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ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) IN THE AMERICAS

The HIV/AIDS epidemic in most of the countries of Latin America and the Caribbean is still concentrated in specific at-risk groups. This situation offers a window of opportunity to increase efforts and mount a broader intersectoral response before the epidemic spreads further to the general population.

This document reviews the status of surveillance, management, and planning of AIDS programs, behavioral interventions, AIDS/HIV care, and sexually transmitted diseases (STD) prevention, and proposes mechanisms to strengthen the national response to HIV/AIDS and STDs. One area in need of special attention is the prevention and control of sexually transmitted diseases, as they contribute significantly to the rapid dissemination of HIV among adolescents and young women and men.

Specifically, the Executive Committee is requested to review WHO's proposed strategy for sexually transmitted diseases prevention and care (STD.PAC) and advise on its suitability for adoption by PAHO and its Member States. The Executive Committee is also asked to provide guidance on the policy issues related to the benefits and costs of antiretroviral therapies, including the use of AZT (zidovudine) to prevent mother-to-child transmission of HIV.

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EXECUTIVE SUMMARY

It is estimated that 1.6 million people in Latin America and the Caribbean are living with HIV. More than 200,000 have developed AIDS and are currently experiencing all the problems related to this condition. In addition, approximately 40 million men and women acquire a sexually transmitted infection each year. The HIV/AIDS/STD epidemic in Latin America and the Caribbean is not homogenous, but consists of a mosaic of low transmission and concentrated and generalized epidemics which require appropriate approaches to halt their spread. The main technical areas of activity of national programs (surveillance, planning, and management; development of prevention and care interventions; and control of sexually transmitted diseases) will need additional strengthening. The document contains a brief description of the current status of these components as well as an update on combination antiretroviral therapy (ARV) for the treatment of HIV/AIDS patients and the use of AZT in the prevention of vertical (mother to child) transmission of HIV.

A major point of the document is the need to strengthen the sexually transmitted diseases control programs in the Region. For this, the secretariat proposes that WHO's strategy for sexually transmitted diseases prevention and care (STD.PAC) be reviewed by the Executive Committee and considered for adoption by Member States. Finally, the document makes reference to some of the mechanisms to strengthen HIV/AIDS/STD prevention and control in the countries, such as intersectoral participation, decentralization of technical expertise, exploration of additional financing mechanisms, and establishment of intercountry cooperation networks.

1. Introduction

The last year has been remarkable in the fight against AIDS. On the one hand, the wider availability of effective—yet expensive—ARV therapies in industrialized countries and in a few developing countries has resulted in a decline in mortality due to AIDS, as well as a reduction in the progression of HIV infection towards clinical disease. This, coupled with well-targeted behavioral interventions and adoption of safer sex practices among young men and women, brings real hope to the possibility of taming this devastating epidemic. Paradoxically, in the vast majority of developing countries AIDS and HIV infections continue to thrive as a result of economic and structural disparities among nations and persisting inequities among individuals and populations. In addition, sexually transmitted diseases continue to affect more than 300 million men and women worldwide each year (40 million of them in the Americas), despite the fact that knowledge and expertise are available to reduce significantly their transmission and impact in most countries of the Region.

2. Typology of the HIV/AIDS/STD Epidemics in the Americas

PAHO estimates that there are 1.6 million people living with HIV in Latin America and the Caribbean (5.4% of the world total) and more than 200,000 people with AIDS (3.0% of the total number of cases reported worldwide). The HIV/AIDS epidemic in Latin America and the Caribbean shows great heterogeneity, with clear differences between and within countries. Consequently, it is essential to identify the typology of the diverse epidemics occurring in the various countries in order to plan and implement the most appropriate prevention and care strategies. The three types of HIV epidemics agreed upon at two global expert reviews (Berlin, 1997, Geneva, 1998) are low-transmission, concentrated, and generalized epidemics.

- *Low-transmission epidemics* are characterized by HIV prevalences below 5% in population groups with high-risk behavior (e.g., commercial sex workers, men with multiple same-sex partners, IV drug users), but HIV prevalence among the general population (measured through women attending prenatal care in urban areas) is practically zero.

- *Concentrated epidemics* are those where HIV prevalence is greater than 5% in one or more population groups with high-risk behavior. However, prevalence among the population at large (as assessed among pregnant women) is still less than 5%.

