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Comparative Examination of Approach to HIV Treatment Between
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A Unique HIV Harm Reduction Perspective from Costa Rica: Hogar de la Esperanza
An Ethnographic Case Study and Comparative Examination of Approach to HIV Treatment
Between the United States and Costa Rica

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Abstract

This case study presents a real, currently operational scenario of harm reduction in action in Costa Rica, focusing on its success and the challenges faced by healthcare professionals, the experiences of those who live at Hogar de la Esperanza, and the implications for healthcare policies and interventions in the United States. By examining this specific case of a Costa Rican community-based HIV treatment model, the aim of this ethnographic report is to shed light on the complexities and factors contributing to the success or failure of harm reduction treatment strategies within the United States and what can be learned by Costa Rica's unique, primary-care-centric approach to healthcare for all. This ethnography also serves as a comparison and critique of the shortcomings in the United States healthcare system with attention paid to the current literature available. The concomitant literature review is extensive but by no means exhaustive and provides a relevant and thorough perspective on the current state of healthcare in Costa Rica and the United States.

Keywords: HIV, HIV Treatment, Harm Reduction, Costa Rica, Central America, Latin America, USA, United States, Community Based Care, Universal Health Care, needle exchange programs, safe consumption sites, community-based HIV care

Introduction

HIV and HIV/AIDS-associated illness continue to be major contributors to morbidity and mortality worldwide. While the burden of the HIV epidemic is of the highest concentration in areas such as sub-Saharan Africa, HIV remains to be both a focal point and a public health priority in Latin America today.¹ In 2017, the Global Burden of Disease estimated over 30,000 HIV/AIDS-related deaths in Latin America.^{2,3} Despite increased access to antiretroviral therapy in several Latin American countries, few countries have shown a substantial reduction in HIV mortality since 2000. An outlier in this data is Costa Rica. Among the six countries considered in multiple cycles of Local Burden of Disease evaluations, Costa Rica had the lowest HIV mortality rates in the greater Central American region. This is likely due to its diligent healthcare system.^{2,3}

In Costa Rica, funding for ART is entirely domestic and access to treatment via primary care and harm reduction models are fundamental to its successful divergence from the overall trend in prevalence of HIV in Latin America.^{2,4,5,6,7,8,9,10} The upscaling of treatment in the region has been achieved due to decentralization, community-centered harm reduction programs, access to primary care for HIV, and expanding local production and distribution of ART drugs. This increased access to, and dissemination of ARV and timely HIV-specific primary care has resulted in decreased mortality due to HIV/AIDS in the region by at least 50 % between 2001 and 2010.^{7,9,14} The following will be an evaluation of one of Costa Rica's long-standing community-centered harm reduction HIV treatment facilities: Hogar de la Esperanza.

Review of Existing Literature

Before demystifying what makes Hogar de la Esperanza such a compelling, inherently Costa Rican, HIV harm reduction strategy, this study will first review the history of Costa Rica's

health care system. This study will then deconstruct how Costa Rica came to be the frontrunner in effective health care for all by incorporating harm reduction and quality improvement within every level of their healthcare model.^{4,7,8,9} The review will also analyze the existing literature on the harm reduction strategies that have been initiated in the United States, the success/efficacy of those strategies, the necessary improvements that must be made within the United States healthcare model, and the lessons that can be learned from Costa Rica's lead.

More Than a Physical Disease: The Emotional Rigor of HIV/AIDS

Currently, the focus on HIV/AIDS treatment in the world is on physiologically stopping the spread of the disease via viral suppression and transmission reduction strategies. There are many global proposals for HIV management, such as the widely familiar 90–90–90 and the Joint United Nations Program on HIV/AIDS, whose aims include raising awareness of the HIV/AIDS epidemic.^{1,11} This ambitious proposal stated the goal that by 2020, 90% of seropositive people be diagnosed worldwide, 90% of them treated, and 90% of them free of viral load, recommending that different governments and their respective policies join forces to control the disease. WHO has also mentioned that the next step is a 95-95-95 goal initiative, which is steep but possible to achieve with diligence.^{1,11} Viral suppressive strategies are indeed the cornerstone of treatment. What ultimately is left behind in current HIV/AIDS strategies is the deep, stigmatized, often complicated mental component to the disease.

While many of the management recommendations made by WHO and other global initiatives focus primarily on the physiological sequelae of HIV/AIDS and reducing transmission, less attention has been paid to the psychological component of the disease. Arias-Colminero and Collins et al. both explored the emotional impact that living with HIV/AIDS has on individuals, the effect it can have on treatment outcomes and mortality, as well as the need for

comprehensive treatment, including psychological care for these patients.^{11,12} Arias-Colminero et al conducted a systematic review, deconstructing the emotional impact an HIV diagnosis has on individuals, highlighting the feelings surrounding their diagnosis and the stigma that those infected with HIV experience. Three types of stigma that patients with HIV suffer disparately from other members of society were identified as relevant in the results of this study; social stigma, self-stigma, and health professionals' stigma were the three most common variants encountered.¹¹

