HIV/AIDS epidemic. This moderate scenario is thought to be the closest to the real situation of the response to the epidemic in the Americas as a whole.*

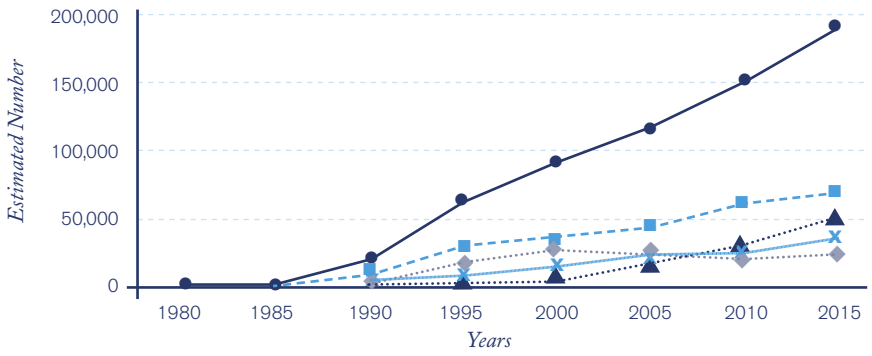
Estimates indicate that there will be between 1.5 and 2 million AIDS deaths in Latin America and the Caribbean during the next decade *(see graph 7)*, and women will represent an increasing number of these deaths.

As the number of people with HIV increases, Latin American and Caribbean countries will face a serious challenge in providing care and treatment. According to WHO/UNAIDS, in 2005, 460,000 people with HIV currently need treatment and this number will grow to 710,000 in 2010 and 960,000 in 2015. The unmet need for ART is estimated at 136,000 people in 2005. In 2010, the projected unmet need will be 143,000 people with HIV and in 2015, it will reach 160,000.

Graph 7_Estimated Number of Deaths due to AIDS (Adults & Children) in Latin America and the Caribbean: 1980-2015 (Middle Scenario)

Source: UNAIDS Reference Group on Estimates, Modeling and Projections

Caribbean ◆ /Southern Cone and Brazil ■ /Andean Area ▲ / Central America and Mexico ✕ /Total ● /

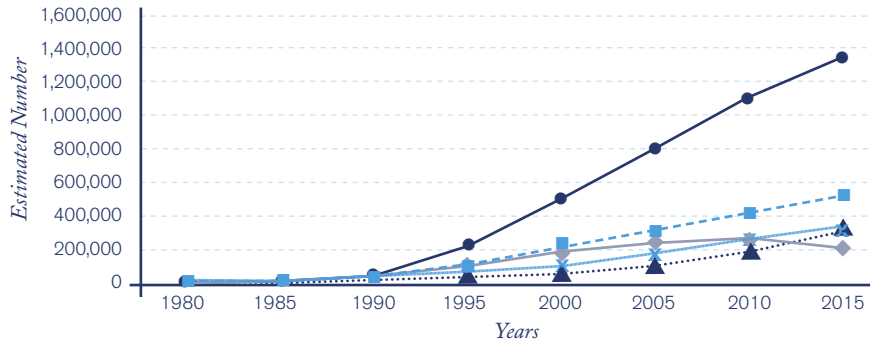


In the coming decade, the Region will also face an increase in the number of children orphaned by AIDS. From 795,000 in 2005, the number of these orphans in Latin America and the Caribbean is projected to grow to an estimated 1.4 million in 2015 *(see graph 8)*.

Graph 8_Estimated Number of Children Orphaned by AIDS in Latin America and the Caribbean: 1980-2015 (Middle Scenario)

Source: UNAIDS Reference Group on Estimates, Modeling and Projections

Caribbean ◆ /Southern Cone and Brazil ■ /Andean Area ▲ / Central America and Mexico ✕ /Total ● /



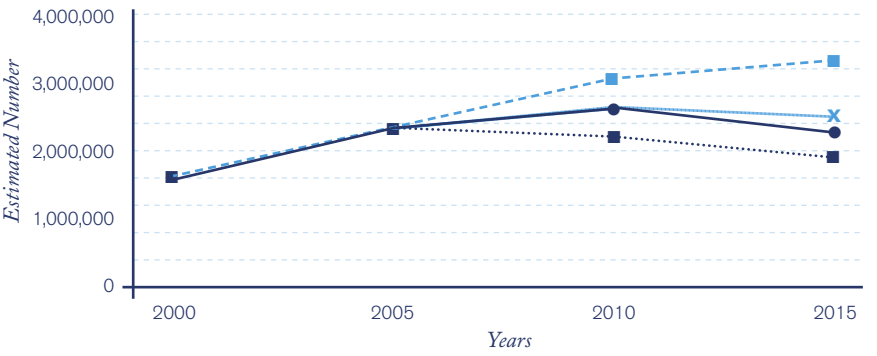
Projections developed to measure the impact of public health interventions have demonstrated the importance of a comprehensive response to the epidemic which combines prevention, care, and treatment to achieve greater impact in significantly reducing the number of new HIV infections. Putting emphasis on prevention alone or care and treatment alone is a false dichotomy and will not lead to a successful response to the epidemic. Therefore, to measure the impact of public health interventions on the spread of the disease, PAHO developed three estimated future scenarios.[11] These scenarios forecast the future of the epidemic based on reductions in new HIV infections by different percentages during the next decade. WHO/UNAIDS projections for Latin America and the Caribbean summarized above are used as a baseline. The three scenarios developed by PAHO focus on the reduction of new HIV infections as a result of a combination of scaled up prevention, care, and treatment programs. They are as follows:

- A low case scenario considering the future of the epidemic when there is a 25% reduction in new HIV infections between 2005-2010 and another 25% reduction in the new HIV infections between 2010-2015
- A medium case scenario considering the future of the epidemic when there is a 25% reduction in new HIV infections during 2005-2010, and a 50% reduction in new HIV infections between 2010-2015
- An optimistic case scenario considering the future of the epidemic when there is a 50% reduction in new HIV infections during 2005-2010 and another 50% reduction in new HIV infections during the period 2010-2015.

The results of these three scenarios are presented in *graph 9*.

Graph 9_Reductions in New HIV Infections and Impact on Number of People with HIV 2005-2015: Baseline and 3 Scenarios

Source: PAHO



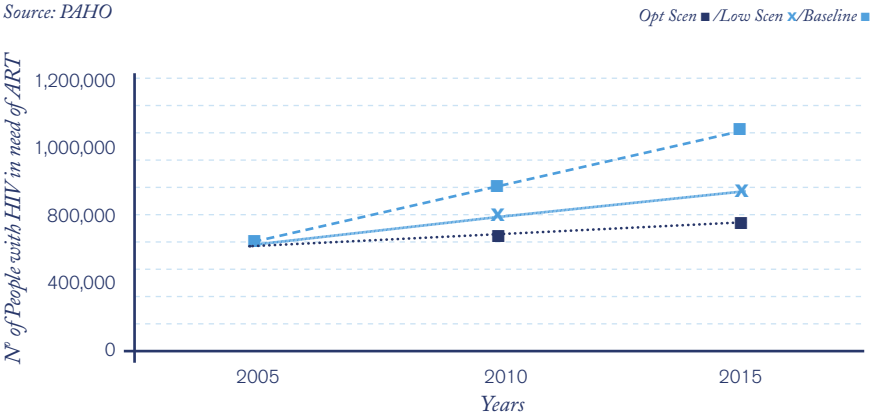
[11] *The scenarios developed by PAHO were informed the research of Solomon et al (Integrating HIV Prevention and Treatment: From Slogans to Impact. Plos Medicine. Vol 2, Issue 1. 2005).*

The optimistic scenario would result in an estimated 1.9 million people with HIV in 2015 rather than the 3.3 million projected in the baseline. This number is close to the number of people with HIV at the end of 2005. In the case of the optimistic scenario, a total number of 1.4 million new HIV infections would be prevented during the period 2006-2015 and the number of AIDS deaths would decline from 1.1 million in the baseline scenario to 800,000 in 2015.

The optimistic scenario would result in a reduced number of people with HIV requiring care and treatment, keeping that number below 600,000 during the next decade *(see graph 10)*.

Graph 10_ART Need: Baseline and Scenarios 2005-2015

Source: PAHO



This reduction would significantly increase the feasibility of universal access to care and treatment in Latin America and the Caribbean. Also, the reduction in overall new infections implied by the optimistic scenario would also significantly reduce the number of children orphaned by AIDS. The number would drop from the 1.35 million projected for 2015 to 800,000, a 41% reduction.

Achieving the optimistic scenario is within the reach of the Region, but depends on a combined scenario of scaling up comprehensive care. In the following section, some key achievements to date in the Region are highlighted, providing the rationale for targeting the optimistic scenario for the Americas.

Populations most affected by the epidemic

The general population is at risk of contracting HIV in all countries and HIV should not be seen as confined to certain groups, classes, or socio-economic characteristics. The health system is responsible for assuring that everyone who seeks their services is provided with relevant and timely information regarding HIV and STI and the risks associated with them. Nonetheless, certain groups are at particular risk due to social, economic, structural, and biological characteristics. Those populations mentioned below are at high risk due to a combination of factors. Socio-economic

marginalization and gender inequalities are cross-cutting issues that increase vulnerability and contribute to a lack of access to health services for prevention and treatment.

Those under 25 represent 30% of the population in the Region, but many **young people** are not involved in national social and economic building processes and have limited access to goods and services. The situation of young people is compounded by poverty in many areas in the Region. This vulnerability, combined with a tendency to engage in risk behaviors including unprotected sex, alcohol use, and drug use, make young people highly susceptible to HIV and STI. Children orphaned by HIV are particularly disadvantaged. Even HIV negative orphaned children still lack the support and nurturing offered by a stable family environment. For those infected, pediatric formulations for children remain highly inadequate, as industry has not invested resources into this area due to the small number of children infected with HIV in the industrialized world. [12]

Injecting drug use plays an important role in the spread of the epidemic, particularly in North America, Brazil, and the Southern Cone. In some cities in Brazil, the HIV prevalence rate among injecting drug users in 2004 was 60 times higher than the rate in the general population. In 2002, **injecting drug users** represented 43% of cumulative reported cases of AIDS in Bermuda. In Puerto Rico in 2003, 50% of all infections were associated with injecting drug use. In Argentina, the HIV prevalence rate among injecting drug users was 7.8% compared to 0.3% among pregnant women in 2003. Although injecting drug users have become a significant factor in the Regional epidemic, with infection rates reaching 60% in some cities, there is limited political support for the development of programs for this group.