- *Generalized epidemics* are epidemics in which HIV has spread from population groups with high-risk behaviors to the general population and, therefore, prevalence of HIV among pregnant women is greater than 5%.

Most epidemics in Latin America and the Caribbean can be classified as concentrated—that is, the national epidemics are still affecting population groups practicing high-risk behaviors, among whom infection rates exceed 5%. Consequently, the epidemic is still taking the greatest toll among men who have unprotected sex with other men and among injecting drug users and their sexual partners.

There are some countries in the Americas with low transmission epidemics, e.g., Bolivia, Cuba, Nicaragua, and Paraguay, and areas and countries with generalized epidemics, such as Haiti and several other countries in the Caribbean (Bahamas, Guyana), as well as some urban areas in Brazil and the Atlantic Coast of Honduras.

For the most part, the HIV/AIDS epidemic in Latin America and the Caribbean has not spread to the population at large. However, there are rising rates in major urban areas, among selected population groups (e.g., women and young adults), and in those segments of society more impoverished, illiterate, and without full access to health services. The low level and concentrated stages of the epidemic offer a window of opportunity for governments, politicians, institutions, professionals, communities, and individuals to take the necessary actions to stop their further spread. Interventions and resources should be consistent with the type and characteristics of the epidemic based on the information collected at the country level. Table 1 shows the relative distribution of HIV infection among selected population groups (injecting drug users, men who have sex with men, and heterosexual populations, including commercial sex workers).

3. Priorities and Current Responses

In order to mount a technically sound response to the HIV/AIDS epidemic, public health authorities and PAHO have concentrated their efforts in the following areas:

3.1 *Surveillance*

Surveillance of the HIV/AIDS epidemic has relied on the monitoring and analysis of reported AIDS cases to determine trends and develop projections and estimates. Many countries have a reliable AIDS case-reporting system which was formally established in the mid-1980s. These national surveillance systems provide information to the regional and global surveillance systems. However, factors such as underreporting and variations in the AIDS case definition used between and within countries limit the usefulness of these data.

Table 2 presents the information on AIDS cases reported to PAHO as of December 1997. The greatest limiting factor to the exclusive use of AIDS case-reporting to monitor the epidemic is that it only gives an idea of the HIV transmission which occurred five, ten, or more years ago. Hence, AIDS case-reporting systems are not the

Table 1

HIV Distribution Among Selected Latin American and Caribbean Populations

	Population Categories		
Subregion/Country	**IDU**	**MSM**	**HET**
Andean Area			
Bolivia	0	+	+
Colombia	0	++	+
Ecuador	0	+	+
Peru	0	+++	+
Venezuela	0	+++	+
Brazil	+++	+++	++
Central America			
Belize	0	++	++
Costa Rica	0	+++	++
El Salvador	0	++	++
Guatemala	0	+++	++
Honduras	0	++	++
Nicaragua	0	+++	+
Panama	+	+++	++
Latin Caribbean			
Cuba	+	+	+
Dominican Republic	++	++	++
Haiti	0	++	+++
Mexico	+	+++	++
Southern Cone			
Argentina	+++	+++	++
Chile	+	++	+
Paraguay	+	+	+
Uruguay	++	++	+

+++ High or rapidly growing
++ Relatively low or plateauing
+ Not a major component
0 No data available

Population Categories:
IDU Injecting drug users
MSM Men having sex with men
HET Heterosexual

Table 2

Number of Reported Cases of AIIDS by Year, and Cumulative Cases and Deaths by Country and Subregion, as of 10 December 1997

