

Advancing towards 2020: progress in Latin America and the Caribbean



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Foreword



In 2015, the world first committed to meeting an ambitious universal agenda for sustainable development, which included the aspiration to end the HIV epidemic as a public health threat by 2030. Global advances in increasing the accessibility and affordability of HIV treatment and the implementation of innovative strategies for prevention and treatment programming, community-based service delivery and adherence support have contributed to a decrease in the number of new HIV infections and HIV-related mortality around the world. Accelerated and innovative actions are needed to reach those left behind and achieve the 2020 targets of 90% of people living with HIV knowing their status, 90% of people living with HIV who know their status on treatment, and 90% of those on treatment achieving viral suppression.

Between 2010 and 2018, several countries in Latin America have demonstrated impressive progress towards these goals, yet overall new infections have increased by 7%. New infections have decreased by 16% in the Caribbean over the same period. The number of AIDS-related deaths have declined in both Latin America and the Caribbean, 14% and 38% respectively. A full 64% of new infection in Latin America and 45% in the Caribbean occur in key populations—sex workers, gay men and other men who have sex with men, and transgender women—and their partners.

While there have been advances toward the goals of reaching zero new infections, zero stigma and discrimination and zero AIDS-related deaths in the region, we cannot lose the sense of urgency. There is no need to wait to scale up innovative interventions to reach those left behind. Strategies such as self-testing, PrEP, community-based services and the use of social media have proven successful in increasing access to testing, improving linkage to care and supporting treatment adherence in the region.

Importantly, Latin America and the Caribbean are facing a dramatic increase in migration due to sociopolitical uncertainties. Migrants and asylum seekers face economic and legal difficulties negatively affecting their access health care services, including HIV prevention and treatment.

At UNAIDS, we recognize the importance of empowering and supporting civil society, communities and individuals to work together for change. As donor funding decreases across the region, sustainable solutions must be identified, such as resource mobilization strategies, price reductions for commodities, better resource allocation – including community-based service delivery – and other efficiency gains. Countries need to implement plans for sustainable, domestically funded HIV responses.

This document provides an overview of the latest data available in Latin America and the Caribbean and demonstrates the importance of community involvement and individual empowerment for the development of rights-based policies and programming that meets the needs of those historically being left behind.

A handwritten signature in black ink, appearing to read 'Cesar A. Nunez', written over a white background.

Cesar A. Nunez
Director of the UNAIDS Regional Support Team
for Latin America and the Caribbean

Executive summary

The global AIDS response has advanced considerably since the start of the epidemic 30 years ago. While there have been impressive achievements, the pace at which the changes are happening is not sufficient to reach the 2020 targets of 90% of people living with HIV knowing their status, 90% of people who know their HIV-positive status on antiretroviral therapy, and 90% of people on antiretroviral therapy with viral suppression. In 2018 approximately 79% of all people living with HIV knew their status, 78% of people who knew their HIV-positive status were accessing antiretroviral therapy, and 86% of people accessing treatment had suppressed viral loads. Among all people living with HIV globally, 62% were on treatment and 53% had suppressed viral loads.

In some areas the Latin American and Caribbean region has surpassed the global achievements, but there is considerable variability between the subregions. Latin America has surpassed the global achievements: 80% [62 – 99%] of people living with HIV know their status, 78% [67 – 84%] of people who know their HIV-positive status are on antiretroviral therapy, and 89% [74 – 96%] of people on antiretroviral therapy are virally suppressed. If the trends in Latin America continue, the 90–90–90 targets are achievable. However, in the Caribbean the estimates are 72% [60 – 86%], 77% [66 – 81%] and 74% [53 – 85%], respectively, which places the Caribbean at risk for not achieving the targets.

Due to increases in diagnosis, linkage to care of people with HIV, earlier initiation of treatment, and improved adherence, rates of new infections and mortality rates have improved over time. Globally since 2010 there has been an 16% decrease in new infections and a 33% decrease in AIDS-related deaths. While estimated new infections in Latin America have increased by 7%, they have decreased by 18% in the Caribbean, matching the global trend. AIDS-related deaths have decreased by 14% in Latin America and 38% in the Caribbean (1).

Cities

Over time, recognition of the importance of local governments, civil society and community members has made it clear that cities are the future of the AIDS response, especially in hard-to-reach populations. In 2014 several mayors signed the Paris Declaration, committing to Fast-Track the AIDS response by achieving the UNAIDS 90–90–90 targets, specifically by focusing on the communities most affected by HIV.

To date, mayors in 46 cities in Latin America and the Caribbean have committed to putting their cities on the Fast-Track to end the AIDS epidemic by 2030. These cities have agreed to use diverse methods to overcome factors that increase vulnerability to HIV, tuberculosis (TB) and other diseases; to promote the participation and leadership of communities; to implement innovative, safe, accessible, equitable and discrimination-free services; and to find innovative financing mechanisms.

Prevention of mother-to-child transmission

In 2015 there were an estimated 11 000 000 pregnant women in Latin America and the Caribbean. While prenatal care coverage in the region is estimated at 83%, late access

and poor-quality prenatal care continue (2, 3). The Pan American Health Organization and World Health Organization Strategy and Plan of Action for Elimination of Mother-to-Child Transmission of HIV and Congenital Syphilis calls for the reduction of mother-to-child transmission of HIV to 2% or less and the reduction of congenital syphilis to 0.5 or fewer cases per 1000 live births by 2020. Major successes have been achieved in the Caribbean, where seven countries and territories have been validated as having eliminated mother-to-child transmission.¹

Increases in HIV screening and antiretroviral therapy coverage in pregnant women have contributed to these successes. However, validation of the elimination of syphilis remains a challenge. In 2015 the incidence of congenital syphilis in countries in Latin America and the Caribbean varied from zero to 6.5 per 1000 live births. (2,3). The greatest barrier to validating elimination of both HIV and congenital syphilis is the challenge of detecting syphilis in pregnant women. In order to reduce congenital syphilis rates, prevention of HIV and sexually transmitted infections and maternal and child health services must be integrated. Additionally, weak information systems for documenting and reporting the detection and treatment of syphilis in pregnant women and follow-up of exposed infants is a barrier to certifying elimination of congenital syphilis.

Combination prevention

Ending the AIDS epidemic by 2030 requires that key populations are not left behind. To achieve this, investment in combination prevention interventions that respond to the specific needs of these groups is necessary. In the Latin American and Caribbean region, key populations are men who have sex with men, female sex workers, transgender women, incarcerated people, and people who use drugs. Indigenous and migrant populations are also a priority in countries whose geographical, economic and cultural contexts have placed these populations in vulnerable conditions, particularly in the Bolivarian Republic of Venezuela, which has contributed to a refugee crisis in the region.

HIV prevalence among key populations is much higher than among adults overall. Relevant data on HIV prevalence in Latin America and the Caribbean indicate that HIV prevalence ranges between 1.1% and 25.4% in men who have sex with men and between 2.3% and 34.8% in transgender women (1). Nevertheless, key populations are often less likely to access prevention and health-care services due to high levels of discrimination in public services.

The comprehensive combination prevention approach has not yet been adopted by many countries in Latin America and the Caribbean. Nevertheless, some countries in both subregions are already strengthening and broadening their combination interventions and adapting them to their local epidemics. For example, Brazil currently offers free pre-exposure prophylaxis in limited areas, and an estimated 54 000 people will receive pre-exposure prophylaxis in the next 5 years; since the inclusion of this programme in the public health sector, Brazil is providing all the interventions required of a comprehensive combination prevention programme. In Chile, Costa Rica, Guatemala, Mexico, Paraguay and Uruguay, pre-exposure prophylaxis can be obtained on a small scale through private health centres, websites, civil society organizations and research projects (4,5).

Youth and HIV

In 2018 an estimated 129 000 people aged 15–24 years people were living with HIV in Latin America and the Caribbean. There were an estimated 25 400 new infections

¹ Anguilla, Antigua and Barbuda, Bermuda, the Cayman Islands, Cuba, Montserrat, and Saint Kitts and Nevis.

in this age group, which represents a third of the all new infections in the region. Changing the trajectory of the epidemic requires protecting younger generations from HIV by providing access to adolescents and young people to comprehensive sex education and youth-friendly sexual and reproductive health services. In more than half of the countries in the region, children aged under 18 years require parental consent to be tested for HIV (1).

Stigma and discrimination

In Latin America and the Caribbean there are still laws and policies that discriminate against lesbian, gay, bisexual, transgender and intersex people, people living with HIV, and the transmission of HIV. Discriminatory attitudes and practices persist in the health system that continue to hinder access to prevention, treatment and social services for people in these populations. In both subregions there are laws criminalizing transmission, non-disclosure and exposure to HIV. However, there has been progress. In February 2018 the Inter-American Court of Human Rights issued an opinion that interprets the American Convention on Human Rights as recognizing same-sex couples and the legal identity of transgender people in Latin America and the Caribbean.

Despite the region's efforts and advances in recognizing the human rights of lesbian, gay, bisexual, transgender and intersex people, violation of their human rights continues. Hate crimes against the lesbian, gay, bisexual, transgender and intersex community in Latin America and the Caribbean are common, but the absence of a universal legal concept of hate crimes hinders the identification and prosecution of violence against and homicides of people in this community.

Sustainability

In the 2016 Political Declaration on HIV and AIDS, United Nations Member States pledged to accelerate the response to HIV and end the AIDS epidemic as a threat to public health by 2030. They reaffirmed the need for concrete policies and actions to fully fund the HIV response. Many countries in the region are being reclassified as upper-middle-income countries, leading to a reduction in funding from international sources and requiring significant increases in national resources to ensure continuity and expansion of HIV and AIDS programmes.

In 2017 the Third Latin American and Caribbean Forum on Sustainability of the HIV Response took place in Haiti. Participants agreed that the challenges of sustainability transcend financial needs and the specific necessity to replace donor funding with national resources, and that countries should develop a more multidimensional perspective that includes addressing policies and their implementation in health systems.

Additionally, several countries have begun exploring or are already implementing mechanisms to ensure fair and accessible pricing of antiretroviral medicines, medications for opportunistic infections, and supplies necessary to provide good-quality sustainable services by improving procurement processes and diversifying suppliers.

Migration

Latin America is experiencing the largest movement of people in its history. It is estimated that up to 5.8% of the population of Latin America is currently migrant. Although migration is not a direct risk factor for HIV, migrant populations face conditions that put them at risk for HIV, including lack of adequate housing, nutrition

and access to educational and health services. Migrants rarely have the same employment rights as citizens of the country they are in, and therefore they do not have the same levels of employment certainty or security from abuse (6).

Increases in stigma and discrimination lead to greater vulnerability to sexual exploitation, human trafficking, labour exploitation and gender-based violence, especially against women living with HIV, transgender women, and men who have sex with men.

Recommendations

Countries that have not yet taken full advantage of the potential of the Fast-Track Cities initiative must seize the opportunities offered via an urban approach to the epidemic and implement local and multisector innovative strategies including all potential local and national organizations. The full participation of people living with HIV and key population groups is essential for achieving Fast-Track targets and ensuring the sustainability of the HIV response. Governments should create mechanisms to finance civil society through national sources to support effective and efficient community-based programming.

Progress has been made to expand HIV testing and increase the number of people living with HIV who know their status. Measures should continue to expand innovative strategies for reaching key populations, including services to young people aged 15–25 years.

The elimination of mother-to-child transmission should be prioritized in the region's political agenda. Best practices from countries that have been validated should be applied across the region, especially in countries that are nearing the criteria for validation.

Combination prevention programmes should be implemented universally across the region. There is sufficient evidence in the region that self-administered tests, pre-exposure prophylaxis and post-exposure prophylaxis are accepted and effective. Greater political commitment, training, collaboration and partnership of government institutions and civil society organizations are needed urgently to accelerate the expansion of combination prevention targeted to key populations. Restrictions on the age at which adolescents can access HIV testing and their results must be removed, comprehensive sexuality education should be universal, and youth-friendly services are necessary to reduce new infections in youth.

Eliminating discrimination and violence towards people living with HIV and key population groups is imperative. Legal frameworks that promote the protection and empowerment of these groups are necessary.

Reducing dependence on external funding in the region requires cost projections for strategic investment, new approaches to resource mobilization, and improved allocation and monitoring of resources. The Call for Action resulting from the LAC III Forum on Sustainability must be implemented and monitored.

State of the epidemic in 2018

IT IS ESTIMATED
THAT 21% OF PEOPLE
LIVING WITH HIV IN
LATIN AMERICA AND
THE CARIBBEAN
DO NOT KNOW
THEIR SEROLOGICAL
STATUS

It is widely recognized that the Latin American and Caribbean response to HIV in migrant populations needs to be articulated among all transit and destination countries. No country should respond to the situation in an isolated manner.

Latin America

- ▶ A total of 1 900 000 [1 600 000–2 400 000] adults and children were living with HIV.
- ▶ The number of new HIV infections was 100 000 [79 000–130 000] (7% increase compared with 2010).
- ▶ The ratio between incidence and prevalence of HIV was 5.4% [4.1–6.8%].
- ▶ A total of 35 000 [25 000–46 000] people died from AIDS-related illnesses (14% reduction compared with 2010).
- ▶ Antiretroviral therapy coverage of people living with HIV was 62% [44–78%].
- ▶ 78% of new infections occur in key populations and their sex partners.
- ▶ ART coverage for prevention of mother-to-child transmission of HIV in pregnancy was 76% [61–95%] and the mother-to-child transmission rate is 14% [12–17%].

Caribbean

- ▶ A total of 340 000 [290 000–390 000] adults and children were living with HIV.
- ▶ The number of new HIV infections was 16 000 [11 000–24 000] (16% reduction compared with 2010).
- ▶ The ratio between incidence and prevalence of HIV was 4.6% [3.2–7.0%].
- ▶ A total of 6700 [5100–9100] people died from AIDS-related illnesses (38% reduction compared with 2010).
- ▶ Antiretroviral therapy coverage of people living with HIV was 55% [42–67%].
- ▶ 53% of new infections occur in key populations and their sex partners
- ▶ ART coverage for prevention of mother-to-child transmission of HIV in pregnancy was 86% [68–>95%] and the rate of mother-to-child transmission was 14% [10–16%].

Progress towards the 90–90–90 targets

In December 2013 the UNAIDS Programme Coordinating Board requested the UNAIDS Secretariat to support country- and region-led efforts to establish new targets for HIV treatment scale-up beyond 2015.

A better understanding of the importance of expanding combination prevention and diagnostic services, improving linkages to health and prevention services, ensuring access to and retention in treatment, and achieving viral suppression has motivated the adoption of a new approach in the response to HIV, recognizing that it will be impossible to end the AIDS epidemic as a global health threat if antiretroviral therapy is not guaranteed for all people who need it.

This new narrative on HIV treatment laid the groundwork for defining new and ambitious, but attainable, targets by 2020:

- ▶ 90% of people living with HIV will know their HIV status.
- ▶ 90% of people who know their HIV-positive status will be accessing treatment.
- ▶ 90% of people on treatment will have suppressed viral loads.

In May 2014, at the Latin American and Caribbean Forum on the Continuum of HIV Care, organized by UNAIDS, the Pan American Health Organization (PAHO) and the World Health Organization (WHO), the countries in the Latin America and the Caribbean (LAC) region pledged to make the efforts necessary to achieve these new ambitious targets.

Knowing one's HIV status is the first pillar of the 90–90–90 cascade. It is therefore important to promote the use of innovative methodologies to rapidly expand access to HIV testing, such as active case identification and case management. Immediately linking people with HIV to health services, especially key populations and other people who avoid using health centres because of discrimination, is essential to step up the response to the epidemic. This will allow for early access to antiretroviral therapy and routine follow-up for people with HIV; provide necessary information on how to maintain health and proper nutrition, avoid opportunistic infections, and overcome barriers to and encourage retention in treatment.

The WHO guidelines recommend the treatment of all people living with HIV, regardless of CD4 cell count, with the aim to eliminate new infections (7). In the LAC region there has been progress towards incorporating the WHO recommendations in national treatment guidelines—but not all countries have adopted them, and late diagnosis continues to hinder timely access to treatment, negatively affecting the impact on HIV-related morbidity and mortality.

Temporary or permanent interruption of treatment is a cause of low rates of viral suppression, contributing to further HIV-related illnesses in people living with HIV and

80% OF PEOPLE LIVING WITH HIV IN LATIN AMERICA KNEW THEIR HIV STATUS IN 2018

increasing the risk of HIV transmission. Ongoing adherence to antiretroviral therapy is essential to achieve and sustain an undetectable viral load (8).²

Civil society plays a very important role in identifying people living with HIV who have not had any contact, or have lost contact, with health services. The use of community-provided services and peer support has demonstrated increases in early diagnosis, linkage to care, retention in health services and, ultimately, treatment adherence (9, 10). Civil society together with the health system can do much to achieve the 90–90–90 targets.

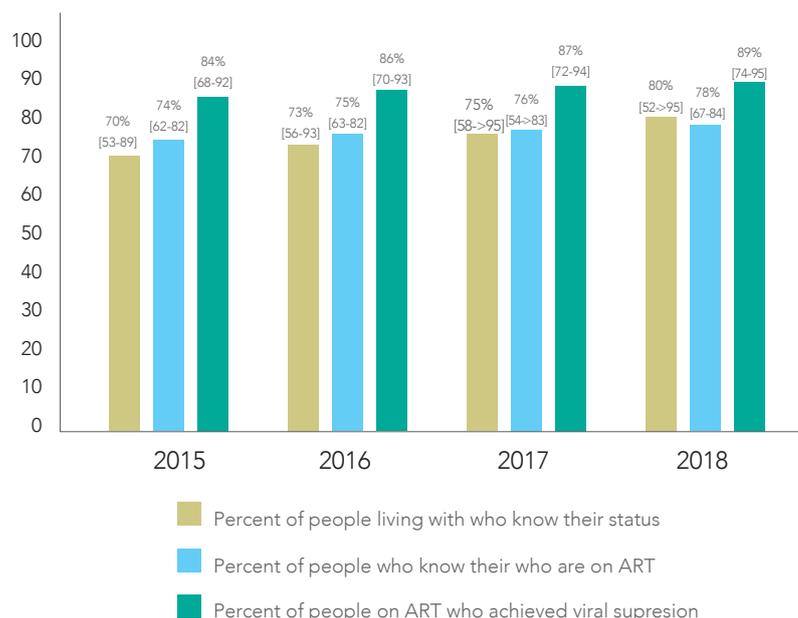
It should be stressed that the region is advancing to reach the targets set for 2020, and several countries are generating innovative strategies for combination prevention and eliminating the structural barriers that limit progress. However, progress in some countries has lagged behind the region at large and the subregions individually (see Annex 1).