The moment of diagnosis is a vitally significant time to begin integrating mental and social health treatment for HIV patients.^{11,12} During this time, these patients are particularly vulnerable, encountering intense feelings of grief, disappointment, confusion, depression, fear, despair, lack of resources for correct information about the disease, in addition to the physiologic symptoms and pain.¹¹ Seropositive women who are or have become mothers reported frustration and feelings of maternal failure because they cannot breastfeed. Social support is essential and valued highly in HIV treatment programs. Early intervention is of the utmost importance among the newly diagnosed because it is linked to improvement of these individuals' outcomes and overall quality of life. Additionally, spirituality may help some people to deal with their diagnosis of HIV/AIDS.^{11,12}

An integral part of HIV harm reduction is incorporating mental health care within the primary care of at-risk populations. The comorbid relationship between mental illness, substance abuse, and HIV risk factors is an often understudied and unrecognized need in developed and developing countries alike.^{11,12} Incorporation of mental health care in addition to the medical care of HIV patients, as well as navigation of social determinants of health via social work and

teaching skills to believe in one's capabilities is integral to the harm reduction model espoused by Hogar de la Esperanza, and arguably the secret to its success in outcomes.¹³

The Face of HIV in Latin America and Costa Rica Today

The face of HIV is evolving in Latin America, trending with a decline in prevalence. Disparities and challenges remain in intervention and outreach in Latin America as a whole. HIV has a disproportionately higher rate of prevalence in men who have sex with men (MSM), predominantly female Commercial Sex Workers (CSW), Intravenous Drug Users (IDU), and Transgender females (persons AMAB) in Latin America. Costa Rica is not immune to these trends.⁶ An estimated 112,000 people in Central America were newly infected with HIV in 2010. Of this group, many are under the age of 30, of lower socioeconomic status and many do not exceed a secondary education level. MSM are overwhelmingly one of the most affected populations in this region, and there is a disproportionately high prevalence among IDU and CSW as well.^{14,6}

Despite several decades of work in Central America, there is still insufficient evidence of how to effectively reach many of the high-risk groups mentioned with effective primary preventative care and harm reduction programs.¹⁴ This is especially true for MSM, IDU, and CSW populations, predominantly in areas where stigma and homophobia are prevalent, and these individuals are not openly available/cannot be reached. Considerable effort has been made in Central America to target at-risk populations, but there is limited evidence to support the success of those efforts.¹⁴

Background

How the Costa Rican Healthcare Model Shaped HIV Care

*“...they repeatedly referred to the importance of the values underpinning their system: of solidarity and of the public nature of the system itself. That is, in Costa Rica the CCSS is part of the national identity of the country. It is uniquely Costa Rican...”*⁷

Costa Rica has proven to be a powerhouse and the model representative for Latin America in how to reach the goal of “healthcare for all” successfully and effectively by modeling a system that not only provides universal coverage at minimal expenditure but also drives significant improvements in both preventative services and subsequent healthcare outcomes. Ranking among the best countries in Latin America and worldwide for both life expectancy and child mortality, Costa Rica demonstrably has outperformed its neighboring Latin American countries with similar national healthcare expenditure and policies, spanning many different populations. How does it manage to provide a system of “equitable health sans wealth?” In short, Costa Rica has built its entire healthcare system on the premise of equity, responsibility, harm reduction, and quality improvement, with “sustained, unified investment” in the public health system.^{4,7,8} Here we will briefly outline the uniquely effective Costa Rican harm reduction healthcare model, with particular attention paid to its efforts surrounding HIV treatment and prevention.

During the 1970s, with the lofty goal to provide healthcare for all by the year 2000, Costa Rica charged headstrong into a massive healthcare restructuring, placing primary preventative healthcare in the central position in the public healthcare system.⁴ Further, they increased efforts to expand access points to basic/essential primary care services for Costa Ricans and encouraged community involvement and participation in improving their own health.⁴ In the early 1990s,

Costa Rica moved to merge its national social security program with its Ministry of Health. The fusion of these two agencies resulted in a single-payer system, which was run by its social security program and financed jointly by employers and the government. Under this system, those who could not afford the single-payer system (the poor, self-employed, immigrants, unhoused individuals, etc.) were covered by government subsidies.⁷ The restructuring project spanned 30 years from inception and took place in three distinct phases to finally land at the healthcare model that Costa Rica utilizes.^{4,5}

Currently, health services in Costa Rica are provided via its social security agency, the Caja Costarricense de Seguro Social (CCSS), which has been such since its inception.^{7,8} Over time, CCSS has expanded the coverage umbrella to not only include federally employed Costa Ricans and their dependents, but the country's entire population, effectively providing healthcare coverage for 88-90% of Costa Ricans.^{4,5} An estimated 10-12% percent of the Costa Rican population is without health insurance, which is a small percentage by comparison to neighboring Latin American countries with similar healthcare models.^{4,5,7} Uninsured people, however, are still allowed to receive treatment and ultimately do utilize public healthcare facilities, such as public hospitals, despite not being officially insured by CCSS.^{7,8}

