

**Report on the country response to commitments
undertaken in UNGASS**

**FINAL REPORT
COSTA RICA**

December, 2005

Approved by: CONASIDA

The general aim of the report is to present country results on progress made regarding compliance with agreements reached in UNGASS on HIV-AIDS.

CONASIDA, 2005

Abbreviations and acronyms

CCSS	Costa Rican Social Security Fund
CONASIDA	National AIDS committee for the comprehensive care of HIV/AIDS
CRIS	Country Response Information System
MSM	Men who have Sex with Men
MH	Ministry of Health
M&E	Monitoring and Evaluation
CVT	Children at risk of Vertical Transmission
UN	United Nations
NGO	Non-governmental Organisations
CSO	Civil Society Organisations
PLWHA	People Living with AIDS
AIDS	Acquired Immunodeficiency Syndrome
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
HIV	Human Immunodeficiency Virus

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Technical note

This report was prepared by Leonardo Moreira Peraza, a consultant contracted by UNAIDS. The report's results are based on a series of bibliographical and documentary studies, interviews and two workshops with representatives from civil society and the government, which were carried out between September to December 2005 in San José, Costa Rica. Johanna Moreira's collaboration during the gathering of information was also valuable.

This report was made possible thanks to the collaboration of all organisations and people from civil society and the government who took part in the workshops and who contributed through their guidance and valuable information to complete each one of the UNGASS country indicators. We hope that this report strengthens the national response to HIV/AIDS. Our thanks to everyone involved.

I. Introduction

In 2001, Costa Rica signed the UNGASS agreement together with the other 188 signatory countries. UNGASS consists of a declaration of commitment to comply with the agreements and it lays down the frequency with which the response to the indicators must be provided depending on their nature. Five key areas are identified:

1. Ensure that everybody, especially young people, knows how to avoid HIV infection;
2. End mother-to-child HIV transmission;
3. Provide treatment to everybody living with HIV/AIDS;
4. Redouble efforts to obtain a vaccine;
5. Provide care to all those people whose life has been devastated by the epidemic, especially the 13 million orphans.

With these aims in mind, ten areas of commitment were decided upon and are reflected in the UNGASS indicators: leadership; prevention; care, support and treatment; human rights; risk reduction; orphans; the social and economic impact; research and development; conflicts, disasters and resources.

UNGASS has grouped the indicators into three thematic sectors or components. The component is of a macro nature or at a primary social structure level and is known as *national commitment and action*. It incorporates two indicators: one aimed at financial aspects to show how much the country has spent on the fight against HIV/AIDS and the second aimed at evaluating the incorporation of HIV/AIDS policies and strategies into the country's agenda.

The other two indicator groups concern a micro level, that is to say, the same level at which the project or programme measures are implemented. One of the components is called *national programme and behaviours* and includes six indicators aimed at evaluating the prevention and mitigation of the harm caused to most-at-risk populations and PLWHA. The last component looks at the *impact* and encompasses values on incidence and prevalence reduction, and values on improving the quality of life of PLWHA, for which there are two indicators.

To follow up these indicators and strengthen the national country response to HIV/AIDS by monitoring actions, UNAIDS created CRIS, a tool that facilitates the surveillance and evaluation of how the country is dealing with HIV/AIDS. CRIS has one module, among others, which is dedicated to indicators that contain UNGASS indicators.

CRIS has played a part in the drafting of this report and therefore a database has been generated with UNGASS country indicators.

Although the country shows little knowledge of the commitments made and their importance and despite the difficulty of national HIV/AIDS surveillance and evaluation, which was the reason why a country report was not presented in 2003, it is convinced of the need to strengthen a process which will develop these authorities.

To produce the report, the work has been broken down into five chapters. The introduction and subsequent chapters outline the methods used to obtain UNGASS indicator information, the participatory workshops and how they were included in CRIS. The third chapter sets out the current situation of HIV/AIDS in Costa Rica and what the UNGASS indicators are that should be met by the country in accordance with the commitment made. The fourth chapter reveals the results from the UNGASS indicators and the conclusions and recommendations are given in chapter five.