Unprotected sexual intercourse between men continues to play a major role in the spread of the epidemic. HIV seroprevalence rates among this group are above 5% in most Member States. In selected countries, percentages are considerably higher. Recent surveys have shown HIV prevalence rates among **men who have sex with men** are as high as 17.7% in El Salvador and 15% in Mexico. Rates of infection in this group are also high in the Andean sub-Region. In Lima, Peru infection among men who have sex with men was as high as 21% in 2002. Discrimination forces men who wish to engage in sexual activities with other men to go "underground" and deny the existence of risk behavior. This deters prevention programs from reaching them and puts their unknowing female sexual partners at risk.

Studies have shown that **commercial sex workers** are disproportionately affected by the epidemic. A recent multi-centric study conducted in Central America showed that HIV prevalence among female sex workers varied from less than 1% in Nicaragua to over 10% in Honduras. In the Dominican Republic, the prevalence rates varied between 4.5% and 12.4% in the study sites in 2000. In Jamaica, HIV prevalence among female sex workers in Kingston was 10% and in Montego Bay 20% in 2001. In Suriname, 21% of female sex workers were infected by HIV in 2003, while in neighboring Guyana the prevalence rate was 31% in 2000.

Gender inequalities are a central issue to HIV. **Women** are biologically more susceptible to contracting the disease through sexual intercourse than men. The presence of inflammation and/or sores or ulcers in the genital tract resulting from a sexually transmitted infection that remains undiagnosed and untreated, increases several-fold the chances of becoming infected with HIV if exposed to infecting fluids.

[12] *UNICEF is the lead U.N. agency working in the area of orphan support, and work in this area is also supported by the World Bank. WHO/PAHO is responsible for the area of comprehensive care for children affected by HIV.*

Women are also vulnerable in a social sense. They often lack the power in relationships to determine whether they will be sexually active and whether a condom will be used. Young women are even more biologically and socially vulnerable than older women. In some countries, sex between young women and considerably older men is common. A high prevalence of violence and sexual coercion also puts women at risk. According to the results of a study in four Latin American and Caribbean countries, the prevalence of STI among women who had experienced violence is higher than among those who had not.

The male-to-female sex ratio of reported AIDS cases is declining rapidly in the Region. Region-wide the proportion of all reported adult cases (for which sex is reported) occurring in women has increased over time, from 6.1% before 1994 to 15.8% in 1999; in 2002, the proportion was 16.5%. In Brazil, this ratio declined from 24:1 in 1985 to 1.5:1 in 2004. In Argentina, the same ratio declined from 15:1 in 1985 to 2.5:1 in 2004. In Trinidad and Tobago, the ratio declined from 6.25:1 in 1985 to 1.5:1 in 2002. In Canada, of the 18,713 cumulative AIDS cases in adults reported up to June 2003, 1555 (8.3%) were women.

Prisoners are a neglected sub-population in terms of public health interventions despite the fact that HIV prevalence among prisoners is very high throughout the Region. In the Caribbean, a series of surveys conducted in 2004-2005 showed that prevalence rates among prisoners varied between 2% and 4%, while in the Dominican Republic and Argentina the rates were 19% and 18.4% respectively.

The mobility of populations plays an important role in the spread of HIV. **Mobile populations,** including **migrant workers,** are vulnerable due to the complications of poverty, lack of access to services, and lack of information, as well as the transient nature of their relations and long periods away from families resulting in increased engagement in transactional sex. Migrant workers who do not have the necessary documents to remain legally in the host country may face difficulties in receiving health care services or may hesitate to seek services out of fear of being deported. For example, the rate of HIV infection in Mexican migrant workers who travel to the United States is 10 times higher than the national rate in Mexico. Migrant workers in the sugar cane industry in the Dominican Republic had a seroprevalence rate of 15% in 1997.[13] The HIV seroprevalence among migrant workers in Guyana was 6% in 2001.[14]

Indigenous communities and some ethnic communities tend to have higher rates of HIV infection than the general population. In Honduras in 1999, the HIV prevalence rate was 6 times higher among the Garifuna communities on the Atlantic Coast than it was among the general population. Also in Honduras the Miskito Indigenous community has been strongly impacted by the HIV epidemic. A seroprevalence study conducted at the end of the 1990 s among the Kuna people in Panama indicated an HIV prevalence higher then the national average. The case among Indigenous populations is similar in Canada. In Suriname, according to a study conducted in 1997, 17% of all cases of HIV/AIDS in the country occurred among the ethic group known as "Maroon", even though the Maroon account for only 10% of the population.

[13] *From a 2004 IOM survey.*
[14] *CDC*

THE STATE OF HIV/AIDS/STI EFFORTS IN THE REGION

Key achievements

The Latin American and Caribbean Region has, since the beginning of the epidemic, swiftly responded to the challenges of the HIV epidemic. The health sector established and maintained National AIDS Programs which have had the responsibility for implementing interventions to prevent and control HIV/AIDS, as well as to ascertain the dimensions and evolution of the epidemic. In the vast majority of countries, mechanisms for intersectoral collaboration involving the education, finance, or social services sectors have also been established, in the form of National AIDS Committees or Councils, in conjunction with the national health authorities.

Several countries in the Region are confronting the HIV epidemic through an approach that seeks to put the same weight on prevention and treatment efforts. This is a comprehensive strategy recognizing that prevention and care do not belong in different realms, but are part of a continuum in which treatment cannot be conceived in the absence of prevention and vice versa. It is an approach in which treatment itself is considered a form of prevention, and primary prevention interventions carried out in health services are considered an integral aspect within the gamut of care. This approach is critical to working efficiently in low resource settings. It also maximizes and synergizes the efforts made by variety of sectors at national and international levels.

Primary prevention actions take place in health services but also occur in other settings under the responsibility and control of other sectors, such as schools, churches, sports and leisure centers, military camps, and prisons. There are many success stories of responsive health services, inclusive of different sectors of society, including people with HIV and civil society. The involvement has been either through actions in health care services and/or through outreach activities. Most countries have successfully implement-

BOX1\

EXAMPLES OF SUCCESSFUL EXPERIENCES IN THE REGION

Bahamas: Prevention of mother-to-child transmission *First well-documented Caribbean success story in this area—universal access to prevention services regardless of legal status led to a decline in HIV incidence and AIDS mortality among infants and children*

Barbados: Primary prevention programs among young people *Resulted in declines in HIV infection among pregnant women ages 15–24*

Brazil: Harm reduction programs *Free needle exchanges, testing, and |training former drug users as outreach workers resulted in a significant decline in new infections among injecting drug users*

Canada: Generic drug programs *A successful experience which has sustainably improved access to antiretroviral treatment*

ed prevention interventions, with a positive effect. For example, prevention of mother-to-child transmission services have resulted in a significant reduction in the number of HIV infected children in the Region.

All the countries of the Region have successfully carried out HIV prevention and control efforts that have laid the groundwork for the development of further activities. For example, in every Member State there is an operational HIV/AIDS surveillance system that, despite difficulties, has supported the countries and the Region as a whole in analyzing and assessing the situation at the national and Regional levels. Most countries in the Region have developed algorithms for the clinical management of HIV infection whether among adults or among children. Many countries have implemented interventions to reduce the chances of transmission among vulnerable populations. Successful experiences in the implementation of the health component of national HIV/AIDS plans can inspire other countries and serve as models by providing evidence of what works as well as why, when, and where a specific strategy/intervention works. Some selected outstanding examples are summarized in text BOX/1.

All countries in the Region have achieved an unprecedented acceleration in the provision of ART, especially during 2004 and 2005, and the goal of treating at least 600,000 people requiring treatment in the Region as a whole has been met and exceeded. Since January 2004, over 100,000 new treatments have been initiated in Latin America and the Caribbean alone. For the first time in history, the Region has access to the necessary resources to begin to match the magnitude of need for care and treatment. The Global Fund has disbursed 480 million in funds to 28 countries in the Region, as well as to sub-Regional mechanisms such as CARICOM and the Caribbean Epidemiology Center (CAREC). Moreover, lower prices achieved through negotiations between countries and pharmaceutical companies have resulted in greatly reduced prices for first line ART. These lower prices and the greatly amplified financing for ART have made universal access to drug treatment a realizable goal. However, a comprehensive approach integrating prevention, care, treatment, and support, facilitated by appropriate policies and legislation, is still essential to the overall success of any one intervention.

Chile: Promoting condom use at the national level *Promotion of condom use to prevent HIV has evolved in the past 15 years to become a campaign using overt and honest messages placed in public view*

Costa Rica: HIV prevention among prisoners *Educating men in prison about the HIV risk associated with violence and addictions resulted in increased HIV-related knowledge and reported condom use*

Cuba: Integrating services at the primary care level *Since 1986, the country has been providing integrated services at the primary health care level and guaranteeing universal access to comprehensive care*

Haiti: Care and treatment programs *A successful example of rolling out decentralized programs involving the community in a setting with extremely limited resources*

Mexico: High level commitment to reducing HIV transmission among men who have sex with men *Implemented a nationwide campaign to combat homophobia and currently testing innovative methods to reach this vulnerable group*

USA: Care and treatment programs *First successful story in the area of scaled up care and treatment—resulted in declining rates of AIDS mortality*

In Latin America and the Caribbean there is now a critical mass of technical capacity, resources, and experience within civil society organizations and organizations of people with HIV. At the international level, organizations are working with specific vulnerable groups as well as in specific technical areas (see text BOX/2). At least 15 countries in the Region have national networks, social organizations, and community based organizations concerned with HIV/AIDS, with a myriad of areas of focus, including advocacy, promoting adherence, operational research and more integrated perspectives. The more successful organizations are those that take an integrated approach involving civil society as well as local and international partners.

