

1st GENERAL MEETING OF THE TECHNICAL ADVISORY COMMITTEE ON HIV/AIDS/STI, PAN AMERICAN HEALTH ORGANIZATION

**January 22–24, 2005
Santo Domingo, Dominican Republic**

BACKGROUND

With the goal of decisively supporting the implementation of the objectives agreed upon in the “3 by 5” *Initiative* to provide three million people with antiretroviral treatment (ART) by the end of 2005, and in response to needs identified during subregional consultations held in 2004 in the Caribbean and Central America, the Pan American Health Organization (PAHO), through its HIV/AIDS Unit, programmed a regional meeting in Santo Domingo, Dominican Republic from January 21 to 24, 2005.

Taking advantage of the valuable experiences contributed by other PAHO programmatic units, such as the Expanded Program on Immunization via the formation of an advisory committee, PAHO decided to create the Technical Advisory Committee (TAC). The committee is composed of important technical leaders in the region and constitutes a group of experts whose purpose is to support and advise the Unit in matters related to the 3 by 5 Initiative as well as the implementation of strategic guidelines defined during a regional meeting held in Washington, DC in January 2004. The objectives of the meeting were:

1. To report on the progress of the PAHO Strategic Guidelines for the 3 by 5 Initiative to provide 3 million people with ART by 2005.
2. To share accomplishments and challenges of countries in the region in the expansion of access to comprehensive care and treatment, including antiretrovirals, and to increase HIV/AIDS transmission prevention efforts.
3. To report on existing tools, methods and resources available through PAHO and Member States that could support both regional and national efforts to expand access to comprehensive care and treatment, and to strengthen HIV/AIDS transmission prevention.
4. To agree on priorities for the adequate and effective use of resources both at the regional and national levels.
5. To present the objectives and members of the TAC.

INAUGURAL SESSION

Dr. Carissa Etienne, PAHO Assistant Director, Dr. Alberto Fiallo Billina, representing the Dominican Republic's Ministry of Health, Dr. Carol Vlassoff, Chief of PAHO's Regional HIV/AIDS/STI Program and Dr. Socorro Gross Galiano, PAHO Representative in the Dominican Republic participated in the inaugural session.

Dr. Etienne presented the vision of PAHO as the main catalyst in ensuring optimum health for everyone in the Americas and in contributing to an improved state of families and communities in the region. In addition, she analyzed the transition period that PAHO is undergoing, a transition that requires numerous efforts to be made in financial and human resource realignment towards areas of need, in the incorporation of contemporary managerial practices and in the creation of a culture of openness and teamwork. In this context, Dr. Etienne explained the current operational structures of PAHO and the Family and Community Health Program, where the HIV/AIDS Unit is located, as well as the work plan to specifically respond to the Millennium Development Goals. The work plan takes into account all age groups, priority countries and the need for all Units to work in collaboration in order to respond to this challenge with excellence. She placed special emphasis on the fact that the meeting was an appropriate and special opportunity to fulfill the mission and vision PAHO has outlined and on the fact that the formation of the TAC can facilitate the achievement of the Millennium Goals, to which PAHO is deeply committed. In addition, Dr. Etienne indicated that universal access to comprehensive HIV care and treatment is a means of achieving equity, a method to reduce suffering and to make prevention activities successful.

Dr. Alberto Fiallo Billini reported on the HIV/AIDS situation in his country, indicating that the first reported case was in 1983, that in 1985 the first Dominican technical unit for the control and prevention of HIV/AIDS was created and that in 1987 the National HIV/AIDS Program and the National HIV/AIDS Commission were formed. The HIV prevalence rate in 2002 was an estimated 1%, based on a national seroprevalence survey. However, the same survey identified regions in the country with seroprevalence rates of up to 5%, 12% in men between 40 and 44 years of age and 8.8% in women between 30 and 34 years of age. This is in contrast to risk perception findings in the country. 53% of women consider themselves to be not at risk of HIV infection but only 16% of them used a condom during their first sexual experience. Dr. Billini concluded his presentation by mentioning governmental commitments to HIV for the period 2004-2008.

Dr. Socorro Gross highlighted PAHO's assistance in responding to the HIV/AIDS situation in the Dominican Republic and reminded the audience that the meeting provided a great opportunity to jointly define more effective solutions to identified problems without forgetting the importance of either prevention or care.

Dr. Carol Vlassoff concluded the inaugural session by presenting the agenda, objectives, methods and expected results for the meeting

Following the inaugural session, the members of the Technical Advisory Committee were presented:

- ❖ Dr. Paul Farmer, Executive Vice President of “Partners in Health” and member of the Infectious Diseases and Social Change Program, Harvard University, USA.
- ❖ Dr. Mercedes Weissenbacher, Lead Researcher for the National Council on Scientific and Technical Research (CONICET), Microbiology Department, Faculty of Medicine, Buenos Aires, Argentina.
- ❖ Dr. Richard Stern, Director of the human rights association Agua Buena, Costa Rica.
- ❖ Dr. Silvia Panebianco Labbe, Human Rights Coordinator, MEXSIDA, Civilian HIV/AIDS Observation and Surveillance Technical Committee, Mexico.
- ❖ Dr. Brendon Bain, Professor, University of the West Indies, Jamaica.
- ❖ Dr. Jane Galvao, Senior HIV/STI/AIDS Program Officer, International Planned Parenthood Federation, Western Hemisphere.
- ❖ Dr. Penny Hitchcock, Senior Fellow, Center for Biosecurity and Prevention of AIDS and STDs in Adolescents, PASA.
- ❖ Dr. Euclides Castillo, Department Head, Preventative Medicine, Sao Paulo University, Brazil.
- ❖ Dr. Rosa Maria Alfaro Moreno, Director, Calandria Association of Communicators, Peru.

After the presentation of the members of the TAC, discussion was opened up to the audience. They pointed out the lack of participation of people living with HIV/AIDS (PLWHA) in the TAC and that the civil society representatives were members of human rights associations and not spokespeople for PLWHA. It was requested that the members of the TAC be elected for a more extended period, following the example of the Immunization committee. In addition, they stressed the need to create a mechanism for active government participation in the implementation of TAC recommendations.

PROGRESS REPORT ON THE “3 BY 5 INITIATIVE” AND PAHO’S CORRESPONDING STRATEGIC OBJECTIVES

Presentation: Dr. Carol Vlassoff

The estimated number of people living with HIV/AIDS (PLWHA) has constantly increased in the region ever since the first case was reported in 1984. However, with the expansion of access to comprehensive care, it has been possible to reduce mortality and the incidence of AIDS cases in some countries such as has been shown in Brazil, Barbados and the Bahamas. There exists a global commitment to achieve universal access to comprehensive HIV care and treatment as expressed in the Nuevo León Declaration, signed in January 2004 by the Presidents of Latin American countries. In accordance with the Declaration, nations pledge to provide antiretroviral treatment to all that need it as soon as possible and to at least 600,000 individuals in 2005. Current coverage in Latin America and the Caribbean (LAC) is 55%, while worldwide it is barely 7%).

The main objective of the “3 by 5 Initiative” is to contribute as much as possible to prolonging survival, restoring the quality of life of people with HIV or AIDS in LAC and advancing towards the ultimate objective of universal access to antiretroviral treatment for those people that need it. Five strategic guidelines have been established with this goal in mind.

Additionally, a classification of countries based on infection prevalence and treatment coverage has been conducted with the aim of focusing and prioritizing technical cooperation and identifying horizontal cooperation opportunities in the region.

Lastly, Dr. Vlassoff described the principal results achieved to date, several work goals for each of the strategic guidelines and PAHO financial and personnel resources available for the 3 by 5 Initiative.