II. Methodology

Three moments in time have been used to obtain information and the participation mechanisms used to produce the report: ex-ante, during and ex-post.

These phases are an integral part of the methodology and procedure used to gather information and produce the UNGASS report as part of the national response to HIV/AIDS.

Ex - ante

The ex-ante phase includes basic activities to establish contacts and to disseminate how the report is going to be prepared and what method is going to be used. This was presented at a workshop with civil society and government representatives. It also includes the bibliographical research phase, which meant the initial chapters of the report could be drafted. The main activities in this phase include:

1. Obtaining a national-institutional flow chart (political and technical) of the national governing body for HIV/AIDS.
2. Studying the national strategic plan or its equivalent to identify the key institutional participants and determine the possible official sources of information.
3. Evaluation of M&E channels that the country uses for HIV/AIDS so as to feed the CRIS indicators and thereby complete the UNGASS report.
4. Presentation of the work plan and strategy to produce the report and incorporation of the suggestions from the participatory workshop carried out with civil society and government representatives.

During: Execution of the strategy

The execution phase relates to the implementation of the strategies and, therefore, the basic preparatory activities of these strategies so as to obtain information and introduce it into CRIS.

5. Collection of information and its application to the CRIS indicators module.

Ex-post: Dissemination and validation of the information

The dissemination and validation of the information was carried out in the ex-post phase.

6. The information which was compiled and integrated into CRIS was disseminated and validated. This process included a workshop in which members of civil society and the government participated.

The success in obtaining information to write the report was based on the participation of the main players that coordinate and carry out activities related to HIV/AIDS.

Country Response Information System (CRIS)

CRIS is an information management tool for country responses to HIV/AIDS which works by integrating the indicators, projects and research that exist on the subject into a single database. Its aim is to support surveillance and evaluation activities in national committees, or their equivalent, by facilitating information organisation, recording, analysis, correlation and reports from a country on HIV/AIDS.

CRIS is based on four independent but interrelated modules. The first, the **Administration** module, is responsible for the general administration of CRIS and the information which is common to the other modules. Therefore, this module contains menus to configure, support and adjust CRIS to the needs of the user as well as add the information common to the other modules (organisations, target population, set of indicators, national strategic plan objectives, geographical level, etc.).

The **Indicators** module is principally designed for recording national HIV/AIDS indicators but grouped into a 'set of indicators' to facilitate the management of these indicators. UNAIDS introduced three sets of indicators: UNGASS, national programme (empty) and Abuja. However, the user may create new names for sets of indicators based on their particular national dynamic. In this case we have added information relevant to UNGASS country indicators to produce the report.

The **Projects** module (PRT) is an integral component of CRIS and as such allows projects related to HIV/AIDS to be recorded with the aim of handling, making an inventory, and analysing projects related to this epidemic in a given country.

The **Research** module records all of the research which was carried out or is being carried out as part of the projects recorded on PRT. This means that research on HIV/AIDS can be managed and recorded in an inventory.

Each of the three operational modules contains four menus. The first is the **List**, in which the user may view the registry of all of the elements entered into CRIS from its respective module and search by the principal reference name. The second menu, **Add**, lets the user add a new indicator, project or research project in line with his needs. The third menu, **Reports**, lets the user build fixed or dynamic reports and save them. Finally, **Export-Import** enables exporting and importing of the module.

UNGASS country indicators were generated in the CRIS indicators module, which requests a series of data for each completed indicator.

Indicators module

Basic information required to complete the module once the basic data is obtained.