Latin America

Latin America has been progressing towards the 90–90–90 targets, Figure 1 shows that in 2018, 80% [62–>95%] of people living with HIV were aware of their HIV status, an increase of 10% compared with 2015. If the trend continues at this rate, the region would reach the 2020 target (see Annex 1) (11).

Figure 1.

Progress towards the 90–90–90 targets in Latin America, 2015–2018



Source: UNAIDS 2019 estimates.

Of the 17 Latin American countries, 88% have partially or fully adopted the WHO treat all recommendations (1). The 15 countries that have adopted these recommendations are Argentina, Bolivia (Plurinational State of), Brazil, Chile, Colombia, Costa Rica, Ecuador, Guatemala, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru and Uruguay.

² WHO defines adherence as “the degree to which a person’s behaviour—taking a medication, following a diet and carrying out lifestyle changes—corresponds to the agreed recommendations of a health-care provider”. Taking at least 90–95% of the prescribed medication is considered ideal adherence.

78% OF PEOPLE WHO KNOW THEIR HIV-POSITIVE STATUS WERE RECEIVING ANTIRETROVIRAL THERAPY IN 2018

Late diagnosis remains a challenge in Latin America, with at least 30% of people at an advanced stage of HIV infection (CD4 count below 200 cells/mm³) at the time of diagnosis in Chile, Colombia, Guatemala, Honduras, Ecuador, Mexico, Panama, Paraguay (11).

Expanding the HIV self-diagnosis strategy would provide an opportunity to increase early diagnosis of HIV, especially to populations that may be reluctant to access health services. Brazil and El Salvador have implemented self-testing pilots, and Brazil and Mexico have incorporated it into the national policy, regulating sale of self-tests in pharmacies since 2017 and 2018, respectively.

The number of people accessing antiretroviral therapy in Latin America has doubled over the past 8 years, from an estimated 506 000 in 2010 to 1 200 000 in 2018. In 2018, 78% [67–84%] of people who know their HIV-positive status were receiving antiretroviral therapy. Mexico has the highest coverage among people who know their HIV status in Latin America, surpassing 90%, followed by Honduras, which exceeds 80%; while the coverage in Brazil, Ecuador and Panama reaches or exceeds 75%.

A full 89% [74–>95%] of people who accessed antiretroviral therapy in Latin America achieved viral suppression in 2018. Twelve-month retention on antiretroviral therapy varies from 67% to more than 96% across countries in the region. However, some studies show that treatment adherence is still below expectations. A meta-analysis of research in Latin America and the Caribbean indicates that people living with HIV in the region can achieve comparable adherence levels to other regions, however, it may not be sufficient for long-term viral load suppression. Continued monitoring of treatment adherence is necessary, particularly given continued challenges in obtaining and administering viral load tests. (12).

89% OF PEOPLE WHO ACCESSED ANTIRETROVIRAL THERAPY ACHIEVED VIRAL SUPPRESSION IN 2018

Argentina: Masantonio House—community involvement in HIV-related services

In the city of Buenos Aires in 2016, the Hogar de Cristo Neighborhood Centers (created by the then Cardinal Bergoglio, current Pope Francis) set up Masantonio House to provide services for people experiencing homelessness and who use cocaine



paste. It is in the neighbourhood of Barracas, within the coverage area of two of the city's main public hospitals.

The project is coordinated by the Social Cooperative of Companions of Users of Paco and is based on an integrated approach for people who

use cocaine paste, prioritizing people living with HIV and tuberculosis (TB) who do not access the public health system.

The programme focuses on the specific needs of this community, with the goal of reconstructing healthy lives for the people reached and facilitating access to sanitary, housing, employment, family and judicial services.

Since 2016, 42 people with HIV have received antiretroviral therapy and 52 people have been treated for TB under the programme. Adherence rates in both groups are greater than 92%. The project has achieved these results with the following methods:

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- ▶ Peer support: a fundamental pillar of Masantonio House is training people who have previously experienced homelessness and drug use, people living with HIV, and people who have previously had TB or HIV/TB coinfection to become health agents and provide peer support. Peers are formally registered in and paid by the Social Cooperative of Companions of Users of Paco, reducing recidivism rates among these peer agents.
- ▶ Individualized treatment plans for people with TB including: directly observed treatment, community based distribution of medications, economic incentives or assistance with food or clothing, and peer accompaniment are all offered.
- ▶ Integrated support services: restoration of dignified living conditions through legal registration housing, employment, schooling, and nutritional support.
- ▶ Decentralized medical care: coordination with public health centres and ministries to promote rapid and decentralized access to medication, tuberculin tests, radiology, laboratory, serology, viral load, CD4 count, and other medical services.
- ▶ Active case finding among people who are homeless.

The project is considered a best practice, providing services within a complex social network and has successfully reached the population via a community-based service model.

Source: Tuberculosis Newsletter in Argentina. No. 1. March 2018. Directorate of AIDS and STDs, Ministry of Health of the Nation, Argentina.

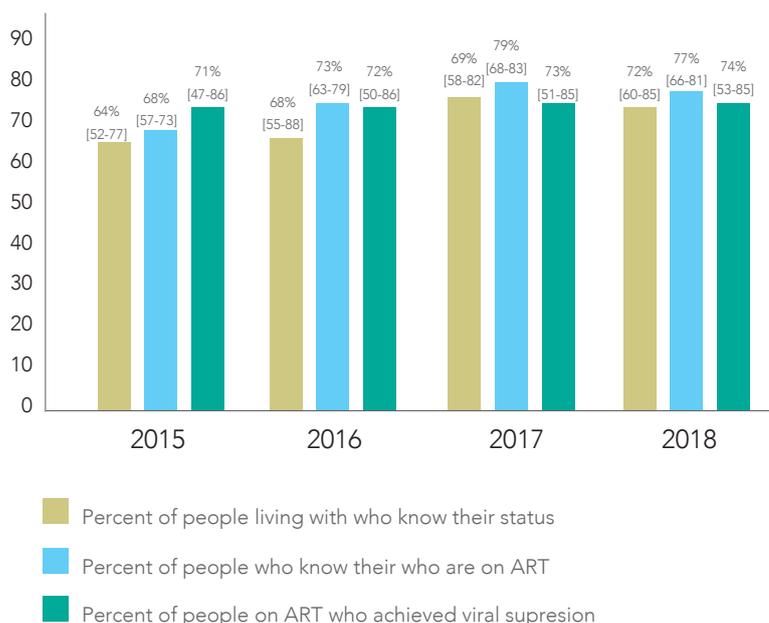
Nota: The findings and conclusions of this case study represent those of the informants/authors and do not necessarily represent the official position of UNAIDS.

72% OF PEOPLE LIVING WITH HIV KNEW THEIR HIV STATUS IN 2018

Caribbean

Figure 2 shows that knowledge of HIV status among people living with HIV in the Caribbean increased from 64% [52–77%] in 2015 to 72% [60–86%] in 2018. Treatment coverage among people living with HIV who know their status increased from 68% to 77% and viral suppression from 71% to 74%.

Figure 2. Progress towards 90–90–90 targets in the Caribbean, 2015–2018



Source: UNAIDS 2019 estimates.

77% OF PEOPLE WHO KNEW THEIR HIV-POSITIVE STATUS RECEIVED ANTIRETROVIRAL THERAPY IN 2018

Late diagnosis remains a challenge in the Caribbean, with at least 20% of people presenting with advanced HIV infection (CD4 count below 200 cells/mm³) at the time of diagnosis in 7 of 10 countries reporting in 2018.

Ten of the 16 Caribbean countries (62%) have partially or fully adopted the WHO recommendation for the treatment of all people with HIV regardless of CD4 count. The countries that have adopted the recommendations are Antigua and Barbuda, Bahamas, Barbados, Cuba, Dominican Republic, Guyana, Haiti, Jamaica and Saint Lucia and Trinidad and Tobago (7).

Despite the fact that self-testing would allow more people to know their HIV status, only the Bahamas, Jamaica, and Trinidad and Tobago report the availability of self-testing kits, but self-testing is not yet part of their national policies.

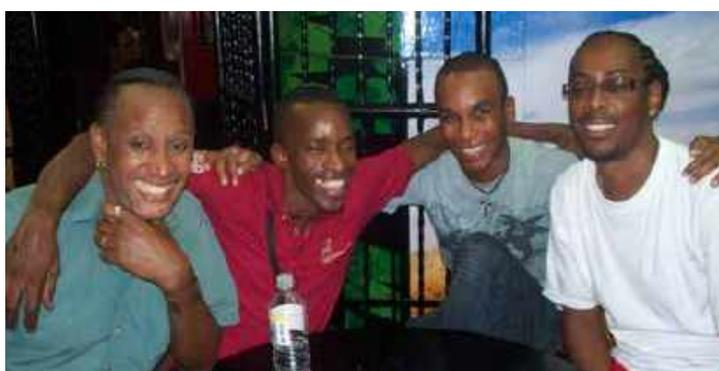
74% OF PEOPLE WHO ACCESSED ANTIRETROVIRAL THERAPY ACHIEVED VIRAL SUPPRESSION IN 2018

Of the people who knew their HIV-positive status, 77% [66–81%] had access to antiretroviral therapy in 2018. The number of people receiving treatment has increased markedly since 2010, up from 67 500 to 186 500 in 2018. Treatment coverage among people who know their status is more than 85% in Cuba, Haiti and Suriname and above 65% in the Dominican Republic and Guyana. Sustained increases in access to antiretroviral therapy over the next four years will likely enable the region to achieve the second “90”.

Of all people living with HIV who were receiving antiretroviral treatment, it is estimated that 74% [53–85%] had reached viral suppression in 2018.

Adherence to antiretroviral therapy continues to challenge the region, especially in key populations. For example, a study conducted in the Dominican Republic shows that among female sex workers with HIV, the probability of interruption of antiretroviral therapy is 3 times higher in those who have experienced discrimination in health centres and 2.4 times higher in those who use drugs (13).

Trinidad and Tobago: Friends for Life refines its strategy for testing, linkage and improving adherence in men who have sex with men



Friends for Life is Trinidad and Tobago's oldest civil society organization primarily serving men who have sex with men and other key population groups such as sex

workers and transgender people. They have been offering support and counselling for 21 years and have acted as an implementor of the United States President's Emergency Plan For AIDS Relief (PEPFAR)–supported Linkages Project.

The work to improve the continuum of HIV services for key populations is especially relevant for Trinidad and Tobago. Among the most at-risk groups are men who have sex with men, who have an HIV prevalence of 32% according to a 2015 study. Friends for Life demonstrates the value of using key population-led organizations to provide basic services and support to people with HIV to navigate the health-care system to access antiretroviral therapy and care.

Friends for Life social worker Luke Sinnette says the transformative experience of supporting someone in starting and staying on treatment is one of the high points of the organization's work. He thinks of the 19-year-old they met with advanced HIV. He'd already been diagnosed but had been too afraid to go to the HIV clinic on his own. Having had the support of peer navigators to access care, he's now healthy, happy and thriving. The organization is currently supporting a woman to resume taking her medicines, responding to her doubts with an appropriate mix of information and heart. They find that clients' needs are as individual as their personalities.

“The health services don’t have to be perfect,” Sinnette explained.

“There is a lot that we can accomplish while we do the work to make health–care settings truly free of stigma and discrimination. People just need to know there is someone there to support them. Someone they identify with.”

Friends for Life finds that it is not enough to stop at health care. Their model involves the use of professional networks and know–how to link clients to a range of psychosocial support services—everything from mental health care to public assistance, identifying holistic solutions to clients’ challenges.

“It’s not enough to treat just HIV. You’re dealing with the whole person who has challenges at the level of family, community, school and workplace. We find that we have to support people to address issues including depression, homelessness and poverty.”

Source: Friends for Life, Trinidad and Tobago, 2016.

Note: The findings and conclusions of this case study are those of the informants/authors and do not necessarily represent the official position of UNAIDS.

The role cities are playing in response to the HIV epidemic

Over the years it has been recognized that cities become increasingly relevant to providing combination prevention services to high-priority populations whose needs have traditionally been more difficult to meet.

Since the commemoration of World AIDS Day in 2014, several mayors and other municipal leaders in Latin America and the Caribbean have signed the Paris Declaration and are committed to putting their cities on the Fast-Track to end the AIDS epidemic as a threat to public health by 2030. In this Declaration, authorities adopt a series of commitments to reach the 90–90–90 targets by focusing on the communities most affected by HIV. They use various methods to address the factors that make people vulnerable to HIV, tuberculosis and other diseases, promoting the participation and leadership of communities, and developing innovative, safe, accessible, equitable and discrimination-free services and innovative financing mechanisms.

Through this initiative, civil society and public and private sectors at the local level come together to ensure investment in effective programmes in places where they can have the greatest possible impact to achieve the Fast-Track targets.

Municipal leaders play one of the most important roles in the Fast-Track Cities approach, extending beyond their political commitment to actively participating in their cities' responses to HIV, speaking publicly, convening working groups, meeting with leaders of community groups and civil society organizations, and mobilizing other institutions and city leaders to promote more collaborative and tailored HIV programmes (14).

In addition to UNAIDS, the strategy has other partners working in all regions of the world to achieve the defined objectives, including the city of Paris, the International Association of Providers of AIDS Care (IAPAC), and the United Nations Human Settlements Programme, UN Habitat, a UNAIDS implementing partner, provides technical assistance to health departments, participates in capacity-building efforts with medical and service providers, community organizations and affected communities, and provides opportunities for collaboration and exchange of best practices.³

Latin America

In 2018 Brazil is one of the countries with the highest number of cities, a total of 42, that have signed the Paris Declaration.⁴ In addition to the cities, the governments of the states of Rio Grande do Sul, Santa Catarina and the Federal District signed the commitment.

Other countries in the region have also joined forces with the Fast-Track Cities approach: Buenos Aires, the city of Mendoza, Cordoba, Godoy Cruz, Guaymallen, Rosario and 22 municipalities in Argentina; Santiago de Chile in Chile; Quito in Ecuador; Comayaguela, Tegucigalpa and San Pedro Sula in Honduras; Mexico City in

³ See <http://www.fast-trackcities.org>.

⁴ Alvorada, Aracaju, Atalaia do Norte, Benjamin Constant, Balneário Camboriú, Belém, Blumenau, Brusque, Cachoeirinha, Campinas, Canoas, Caxias do Sul, Chapecó, Criciúma, Curitiba, Esteio, Florianópolis, Fortaleza, Gravataí, Guaíba, Itajai, Jaguaríuna, Jaraguá do Sul, Joinville, Lages, Manaus, Palhoça, Palmas, Porto Alegre, Rio de Janeiro, Rio Grande, Salvador, Santana de Parnaíba, Santana do Livramento, São José, São Leopoldo, São Paulo, Sapucaia do sul, Tabatinga, Uruguaiana, Viamão, Vitória.

Mexico; the city of Panama, Colon and San Miguelito in Panama; Asuncion in Paraguay; and Montevideo in Uruguay (15).

More than 50 cities in Latin America are looking for innovative ways to offer programmes to key populations, such as decentralization of services at the community level, new approaches to HIV testing such as self-testing, and other combination prevention strategies such as pre-exposure prophylaxis.

The city of São Paulo has become involved in the Fast-Track strategy by expanding HIV prevention services, making services more accessible to key populations, and promoting the active participation of civil society. In 2016 condom dispensers were placed in at least 36 strategic locations such as public transport stations and health centres. It is estimated that by the end of 2016, the number of available condoms in the city reached 120 million.

At the same time, priority has been given to innovative technologies such as mobile applications to reach young people, especially gay youth and other men who have sex with men. Other initiatives have been designed to reach men who have sex with men and transgender people, such as a mobile unit for HIV testing and counselling managed by the civil society organization Viva Melhor Sabendo Jovem (“Live Better Knowing Young”) (16).

In 2015 the city of Curitiba launched the project The Time Is Now, focused on men who have sex with men. To expand HIV testing options, testing was made available in public health facilities, mobile units and in the offices of civil society organizations. The project also implements an innovative e-testing strategy that enables people to request oral testing for self-diagnosis through a virtual platform, with the option of receiving the test by mail or at a pharmacy (17,18).

In Mexico City civil society organizations have partnered with municipal HIV and AIDS programmes to reach key populations through mobile services and have also implemented specialized centres for transgender women. Montevideo in Uruguay has positioned itself as one of the leading cities in the Fast-Track initiative, promoting HIV testing and counselling in the 24 primary level care polyclinics and implementing lesbian, gay, bisexual, transgender and intersex-friendly service delivery strategies, particularly for for transgender people (19).

Montevideo: Fast-Track city

The Health Division and the Secretary of Diversity of the municipality of Montevideo, in close collaboration with civil society and with the joint support of UNAIDS and the United Nations Population Fund (UNFPA), has been a key actor in the Fast-Track response. The Intersections project was created as a space for dialogue between experts, political decision-makers and activists on the rights and unique experiences of lesbian, gay, bisexual, transgender and intersex people and the multiplicity of factors that generate inequity and inequalities. Based on national and regional best practices, the project promotes the development of common agendas between different actors and the design of public policies that incorporate the principle of intersectionality and recognition of the full legal and social equality of

lesbian, gay, bisexual, transgender and intersex people. The initiative will be expanded in 2019 to other Latin American and European cities through the project Intersectionality in Metropolitan LGBTI Policies, supported by the Metropolis Project/World Association of Large Metropolises, bringing together Barcelona, Berlin, Buenos Aires, Medellin, Mexico City and Montevideo.