SESSION 1: LESSONS LEARNED ABOUT THE EXPANSION OF ACCESS TO COMPREHENSIVE CARE AND TREATMENT

Panel 1

Participants:

Dr. Paul Farmer (President)	Executive Vice President, Partners in Health
Dr. Jessica Salas	Head, National HIV/AIDS Program, Costa Rica
Dr. Perry Gomez	Head, National HIV/AIDS Program, Bahamas
Dr. Anabella Arredondo	Head, National HIV/AIDS Program, Chile
Dr. José Luis Sebastián Mesones	Head, National HIV/AIDS Program, Peru
Dr. Jorge Saavedra	General Director, National AIDS Prevention and Control Center, Mexico
Dr. Amalia Del Riego (Rapporteur)	HIV/AIDS Unit, PAHO, Washington, DC

COORDINATION WITH OTHER SECTORS IN COSTA RICA

Dr. Jessica Salas Martínez

Currently, comprehensive care is centralized in five national hospitals that work with therapeutic management protocols. The National Strategic Plan for 2001-2004, the norms and procedures for HIV/AIDS care in the correctional system and the organizational and operational regulations of the National Health Surveillance System have been evaluated and re-adapted. At the end of 2004, the number of people that were receiving antiretroviral care was 1,987.

The main difficulties encountered to date are: the centralization of care, the absence of rules governing comprehensive care, inequality in the distribution of resources between prevention and care, the lack of an epidemiological surveillance protocol, the weakness of the epidemiological surveillance system, stigma and discrimination, a reduced focus on sexual and reproductive health, reduced care for illegal immigrants and NGO sustainability.

Consequently, the challenges that need to be addressed are the implementation of policies, plans, permanent and sustainable programs and projects, comprehensive sex education, legislative and regulatory consolidation and the strengthening of NGOs. The first steps that should be taken immediately in order to reach these objectives are the monitoring and support of the National Health Policy, the implementation of permanent information, education and communication (IEC) strategies, the development of national HIV/AIDS/STI care regulations, the development of an epidemiological surveillance protocol, the updating of the General HIV/AIDS Law and, lastly, the evaluation of the National Epidemiological Surveillance System and current situational analysis of comprehensive health services.

IMPROVED MOTHER-TO-CHILD TRANSMISSION PREVENTION IN THE BAHAMAS

Dr. Perry Gomez

The Bahamas has observed a moderate increase in the number of AIDS cases since the beginning of the epidemic. However, cases of asymptomatic HIV infection have dropped since 1994. In the last ten years, the estimated prevalence rate at prenatal care clinics has reduced noticeably, going from 4.3% in 1993 to 3.1% in 2003. The following are the results of the vertical HIV transmission prevention program: total births: 74, live births: 61, abortions/miscarriages: 8, stillbirths: 3 and intrauterine deaths: 2. Obstetric cases have mainly come from the Bahamas (65%), Haiti (32%) and Jamaica (3%). Between October 2001 and December 2004, triple ART has been administered to 1,547 patients, a figure that in 2004 increased by 360 new patients.

During this period the Bahamas have manifested distinct needs: to achieve a national commitment to treatment expansion, to establish a public program and a vertical transmission program at the national level, to improve the infrastructure of public health services and to develop professional leadership. In addition, the desire of professionals to provide health care free from discrimination, stigmatization and prejudice has become an important priority, the importance of “entry points” and the consideration of care as a preventative factor have been stressed. The presentation concluded with recommendations for the development of a work plan.

POLITICAL COMMITMENT AS THE KEY TO EXPANDING ACCESS IN CHILE

Dr. Anabella Arredondo

By December 2003, 33,314 people were living with HIV/AIDS in Chile. Of these, there were 6,060 reported AIDS cases and 6,514 reported asymptomatic HIV infections. In addition, 3,860 people had died from AIDS. The AIDS epidemic is characterized by sexual transmission, most predominantly in homosexuals. Trends towards the feminization, ruralization and pauperization of the epidemic are also being observed.

An increase in the assigned national budget, which has permitted the expansion of coverage and improved quality of treatment and which has continued to increase since the beginning of a project from the Global Fund to Fight AIDS, TB and Malaria (GF), the inclusion of AIDS as a priority health problem of the reform movement and the approval of the AIDS Law are three key elements that demonstrate the political commitment of the government in the fight against AIDS.

There are 32 care centers in the country for people affected by HIV/AIDS and between October 2002 and August 2004 3,360 new patients had been admitted. Among the main characteristics of access to comprehensive care that can be highlighted are 100% access to treatment for adults and children, vertical transmission prevention, monitoring of CD4 counts and viral load every four to six months, genotyping up until a second failure, the permanent capacity improvement of public health teams in the entire care network, the accreditation of

HIV care centers, quality control of medications, CD4, viral load and genotyping, evaluation of results and cost-effectiveness analysis of ART.

To date the principal difficulty has been therapeutic failure, which is related to a mortality increase since the year 2000. Although antiretroviral expenditure has increased, hospital costs have dropped noticeably, resulting in a positive financial balance from avoided hospital costs. In addition, the number of missed workdays has decreased and the number of days worked by patients has increased. Lastly, adherence to treatment has improved, as has condom use.

The challenge for the future is the continuation of antiretroviral therapy. The following strategies have been established to meet this challenge: its inclusion in the private health system, a greater budget for antiretroviral medications, continuation of national and international negotiation with pharmaceutical companies, centralized purchasing and the incorporation of generic antiretroviral medications in the therapeutic arsenal.

THE INTEGRATION OF TUBERCULOSIS AND HIV/AIDS IN THE NATIONAL HEALTH STRATEGY IN PERU

Dr. José Luis Sebastián Mesones

81% of HIV/AIDS cases in Peru come from the capital city of Lima while the rest of the country accounts for the remaining 19%. 20% are women and 80% are men. In cases of TB/HIV coinfection, 79% have presented pulmonary TB and 21% extrapulmonary TB.

Before the inclusion of antiretroviral therapy (HAART), programs were vertical and standards were set through directives. There was no HAART access in the public sector and medications and supplies were provided at the central level.

In 1996, all health services incorporated TB screening for all individuals diagnosed with HIV infection and, since that date, there has existed a technical standard for TB/HIV that stipulates the functions and roles for those that care for individuals suffering from both diseases. Chemoprophylaxis in PLWHA went from 139 patients in 1994 to 1,700 in 1999.

In the post-HAART era, the main characteristics of service offerings are the following: the “horizontalization” of programs, the existence of technical standards, large-scale access to antiretroviral therapy in the public sector and adequate medications and supplies at all levels. The incorporation of ART has been based on the DOTS experience for tuberculosis.

Lastly, the measures that have been identified as key elements for consolidating teamwork are: the improvement of the level of coordination between the TB and HIV/AIDS programs, the application of technical standards in the clinical management of TB/HIV coinfection, the incorporation of HIV/AIDS screening in TB patients, the supervision of TB chemoprophylaxis in PLWHA and the strengthening of the management of opportunistic infections (tuberculosis) in PLWHA.

HUMAN RIGHTS AND THE EXPANSION OF CARE AND TREATMENT IN MEXICO

Dr. Jorge Saavedra

In Mexico an estimated 160,000 people are infected by HIV. Of these, there were 90,043 reported cases up until November 2004. The virus is primarily transmitted by sexual contact, especially in homosexuals and bisexuals (54%), followed by heterosexuals (39%).

A pillar of the Action Program for the Prevention and Control of HIV/AIDS and STI is the inclusion of respect for human rights in all activities and strategies. Antiretroviral therapy began in 1993, and in 1997 triple therapy was incorporated, thanks in part to pressure exerted by organizations of PLWHA. In 1998, a private trust (FONSIDA) was created to provide ART to pregnant women and children. FONSIDA disappeared in 2001, but the Free and Universal Access to Antiretrovirals Policy went into effect. By December 2003, free and universal access to antiretroviral medications had been achieved. In 2004 the President of the Republic announced the incorporation of all individuals with HIV/AIDS lacking social security into the social welfare system.