In countries such as Canada, the United States, Brazil, Costa Rica, Haiti and the Bahamas where ART has been provided through the health system for several years, death rates have declined dramatically. These countries recognized early on that treatment is key for prevention and control, as well as for its direct, positive impact on the lives of people with HIV. By 2003, the Bahamas had experienced a 56% reduction in AIDS deaths overall and a reduction of 89% in children since the introduction of ART. Moreover, prevention was also dramatically affected, reducing mother-to-child transmission from 28% to 3%, a 44% reduction in new HIV cases, a 41% decline in HIV prevalence rate among STI patients, a 38% decline in HIV prevalence among pregnant women, and a 24% reduction in new AIDS cases.

Since the beginning of the epidemic, several countries in the Region have taken part in the global effort to find a vaccine for HIV. Currently, the United States, Brazil, Haiti, Peru and Trinidad and Tobago are active research sites. HIV poses a particular challenge to vaccine developers. There is more than one strain of HIV, and the virus is constantly mutating as part of its strategy to elude the immune system of the host, so an effective vaccine needs to prevent multiple strains

BOX2\

EXAMPLES OF CIVIL SOCIETY ORGANIZATIONS IN LATIN AMERICA AND THE CARIBBEAN WORKING ON HIV/AIDS

Latin American Network of people living with HIV/AIDS (REDLA+)
20 countries ***Mission:*** *Data collection on access to treatment, strengthening of national networks, and capacity development*

Coalition of Positive Women (ICW Latina)
17 countries ***Mission:*** *Activities similar to REDLA+, but with a focus on women*

LACASSO
15 countries ***Mission:*** *National networks and social services*

RELARD
20 countries ***Mission:*** *Harm reduction for drug users*

Network of Latin American Sex Workers
11 countries ***Mission:*** *Defending the rights of sex workers*

ASICAL
9 countries ***Mission:*** *Social, political, and cultural rights of gay men and other men who have sex with men*

The Caribbean Regional Network of People Living with HIV/AIDS (CRN+)
23 Caribbean countries ***Mission:*** *Provides leadership in human rights and advocacy in the Caribbean.*

The Caribbean Forum for Lesbians, All sexes, and Gays (C-Flag)
21 Caribbean countries ***Mission:*** *Advocacy and HIV prevention*

GYCA: Global Youth Coalition on AIDS
Global ***Mission:*** *Virtual portal to mobilize youth in developing countries; focuses on the needs of youth living with HIV*

and to disable the virus in spite of mutations. In 2002, clinical trials began with a new vaccine that targets the three most globally important HIV1 subtypes (A, B, and C) which together are associated with some 90 percent of all HIV infections worldwide. Preliminary results of these trials appear promising.

Challenges

The scaling up of HIV/AIDS activities in the Region in recent years has led to several challenges. Despite the widespread recognition that HIV is not only a health problem but spreads into virtually all areas of human, social, and economic development, HIV is still seen as the responsibility of the health sector alone in many countries. There are, however, challenges associated with the involvement of multiple sectors. Civil society, including organizations of people with HIV, is key to the formulation of comprehensive and integrated policies and programs yet has not been a full partner in national efforts. With the creation of UNAIDS and U.N. Theme Groups at the country level, multi-sectoral responses to the HIV epidemic have been strengthened. Nonetheless, most countries have not achieved a truly integrated, multi-dimensional response, with clear responsibilities defined and shared among stakeholders.

Within the health sector many challenges are yet to be fully addressed. In most countries, services are still centralized in specialized clinics located in large cities, and the integration of services at the primary level of care is still very limited. The provision of vertical services in specialized HIV and STI clinics is a known barrier to access to care, as it further isolates people suffering from these illnesses and may even perpetuate stigma and discrimination. The spontaneous demand for counseling and testing, essential for the early detection of HIV positive individuals, is also compromised due to the limited availability of quality services at the community level backed up by appropriate referral systems.

While prevention is key to the success of the fight against HIV, primary health care services are not equipped to provide comprehensive prevention services for vulnerable groups such as youth and children, injecting drug users, and commercial sex workers. Part of the problem is the paucity of sound, evidence-based examples of best practices in the prevention area, and practices which are known to provide protection from HIV (needle exchange, condom use, and promotion of healthy sexuality) are still largely taboo in the Region. Similarly, the prevention and treatment of STI, an important risk factor for HIV, have not received adequate attention in the health sector in recent years. Another neglected areas is services for children affected by the epidemic, especially as part of the health sector response and as an aspect of research projects.[15]

Rapid scale up of comprehensive care and treatment requires an array of essential support services which, until now, have been largely inadequate in most countries of the Region. Drug procurement and management systems have not expanded rapidly enough to effectively support the provision of direct patient care. The supply of antiretroviral drugs and laboratory diagnostics has been hampered by inconsistent pricing policies by manufacturers in the Region. However, price negotiations conducted by 11 countries of the Region with 26 pharmaceutical companies in 2005 have helped to lower the cost of first line AIDS medicines to prices lower than those achieved in 2003 in previous joint negotiations. Obtaining further reductions, particularly in second line medicines and diagnostics, is a priority for the Region.

[15] *UNICEF, in collaboration with other development partners, is implementing a strategy for an integrated HIV response for children. PAHO/WHO will be leading the pediatric care component of this strategy.*

The extension and expansion of services for people with HIV is occurring within a context of limited qualified human resources. Health providers may not be equipped or motivated to provide comprehensive care and treatment, they often lack the necessary training and specialization, and they may not be deployed to the areas where services are needed. Training in the supply management of drugs and diagnostics must be provided. In addition, public health professionals and health systems and services managers require training in the rational use of laboratory diagnostics and continuing education to allow them to keep abreast of advances in technology. There is a lack of human resource strategic planning and management processes to inform Ministries of Health on critical issues related to policies, staffing, cost, and accreditation needs. Moreover, some of the fiscal policies implemented by countries impose limitations on the Ministries of Health regarding the acquisition and retention of staff. The benefit package offered by the public health sector generally cannot compete with that offered by the private sector or even those offered by externally funded projects within the public sector.

The proliferation of services in the for-profit and non-profit sectors has contributed to the rapid expansion of HIV services and has positively affected access to care for specific population groups or people living in specific geographical areas. Nonetheless, these services can present a challenge for improving public health systems because public services may lack the authority to regulate private services, resulting in a lack of consistency in guidelines and treatment protocols, as well as poorly defined referral systems.

Scaling up services also presents challenges in the areas of management, monitoring, and evaluation. The majority of countries do not have adequate health information systems, and challenges exist in regard to collection of HIV data, assurance of confidentiality, and integration into existing systems. Patient-based data on outcomes, adherence, and resistance to treatments is lacking in many countries, and capacity building in this area is an urgent need. The lack or limited availability of quality and timely data has been recognized as a major obstacle to inform country and Regional efforts.

While the increased investment in HIV/AIDS in Latin America and the Caribbean by a variety of development initiatives has clearly benefited countries, it also leads to the fragmentation of local responses and puts considerable pressure on countries' limited human and financial resources. Despite wide acknowledgement of the importance of the "Three Ones," three principles for the coordination of national AIDS responses,[16] development partners continue to stress their own agendas, including separate monitoring and evaluation mechanisms. In order to cope with these pressures, national programs are forced to make strategic choices in order to make the most of the increased support. They face the challenges of streamlining efforts to avoid parallel processes and ensure balanced investment in multiple sectors of society.

[16] *The Three Ones promotes the following: One agreed HIV/AIDS Action Framework that provides the basis for coordinating the work of all partners; One National AIDS Coordinating Authority, with a broad-based multisectoral mandate; One agreed country-level Monitoring and Evaluation System.*

OVERALL OBJECTIVE 6

By 2015, to halt and begin to reverse the spread of HIV/AIDS[17] as well as STI in the Region by providing universal access to prevention, care, and treatment.

OVERALL TARGETS

TARGET 1: By 2010, there will be a 50% reduction in the estimated number of new HIV infections followed by a further 50% reduction in new infections by the end of 2015.
TARGET 2: By 2010, there will be universal access to comprehensive care including prevention, care, and antiretroviral treatment.
TARGET 3: By 2015, incidence of mother-to-child transmission of HIV will be less than 5% and incidence of congenital syphilis will be less than 0.5 cases per 1000 live births.

CRITICAL LINES OF ACTION, TARGETS, AND MILESTONES 7

To achieve the overall objective of the Regional Plan and to respond to countries' needs,[18] five critical lines of action have been identified:

1_Strengthening health sector leadership and stewardship and fostering the engagement of civil society
2_Designing and implementing effective, sustainable HIV/AIDS/STI programs, and building human resource capacity
3_Strengthening, expanding, and reorienting health services
4_Improving access to medicines, diagnostics, and other commodities
5_Improving information and knowledge management, including surveillance, monitoring and evaluation, and dissemination

These lines of action describe strategies for the improvement of prevention, care, and treatment services. Each is followed by targets to be achieved by 2010 or 2015 and milestones to mark progress along the way. It is recognized that the levels of existing infrastructure, human resource capacity, and available funding differ among countries in the Region. Therefore, a number of strategies and targets are presented, from which countries can determine those most appropriate for their settings.

[17] *In line with Goal 6 of the UN Millennium Declaration and with the 19 Sep 2005 Statement of the UN Summit on HIV/AIDS and other health issues.*
[18] *A questionnaire was sent to all countries in the Region to elicit input on the content, scope, and development of the plan. Feedback was used to shape the present document.*

1/
Critical line of action

Strengthening health sector leadership and stewardship and fostering the engagement of civil society

2/
Critical line of action

Designing and implementing effective, sustainable HIV/AIDS/STI programs, and building human resource capacity

3/
Critical line of action

Strengthening, expanding, and reorienting health services

4/
Critical line of action

Improving access to medicines, diagnostics, and other commodities

5/
Critical line of action

Improving information and knowledge management, including surveillance, monitoring and evaluation, and dissemination

Critical line of action 1/

Strengthening health sector leadership and stewardship and fostering the engagement of civil society

Increased political commitment to the highest possible standard of health services for prevention, care, and treatment to address the HIV epidemic as well as STI, combined with an understanding of the costs of inaction and the benefits of action, are fundamental to the success of efforts in the Region

In order to improve the health sector response to HIV/STI, national health authorities in the Region must exercise strong leadership and stewardship for the formulation and implementation of clear, evidence-based national policies that respond to the needs of all people with or at risk for HIV/STI, and eliminate laws and policies that perpetuate discrimination and stigmatization in the health sector and in society at large. Key to the success of such national policies is the effective mobilization and allocation of resources to strengthen overall capacity of the health system for sustainable, comprehensive programs and services. Medium- and long-term financing mechanisms that maximize the use of national resources and mobilize international resources need to be implemented. Reinforcing the steering role of health authorities is essential to ensure that various financing modalities are sufficiently complementary to permit universal access to health services and to monitor the sectoral financing process.