1. Indicator name
2. Indicator description
3. Indicator group and type (absolute value, percentage, rate)

4. Indicator status (approved, draft, etc.)
5. Principal / secondary target population for the indicator
6. Principal / secondary organisation that receives the indicator report (e.g. national committee)
7. Objectives of the national strategic plan or its equivalent related to the indicator
8. Programme area related to the indicator (national committee and action, national programme and behaviour and impact, other)
9. Classification of indicator type under M&E (supplies, process, product, result, impact, other)
10. Thematic M&E area for the indicator (prevention, treatment, etc.)
11. M&E objective for the indicator (associated to thematic area: ART, condom distribution, information, communication and education, etc.)
12. Definition date for the indicator
13. Data source for the most recent indicator
14. Type of most recent data source
15. Frequency of the indicator
16. Period of indicator

Other data required to complete the indicator's calculation

17. Name of the data source
18. Type of information source
19. Period of data collection
20. Frequency of the report
21. Period of the indicator (annual, biannual, etc.)
22. Observations
23. Indicator's numerator or its equivalent for the respective calculation of the indicator
24. Indicator's denominator or its equivalent for the respective calculation of the indicator
25. Value of the result of the indicator operation (automated operation)

Structure of the information from each indicator

The information structure from each UNGASS indicator integrated into CRIS requests the following information that has to be completed:

1. Source and frequency of the indicator

Name of origin of data: select an option

Type of origin of data: select an option

Period of time: dd mm yy up to: dd mm yy

Frequency: year

As of date: dd mm year

Observations:

2. Structure of the indicator (percentage, rate, absolute data, segmentation - zone, gender, age)

	<u>Capital City</u>	<u>Other urban areas</u>	<u>Rural</u>
Part 1			
Data requirement	HIV+ Test carried out % HIV+	HIV+ Test carried out % HIV+	HIV+ Test carried out % HIV+
1. Young people of 15			
2. Young people of 16			
3. Young people of 17			
4. Young people of 18			
5. Young people of 19			

3. Calculation of the indicator (automatic calculation of the UNGASS indicator result)

Part II

CALCULATION OF INDICATORS

12. Young people of 15-19

13. Young people of 20-24

14. Young people of 15-24

*Based on statistics from the National Census Office

Back Print Enter values

Each one of the UNGASS indicators in CRIS is built by following these steps. This is why the database contains this information.

III. HIV-AIDS situation in Costa Rica and UNGASS indicators

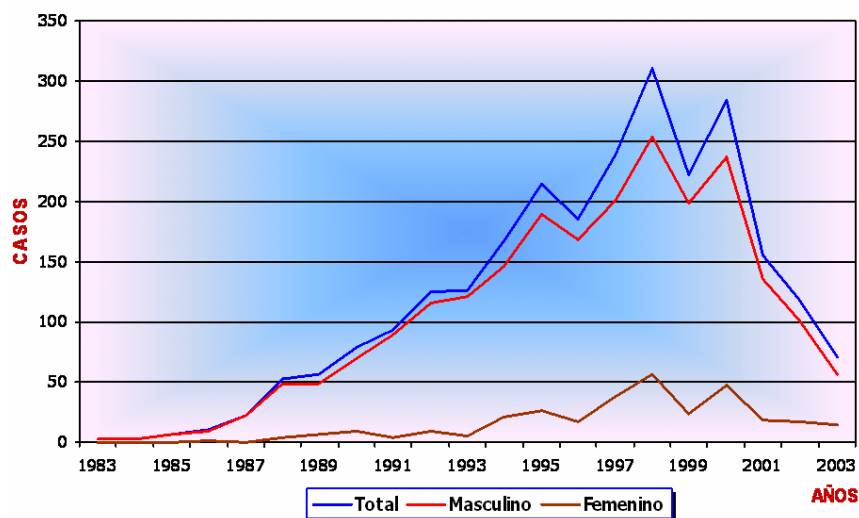
HIV-AIDS situation in Costa Rica

HIV/AIDS in Costa Rica is concentrated and its prevalence rate is low in comparison to the rest of Latin America and the world. This is outlined in the following pages in which the current situation of the pandemic in Costa Rica is described.