Currently there are 28,150 PLWHA on ART. In addition, there exist 89 specialized services for HIV/AIDS care in the country as well as 119 detection and counseling services in 24 states for individuals with AIDS and other STI. Negotiations with the pharmaceutical industry have led to a 48% reduction in average cost of treatment per person/year. A presidential decree in November 2004 mandated the use of the National Guide on ART Management, which compels all institutions in the health sector to carry out activities in discrimination prevention, stigma reduction and human rights protection for PLWHA. Despite the presidential decree there remain problems. The main obstacles Mexico is facing are homophobia, ignorance surrounding HIV and budgetary limitations.

Lessons learned in the fight against this epidemic in Mexico include the need to guarantee long-term universal access, to invest in training for doctors and to provide access to necessary laboratory tests (CD4 and viral load). In addition, it is essential to motivate patients to actively participate in all aspects of their care and to invest in the improvement of service quality. Comprehensive care requires prevention activities and appropriate measures to reduce stigma and discrimination. Lastly, it is necessary to undertake more intense activities in social awareness in order to change “universal coverage” to “universal access”.

PANEL SUMMARY AND DISCUSSION

Dr. Jessica Salas from Costa Rica described her country’s experience in coordinating with other sectors, emphasizing the difficulties encountered in centralizing care and the lack of norms to govern comprehensive care. In addition, she highlighted the existing inequality in the distribution of resources between prevention and care, and the challenges currently being addressed such as establishing policies, plans, permanent and sustainable programs and projects, legislative and regulatory consolidation and the strengthening of work with NGOs. Dr. Perry Gomez spoke on the expansion of the Mother-to-Child Transmission Prevention

Program in the Bahamas and lessons learned in his country, especially the need to reach a national commitment to expand treatment and improve the infrastructure of the public health services. In terms of the integration of HIV/AIDS and TB services in Peru, Dr. José Luis Sebastián Mesones noted that the incorporation of HAART has been based on the DOTS experience for tuberculosis. In addition, he indicated the need to improve the level of coordination between TB and HIV/AIDS programs and incorporate HIV/AIDS screening in TB patients. Dr. Anabella Arredondo from Chile pointed out that political support is key for expanding access and offered several examples of such support in Chile. Dr. Jorge Saavedra of Mexico discussed the relationship between human rights and the expansion of care and treatment, and stated that the participation of patients in all aspects of their care, more investment, the development of more social awareness activities and changing from “universal coverage” to “universal access” are fundamental to improve the quality of care services.

In the general debate the following comments were made:

- Access to service has not been achieved through the goodwill of government, rather through the demands of patients.
- Homosexual and bisexual populations have been left out.
- Although it hasn’t happened, it is very important that PLWHA participate in all meetings of stakeholders. The increase in financial resources to fight AIDS has occurred, in part, thanks to the demands of these individuals. Similarly, interdisciplinary teams should include PLWHA.
- Care for patients with HIV/AIDS should include not only ART but also nutritional care. The fundamental role that other health professionals play and satisfying the need to train and manage human resources should be taken into account.
- A question was raised about what concept of participation is being used, given that getting to know the opinions of affected individuals is distinct from them actively participating in decision-making.
- Homophobia was identified as a main obstacle to increasing access to comprehensive care.

COMMUNITY APPROACH TO INCREASING CARE AND TREATMENT: HIV EQUITY INITIATIVE, HAITI

Dr. Paul Farmer
Dr. Paul Zintl
Dr. Jaime Bayona

Haiti, the first country in the Americas to receive support from the GF, turned to deeply-rooted community networks to create foundations and achieve programmatic successes. Thanks to the Partners in Health program and the HAART-DOT method, adherence to TB and HIV treatment has been successful. In addition, the effectiveness of the program has helped noticeably to reduce stigma related to HIV infection.

As part of prevention programs, the slogan “*I won’t transmit HIV because life is so beautiful*” is used by PLWHA and health promoters to educate community members. To date, there are approximately 200 health promoters offering services to 1,500 individuals with TB, and clinics are performing the function of medical assistants, as care is taught in medical centers but applied in the communities.

Among the achievements highlighted are the following: in some regions of Peru, TB treatment efficiency indexes exceed 85%. During the first five-year period, the first cases of TB resistance were not treated adequately due to a lack of resources. International pessimism about the potential for community activities also grew as it was considered impossible that countries with low or mid-level resources could control the epidemic.

Treatments have been administered in the homes of affected individuals and both nutritional problems and social needs (job availability, training activities, economic success, etc.) have been taken into account. The role of the promoter, the ideal person for the job, consists in transmitting messages to the community and helping to eliminate stigma.

The most important efforts have been directed at the supervision of treatments and their side effects as well as providing moral and emotional support. One of the greatest achievements is that affected individuals are providing moral support to other patients. The Haitian experience has proven to be cost effective despite the prejudices shown in this regard by the international and academic communities.

SESSION 2: RESOURCES FOR COMPLYING WITH THE “3 BY 5 INITIATIVE”

Participants:

Dr. Mercedes Weissenbacher (President)	Lead Researcher, National Council on Scientific and Technical Research, University of Buenos Aires
Dr. Carol Vlassoff	HIV/AIDS/STI Unit Chief, PAHO, Washington, DC
Dr. Amalia Del Riego	Regional Coordinator for the 3 by 5 Initiative, PAHO, Washington, DC
Dr. Mariângela Batista Galvão Simão	External Cooperation Advisory, National Program of Brazil

OPERATIONS STRATEGY AND AVAILABLE FINANCIAL RESOURCES AT PAHO TO IMPLEMENT THE 3 BY 5 STRATEGY

Dr. Carol Vlassoff

PAHO, as an Organization, has defined five strategic objectives for operational change. With this, it is expected that by 2008 PAHO will be able to better respond to countries' needs, have established a forum for debate, have adopted new methods for technical cooperation and have improved managerial processes, and thus have converted into a knowledge and learning organization.

The main challenge to confront these challenges, and at the same time one of the greatest opportunities, is the wide range of diversity in the countries in the region. The classification of countries according to prevalence rates and coverage of comprehensive HIV services can serve as a guide to target technical cooperation given that some countries can benefit others in sharing the accumulation of successful experiences in the region and qualified human resources. On the other hand, financial and human resources of the PAHO HIV/AIDS Unit are limited and there are multiple international partners. The 3 by 5 Initiative is ambitious with a timeline of only 49 weeks. In addition, available international resources exceed local absorption capacity.

An additional opportunity is represented by the fact that PAHO can provide and coordinate technical cooperation at the regional level and thereby increase the response capacity of the individual countries, providing resources to facilitate the inclusion of regional and national professionals and reinforcing strategic support to the region. PAHO's credibility and technical leadership can also mobilize financial resources.

The proposed operational framework is based on three areas: focusing work at the country level, energizing regional activities and expanding PAHO's response to HIV/AIDS/STI. The next steps will include the distribution of the budget in accordance with the 2005 work plans of each country, the synchronization of PAHO's response at all levels, the definition of roles and responsibilities of Unit personnel, the integration of additional personnel in the individual

countries and the sustainability of the expansion of PAHO's response (Biennial Budgetary Plan 2006-2007).

TECHNICAL RESOURCES IDENTIFIED IN THE REGION BY PAHO

Dr. Amalia Del Riego

In a recent consultation, technical cooperation needs for countries in Central America and the Caribbean were discussed. The description of needs will be completed with consultations scheduled with other countries in 2005.

During the consultations the following gaps and opportunities for technical cooperation were identified: control of antiretroviral costs, management systems for medications and laboratory support, service decentralization and integration of chronic care for patients infected by HIV, primary care, voluntary counseling and testing (entry points), human resource management and the monitoring, evaluation and quality of services provided.

The concerns expressed by the individual countries in regard to technical cooperation were the level of technical and financial support to be provided – from the regional level, insufficient communication between the regional and national levels, coordination between different partners and the need of the regional level to clearly identify the needs and degree of support required for each country requirement.