An outstanding quality of Costa Rica's universal healthcare system is placing primary care at the central position in the model, its implementation of continuous epidemiological data trending, with subsequent drive for continuous adaptation and quality improvement to drive more favorable outcomes.^{8,9,10} The secret to the model's success is the trifecta of expanding access and building of capacity via community-centered primary care EBAIS teams, applying a lens of equity by targeting areas of focus to socioeconomically vulnerable communities, and community engagement/trust building in the EBAIS systems which increase the likelihood these

communities will utilize the services available to them.^{8,9,10} Harm reduction organizations work in tandem within the medical system (a contrast to many healthcare models in which harm reduction and medical treatment organizations are set in opposition to each other), and harm reduction strategies are implemented wherever possible throughout the primary care network.^{8,9,10}

Essentially all primary care healthcare providers are partitioned into sectors and evaluated on their ability to drive satisfactory healthcare improvements and outcomes based on the data collected among those who live in their specific area. The model is comprehensive by design and prioritizes both individual and population care/prevention within their primary healthcare system, which has enabled both initial success and sustainability.^{8,10} Whether it is the ability to drive preventative screening or higher quality of treatment adherence of chronic illness, Costa Rican primary care providers and their healthcare strategies essentially live and die by the creed of the health index data collection system: “Trend. Identify. Adapt. Improve. This is the way.” If the statistics dictate that changes are necessary to drive improvement, then functional adaptations are made immediately. A phase of follow-up data collection begins shortly thereafter.⁹

What drives primary care providers to improve, is each individual EBAIS network’s collective pride and belief in the system and seeing their QI initiatives lead to desired improvement. There also exists a motivational effect from the shame that comes from being unable to improve upon their data progressively over time, which also drives quality improvement efforts.^{8,9,10} Where many countries have failed in their attempt to provide equitable, universal healthcare, Costa Rica appears to have flourished by utilizing this system, which is often touted as the most successful healthcare model in current Latin America.^{4,5,7} This system,

though currently effective, is not perfect and has undergone several iterations since its inception. With recent changes to the Costa Rican political environment and an increase in population size, time will tell if this model can retain its sustainability and success.

Examples of Harm Reduction Projects in Costa Rica

HIV prevention and treatment is not the only area in which harm reduction models have improved patient outcomes in the Costa Rican model. From the beginning, Costa Rica has been utilizing harm reduction strategies in various capacities to place them among the highest-ranking countries for life expectancy in the world, and one of the lowest infant mortality rates in the world as well.^{5,7} This review focuses on HIV-specific harm reduction strategies that have been shown to drive improvement and is limited to that data.

Many health programs place the medical and harm reduction components to care in opposition to each other, and subsequently struggle to succeed in incorporating harm reduction into practice. This has not been the case in Costa Rica, who has found a way to merge medical and harm reduction into a symbiosis of preventative care.^{8,9,10} Costa Rica has shown success in its utilization of Community Healthcare Workers (CHW) to drive harm reduction programs, reach high-risk individuals and keep overall costs low.¹

In Costa Rica, CHW are often the connection between those at high risk for contracting HIV and the harm reduction/preventative treatment modalities that are in place, such as safe consumption sites, community-based treatment programs, and sterile syringe exchange programs.¹ CHW are the cornerstone of the outreach programs that provide testing, supplies, and education for pregnancy while HIV positive, safe sex and safe injection practices. They provide

education on and resources for safe consumption locations and can run testing and grant access to Pre-Exposure Prophylaxis for identified high-risk communities and do so in a way that they are regarded more as fellow community members, rather than from a place of medical authority.¹

The relationship between CHW and their respective communities can be a special trust relationship that often cannot be gained between a medical provider and their patients. Because they provide that conduit between the community, harm reduction and medical teams, CHW are also helpful to newly diagnosed individuals to assist in disclosure of their HIV status.¹ The WHO has commended national health programs, like Costa Rica, that incorporate CHW to reach those who are at most risk for HIV infection and transmission, stating that they are the necessary bridge between the medical and harm reduction approaches to HIV treatment.¹

A particularly effective strategy in harm reduction employed by the Costa Rican healthcare system was to initially make antiretroviral monotherapy and eventually triple antiretroviral therapy (ART) free to all HIV-positive patients within the country during the early 2000s.^{5,7} This strategy was an effort that not only expanded access to treatment to the most at-risk populations but did so in a way that made it affordable to attain necessary ART, reducing mortality and increasing the number of patients receiving and adhering to viral suppressive therapy.^{8,13}

In addition to ART being free and widely accessible to HIV-positive Costa Ricans, the evolution of community-based care within the HIV-positive population took hold within Costa Rica. A representative of this design is Hogar de la Esperanza.¹⁴ “Esperanza” was established in

1992. Its concept was derived from a collaboration between a Franciscan hospice and a network of 15 civil service and public sector organizations in and around the capital city of San José.¹⁴ This center, operated primarily by volunteers, is a holistic, self-governed community, dedicated to providing dignified, consistent, and safe care to HIV-positive patients in various stages of the disease.¹⁴

Originally, Esperanza was established as a hospice but evolved into a shelter and point of access for members of particularly high-risk populations of HIV-positive individuals within San José, (sex workers, homeless, mentally unwell, members of the LGBTQIA community, and those recovering from substance use disorder).¹⁴ It has evolved further to provide more than shelter, but a place of “solidarity and accompaniment” for those who may not have an active support system, those who are looking to be tested for HIV, a safe environment to get individuals off the street or out of a dangerous living situation, a resource for providing help applying for national health services and helping initiate and maintain adherence to ART therapy regimens.¹⁴

