Improving access to AIDS services in Latin America: What can be done?

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The World Bank
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Outline

1. The HIV/AIDS-poverty nexus
2. The socio-economic determinants of access to AIDS services in Latin America
3. Program and policy implications:
   - What works?
   - Some issues to debate....
Key Messages

- Who gets AIDS prevention and treatment care in the region? Poverty and gender matter
- High-risk groups are being neglected
- There are a few examples of success – but much to be done
- Data collection and monitoring on access are insufficient, must improve
The AIDS-Poverty Nexus

- Clear evidence that AIDS causes, deepens poverty
- Poverty can also drive the epidemic and its response
  - AIDS not simply a disease of the poor...but...
  - Some dimensions of being poor increase risk and vulnerability
- Employment-based vulnerability, e.g. migration
- High risk behaviors, e.g., commercial sex, injecting
- Lower educational status → less access, ability to use information on prevention and care
- Lack of access, affordability of care once infected

- Lost household income
- Catastrophic costs of health care
- Decreased ability to manage in families headed by elderly, orphans.
- Inter-generational effects, e.g. undernutrition, low school enrollment
- Macroeconomic impact in high prevalence settings
Socioeconomic factors that limit access to HIV/AIDS prevention and treatment

- Income (poverty)
- Gender
- Marginalized status (MSM, CSW, Migrants)
- Geography
- Race/ethnicity
Income matters: condom use by men, Latin America and Africa

Brazil Haiti Benin Zimbabwe

Percentage using condoms

- Lowest 20%
- Second
- Third
- Fourth
- Richest 20%
Income matters:
Use of HIV testing and counseling services among women, three LAC countries

![Chart: Income matters: Use of HIV testing and counseling services among women, three LAC countries](chart.png)
Gender matters: Knowledge about HIV/AIDS, six LAC countries

Income Quintiles

Percent

Women
Men

Poorest  Second  Middle  Fourth  Highest
Marginal social status matters: HIV infection rates in Quito, Ecuador, 1999-2001

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<tr>
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<th>Illegal FSW</th>
<th>MSM</th>
<th>Legal FSW</th>
<th>ANC</th>
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<td>PNS-INH-MSP</td>
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Geography matters: estimated coverage of HIV+ pregnant women with ZDV during labor, Brazil 2001

Brazil: ~ 35%
Gender and race matter: mortality rates due to AIDS, São Paulo, Brazil 1998-2002

![Graph showing mortality rates by gender and race from 1998 to 2002.](Governance & Policy; PAHO, 2004)
Policy and Program Implications

- Make national AIDS plans more poverty, gender-oriented (Guatemala)
- Improve targeting, e.g. condom promotion for poor, less educated; services for high risk groups, mobile pop (CRN+)
- Support NGOs/civil society for hard-to-reach populations (PROSA-Peru, GAPA-Brazil)
- Use methods for resource allocation and monitoring that measure equity (ABC Model)
What Works in Targeting? Partners In Health (PIH), Haiti

The HIV Equity Initiative sought to show that ARV treatment can be delivered in poor settings, by:

- Adapting methods of successful TB program -- community health workers as the link between PLWA and clinic
- Training health workers in administration, daily follow-up of ARV therapy
Progression of HIV+ patient enrolment
Partners in Health, rural Haiti
The Equity Initiative: success in treatment also drives HIV prevention

- Sharp increase in uptake of VCT
- Staff spent more time reinforcing safe sex messages, not managing infections
- Decreased stigma associated with AIDS
- Lower expenditure for hospital care, increased resources for prevention
What works in universal access?
The Brazil ARV Program

- Policy on universal, free access to ARV drugs initiated in 1991 (presidential decree, Nov 1996)
- National network of alternative public care services - over 900
- Supporting infrastructure – 165 CD4+/CD8+ labs, 480 computerized dispensaries
- Participation of civil society – information, rights, counseling
Patients on ARV therapy in the public health system - Brazil, 1997 - 2001*

* preliminary data

Source: Ministry of Health
What Works? ARV distribution can be cost-saving, Brazil, 1997 - 2001 *(UNAIDS)*
What works in modeling resource allocation? The ABC model

- Allocation By Cost-Effectiveness
- The ABC model:
  - focuses on prevention
  - analyzes alternative resource allocations by intervention and target group
  - enables comparisons among different allocation scenarios
Which interventions prevent the most infections? Honduras 2002
What Works?
Findings of the ABC model

- Substantial impact can be achieved with limited resources: $1 \text{ m} \Rightarrow 5000$ infections averted
- Services that target the poor and at-risk are also most cost-effective:
  - free condom distribution targeted to high-risk groups
  - condom social marketing
  - information for high-risk groups including MSM, sex workers and prisoners
  - counseling/testing
Some issues for discussion

- What special efforts are needed to increase use of AIDS services by the poor and marginalized?
- How can Latin American countries learn from each other, and from other regions?
- What can be done to improve monitoring of access?