PAHO is confronting challenges of diversity, deciding how to respond effectively to the above-mentioned needs with limited resources, knowing what added value it can contribute and determining how to make individual countries place more importance on the HIV/AIDS epidemic.

The PAHO team has a number of technical capacities including in health systems and services, prevention and behavioral science, monitoring and evaluation, communication, STI, human resources, access to medication and management systems and laboratory, gender, ethnicity and health services, all of which are complemented by the experience of personnel from WHO headquarters in clinical management and other areas.

PAHO has four subregional groups (Caribbean, Central America, the Andean Area and the South Cone). Each has specific capacities especially in service management of HIV programs, human resources, access to medications and management, gender and health systems (the last entry only available in Central America). In addition, there exist specific resources in each of the countries such as PAHO experts in all health areas and national professionals and institutions that support the technical cooperation of the organization.

Steps that should be taken in the short-term are: completing the recruiting process of new technical personnel, stepping up orientation and training processes of PAHO personnel and short-term consultants, providing individual countries with detailed information about available PAHO human resources (internal and external), offering options to identify PAHO technical cooperation needs for 2005 and mobilizing resources to address these needs.

TECHNICAL RESOURCES IDENTIFIED BY THE HTCG

Dr. Mariângela Batista Galvão Simão

The Horizontal Technical Cooperation Group (HTCG) was created in 1995 with representatives from 21 countries (Coordinating Directors of National Programs). Seven Latin American community networks (ASICAL, ICW, LACCASO, MCM+, REDLA, RELARD, REDTRABSEX) currently participate in the Group. Its main goals, based on a horizontal approach, are:

- Experience sharing (knowledge and technology exchange)
- Strengthening national efforts
- Increasing the capacity to respond to the epidemic in LAC

In terms of cooperation in this field, changes such as an increase in financial resources (from institutions such as the World Bank, the IDB, etc.), the strengthening of national responses, greater access to ART and the participation of different actors have been identified. All of the above underlines the need of the HTCG to demonstrate results.

HTCG's strategies include Latin American and Caribbean HIV/AIDS/STI forums, the creation of statutes for the Group that define roles and responsibilities, improved communication among its members, the creation of alliances with other Caribbean nations and organizations as well as the Group's participation in international policy design forums.

The HTCG has also undertaken work in the area of human rights, establishing alliances with the Inter-American Human Rights Commission of the Organization of American States (OAS) and preparing a document to be reviewed by HTCG members and subsequently debated by the Brazil Commission and LACCASO.

It is important to clarify that the HTCG is a facilitation body and not a direct provider of technical assistance. The methodology employed is the establishment of communication and alliances between all participants according to the needs of the individual countries and a horizontal cooperation strategy.

Specific needs and technical assistance possibilities have been identified through self-evaluations in the areas of promotion, prevention and protection, diagnosis, treatment and care, institutional development and management, human rights, civil society capacity building and GF project implementation.

Priorities identified were promotion, prevention and protection of incarcerated individuals and PLWHA and the need for social marketing of condoms. In terms of diagnosis, treatment and care, priorities are prenatal care, access to services for PLWHA, treatment adherence and social support. The highlighted priorities in the area of institutional development and management are supply logistics and monitoring and evaluation of information systems. In the area of human rights, the pressing priorities are the strengthening of civil society, sustainability and human rights advocacy.

The recommended next steps are: the completion of priority identification for technical cooperation, the development of a database of existing human resources in the region, to debate the role and commitment of the HTCG, UNAIDS and other partners and the implementation of work plans to address needs and priorities.

PANEL SUMMARY AND DISCUSSION

After the presentations on resources available at PAHO headquarters in Washington, resources identified by PAHO at the country level and resources identified by the HTCG, discussion was opened to the audience. The following are the principal observations and comments:

PAHO was asked about areas for improvement. The response was that it is necessary to increase direct financial, technical and human resource support to countries in the region. It was recognized that there was a period of distance and fragmentation of PAHO's response to the individual countries, which is now changing as demonstrated by the will and leadership to improve cooperation.

The issue of the large number of sectors involved in the epidemic and the need to take them into account was mentioned, as well as the necessity of coordinating work between both actors and sectors in order to create an adequate response to the HIV epidemic, especially in terms of the coordination of inter-agency responses.

It was stressed that, if adequate results are to be obtained, there is a need to increase financial resources. It is also necessary to learn more about the characteristics of available human resources due to the large number of professionals that exist in the region. In addition, it is important to establish links with organized groups, such as the scientific community, and involve them in the initiative effort. Lastly, work to increase access to generic medications and cost reduction should be undertaken.

ROUND TABLE: Challenges for interagency coordination for the implementation of the 3 by 5 Strategy

Participants:

Dr. Carissa Etienne (Chair)	Assistant Director, PAHO
Dr. Rachel Child	HIV/AIDS Prevention Specialist, UNFPA
Dr. Lourdes Kusunoki	Consultant, ORAS
Dr. Jantine Jacobi	Senior Advisor, UNAIDS
Dr. Malcolm McNeil	Senior Health and Population Advisor, DFID
Mr. Roer Per Kristian	First Secretary, Royal Norwegian Embassy
Ms. Carol Kerfoot	Program Manager, CIDA
Dr. Pamela Teichman	GH/OHA LAC Regional Advisor, USAID
Dr. Joan Atkinson	HIV/AIDS Technical Advisor, USAID
Dr. Ernest Massiah	Social Development Specialist, IADB
Dr. Robert Brohim	Programme Manager for Health Sector Development, CARICOM
Dr. Christoph Kurowski	Health Specialist, WB
Ms. Kate Condliffe	Regional Manager, Clinton Foundation
Dr. Arletty Pinel	Senior Advisor, GFTAM
Dr. Edgar Monterroso	Director, Global AIDS Program for Central America and Panama – CDC
Dr. Mark Connolley	Regional Advisor HIV/AIDS, UNICEF
Ms. Monica Brana (Rapporteur)	Program Officer, PAHO

ROUND TABLE SUMMARY

HIV/AIDS activities, collaboration gaps, and challenges in interagency coordination for the implementation of the 3 by 5 Strategy were discussed during the round table. Each of the bilateral partners mentioned above summarized current HIV/AIDS activities and identified collaboration gaps with PAHO.

Gaps and challenges identified included:

- making the Three Ones happen: “practice what we preach”
- lack of coordination among development partners: too many demands on countries
- risk of building parallel structures rather than supporting existing systems
- countries are ‘over assessed and under assisted”
- inadequate commitment of public and private sectors
- weak capacity in HIV/AIDS programs and need to sustain existing capacity
- monitoring and evaluation capacity
- need for greater support to GF projects, including an early warning system
- focus on families and communities is largely missing
- distance between national and regional dialogues (e.g. prices, policies, etc.) and community realities; and
- children and families affected by HIV/AIDS are not receiving sufficient attention.

SESSION 3: MANAGEMENT OF MEDICINES AND LABORATORY SUPPLIES

Panel 2

Participants:

Professor Brendan Bain (President)	TAC Member, University of the West Indies
Mrs. Maryam Hinds	Director, Barbados Medicine Services
Dr. Jorge Bermúdez	Head, Health Medicine, Vaccination and Technology Unit (THS/EV), PAHO, Washington, DC
Mrs. Kate Condliffe	Clinton Foundation HIV/AIDS Initiative
Dr. James Fitzgerald (Rapporteur)	THS/EV Unit, PAHO, Washington, DC

NECESSARY INFORMATION USED BY THE BARBADOS DRUG SERVICE, PAHO COLLABORATING CENTER, FOR THE PURCHASE OF HIV MEDICINES AND DIAGNOSTICS

Mrs. Maryam Hinds

The beneficiaries of ART are citizens and residents of the country, those that suffer a work accident, all reported cases and pregnant women with the HIV infection.