The first AIDS cases appeared at the beginning of the 1980s with a total of approximately 250 cases registered over this decade. In subsequent years, the HIV/AIDS behavioural trend increased to the end of the 1990s (2263 cases were registered between 1983 and 2001), which was when the country introduced antiretroviral therapy, as can be seen in graph n° 1. Since 2000, the number of new HIV/AIDS cases has dropped. In 1985, the first cases of AIDS among men who have sex with men (MSM) were reported. Currently, the principal infection route for HIV/AIDS in the country is through sex and concerns this population group. Statistics, which show that 43.7% of AIDS cases occur among MSM, confirm the previous point. Recent reports indicate that in the AIDS clinic in Hospital México, 78% of new cases of this epidemic concern men who have sex with men.

The composition of the groups of people with this disease is characterised by a predominance of males (7:1 in 2001, with respect to women) and has affected to a greater extent the population groups aged between 25 and 34. This population is located mainly in San José, Heredia, Alajuela, Limón, Puntarenas, Cartago and Guanacaste.

Graph n° 1. Registered cases of AIDS by year and gender (1983-2003)



Source: Statistics unit, Ministry of Health, 2004

Graph key

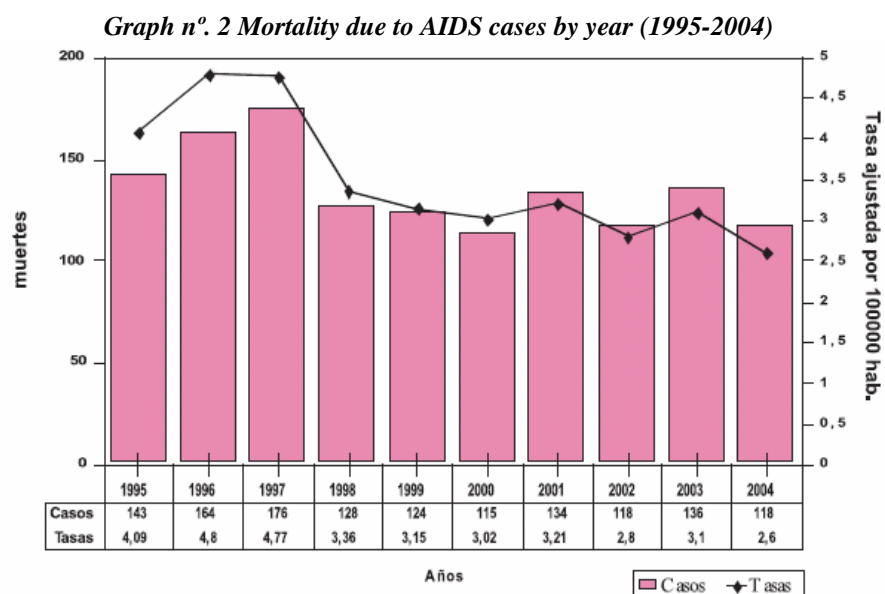
CASOS - CASES

AÑOS - YEARS

Total – Total / Masculino – Males / Femenino - Females

In 1985, AIDS was declared an obligatory notification disease and the recording of cases, which had been done manually and computerised, was formalised.

There is a generally accepted system of legal regulations concerning human rights. A General Law on HIV/AIDS in Costa Rica was approved in May 1998 and made the National committee for the comprehensive care of HIV/AIDS (CONASIDA) the governing body for national policies and actions on AIDS. Approval of the Law led to a legislative framework on the rights and obligations of people living with AIDS (PLWHA) and established the general guidelines for education, health promotion, prevention, diagnosis, epidemiological monitoring, care and research on HIV and AIDS.



Source: INEC-Statistics Unit, Ministry of Health, 2005

Graph key

Muertes - Deaths

Tasa ajustada por 100,000 hab. - Adjusted rate per 100,000 inhabitants

Años - Years

Casos - Cases

Tasas - Rates

In relation to death caused by AIDS based on gender, 92 of the total number of deaths concern males, and represent 78%, while 26 concern females. With respect to the age group, 53% of the total number of deaths corresponds to those aged between 35 and 49.