SUBREGION Country or Territory	Number of Cases Through 1991	1992	1993	1994	1995	1996	1997(a)	Cumulative Total(b)	Total Deaths	Date of Last Report
TOTAL REGIONAL	**331,634**	**104,026**	**107,635**	**100,560**	**93,247**	**68,826**	**5,896**	**812,162**	**472,562**	
LATIN AMERICA	**61,432**	**23,178**	**26,935**	**28,410**	**28,350**	**29,508**	**5,268**	**203,378**	**92,175**	
ANDEAN AREA	**6,865**	**2,551**	**2,489**	**3,369**	**2,843**	**2,946**	**1,165**	**22,228**	**10,210**	
Bolivia	47	19	21	19	15	28	8	157	104	30/Jun/97
Colombia	2,804	934	740	1,361	910	1,095	589	8,433	3,375	31/Dec/97
Ecuador	198	69	90	117	69	67	15	625	430	31/Mar/97
Peru	1,337	645	665	782	1,050	1,106	404	5,989	2,220	30/Sep/97
Venezuela	2,479	884	973	1,090	799	650	149	7,024	4,081	30/Sep/97
SOUTHERN CONE	**2,724**	**1,420**	**1,798**	**2,471**	**2,117**	**2,697**	**1,511**	**14,743**	**5,214**	
Argentina	1,874	1,103	1,413	2,036	1,682	2,165	1233	11,506	3,282	31/Dec/97
Chile	535	199	237	292	285	323	96	1,967	1,241	30/Jun/97
Paraguay	70	28	45	24	23	53	56	304	178	30/Sep/97
Uruguay	245	90	103	119	127	156	126	966	513	30/Sep/97
BRAZIL	**33,352**	**13,420**	**15,228**	**15,994**	**16,382**	**16,469**		**110,845**	**54,813**	31/May/97
CENTRAL AMERICAN ISTHMUS	**3,379**	**1,326**	**1,890**	**1,961**	**2,107**	**2,705**	**1,344**	**14,974**	**3,714**	
Belize	46	13	24	18	28	38	…	198	190	31/Dec/96
Costa Rica	325	127	127	163	207	202	127	1,284	674	30/Sep/97
El Salvador	315	114	176	387	380	417	230	2,019	289	30/Jun/97
Guatemala	277	94	178	110	141	831	152	1,787	455	31/Mar/97
Honduras	2029	851	1,183	1,058	1,127	949	661	7,926	1,063	30/Sep/97
Nicaragua	29	10	24	38	21	25	5	157	94	30/Jun/97
Panama	358	117	178	187	203	243	169	1,603	949	30/Nov/97
MEXICO	**9,057**	**3,210**	**5,058**	**4,111**	**4,310**	**4,216**	**1,008**	**30,970**	**16,636**	30/Jun/97
LATIN CARIBBEAN	**6,055**	**1,251**	**472**	**504**	**591**	**475**	**240**	**9,618**	**1,588**	
Cuba	109	70	82	102	116	94	26	599	433	30/Jun/97
Dominican Republic (c)	1,785	375	390	402	475	381	214	4,052	858	30/Sep/97
Haiti	4,161	806	...	...	...	...	...	4,967	297	31/Dec/92
Puerto Rico (d)	8,683	2,250	2,374	673	...	...	...	13,980	8,183	30/Sep/94

SUBREGION Country or Territory	Number of Cases Through 1991	1992	1993	1994	1995	1996	1997(a)	Cumulative Total(b)	Total Deaths	Date of Last Report
CARIBBEAN	**3,783**	**1,138**	**1,319**	**1,476**	**1,802**	**1,811**	**539**	**11,909**	**7,096**	
Anguilla	5	0	0	0	0	...	...	5	3	31/Dec/95
Antigua and Barbuda	16	14	18	16	7	13	2	86	66	30/Jun/97
Aruba	11	3	1	0	6	1	...	22	17	30/Jun/96
Bahamas	838	254	297	322	390	374	92	2,567	1,643	31/Mar/97
Barbados	252	78	88	119	95	130	58	820	689	30/Jun/97
Cayman Islands	11	4	0	3	0	3	1	22	18	30/Jun/97
Dominica	12	0	14	6	5	14	5	56	74	31/Mar/97
French Guiana	230	73	52	70	78	44	...	588	267	31/Dec/96
Grenada	31	4	21	7	18	18	2	101	65	30/Jun/97
Guadeloupe	311	81	77	104	104	54	...	731	226	31/Dec/96
Guyana	230	160	107	105	96	144	...	842	304	31/Dec/96
Jamaica	333	100	236	359	505	527	241	2,301	1,265	30/Jun/97
Martinique	193	44	43	49	38	35	...	402	184	31/Dec/96
Montserrat	6	0	1	0	0	0	0	7	0	31/Mar/97
Netherlands Antilles	100	10	47	0	76	...	...	233	74	31/Dec/95
Saint Kitts and Nevis	31	4	3	5	5	6	2	56	32	31/Mar/97
Saint Lucia	33	8	12	13	10	14	8	98	95	30/Jun/97
Saint Vincent and the Grenadines	41	5	8	8	6	19	8	95	93	31/Mar/97
Suriname	106	28	35	20	20	2	...	211	191	31/Dec/96
Trinidad and Tobago	968	263	243	269	340	412	118	2,613	1,754	31/Mar/97
Turks and Caicos Islands	21	4	14	...	...	...	...	39	30	30/Sep/93
Virgin Islands (UK)	4	1	2	1	3	1	2	14	6	30/Jun/97
NORTH AMERICA	**266,419**	**79,710**	**79,381**	**70,674**	**63,095**	**37,507**	**89**	**596,875**	**373,291**	
Bermuda	191	17	15	44	48	17	13	345	241	30/Jun/97
Canada	7,690	1,709	1,725	1,671	1,433	797	76	15,101	11,046	30/Jun/97
United States of America (d)	258,538	77,984	77,641	68,959	61,614	36,693	...	581,429	362,004	31/Dec/96