Since 1993, the Intendencia project, in conjunction with the civil society organization “Asociación de Ayuda al Positivo” (ASEPO), has implemented the only free and confidential nationwide telephone service providing information, support and guidance on HIV, sexuality and human rights. The initiative has implemented two strategies in the 24 primary care polyclinics, training health workers in sexual and reproductive health related rights and sexual diversity.

Caribbean

Four cities in the Caribbean region have signed the Paris Declaration: Havana in Cuba; Acul-du-Nord and Port-au-Prince in Haiti; and Kingston in Jamaica.

Kingston has the largest number of people diagnosed with HIV in Jamaica (14): 64% of people with living with HIV in Jamaica are in Kingston, and the city is the location for nearly half of the country’s antiretroviral therapy centres (11).

In 2016 Kingston led a series of HIV testing campaigns, increasing access to HIV testing, especially for young people. A community-based consultation was conducted, examining the social risk factors for acquiring HIV, including gender-based violence and discrimination. The city also mobilized for representation at the United Nations General Assembly High Level Meeting on HIV/AIDS in 2016 (15).

Community-led initiatives, such as the organization Jamaica AIDS Support for Life, are playing an important role in reaching key populations in Kingston and Montego Bay, adopting an innovative navigator approach in which peers accompany people with HIV from initial diagnosis to the achievement of viral suppression.

In 2015 it was estimated that there were almost 11 000 000 pregnant women in the region. The coverage of hospital deliveries was estimated at 92%. While 97% of pregnant women received at least one prenatal care visit, it is widely recognized that one visit is not sufficient. There is great variability between the subregions and

Progress towards the elimination of mother-to-child transmission of HIV and congenital syphilis

IT IS ESTIMATED THAT IN 2018 MORE THAN 4100 NEW MATERNAL AND CHILD INFECTIONS WERE AVOIDED IN LATIN AMERICA AND THE CARIBBEAN.

countries, and lack of access, late access and poor-quality prenatal care (fewer than four antenatal care consultations with qualified staff) are still challenges that need to be overcome.

Early detection of HIV and appropriate treatment for pregnant women living with HIV are essential to eliminating vertical transmission. Some of the major successes of the regional HIV response have been achieved in this area, showing the political commitment of the ministries of health of many countries in the region, such as Brazil and Mexico. Furthermore, seven countries and overseas territories in the Caribbean have been validated as having eliminated mother-to-child transmission: Anguilla, Antigua and Barbuda, Bermuda, the Cayman Islands, Cuba, Montserrat, and Saint Kitts and Nevis. Cuba has since been revalidated.

In September 2010 PAHO and WHO launched the Strategy and Plan of Action for Elimination of Mother-to-Child Transmission of HIV and Congenital Syphilis, which established the following targets for 2015:

- ▶ Reduce mother-to-child transmission of HIV to 2% or less.
- ▶ Reduce the incidence of congenital syphilis to 0.5 or fewer cases (including stillbirths) per 1000 live births.

This commitment was renewed and expanded in 2016, when the Member States approved the Plan of Action for the Prevention and Control of HIV and Sexually Transmitted Infections 2016–2021, in the 68th Session of the WHO Regional Committee for the Americas. The goal of the Plan of Action is to accelerate progress towards reducing the incidence of new cases of HIV in pregnant women, AIDS-related mortality and complications related to sexually transmitted infections (16,17). Because HIV and syphilis can be asymptomatic, timely and effective diagnosis during pregnancy is essential, along with prophylactic antiretroviral therapy and planning for safe delivery options and feeding alternatives.

In 2018, syphilis screening coverage ranges from 27% (Venezuela) to 100% (Antigua and Barbuda, Chile, Cuba) in Latin America and the Caribbean. The percentage of pregnant women tested for syphilis who had a positive result varied from 0.03% to 3.2%⁵. Despite this, the region has not progressed as expected in the reduction of congenital syphilis, showing figures higher than the elimination goal in several countries, especially in Latin America.

The outlook for the elimination of mother-to-child transmission of HIV seems more encouraging. HIV screening and antiretroviral therapy coverage in pregnant women have had a sustained increase, leading to a reduction in the rate of mother-to-child transmission of HIV in the entire region and enabling several countries to reach or approach the goal of elimination (17). However, there are significant differences between the sub-regions and countries within each subregion, and even differences within regions of the same country.

⁵ Excluding Saint Kitts and Nevis

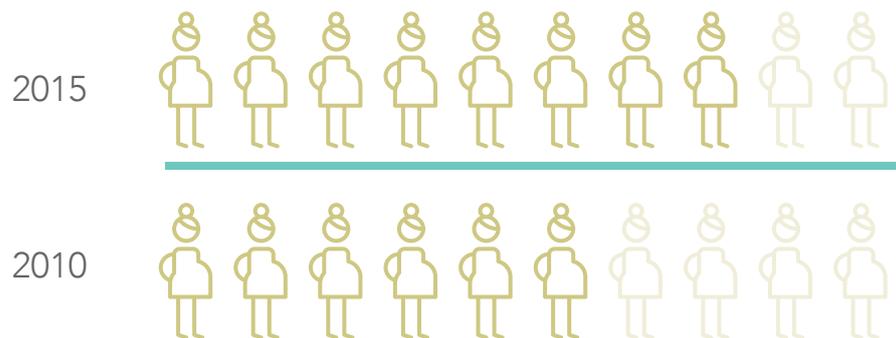
To achieve the elimination of HIV transmission and congenital syphilis, sexual and reproductive health, HIV prevention treatment, and care and maternal and child health services must be integrated.

Latin America

The mother-to-child HIV transmission rate in Latin America was 14% [12–17%] in 2018, one of the lowest in the world, a 30% decrease compared to 2010.

8 OF EVERY 10

mothers in need receive PMTCT in 2018



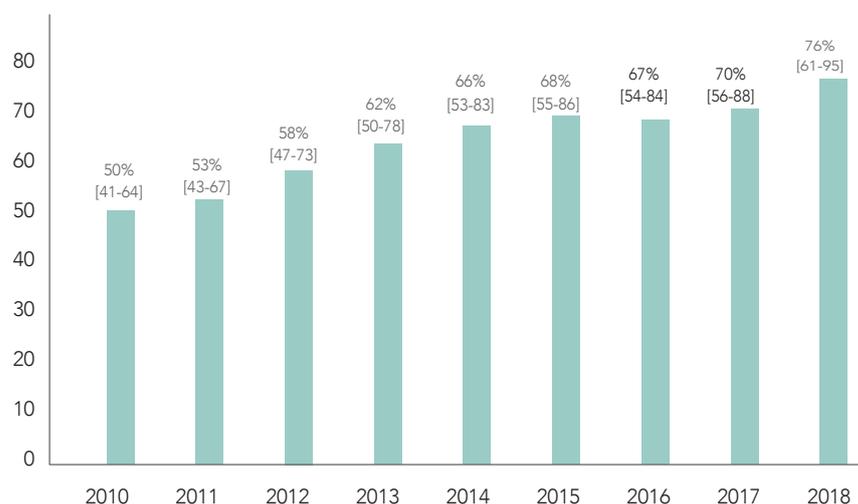
It was estimated that in 2017, 73% of pregnant women in Latin America attended prenatal care services and underwent an HIV test or already knew their HIV status. The combination of education and testing strategies implemented in the region led to a nearly 10% increase in the screening of pregnant women since 2010 (22).

Figure 3 shows that treatment coverage of pregnant women with HIV has increased from 50% [41–64%] in 2010 to 76% [61–95%] in 2018. However, this increase does not reflect the differences in coverage between countries, which ranges from 21% in Colombia to more than 95% in Argentina, Bolivia (Plurinational Republic of), Chile, Ecuador and Uruguay (see Annex 2) (11).

The significant increase in antiretroviral therapy coverage in pregnant women living with HIV has contributed to a decrease in the mother-to-child transmission rate, from

Figure 3.

Coverage of antiretroviral treatment in pregnant women in Latin America, 2010–2018



Source: UNAIDS 2019 estimates.

20% [17–24%] in 2010 to 14% [12–17%] in 2018. In addition, 20% of infants exposed to HIV benefited from early diagnosis in 2018 ranging from 24% to more than 90% across countries (see Annex 2) (21).

Data from 2018 show that Argentina and Uruguay are close to achieving elimination of mother-to-child transmission of HIV, registering mother-to-child transmission rates of 5.26% and 5.01%, respectively. Countries with transmission rates between 5.5% and 10% include Chile (7%) and Nicaragua (10%).

Ministry of Public Health of Uruguay: surveillance of HIV positive pregnant women

In Uruguay the mother-to-child transmission rate of HIV in 2015, 2016 and 2017 was 2% or less. This is the result of a historical prioritization of maternal and child health that continues in the current government, being one of the targets included in the National Health Goals 2015–2020. Since 1990 the country has implemented evidence-based interventions such as replacement feeding (1990), Protocol 076 (use of zidovudine monotherapy in children in the first six weeks postpartum as prophylaxis of vertical transmission) (1996), universal HIV screening during pregnancy (1997), high-efficacy antiretroviral therapy (1998), elective caesarean section (2000), and three syphilis screening tests throughout pregnancy and testing of sexual partners (2013). Other programmatic strategies have also been developed, such as integrating HIV and sexually transmitted infection prevention with sexual and reproductive health programmes; the incorporation of HIV and syphilis prevention and treatment at all levels of care; performance goals linked to HIV and syphilis testing; and compulsory use of the Perinatal Information System.

In 2013 the Ministry of Health began to implement the surveillance and follow-up for HIV positive women diagnosed during pregnancy, labour or post-partum. The strategy has been implemented as a fundamental tool to monitor compliance with guidelines and regulations aimed at reducing perinatal transmission by 2020.

THE MOTHER-
TO-CHILD
TRANSMISSION RATE
IN LATIN AMERICA IN
2018 WAS 14.07%



The process is triggered by the registration of a positive HIV test in a woman during pregnancy, in labour or postpartum. The records are obtained from the Perinatal Information System and electronic certificate of live birth. A form is completed that gathers data on sociodemographic variables, previous and current pregnancies, HIV screening, treatment, sexual partners, and childbirth history. Children exposed to HIV are monitored until confirmed as being positive or negative for HIV. Analysis of follow-up is carried out and feedback offered to each health provider with suggested corrective measures. Once the follow-up of an infant exposed to HIV is completed, it is included in a consolidated national report shared with service providers and the public.

The implementation of this strategy is a key monitoring tool to identify existing gaps and enable quality supervision and training of health teams, contributing not only to the prevention of mother-to-child transmission of HIV but also to improving the quality of the health-care service.

Source: Report on vertical transmission of syphilis and HIV. Ministry of Public Health, Uruguay. <http://www.msp.gub.uy/noticia/informes-de-trasmisi%C3%B3n-vertical-de-s%C3%ADfilis-y-vih>

Note: The findings and conclusions of this exemplary case are the responsibility of the informants/authors and do not necessarily represent the official position of UNAIDS.

Caribbean

The mother-to-child HIV transmission rate in the Caribbean was 13.57% [10.387–16.22 %] in 2018, one of the lowest in the world, and 40% lower than the rate of 22.44 % [17.157–26.79 %] in 2010.

Anguilla, Antigua and Barbuda, Bermuda, the Cayman Islands, Cuba, Montserrat, and Saint Kitts and Nevis have achieved the elimination of mother to child transmission of HIV.

8 OF EVERY 10

mothers in need receive PMTCT in 2018



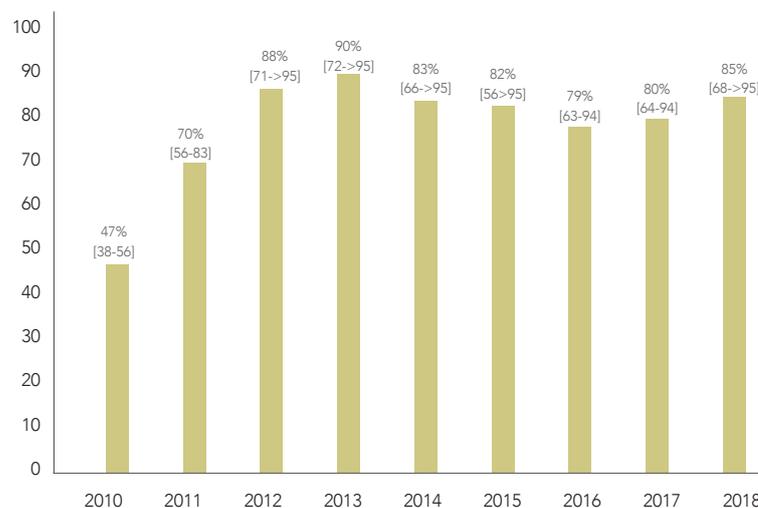
As seen in Figure 4, there has been an increase in coverage of antiretroviral therapy in pregnant women living with HIV, from 47% [38–56%] in 2010 to 86% [68–>95%] in 2018. Despite this notable increase, the trend was variable between 2013 and 2016 and stabilized in 2016–2018. As in Latin America, coverage is highly variable between the countries of the Caribbean, ranging between 44% and more than 95% (see Annex 2) (23).

Early infant diagnosis in 2018 ranged between 46% and more than 95% among countries (see Annex 2).

The number of infant HIV infections averted in the Caribbean has increased from <1000 [<5007–<1000] in 2010 to 1300 [<10007–1800] in 2018 (11).

Figure 4.

Coverage of antiretroviral therapy in pregnant women in the Caribbean, 2010–2018



Source: UNAIDS 2019 estimates.

Antigua and Barbuda: key strategies to eliminate mother-to-child transmission of HIV and congenital syphilis

On 1 December 2017 Antigua and Barbuda became one of the Caribbean countries and territories validated by WHO for having eliminated mother-to-child transmission of HIV and congenital syphilis. To achieve this feat, this small island nation has innovated health services to ensure that women access early prenatal care, that Spanish-speaking migrants have access to services, and that private health service data are included in the national health information system.

According to the Medical Director of Antigua and Barbuda, Dr Rhonda Sealey-Thomas, the Ministry of Health, Welfare and the Environment devised strategies to ensure that pregnant women feel empowered and supported to begin prenatal care as soon as possible. The state employs a community nursing model in which district nurses perform

home visits to encourage women to attend health centres near the onset of their pregnancies and to keep their appointments. The country took full advantage of its primary health-care system, using its 26 community clinics to ensure that all women had easy access to prenatal care.



The Ministry of Health of Antigua and Barbuda provides free antiretroviral treatment to women living with HIV. It also encourages mothers living with HIV not to breastfeed by providing free formula. Dedicated counsellors monitor mothers living with HIV by establishing contacts with the Clinical Care Coordinator at the HIV Clinic of Mount St John Medical Center as needed. The hospital's paediatric unit also provides follow-up care for infants exposed to HIV and children living with HIV through their outpatient clinic.

Antigua and Barbuda's approach addresses the barriers of language and immigration status, as it provides medical care in Spanish to Latin American migrants. Using a group of Spanish-speaking health-care providers, the Ministry of Health ensures that Hispanic women receive good-quality treatment and care in their native language.

"Services at the community health clinics are free of charge. Nationality doesn't matter. If migrants are not provided with health care, it costs more in the longer term. By protecting the health of migrants, you are indirectly protecting the health of your own people," explained Dr Sealey-Thomas.

The small size of the country facilitates access to services. However, the small population of just over 90 000 inhabitants, requires particular attention given to strengthening confidentiality and addressing discrimination in health-care settings. A human rights office at the National AIDS Secretariat and two nongovernmental organizations work with the Ministry of Health to address discrimination in the health

THE SCOPE OF PREVENTIVE INTERVENTIONS IS STILL INSUFFICIENT IN KEY POPULATIONS TO ACHIEVE FAST-TRACK GOALS

care setting. In addition, health-care providers have received anti-stigma and discrimination training to address unconscious bias and confidentiality.

Dr Sealey-Thomas notes that by associating the information between the public and private health sectors, the dedication of the country's nurses and the strength of prenatal care services are the reasons for the success of the prevention of mother-to-child transmission in Antigua and Barbuda. She also commended the National AIDS Secretariat, which, according to her, provided the leadership to drive the validation process.

Source: Ministry of Health and Environment of Antigua and Barbuda.

Note: The findings and conclusions of this exemplary case are the responsibility of the informants/authors and do not necessarily represent the official position of UNAIDS.

Advances in combination prevention in key populations

Ending the AIDS epidemic as a threat to public health in Latin America and the Caribbean requires that key populations are not left behind. To achieve this goal, greater investment is needed in combination prevention interventions that respond to the specific needs of these groups, focusing on preventing new infections and ensuring early detection of people with HIV and their inclusion in care and treatment services, with the objective of achieving and maintaining viral suppression.

In most countries in the region, key populations are men who have sex with men, female sex workers, transgender women, incarcerated people, and people who use drugs.⁶ Almost all countries also include adolescents as a group at higher risk of acquiring HIV. Indigenous and migrant populations are considered high-priority populations in countries whose geographical, economic and cultural contexts have placed these populations in vulnerable conditions (23,24).

Comprehensive combination prevention programmes have been defined as those based on evidence that incorporate a rights-based focus and community-based services.⁷ These programmes propose a combination of biomedical, behavioural and structural interventions aimed at responding synergistically to the HIV prevention needs of specific individuals and communities.

The success of the biomedical and behavioural components depends on structural interventions—protective laws, reduction of discrimination, and improved quality of services. The full participation of affected communities is imperative to ensure the effectiveness and continuity of combination prevention programmes (25).