At any given time, the community supports 25-28 residents, many of whom are in more advanced stages of HIV. Those who are well and more physically able, are not housed on-site in the community. However, they are encouraged to be active members of the Esperanza community during the day, assisting with group activities, participating in sessions, and, if they are well enough, encouraged to attempt to find safe work. If the more able-bodied community members require safe shelter, they stay off campus in a participating dormitory, which extends the housing capabilities of Esperanza’s main campus.¹⁴

Staff and community members alike help to ensure medication is distributed and that health and wellness, and treatment adherence, are maintained within the community, approaching their healthcare not only on the physical level, but psychologically, and spiritually as well. Esperanza provides a judgement-free care environment and housing for those that had been homeless, jobless, or socially isolated from family or support systems due to their HIV diagnosis or lifestyle.¹⁴ Esperanza echoes the cry of Costa Rica's national identity and values of solidarity and social responsibility, where the system values and views health in a way that transcends the hospital and clinic environment but pushes into health promotion and aid via the community itself, which in turn helps to move beyond social determinants of health.^{7,13,14}

Methods/Research

Clinical Case Study: Hogar de la Esperanza- A Harm Reduction HIV Treatment Perspective in Costa Rica

The following is an ethnographic case study outlining the structure, evolution, and experiences of those at Hogar de la Esperanza, conducted on July 11, 2023. As outlined in the above literature review, Hogar de la Esperanza (Esperanza) is a community residential facility located in the capital city of San José that utilizes a harm reduction model to provide treatment, shelter, and education/career/self-belief and sufficiency skills for individuals with HIV/AIDS, while embracing a comprehensive, community-based, harm reduction approach to care. This study was conducted in a group setting with the founder and co-manager of the facility, residents of Esperanza, and the center's on-site leadership. Information was gained via a group discussion about the facility's structure, shared testimonies of experiences from those who live and work within Esperanza's community, and a tour of the facility. The identities of all participants in the discussion have been protected for confidentiality and privacy.

The History of Hogar de la Esperanza

Esperanza was established 30 years ago as a collective project through the community of San José, primarily run by a local Franciscan Catholic church and volunteer healthcare workers in the early times of the HIV epidemic in Costa Rica. It was initially constructed to be a hospice for those suffering from the end stages of AIDS. There, volunteers would help care for individuals in need of medical and social support as they died, while providing them with dignity, love, shelter, medical care, and food. At that time, every patient who arrived at Esperanza died there.

At the time of Esperanza's inception in 1992, ART monotherapy was primitive and not yet widely available. Additionally, many individuals were unaware of their HIV seropositivity until they had progressed to the terminal stages of AIDS. Mortality from the disease was extremely high during this time. When ART did eventually become available to Costa Rica in 2000, the pharmaceutical formulations had still not been fine-tuned, and many individuals with AIDS taking ART monotherapy encountered severe adverse effects from the drugs or lethal toxicity, leading to an increase in mortality. The group referred to this as a very depressing, dark time for the community project, as there was little they could do for the patients once they arrived at Esperanza, only to comfort them and ensure they would not die alone.

In 2004, new ART formulations became available and were broadly distributed to all HIV-positive individuals at no cost via the Costa Rican Ministry of Health as a public health initiative. The new formulations were more tolerable and, most importantly, more effective at viral suppression, with less risk of life-threatening toxicity. Less of those seeking shelter at

Esperanza were dying under its roof. In fact, they were thriving. A paradigm shift had happened. People were living with HIV rather than dying from AIDS. A diagnosis was no longer the death sentence it had been in years prior.

Esperanza adapted to this shift toward an increased life expectancy of their community members. They restructured their vision as a community and decided to frame Hogar de la Esperanza around a newer treatment philosophy: “Reducción del Daño,” a multi-faceted, harm reduction model for HIV treatment. By 2017, the harm reduction model proved to be so effective that Esperanza became an official HIV-focused public health program through the Costa Rican Ministry of Health.

The Esperanza of 2023 is no longer the dark and sad hospice of 1992, but a vibrant and alive cooperative community living space, offering gardens, a community-run chicken coop, murals, a clinic, music, and art projects, which is complemented by equally vibrant staff and residents who maintain the common space. Esperanza offers a multi-level support team that cares for its capacity of 28 patients by utilizing psychologists, social workers, medical doctors and nursing staff, substance abuse treatment professionals, and nutritionists, many of whom work there voluntarily.

The facility has also made training available for residents to gain life/job skills (cooking, construction, metal work, carpentry, computer/IT, gardening, caring for the chickens, yoga, exercise skills, etc.) to help foster self-esteem and belief in their abilities. These tools help the residents gain employment and housing when they are ready to eventually leave Esperanza with

the goal of reintegrating into their community. The ultimate objectives are for every resident to gain self-confidence, maintain adherence to ART and effective subsequent viral suppression, maintain sobriety and avoid relapse of substance use/abuse/other high-risk behaviors, gain skills that would be applicable to educational advancement/to become employed, and to gain an understanding of their HIV diagnosis and coping skills to sustain effective treatment adherence.

