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Challenges to successful implementation of HIV and AIDS-related health policies in Cartagena, Colombia

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ABSTRACT

The Caribbean region presents the highest prevalence of HIV/AIDS worldwide after sub-Saharan Africa; leading to serious social, economic and health consequences at the local scale but also at the regional and global levels. In Colombia, a national plan to tackle the epidemic was formulated with little evidence that its implementation in the local context is effective. This study focused on Cartagena – one of Colombia's largest cities and an international touristic hub – that presents one of the highest HIV prevalences in the country, to investigate whether the national plan accounts for local specificities and what are the barriers to local implementation. Based on the Contextual Interaction Theory (CIT), this qualitative research relied upon 27 interviews and 13 life stories of local inhabitants and stakeholders, collected in a first fieldwork in 2006–2007. A follow-up data collection took place in 2013 with 10 participants: key policymakers and implementers, NGO representatives and local inhabitants. Barriers identified by the participants included: local population's understandings and beliefs on condom use; stigma and discrimination; lack of collaboration from the Church, the education sector and local politicians; corruption; high staff turnover; frequent changes in leadership; lack of economic and human resources; and barriers to health care access. The findings suggest that global influences also have an impact on the CIT framework (e.g. international organisations as a major financier in HIV prevention). The participants put forward several feasible solutions to implementation barriers. We discuss how several of the proposed solutions have been applied in other Latin American and Caribbean countries and yielded positive results. However, further research is needed to find possible ways of overcoming certain barriers identified by this study such as corruption, the lack of collaboration of the Church and barriers to health care access.

1. Introduction

The Caribbean region presents the highest prevalence of HIV/AIDS worldwide after sub-Saharan Africa (The Lancet, 2008). This high prevalence was associated with the rise of sex tourism within the growing tourism industry, with large social inequalities and with the *machismo* culture (Cabezas, 2009; Inciardi, 2005; Padilla et al., 2010). Consequently, the main pattern of HIV transmission in the Caribbean remains heterosexual sex with vulnerabilities chiefly embodied by women and the youth (PANCAP, 2008).

The Caribbean HIV/AIDS epidemic has serious social, economic and health consequences at the local scale but also at the regional and global levels. Firstly, if ineffective efforts are made at all levels of governance to reduce poverty - one of the main determinants in the region - it would seem unlikely that public health efforts could be successful in decreasing HIV incidence (Grenade, 2008; HEU, 2009). The tourism industry also has a role to play in HIV prevention. Practice of unsafe sex in the context of sexual tourism places the locals and their clients at risk. Given that locals migrate to touristic areas in hopes of finding employment, and that sexual tourism takes place in international touristic hubs, there is a risk of spreading HIV beyond borders (Padilla et al., 2010). Moreover, there is a long-term risk of having the most economically active section of the population heavily burdened by the disease, since HIV/AIDS affects prominently the 15–44 age group and a rising number of children is involved in sex tourism (PANCAP, 2008). Besides the health consequences and the strain on health systems, the possible loss of labour force and productivity due to HIV morbidity and AIDS mortality is also relevant in this region (McDonald and Roberts,

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2006). Finally, although the number of children exploited by sexual tourism is rising, few specific interventions target the youth (PANCAP, 2008).

While it is recognised that HIV risk factors within the region are broad and numerous, public health efforts to tackle the epidemic have not been tailored to address the specific determinants of this region (PANCAP, 2008). Even if health policies were designed specifically to the Caribbean region, for local implementation to be effective, specificities of the local context need to be taken into account. While implementation research at the nexus of sexual tourism and HIV and AIDS in Asia is abundant, similar studies conducted within the Latin American context are sparse (Padilla et al., 2010; Quevedo-Gomez et al., 2011).

To fill the knowledge gap, Cartagena, located on the Colombian Caribbean coast, was chosen as a case study to demonstrate whether the national plan was formulated taking into account the local context. Compared to Colombia's national HIV/AIDS prevalence of 0.57%, in Cartagena, one of the largest Colombian cities, average prevalence is 1.6%; reaching up to 10% amongst vulnerable populations (Ministerio de Salud y Protección Social, 2012). However Arrivillaga et al. (2009) estimated that for each HIV case reported in Colombia, seven are not. Social and structural determinants of HIV in Cartagena are intertwined with social inequalities (Quevedo-Gomez et al., 2011). As a result, men, women and children turn to sexual tourism to survive; an activity that some locals do not consider prostitution (i.e. sex for 'profit', per-se) since it is for many the only means for subsistence (Quevedo-Gomez et al., 2012).