With regard to the measures being implemented by the country on prevention, PLWHA treatment and the social insertion of these people into society, important progress in prevention is highlighted, in which the training of state school teachers and communication campaigns by different media, are noteworthy. The social security institution and some NGOs are distributing condoms to most-at-risk populations and to the population in general despite the lack of a social policy on the distribution of

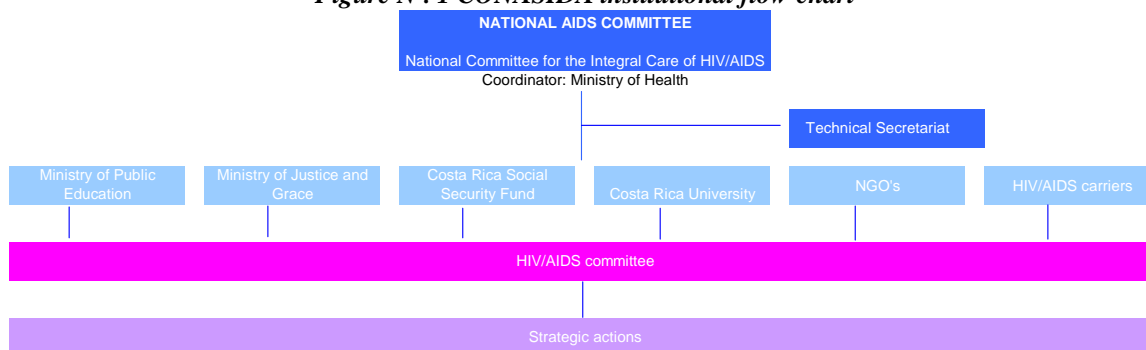
condoms and the lack of large scale awareness campaigns on the use and importance of a condom to prevent this disease.

The comprehensive care of PLWHA is centralised in the four national hospitals and one regional hospital (third level) administered by the Costa Rican Social Security Fund (CCSS). Costa Rica is close to complying with the requirements of ‘Situation III on care’ as the health services cater for all PLWHA who request care. As illustrated in graph n° 2, the mortality rate due to HIV/AIDS varies around 3 deaths per 100,000 inhabitants, a figure which has remained constant since 1998. This service is not limited to national patients, it also includes foreign patients living in Costa Rica and who are insured. However, neither the second nor the first care levels have the financial or human resources to reach ‘Situations I and II’ and provide comprehensive quality care from a community level, increasing according to the level of complexity and previously established competences.

The country has a governing body on the epidemic known as the National committee for the comprehensive care of HIV/AIDS (CONASIDA) which is the maximum authority at a national level responsible for recommending policies and programmes in the entire public sector.¹ CONASIDA is made up of public organisations, state institutions, NGOs and other civil society organisations which deal with this national epidemic from different locations.

Created through the General Law on HIV/AIDS, CONASIDA recommends national policies to deal with HIV/AIDS to the Ministry of Health and updates HIV/AIDS master plans. It also coordinates matters related to this epidemic with the various institutions by encouraging inter-institutional coordination and agreements. It also monitors that the rights and guarantees of people carrying HIV or AIDS patients, their families and friends are fully observed and respected. Finally, it collaborates with the Ministry of Health on the inspection and evaluation of the implementation and effectiveness of measures, provisions and actions considered in regulations related to this epidemic, in the HIV/AIDS master plan and other national plans.

Figure N°. 1 CONASIDA institutional flow-chart



Source: Drafter of report

¹ CONASIDA is made up of the Ministry of Education, Ministry of Justice, Ministry of Health, the Costa Rican Social Security Fund, University of Costa Rica, NGOs and people carrying HIV/AIDS.

One of CONASIDA's biggest responsibilities has been the creation of the 2001-2004 strategic plan to fully deal with HIV/AIDS. This plan defined the strategic action framework for the institutional coverage of HIV/AIDS, which was designed in an integral and coordinated manner.