Most occupants at the main campus of Esperanza today, are a variety of unhoused, HIV-positive individuals, at various stages of the disease. Many are recovering from addiction. Several are former sex workers. The majority identify in some capacity as LGBTQ, and several are in the process of gender transition. A few residents have been at the shelter for over a decade, having sustained many complications, requiring significant assistance and care for activities of daily living. These individuals are unwell and in the later stages of the disease. The majority have lived there between six months and five years. By and large, the residents are physically healthy, in good spirits, and able to participate in continuing education, community chores such as laundry, cleaning, cooking, gardening, and helping to care for other, more infirm residents.

In addition to their shared common HIV seropositivity, the residents of Esperanza all occupy space within several stigmatized, marginalized communities in Costa Rica. These communities include IDU, CSW, LGBTQ, and homeless individuals. Many of the residents in the group discussion mentioned the struggle to live with a disease that exacerbates and complicates the burden of existence and the cycle of despair. This composite of marginalization creates a multifarious “onion” of layered societal stigma and shame that they face due to their

homeless status, sexual and gender identity, loss of connection or erasure from family or their pre-HIV social support system, poly-substance use, mental illness, etc.

“The societal stigma surrounding HIV leads one to believe that their seropositivity equates imminent death. Families and friends will often distance themselves from someone due to their lifestyle and diagnosis, because they are ignorant to the facts of HIV...It is hard to change people’s perceptions on this disease. And what if you don’t have any social support system? Hogar de la Esperanza is the only thing standing in between life worth living, with meaning... and death on the street for so many of the people that come here.” C: Esperanza Leadership/On-site Manager.

The Model in Action

“HIV is a condition that you live with. It is not a death sentence... Before I came here, I did not know that. I was shut off from my family. Every day I wanted to die. I wanted to jump off a bridge. Living on the street, alone, HIV positive and addicted to drugs was a despair I cannot describe. I was isolated and psychologically killing myself. If it were not for being referred to Hogar de la Esperanza, I would not be alive today.” - M: Resident Community Member

Many patients come to Esperanza shortly after learning their HIV diagnosis after being hospitalized for a different illness. A network of social workers through the hospital system is in contact with Esperanza to help patients gain access to the program. The admission process that each patient goes through at Esperanza is individualized based on their particular set of needs and challenges.

“I learned I had HIV when I was hospitalized for COVID. I had been homeless and using drugs. I was so sick. They thought I would die in the hospital... I managed to survive COVID, and the hospital social worker was able to find me a place here at Hogar de la Esperanza... When I got here my CD4 was only 200. I am now feeling well and am healthy enough to take classes in computers and metal work so that I will be able to get a job. I feel like I have a purpose here. My outlook is no longer so dark. I owe these people my life.” J: Resident Community Member

Upon arrival, all patients receive a personalized intake file that links each level of their care: the harm reduction team, psychological, social work, nutrition, substance abuse treatment, primary care, and HIV-specific ART and management. All patients are advised and guided to maintain strict adherence to the program and to their viral suppressive therapy regimen, but each lived process here differs from resident to resident. The most important part of their patient intake process is to discover the “why” and “how” each patient came to arrive at Esperanza, which is done via a patient first contact form. The form provides essential baseline data on each patient and is a detailed inventory of all discoverable issues that the individual resident has, medically, socially, and psychologically. The form is repeated yearly to track individual progress and to adjust their individualized treatment plan.

When coming to Hogar de la Esperanza, the common objective for every resident is to accept their HIV diagnosis and commit to adherence to antiviral therapy and the treatment program there. This program is anchored in CD4 monitoring and tracking, with emphasis placed on every patient to know and understand their CD4 level, and adhere to ART and lifestyle

modifications, to maintain consistent viral load suppression. Suppose a patient is unable to maintain adherence to the program, due to refusal to maintain their ART regimen, or to maintain progress in reducing or eliminating consumption of drugs. In that case, the resident is reviewed by the team and an action plan is established to help them achieve those requirements. If the resident is still unable to adhere to the program at Esperanza after the action plan and meeting with the team, they may be asked to leave the facility. This scenario, while rare, is never easy for the program or the residents if it occurs.

Patient education is the cornerstone of the comprehensive treatment program at Esperanza. The idea that knowledge about one's illness is power is regularly emphasized here. The residents all know their CD4 and individual medication regimen, and this data is recorded on a bulletin board in the medical office, as well as in their patient file. A commitment to viral load reduction, CD4 tracking, and understanding what causes people to return to high-risk behaviors, is ultimately how Esperanza maintains such high levels of treatment adherence and quality of life/outcomes among those who live there.

Residents are continually educated on topics regarding health maintenance and how it is affected by HIV. Class discussion sessions called "my knowledge is your knowledge" are regularly held by the Vice President of Esperanza and his spouse. These sessions are tailored to topics relating to HIV that the residents have requested to learn and are often centered around psychological health, human behavior and how to navigate society with HIV. Many residents noted that these classes helped them to better inform their estranged friends and family after learning their diagnosis and that it helped many of them to reunite with family members who were scared and misinformed about HIV.