* Cases reported in 1997 are included in 1996.
(a) 1996 data are incomplete due to delayed reporting. (b) May include cases for year of diagnosis unknown. (c) Country has revised data.
(d) Cumulative total number of cases and deaths for the United States of America includes data from Puerto Rico. Total number of cases and deaths reported by Puerto Rico as of 30/Sep/94 has not been included in the Latin Caribbean totals.

best sources to determine the speed of spread or detect rapid changes in the epidemic. For this reason, data supplied by a well-designed HIV sentinel surveillance system are necessary for projecting the future of the epidemic.

Almost all the countries in the Region have HIV sentinel surveillance in place, although variations in the way it is conducted sometimes make the analysis and interpretation of data difficult. Strengthening the existing HIV surveillance systems should result in what WHO and UNAIDS now call second-generation surveillance (SGS), which builds on the present country scenarios and introduces innovations that will help improve knowledge of the epidemic. Second-generation surveillance in Latin America and the Caribbean will resort to a mix of old and new instruments and approaches such as HIV and AIDS case-reporting, HIV serosurveillance, molecular surveillance, mortality indicators, and behavioral sentinel surveillance. This will provide

Member States and national AIDS programs with the necessary information to mount and extend appropriate and effective HIV/AIDS prevention and care interventions.

3.2 *Managerial and Health Policy Issues*

For most Member States, the development and availability of a well-qualified national cadre of technical and professional staff has been achieved. In a few countries, targeted recruitment of managerial expertise and in-service management training have resulted in availability of better managerial skills and practices within the AIDS program. However, the development of national skills in health policy and management has not progressed as rapidly as in other technical areas (e.g., laboratory, epidemiology, counseling). Therefore, more attention should be paid to the areas of strategic planning, project design, implementation, and evaluation, as well as to the ability to mobilize internal and external resources and collaborate with other sectors.

From a health policy perspective, the HIV and AIDS epidemic has raised major technical, social, economic, political, and ethical issues which are being addressed with varying degrees of attention and success in the countries. Some successful examples include policies and practices to ensure the safety of blood and blood products in all countries and the testing and counseling of pregnant women, as well as the availability of AZT to prevent perinatal transmission in an increasing number of countries.

On the other hand, clear policies related to controversial issues, such as social marketing of condoms, sex education in schools, access to antiretroviral drugs, and services for migrant or commercial sex workers, have sometimes been more difficult to formulate. It is imperative that, in the context of social and cultural values, respect for individual rights and collective welfare, Member States continue to establish the most appropriate policies, including legislative measures, to aid the fight against HIV/AIDS. Examples of such policies include non-discrimination in access to education, work, health services, and housing for HIV-affected individuals.

3.3 *Behavioral Interventions*

Behavioral change and the adoption of preventive practices continue to be cornerstones in curbing the HIV/AIDS and STD epidemics. Sound initiatives should consist of two converging strategies: (1) establishment of adequate societal environments and (2) development of appropriate interventions.

3.3.1 *Establishment of Adequate Societal Environments*

Allocation of adequate resources and development of supportive policies and/or legal instruments to undertake preventive actions have proved to be key activities in establishing adequate societal environments conducive to healthier behaviors. For

example, it has been shown that well-designed media messages sponsored by health authorities have a unique aura of dependability and credibility. These messages contribute to creating favorable opinions and attitudes and maintaining social awareness about health and health problems among the general public. Thus, health campaigns geared to the public are solid starting points in the development of behavioral interventions, even if they may not trigger individual behavioral changes by themselves.