In Barbados, a pre-qualification of producers and supplies, taking all aspects of the law into account, is conducted before selecting supplies to purchase. Providers must provide product samples to be evaluated, present information on manufacturing practices, provide product inserts, comply with specified terms and conditions and have a local agent if necessary. In addition, providers are monitored to ensure quality products and services and storage conditions are reviewed via a verification list.

The purchase process is carried out through the use of a purchase plan, a record of problems encountered, a subsequent revision of the plan, the introduction of necessary changes and the assurance of transparency in the process. Responsibilities in the process are clearly defined. The WHO pre-qualification system and the establishment of selection criteria are used to choose a provider. For single-source drugs, the *UN Pilot Procurement Sourcing List* of providers who are authorized members of the Pharmaceutical Convention of the Drug Regulatory Authority are used. Other authorized providers exist such as the members of the International Conference on standardizing technical requirements to register drugs for human use and organizations pre-qualified by PAHO.

ESTIMATED NEED FOR MEDICATIONS AND LABORATORY AGENTS FOR THE EXPANSION OF ACCESS TO COMPREHENSIVE CARE: THE ARGENTINIAN EXPERIENCE

Dr. Gabriela Hamilton

Allocations specified in Argentina's National Strategic HIV/AIDS Plan guarantee timely and access to quality antiretroviral and other medications, monitoring tests (viral load and CD4), filtering and confirmation tests for pregnant women and formula milk for babies infected with syphilis or HIV; as well as condoms, brochures and other educational material.

The National HIV/AIDS Program has 16 antiretrovirals in 29 pharmaceutical forms at its disposal. Currently, there are 29,000 PLWHA receiving antiretroviral therapy and 5,000 being monitored.

To estimate the need for ART and other medications, average quarterly consumption, a historical analysis, evolution, the number of patients per treatment type, new HIV and AIDS diagnosis and an extra percentage, are taken into account. CD4 and viral load estimation are based on three tests per patient per year, despite the fact that historic use has increased from 1.7 to 2 viral loads per patient per year. The country has 12 testing centers. The main challenges are to reach 100% coverage in pregnant women, incorporate new treatments, strengthen work being conducted on adherence and regionalization and to facilitate accessibility to emerging vulnerable groups.

In addition to treatment, there are certain aspects of any comprehensive program that are fundamental, including prevention. Comprehensive care of those infected by HIV/AIDS also includes medications and monitoring that should always go hand in hand. Treatment should be administered with three medications and a strong vertical transmission prevention program should exist. Comprehensive care must be supported by an adequate information system and national responses should be multisectoral and multidisciplinary.

INTELLECTUAL PROPERTY AND ITS IMPACT ON ACCESS TO MEDICATIONS: CHALLENGES FOR THE REGION

Dr. Jorge Bermúdez

In 2003 the transition to take PAHO into the future was begun. This effort is based on several central commitments. PAHO is an organization with a health vision for the Americas that is based on equity, Panamericanism and supported by a three focuses: key countries, special populations and technical priorities. Integration with WHO has been improved and coordination between both organizations has increased. There is a strong commitment to reaching the Millennium Development Goals but progress is slow, especially in countries with few resources.

HIV/AIDS medications are on media and governmental agendas as they save lives and improve the health conditions of populations. An example of this is the impact of ART in Brazil, where 90,000 deaths have been averted and hospital admissions have been reduced by 80%. In addition, the characteristics of national trade in antiretroviral medications are distinct from those of other manufactured products.

Nevertheless, countries are not fully and systematically incorporating the flexibilities and safeguards planned in the TRIPS Agreement into policy. Nations should improve their policies to ensure better health conditions for their populations and should also seek out a potential global balance between the need for industry to invest in innovation and provide access to new medications. The same concerns and safeguards should be taken into account when negotiating new regional or bilateral commercial agreements.

Too many people lack access to medications. WHO's policy on the matter is based on the premise that access to essential medications being is a human right. Essential medications are not typical merchandise. Medications that can save lives should be treated as a public good and appropriate incentives should be identified to ensure continued research and the development of new medications.

Challenges and conclusions can be summarized as follows: patents can represent a barrier to access to medications and contribute to a monopoly that delays competition (generics) and affects prices. They also benefit large countries by consolidating the domination of transnational pharmaceutical companies and increase the technical and economic dependency of smaller nations. Today there exist explicit strategies to increase the rigidity and restrictive character of the intellectual property system (CAFTA, ALCA, bilateral agreements). However, nations still have the opportunity to reform their policies in order to fully incorporate the flexibilities and safeguards of the TRIPS Agreement. In the effort to reach an equilibrium between intellectual property rights and the right of access to medicines, international organizations and organized civil society are playing a fundamental role. The current system of intellectual property rights should be reviewed in terms of pharmaceutical products for developing countries. PAHO is playing a strategic role in this matter in the formation of alliances to respond to identified needs.

SELECTION AND PURCHASE OF HIV DIAGNOSTIC TESTS

Mrs. Kate Condliffe

Efficient and effective management can reduce HIV diagnostic test costs. In general, laboratory tests constitute 23.3% of total treatment cost. Establishing an effective and efficient system for high-quality laboratory tests is necessary. In addition, it is essential to have a plan for coordination between laboratories and processes and to consistently apply laboratory testing algorithms for HIV diagnosis and standards established for HIV disease monitoring and drug resistance issues.

WHO recommends serial rather than parallel use of diagnostic tests, confirmation of HIV infection diagnosis and the use of rapid tests for preliminary diagnosis due to the advantages

they offer (reduced cost, easy use, ease of diagnostic decentralization, etc.) and the quick availability of results.

A comparison between different CD4 and viral load tests shows that prices range between USD\$20-\$125 depending on the provider, quantity and recipient country. Factors that should be considered when acquiring laboratory tests are the quality of the tests, maintenance and repair of equipment, total purchase cost, system flexibility, infrastructure requirements, the possibility of renting rather than purchasing equipment and issues related to centralized versus decentralized management.

The importance of including other tests in the analysis, such as tests for STI and opportunistic infection, medication toxicity, drug resistance and tests for pediatric use, should be stressed.

PANEL SUMMARY AND DISCUSSION

In the presentation on required information for HIV/AIDS medicines and diagnostic supplies, Mrs. Maryam Hinds, Director of the Barbados Drug Service highlighted the need for legislation to ensure medication quality and to control purchasing processes in all countries in the region. Continuity in the provision of HIV/AIDS medicines is essential and can be ensured by developing an efficient purchase and supply management system. In addition, she described how Barbados developed transparent purchase processes that facilitate increased treatment coverage for PLWHA. In the Caribbean, the possibility of expanding purchase capacity through PAHO's Strategic Fund should be considered.

The experience of the Barbados was compared to Argentina's, where complexities of its federal structure had led to complications. The immense amount of work and effort made by Argentina to provide comprehensive care and treatment to PLWHA was illustrated. ART has been provided to almost 30,000 people despite the recent economic crisis. In terms of antiretroviral management, Dr. Gabriela Hamilton, Director of the National HIV/AIDS Program, highlighted the success that Argentina has had in issues of planning and programming to respond to the increase in the number of patients that receive treatment, as well as that entailed by introducing new medications into treatment regimens. The presentation on programming and planning methods centered on the historic use of medications and activities carried out to increase the number of PLWHA being treated. However, planning processes should be accompanied by efforts to promote treatment adherence not only in Argentina but also in the entire region.

Dr. Jorge Bermúdez from PAHO addressed the issue of intellectual property and highlighted the need to continue promoting treatment access, especially in joint efforts to adopt and utilize the versatility outlined in the TRIPS Agreement and reaffirmed in the DOHA Declaration on public health. Dr. Bermúdez insisted that some recent bilateral and sub-regional trade agreements went beyond that which is required by the TRIPS Agreement. The adoption of the TRIPS PLUS Agreement will reduce access to medicines. In addition, he described PAHO's position on the protection of intellectual property, TRIPS and access to medicines, stressing that essential medicines are public goods and that the protection of public health requires access to them. He also indicated that PAHO has had a clear mandate

to provide support to countries in the region ever since the World Health Assembly of 1999 and, more recently, through Resolution CD.45 R7 of the organization's Directing Council in September 2004. Assistance is provided to nations in the areas of: adapting to the availability and flexibility of the TRIPS Agreement, technical support for its implementation, monitoring the impact of intellectual property regulatory changes and capacity building for negotiating commercial agreements that affect public health and access to medicines.