The national plan to respond to the HIV/AIDS epidemic developed by the Colombian government focuses on targeting the following vulnerable populations: people living with AIDS, men who have sex with men, sex workers, persons deprived of freedom, people living in the streets, displaced youths and persons demobilised from illegal armed groups (Ministerio de la Protección Social, 2008). The national plan thus leaves out the vulnerable populations of Cartagena (as identified by Quevedo-Gomez et al. (2011)): housewives, people engaging in sexual tourism and people with low socio-economic status (SES). With its four foci (promotion and prevention; comprehensive care; support and social protection; monitoring and evaluation of the response) the national plan seems exhaustive. Yet, there is little evidence that its implementation and monitoring are efficient at the local level (Moreno et al. 2012). Research into implementation performance is needed at a more local scale; particularly in cities such as Cartagena, with high HIV/AIDS prevalence.

This research aims, through a qualitative approach, to identify the factors affecting the implementation of HIV/AIDS related activities in Cartagena, where health policies are crucial to curbing the HIV epidemic. This study further investigates potential solutions to overcome the barriers identified.

2. Methods

2.1. Theoretical framework

This research is based upon the Contextual Interaction Theory (CIT), a framework originally developed by Bressers (1983) and since then continuously updated (O'toole, 2004; De Boer and Bressers, 2011). It was previously used to identify barriers to HIV/AIDS policy implementation in Indonesia, Vietnam and China (Spratt, 2009). CIT is based on the assumption that the outcome of policy implementation depends on the policy instruments chosen, and - more importantly – characteristics (i.e. motivation, information and power) of the actors involved in the policy process (policymakers, implementers and populations targeted by the policy) (Bressers, 2004). Factors influencing policy implementation have an impact on the aforementioned key characteristics, which will in turn shape (and be shaped by) the interaction processes between the actors (De Boer and Bressers, 2011). Accordingly, determining the factors that impact the motivation, information and power of the implementation actors will lead to the identification of possible barriers to HIV/AIDS policy implementation.

2.2. Data collection

The data collection was divided in two parts (Table 1). Part I aimed to identify the barriers to successful HIV/AIDS policy implementation in Cartagena using CIT. Data used to identify those barriers were based on primary research conducted by the second author during fieldwork in Cartagena for a 7-month period between 2006 and 2007. The data was originally collected for the purpose of identifying social and structural determinants of HIV/AIDS in Cartagena. This original data presented opportunities for further analysis with regards to implementation barriers due to its qualitative richness and the diversity of stakeholders whose perspectives were captured during initial fieldwork. Part II was a follow-up data collection to track changes over time and to verify whether barriers identified in Part I were viewed by national policymakers in Bogotá and local stakeholders in Cartagena as such. With the collaboration of Part II participants, the aim was then to identify possible solutions to overcome the implementation obstacles identified. Data collection for Part II was conducted in a 3-week period in June 2013 by the first author during fieldwork in Bogotá and Cartagena.

For Part I, 13 life stories of persons living with HIV/AIDS (PLWHA) and 27 open-ended interviews with local inhabitants and other stakeholders (tested HIV negative or not diagnosed) conducted in Spanish were included in the data analysis. This sample included 18 men and 22 women, from ages 15 to 60. Participants were recruited by the second author through purposive sampling due to their knowledge of the social context of the epidemic, and came from an array of socio-economic backgrounds, ethnicities and sexual orientations.

Part II entailed 9 semi-structured interviews, where one interview was conducted with two participants simultaneously. Interviews were conducted in Spanish and lasted approximately 1 h 10 participants, 6 men and 4 women, all university level educated, were recruited through quota and snowball sampling:

- 2 policymakers at the national level that were involved in the formulation of the national plan;
- 1 governmental implementer for the regional level;
- 2 governmental implementers for the municipal level;
- NGOs are also an important implementer identified in the national plan, thus 2 NGO employees, considered experts by their community regarding Cartagena's HIV situation, were further included;
- To represent the target population, 3 local inhabitants affected by the epidemic (or one of its determinants) were interviewed ensuring that the policymaking vocabulary was adapted to their level of knowledge.

Each participant was asked about the barriers identified in Part I and whether they were still perceived as barriers. Participants were also invited to expand on the barriers previously identified and to add any obstacle they deemed relevant. They were further asked to comment on the knowledge, motivation, interaction processes and power relationships between the policymaking chain's actors. Finally, participants were invited to think about and share possibilities to overcome the mentioned barriers to policy