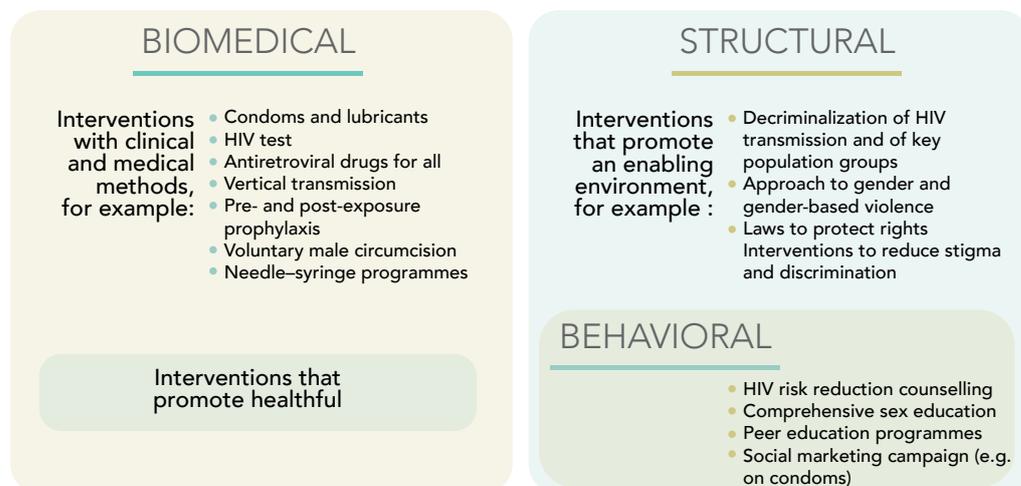
HIV prevalence among key populations is much higher than among adults overall. Available data indicates that region indicate that HIV prevalence in men who have sex with men ranges between 1.1% in Cuba to 25.4% in Bolivia, while HIV prevalence in transgender women ranges between 2.3% in Peru to 34.8% in Ecuador. (see Annex 3) and demonstrate the high level of variability between countries.

⁶ Except for Mexico, countries define drug users as people who use non-injectable drugs such as cocaine base paste or crack.

⁷ This was initially proposed by PEPFAR. In 2009 the UNAIDS HIV Prevention Reference Group adopted and expanded it. Years later it was updated in the Accelerated Action document for combination prevention.

Figure 5.

Areas of the approach of the combination prevention of HIV infection



Source: HIV prevention in the spotlight. Washington, DC: Pan American Health Organization and Joint United Nations Programme on HIV/AIDS; 2017.

Despite this, key populations are often less likely to access combination prevention services. A lack of services addressing the specific needs of these populations and high levels of discrimination continue to be an obstacle to the effective prevention of HIV in the region.

UNAIDS has defined the need for combination prevention packages that include:

- ▶ HIV testing, including oral tests, rapid tests, self-testing and counselling.
- ▶ Diagnosis and treatment of sexually transmitted infections.
- ▶ Pre-exposure prophylaxis.
- ▶ Post-exposure prophylaxis.
- ▶ Distribution of male and female condoms and lubricants.
- ▶ Antiretroviral therapy for all, regardless of CD4 count or clinical infection stage.
- ▶ Community outreach activities through peers.
- ▶ Sexual health information and education.

Unfortunately, the comprehensive approach has not yet been adopted by many countries in the region. The level of political commitment and progress in implementation is heterogeneous, and funding for a significant proportion of HIV prevention activities for key populations comes from the Global Fund to Fight AIDS, Tuberculosis and Malaria and the Presidents Emergency Plan for AIDS Relief of the United States government (PEPFAR). Despite this, some countries in both subregions are already strengthening and broadening their combination interventions and adapting them to their local epidemics.

Latin America

In 14 countries in the region, the HIV prevalence in female sex workers ranges from 0% to 7%. The HIV prevalence in men who have sex with men is above 10% in 12 of

16 Latin American countries and HIV prevalence in transgender women in the region ranges from 7.4% to 34.8% (see Annex 3).

It is estimated that the number of men who have sex with men in Brazil is 2 million, and the number of female sex workers is more than half a million. In Mexico there are an estimated 1 200 000 men who have sex with men, 240 000 female sex workers and about 120 000 transgender women (11).

In Latin America the median coverage for HIV testing in the past 12 months was 48% for men who have sex with men, 64% for female sex workers, and 74% for transgender women (see Annex 3).

Almost all countries in the region have reported that they offer HIV tests specifically to key populations (24), but coverage is still limited.

The results of a cross-sectional study of 8000 men who have sex with men from 24 cities in Mexico in 2011 showed that more than two-thirds of those living with HIV were unaware of their serological status (25). A study conducted in 2009 in men who have sex with men in 10 cities in Brazil showed that of a total of 3800 respondents, half of those who tested positive for HIV did not know their status (26).

Since 2017 Brazil has been a pioneer in the region to regulate the sale of self-tests in pharmacies. In 2018, both Brazil and El Salvador began distributing self-test kits in some health services as part of the national strategy of combination prevention.

Since 2009, looking to generate opportunities to increase the access of men who have sex with men and transgender women to existing health services, Argentina has been developing key population-friendly clinics coordinated by the Ministry of Health, the model of which is now included in public policy opening opportunities for scale-up. Uruguay has also sought to improve the provision of key population-friendly services at municipal levels in the country's capital and through the public health services in other states (25, 26, 27).

The ministries of health of El Salvador, Guatemala, Honduras, Nicaragua and Panama have adopted the strategy of surveillance and treatment clinics for HIV and sexually transmitted infections for key populations, providing prevention activities and extended hours to reach groups that cannot access these services during regular hours. In addition, PEPFAR is funding a pilot programme in 37 sites in the 5 countries to implement differentiated service delivery models for key population groups, creating patient profiles that allow, among other things, the distribution of enough antiretroviral medicines to reduce the number of clinic visits for people in a stable condition (26).

The implementation of pre-exposure prophylaxis is a challenge in the region, but Brazil is promoting the strategy in public health services. Since May 2017, Brazil's national health system began offering free pre-exposure prophylaxis to populations at higher risk estimated 9000 men who have sex with men, female sex workers and transgender women received pre-exposure prophylaxis through the national health system in the first year. Pre-exposure prophylaxis is being offered in 36 health units across the Federal District and 10 states. In April 2018, 29 new health service providers in the remaining 16 states were trained to provide pre-exposure prophylaxis (25). An estimated 54 000 people will receive pre-exposure prophylaxis in the next 5 years. Since the inclusion of its pre-exposure prophylaxis programme in the public health sector, Brazil is providing all the interventions of comprehensive combination prevention.

In Chile, Colombia, Costa Rica, Guatemala, Mexico, Panama, Paraguay and Uruguay, pre-exposure prophylaxis can be obtained on a small scale through private health centres, websites, civil society organizations and research projects.

Pre-exposure prophylaxis in Brazil

A pre-exposure prophylaxis pilot project in Brazil, the results of which were published in *The Lancet* in February 2018, has provided evidence on the benefits of this innovative HIV prevention technology, especially for men who have sex with men and transgender women.

The Brazil study evaluated the administration of pre-exposure prophylaxis (tenofovir and emtricitabine) to prevent HIV during 48 weeks in 450 men who have sex with men and transgender women living in Sao Paulo and Rio de Janeiro.

At the beginning of the study, all participants were HIV-negative and referred to the programme after reporting risky sexual intercourse, defined as having unprotected anal sex, two or more episodes of anal sex with a partner with HIV, or a history of sexually transmitted infections.

83% of the participants remained in the study for 48 weeks. 75% of this group demonstrated serum concentrations of the medicines consistent with high levels of adherence, indicating that they took at least four doses per week. While risky sexual behaviour was generally high in those who participated in the study, only two people seroconverted during the study, and they had undetectable concentrations of tenofovir in the blood. The results demonstrate the importance of increasing access to PrEP to keep the HIV epidemic under control among key populations.

The authors point out that more work is needed to increase and expand awareness and to develop adherence support strategies. They also point out that pre-exposure prophylaxis programmes for transgender women need to be explored further, given that only 25 participants in the study were transgender women.

All the countries in the region provide post-exposure prophylaxis, either in primary care centres or at emergency services for occupational exposure and cases of sexual assault (20). In addition, Argentina, Brazil, Colombia and Uruguay have incorporated the WHO recommendations to provide post-exposure prophylaxis in cases of unprotected sexual intercourse.

Paraguay: SOMOSGAY Community Center—bringing health services closer to key populations



The Kuimba'e Clinic is in the SOMOSGAY Community Center and is part of a broader programme to support men who have sex with men and people with HIV. The programme was conceptualized and is implemented by community members.

SOMOSGAY offers a range of health and social services and advocates for public health and educational policies that include HIV. It has also served as an incubator for grassroots groups to meet and create new networks. Two have emerged: LESVOS, a group of lesbian women, and DIVERSA, a national advocacy network for young people living with or affected by HIV.

The Kuimba'e Clinic offers free testing, clinical care, treatment and referrals, with an emphasis on the prevention of HIV and other sexually transmitted infections. The clinic opens from Monday to Saturday and offers extended hours. It distributes condoms and water-based lubricants and provides pre-exposure prophylaxis for people who qualify. The clinic also runs widespread HIV testing programmes and campaigns in public places reaching many people with information, prevention kits, testing, counselling, and subsequent referrals and linkage to health care.

A closely related programme is Community Agents in Human Rights and Health, which offers workshops focusing on training and empowering lesbian, gay, bisexual, transgender and intersex youth, providing basic information, prevention kits, counselling, leadership and training to community members. There are currently more than 200 Community Agents nationwide.

SOMOSGAY has developed, EQUIS, a free smartphone application. EQUIS contains useful information on HIV prevention, testing and treatment and other services available to the lesbian, gay, bisexual, transgender and intersex community and information on HIV prevention, testing and treatment.

Source: SOMOSGAY.

Note: The findings and conclusions of this exemplary case are the responsibility of the informants/authors and do not necessarily represent the official position of UNAIDS.

Caribbean

In Cuba there are an estimated 260 000 men who have sex with men, 89 000 female sex workers and 3500 transgender women. In the Dominican Republic there are an estimated 120 000 men who have sex with men (see Annex 3). The median coverage of HIV testing in the past 12 months was 57% for men who have sex with men and 65% for female sex workers (see Annex 3).

Various strategies have been used to increase testing uptake in key populations. Jamaica uses community peer outreach and home-based interventions to increase testing among men who have sex with men (15).

In Caribbean countries, HIV prevalence among men who have sex with men ranges from 1.3% to 32.8%. HIV prevalence in female sex workers varies from 0% to 8.4%. Only Guyana and Cuba have provided HIV prevalence data for transgender women, 8.4% and 19.7% respectively (see Annex 3).

Despite the WHO recommendations and significant contributions from research on pre-exposure prophylaxis, countries in the region have been slow to include this as a prevention tool in public policies. Pre-exposure prophylaxis is offered through the public health system only in the Bahamas and Barbados as part of the national HIV strategies. In Jamaica, the Dominican Republic and Suriname, pre-exposure prophylaxis is offered through private health centres.

All Caribbean countries provide post-exposure prophylaxis in both primary care and emergency services for occupational exposure and in cases of sexual assault. In addition, some countries, such as the Bahamas, Barbados, Haiti, and Jamaica, have incorporated the WHO recommendations to provide post-exposure prophylaxis in cases of unprotected sexual intercourse.

Jamaica: Tevin Gordon

“You’re a very young boy; if you weren’t gay you wouldn’t have HIV now.” These are the words that Tevin Gordon remembers hearing from a pharmacist when he went to pick up his antiretroviral medicine from one of the public pharmacies that provide subsidized treatment for people living with HIV.

Tevin is 23 years old and has been living with HIV for the past 5 years. He says the positive diagnosis was a wake-up call and led him to revise his approach to life, which had been “negative, unpleasant, sour and bitter”. The support and acceptance he received from friends and family made him more determined to live positively with HIV.

Tevin reports that the biggest rejection and discrimination he has faced is from health-care staff. He states: “It is unfortunate that I experienced the rejection of the people I had expected to be supportive.” In addition to his experience with the pharmacist, he recalls denigrating

comments about being gay and living with HIV from a phlebotomist. He adds that people are also discriminated against in health centres based on their “dark skin and social level”. As an effeminate man living with HIV, he has experienced his share of ridicule. However, Tevin says he never lets these experiences hold him back.



He is now an employee of the Jamaica Network of HIV Positives (JN+) as a community facilitator, where he supports people newly diagnosed with HIV to navigate the health system and ensures retention in care and adherence and eventually achieving viral suppression. He points out that in this position

he has found and interacted with “amazing” health staff that support and walk hand in hand with people with HIV. Community facilitators are an important branch of the HIV response of the nation’s Ministry of Health and for the implementation of the test and initiation policy. JN+ expanded the policy to Try, Start and STAY, and it depends on motivated people like Tevin.

Source: Joint United Nations Programme on HIV/AIDS, Jamaica.

Note: The findings and conclusions of this exemplary case are the responsibility of the informants/authors and do not necessarily represent the official position of UNAIDS.

The importance of young people in the HIV response

Changing the trajectory of the epidemic requires protecting younger generations from HIV through the elimination of new HIV infections among children and providing access to comprehensive sex education, youth-friendly sexual and reproductive health services, and other combination prevention interventions for adolescents and young people.

In 2018 an estimated 130 000 [91 000 – 180 000] people aged 15–24 years were living with HIV in the region, 56% of whom were men. There were 25 000 [18 000 – 34 000] new HIV infections among people in this age group, representing a fifth of the total new infections in the region. This means that in the past 8 years there was a 7% reduction in new infections, which implies that the regional goal of reducing new infections in young people by 75% by 2020 will be a challenge (11).

In the Second Latin American and Caribbean Forum on the Continuum of HIV Care in 2015, the participating countries committed to the reduction of new HIV infections in people aged 15–24 years by 75% by 2020 and by 90% by 2030. They proposed working to afford young people living with HIV protection within their communities and equal access to health, employment, justice, education, nutrition and social services.

The IV Conference of HIV Positive Youth in LAC, held in 2017 in Cuzco, Peru, brought together young people living with HIV for the purpose of reviewing the progress, achievements and difficulties that national networks have encountered, redefining the internal operational structures, and defining work strategies for the next few years.

In the region, although HIV prevalence in people aged 15–24 years is low (0.1% in men and <0.1% in women in Latin America; 0.3% in men and 0.5% in women in the Caribbean (5), this population is considered more likely to participate in risky health behaviours. Established and perceived gender norms may increase risk behaviours in men, for example having intercourse without protection and being less likely to access health services when needed.

Furthermore, all forms of violence, including gender-based violence, sexual violence, intimate partner violence and institutional violence, can increase women's risk of HIV. Thus, eliminating gender inequalities and increasing the empowerment of young women is essential for them to be protected from HIV.

There are also challenges to the recognition and respect for sexual and reproductive rights of adolescents and young people with HIV, in part because of legal barriers to sexual and reproductive health education, including HIV, and policies restricting access to HIV testing and results without parental consent.

Structural conditions existing in the different countries—socioeconomic variables, prohibitive laws, legislative barriers, gender norms, religion and culture, among others—are heterogeneous, affecting the rights of teenagers and young people differently across countries.

CONDOM USE AT LAST SEX BY MEN IS DOUBLE THAT OF WOMEN

Latin America

In 2018 it was estimated that the number of new cases of HIV in people aged 15–24 years in Latin America was 21 000 [15 000 – 27 000], corresponding to 21% of the total number of new infections in the region. This represents only a 5% decrease compared with 2010. It is estimated that in Latin America there were less than 1000– AIDS–related deaths in people aged 15–24 years in 2018, a slight decrease from 1100 [<1000–2000] in 2010.

Based on the information provided by the United Nations Children’s Fund (UNICEF) Multiple Indicator Cluster Surveys (MICS) in 5 countries across the region, more than 90% of adolescents and people aged 15–24 years have heard about HIV,⁸ but data related to knowledge on HIV prevention remain scarce, as reported in the Global AIDS Monitoring 2017 report.

Knowledge of HIV prevention among young people was 22.4% in women and 27.7% in Bolivia, 31.6% in women and 28.5% in men in Colombia; 31.1% in women and 33.9% in men in El Salvador; 22.2% in women and 21.9% in men in Guatemala; and 33.1% in women and 34.7% in Honduras. 40.3% in women in Argentina; 33.1% in women in Costa Rica and Mexico; 16% in women in Nicaragua; 37.1% in women in Panama, 27.5% in women in Paraguay; 75.3% in women in Peru; and 34.5% in women in Uruguay⁹. These data reinforce the need to intensify efforts to advance comprehensive sexuality education programmes as in the agreement established during the Montevideo Conference on Population and Development.

The percentage of people aged 15–24 years who identify condoms as a means for reducing the risk of HIV transmission varies in the region from 68% to just over 90% and marked differences in knowledge between men and women. In almost all countries with data disaggregated by sex, women consistently report lower knowledge of condoms as a method to reduce HIV transmission (i.e. Bolivia men: 83%, women: 75%; Honduras men: 84%, women: 76%). In most countries a greater percentage of men than women identify that having one single partner reduces transmission of sexually transmitted infections (i.e. Honduras men: 93%, women: 88%). In all countries the probability that a man reported using a condom at last sexual intercourse is almost double that in women. In general, the use of condoms decreases with age. On the other hand, the probability of taking an HIV test at any time in life is almost double for woman compared with men in all countries (see Annex 4) (29).

While all Latin American countries have established HIV prevention, counselling and testing policies, in Bolivia (Plurinational State of) Guatemala, Honduras, and Peru adolescents under the age of 18 years require the consent of a parent or guardian for HIV testing. In Brazil, Costa Rica, Ecuador, El Salvador, Mexico, Nicaragua, Paraguay and Uruguay, parental or guardian consent is not required for adolescents to receive an HIV test. Some countries, including Argentina, Chile, Colombia, Panama and Venezuela (Bolivarian Republic of), require parental or guardian consent for people aged under 16 years to receive an HIV test. These factors contribute to low HIV testing coverage in this population.

Young people also face other barriers to access to HIV services in countries that do not provide CD4 lymphocyte and viral load tests free for all (Chile, Colombia, Panama) (28,29).