Mrs. Kate Condliffe, from the Clinton Foundation's HIV/AIDS Initiative, made a presentation on cost management of HIV/AIDS diagnosis and stressed that diagnostic costs represent up to 25% of total care and treatment costs, constituting the second highest cost after medications (44%). She presented different diagnostic algorithm options, their cost implications and highlighted the importance of planning in the selection and purchasing of HIV/AIDS/STI diagnostic supplies given that total cost of diagnostic tests varies according to test type, test quantity, and the costs of labor, laboratory and equipment. For the CD4 test, purchasers can choose between buying or renting equipment and laboratory supervisors. Service potential and technical support costs should also be examined when considering the relative benefits of each option.

The plenary discussion centered on the selection and cost of HIV/AIDS diagnosis. Argentina requested that their experience using Ag P24 for pediatric diagnosis be documented and published given that other countries are faced with similar challenges in the diagnosis of children. In addition, the importance of issues of selection and purchase of diagnostic tests was recognized in the plenary session, and there was a call to attention of work that needs to be done to develop basic laboratory capacity. The Clinton Foundation was asked to continue its efforts in negotiating the prices of ART and diagnostic tests, and to consider providing assistance in validating diagnostic methods and algorithms that could be more cost-effective in the future.



SIMULTANEOUS PANELS: CHALLENGES TO STRENGTHENING PREVENTION OF HIV/AIDS TRANSMISSION

PANEL 1A: CHALLENGES TO STRENGTHENING PREVENTION OF SEXUAL TRANSMISSION OF HIV/AIDS

Participants:

Dr. Elizabeth Rodríguez	UNFPA, El Salvador
Dr. Sonia Caffé	Epidemiologist and Public Health Advisor, CAREC/PAHO, Suriname
Dr. Ricardo Luque	Head, Colombian National HIV/AIDS/STI Program
Dr. Paulo Lyra (Rapporteur)	HIV/AIDS Unit, PAHO, Washington, DC

HIV/AIDS PREVENTION ACTIVITIES WITH YOUTH: THE EL SALVADOR EXPERIENCE

Elizabeth Rodríguez

Up until July 2004, a total of 13,665 HIV cases had been reported in El Salvador. The difficulties encountered in youth education include scarce systematization and consolidation of innovative educational strategies, incipient integration of sectorial and inter-institutional operations, poor implementation of national and international indicators, lack of a sustainable campaign for youth education and sustainable strategies for behavior change, transmission vulnerability in youths, scarce resources allocated to address prevention and monitoring and evaluation of preventive interventions, inadequate training of service providers in addressing issues related to adolescents and youths, the existence of pressure groups (gangs, religious groups, parental associations) and the socio-economic situation of the country.

Challenges include coordinated and validated inter-agency assistance, a well-established policy on sexual and reproductive education for youths, the systemization and evaluation of successful youth education strategies, effective and sustainable behavior change campaigns, addressing agents of change regarding youth education, financial management of activities, the evaluation of specific indicators for adolescent and youth populations, the existence of empowered and trained adolescents and youths as agents of change, efficiency in youth project execution and the participation of effective institutions in the formation of human resources.

Some of the strategies that have been used in El Salvador are the development of manuals for teachers; the *Participatory Tour* project whose target groups are adolescents, youths, institution personnel and vulnerable populations; and a project using both formal and nonformal methodologies, coordinated with the Ministry of Education.

HIV/AIDS PREVENTION AMONG FEMALE SEX WORKERS: THE SURINAME EXPERIENCE

Dr. Sonja Caffè

Overall, commercial sex workers (CSW) are identified as a priority population for HIV/AIDS prevention interventions because of the high prevalence rates in the population and the risk of generalizing the epidemic via their clients. The development of comprehensive and effective programs for this population has proved to be a challenge due to the continued criminalization and moral condemnation of CSW and because activities carried out with the population are sometimes construed as support for commercial sex work as such.

In Suriname, commercial sex workers are greatly affected by HIV/AIDS. Various studies have revealed a relative low prevalence rate among workers in social clubs (2.5% in 1990), but a high prevalence rate among street sex workers (22%). The National HIV/AIDS Program was created in 1990 and since its inception it has focused on high-risk populations, including CSW and men who have sex with men (MSM).

An analysis conducted in 1990 of the situation of CSW provided a basis for developing prevention programs for this group, including early condom distribution initiatives and reintegration programs. In 1992, the program was reorganized within an independent NGO, the Maxi Linder Foundation. In the past 20 years, the Foundation has implemented programs for CSW that respect human rights and promote destigmatization. Permanent components of the program include the continuous promotion and distribution of condoms, lubricants and other supplies, HIV diagnostic tests and counseling and support activities. In addition, the Maxi Linder Foundation has become an advocate for CSW rights to decision-makers and politicians, giving them voice when their human rights are violated.

In the most recent study of this group, conducted by the Maxi Linder Foundation and CAREC/PAHO, a seroprevalence rate of 21% was found among commercial sex workers. For the first time, male sex workers were included in the study, whose prevalence rate was estimated to be 36%. Compared with the overall estimate from eight years earlier, the prevalence rate had dropped by 1%. The prevalence rate stabilization can be considered a success, although the risk of transmission to the general population has not been reduced. Obstacles to maintaining or expanding the Foundation's program include delays in the regulation of sex work, permanent stigmatization surrounding CSW and delays in receiving governmental and donor funds.

In order to strengthen and expand the Maxi Linder Foundation program, it is necessary to accept some old truths and some new realities: CSW have always existed and this line of work will not likely disappear; members of society use their services; and CSW are human beings that deserve to be treated with dignity and respect.

HIV/AIDS PREVENTION AMONG MEN WHO HAVE SEX WITH MEN: THE COLOMBIAN EXPERIENCE

Dr. Ricardo Luque

In Colombia the prevalence rate of HIV/AIDS in the age group 15 and 49 years old is estimated to be 0.7%, representing about 180,000 cases of infection. The epidemic continues to be concentrated in groups of homosexual men. According to the UNAIDS 2004 World Report, in Lima MSM could account for 21% of cases, 17% in San Salvador, 24% in Buenos Aires and 23% in Guayaquil.

The denial that men have homosexual relationships is one of the main obstacles for prevention programs. This, together with stigma and discrimination, translates to a denial of the real problem, a lack of epidemiological information and difficulties in working effectively with this segment of the population, both through media campaigns and health services.

The AIDS epidemic in the MSM population is not only a consequence of unprotected sexual behavior or a greater probability of vulnerability. Sexual relations without condom use is the last link in a series of factors that precede risky behavior.

Social and political factors exist that accelerate, maintain or reduce the course of the infection in a specific population. An individual is more vulnerable if he or she lacks access to information, cannot negotiate for personal protection, is denied health services or subject to human rights violations. In an attempt to reduce stigma and inform other sectors of the population, a *de-homosexualization* of AIDS has been attempted, stating that AIDS affects everyone equally and minimizing the devastating consequences of the epidemic on the homosexual community. In many countries, including Colombia, this has meant that insufficient resources have been devoted to resources to provide education, support and services to homosexual men, a lack of interest by donor organizations in the issue and national programs that do not provide care to this population. Colombia, being a country with a low prevalence rate with the epidemic still concentrated in specific communities, needs to concentrate efforts on certain key groups (CSW and their clients, MSM, incarcerated individuals and members of the military) in order to maintain a low HIV infection prevalence rate in the general population. For this to be possible it is necessary not only to make adequate resources available, but also to strengthen health services to care for these populations, free from stigma and discrimination, promote the uninterrupted use of condoms, strengthen community-based organizations for peer education, make affected population visible via sensitive mass media campaigns, eliminate existing social and cultural barriers regarding homosexual relations and promote anti-discrimination laws to reduce human rights violations against these individuals.