“After learning I had HIV, my mother would not touch me. She moved me to a room out of the house. She gave me my own set of plates, cup, and silverware. She made me use a different toilet and clean the bathroom every time I used it. I couldn’t live in her home anymore because she thought I was contagious... Hogar de la Esperanza helped me to reconnect with my mother. She was scared and just needed the right person to give her the correct information. When I was brave enough, I asked her, ‘Mom. Will you please come with me to my doctor appointment? He will tell you everything you need to know.’ My doctor answered all her questions. After that, my mother now embraces me. She has let me back into the family and I am welcome at her house. Now I am attending school online and want to go to college and become a nurse so I can help people like me. I want to live now because I came here.” A: Resident Community Member

Challenges

Despite the program at Hogar de la Esperanza being an effective, long-standing harm reduction access point for the HIV-positive population, the center does meet some challenges. The center’s leadership discussed that maintenance for the facility is a constant challenge for the program. On average, it costs \$12,000.00 a month to keep the facility operational. This includes the cost of electricity, water and utilities, food for the residents, toiletries, cleaning supplies, and medical supplies.

Esperanza relies almost entirely on community donations to afford the cost of operation for the facility. The staff there operate on an entirely volunteer basis. Even though Esperanza is considered an official public health program through the Costa Rican Ministry of Health, the amount of funding received from the Costa Rican government is insufficient to meet the cost of

operation to maintain the capacity of 28 residents on campus. The campus is perpetually at capacity at 28 residents, and there is a long waiting list for prospective residents who wish to live there.

Donation inconsistency leaves the center in cycles of abundance, alternating with drought cycles in terms of available resources. It is a constant challenge to redistribute resources where they are needed and ensure other areas are not being neglected in the process. During the discussion, the onsite manager mentioned that there were days that the residents were subsisting on rice and macaroni because that was the food they could afford to feed them. It was also mentioned that the impetus to start the gardening and the chicken coop projects at Esperanza was a solution to the cyclical food scarcity. They were able to supplement their diet with fresh vegetables from their garden and eggs from the chickens.

Ultimately, the entire group during the discussion agreed that the hardest challenge was seeing their fellow community members struggle. They admitted that it was always disheartening when they would see a friend and fellow community member die. Additionally, it was hard on the residents to see one of their own leave the community because they were unable to adhere to their program contract or see them relapse into high-risk behaviors or return to the street.

Hope for the Future

Hogar de la Esperanza literally translates to “Home of Hope.” Over the last 30 years, it has provided more than a roof over its residents’ heads and food in their stomachs. It has given them consistent access to HIV viral suppression therapy, a safe place to be openly LGBTQ, an

outlet for sobriety, a conduit for skill/confidence building and community reintegration, a community of solidarity consisting of their peers, and knowledge about their complicated diagnosis, through the hundreds of residents that have passed through its doors. It has done this in a compassionate and nonjudgmental way.

Esperanza truly has given those who are members of its community a hope for survival and life beyond their HIV seropositivity. All the residents participating in the discussion group shared the common theme, that they would not be alive had they not found Esperanza. When they arrived at the steps of Esperanza, they were hanging on by a fine thread. They were homeless, jobless, hopeless, and isolated. The unique whole-person approach to the care they received here provided them with something medical care often leaves out: the will to live, and hope for a future. The final resident to speak in the group had learned so much from their time living at the center that they chose to come back and work there as a token of their gratitude for the life Esperanza has allowed them to live.

“I arrived at Hogar de la Esperanza as a mother, a grandmother, HIV positive, a drug addict, and struggling with my identity as trans...and the alienation from my entire family when I came out to them that I had HIV and was trans. I came here because I was sick, alone, addicted, and did not know who I was. I had nobody. If I hadn’t found Esperanza, I would not be able to speak to you today, as a mother, a grandmother, HIV positive, proudly trans, and celebrating 8 years of sobriety from drugs...I was able to be reunited with my family because of what I learned while I lived here for 4 years. I am no longer a resident of Hogar de la Esperanza. I now work here, to help people like me survive.” R:Former Resident, Current Volunteer Employee

A Discussion on Harm Reduction Strategies within the United States and What Can Be Learned from Costa Rica's Harm Reduction Model

Harm Reduction in the United States

The healthcare system of the United States and subsequent harm reduction strategies within it, sits in stark contrast to that of Costa Rica in terms of providing equitable healthcare for all. Baker and Gallicchio outline this in their 2020 comparison of the US and Costa Rican health systems.⁵ What makes the United States a particularly complex case in terms of implementing necessary change in the harm reduction arena is its inability to expand, create, or build upon necessary healthcare reform.⁵ Extreme bipartisanship has created gridlock in the ability to advance meaningful change in the healthcare system. Programs can be advanced or thwarted purely based on the political party that is presenting the reform, often in paradoxical fashion.⁵

DesJarlais, Nadelmann and LaSalle highlight further the primary failure in the US system is the attitude that drug addiction, injection drug use, sexuality or sex work, homelessness, lack of insurance, mental illness, HIV status, etc. are not epidemiological issues but the result of some sort of moral failure on the part of those who are in need of care, and therefore, these individuals “deserve” the situation they are in, and the subsequent suffering associated therewith.^{15,16} The great shame and tragedy of the US response to HIV/AIDS among IDU persons has been the persistent resistance to incorporating more harm reduction strategies for treatment and prevention, in ways such as facilitating legal access to sterile syringes, or opiate agonist therapy.^{15,16}