A list of institutions which have departments, areas, programmes, projects and/or activities concerning HIV/AIDS depending on their grouping and type has been established in the framework of local and institutional plans and the organisational structure of the country.

Table n° 1 List of institutions involved in HIV/AIDS

Governmental:	Group:
Ministry of Health Costa Rican Social Security Fund (CCSS) Ministry of Education (MEP) Ministry of Justice Ombudsman Mixed Social Welfare Institute National Literacy Institute Ministry of Work and Social Security Ministry of the Interior and Police	CONASIDA
NGOs:	Group:
3-H Rotary Association Centre for Investigation and Promotion for Human Rights in Central America (CIPAC/HR) Household of Hope LIFE Foundation Costa Rica Association for People who Live with HIV/AIDS (ASOVIH/SIDA) Foundation for the fight against AIDS (FUNDESIDA) Defence for Children International (DNI) Life and Hope Group from Cartago HIV Patients Association (APAVIH) Association of Women in Network who drive Quality and Health (AMERICAS) Development for Children International (DNI) Costa Rican Movement for the Fight Against AIDS Costa Rican coalition of youth organisations for the prevention of incorrect use and abuse of drugs and HIV/AIDS	Network of NGOs
Institution:	Group:
Costa Rica University National University	National AIDS Council
International institutions/private sector	Group:
UNAIDS Global Fund UNICEF ILO UNDP PAHO Price Waterhouse Coopers Family Health International and National Institute of Public Health of Mexico Rotary International ICW (International Community of Women living with HIV/AIDS)	Source of Finance

National response and international cooperation

As a section which looks at the national response and international cooperation, a series of actions aimed at improving the quality of life of PLWHA, and organisations and people who work towards this end, are mentioned.

An essential element in this process is the functioning of a health system in which the social security system is responsible for providing, under the principles of universality, solidarity and equality, the resources and services required by all citizens. This insurance, which is administered by the Costa Rican Social Security Fund (CCSS), covers 80% of citizens. It must provide care related to drugs, diagnostic and monitoring tests, prevention and promotion campaigns, mother-to-child transmission of the virus, work incapacity subsidies and financial aid for burials, among other services.

The Ministry of Health, in its role as the sector's governing body, is responsible for the implementation and definition of policies, plans and programmes and projects related to HIV/AIDS in partnership with governmental and non-governmental institutions working in this field. It is also responsible for epidemiological surveillance and the regulation of public and private health services that provide comprehensive care to people with HIV/AIDS.

The Ministry of Justice must have a team of professionals that provide primary health care to prisoners, including HIV/AIDS care. The national penitentiary commission for HIV/AIDS (COPESI) carries out prevention based measures among prisoners and puts in place measures to make prison wardens and guards from the various prisons in the country aware of the regulations in force and encourage them to put these regulations into practice.

The Ministry of Education provides information on the disease and comprehensive sex education which focuses on the prevention of HIV/AIDS through study programmes taught in schools as well as extra-curricular projects or activities with community participation.

All workers in the country have obligatory insurance under the 'risks at work insurance' scheme of the National Insurance Institute for the possible occurrence of accidents and diseases to which workers are exposed at work. The insurance provides medical, surgical, hospital, pharmaceutical and rehabilitative care. Compensation for death and temporary and permanent incapacity is also awarded.

Non-governmental organisations participate in the fight for the rights of PLWHA. They create programmes and plans for the training, prevention and awareness of most-at-risk groups and provide emotional support and financial assistance, etc.

Among the main actions carried out in the country in this field, the printing of the manual entitled, 'Sexuality and sexual and reproductive health of adolescents with an emphasis on education and prevention of HIV/AIDS' and the manual 'Counselling on sexual and reproductive health in adolescents with an emphasis on HIV/AIDS' by Defence for Children International (DNI) stand out. Promotional strategies to deal with the disease among at-risk children and adolescents or those living with HIV/AIDS have also been carried out in 20 educational regions with respect to the open classroom population and in five educational regions with respect to the regular classroom population.