To ensure rational and effective use of the resources available to the health sector to fulfill its role, national health authorities must coordinate the diverse agendas and activities of many agencies and organizations. Mechanisms to ensure the harmonization of resources in the health sector, rapid action, and results-based management must be implemented within the framework of the Three Ones.

Universal access to prevention, care, and treatment for HIV requires a strategic, transparent, health sector-wide approach involving all stakeholders in the public and private sector including civil society, families, and people with HIV. A comprehensive national response to the HIV epidemic requires a multi-sectoral developmental approach. Therefore, the health sector should continue advocating for the full participation and involvement of other relevant sectors (education, labor, finance, and social services).

Mechanisms to review and update health sector strategies for HIV/STI will need to be implemented within the context of the Regional Plan, including the definition of national targets. Linkages with on-going health sector reform efforts need to be established.

CRITICAL LINE OF ACTION 1: *Strengthening health sector leadership and stewardship and fostering the engagement of civil society*

STRATEGY 1.1: Implementing national policies for universal access and financing mechanisms through a health sector-wide approach and engagement of civil society including families and people with HIV.

TARGET 1.1: **By 2010, policies and necessary health reforms including financing will be implemented to ensure universal access to health services for prevention, care, and treatment for HIV/STI within countries.**

> **Milestones:**

1.1.1_By 2010, a strategic planning process for the national health sector response will be institutionalized, with active involvement of main stakeholders, particularly people with HIV.

1.1.2_By 2010, financial plans for universal access to prevention, care, and treatment will be implemented and resource needs will be covered.

1.1.3_By 2008, policies for health service delivery will be in place, including adequate training for health workers, to eliminate stigma, discrimination, gender disparities, and other barriers to HIV and STI prevention, care, and treatment.

1.1.4_By 2007, a national strategy with clear targets for the health sector response including prevention, care, and treatment will be defined. This will be an integral part of one multi-sectoral national strategic plan within the context of the Millennium Development Goals.

STRATEGY 1.2: Advocating for universal access to comprehensive care and for appropriate supporting policies

TARGET 1.2: Throughout the period covered by this Plan (2006-2015), universal access to health services for HIV prevention, care, and treatment will be a priority in sub-Regional and national political and public health fora.

> **Milestone:**

1.2.1_By 2010, advocacy efforts will engage policy makers from other key sectors such as education, national and religious leaders, and the private sector on actions that they can take to improve prevention, care, and treatment for HIV/STI.

STRATEGY 1.3: Harmonization of health sector resources within the context of the national HIV/AIDS plans and the Three Ones

TARGET 1.3: By 2010, a mechanism for harmonization of resources will be implemented within the health sector.

> **Milestone:**

1.3.1_By 2007, a mechanism for harmonization of resources will be developed that includes options for coordinating the work of all partners, linkages with the national coordinating authority, and monitoring and evaluation.

STRATEGY 1.4: Fostering intersectoral collaboration

TARGET 1.4: By 2010, health sectors will be working actively with other relevant sectors to provide comprehensive programs for HIV/STI and to promote general wellness.

> **Milestone:**

1.4.1_By 2008, health sectors will identify areas for intersectoral work, make linkages with appropriate partners and define joint priorities.

Critical line of action 2/

Designing and implementing effective, sustainable HIV/AIDS/STI programs, and building human resource capacity

National policies to ensure universal access to prevention, care, and treatment for HIV should be translated into comprehensive programs and services.

National AIDS Programs within Ministries of Health are the functional entities responsible for program planning and management. These programs need the appropriate human and financial resources and authority to be able to identify opportunities and to develop innovative interventions to link prevention and care services and integrate HIV/STI interventions into other health programs.

National AIDS Programs can contribute to overall development of the health system infrastructure and capacity by defining the essential package of services for HIV/AIDS/STI and organizing or reorganizing health care delivery systems accordingly. Once countries have done this, the National AIDS Programs will play a coordinating and leading role in supporting health facilities and health providers in the development of operational plans. National AIDS Programs should actively seek the participation and input of people with HIV in the formulation and execution of operational plans. These plans should enable the provision of quality services as per established norms and standards. Quality improvement systems should be implemented to enforce quality care.

Key to this process is a health promotion and evidence-based approach to program planning that takes into consideration the necessary behavioral changes not only in individuals but in society at large. This will facilitate the removal of structural barriers that perpetuate vulnerability to HIV.

Carrying out comprehensive programs implies the full integration of prevention efforts and interventions at all levels of the health system, along with other clinical and support services.

Those populations most at risk in each country must be identified and their characteristics and situations understood. Among them are young people, women, men who have sex with men, sex workers, injecting drug users, migrant populations, mobile workers, and indigenous peoples. Existing programs, while focusing on the population at large, must also take into account the needs of vulnerable groups and interventions must be undertaken where they do not exist in order to specifically reach these groups.

Comprehensive programs should include the following set of interventions. These may be prioritized according to country capacity and needs:

- Promotion and protection of sexual health[19]
- Evidence-based health promotion activities
- Condom promotion and behavior change communication for vulnerable or at-risk individuals
- Communication activities that promote dialogue concerning the root causes of the epidemic and generate the political and social environment necessary for individual behavior change
- Targeted interventions to provide access to prevention and care for vulnerable groups
- Harm reduction services for injecting drug users, including needle and syringe exchange, and management of injecting drug users
- Access to products and commodities to protect people against HIV/STI transmission (condoms and other mechanical barriers, microbicides, and safe blood)
- Positive prevention (see glossary)
- Protection from abuse, in particular gender based, sexual, and domestic violence
- Prevention of HIV transmission in health care settings (blood safety[20] and infection control) including post-exposure prophylaxis for health care personnel
- Prevention of mother-to-child transmission of HIV and syphilis, and ART for eligible HIV infected women and children
- Integrated care and treatment with active family participation for children affected by HIV
- Voluntary and confidential HIV counseling and testing services
- The highest possible standard of health care for all people with HIV including ART, treatment of common opportunistic infections, laboratory testing, psychosocial support to people with HIV and their families, and treatment adherence support
- Linkages between TB and HIV programs including prophylactic therapy and TB prevention for eligible HIV infected people and HIV prevention services for people with TB
- Nutritional interventions for people with HIV and general care including oral health
- STI case management at point of first contact

Human resource planning and management must be strengthened to ensure that health services are appropriately staffed to meet HIV/AIDS/STI needs. Countries need to address critical issues such as level and quantity of personnel required, recruitment, deployment and retention issues, and training. Comprehensive plans for human resources development and technical capacity building are necessary and must be based on systematic assessment of human resources needs and gaps.

To fulfill their expanded role, National AIDS Programs will need to develop effective results-based management systems as well as monitoring and evaluation programs. Mechanisms must be developed to maximize partnerships and involve stakeholders in the strategic management of programs.

[19] *HIV prevention must be strongly based on open discussions of sexuality, gender, and relationships, and must trigger processes for improving overall sexual and reproductive health and foster positive changes in gender interactions, in particular among young people.*

[20] *Blood safety needs are addressed by the Regional Initiative for Blood Safety and Plan of Action for 2006–2010.*

CRITICAL LINE OF ACTION 2: *Designing and implementing effective, sustainable HIV/AIDS/STI programs, and building human resource capacity*

STRATEGY 2.1: Strengthening the planning and management capabilities of the National AIDS Program

TARGET 2.1: From 2006-2015, National AIDS Programs will be priority programs with a mandate and adequate resources to carry out the health sector HIV/AIDS/STI strategy.

> **Milestones:**

2.1.1_By 2010, annual assessments of progress on the achievement of program objectives and national targets as measured through priority indicators will be conducted.

2.1.2_By 2010, disaster preparedness plans will have a component that ensures the continuity of HIV/AIDS/STI activities and services including access to condoms and medications.

2.1.3_By 2007, National AIDS Programs will establish and/or maintain mechanisms for strategic planning and management involving relevant stakeholders including people with HIV.

2.1.4_By 2007, packages of essential public health interventions and health services for prevention, care, and treatment, as well as an updated HIV/STI program and plan will be defined. The plans should explicitly include: communications strategies, strategies to eliminate stigma and discrimination, vulnerable groups, and modalities of health care delivery.

2.1.5_By 2007, National AIDS Programs will define the ethical framework essential to the programming of HIV/STI prevention and care services and establish the mechanisms for its implementation.[21]

STRATEGY 2.2: Planning interventions for vulnerable groups

TARGET 2.2: By 2015, targeted prevention interventions will have been implemented to reach vulnerable groups based on the local characteristics and trends of the epidemic.

> **Milestones:**

2.2.1_From 2006-2015, there will be at least one annual mass media campaign underlining the importance of preventing HIV/STI and raising awareness among those at risk.

2.2.2_By 2012, national health authorities will have ascertained the health needs of migrant populations related to HIV/STI as well as options to ensure their universal access to comprehensive care.

[21] *This includes PAHO TAC recommendation # 13*

2.2.3_By 2010, health authorities will have strategies in full operation to address the linkages between domestic violence (including sexual violence) and HIV/STI.

2.2.4_By 2007, a set of interventions proven to be effective to prevent transmission in vulnerable populations (in particular men who have sex with men and sex workers) will be identified and subsequently scaled up in collaboration with relevant community-based organizations.

STRATEGY 2.3: Improving quality assurance systems for HIV/STI comprehensive health care services

TARGET 2.3: **By 2015, quality assurance systems for comprehensive health care will be established.**

> **Milestones:**

2.3.1_By 2012, mechanisms to assess compliance with national guidelines, norms and protocols will be established.

2.3.2_By 2009, technical guidelines and management protocols will be updated/developed for all relevant HIV and STI prevention, care, and treatment interventions and services according to internationally recommended practices.