8 LAC countries where MICS surveys have been conducted: Argentina, Barbados, Belize, Bolivia, Colombia, Costa Rica, Cuba, Dominican Republic, Ecuador, El Salvador, Guatemala, Guyana, Haiti, Jamaica, Mexico, Panama, Peru, Saint Lucia, Suriname, Trinidad and Tobago, Uruguay.

9 Ibid.

Ecuador: municipality of the Metropolitan District of Quito—young people as protagonists

The Metropolitan District of Quito works in coordination with other metropolitan authorities and the national health system to implement projects on sexual and reproductive health emphasizing the prevention violence, pregnancy, sexually transmitted infections and HIV in adolescents. A project with support from the Japan International Cooperation Agency (JICA), the Technical Cooperation Project and the United Nations Population Fund (UNFPA), called Knowledge is Catching, promotes sexual and reproductive health for adolescents.

The Knowledge is Catching project is a youth-friendly service for teens who attend the the Center, North and South Metropolitan Health Units with the objective of engaging adolescents and young people in activities for productive use of free time through educational training workshops in which facilitators utilize The Sexuality Handbook: Knowledge is Catching, developed by the project for

In addition, the municipality continues to promote change in the culture of governmental health institutions, to empower youth to be protagonists in the exercise of their sexual and reproductive rights, promote gender equality and peaceful coexistence, and increase access to condoms contributing to the reduction of sexually transmitted infections, including HIV. A Handbook of Technical Procedures for Promotion and Prevention for the Municipal Authorities for the Engagement of Adolescents was developed by the project and is used in training activities.

The Secretary of Health and the Secretary of Education have agreed to work together to holistic youth-friendly services. Psychologists hired by the secretariats trained teachers in the Student Participation Program, which includes sexual and reproductive health modules. Teachers, with the support of the Secretary of Health, train students to be spokespeople for their peers. In 2017, 12 269 students were reached with 224 trained peer educators.



Source: Metropolitan Department of Health Promotion, Prevention and Monitoring. Municipality of the Metropolitan District of Quito.

Caribbean

It is estimated that in 2018 there were 4400 [2600–6900] new cases of HIV in people aged 15–24 years, representing a decrease of 17% since 2010 and 27% of new infections in the subregion. HIV-related deaths in people aged 15–24 years in 2018 were estimated at fewer than 500.

Access to health care, HIV testing, and antiretroviral therapy, especially in young men, continues to lag in Caribbean countries. Faced with laws that criminalize sexual intercourse between people of the same sex, the risk for young men who have sex with men in the Caribbean is very high (24,25). HIV prevalence in men who have sex with men under 25 years of age is high, ranging between 1.1% and 26.6% in the countries that report these data (11).

According to MICS surveys conducted in Caribbean countries, more than 90% of adolescents and people aged 15–24 years have heard about HIV but have low knowledge on HIV prevention indicators. Knowledge of the three methods for HIV prevention is only 2.8% in women and 5.8% in men in the Bahamas; 47.6% in women and 44.8% in men in Barbados; 41.4% in women and 45% in men in Belize; 60.9% in women and 58.6% in men in Cuba; 46.4% in women in the Dominican Republic¹⁰; 51.5% in women and 40% in men in Guyana; and 38.3% in women and 36.2% in men in Haiti.

The percentage of adolescents and young men aged 15–24 years in the region who identify condom use to reduce the risk of HIV transmission rates ranges between 85% to just over 90%, whereas that knowledge ranged from 74% (Belize) and Barbados (93%). In three countries whose data can be disaggregated by sex, women report lower levels of knowledge of condom use as a method to reduce HIV transmission (i.e. Haiti, men: 88%, women: 85%).

In Guyana and Haiti, a greater percentage of men than women identify that having one partner reduces transmission of sexually transmitted infections. Women report greater knowledge than men in the Dominican Republic.

The percentage of young people (21–30) who have taken an HIV test at any time in their life in Guyana and Haiti is more than double for young women compared with young men; in the Dominican Republic, this percentage is nearly three times higher (see Annex 4) (31).

A study conducted in Haiti reported that young women demonstrated low-risk behaviours but were at higher risk of HIV due to the high-risk behaviours of their partners (32).

In the Dominican Republic, Haiti, Jamaica and Saint Lucia, the age of consent for an HIV test is 16 years. Antigua and Barbuda maintains restrictions on access to HIV tests in people under 14 years of age.

THE NUMBER
OF NEW HIV
INFECTIONS IN
YOUNG PEOPLE
DECLINED BY 17%
IN THE CARIBBEAN
BETWEEN 2010
AND 2018

Jamaican Ministry of Health: bringing reproductive health services and other high-priority services to young people in Jamaica

Responding to the need for increased access to sexual and reproductive health services for adolescents and youth in Jamaica, a teen and youth centre called Teen Hub was established at the busiest

¹⁰ Data is only available for women

transportation centre in Kingston. The centre opened in April 2017 with an official launch in November of the same year.



More than 2660 visits were made to the adolescent centre within the first year. This includes visits for 700 HIV tests among people aged 16–24 years. The centre is operated by the Ministry of Health in collaboration with the AIDS Health Foundation.

Services provided include mental health support, HIV and other sexually transmitted infection screening, and other reproductive health services are offered in the center.

Source: Teen Hub, Ministry of Health, Jamaica.

Note: The findings and conclusions of this exemplary case are the responsibility of the informants/authors and do not necessarily represent the official position of UNAIDS.

Reducing stigma and discrimination

STIGMA AND DISCRIMINATION ARE BARRIERS TO SERVICE ACCESS AND UPTAKE

In Latin America and the Caribbean there are still laws and policies that discriminate against specific groups of people based on their sexual orientation, gender identity and its expression, or their HIV status. Stigmatizing and discriminatory attitudes and practices persist in the health system, which, together with gender inequality and gender-based violence in the region, continue to hinder efforts to achieve the 90–90–90 targets. These factors constitute real structural barriers to accessing prevention, treatment and care services, especially in key population groups.

Despite the region's efforts and advances in recognizing the human rights of lesbian, gay, bisexual, transgender and intersex people, discrimination against them continues to be the norm. Monitoring by the Inter-American Commission on Human Rights has detected diverse and particular manifestations of violence against lesbian, gay, bisexual, transgender and intersex people, based on the desire to punish "identities, expressions, behaviours, or bodies that differ from traditional gender norms and roles, and defy the male/female binary system". Reports of the Special Rapporteur on torture and other cruel, inhumane or degrading treatment or punishment describe that lesbian, gay, bisexual, transgender and intersex people "are disproportionately subjected to torture and other forms of ill-treatment because they fail to conform to socially constructed gender expectations. Indeed, discrimination on grounds of sexual orientation or gender identity may often contribute to the process of the dehumanization of the victim, which is often a necessary condition for torture and ill-treatment to take place" (32,33).

Hate crimes against the lesbian, gay, bisexual, transgender and intersex community in Latin America and the Caribbean have been frequent and continue today, even in countries with broad recognition of the rights of this group. The absence of a universal legal concept of hate crimes hinders the documentation of homicides based on sexual orientation or gender identity (33,34).

The discrimination experienced by women with HIV is also very high. Long-standing gender norms contribute to discrimination, physical, sexual and emotional abuse of women in general and particularly among women living with HIV. (34). A study conducted in Brazil confirms that women who have survived violence at some time in their lives had a higher risk of HIV infection, highlighting the importance of the development of integrated violence prevention programmes (35). The Human Rights of Women with HIV in the Americas report found a lack of access to treatment in some countries, limited access to information and protection services, and high levels of discrimination in the family, community and health services (34).

When HIV-related discrimination occurs in health or social services, people with HIV are less likely to access the necessary services. The perception of mistrust and lack of confidentiality of health workers enhances fears and reluctance of people to access services.

In both subregions some countries have laws criminalizing non-disclosure of HIV status and HIV transmission. States continue to disregard the repeated recommendations made by international organizations to eliminate these laws and underestimate the negative effects they have on access to prevention and treatment services, especially by key populations.

In February 2018 the Inter-American Court of Human Rights issued an advisory opinion, at the request of the Government of Costa Rica, which interprets the American Convention on Human Rights as recognizing same-sex couples and legal identity of transgender people in Latin America and the Caribbean. This decision will contribute to a more inclusive society by facilitating lesbian, gay and bisexual people access to health services, including HIV care, in a safe and friendly environment and provide prevention, treatment and care in an equitable manner.

Latin America

Most of the constitutions of Latin American countries contain generic provisions on equality and non-discrimination that apply to all people but do not provide explicit protection based on sexual orientation or gender identity. Some countries do have specific articles in their constitutions that prohibit discrimination based on sexual orientation, for example Ecuador (1998), the Plurinational State of Bolivia (2009) and Mexico (2011) (33).

Since 2010 several countries in the region have modified their national legislation seeking to expand protections for lesbian, gay, bisexual, transgender and intersex people. The Plurinational State of Bolivia (2010), Chile (2012), Argentina (2012), Honduras (2013) and El Salvador (2015) specifically criminalize acts of violence based on sexual orientation or gender identity in their criminal codes. They join other countries that have already done so: Colombia (2000), Uruguay (2003), Nicaragua (2008) and Ecuador (2009) (see Annex 5) (32).

Argentina (2010), Uruguay (2013) and Colombia (2016) have passed marriage laws for same-sex couples. In Mexico, laws vary considerably between states, and not all policies and laws are implemented at the Federal level. Some states, such as Mexico City, are more progressive and recognize the marriage of same-sex couples, and the adoption of minors by same-sex couples, while other states remain very conservative.

Also seeking to expand specific rights of transgender people, Uruguay (2009), Argentina (2012) and the Plurinational State of Bolivia (2016) have approved gender identity laws, and there are bills pending approval in the parliaments of El Salvador and Guatemala. In Chile, the Congress recently passed a law on gender identity, which allows transgender people over 14 to modify their name and gender in public records. None of the countries in the region has reported laws that criminalize transgender people (14).

Despite progress in securing protection and recognition, legal barriers are still present in Latin America. In Bolivia (Plurinational State of), Colombia, El Salvador, Mexico, Nicaragua, Panama and Peru, there are still laws that criminalize transmission of, non-disclosure of, and exposure to HIV. In Costa Rica, Guatemala and Honduras, although there are no laws that criminalize HIV transmission, prosecutions can be brought based on general criminal laws (14).

In the region, hate crimes based on gender identity have not ceased. The project *Transrespect vs Transphobia* reports that in Latin America there were at least 200 hate crime homicides of transgender women in 2017 and a cumulative 1700 deaths in the period 2010–2017 (34, 35, 36).

According to the Stigma Index, people with HIV report high levels of breaches of confidentiality in health services (31). Of people surveyed, 15% in Costa Rica, 10% in Honduras and 8% in Nicaragua reported that a health-care professional had revealed their HIV status without their consent. In Guatemala 10.2% of men and 6.8% of women said health-care professionals had communicated their HIV status without their consent. Most people consulted in all three countries said their medical records are not handled in a confidential manner. In Guatemala 5.3% of men and 4.3% of women interviewed said they were convinced that their medical records are not kept confidential, while 21.8% of men and 16.3% of women said they are not sure of the confidentiality of their medical records.

In Brazil 62.7% of men who have sex with men have avoided medical care in the past 12 months due to stigma and discrimination. In Paraguay 5.8% of female sex workers and 23.6% of men who have sex with men have avoided seeking medical services. In Guatemala 14.3% of men and 11.0% of women said they had avoided going to the hospital, and 16.7% of men and 12.9% of women had avoided attending a local clinic (11).

Ministry of Health of Peru: preparing the health system to care for transgender women and indigenous communities in the Peruvian Amazon

In December 2016 the Peruvian Ministry of Health approved two regulations to strengthen the response in key populations and sensitize health workers to generate friendlier and discrimination-free environments.

Regulation 126 MINSAs/2016/DIGIESP, for the comprehensive care of the transgender women population for the prevention and control of sexually transmitted infections and HIV/AIDS, establishes guidelines for implementing advocacy interventions and education for health, sexually transmitted infections and HIV prevention in transgender women, implementing strategies that promote transgender women's access to health services; and implementing processes for the integrated care of transgender women with HIV.

This norm introduces gender identity and expression as factors that place clients at risk of discrimination in health services, incorporates access to free hormone treatment as part of the comprehensive care of transgender women, and mandates the recognition of the patient's chosen name in all services. It also strengthens the strategy of peer educators and ensures training and awareness of clinical and administrative staff at all levels of the health care system

Regulation 129-MINSAs/2016/DIGIESP, for the prevention and control of infection by the human immunodeficiency virus in Amazonian indigenous people, proposes to strengthen HIV prevention activities

in Amazonian people. It recognizes the differing perspectives among socio-linguistic groups and mandates the incorporation of multi-lingual materials and dedicated health care staff for HIV screening, comprehensive care and antiretroviral therapy, combating stigma and discrimination in the country's Amazonian indigenous areas. The main strategies are training of health-care personnel in indigenous areas; the use of multilingual teams of health personnel, community leaders and families; mobile brigades moving through the rivers of the Amazon, bringing primary health care, HIV prevention information, HIV and syphilis screening; short-term linkages to treatment; and comprehensive care for people with HIV in indigenous communities. The implementation of this regulation has been crucial to strengthening the interventions that the Ministry of Health has been leading in the zones of Condorcanqui and Datem del Marañon, located in the northern part of the Peruvian Amazon, where in recent years there has been an increase in reported cases of HIV and AIDS-related deaths.

In 2017 more than 400 physicians, nurses, psychologists, obstetricians and health technicians and 50 female community leaders were trained. To date, the screening of HIV and syphilis has intensified among transgender women members of the Awajun and Wampis communities of the country's north-eastern Amazon Rainforest. With support from the Global Fund, primary health care has been brought to nearly 60 indigenous communities and treatment to approximately 15 000 people. HIV cases are linked to antiretroviral therapy regardless of CD4 count.

These policies strengthen and focus HIV prevention and control interventions while recognizing the needs of key and vulnerable populations and the importance of working to eliminate discrimination in health services.

Source: Ministry of Health of Peru, Direction of Prevention, Control of HIV/AIDS, STDS and Hepatitis.

Caribbean

The recognition and protection of rights of lesbian, gay, bisexual, transgender and intersex people remain variable across the region. Despite this, some progress can be identified in recent years. In 2016, the Supreme Court in Belize ruled that Section 53 of the Criminal Code, which made same-sex sexual relations punishable for up to 10 years, was unconstitutional, contravening protections of equality, dignity and personal privacy. (32). Trinidad and Tobago also reached a significant milestone: in April 2018 the High Court of Justice of Trinidad and Tobago declared the criminalization of consensual sexual relations between same-sex adults as unconstitutional. Exemplifying the power of civil society engagement, activist Jason Jones filed a lawsuit against the government of Trinidad and Tobago to annul Sections 13 and 16 of the Sex Crimes

IN 11 CARIBBEAN
COUNTRIES,
SEX WORK IS
CONSIDERED
CRIMINAL CONDUCT

Act, alleging they were unconstitutional and a violation of his right to privacy and freedom of expression (32).

Consensual sexual relations between people of the same sex continue to be criminalized in 8 countries, where prison sentences can be up to 10 years in Dominica, Grenada, Jamaica, Saint Kitts and Nevis, Saint Lucia, and Saint Vincent and the Grenadines; up to 15 years in Antigua and Barbuda; and life Guyana (31). Civil society in some countries has reported that there are instances of arbitrary arrests with the apparent motivation of sexual orientation and gender identity and that members of the lesbian, gay, bisexual, transgender and intersex community have decided to seek asylum in other countries (39).

The Bahamas, Cuba, the Dominican Republic, Saint Lucia and Suriname have laws criminalizing non-disclosure and transmission of HIV.

In 11 Caribbean countries, sex work is considered criminal conduct (Antigua and Barbuda, Bahamas, Barbados, Belize, Dominica, Grenada, Guyana, Jamaica, Saint Lucia, Suriname, Trinidad and Tobago) (14).

Guyana Trans United: the organization of transgender people defies discrimination

In February 2009 a group of transgender people were arrested in the city of Georgetown under a law from the Colonial era that makes it a crime for men to dress up in women's clothing, and vice versa. Guyana is among the 10 countries in the region that maintain legislation that prohibits sexual intercourse between people of the same sex and is the only Caribbean nation with a law against transvestism.

In 2010, with the support of the Human Rights Advocacy Project of the University of the West Indies and the Society against Sexual Orientation Discrimination, four of the arrested people launched a court case challenging the law. They claimed that the law was based on stereotypes of gender roles and has a disproportionate impact on transgender people. Since June 2018 the Court of Justice of the Caribbean in Port of Spain has been reviewing the final appeal.

The arrest in 2009 also led the organization of transgender people to an unprecedented level of activism. Guyana Trans United is now addressing the health, socioeconomic and human rights challenges that transgender people face in the country. Along with institutional strengthening, their initiatives have included job training, counselling and mentoring. They have hired qualified medical personnel to provide specialized services. They play an important role in supporting the prevention and treatment efforts of the national AIDS programme in Guyana by linking people with the information they need.

The coordinator of Guyana Trans United, Devanand Milton, described the personalized approach they use to support transgender people in access to services: “We know our community and how to address them. We take them to testing, counselling and prevention more easily than anyone else. They’re comfortable with us. When people are afraid to go to the clinic, we accompany them and help them follow the process. The stigma is not so strong if we are two or three there.”



Source: Guyana Trans United protest in Georgetown, Guyana (SASOD). LAC IN FOCUS // Vol. 001 – June 2018

Note: The findings and conclusions of this exemplary case are the responsibility of the informants/authors and do not necessarily represent the official position of UNAIDS

Status of health information systems with an emphasis on HIV

HIV prevalence and behavioural surveillance and key population size estimate surveys have become more frequent in Latin America and the Caribbean. National AIDS programmes have made concerted efforts to provide rigorous monitoring of the prevalence of HIV and coverage of prevention programmes and antiretroviral therapy.

An exemplary case is the System of Monitoring, Evaluation and Epidemiological Surveillance of HIV/AIDS in El Salvador that has been functioning for more than 10 years and has allowed for the integration of surveillance data with the data from health-care service monitoring. This system has managed to consolidate information from the first diagnostic test to treatment and continued follow-up.