Within this framework, the General Public Health Office has focused efforts on the MSM population and, although it is still necessary to strengthen prevention programs, it has made progress at the central level in characterizing the group, highlighting MSM through social communication media campaigns and is currently working on technical assistance processes.

PANEL SUMMARY AND DISCUSSION

In the subsequent plenary discussion the Colombian representative was asked if the prevention video for MSM presented during the meeting had been aired on national television, as the video depicted the current government as conservative on health policy issues. Dr. Luque responded that it had been aired on television without problems and that there had been an important change in health policy in terms of sexual health, which is now much more broad and inclusive. In response to the question whether youth projects like those in Colombia and El Salvador had included displaced youths, Dr. Rodriguez said that there was also a project working with deportees from the United States and others that included VCT services in frontier regions for mobile populations. It was also mentioned that in Suriname gold mine workers were targeted because this population is characterized by difficult access and frequent mobility, as many are foreigners, especially Brazilians. Attention was called to the great difficulty of convincing donors to support projects working with CSW due to the great stigma associated with this group, which constitutes a challenge for preventative activities. The support received from donors has tended to be oriented to reintegration of CSW into other jobs, and not to prevention activities.

PANEL 1B: SEXUAL HEALTH PROMOTION AS A HIV/AIDS PREVENTION STRATEGY

Participants:

Dr. Rafael Mazín	HIV/AIDS Unit, PAHO, Washington, DC
Dr. Bill Smith	Director, SIECUS, USA
Dr. Ester Corona	President, Mexican Association on Sexual Education
Dr. Eli Coleman	Ex-President, World Sexology Society
Dr. Paloma Cuchí (Rapporteur)	HIV/AIDS Unit, PAHO, Washington, DC

SEXUAL HEALTH PROMOTION: A NECESSARY INTERVENTION FOR HIV/AIDS PREVENTION

Dr. Rafael Mazín

HIV and STI are health problems associated with sexual behavior. As such, activities should promote healthy behaviors and interventions to modify behaviors that do not lead to good health and well-being. Appropriate and effective prevention is a requisite for ensuring the sustainability of comprehensive care and treatment programs. The simultaneous increase in prevention and treatment is an essential step towards successfully confronting the challenges of HIV/AIDS. Prevention programs should be evidence-based, i.e. on adequate knowledge of human sexuality.

Essential elements of HIV prevention programs should include the promotion of sexual health and well-being, the analysis of environmental conditions, the definition of a working

group capable of recognizing needs, model selection, theories and interventions, activity design and planning, the adoption of necessary measures, the development of materials and the documenting and exchange of lessons learned.

Working in prevention includes making efforts to prevent problems or diseases, and above all, to promote health, well-being, pleasure and harmony at all levels. For this reason, *best experiences*, rather than *best practices*, should be promoted.

POLITICAL CHALLENGES FOR EFFECTIVE HIV/AIDS PREVENTION

Dr. Bill Smith

The challenges to providing effective HIV/AIDS prevention are significant to the country or region where the prevention activities are occurring. These challenges are fundamentally logistical and cultural. However, it is increasingly obvious that political challenges to implementing programs and offering effective services threaten to undo progress achieved to date. Policies are being designed, but stem from ideological, religious and moral approaches to public health. These policies are affecting resources available for countries that most need them.

The proliferation of censorship and distorted medical information, characteristic of “abstinence only until marriage” programs, currently officially constitute the dominating element of the United States HIV/AIDS policy. For example, during deliberations held at the United Nations on sexual and reproductive health and on issues of reproductive and sexual rights, including those related to HIV/AIDS, condoms were discredited and policies were adopted that threaten the system of service delivery, as funds can be withheld if the activities are outside the limited scope referred to above.

It is essential to draw attention to prevention policies that threaten effective sexual and reproductive health and the rights of affected individuals. Policies also should offer advancement possibilities for technical personnel working on these issues in order to improve knowledge and advice on policies that affect public health.

HIV/AIDS NETWORKS AND PREVENTION

Dr. Ester Corona

Given the diversity of societal functions, structures and systems, networks constitute a social coordination mechanism that combines independence (autonomous organizations) and interdependence (cooperation between organizations). In this presentation, several definitions of networks were discussed, including those developed specifically for people working in HIV/AIDS. The methods adopted by the networks were analyzed according to criteria used to unite them.

In working with HIV/AIDS, networks offer many advantages. However, they also are at risk of running into problems if they do not establish adequate coordination mechanisms and clear objectives.

Several suggestions were made to improve the use of networks for a comprehensive and integrated approach to the promotion, prevention and care related to HIV/AIDS and sexual health.

THE PROMOTION OF SEXUAL HEALTH AND HIV/AIDS PREVENTION IN ADOLESCENTS AND YOUTHS

Dr. Eli Coleman

Young people are at the center of the HIV/AIDS epidemic in terms of transmission, impact, vulnerability and potential for change. Of the 14,000 new HIV infections diagnosed every day, 8,000 correspond to children and youths.

All young people need easy access to preventative services to help them reduce the risk of HIV infection. In addition, dealing with the needs of young people already infected is essential. Many young people should be participating in interventions designed to reduce their vulnerability, especially if they belong to a high-risk group. Young people who are already infected require assistance focused on maintaining an active sex life while minimizing the risk of further transmission. Developing local and national strategies is fundamental for this to work. Health workers, for their part, need to strengthen their capacity to work effectively with youth and promote sexual health in order to prevent the disease and also to respond to adolescents' needs for knowledge, guidance and advice. Aside from the need for capacity building and technical knowledge, these activities require a sense of compassion and non-critical approaches. Young people need to listen but also to have the opportunity to speak. Creative interventions and best practices should be evaluated.

Public health is imperative and omitting this principle is unacceptable. The silence barrier must be overcome and we must all contribute to creating a healthy world from the point of view of human sexuality.

PANEL SUMMARY AND DISCUSSION

The issue that most captured the attention of the audience was that presented by Dr. Smith about programs that promote “only abstinence until marriage”. He was asked about the average age for entering into sexual activity and the average age for entering into marriage in the United States. Dr. Smith responded that there is an early entrance into sexual activity and that there are marriages of youths as young as 14. The participants also asked how it was possible to explain the use of public funds in programs that weren't supported by evidence, to which Dr. Smith responded that these programs stem from political postures and decisions associated with them. It was also asked how people could help rectify the problem, to which he responded that the best option is to guarantee that sexual and reproductive health interventions with public funds be based on scientific evidence. Another participant asked about ways to reduce stigma and discrimination in the health sector, to which he responded that to achieve such a reduction, a more adequate climate must be created to allow for open

debate about sexuality. Lastly, he highlighted that health workers also need to be trained to work with sexual minorities, sex workers and drug users.

PANEL 2: ENTRY POINTS FOR COMPREHENSIVE HIV/AIDS CARE

Participants:

Dr. Rosalinda Hernández	Head, National HIV/AIDS Program, Honduras
Dr. Osmany Ricardo Piug	Head, National HIV/AIDS Program, Cuba
Dr. Belkis Marcelino	Chief, National HIV/AIDS Program, Dominican Republic
Dr. Sandra Jones	HIV/AIDS Focal Point Representative, PAHO, Belize
Dr. Julia Valderrama	HIV/AIDS Unit, PAHO, Washington, DC

PREVENTION OF MOTHER TO CHILD TRANSMISSION (PMTCT) AS A HIV CARE ENTRY POINT: THE HONDURAN EXPERIENCE

Dr. Rosalinda Hernández

Up until June 2002, 718 cases of perinatal HIV infection had been presented in Honduras, corresponding to 6.1% of all reported cases in the country (Honduras has the most in Central America).