3.3.2 *Development of Interventions*

This involves the planning and implementation of educational and skills-development activities, as well as procurement and logistics systems for commodities (e.g., condoms, latex gloves) to protect individuals at risk. In countries with low-level epidemics of HIV (such as Bolivia and Cuba), interventions should be targeted to specific population groups with high-risk behavior. Results of baseline behavioral studies should serve to develop and support appropriate approaches.

In countries with a concentrated epidemic (most of the countries in Latin America), targeted interventions should take into account the variety of positive and negative social interactions that may support or adversely affect learning and behavior. For example, educating youth seems to have a greater impact when at-school interventions are combined with peer education and use of non-formal approaches (e.g., comics, video-clips, video games). Among persons with high-risk practices, well-designed counseling activities contribute significantly to the adoption of safer sex practices.

Evidence from all over the world shows that, regardless of the target group, behavioral interventions must include the development of skills such as decision-making, resisting peer pressure, negotiating safer sex practices, learning effective communication with sexual partners, and adopting health-seeking behaviors and other skills to enhance self-care and social responsibility. Access to good quality condoms and sterile syringes and needles is of paramount importance to further reduce the risk of disseminating HIV/STD. Therefore, logistic systems for procurement and distribution of condoms and injection equipment should be in place to ensure that prevention strategies are not constrained by lack of material resources.

In countries with a generalized epidemic, the incidence of pediatric HIV infection is higher as a result of more cases of mother-to-child transmission. Therefore, efforts should be devoted to prevent the transmission from women to their babies. In addition to the biomedical approaches already available (see section 5.2), education and counseling of pregnant women and their partners is a critical component to reduce perinatal transmission.

3.4 *Models of HIV/AIDS Care*

The increasing demand for comprehensive care for persons living with HIV/AIDS originates from the continuous expansion of the epidemic and a growing need and awareness about successful ARV therapies among patients, health providers, and the general public. Health providers are more adept at recognizing manifestations of HIV-related diseases, and people are more willing to seek health services if they perceive themselves to be at risk of infection or hope to benefit from recent developments in antiretroviral therapy. Since care for people living with HIV/AIDS is complex and expensive, it is important to define points in a care continuum in accordance with the epidemiological and economic situation of Member States. This would help countries to establish priorities and rationally invest available resources.

In those places where the HIV/AIDS epidemic is low level or concentrated, the first consideration should be to ensure access to counseling and testing and to establish patient referral systems. If the epidemic has spread beyond specific at-risk groups (i.e., generalized epidemic), prophylaxis and measures to prevent transmission of opportunistic infections, especially tuberculosis, as well as interventions to reduce vertical transmission, should be available. In countries where HIV/AIDS is producing increasing morbidity and mortality, home-based care models should be considered as a means to relieve overloaded health services. Options for the increased availability of ARV therapies (e.g., bulk purchasing, rotating fund mechanisms) should also be explored.

3.5 *STD Prevention and Control*

The interaction of other sexually transmitted diseases, especially those producing genital ulcers (i.e., syphilis, chancroid, herpes) or inflammatory processes (i.e., gonorrhea, trichomoniasis, chlamydial infection), and the transmission of HIV has been firmly documented. Furthermore, the successful management of STDs has been shown to reduce the incidence of HIV by more than 40% in comparable communities in Mwanza, Tanzania. Even without consideration of this interaction with HIV, sexually transmitted diseases merit full attention by public health authorities because of their impact and consequences on young adults, especially women, as well as on children (i.e., pelvic inflammatory disease, carcinoma of the cervix, infertility, congenital syphilis). However, for the last decade not enough attention has been paid nor have sufficient resources been devoted to the prevention of these diseases in the Region. Because of a renewed scientific, technical, and financial interest, the conditions are now favorable to mount a more forceful and comprehensive response for STD prevention and control at the regional and country levels. For this, WHO's STD.PAC strategy is being proposed by the PAHO Program on AIDS and Sexually Transmitted Diseases to be considered for adoption by the Member States.