STRATEGY 2.4: Strategic management of human resources and capacity building

TARGET 2.4: **By 2015, human resource management systems will be in place to ensure that health services will be appropriately staffed to meet HIV/STI requirements, and distributed according to need.**

> **Milestones:**

2.4.1_By 2010, policies, legislation and regulations will be put into place to ensure adequate staffing (recruitment, deployment, retention, and workplace safety) for implementation of health interventions and the provision of comprehensive health services for HIV/STI.

2.4.2_By 2010, educational programs for health professionals will have incorporated prevention, care, and treatment of HIV/AIDS/STI in their curricula at all levels and disciplines.

2.4.3_By 2008, in-service continuing education needs for HIV/STI health workers will be defined and capacity development programs[22] will be underway, monitored, and evaluated.

[22] *Programs should assist in the development of linkages with stakeholders such as teachers and social workers as well as provide joint counseling and adherence programs with members of the community.*

Critical line of action 3/

Strengthening, expanding, and reorienting health services

Expanding services for effective prevention, care, and treatment to satisfy demand.

HIV care must be comprehensively provided at all levels of the health system. Many models of health care delivery still concentrate services in specialized health facilities that are not accessible to large segments of the population. In many cases, providing accessible services for prevention, care, and treatment will require a reorientation or reorganization of health care delivery systems. Stigma and discrimination within the health sector remain prevalent in the Region and can deter people from seeking diagnosis and care services. The first step in reorienting services is to sensitize health workers at every level to provide compassionate and caring quality care in a non-judgmental setting.

A primary health care approach to service delivery provides not only an opportunity to strengthen existing services, but also a way to realize the provision of an essential package of services that are necessary to achieve universal access to prevention, care and treatment. A clear definition of the range of services that must be provided at each level of the health care system (primary, secondary and tertiary levels)[23] is necessary along with the corresponding referral system as per established protocols. The network of health facilities will need to develop the necessary infrastructure, human resources, and work processes to be able to implement the required package of services.

There are two important elements to making this approach operational:

- Integrating voluntary counseling and testing, as well as other appropriate HIV services, into the primary level of care, taking advantage of existing services.
- Utilizing existing services as entry points for HIV prevention, care, and treatment. Examples of entry points are: voluntary counseling and testing, TB services, medical clinics, antenatal and mother and child health care services, STI services, domestic violence services, reproductive health services (including family planning), drug dependence treatment and harm reduction services, and blood safety.

In line with the primary health care approach, communities have much to contribute to the planning, provision, and monitoring of health services, in particular people with HIV. People with HIV have an important role to play in supporting health services for adequate identification of needs, motivating people

to come forward for testing and treatment, and in providing peer support and promoting treatment adherence. The involvement and participation of people with HIV and community based organizations in the planning, monitoring, and provision of services is key to the success of these interventions.

To increase health seeking behavior, services need to be user friendly and respond to the specific needs of various population groups. Health facilities and health service delivery points (outreach programs) will require gender sensitive, age specific, and culturally appropriate settings and practices and health personnel must to be educated accordingly.

CRITICAL LINE OF ACTION 3: *Strengthening, expanding, and reorienting health services*

STRATEGY 3.1: Integrating the appropriate package of HIV care and treatment services at each level of care

TARGET 3.1: By 2015, HIV care will be available at each level of care as defined by the essential package of services, with appropriate referral systems for secondary and tertiary care.

> **Milestones:**

3.1.1 By 2008, mapping of available services and identification of gaps will be completed.

3.1.2 By 2008, training will be provided to reduce stigma and discrimination, and to increase confidentiality for clients in health care settings at all levels.

3.1.3 By 2008, workplace safety rules, regulations, and supplies, including post-exposure prophylaxis, will be in place to protect health workers who come in contact with the HIV virus.

STRATEGY 3.2: Strengthening STI prevention and treatment through population-based screening and treatment programs, the promotion of STI management at the point of first contact with health providers, partner notification, the use of syndromic management, and other innovative approaches

TARGET 3.2: By 2010, all primary health care facilities will be implementing an STI control basic package including counseling, diagnosis, contact referral, HIV testing, treatment.

[23] *To be described further in forthcoming guidelines on the Essential Package of Services from WHO.*

STRATEGY 3.3: Utilizing services as entry points for HIV prevention, care, and treatment

TARGET 3.3: By 2015, there will be increased accessibility and availability of HIV/STI prevention and care services through entry points.

> **Milestones:**

3.3.1_By 2012, substance abuse treatment services will have access to health services for harm reduction, prevention, care, and treatment of HIV/STI.

3.3.2_By 2010, TB clinics will be providing comprehensive prevention, care, and treatment for people coinfected or at risk of HIV.

3.3.3_By 2010, domestic violence services will have access to voluntary counseling and testing, as well as prevention, care, and treatment services for HIV/STI.

3.3.4_By 2010, blood donation services will have access to counseling services and referrals for prevention, care, and treatment of HIV/STI.

3.3.5_By 2010, voluntary counseling and testing services[24] will be integrated into the primary level of care and linked to care and treatment and prevention services for specific population groups. Each country will be implementing a "Know Your Status" campaign every year.

3.3.6_By 2007, at least three entry points will have been identified within existing health services and operational plans will be developed to strengthen and expand these services.

3.3.7_By 2007, prevention of mother-to-child transmission interventions, including the prevention of congenital syphilis, will have been integrated into antenatal services. Follow up will include ART for eligible women with HIV and care for the mother and infant after delivery ("PMTCT+").

3.3.8_By 2007, pediatric care services for HIV will be sensitized to respond effectively to the needs of children and their families.

STRATEGY 3.4: Ensuring services for specific vulnerable groups identified in the national health sector strategy

TARGET 3.4: By 2015, there will be a 75% increase in reported condom use at last risky sexual encounter among vulnerable populations.

> **Milestones:**

3.4.1_By 2010, youth-friendly health services[25] will be integrated into health services.

3.4.2_By 2010, appropriate health care services for the prevention, care and treatment of HIV/STI (within health facilities or outreach) in hard-to-reach populations including men who have sex with men, sex workers, and migrants will have been established.

[24] *Voluntary counseling and testing services, to be effective, must be supported by access to non-stigmatizing, non-discriminating counseling, care and support services and encourage routine offering of counseling and testing to special population groups identified according to the epidemiological situation.*

[25] *These will include providing a comprehensive array of services including HIV/AIDS education relevant to young people's behaviors, comprehensive sex education, and counseling. Condoms should be made available for sexually active young men and women. Services must be affordable, conveniently located, and confidential.*

STRATEGY 3.5: Participation of people with HIV and community based organizations in the monitoring and provision of health care

TARGET 3.5: **By 2010, people with HIV will be fully participating in the promotion and provision of health services.**

> **Milestones:**

3.5.1_By 2008, organized groups of people with HIV will be supported (technically and/or financially) to contribute to the provision of services through peer counseling, support for treatment adherence, monitoring, and quality assurance.

3.5.2_By 2008, functional, community based referral and collaboration networks, including people with HIV, community leaders, and NGOs will be linked to health services.

3.5.3_By 2007, strategies and mechanisms will be identified to mainstream the participation of NGOs and other groups in the provision of services.

Critical line of action 4/

Improving access to medicines, diagnostics, and other commodities

Access to medicines, diagnostics, and other commodities is essential to ensure quality care.

A comprehensive approach to access to care includes the necessary tools and commodities for prevention, diagnosis, treatment, and patient monitoring. Good pharmaceutical management practices are necessary to ensure the quality of these diagnostic tools and medications. HIV disease has become a chronic condition and as such, issues related to affordability and supply systems are critical to achieve and sustain universal access to care and treatment. Care and treatment sites should have timely access to quality laboratory tests and treatment points should be equipped with quality medicines including antiretroviral drugs to ensure that universal access to treatment is effectively achieved.

Regional efforts to reduce the price of medicines, such as joint negotiations and pooled procurement, must be maintained and expanded to include a wider range of essential public health supplies. PAHO's Regional Revolving Fund for Strategic Public Health Supplies is one mechanism to facilitate access to medicines and other public health supplies for all member countries under the principles of cost effectiveness and solidarity.

Laboratory services must be improved to assure the reliable diagnosis of infectious diseases, monitoring of disease progression, treatment, evaluation of drug resistance, and epidemiological surveillance. Care and treatment sites must have timely access to quality laboratory tests as required by protocols, and sub-Regional or inter-country laboratory networks must be implemented to allow for sharing of services and expertise.

CRITICAL LINE OF ACTION 4: *Improving access to medicines, diagnostics and other commodities*

STRATEGY 4.1: Ensuring effective systems for the management and regulation of essential public health supplies (medicines, diagnostics and other commodities)

TARGET 4.1: **By 2010, countries will procure and manage antiretroviral drugs, essential medicines, diagnostics, and other commodities including condoms, reagents, and necessary supplies.**

> **Milestones:**

4.1.1_By 2008, there will be a mechanism to secure supply chains from drug suppliers to service sites.

4.1.2_By 2006, countries will be fully utilizing the flexibilities of intellectual property agreements as appropriate and as defined in the Doha Declaration.

STRATEGY 4.2: Strengthening capacity in quality control evaluation and rational use of medicines and other commodities

TARGET 4.2: **By 2010, a Regional mechanism will exist to ensure quality control of diagnostics, medicines, and commodities and their rational use.**

> **Milestone:**

4.2.1_By 2008, Regional guidelines will be available and used for the development of national quality control measures and the rational use of medicines and other commodities.

STRATEGY 4.3: Establishing and strengthening national laboratories and Regional networks

TARGET 4.3: **By 2012, all care and treatment sites will have access to the necessary laboratory services for diagnosis, clinical staging, and monitoring treatment outcomes.**

> **Milestones:**

4.3.1_By 2010, a comprehensive public health laboratories network with strengthened core functions will be operating in the Americas.

4.3.2_By 2008, laboratory services will be equipped and staffed to perform laboratory testing to support the essential package of services.

4.3.3_By 2008, sub-Regional reference laboratory networks will be created to support external quality control of HIV/STI-related lab services and surveillance including ARV resistances.

4.3.4_By 2007, quality standards for laboratory testing will be implemented (including standard operating procedures, algorithms, and internal and external quality assessment schemes).