Nevertheless, there are opportunities for improvement across the region. Most countries will have to multiply their efforts to develop rigorous and reliable strategic information systems that provide much needed evidence for a more effective response.

Elimination of mother-to-child transmission of HIV and congenital syphilis

Information systems for monitoring maternal-child transmission of HIV have improved across the region. However, congenital syphilis surveillance remains a major challenge. Under-registration of positive syphilis results in pregnant women and lack of standardized definitions for congenital syphilis aligned with international standards continue to be major obstacles to achieving adequate congenital syphilis surveillance (21).

Key populations

While the availability of data on the prevalence of key populations has improved substantially, there is still insufficient information, especially in adolescents, transgender people, incarcerated people and people who inject drugs. While some countries have invested in estimates of the size of key populations. Routine collection of disaggregated data on key populations remains limited, which poses serious obstacles to understanding new infections, transmission patterns and HIV prevention in these populations. In addition, there is a diversity of criteria for measuring access to prevention programmes.

Research on key populations remains insufficient, and the available information comes from behavioural studies that are financed with support from international resources in about a third of the countries, posing an obstacle for the collection or updating of information by national programmes (25).

Stigma and discrimination

Multiple actors across the Latin American and Caribbean region developed and vetted indicators on stigma and discrimination and successfully advocated for their inclusion in the Global AIDS Monitoring report. Monitoring regional targets of zero discrimination is inadequate. Only nine countries in Latin America and the Caribbean have been able to report on discriminatory attitudes towards people with HIV. Only Brazil, Cuba and Paraguay have been able to report on the avoidance of health services by key populations because of stigma and discrimination.

Response financing

Obtaining adequate information on the funding of the response remains another challenge in most Latin American and Caribbean countries. The institutionalization and systematic use of methodologies such as the National Aids Spending Assessments of UNAIDS, the National Health Accounts methodology recommended by WHO, or similar methodologies and studies remains infrequent. In 2018 and 2019, UNAIDS sponsored and facilitated two workshops on the National AIDS Spending Assessment, one in Lima and one in El Salvador. Since then Chile, Argentina, Uruguay and Panama have conducted or are in the process of conducting a NASA which will generate much needed data for programmatic decision-making at both the national and regional levels.

Attaining sustainability of the HIV response

THERE IS A HIGH DEPENDENCY ON EXTERNAL FINANCING FOR HIV PREVENTION STRATEGIES TARGETING KEY POPULATIONS

In the 2016 Political Declaration on HIV and AIDS, United Nations Member States pledged to accelerate the response to HIV and end the AIDS epidemic as a threat to public health by 2030. They also reaffirmed the need for concrete policies and actions to close the global HIV resource gap and to fully fund the response.

During the third Latin American and Caribbean Forum on Sustainability of the HIV Response conducted in November 2017 in Haiti, participants recognized that countries are in a transition period from receiving Global Fund and PEPFAR financing and called for significant increases in national resources to ensure continuity and expansion of HIV programmes. They also acknowledged that the challenges of sustainability transcend financial needs and that countries should develop a more multidimensional perspective that includes addressing the institutional and political characteristics of health systems (40).

Many countries in the region have transitioned from lower income countries to middle–upper income countries according to the World Bank classification system, resulting in ineligibility for international funding, such as the Global Fund and PEPFAR which have mainly supported civil society activities for key populations. Civil society plays a transcendental role in ensuring the response to HIV is more effective in key populations. Latin America and the Caribbean have the advantage of strong civil society networks that will require increased national funds, or social contracting. This implies that many dependent countries require significant increases in national resources through short–, medium– and long–term transition plans to ensure continuity and expansion of HIV programmes.

Reducing the costs of medicines, and overcoming intellectual property and trade barriers, are critical to sustainability. Therefore, several countries have started to explore or are already implementing mechanisms to ensure fair and accessible pricing of good–quality medicines and supplies to extend treatment coverage in a sustainable way.

Countries and regional organizations are reviewing bidding and procurement processes, diversifying suppliers and looking for opportunities for pooled purchasing. Not all countries have the political commitments needed to do this, posing significant challenges to the sustainability of the national and regional responses.

Latin America

Latin American countries used domestic resources for 95% of the region’s HIV response financing in 2018. The availability of financial resources for HIV responses in the region has increased by 50% since 2010, mainly due to a 55% increase in domestic public resources, which accounted for US\$ 2.4 billion in 2018 (2016 constant US dollars). Over the same period, bilateral contributions from the Government of the United States of America decreased by 62% and contributions from the Global Fund to Fight AIDS,

**IN LATIN AMERICA,
THE FUNDING GAP
FOR REACHING THE
2020 TARGET WAS
US\$ 660 MILLION
IN 2018**

Tuberculosis and Malaria (the Global Fund) decreased by 44%. Contributions from all other donors increased by 47%.

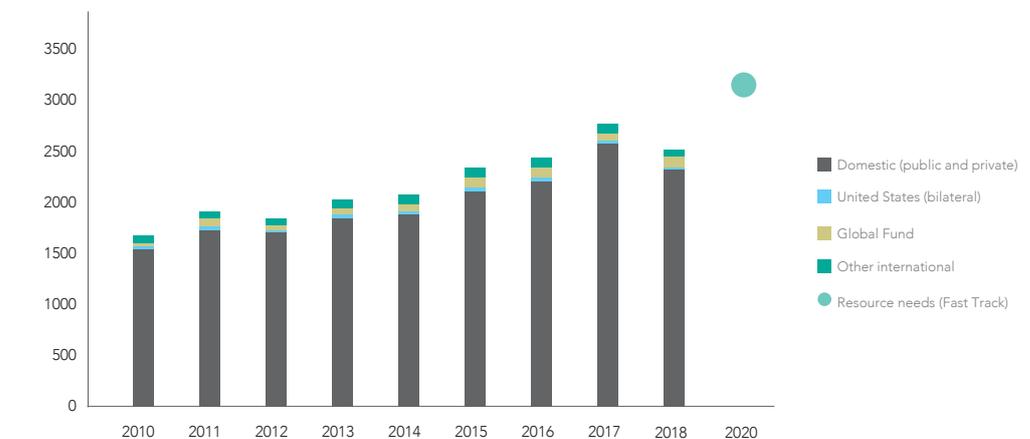
Funding from all sources decreased in 2018 compared to 2017. Domestic resources decreased by 7%, and international funding decreased by 8% overall: bilateral contributions from the Government of the United States decreased by 56%, contributions from the Global Fund decreased by 42% and contributions from all other international sources decreased by 10%, for a total of US\$ 124 million (2016 constant US dollars). The funding gap for reaching the 2020 target was US\$ 660 million in 2018.

Resource mobilization strategies, price reductions for commodities, better resource allocation and other efficiency gains are needed, as is greater investment in key populations and social enablers. Countries that are still heavily reliant on donor funds need to develop and implement plans for a transition to sustainable, domestically resourced HIV responses

Brazil and Ecuador have issued compulsory licences for antiretroviral medicines, resulting in lower prices (35,36). However, most countries in the region cannot buy antiretroviral medicines from generic manufacturers because of patent laws and therefore have trouble accessing lower prices. Lessons from the region show the importance of public procurement policies in line with intellectual property rights guaranteeing the sustainability of access to antiretroviral drugs using the flexibilities identified by the World Trade Organization.

Figure 6.

Available resources and resource need in Latin America, 2010–2018



Source: UNAIDS 2019 resource availability and needs estimates

Caribbean

The financial resources available for HIV responses in the Caribbean have fluctuated over time, reaching the same level in 2018 as in 2010 (constant 2016 US dollars). In total, US\$ 326 million was available for the Caribbean’s HIV programmes in 2018, considerably less than the US\$ 600 million needed to achieve its Fast-Track Targets by 2020.

The availability of domestic resources for the HIV response increased by 69% during this eight-year period, reaching 27% of the total resources for HIV in the region. International donors decreased their share from 84% in 2010 to 73% by 2018: during that period, bilateral contributions from the Government of the United States of America increased by 13%, while disbursements from the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) and all other international sources decreased by 32% and 91%, respectively.

Total funding for the region increased by 13% in 2018 compared to 2017. Domestic resources increased by 8%, bilateral funds from the Government of the United States increased by 9% (reaching 60% of all funds for the region), and Global Fund contributions increased by 63% (reaching 12% of the total). All other international sources decreased by 10% and accounted for just 1% of total HIV resources in 2018.

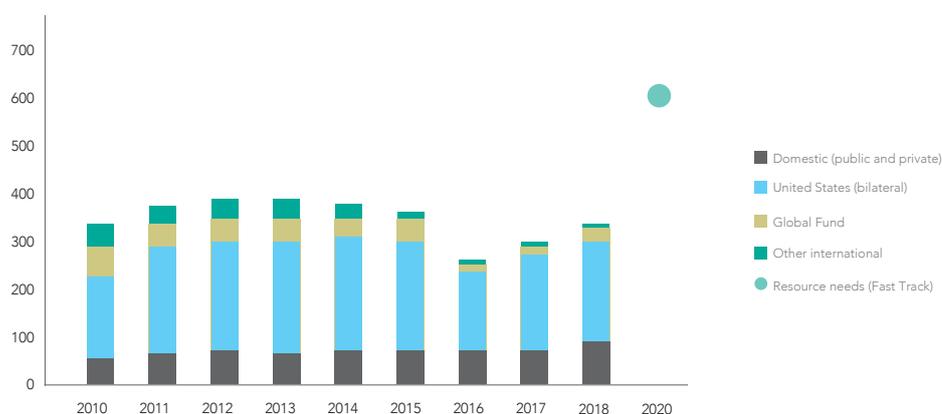
Some Caribbean countries are leveraging the advantages of innovating bidding and purchasing processes and diversifying suppliers.

The pharmaceutical procurement scheme of the Organization of Eastern Caribbean States centralizes the procurement and management of pharmaceutical products and medical supplies to increase the negotiating power of its member states and reducing costs.

Several countries in the region, including Guyana have worked with UNAIDS and other partners to develop transition and sustainability plans, using the Resource Needs Model.

Figure 7.

Available resources and resource need in the Caribbean, 2010–2018



Source: UNAIDS resource availability and needs estimates

Dominican Republic: sustainability of the response—financing the total cost of antiretroviral medicines

Between 2004–2012 the purchase of antiretroviral medicines, rapid HIV tests, laboratory reagents and other supplies was initially financed by a loan from the World Bank and then via Global Fund projects. To cover the frequent and recurrent shortages, PEPFAR, through the local mission of the United States Agency for International Development (USAID), allocated resources.

In 2012 for the first-time resource needs modelling was carried out with the support of the Ministry of Health, the national health service and the National AIDS Coordinating Commission, with the technical assistance of USAID. The cost of antiretroviral medicines and other supplies was estimated at US\$ 6.1 million; of this, the Global Fund would provide US\$ 3.6 million (59%), leaving a financial gap of US\$ 2.5 million (41%). During that year, evidence-based political and advocacy strategies were established with national authorities, nongovernmental organizations and international agencies, with the aim of mobilizing national resources to bridge the gap. These strategies included the following:

- ▶ Presentation of the results of the estimates and projections to government entities and agencies, with the objective of validating the data and establishing strategies to close the financial gap.
- ▶ More extensive analysis of the cost of antiretroviral therapy and other supplies and delivery times of different international suppliers.
- ▶ Identification and authorization of a new purchasing agent and signing and MOU with the Partnership for Supply Chain
- ▶ Management, which resulted in a reduction in the price of antiretroviral therapy and led to a budget surplus of US\$ 975 000.

The Dominican Republic created a technical working group on antiretroviral therapy that oversees the estimation and costing process each year via a systematic analysis of the financial gap in the HIV response. Data are presented and discussed, with a combination of advocacy efforts by the National Council for HIV and AIDS and the Ministry of Health early in the budgeting process to ensure the inclusion of HIV needs in the national budget. Likewise, there is a strong integrated logistics system that provides information on the consumption and availability of products every month and at all levels

used to publish quarterly newsletters on the availability of antiretroviral therapy, tuberculosis medicines and other essential medicines.

As a result of all these efforts, in 2013 the Ministry of Health budgeted for the first time US\$ 1.9 million for the purchase of antiretroviral therapy, closing the financial gap. Since 2015 the Government has been solely responsible for the acquisition and provision of antiretroviral therapy, proving that the transfer of financial responsibility for the HIV response is possible.

Sources: Dominican Republic Global Access and Country report: Analysis of the preparation for the Transition, Ministry of Health. Dominican Republic. 2017.

Note: The findings and conclusions of this exemplary case are the responsibility of the informants/authors and do not necessarily represent the official position of UNAIDS.

Supporting migrants in Latin America and the Caribbean

Latin America is experiencing the largest movement of people in its history. It is estimated that up to 5.8% of the population of Latin America is currently migrant.

Although migration is not a direct risk factor for HIV, migrant populations face conditions that put them at risk for HIV. Migrants may be separated from their partners and families, face linguistic barriers, lack adequate housing, and be thrust into abusive work environments, if they are able to obtain employment at all. Migrants rarely have the same employment rights as citizens of the country they are in, and therefore they do not have the same levels of employment certainty or security from abuse.

HIV has an impact not only on the health of individuals but also on social dynamics and health-care systems at large. Neglecting to implement an integrated response to HIV has many consequences, including an increase in new HIV and opportunistic infections, mother-to-child transmission, resistance to antiretroviral medications, and increases in the number of AIDS orphans—all of which imply a greater cost to health-care systems. Increases in stigma and discrimination lead to greater vulnerability to sexual exploitation, human trafficking, labour exploitation and gender-based violence, especially against women living with HIV, transgender women, and men who have sex with men.

Systems for epidemiological surveillance in Latin America and the Caribbean are struggling to meet data needs for evidence-based programming. The majority of countries are not generating data on the health conditions of migrants and refugees, including HIV. Additionally, the high level of mobility of migrants and refugees inhibits their access to health services and medicines, contributing further to the difficulty in capturing data specific to these populations.

Furthermore, national budgets of countries receiving a large influx of refugees and migrants are not sufficient to guarantee the sustainability of public services for migrants at the national or local level. Receiving communities are experiencing a strain on public services, housing and employment, which contributes to rising tensions.

AN ESTIMATED
40 000
VENEZUELAN
ARE CURRENTLY
RESIDING IN
TRINIDAD AND
TOBAGO, 36 400 IN
GUYANA, AND 28 500
IN THE DOMINICAN
REPUBLIC

Central America and the Caribbean

Mexico and the northern Central American countries (El Salvador, Guatemala, Honduras) have a long history of migration. According to the United Nations Economic Commission for Latin America and the Caribbean, it is estimated that 15 million people in Central America and Mexico live outside their country of origin; at the end of 2018 an estimated 353 000 people from El Salvador, Guatemala and Honduras were living as refugees or seeking asylum in other countries. Furthermore, an estimated 22% of the population of El Salvador, 7% of Honduras and 6% of Guatemala have emigrated to other countries, mainly Mexico and the United States of America.

Throughout 2018, migrants from El Salvador and Honduras formed large groups to make the journey north to Mexico and the United States. While there are numerous reasons for this marked emigration, most migrants report fleeing their countries to escape violence and persecution, and lack of employment resulting in economic hardship and food insecurity.

Migrants travelling north from Central America are at significant risk of extortion, robbery and abuse and are reluctant to report crimes against them due to mistrust of authorities. Young women and girls are at particularly high risk of sexual violence during the trip north. A study conducted in 2016 reported that 7 in 10 women experienced sexual abuse on the journey through Mexico (39).

The migrants of Central America tend to cross countries quickly, making it difficult to collect accurate information on the numbers of people passing through countries and receiving public services. Most migrants are reluctant to seek services; therefore, detecting people with specific needs, such as HIV care, is a significant challenge.

Countries of origin are faced with immense challenges meeting the health needs of the large number of deportees arriving on a daily basis. While most have received medical care in the detention centres in the United States, people living with HIV face additional challenges: primarily, they must be identified among the thousands returning—but then they must receive immediate medical assessment and care as needed. Additionally, if they have been prescribed the antiretroviral regimen provided in the United States, they need to be transitioned to the regimen prescribed in their country of origin.

El Salvador

The Ministry of Health in El Salvador has developed a strategy to address the needs of returned migrants and repatriated citizens living with HIV. The strategy revolves around creating safe places where people can go to receive information about their rights and medical care as needed.

The national AIDS programme works in 12 sites around the country, including airports, border crossings and the port in La Libertad, to identify returning migrants living with HIV. Additionally, the programme conducts training with employees in the National Office of Migration and Alien Status on the care and protection of returning migrants living with HIV and provides post-exposure prophylaxis and psychosocial support to migrants.

Under this strategy, returning migrants who disclose their HIV-positive status are immediately linked to any of the 20 Ministry of Health hospitals in the country. In 2018, 100% of the 129 returning migrants living with HIV received medical evaluation and immediate care for any urgent health needs and were referred to any of the 20 Ministry of Health hospitals offering decentralized HIV care. A total of 85 of 129 returning migrants living with HIV have received CD4 and viral load tests and antiretroviral medicines; 47 of these 85 people are still on treatment, and 41 have achieved viral suppression (46).

Haiti

Around 497 825 Haitian migrants live in the Dominican Republic, representing up to 4.9% of the total population. Between 2012 and 2017 an estimated 31 000 Haitian migrants entered the Dominican Republic. Over 57% of Haitian migrants report that they left their home country due to unemployment.

In 2015 the Government of the Dominican Republic launched the Plan for Regularization, which dictates the nullification of citizenship of people born between 1929 and 2007 to immigrant parents without legal residency. After much international criticism, the Government passed a law that recognizes nationality for people who were previously documented in the civil registry. According to the most recent immigration survey, an estimated 203 547 Haitians born in the Dominican Republic applied for naturalization, of whom 196 124 were accepted.