4. World Health Organization's STD.PAC Strategy

At the 5th meeting of WHO Headquarters and Regional STD/HIV/AIDS Advisors (Geneva, 5-6 March 1998) WHO's proposal for a comprehensive strategy for sexually transmitted diseases prevention and care (STD.PAC) was presented.

4.1 *Basic Elements of STD.PAC*

Most of the basic elements to integrate STD prevention and care into the health systems have already been developed. The STD.PAC strategy aims to produce a comprehensive and integrated national response to the problem of sexually transmitted diseases and their consequences. The key elements of STD.PAC at the community, health services, and management structure levels are the following:

4.1.1 *Community*

- Promotion of safer sexual behavior integrated in health education; condom programming and marketing (where appropriate); promotion of health care-seeking behavior; and information, education, and communication, with clear and well-targeted messages.

- Screening and case-finding (i.e., tests in populations to detect probability of infection (screening) and tests in individuals seeking care for other reasons, to detect presence of STDs (case-finding)).

- Disease prevention and promotion of care among especially vulnerable groups (e.g., migrant workers, truck drivers, commercial sex workers, and their clients).

4.1.2 *Health Services*

- Early diagnosis and treatment of women and men and appropriate management of partners, with integration of STD care into basic health services (primary health care).

- Comprehensive, etiologic, and syndromic case management (all services, according to resources).

4.1.3 *Management Structure*

- Efficient management structure integrated with HIV/AIDS programs and addressing issues such as availability and access to drugs; training; surveillance; research; laboratory support; and ability to coordinate with other health programs, institutions, and sectors.

4.2 *Implementation of STD.PAC at Country Level in the Americas*

Although the knowledge and technical skills to implement STD.PAC are available in every country in the Americas, it is necessary to obtain the political and financial commitment of the national and local governments to promote STD.PAC on a broader scale. Depending on the country, examples of the activities related to STD.PAC may include:

- Strengthening STD surveillance.
- Producing updated national guidelines for STD prevention and care based on the principles of the STD.PAC.
- Establishing clinical sites, integrated in general health services, to provide care to STD patients.
- Establishing clinical laboratory reference centers.
- Developing specific integrated services for adolescents.
- Establishing or expanding screening for syphilis in pregnant women and treating identified cases in order to reduce the incidence of congenital syphilis.
- Training heath care providers in STD case management.
- Collecting data on a continuous basis on urethral, genital ulcer, and vaginal discharge; prevalence of syphilis in pregnant women; and cases of congenital syphilis; and utilizing it for advocacy and planning purposes.
- Including STD drugs in the essential drug list, to purchase and make them available on an integrated and continuous basis to places providing care to persons with STDs.
- Purchasing and making condoms available on an integrated and continuous basis to the sites defined as providing care to persons with STDs.
- Applying the WHO Global Program on AIDS preventive indicators for monitoring and evaluation and developing further indicators of care.

During 1998, the PAHO Program on AIDS and Sexually Transmitted Diseases, working with the national programs, will prepare an inventory of needs as well as an update on the current status of STD prevention in the Member States in order to develop

mechanisms to strengthen country-specific technical collaboration activities. In addition, it is suggested that a Task Force on STDs be established at the regional level with the participation of country experts, the Latin American Union Against Sexually transmitted Diseases (ULACETS), other institutions and agencies, and other regional programs (e.g., Family Health and Population, Women, Health and Development; Health Promotion and Protection), specifically to help identify additional needs and technical and financial resources for STD prevention and control.

5. State of Science in Antiretroviral Therapies and Prevention of Perinatal Transmission

At its last meeting the Directing Council asked to be updated on these two topics.

5.1 *Antiretroviral Therapies*

The enthusiasm about positive results (i.e., reduction of mortality and morbidity) of combination ARV therapies continues. However, ARVs, far from being a panacea, have problems that restrict their usage. Because of high cost, they are still not accessible to many people who might benefit from them. The PAHO Secretariat is exploring with the pharmaceutical industry several options to reduce the costs of these products in the Americas. At the present time, UNAIDS is also exploring globally mechanisms to improve access to ARV drugs, with the participation of Chile in this initiative. One of the possibilities, the creation of an intercountry or regional rotating fund for bulk purchases, still requires financial capital for its launching.