Critical line of action 5/

Improving information and knowledge management, including surveillance, monitoring and evaluation, and dissemination

Timely and accurate health data constitutes the essential foundation for policy making, planning, program implementation and measuring progress and success. Health information systems must be able to respond to new information needs to measure progress and guide the health sector response.

Tracking the HIV epidemic and its trends is an essential part of the response. As the epidemic evolves, the strategic data needed to understand its direction and progression and to guide the response become increasingly complex. In consequence, information systems need to evolve accordingly to accomplish their objectives. At the same time, systems need to be kept simple and flexible so as not to overwhelm the national capacity to operate them. Mechanisms should be in place to guarantee comparability and assure continuity over time. To achieve both, respond to new data demands, and ensure timeliness and relevance, information systems should be strengthened through guided growth and careful planning.

Good surveillance systems should provide information about the magnitude of the epidemic as well as trends over time, and project the future of the epidemic. Good monitoring and evaluation systems should provide information on the progress, pertinence, and effectiveness of the health response. Without measuring the response, countries' efforts may not be making the biggest impact on the epidemic; worse still, they may be wasting resources. Monitoring and evaluation systems at the country level will also facilitate the measurement of progress toward achieving Regional and global goals to which countries have committed.

This requires improved national capacity to analyze data and disseminate information in support of health sector efforts. Systems need to have the capacity to analyze data "beyond the numbers." For example, they should be able to identify gaps and inequities undermining progress toward achieving the targets.

Surveillance systems must also disseminate results and provide feedback to various audiences in a user-friendly manner. Relevant data needs to be shared quickly with policy and decision makers, communities, and other interested groups.

In line with the Three Ones, the surveillance, monitoring, and evaluation components of the national health sector plan for HIV will enhance the country's ability to focus the response. These components should be jointly prepared and implemented by relevant partners to ensure a richer data base that can be used by all involved parties. Strategic links with key actors involved in data collection (such as prevention of mother-to-child transmission services, voluntary counseling and testing, STI, antenatal care, TB, laboratory, and blood programs) should be established and/or strengthened. Strategic alliances should also be developed with the community to convert subjects of surveillance into partners of the system. Specialized institutions (academic institutions and collaborating centers) are also key partners to help answer research questions. This networking approach will promote the exchange of data, the triangulation of information, and analysis from various perspectives.

Finally, countries should foster an enabling environment for surveillance, monitoring, and evaluation systems. This means ensuring the necessary political commitment, translated into human and financial resources to achieve high quality systems.

CRITICAL LINE OF ACTION 5: *Improving information and knowledge management, including surveillance, monitoring and evaluation, and dissemination*

STRATEGY 5.1: Strengthening HIV surveillance systems using state of the art techniques

TARGET 5.1: By 2010, national surveillance systems will be providing comprehensive data on all the necessary key components of state of the art surveillance systems.[26]

> **Milestones:**

5.1.1_By 2008, national standardization of key components of minimum surveillance systems including definitions, variables, disagreggation by age and sex, indicators, forms, and reports will be completed.

5.1.2_By 2008, mechanisms for surveillance and monitoring of ARV resistance will be established.

5.1.3_By 2007, surveillance systems will include adequate geographical coverage and representativeness of population groups relevant to the epidemic.

[26] *Key components of state of the art surveillance include HIV (including PMTCT), AIDS, behavioral surveillance (including condom use rates), congenital syphilis cases and other STI, TB/HIV and STI/HIV coinfection rates, and access to antiretroviral treatment.*

STRATEGY 5.2: Development and strengthening of monitoring and evaluation systems in the health sector as part of the global efforts in monitoring and evaluation

TARGET 5.2: By 2010, national capacity will be built for monitoring and evaluation to assess prevention, care, and treatment progress.

> **Milestones:**

5.2.1_By 2007, countries will evaluate their programs to determine best practices for prevention, care, and treatment interventions and health promotion efforts.

5.2.2_By 2007, capacity to monitor treatment outcomes will be in place.

5.2.3_By 2007, countries will collect core Regional and national indicators for prevention, care, and treatment.

5.2.4_By 2007, all programs will contain evaluation methodologies and criteria in order to determine effectiveness and impact.

STRATEGY 5.3: Developing networks and partnerships to support a common HIV/STI surveillance, monitoring, and evaluation framework for the health sector.

TARGET 5.3: By 2015, mechanisms for effective participation of relevant actors, institutions, and programs in the surveillance, monitoring, and evaluation systems will be working successfully.

> **Milestones:**

5.3.1_By 2010, relevant programs and institutions will report agreed upon data to the HIV/STI health information system.

5.3.2_By 2007, formal agreements and procedures will be established between services relevant to common surveillance, monitoring, and evaluation systems.

STRATEGY 5.4: Building capacity for information, knowledge management, and dissemination

TARGET 5.4: By 2010, national capacity will exist to analyze, use, and disseminate user-friendly data, and this data will be distributed within and among countries.

> **Milestones:**

5.4.1_By 2008, country profiles analyzing the status of the HIV epidemic and its trends as well as relevant data on prevention, care, and treatment will be available.

5.4.2_By 2008, priorities for operational research in support of prevention, care, and treatment strategies will be defined.

8 PAHO'S SUPPORT TO THE REGIONAL PLAN[27]

In partnership with the Member States and UNAIDS, PAHO's work in the Region over time has supported national planning and implementation of HIV/AIDS programs, systematic improvements in epidemiological surveillance, improvements in blood safety, and targeted prevention interventions, especially for youth and vulnerable groups, that include sexuality and a gender perspective. CAREC, a PAHO Center, has supported countries in the Caribbean in strengthening their response to HIV/STI in several important areas, including strategic planning, epidemiological surveillance, prevention, care, and treatment, and behavior modification communication. CFNI has provided technical support in nutrition and HIV.

As the focus of international HIV work has moved in recent years to a more comprehensive approach that includes both prevention and treatment, PAHO developed the Building Blocks, a series of modules detailing the core components of care for people with HIV. PAHO has championed equitable access to treatment by supporting Member States in the negotiation of ART and has established the Strategic Fund for Health Supplies to allow Member States to access medicines and supplies as well as technical advice on quality and other aspects of these commodities. PAHO has also offered considerable technical support from its core budget to the development and implementation of projects in the Region from the Global Fund, including in the areas of governance, management, procurement, logistics, and overall project design.

During the next ten years, PAHO will focus its technical cooperation on areas where it has a comparative advantage vis a vis other organizations and programs in the Region. PAHO's work in HIV/STI will continue to focus on support to national and other health sector programs, with a special focus on their impact on the quality of life of people with HIV. Seven lines of action have been determined in consultation with stakeholders in countries and development partners. They are: (1) technical support to implementation of the Plan (2) facilitating technical cooperation between countries (3) advocacy (4) strengthening Regional alliances and partnerships (5) intensifying direct support to countries (6) mainstreaming HIV/AIDS in PAHO (7) costing and mobilizing resources.

TECHNICAL SUPPORT FOR THE IMPLEMENTATION OF THE REGIONAL PLAN

PAHO's technical support to countries will focus on the health sector's response to HIV. It will be based on strengthening the essential public health functions to effectively combat the epidemic and reduce its impact. Particular attention will be given to human resource development and upgrading, the development and adaptation of norms and guidelines, methodologies and tools, and the dissemination of strategic information.

PAHO's Strategic Fund will facilitate not only the purchasing of supplies, but also the provision of technical support to countries to achieve effective pharmaceutical management and regulatory systems. This assistance includes training of human resources and harmonization of principles in source selection and quality criteria, with a public health perspective.

[27] *This section refers specifically to the activities and programming of the PAHO Secretariat.*

In collaboration with WHO, the Regional program will create and maintain a database of professionals with proven expertise that can support countries' requirements for technical cooperation. The specific areas of collaboration will be determined by country and Regional needs as well as PAHO's comparative advantage in the area vis-a-vis that of other organizations.

Policy guidance related to equitable and universal access to prevention, care, and treatment free of charge at the point of delivery will be provided by the Organization to advocate for long term sustainability of health systems initiatives.

PAHO's technical cooperation is not limited to Ministries of Health but also includes all partners working in the health sector, including NGOs, people with HIV, and collaboration with bilateral and multilateral organizations.

The monitoring of the Regional Plan will be facilitated by the active participation of PAHO's Technical Advisory Committee, which includes a multi-sectoral group of experts representing key stakeholders.

FACILITATING TECHNICAL COOPERATION BETWEEN COUNTRIES

As part of the Organization's intensified focus on inter-country cooperation, PAHO has stimulated and enabled inter-country technical cooperation in HIV/AIDS. The use of PAHO's mechanism of Technical Cooperation Among Countries (TCC) will be central to this process. PAHO will continue to facilitate the sharing of expertise, lessons learned, and resources among countries. The further promotion of horizontal technical cooperation will be achieved through closer coordination with the Region's Horizontal Technical Cooperation Group, and with emerging initiatives in the Region such as Brazil's International Center for Technical Cooperation on HIV/AIDS (ICTC/AIDS). Efforts will also be made to tap the expertise of Canada and the United States in a more strategic and consistent manner.

ADVOCACY

Advocacy for equitable universal access to prevention, care, and treatment is of pivotal importance for all organizations working in HIV, including PAHO. Advocacy for countries to scale up care and treatment as part of their commitment to the Declaration of Nuevo Leon has helped move the Region forward together towards a common goal. The Regional Directors Group of Co-sponsors of UNAIDS is also a useful mechanism for advocacy at the highest level, and a joint advocacy strategy already exists to promote the dissemination of common messages and strategies.

Stigma and discrimination against people with HIV and vulnerable groups is a major obstacle to the implementation of effective country responses. Equitable access to prevention and care for HIV/AIDS is based on the principle of health as a human right; a right that the Organization will continue to promote and defend at all levels.

Advocacy will take the form of Regional and national communication strategies, interventions by the Director and PAHO Representatives, policy dialogues, ongoing feedback to PAHO's Governing Bodies and participation in relevant international fora, among others.

A communication strategy to support the roll-out of the Regional Plan, publicize progress and sustain momentum will be implemented and maintained throughout the ten year period.