Thirty civil servants from CCSS have been trained in prevention and education activities. This training was carried out with the aforementioned counselling manual. Teachers also received training in sex education with an emphasis on the prevention of HIV/AIDS and the promotion of the rights of minors with the disease.

HIV/AIDS workshops comprising eight sessions per workshop have been carried out for prisoners in eight prisons.² Three training workshops were also carried out for AIDS subcommittee members on subjects relevant to HIV/AIDS prevention in prisons.

Another measure was the installation of condom dispensers by CIPAC in places where men who have sex with other men socialize. The magazine, SER+, by ASOVIHSIDA, was also published and handed out.

Through CIPAC, more than 4000 consultations were made through the electronic on-line system and 4800 telephone calls were taken thanks to the free-phone line. All of the consultations and calls concerned sexuality and HIV/AIDS.

1600 people have been seen in psychological clinics, counselling and self-support groups and 50,000 information leaflets have been distributed. The research on drugs and alcohol among MSM carried out by CIPAC was also finished.

At a regional level, Costa Rica participates and also presides over Central American measures in the fight against HIV/AIDS. One of these projects is the MesoAmerican project which involves strengthening care to mobile and most-at-risk populations in border areas. The country also participates in the project on enhancing detection by setting up a regional reference laboratory in the Gorgas Commemorative Institute, Panama.

These are a series of actions which have been jointly undertaken by the government and civil society who have been working to improve the quality of life of people living with HIV/AIDS and strengthen the relationships between organisations and people who work towards this end.

Although the work is not finished, UNGASS indicators paint a picture of the conditions in the country and its response to HIV/AIDS when a lack of information or underestimations hinder the precise calculation of national measures.

² The prisons are: Buen Pastor, Cocorí, Puntarenas, Gerardo Rodríguez, San Rafael, Limón, Pérez Zeledón and la Reforma.

UNGASS indicators for Costa Rica

In line with the criteria that guide the selection of indicators based on the pandemic's scope and characteristics, the indicators that the country must respond to based on the evaluation period required by the indicator are listed below.

The following indicators are those that the country must respond to in this report based on having a concentrated and low prevalence pandemic.

Component I: National commitment and action

1. National funds allocated to HIV/AIDS by governments.
2. National Composite Policy Index.

Component II: National programme and behaviours

1. Number and percentage (most-at-risk population) that have received HIV testing in the last 12 months and know the results.
2. Number and percentage reached with prevention programmes.
3. Number and percentage that both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV/AIDS transmission.
4. Percentage of male and female sex workers reporting the use of a condom with partners.
5. Percentage of men reporting use of a condom when they have anal sex with another man.
6. Percentage of most-at-risk population that is infected with HIV/AIDS.

Component III: Impact

1. Reduction in the prevalence of HIV among young people aged 15-24 (Target: 25% reduction in most-affected countries by 2005; 25% reduction globally by 2010).
2. Reduction of mother-to-child transmission (percentage of children affected by HIV) Target: 20% reduction by 2005; 50% reduction by 2010.)

The following chapter looks at the results for each of the indicators in line with the most recent data published by the country or data from an official source which has been validated in the workshop where the results were presented.

IV. Results from UNGASS indicators in Costa Rica

National commitments and action

1. Government funding for HIV/AIDS

The purpose of this indicator is to monitor the flow of national funding to HIV/AIDS, thereby reflecting the financial commitment by the government to fight HIV/AIDS.

The indicator is assessed twice a year. The source of the information may be a survey on national government expenditure on HIV/AIDS programmes. The cost of government programmes funded by international, bilateral or multilateral donors are excluded. Likewise, all programmes by local NGOs except programmes (or parts of programmes) funded by the national government are also excluded.

Structure of the indicator

The national funds disbursed include expenditure on the following four programme categories, whose totals should be broken down separately:

1. STD control activities
2. HIV prevention
3. HIV/AIDS clinical treatment and care
4. HIV/AIDS impact reduction

This indicator is a measurement of the financial commitment to boosting the national response to HIV/AIDS. It is not designed to be used as a measurement of the resources available.