Even the most progressive jurisdictions in the United States have lagged consistently behind much of Europe and Australia in terms of embracing clean syringe exchange policies, with a deficit of about 20 years.¹⁶ Meanwhile, more politically conservative areas of the US

maintain prohibitory regulation of syringe exchange programs and opiate agonist therapy.^{15,16} Fourteen states still effectively have zero syringe exchanges in place today. In 12 other states, programs are only available in one area for the entire state. The programs that are available meet a meager 3% of the estimated need.^{15,16} The tragedy that has resulted from lack of resources for these programs is that a staggering amount of people who have died of HIV/ AIDS who would have likely survived had the US implemented harm reduction strategies in the 1980s and 1990s when other fast acting developed nations had done so.^{15,16}

The US failure to achieve equitable healthcare for all and improve upon dwindling life expectancy, poor health outcomes, and escalating infant mortality (despite being touted as the “greatest healthcare in the world”) is almost entirely due to the hyper-partisan nature of the US government structure, and its relationship with the for-profit structure of its health insurance system.^{5,13} Unfortunately, public health programs and agencies within the US and the bodies that draft legislation often neither have a direct line of communication to the legislature, nor the funding to ensure their recommendations are lucrative or financially enticing enough to be heard.

The call for improvement via a “sustained unified responsibility and national investment” that ultimately drives the cultural pulse of Costa Rica, largely falls on deaf ears in the United States, which has subscribed to a profit driven, “rugged, politicized, individualism” approach to healthcare.^{5,7} Healthcare costs are drastically inflated due to corporate greed, which seeks profit first and outcomes second. There is also the pervasive component of moral shame within US societal perceptions of health, in which the idea is perpetuated that chronic illness is a result of one’s poor life choices, and prevention of chronic illness should be a spontaneous, individual effort on the part of the patient, not the system.^{15,16} The result of this mindset is a reactive

approach managing chronic disease rather than a proactive/preventative one. The reactive approach also provides additional profit advantage to the US insurance system, which in turn drives up cost to the patient. It is overwhelmingly more profitable for patients to remain ill, than to prevent their chronic illness from happening.^{5,7,15}

The cost of care for patients managing chronic diseases, including HIV, is a significant obstacle for many individuals, primarily those of lower socioeconomic status and under-represented and marginalized populations.^{5,15} While it is true, in the US patients may receive state of the art, high quality treatments and can access that care in rapid fashion, many simply cannot afford the thousands to millions of dollars that they must pay out of pocket to receive the necessary treatment/care, be it preventative, acute, or life sustaining.⁵ Using the example of triple ART for HIV, a treatment that is free to all patients in Costa Rica, would cost an HIV positive, insured, US resident thousands of dollars per month (more if uninsured) to maintain necessary viral suppressive triple therapy, because there is no national regulation on both the insurance coverage for the therapy or the cost of the drugs via the pharmaceutical companies.⁵

A harm reduction strategy that has been implemented with some success by the United States has been needle exchange programs.¹⁷ Needle exchanges work to attempt to quell the spread of HIV among IDU individuals by reducing needle sharing within a population that harbors an increased risk for contracting HIV.¹⁷ Harm reduction policies/attitudes surrounding harm reduction in the United States have substantially advanced in recent years. However, they continue trailing other developed countries with established, sophisticated, well-funded

healthcare systems. Ideological resistance to harm reduction is also fading in the US, though it can be argued that it is too late and too slowly.¹⁶

Thirty years of research on harm reduction in the USA has unequivocally demonstrated these programs to be effective at minimizing HIV transmission among IDU populations. Despite the preponderance of evidence, major obstacles remain in implementation of research for providing harm reduction services to IDU populations in both suburban and rural areas. These areas generally are devoid of existing services, with an added challenge of transportation and economic paucity for providing the needed services.^{15,16,17} The roll-out and utilization of these programs have varied in efficacy and support depending on the location of these programs, and the social/political cultural climate within those areas.¹⁷

Heller, DesJarlais, Nadelmann et al. highlight the timeline of ongoing obstacles and inequities within the current US HIV/AIDS harm reduction strategies spanning from 2004-present.^{15,16,17} These familiar inequities in care, outcomes and prevention success are driven by social determinants of health and exacerbated by deficits in the US healthcare model, competing healthcare needs and basic survival needs of at-risk groups. While the overall national AIDS mortality rate has declined in the US, the decline across different populations has not been consistent or similar across all populations.¹⁷ Additionally, AIDS mortality has decreased only marginally among minority groups and IDU, and in certain circumstances has plateaued by comparison to white or non-IDU groups. The researchers unanimously concluded that the reason for these trends are social determinants of health, lack of access to care/services and inability to maintain adherence to treatment.^{15,16,17} Minority, unhoused, and IDU populations do not have the

ability to afford or the access to HIV primary care, on average do not have access to HAART, (or cannot maintain or afford treatment adherence) and do not have access to consistent primary care, let alone HIV focused primary care.^{15,16,17}