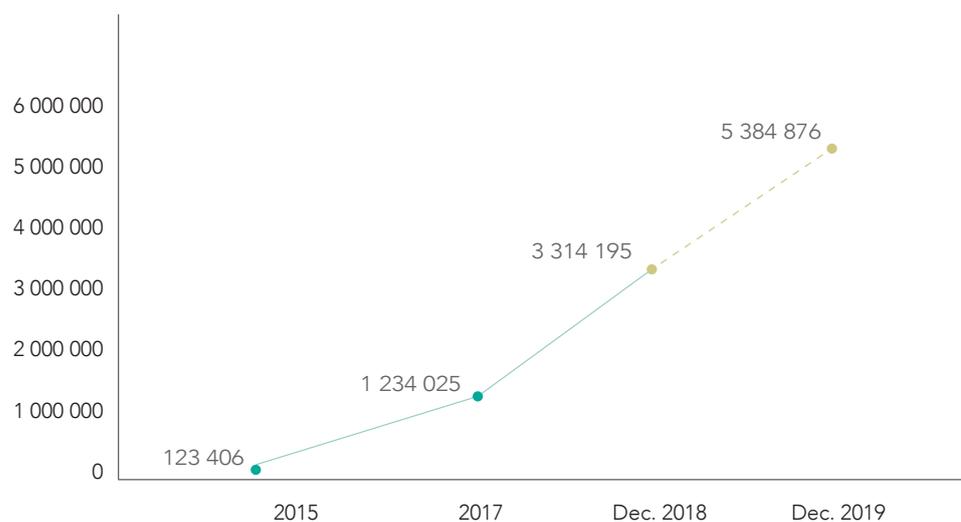
Of the Haitian migrants in the Dominican Republic, 95% do not have access to health insurance. As of 2017, an estimated 25 000 Haitian migrants were living with HIV in the Dominican Republic. The estimated HIV prevalence in the migrant population in the Dominican Republic was 4% in 2018. In the same year, an estimated 55% of new HIV infections in the Dominican Republic occurred in Haitian migrants. Of concern, less than 20% of the Haitian migrants living with HIV are on antiretroviral therapy.

The Migrant Situation of the Bolivarian Republic of Venezuela

In the initial stages of the Venezuelan migrant crisis, countries receiving Venezuelan migrants in Latin America maintained policies for open borders and broad support programmes for refugees. However, in many countries the influx of refugees has surpassed national capacity to meet their needs. Currently, a significant number of Venezuelans remain without documentation or rights to stay, including those not able to apply for asylum because of bureaucratic procedures. In many cases, lack of documentation restricts access to legal and other basic services, placing people at increased risk of exploitation, abuse, human trafficking, discrimination and xenophobia.

The failing health-care system in the Bolivarian Republic of Venezuela is the primary motivation for the migration of people with HIV due to extensive stockouts of antiretroviral treatment and medicines for opportunistic infections. Furthermore, many people living with HIV are members of the lesbian, gay, bisexual, transgender and intersex community and have experienced stigma and discrimination, making them one of the most vulnerable groups in situations of forced migration.

Figure 8. Refugees and migrants from Venezuela in Latin America and the Caribbean



Source: UNAIDS resource availability and needs estimates

“We didn’t leave the country because we wanted to. I didn’t leave, I escaped.”

The doctor spoke to him bluntly. “If you want to live, you have to leave Venezuela” (48).

To access an immigration card in Peru, a migrant with HIV must obtain an appointment at a public hospital, obtain a medical report verifying their HIV-positive status, and



submit the report to the immigration authorities. The medical report is then validated by the national AIDS programme. The length of the process is indeterminate and depends on the efficiency of the institutions responsible for each step. The application costs approximately US\$ 15, which many migrants do not have (49).

In some countries, including Brazil, Ecuador and Peru, Venezuelan migrants can access public services, including education and health care. However, capturing information on migrants with HIV in health information systems is a particular challenge. In many countries, case registration and clinical intake forms do not require documentation of migratory status or country of origin, although Chile, Colombia and Peru have the capability to do so.

In Colombia, the Ministry of Health reported 109 cases of HIV in Venezuelan migrants in 2018, up from 28 in 2017. The number of deaths related to HIV among Venezuelan migrants living with HIV increased from 20 in 2017 to 82 in 2018 (50).¹¹

In Peru, the national AIDS programme registered 1338 Venezuelan migrants on antiretroviral therapy in 2018, of whom 90% are in the capital city of Lima (49).

Caribbean

In the early days of the Venezuelan crisis, many Caribbean countries provided only temporary visas, denied entry, and deported people without official migratory status. While many migrants entered countries in the subregion according to current migratory procedures, they continue to encounter significant challenges. In some countries, laws and policies do not contain regulations for processing requests for asylum. Restrictions on entry and stay prohibit migrants from obtaining employment and placing many migrants, especially women, youth and children, at risk of sexual exploitation and human trafficking.

In March 2019 the Trinidad and Tobago Ministry of Health announced a policy of providing healthcare, including HIV treatment, regardless of a patient’s country of origin. During mid-2019 Trinidad and Tobago launched an exercise which authorizes registered Venezuelan migrants to work legally for one year. However, just 16,523 Venezuelans were registered during this process.

According to a Pan Caribbean Partnership against HIV and AIDS (PANCAP) 2019 desk review on migrant health access in the region, discrimination and barriers to HIV

¹¹In Colombia, eight nongovernmental organizations provide testing and treatment for sexually transmitted infections, but only two organizations provide antiretroviral treatment to migrants—and only then to people who are registered in the General Social Security System for Health are eligible (43).

services have been reported in all countries. In isolated cases non-nationals have been refused treatment and user fees in a few countries are a barrier for some.

Many migrants are either fearful of presenting for services or unaware of where and how to access them. An International Organization of Migration Survey of Venezuelan migrants to Trinidad and Tobago published in September 2018 found that 35% of those requiring health services did not have access. The chief barriers were not knowing where to go (32%), fear (19%) and being denied services (13%).

Language presents a further challenge for the provision of services to migrants. Some countries have made some efforts to address the gaps. Antigua and Barbuda uses a cadre of Spanish-speaking health care providers to ensure migrant patients received quality treatment and care in their native language. In the Bahamas there are translators and educational materials available in Haitian Kreyol.

However, inadequate access to services in migrants' native languages continues. There is also a need for more culturally relevant prevention information, treatment adherence resources and behavior change communication in the appropriate languages for the region.

Key messages and recommendations for Latin America and the Caribbean

- ▶ Countries that have not taken full advantage of the potential of the Fast-Track Cities initiative must understand that real opportunities exist if countries and cities seize the advantages of the urban approach to the epidemic and carry out local and multisector innovative strategies, including all potential local and national actors.
- ▶ Progress has been made to improve access to HIV testing, and more people with HIV know their status; however, the constraints on key population groups are still present. In addition, late diagnosis continues to be high. Measures should continue to expand innovative strategies for reaching key populations with testing services, including services to people aged 15–25 years.
- ▶ The elimination of mother-to-child transmission should be prioritized on the region's political agenda.
- ▶ The distribution of male and female condoms and lubricants is a crucial step in implementing a comprehensive, effective and sustainable approach to combination HIV prevention and should continue prioritizing promotion, especially in key population groups.
- ▶ Reducing new infections in young people requires reducing the age at which adolescents can independently access HIV tests and meet the needs of key youth groups through a specific comprehensive approach.
- ▶ Despite clear evidence-based recommendations of WHO, including significant contributions from research in Latin America and the Caribbean, the adoption of public policies, including self-administered tests, pre-exposure prophylaxis and post-exposure prophylaxis, is slow. Greater political commitment, training, collaboration and partnership of government institutions and civil society organizations are urgently needed to accelerate the expansion of combination prevention targeted at key populations.
- ▶ Eliminating discrimination and violence towards people with HIV and key population groups is imperative to strengthen the regional response to HIV. It is necessary to intensify efforts for the creation of legal frameworks that promote the protection and empowerment of these groups. Without a change in discriminatory laws, these key population groups will continue to fall behind.
- ▶ Achieving adequate monitoring of the goals of combination HIV prevention and zero discrimination means strengthening national strategic information systems.
- ▶ Reducing dependence on external funding in the region requires new approaches to resource mobilization, improved allocation and monitoring of resources, and cost projections for strategic investment. It also involves disseminating and monitoring progress towards the call to action of the LAC III Forum on Sustainability of the HIV Response.
- ▶ The full participation of people with HIV and key population groups is an essential condition for achieving Fast-Track targets and ensuring sustainability of the HIV response. This means that governments must create lines and mechanisms to finance civil society through national sources to support HIV prevention interventions and, in countries where this already exists, increase the allocations.

Annexes

Annex 1. 90–90–90 progress

Table 1.
90–90–90 progress, Latin America, 2016–2018

Country	2016			2017			2018		
	First 90	Second 90	Third 90	First 90	Second 90	Third 90	First 90	Second 90	Third 90
Argentina	... [... – ...]	... [... – ...]	... [... – ...]	... [... – ...]	... [... – ...]	... [... – ...]	... [... – ...]	... [... – ...]	... [... – ...]
Bolivia (Plurinational State of)	... [... – ...]	... [... – ...]	70 [63 – 77]	... [... – ...]	... [... – ...]	69 [62 – 76]	... [... – ...]	... [... – ...]	74 [67 – 81]
Brazil	83 [64 – >95]	72 [55 – 89]	91 [70 – >95]	84 [65 – >95]	75 [58 – 93]	92 [71 – >95]	85 [66 – >95]	77 [60 – >95]	94 [72 – >95]
Chile	... [... – ...]	... [... – ...]	... [... – ...]	... [... – ...]	... [... – ...]	... [... – ...]	... [... – ...]	... [... – ...]	... [... – ...]
Colombia	... [... – ...]	... [... – ...]	... [... – ...]	... [... – ...]	... [... – ...]	... [... – ...]	... [... – ...]	... [... – ...]	... [... – ...]
Costa Rica	... [... – ...]	... [... – ...]	... [... – ...]	... [... – ...]	... [... – ...]	... [... – ...]	... [... – ...]	... [... – ...]	... [... – ...]
Ecuador	55 [37 – 90]	80 [54 – >95]	... [... – ...]	67 [45 – >95]	76 [50 – >95]	... [... – ...]	76 [51 – >95]	75 [50 – >95]	89 [59 – >95]
El Salvador	64 [52 – 76]	69 [56 – 82]	80 [65 – 95]	69 [56 – 81]	66 [54 – 78]	83 [68 – >95]	74 [61 – 87]	63 [52 – 73]	85 [70 – >95]
Guatemala	58 [54 – 63]	64 [59 – 70]	83 [76 – 90]	61 [56 – 66]	62 [57 – 68]	83 [76 – 90]	62 [57 – 68]	69 [64 – 75]	80 [74 – 87]
Honduras	56 [45 – 68]	83 [67 – >95]	84 [68 – >95]	59 [47 – 71]	85 [68 – >95]	82 [66 – >95]	60 [47 – 72]	85 [67 – >95]	83 [66 – >95]
Mexico	64 [55 – 74]	93 [81 – >95]	83 [72 – >95]	66 [57 – 75]	94 [81 – >95]	82 [71 – 94]	76 [65 – 86]	93 [79 – >95]	89 [76 – >95]
Nicaragua	... [... – ...]	... [... – ...]	... [... – ...]	... [... – ...]	... [... – ...]	... [... – ...]	... [... – ...]	... [... – ...]	74 [60 – >95]
Panama	65 [58 – 71]	72 [65 – 79]	... [... – ...]	68 [61 – 74]	76 [68 – 83]	... [... – ...]	70 [64 – 77]	76 [69 – 84]	76 [68 – 83]
Paraguay	... [... – ...]	... [... – ...]	... [... – ...]	... [... – ...]	... [... – ...]	76 [58 – >95]	71 [54 – >95]	57 [44 – 82]	79 [61 – >95]
Peru	... [... – ...]	... [... – ...]	... [... – ...]	... [... – ...]	... [... – ...]	... [... – ...]	... [... – ...]	... [... – ...]	... [... – ...]
Uruguay	76 [57 – >95]	65 [49 – 84]	71 [53 – 92]	79 [57 – >95]	66 [48 – 85]	81 [58 – >95]	82 [58 – >95]	70 [49 – 92]	86 [61 – >95]
Venezuela (Bolivarian Republic of)	... [... – ...]	... [... – ...]	... [... – ...]	... [... – ...]	... [... – ...]	... [... – ...]	... [... – ...]	... [... – ...]	... [... – ...]

Source: UNAIDS 2019 estimates.

Table 2.

90–90–90 progress, Caribbean, 2016–2018

Country	2016			2017			2018		
	First 90	Second 90	Third 90	First 90	Second 90	Third 90	First 90	Second 90	Third 90
Antigua and Barbuda							... [... – ...]	... [... – ...]	44 [41 – 48]
Bahamas	... [... – ...]	... [... – ...]	... [... – ...]	... [... – ...]	... [... – ...]	... [... – ...]	... [... – ...]	... [... – ...]	... [... – ...]
Barbados	71 [63 – 80]	58 [51 – 65]	... [... – ...]	70 [61 – 78]	65 [57 – 73]	80 [71 – 90]	... [... – ...]	... [... – ...]	88 [77 – >95]
Belize	52 [48 – 58]	52 [47 – 57]	59 [53 – 65]	53 [48 – 58]	51 [46 – 56]	... [... – ...]	49 [44 – 53]	58 [53 – 64]	65 [59 – 71]
Cuba	77 [59 – 92]	80 [61 – >95]	... [... – ...]	80 [61 – >95]	83 [64 – >95]	65 [50 – 78]	83 [64 – >95]	86 [66 – >95]	67 [52 – 80]
Dominica	... [... – ...]	... [... – ...]	... [... – ...]	... [... – ...]	... [... – ...]	46 [40 – 53]	... [... – ...]	... [... – ...]	55 [47 – 63]
Dominican Republic	... [... – ...]	... [... – ...]	... [... – ...]	74 [58 – 94]	68 [53 – 86]	63 [49 – 80]	82 [64 – >95]	68 [52 – 89]	67 [52 – 88]
Grenada									12 [10 – 14]
Guyana	84 [76 – 95]	73 [66 – 82]	82 [73 – 92]	88 [78 – >95]	74 [66 – 84]	82 [73 – 94]	93 [82 – >95]	73 [64 – 84]	81 [71 – 92]
Haiti	63 [58 – 70]	87 [79 – >95]	... [... – ...]	66 [60 – 74]	93 [84 – >95]	... [... – ...]	67 [60 – 75]	86 [78 – >95]	... [... – ...]
Jamaica	63 [54 – 71]	45 [39 – 52]	... [... – ...]	64 [56 – 73]	47 [41 – 53]	... [... – ...]	... [... – ...]	... [... – ...]	80 [70 – 91]
Saint Kitts and Nevis	... [... – ...]	... [... – ...]	57 [50 – 64]	... [... – ...]	... [... – ...]	54 [47 – 62]	... [... – ...]	... [... – ...]	60 [52 – 69]
Saint Lucia	... [... – ...]	... [... – ...]	28 [25 – 32]	... [... – ...]	... [... – ...]	15 [13 – 17]	... [... – ...]	... [... – ...]	35 [31 – 40]
Saint Vincent and the Grenadines	74 [64 – 83]	47 [41 – 53]	78 [67 – 87]	72 [62 – 81]	49 [43 – 55]	83 [72 – 94]	70 [60 – 79]	47 [41 – 53]	81 [70 – 92]
Suriname	... [... – ...]	... [... – ...]	... [... – ...]	... [... – ...]	... [... – ...]	... [... – ...]	60 [40 – 86]	87 [58 – >95]	87 [58 – >95]
Trinidad and Tobago	... [... – ...]	... [... – ...]	... [... – ...]	... [... – ...]	... [... – ...]	... [... – ...]	... [... – ...]	... [... – ...]	... [... – ...]

Source: UNAIDS 2019 estimates.

Annex 2. Prevention of mother-to-child transmission of HIV

Table 3.

Early infant HIV diagnosis, Latin America, 2018

Country	(%)
Argentina	71 [65 – 80]
Chile	81 [74 – 90]
Colombia	31 [26 – 37]
Guatemala	24 [22 – 26]
Honduras	45 [36 – 54]
Nicaragua	77 [60 – >95]
Panama	90 [82 – >95]
Paraguay	60 [40 – 88]
Peru	82 [62 – >95]
Uruguay	75 [56 – >95]

Source: UNAIDS 2019 estimates.

Table 4.

Early infant HIV diagnosis, Caribbean, 2018

Country	(%)
Bahamas	59 [53 – 68]
Cuba	>95 [>95–>95]
Grenada	>95 [>95 – >95]
Guyana	61 [47 – 81]
Haiti	46 [40 – 57]
Honduras	45 [36 – 54]
Dominican Republic	68 [52 – 89]
Saint Lucia	71 [63 – 71]

Source: UNAIDS 2019 estimates.

Table 5.

Antiretroviral therapy coverage in pregnant women, Latin America, 2018

Country	Antiretroviral therapy coverage (%)
Argentina	>95 [85 – >95]
Bolivia (Plurinational State of)	>95 [>95 – >95]
Chile	>95 [>95 – >95]
Colombia	21 [17 – 25]
Ecuador	>95 [68 – >95]
El Salvador	40 [33 – 46]
Guatemala	34 [31 – 38]
Honduras	59 [48 – 72]
Nicaragua	90 [73 – >95]
Panama	92 [83 – >95]
Paraguay	88 [60 – >95]
Peru	85 [67 – >95]
Uruguay	>95 [71 – >95]

Source: UNAIDS 2019 estimates.

Table 6.

Antiretroviral therapy coverage in pregnant women, Caribbean, 2018

Country	Antiretroviral therapy coverage (%)
Belize	44 [39 – 49]
Cuba	>95 [86 – >95]
Grenada	>95 [>95 – >95]
Guyana	89 [67 – >95]
Haiti	83 [67 – >95]
Jamaica	>95 [>95 – >95]
Dominican Republic	84 [64 – >95]
Suriname	>95 [84 – >95]

Source: UNAIDS 2019 estimates.

Annex 3. Key populations

Table 7.