STRENGTHENING REGIONAL ALLIANCES AND PARTNERSHIPS

The HIV epidemic is attracting an increasing number of stakeholders in the Region. They bring considerable assets (political, financial, and scientific) to bear on the issue and are valuable partners whose collaboration must be cultivated for the benefit of the health sector and people with HIV.

PAHO will work to clarify not only its comparative advantage, as an organization responsible for support to HIV in the health sector, but will work with other stakeholders to define the roles and responsibilities of other UN agencies, the Organization of American States, sub-Regional organizations, and other development partners.[28] In collaboration with UNAIDS, advocacy for the effective implementation of the Three Ones will continue at country and Regional levels.

PAHO will ensure the effective participation of Member States including people with HIV and NGOs, relevant UN agencies, private organizations, and major development partners in the roll out of the Plan, including its implementation, monitoring, and evaluation. PAHO will continue to play an active role in the Regional Directors Group of Regional Co-sponsors of UNAIDS as well as other related committees, and will continue advocating and supporting Regional, sub-Regional and national efforts to harmonize technical and financial resources.

INTENSIFYING DIRECT SUPPORT TO COUNTRIES

PAHO will take advantage of its unique position as an agency with established infrastructure in 28 countries of the Americas to intensify direct support to countries, emphasizing the strengthening of a comprehensive health response to the epidemic. PAHO HIV/STI staff will be strengthened with the core competencies necessary for a comprehensive technical cooperation approach. This cadre of professionals will be supported by other PAHO staff with expertise in health policy and health services, human resources, epidemiology, gender and health, health promotion, and mental health. All country offices will have access to these core competencies either on or off site.

PAHO recognizes that responsibility for the provision of technical cooperation does not lie in one specialized unit but is a corporate responsibility. Many other areas of the Organization have a role to play in strengthening PAHO's response and implementing the Regional Plan. Inter-programmatic mechanisms will be strengthened and professional and administrative staff will be sensitized, trained, and constantly updated on HIV/STI issues. The HIV/STI Core Team consisting of representatives from relevant units will be maintained and similar teams established in each sub-Region. A team approach will be fostered at all levels of the organization in order to create a synergetic process that will position the Organization to effectively carry out

[28] *According to the Final Report of the Global Task Team 14 June 2005.*

its leadership and stewardship functions to coordinate and manage the implementation of the Regional Plan.

During the ten year period of this Plan, and in collaboration with countries, PAHO will monitor the magnitude and trends of HIV/STI and progress toward universal access at Regional and country levels, providing disaggregated data for different sub-groups of the population where possible. An interactive database with key indicators agreed upon with countries will be available on line to facilitate access to quality and timely information. PAHO's quarterly newsletters will be continued. Information will also be shared regularly with PAHO's Governing Bodies and at other relevant fora including summits of Heads of State.

In line with the sub-Regional policy being implemented by the Organization, the Regional and sub-Regional staff will coordinate inter-disciplinary "Sub-Regional Technical Response Teams" for HIV/STI (CAREC, Caribbean, Central America, Andean Region, Southern Cone). Strategic alliances with relevant PAHO units have been established to undertake this challenge and will be maintained. These Technical Response Teams will provide direct support to sub-Regional bodies such as CARICOM, SICA, MERCOSUR, ANDEAN to strengthen their action for universal access to prevention, care, and treatment.

Essential to this strategic approach is the decentralization of financial resources. PAHO will maintain its budget distribution policy for HIV/AIDS, allocating at least 70% of resources to countries. All countries in the Region will benefit from resources mobilized through the Regional Plan. PAHO's Centers will also increasingly assume responsibility for direct country support, such has been the practice of CAREC in recent years in placing CAREC/PAHO technical officers in high priority countries.

MAINSTREAMING HIV/AIDS IN PAHO

Assuring that the entire organization speaks with a single voice, from the Director to the PAHO support staff in countries is a powerful strategy to support the implementation of the Regional Plan. In 2005 PAHO recognized the need for greater participation of PAHO staff from different technical fields to join efforts in the fight against HIV, and to look inwardly within the PAHO Secretariat itself to assure that best practices were being observed. As a result, a decision was made to establish an internal HIV policy.

An HIV internal policy document for the PAHO Secretariat was prepared in 2005 to establish PAHO's commitment to comprehensive care and treatment for staff or family members with HIV and to the periodic training and updating of all staff in HIV prevention. This internal policy will be fully implemented in 2006-2007. As part of this policy, PAHO staff are entitled to request confidential and voluntary HIV testing as part of their routine annual physical examinations, and counseling services are available.

Accountability will be fostered by strengthening mechanisms for the external evaluation of PAHO's work and these will be undertaken with the active participation of Member States and other partners.

COSTING AND MOBILIZING RESOURCES TO SUPPORT IMPLEMENTATION OF THE REGIONAL PLAN

Despite the increase in financial resources in the Region for care and treatment of people with HIV during the last five years, there are still gaps in financing, particularly for the health sector. Gaps in both financial and human resources have been identified and efforts will be made to mobilize resources and coordinate with development partners in order to fill these gaps. PAHO will intensify mobilization of resources for effective implementation of the Regional Plan with Member States and development partners. Resources mobilized will be decentralized to country offices so that they can better support national authorities in the implementation of their country plans.

PAHO'S COMMITMENTS TO THE REGIONAL PLAN

TARGET 1: By 2015, all key national and regional stakeholders will have collaborated harmoniously to achieve the successful implementation of the Regional Plan.

> **Milestones:**

1.1_From 2006-2015, all key stakeholders will meet annually to assess progress and plan for jointly addressing weak areas and new challenges.

1.2_In 2010, a mid-term evaluation of the Regional Plan with the participation of all key stakeholders will be conducted and the Plan will be revised accordingly.

TARGET 2: By 2015, PAHO will be effectively supporting all priority Regional and country level needs for technical cooperation on HIV/STI in the health sector.

> **Milestones:**

2.1_From 2006-2015, PAHO will provide countries with strategic information on HIV/STI and health sector response in support of the implementation of the Regional Plan.

2.2_By 2015, adequate resources, as defined by bi-annual program budgets, will be mobilized by PAHO and countries to support the implementation of the Regional Plan in all countries of the Region.

2.3_By 2010, adequate resources will be mobilized by PAHO and countries to support the implementation of the Regional Plan in all priority countries for HIV/STI.

2.4_By 2007, PAHO's human resources needs will be met at Regional, sub-Regional and country levels to ensure high quality technical support for the implementation of the Regional Plan.

NEXT STEPS 9

INTEGRATING THE REGIONAL PLAN WITH NATIONAL PLANS AND OTHER EXISTING PLANS

PAHO encourages countries to hold national level meetings to review the Regional HIV/STI Plan and to determine how it links to existing HIV/STI plans and activities. The Regional Plan can be used as a checklist to ensure that all important elements of the health sector response are being undertaken or are being planned within health sector programs. Moreover, when beginning new planning cycles, the Regional Plan can provide information and guidelines for policy and program development and for setting national targets and milestones.

On an annual basis PAHO's Technical Advisory Committee meeting will provide an opportunity for countries to report on progress and challenges and to share experiences among countries. The Technical Advisory Committee will help countries to assess needs and opportunities and to plan strategically for the long term. PAHO country office staff will assist national counterparts with the ongoing monitoring and evaluation of the implementation of national plans and their links to Regional targets and milestones.

COSTING THE PLAN

Annex 1 contains the 2006-2007 Biennium Program Budget for PAHO. These amounts estimate the funds needed for the Secretariat to support the activities outlined in the Regional Plan and fulfill its commitments during the two-year period. Having identified the gaps between the funds needed and those available, PAHO will prioritize further resource mobilization. Costing for the full range of services in each country must be done on an individual basis as resource needs will vary according to variables such as epidemic types, demographic parameters, and unit costs. Many documents exist to assist countries with the estimation of needed resources. Guidelines can be found at www.unaids.org.

ANNEX 1 PROPOSED BPB 06-07 IN SUPPORT OF THE REGIONAL HIV/STI PLAN FOR THE HEALTH SECTOR 2006-2015 - PAHO

PROJECT STRUCTURE	INDICATORS	ACTIVITIES	ESTIMATED COST	PROJECT FINANCING*	GAP
GOAL By 2015, to halt and begin to reverse the spread of HIV/AIDS as well as STI in the Region by providing universal access to prevention, care, and treatment	1_By 2010, there will be a 50% reduction in the estimated number of new HIV infections followed by a further 50% reduction in new infections by the end of 2015. 2_By 2015, incidence of mother-to-child transmission of HIV will be less than 5% and incidence of congenital syphilis will be less than 0.5 cases per 1000 live births.				
PURPOSE Improved health sector response to the HIV epidemic as well as STI.	1_By 2010, there will be universal access to comprehensive care including prevention, care and antiretroviral treatment.				
EXPECTED RESULTS OR OUTPUTS Strengthening health sector leadership and stewardship and fostering the engagement of civil society	1_By 2007, a national strategy with clear targets for the health sector response including prevention, care and treatment will be defined. This will be an integral part of one multi-sectoral national strategic plan within the context of the Millennium Development Goals.	1_Regional and sub-regional interventions and advocacy for universal access to prevention, care and treatment based on human and reproductive rights approach. (Includes interventions to reduce stigma and discrimination in the health sector and policy recommendations for financing).	500,000	500,000	-