A way to address the resource desert in providing care to at-risk populations is to increase access to care for impoverished/lower-income IDU groups. This is done by increasing partnerships between community-based harm reduction organizations with good reputations/trust relationships with IDU within the communities they serve and medical providers who are willing to put forth a collaborative effort with them.¹⁷ Collaborations described above, however, are difficult to initiate and even more difficult to sustain, as the majority of medical and harm reduction organizations often operate under very different tenets and approaches to care in the IDU population. These major differences in program philosophy or treatment paradigm are significant barriers to consistent quality care coordination.¹⁷

The researchers agreed that the United States healthcare system is not assembled in a way to navigate social determinants of health, nor does it have the infrastructure and legislative support to make the necessary changes in healthcare reform to address these familiar disparities.^{4,5,15,16,17} In essence, harm reduction strategies can only go so far, in a system that is ultimately designed to work primarily for those who have unfettered access to resources.^{5,17} Those who would benefit the most from harm reduction strategies are often left as collateral damage.^{4,6} This is an area that the US must improve upon going forward.^{5,17}

Recommendations for Current Practice in HIV Care and Improvements to Current US Models

What can be done to improve upon the US healthcare system's approach to harm reduction and strategies to improve HIV treatment? Much of the available literature recommends that the United States must adopt the effective harm reduction strategies that other progressive countries with developed healthcare systems have utilized for the last 20 years.^{4,5,7,13,15,16,17} These strategies include increasing the amount of available needle and syringe exchange programs, available supervised use sites, access to opiate agonist therapy, and harm reduction based community residential programs, much like that illustrated at Hogar de la Esperanza.^{15,16}

Harm reduction programming and associated research operate under two themes. Those themes are identifying what is pragmatic and effective, and respecting the human rights of IDU persons being treated.^{15,16} The history of harm reduction in the US is fraught with several competing components of US society, namely, moral condemnation of drug dependence and drug use, stigmatization of minority groups, and stigmatization of drug use by marginalized groups.^{15,16} The discovery of AIDS among IDU groups in the USA made it challenging to apply primary preventative strategies effectively. The discovery also came after the HIV virus had already spread rapidly in areas of the country during a tandem crack cocaine epidemic, which made it all the more challenging to approach the epidemic among IDU individuals via a public health lens.^{15,16}

Needle exchanges have been tested and proven to be exceptionally effective in reducing HIV transmission. Today, most syringe exchanges also are expanding with harm reduction philosophies that address the health and social needs of their participants.^{15,16} US activist groups

advocated for a more harm reduction focused approach by initiating syringe exchange programs in several parts of the country. This was met with much resistance from local legislators and programs. Despite the resistance, harm reduction researchers were able to collect enough data to convince state and local government officials to agree to fund the implementation of larger-scale syringe exchange programs.^{15,16}

Is the effort too little and too late for the US? Despite being the self-proclaimed “greatest healthcare system in the world,” the US trails behind the rest of the wealthy, developed healthcare systems of Canada, Australia, and the majority of Europe and Asia. These healthcare systems operate under more universal systems, while the US has framed its healthcare system on a privatized, for-profit system.^{15,16} The more progressive areas of the US are growing increasingly supportive of harm reduction in implementing sterile needle exchange systems, supervised consumption sites, and opioid treatment programs. However, more conservative jurisdictions, and their elected officials are slower to accept syringe exchange programs and the value of opioid agonist therapy.^{15,16} Extreme political bipartisanship has slowed progress in the US in this area by decades. Unfortunately, abstinence-only treatment programs still dominate, due to the stigma surrounding HIV and associated drug use.

Fortunately, harm reduction practice models are growing as a new generation of treatment professionals are asserting themselves and reinventing/influencing treatment strategies. The tandem HIV/opioid epidemic in the US forces much of this new openness to change. This is especially true in statistically more conservative areas of the US, as mostly Republican-elected officials are clamoring to respond to cries for solutions by their disproportionately white, constituents who are affected by the increasing HIV and drug epidemic.^{13,15,16}

Conclusion

This has been an ethnographic case study and analysis of Costa Rica's utilization of a harm reduction, community-based HIV treatment strategy at Hogar de la Esperanza. This HIV treatment center has proven to be sustainably effective for over 30 years. The success of Hogar de la Esperanza can be directly linked to the national commitment to community care, quality improvement and universal access to free ART, coupled with the cooperative union of medical and harm reduction treatment models within the Costa Rican healthcare system.

The United States, by comparison, is only recently becoming more open to the prospect of harm reduction strategies to battle the dual epidemic of HIV and drug use, as it is expanding to communities otherwise incorrectly assumed to be "safe" from HIV risk. It is yet to be determined if the United States' adoption of harm reduction strategies, in the form of needle exchange programs, opiate agonist therapy, and safe consumption sites, will reach the levels of success that other developed nations with universalized healthcare have with implementation of these interventions. Much more work must be done in the United States in order to provide dignified, harm reduction programs to the areas and communities that need them most. These efforts will undoubtedly be tested in their veracity by the for-profit healthcare system and the hyper-partisan legislative bodies that govern it within the United States.

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