Additional concerns about ARV treatment are (1) impairment of individual quality of life (side effects, drug interactions, need to strictly adhere to treatment schemes); (2) social pressure grounded on false hopes and expectations; (3) augmented probabilities of HIV developing drug resistance; and (4) ethical issues and dilemmas (who should benefit if treatments are only available for a limited number of patients). In some contexts, this last point is being addressed by defining priority groups according to various criteria. Other problems are being dealt with by the introduction of new formulations of available drugs or introduction of new or improved pharmaceuticals. Any decision regarding the provision of drugs in a limited manner would cause concerns about equity and human rights. In an ideal comprehensive care continuum, all the resources to ensure appropriate, humane, and ethical care of people living with HIV/AIDS would be accessible to everyone.

5.2 *Prevention of Perinatal Transmission*

It has been known since 1994 that AZT administered to pregnant HIV-infected women during pregnancy and delivery and to the child postpartum can decrease the risk of perinatal transmission of HIV by two-thirds (from 25% to 8%). However, the initial

treatment schedule known to be effective is cumbersome and expensive and is, therefore, not appropriate in most developing countries. During a UNAIDS/WHO/UNICEF meeting held in March 1998 in Geneva, participants emphasized that the prevention of mother-to-child transmission of HIV should become a global public health priority. This proposal was supported by recent findings in Thailand showing the efficacy of less-expensive (i.e., US$ 100 vs. $1,300), simplified regimes of AZT in lowering the risk of perinatal transmission by 51%.

In addition to these results, a substantial argument in support of the proposal was the announcement in early March 1998 that Glaxo-Wellcome, the company that produces AZT, drastically reduced its price to make it available to HIV-infected pregnant women in developing countries. However, some factors should be taken into consideration prior to recommending the universal adoption of this treatment regimen. These include cost and sustainability, management options for the mother after delivery, and the services that are needed to ensure optimal outcome of prophylactic use of AZT.

6. Prospects for the Future

Although steady progress has been made in building the core infrastructure for HIV/AIDS/STD prevention in the last decade, one of the major components, STD control, has not received enough attention. A few of the countries in the Region have become technically and financially self-reliant and are now able to provide technical cooperation and share resources for AIDS prevention with other countries. However, the majority of national AIDS programs still require significant support and external resources to better respond to new realities, including the principles and operational guidelines promoted by UNAIDS. As a consequence, AIDS and STD prevention activities in some countries were reduced considerably while the epidemic kept growing. With the experience acquired assisting UNAIDS in trying to mount a broader national response, and the knowledge acquired through almost 15 years of collaboration with Member States in AIDS prevention, the Secretariat would like to propose to the Executive Committee the following mechanisms to strengthen HIV/AIDS/STD prevention and control in the countries:

- National programs should continue to recognize, invite, and even demand the participation of all relevant partners at the national level (e.g., non-health sectors of governments, NGOs, private sector) in the fight against HIV/AIDS/STD.

- More technical expertise should be transferred to the local levels as part of the process of decentralization. Examples of this approach include: the Ministry of Health/PAHO/Inter-American Development Bank experience with community educators-managers in Honduras; training of local health workers on proper care of STD in Uruguay; the dissemination and application of STD treatment

guidelines in several countries; and the formation of municipal groups in charge of AIDS prevention in Mexico and Brazil, among others.

- Opportunities should be sought to include the financing of HIV/AIDS/STD prevention activities within the context of multilateral banking loans and bilateral and multilateral agency projects for social development.

- Following the example of the Technical Group on Horizontal Cooperation, which is constituted by several national AIDS programs directors, similar networks of intercountry cooperation should be promoted and/or strengthened in other sectors and groups such as NGOs; professional, academic, and religious groups; and persons living with HIV/AIDS.

- Most importantly, although HIV/AIDS and STDs are problems that require a multisectoral approach, public health authorities must not relinquish their responsibility to lead and orient the technical efforts against HIV/AIDS and STDs within the multisectoral response promoted by the United Nations system and its agencies through UNAIDS.

During the 1998-1999 biennium and beyond, the Organization will continue to provide technical collaboration and work with the countries in (a) strengthening of epidemiological surveillance; (b) improvement, integration, and sustainability of national HIV/AIDS and STD prevention and control programs; (c) design of country-specific interventions; (d) development of appropriate patient care models; and (e) promotion of a broader intersectoral and intercountry response in the fight against HIV/AIDS and STDs.