** Based on actual expenditure '0405*

PROJECT STRUCTURE	INDICATORS	ACTIVITIES	ESTIMATED COST	PROJECT FINANCING*	GAP
	2_By 2007, a mechanism for harmonization of resources will be developed that includes options for coordinating the work of all partners, linkages with the national coordinating authority, and monitoring and evaluation.	2_Direct support to countries for the development and or updating of a national strategy to strengthen the health sector response including prevention, care and treatment in line with the Regional HIV/STI Plan for the Health Sector 2006-2015.	1,200,000	-	1,200,000
			1,700,000	500,000	1,200,000
Designing and implementing effective, sustainable HIV/AIDS/STI programs, and building human resource capacity	1_By 2007, National AIDS Programs will establish and/or maintain mechanisms for strategic planning and management involving relevant stakeholders including people with HIV.	1_Regional and sub-regional consultations for the definition of packages of essential public health interventions and health services for prevention, care and treatment of HIV/STI.	500,000	436,000	64,000
	2_By 2007, packages of essential public health interventions and health services for prevention, care, and treatment as well as an updated HIV/STI program and plan will be defined.	2_Development/adaptation of technical guidelines for standards of care for HIV/STI management and quality assurance systems, including pediatric care.	500,000	250,000	250,000
	3_By 2007, National AIDS Programs will define the ethical framework essential to the programming of HIV/STI prevention and care services and establish mechanisms for its implementation.	3_Training in strategic planning and management for National AIDS Program coordinators/directors.	350,000	-	350,000
	4_Two mass media campaigns underlining the importance of preventing HIV/STI and raising awareness will be conducted (one 2006, one 2007) in each country.	4_Adaptation of integrated management of adult illnesses (IMAI), including a module for stigma and discrimination in the health sector and roll out in the Region.	500,000	120,000	380,000

** Based on actual expenditure '0405*

PROJECT STRUCTURE	INDICATORS	ACTIVITIES	ESTIMATED COST	PROJECT FINANCING*	GAP
	5_ By 2007, a set of interventions proven to be effective to prevent transmission in vulnerable groups (in particular men who have sex with men and sex workers) will be identified and subsequently scaled up in collaboration with relevant community-based organizations. 6_By 2015, quality assurance systems for comprehensive health care will be established. 7_By 2009, technical guidelines and management protocols will be updated/developed for all relevant HIV/STI prevention, care and treatment interventions and services according to internationally recommended practices. 8_By 2015, human resource management systems will be in place to ensure that health services will be appropriately staffed to meet HIV/STI requirements, and distributed according to need.	5_Technical guidelines for human resources assessment and planning for HIV/STI developed and disseminated.	250,000	100,000	150,000
		6_Technical guidelines for the development and implementation of interventions to ascertain changes in risky sexual practices within a reproductive health approach and vulnerability analysis. Evaluation of interventions and programs and capacity building.	500,000	147,000	353,000
		7_Regional interventions for the promotion of sexual health to prevent HIV/STI transmission, including communication campaigns and research.	250,000	250,000	-
		8_Technical guidelines for the development of entry points for prevention, care, and treatment utilizing existing services (emphasis on blood donation services and domestic violence services).	350,000	40,000	310,000
		9_Direct support to countries for strategic planning and management of health sector response plans.	2,400,000	1,300,000	1,100,000
		10._Direct support to countries for the development of interventions to ascertain changes in risky sexual practices within the context of prevention and sexual health promotion programs, including mass media campaigns.	3,000,000	90,000	2,910,000
			8,700,000	2,796,000	5,904,000

** Based on actual expenditure '0405*

PROJECT STRUCTURE	INDICATORS	ACTIVITIES	ESTIMATED COST	PROJECT FINANCING*	GAP
Strengthening, expanding, and reorienting health services	1_By 2015, HIV care will be available at each level of care as defined by the essential package of services, and with appropriate referral systems for secondary and tertiary care. 2_By 2008, mapping of available services and identification of gaps will be completed. 3_By 2007, at least three entry points will have been identified within existing health services and operational plans will be developed to strengthen and expand these services. 4_By 2010 voluntary counseling and testing services will be integrated into the primary level of care and linked to care and treatment and prevention services. Each country will have implemented a "Know Your Status" campaign. 5_By 2007, prevention of mother-to-child transmission interventions, including the prevention of congenital syphilis, will have been integrated into antenatal services. (PMTCT +) 6_ By 2010, youth-friendly health services will be integrated into health services. 7_By 2010 appropriate health care services for the prevention, care and treatment of HIV/STI (within health facilities or outreach) in hard-to-reach populations including men who have sex with men, sex workers, and migrants will have been established. 8_By 2007, strategies and mechanisms will be identified to mainstream the participation of NGOs and other groups in the provision of services.	1_Prototype of interventions and services to be provided at each level of care as per proposed essential package defined and identified requirements. Evaluation of interventions and services and capacity development.	700,000	700,000	-
		2_Adaptation and implementation of SAM.	350,000	78,000	272,000
		3_Evaluation and capacity development for entry points.	500,000	465,000	35,000
		4_Development and dissemination of VCT guidelines and training.	250,000	20,000	230,000
		5_Regional "Know Your Status" campaigns.	200,000	70,200	129,800
		6_Direct support to countries for the expansion and reorientation of services to ensure universal access to prevention, care and treatment of HIV/AIDS.	5,400,000	1,800,000	3,600,000
		7_Direct support to countries for the development of mechanisms for the participation of people with HIV in the planning, delivering, monitoring and evaluation of services at primary care level.	500,000	-	500,000
			7,900,000	3,133,200	4,766,800

** Based on actual expenditure '0405*

PROJECT STRUCTURE	INDICATORS	ACTIVITIES	ESTIMATED COST	PROJECT FINANCING*	GAP
Improving access to medicines, diagnostics, and other commodities.	1_By 2008, there will be a mechanism to secure supply chains from drug suppliers to service sites. 2_By 2006, countries will be fully utilizing the flexibilities of intellectual property agreements as appropriate and as defined in the Doha Declaration. 3_By 2008, Regional guidelines will be available and used for the development of national quality control measures and the rational use of medicines and other commodities. 4_By 2008, laboratory services will be equipped and staffed to perform laboratory testing to support the essential package of services. 5_By 2008, sub-regional reference laboratory networks will be created to support external quality control of HIV/STI-related lab services and surveillance including ARV resistances. 6_ By 2007, quality standards for laboratory testing will be implemented (including standard operating procedures, algorithms, internal and external quality assessment schemes).	1_Consolidation of Strategic Fund for Public Health Supplies. 2_ Development and dissemination of Regional policies and guidelines for the rational use of medicines and other commodities and technical support to supply systems and quality control. 3_Monitoring impact of price negotiations and supporting new negotiation initiatives. 4. Direct support to countries for drug supply management, quality control. 5_Establishment of sub-regional reference laboratory networks and external quality control of HIV/STI, including ARV resistance. 6_Development and dissemination of quality standards for laboratory testing and support for its implementation. 7_Direct support to countries to strengthen laboratory services and implement quality assurance systems.	3,000,000 560,000 150,000 1,400,000 450,000 350,000 1,000,000	100,000 310,000 80,000 20,000 20,000 60,000 60,000	2,900,000 250,000 70,000 1,380,000 430,000 290,000 940,000
			6,910,000	650,000	6,260,000

** Based on actual expenditure '0405*

PROJECT STRUCTURE	INDICATORS	ACTIVITIES	ESTIMATED COST	PROJECT FINANCING*	GAP
Improving information and knowledge management, including surveillance, monitoring and evaluation	1_By 2010, national surveillance systems will be providing comprehensive data on all the necessary key components of state of the art surveillance systems. 2_By 2008 mechanisms for surveillance and monitoring of ARV resistance will be established. 3_By 2007, surveillance systems will include adequate geographical coverage and representativeness of population groups relevant to the epidemic 4_By 2007, countries will collect core Regional and national indicators for prevention, care, and treatment. 5_By 2007, all programs will contain evaluation methodologies and criteria in order to determine effectiveness and impact. 6_By 2007, formal agreements and procedures will be established between services relevant to common surveillance, monitoring and evaluation systems. 7_By 2008, priorities for operational research in support of prevention, care, and treatment strategies will be defined. 8_By 2008, country profiles analyzing the status of the HIV epidemic and its trends as well as relevant data on prevention, care, and treatment will be available.	1_Development of Regional database with core data indicators for prevention, care and treatment for HIV/STI. Periodic analysis and dissemination of information.	500,000	380,000	120,000
		2_Evaluation of national surveillance systems for HIV/STI and capacity building, including technical guidelines and standards of quality.	450,000	80,000	370,000
		3_Establishment of mechanisms for regional surveillance and monitoring of ARV resistance.	500,000	125,000	375,000
		4_Technical guidelines and capacity building for patient based information systems for the monitoring and evaluation of prevention, care and treatment interventions for HIV/STI.	450,000	150,000	300,000
		5_Development of virtual health library for HIV/STI (in collaboration with Bireme/IKM)	150,000	-	150,000
		6_Development of an operational research agenda and action plan to support universal access to prevention, care and treatment.	380,000	75,000	305,000
		7_Direct support to countries for the strengthening of their surveillance systems.	1,400,000	170,000	1,230,000
			3,830,000	980,000	2,850,000

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PROJECT STRUCTURE	INDICATORS	ACTIVITIES	ESTIMATED COST	PROJECT FINANCING*	GAP
Strengthening PAHO's capacity to support Regional Plan	1_From 2006-2015, all stakeholders will meet annually to assess progress and plan for jointly addressing weak areas and new challenges. 2_From 2006-2015 PAHO will be providing countries with strategic information on HIV/STI and health sector response in support of the implementation of the Regional Plan. 3_By 2010, adequate resources, as defined by bi-annual program budgets, will be mobilized by PAHO and countries to support the implementation of the Regional Plan in all countries in the Region. 4_By 2007, PAHO's human resources needs will be met at Regional, sub-regional and country levels to ensure high quality technical support for the implementation of the Regional Plan.	1_Regional meetings to monitor progress of regional plan. Support to TAC.	350,000	300,000	50,000
		2_Mobilization of resources and strengthening of alliances and partnerships to support the Regional Plan, including meetings with partners and participation in relevant regional, sub-Regional and international events for advocacy.	165,000	-	165,000
		3_Establishment of a monitoring and evaluation system for monitoring and evaluating the Plan (end of BPB evaluations/mid-term evaluations)	450,000	-	450,000
		4_Regional advocacy and communication strategy for the Regional Plan.	250,000	-	250,000
		5_Support for the development of inter-disciplinary Regional, sub-Regional and national response teams, including the hiring and/or retention of qualified human resources.	3,502,010	3,460,000	42,010
		6_Support for the sharing of expertise between countries through Regional/sub-Regional resources networks including technical cooperation among countries.	450,000	188,000	262,000
		7_PAHO Staff development program on HIV/STI.	250,000	-	250,000
			5,417,010	3,948,000	1,469,010
Grand Totals			34,457,010	12,007,200	22,449,810

** Based on actual expenditure '0405*

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