Estimates of key population sizes, Latin America, most recent year

Country	Men who have sex with men	Female sex workers	Transgender people
Argentina	206 000	74 900	5 400
Bolivia (Plurinational State of)	30 300	13 500	900
Brazil	2 000 000	1 400 000	
Colombia	577 000	244 400	24 000
Costa Rica	10 100	3 000	400
Ecuador	47 400	34 400	12 200
El Salvador	54 100	45 000	1 800
Guatemala	55 200	21 300	4 800
Honduras	40 900	22 800	2 700
Mexico	1 200 000	241 000	118 900
Nicaragua	34 100	14 800	6 500
Panama	28 900	8 300	3 100
Paraguay	15 900	5 200	700
Peru	252 000	67 800	33 900
Uruguay	25 300	6 900	1 600

Source: UNAIDS 2019 estimates.

Table 8.

Estimates of key population sizes, Caribbean, most recent year.

Country	Men who have sex with men	Female sex workers	Transgender people
Bahamas	2 800		
Barbados	2 600		
Cuba	279 200	82 500	3 500
Dominica	500		
Grenada	2 400	1 000	
Guyana	3 300	5 300	
Haiti	30 900	70 300	
Jamaica	42 400	18 700	3 800
Dominican Republic	132 000	97 800	9 400
St Lucia	3 000	1 700	300
St Vincent and the Grenadines	300	200	
Suriname	1 300	2 200	

Source: UNAIDS 2019 estimates.

Table 9.

Prevalence of HIV in key populations, Latin America, most recent year available (2011–2018)

Country	General population aged 15–49 years (%)	Men who have sex with men (%)	Female sex workers (%)	Transgender people (%)	People who use drugs (%)
Argentina	0.4	15.7	5.4		
Bolivia (Plurinational State of)	0.3	25.4	4.3	22.6	
Brazil	0.5	18.3	5.3	30.0	5.9
Chile	0.5	13.9	0		
Colombia	0.4	17.0	1.2	21.4	2.8
Costa Rica	0.4	15.4	1.4	24.6	
Ecuador	0.4	16.5		34.8	
El Salvador	0.6	12.0	2.2	15.3	
Guatemala	0.4	9.0	1.0	22.2	1.6
Honduras	0.3	8.4	2.0	8.2	
Mexico	0.2	12.6	1.0	8.7	4.3
Nicaragua	0.2	8.6	2.6	8.1	
Panama	1.0	6.7	.6	29.6	
Paraguay	0.5	20.7	1.3	23.0	
Peru	0.3	3.0	.7	2.3	
Uruguay	0.6	8.5	1.0		

Source: UNAIDS 2019 estimates.

Table 10.

Prevalence of HIV in key populations, Caribbean, most recent year available (2012–2018)

Country	General population aged 15–49 years (%)	Men who have sex with men (%)	Female sex workers (%)	Transgender people (%)	People who use drugs (%)
Antigua and Barbuda	1.1		0.5		
Bahamas	1.8	19.6			
Barbados	1.5	2.8	0		
Belize	1.9	13.9	0.9		
Cuba	0.4	1.1	.8	3.1	
Dominica	0.5				
Dominican Republic	0.9	4.0	4.2	27.7	
Grenada	0.5	1.7			
Guyana		4.9	6.1	8.4	
Haiti	2.0	12.9	8.7		
Jamaica		29.8	2.0	51.0	
St Kitts and Nevis	0.5	1.3			
St Vincent and the Grenadines	1.5	29.6	.6		
Suriname	1.4	16.6	10.3		
Trinidad and Tobago		26.6			

Source: UNAIDS 2019 estimates.

Table 11.

Percentage of men who have sex with men, female sex workers and transgender women who know their status in Latin America, most recent year available

Country	Men who have sex with men	Female sex workers	Transgender people
Brazil	73	52	77
Chile	62	58	
Colombia	26	91	43
Costa Rica	100	100	
Ecuador	56		60
El Salvador	77	90	74
Guatemala	78	86	92
Mexico	40	66	62
Nicaragua	99	83	94
Panama	99	97	96
Paraguay	80	79	87
Peru		29	

Source: Source: UNAIDS Global AIDS Report. 2018.

Table 12.

Percentage of men who have sex with men, female sex workers and transgender women who know their status in the Caribbean, most recent year available

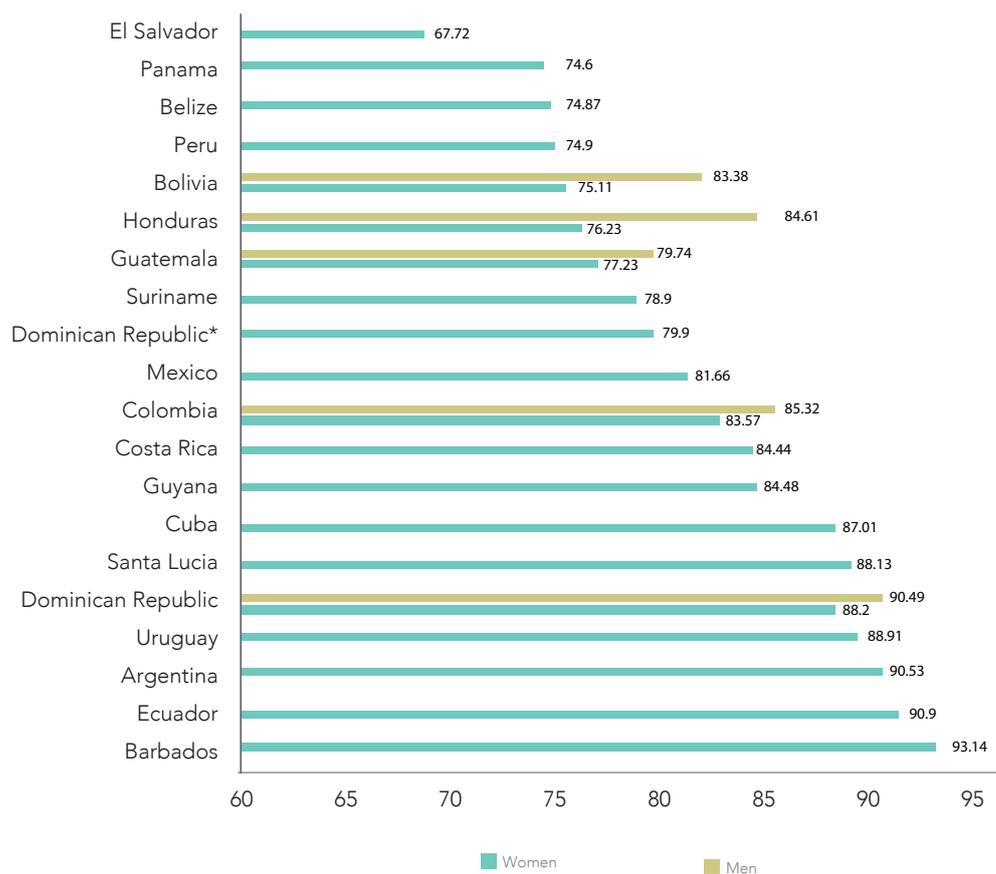
Country	Men who have sex with men	Female sex workers	Transgender people
Barbados	46	39	
Belize	44	62	
Dominican Republic	63	91	83
Haiti	70		
Jamaica	88	93	
St Vincent and the Grenadines	55		
Suriname	98	51	

Source: Source: Source: UNAIDS Global AIDS Report. 2018.

Annex 4. Knowledge of condom as HIV prevention method

Figure 1.

Adolescents and people aged 15–24 years who identify that condom use reduces the risk of HIV transmission in Latin America and the Caribbean, by country and sex, most recent year.

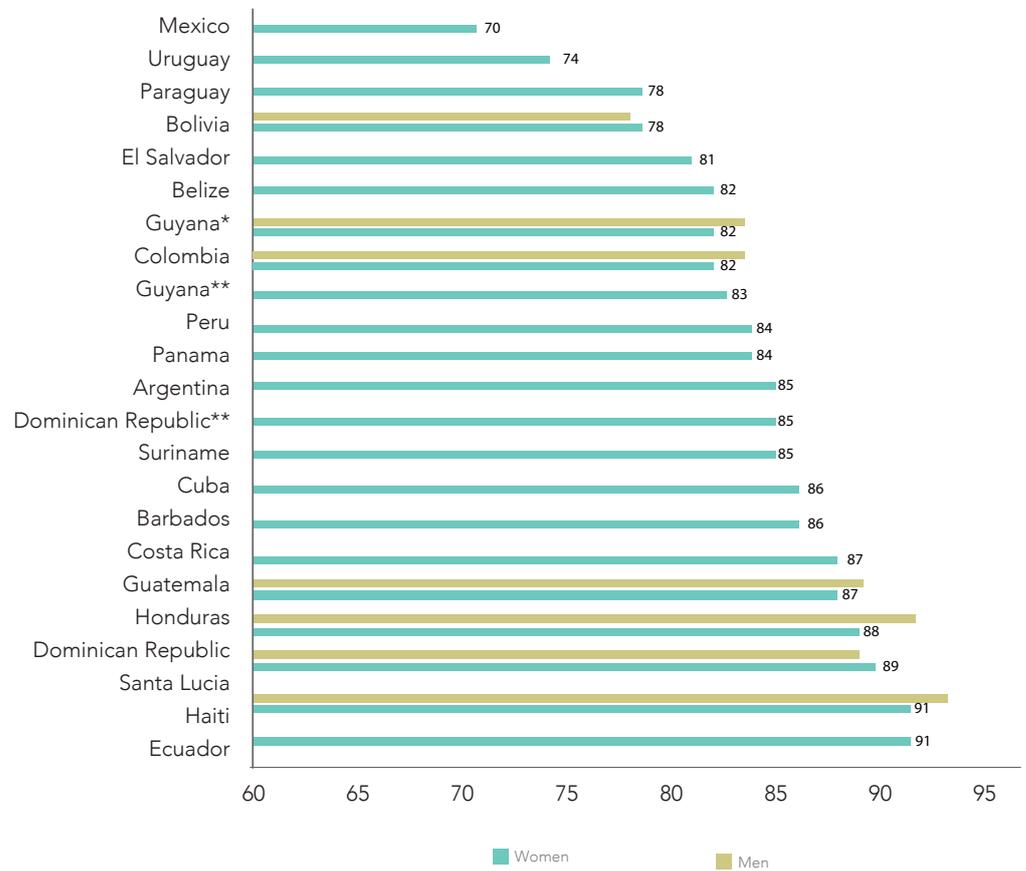


* DHS ** MICS

Source: Strategic information on adolescents and HIV in Latin America and the Caribbean report. United Nations Children's Fund Latin America and the Caribbean. In print

Figure 2.

Adolescents and people aged 15–24 years who identify that having a single sexual partner reduces the risk of HIV transmission in Latin America and the Caribbean, by country and sex



* DHS ** MICS

Source: Strategic information on adolescents and HIV in Latin America and the Caribbean report. United Nations Children's Fund Latin America and the Caribbean. In print.

Table 13.

Adolescents and young adults who used condoms in the most recent sexual relationship, by country, sex and age group, most recent year available

Country	Females				Males			
	15–24 years*	13–14 years	15–19 years	20–24 years	15–24 years*	13–14 years	15–19 years	20–24 years
Bolivia (Plurinational State of)					35.16 [31.28–39.05]		40.93	32.08
Colombia	30.28 [28.71–31.85]	55.69 [45.68–65.69]	37.19 [34.56–39.82]	25.74 [23.72–27.76]	56.10	72.75 [64.35–81.16]	68.37 [65.95–70.78]	48.27 [45.91–50.63]
Dominican Republic	20.89 [16.53–25.24]		22.67 [16.35–28.99]	19.47 [14.04–24.91]	59.26 [54.33–64.18]		73.93 [67.50–80.37]	49.43 [42.98–55.87]
Guatemala	10.87 [9.69–12.04]		12.28 [10.22–14.35]	10.13 [8.84–11.43]	43.77 [41.19–46.34]		57.28 [53.15–61.41]	35.70 [32.72–38.67]
Guyana	32.15 [27.94–36.35]		37.58 [30.33–44.83]	29.11 [24.40–33.81]	62.26 [57.19–67.32]		82.27 [76.37–88.18]	51.88 [45.26–58.50]
Haiti	36.52 [33.96–39.08]		44.38 [40.34–48.41]	32.20 [29.42–34.98]	60.72 [57.71–63.72]		58.44 [53.97–62.90]	62.38 [58.34–66.42]
Honduras	13.61 [12.24–14.99]		15.46 [13.30–17.63]	12.46 [10.70–14.21]	50.35 [46.84–53.86]		67.44 [62.39–72.50]	38.65 [34.49–42.82]
Peru	19.34 [17.48–21.20]		19.15 [15.83–22.48]	19.42 [17.21–21.63]				

Source: Strategic information on adolescents and HIV in Latin America and the Caribbean report. United Nations Children's Fund Latin America and the Caribbean. In print.

Table 14.

Percentage of adolescents and young adults who have ever taken an HIV test, by country, sex and age group, most recent year available

Country	Females				Males			
	15–24 years*	13–14 years	15–19 years	20–24 years	15–24 years*	13–14 years	15–19 years	20–24 years
Bolivia (Plurinational State of)					5.73 [4.46–7.00]		3.19 [1.88–4.50]	9.10 [6.77–11.42]
Colombia	30.72 [29.40–32.05]	1.05 [0.57–1.54]	17.97 [16.59–19.36]	55.57 [53.27–57.88]	13.75 [12.74–14.77]	0.52 [0.02–1.02]	6.04 [5.02–7.05]	26.84 [24.88–28.81]
Dominican Republic	56.73 [52.91–60.56]		38.10 [32.98–43.21]	82.76 [77.60–87.93]	22.56 [19.06–26.07]		10.64 [6.91–14.37]	36.58 [31.24–41.93]
Guatemala	24.13 [22.83–25.42]		11.54 [10.49–12.59]	39.12 [36.98–41.26]	11.29 [10.07–12.51]		3.92 [3.05–4.78]	22.02 [19.59–24.45]
Guyana	47.45 [44.42–50.48]		31.98 [28.30–35.66]	67.93 [63.88–71.99]	27.57 [24.42–30.71]		18.25 [14.63–21.87]	39.91 [34.07–45.75]
Haiti	36.05 [34.23–37.87]		18.41 [16.73–20.08]	56.79 [54.14–59.44]	17.36 [15.67–19.04]		7.93 [6.52–9.33]	29.39 [26.50–32.29]
Honduras	38.47 [37.09–39.84]		21.51 [20.12–22.90]	59.26 [56.96–61.55]	17.21 [15.01–19.41]		4.47 [3.21–5.73]	32.43 [28.38–36.47]
Peru	78.59 [77.25–79.92]		77.34 [75.71–78.98]	80.14 [78.22–82.06]				

Source: Strategic information on adolescents and HIV in Latin America and the Caribbean report. United Nations Children's Fund Latin America and the Caribbean. In print.

Annex 5. Hate crimes based on sexual orientation as an aggravating circumstance

Argentina 2012	The criminal code establishes aggravated penalties for crimes of homicide (Art. 80.4) and injuries (Art. 92) whose motivation resides in the “hatred towards the sexual orientation of the victim” (among other reasons)
Bolivia (Plurinational State of) 2010	Article 40bis of the criminal code aggravates the penalties of the offences caused by any of the grounds of discrimination included in Articles 281 quinquies and sexies (the latter includes sexual orientation)
Brazil	There are no federal provisions that aggravate the penalties for crimes motivated by the sexual orientation of the survivor in Brazil. Some states have enacted local laws imposing sanctions such as fines or revocation of licenses to acts of violence and acts of discrimination based on sexual orientation; these include Amazonas (2006), Bahia (1997), Espirito Santo (2014), Federal District (2000), Fortaleza, Maranhao (2006), Mato Grosso del Sur (2005), Minas Gerais (2002), Para (2011), Paraiba (2003), Piauı (2004), Recife, Rio de Janeiro (2015), Rio Grande del Norte (2007), Rio Grande del Sur (2002), Santa Catalina (2003), Sao Paulo (2001)
Chile 2012	Article 12(21) of the criminal code (amended by Art. 17 of Law No. 20 609) includes “sexual orientation” among the aggravating circumstances entailing to more severe penalties
Colombia 2000	Art. 58(3) of the criminal code determines that the motivation based on the sexual orientation of the survivor constitutes an aggravating circumstance. Art. 134a (introduced by Law 1482 of 30 November 2011) criminalizes acts of racism and discrimination, including those based on sexual orientation
Ecuador 2009	Art. 177 of the criminal code criminalizes acts of hatred, whether physical or psychological, based on sexual orientation; this provision also establishes penalties aggravated by physical damage and death caused by hate acts based on sexual orientation (among other reasons)
El Salvador 2015	Art. 129(11) of the criminal code (amended by Legislative Decree No. 106/2015) aggravates the crime of homicide when perpetrated on the basis of sexual orientation of the victim
Honduras 2013	Art. 27(27) of the criminal code (amended by Decree No. 23–2013) establishes that the motivation based on the sexual orientation of the victim (among other reasons) operates as an aggravating circumstance
Nicaragua 2008	Art. 36(5) of the criminal code establishes aggravated penalties for crimes motivated by the sexual orientation of the survivor
Peru 2017	Art. 46(d) of the criminal code (amended by Legislative Decree No. 1323) aggravates penalties for crimes motivated by the sexual orientation of the survivor
Uruguay 2003	Art. 149TER of the criminal code (amended by Law 17 677 of 2003) considers more severe penalties for acts of moral or physical violence of hatred or contempt motivated by “sexual orientation” or “sexual identity”; the person who commits acts of moral or physical violence of hatred or contempt against one or more persons by reason of the colour of their skin, their race, religion, national or ethnic origin, sexual orientation or sexual identity, will be punished with 6–24 months in prison

Source: Carroll A, Mendos LR. State sponsored homophobia 2017: a world survey of sexual orientation laws—criminalization, protection and recognition. Geneva: International Lesbian, Gay, Bisexual, Trans and Intersex Association; 2017.

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