The activities that have been implemented to date have been focused on avoiding infection of women of reproductive age, getting infected women of reproductive age to plan their lives and receive comprehensive care and assisting pregnant, infected women to receive the care prescribed in the PMTCT care protocol.

Between the years 1999 and 2000, a PMTCT pilot project was launched with the support of UNICEF that, beginning in 2001, had been introduced in the entire country. The goal of the project is to reduce mother-to-child transmission by at least 50% in municipalities where it has been implemented. Notable strategies that have been developed to date include the promotion of the project and care protocol, institutional strengthening, personnel training, team organization and support to laboratories and monitoring, supervision and evaluation activities.

Among the results of the project is an increase in the number of pregnant women that have received counseling and an increase in the number of HIV diagnostic tests conducted for this population. In addition, the number of pregnant women that are receiving vertical HIV transmission prevention treatment has risen.

Despite this progress, it is still necessary to strengthen early intervention with pregnant women, extend follow-up services up until treatment completion, improve birth care conditions and access to comprehensive care, update care norms, improve intra and inter-

institutional coordination, promote the prenatal control program, increase access to counseling for pregnant women, closely follow groups of boys and girls exposed during the perinatal period, review the information system and strengthen the remaining prevention interventions.

STI PREVENTION (ESPECIALLY CONGENITAL SYPHILIS) AS AN ENTRY POINT FOR HIV/AIDS CARE: THE CUBAN EXPERIENCE

Dr. Osmany Ricardo Piug

Dr. Piug began by describing the historic transformation that STI care in Cuba has experienced since before 1962. The congenital syphilis prevention program in Cuba covers 170,000 annual pregnancies, 98% of which in the first trimester. 99.8% of births are in institutions, family physician and nurse coverage is 98% and there are around 30,000 family physicians in the country, including in rural areas. HIV testing is conducted on all pregnant women under antenatal control as a routine laboratory test and program components are included at all health levels.

If a pregnant woman has a positive VDRL test, she is administered penicillin benzathine and referred to a dermatologist for comprehensive study of her case. If the case is confirmed as syphilis, she is notified and an epidemiological study is begun, including a follow up of her sexual partners. In addition, monthly serological follow-up until birth is provided as well as a comprehensive study of the newborn.

The main achievement of this program is the constant and significant reduction of cases of congenital syphilis. In the last two years, no case of congenital syphilis has been reported and the number of cases in women has been reduced noticeably.

The decisive factors in obtaining these results have been political will and the characteristics of the National Health System. The STI Program, created in 1972, has been progressively strengthened and integrated with the Primary Health Care Program. This program is based on a model of Family Medical Care that was developed in the early 1980s. This model gives priority to the Comprehensive Care for Women and Children Program (prenatal care coverage and quality).

TB/HIV COLLABORATION: “TWO DISEASES, ONE PATIENT”: THE DOMINICAN REPUBLIC EXPERIENCE

Dr. Belkis Marcelino

The HIV seroprevalence in the Dominican Republic is 1%, although in some populations it is as high as 5.2% in women. The percentage of TB/HIV coinfection has varied from 18.4% in 2000 to 9% in 2003. Chemoprophylaxis administration has also increased considerably.

In 1998 a project was begun for the joint prevention of TB/HIV. In 2000, the pilot phase began in four health centers. In 2002, the project, which had been implemented in 32 providences, was expanded to the national level. In 2004, the project began activities to improve service quality and evaluate impact.

A comprehensive care network exists in the country that includes comprehensive counseling services, clinic personnel trained in antiretroviral administration, medical file systems, access to a follow-up laboratory, a logistics system and the continual provision of medications and supplies for palliative care. The care model is based on supply.

The achievements include: an increase in coverage for chemoprophylaxis of TB in non-symptomatic HIV/AIDS patients, the continual supply of medications for treatment and TB chemoprophylaxis, the introduction of ART, an increase in the curing of active TB in co-infected patients and the reduction in mortality of those with bacillus tuberculosis.

The proposal for controlling TB-HIV coinfection consists of expanding comprehensive care of PLWHA through Basic Care Units utilizing DOTS, the formation of a group of TB/HIV/AIDS/DR experts from the Dominican Republic and Haiti, the development of a HIV/AIDS/TB Care Guide, training for health personnel who treat these patients and comprehensive TB/HIV/AIDS counseling.

MANAGEMENT OF DOMESTIC AND SEXUAL VIOLENCE AS AN ENTRY POINT FOR HIV CARE: THE CENTRAL AMERICAN EXPERIENCE

Dr. Diny's Luciano and Dr. Sandra Jones

Sexual violence is directly related to an increased vulnerability of women to HIV/AIDS. Diverse studies show that more than 36% of girls and 29% of boys have suffered sexual abuse and a third of adolescents have been coerced to begin sexual relations. Sexual violence committed by husbands is a frequent situation and trafficking in women and girls for sexual exploitation is another key factor in HIV/AIDS propagation. Violence is not only a risk factor for contracting the HIV infection, but also can be a result of the epidemic.

A model for comprehensive care for gender-based violence is currently being implemented in 10 countries in Latin America (Bolivia, Panama, Honduras, Costa Rica, El Salvador, Nicaragua, Peru, Guatemala, Ecuador and Belize) and incorporates community, sectoral and national activities. The presentation described the sexual and domestic violence intervention and opportunities to integrate HIV/AIDS prevention activities. These interventions include

activities such as the approval of national laws on family and sexual violence and specific prevention and treatment measures, such as diagnostic tests and HIV infection.

PANEL SUMMARY AND DISCUSSION

The participation of men in the control of HIV infection in pregnant women is important and should be encouraged at the community level, introducing essential infection concepts and highlighting the importance of preventing domestic violence.

In Honduras, congenital syphilis prevention has been incorporated into vertical HIV transmission prevention activities, children are monitored as are mothers after delivery and other STI play a key role in the control of the epidemic.

In the Dominican Republic, strategies have been designed to administer infant formulas every six months as well as HIV treatments.

In Cuba, follow-up of affected individuals is carried out both in communities and in primary health care and family physicians are in charge of the flow charts.

Although diagnostic tests are offered, many mothers do not consent for reasons such as their status as pregnant adolescents and a lack of information about the benefits of the test. Although a gender sensitive approach would help women to protect themselves against the possibility of becoming infected, the lack of empowerment of women contributes to the result of risky behavior falling on their shoulders.

ROUNDTABLES ON TOOLS AVAILABLE FOR “3 By 5”

The idea of tool roundtables came from an induction meeting for 3 by 5 project managers, held in Johannesburg, South Africa in October 2004. WHO had prepared several summary documents and other resources for meeting participants. PAHO based the “roundtables” on these documents, and adapted them, or introduced new ones, in some cases. These documents are still drafts and some of them are not available for general circulation. Each roundtable was presided over by PAHO personnel from the HIV/AIDS and other Units including the Essential Medication and Vaccines Unit, the Gender Unit, the Human Resources Development Unit and Ethnicity and Health Unit.

The objective of these roundtables was to inform on available tools, methodologies and resources available at PAHO/WHO and in member countries in order to support regional and national efforts with the goal of expanding access to comprehensive care and treatment and increasing the prevention of HIV/AIDS transmission.

FINAL PLENARY: PRESENTATION OF CONCLUSIONS AND RECOMMENDATIONS OF THE TECHNICAL ADVISORY COMMITTEE

Dr. Mercedes Weissenbacher, Co-Chair of the Technical Advisory Committee, presented its final recommendations that consisted of 24 points. These were discussed and augmented by the plenary discussion to a total of 33 recommendations (see Annex 1).

The recommendations are also available on PAHO's website at: http://www.paho.org/english/ad/fch/ai/TAC_2005.htm