Result of the indicator

The most recent data the country has officially is for 2003. Another important aspect is how resources for actions that fight HIV/AIDS are divided into two groups in the budget: prevention, which also includes STD control activities and clinical care, and treatment, which includes the investment in impact mitigation.

In 2003³, investment in HIV/AIDS stood at \$13.8 million, of which \$8.3 million went to prevention and the remaining \$5.4 million to treatment.

³ In 2003 there was a shift in how resources were distributed between prevention and treatment. Between 1998 to 2002 the average investment made in treatment was over 64% compared to 32% in prevention. This is mainly due to two phenomena, one involving the lower cost of ART drugs and the purchasing of more condoms for anal use, which are more expensive.

Investment in HIV/AIDS during 2003 in US dollars

1. Prevention of HIV and STD control	8,350,27
2. Clinical care and treatment of HIV/AIDS and	5,466,22
Calculation of indicators	13,816,4

Analysis of the indicator

In 2001, the amount disbursed by the government to fight HIV/AIDS represented 0.05% of GDP compared to 0.08% in 2003. In 2001, expenditure on HIV/AIDS represented 0.59% of national health spending compared to 1.29% in 2003.

In 2003, government funding aimed at the fight against the pandemic stood at \$13.8 million, 56% of which went on prevention and 44% on treatment.

Conclusion of the indicator

Investment has been channelled in the last five years mainly towards treatment and, to a lesser extent, prevention in line with the pandemic's characteristics in Costa Rica which indicate that resources should be aimed at the target population and prevention. It is essential that the change of course seen in spending in 2003 remains constant so that the fight against HIV/AIDS is more effective.

2. National Composite Policy Index

The aim of this indicator is to evaluate the progress made on developing HIV/AIDS policies and strategies at a national level.

The composite index includes four major policy areas:

- A. Strategic plan
- B. Prevention
- C. Human rights
- D. Care and support

A series of specific indicators for each one of these policy areas has been identified. A separate index is obtained for each policy area by adding the marks (yes = 1, no = 0) for the specific indicators of relevant policies and by calculating the general percentage mark. The composite index is calculated by obtaining the average marks from the four components.

This indicator's value was obtained during a CONASIDA special session due to its HIV/AIDS governing body status in the country. The process consisted in members reading and responding to each item. When there was disagreement the definitive answer was determined by a majority vote. This process meant specific remarks were made on some of the items. These remarks have been added to the report.

Structure and result of the indicator

The national composite policy index is structured in a table with the 4 components and each component with the respective lists that the interviewees should answer with a YES or a NO to determine the final evaluation of the indicator.

National Composite Policy Index	RESPONSE	
	YES	NO
A. Strategic Plan		
1. The country has developed multisectorial strategies to fight against HIV/AIDS.	✓	
2. The country has integrated HIV/AIDS into its general development plan.		✓
3. The country has a national multisectorial body for management/coordination on HIV/AIDS.	✓	
4. The country has a specific national body on HIV/AIDS that encourages interaction between the government, the private sector and civil society.		✓
5. The country has a specific governing body on HIV/AIDS that helps to coordinate civil society organisations.	✓	
6. The country has evaluated the impact on HIV/AIDS on its socio-economic situation with the purposes of planning.		✓
7. The country has a strategy that deals with HIV/AIDS issues among its national uniformed services (including the armed forces and civil protection forces).	✓	

B. Prevention		
1. The country has a general policy or strategy to develop information, education and communication (IEC) on HIV/AIDS.		✓
2. The country has a policy or strategy to promote sexual and reproductive health education among young people.		✓
3. The country has a policy or strategy that encourages information, education and communication and other health interventions for groups with high or growing HIV infection rates.		✓
4. The country has a policy or strategy that encourages information, education and communication and other health interventions for cross-border migrants.		✓
5. The country has a policy or strategy to broaden access to basic preventive products, including most-at-risk populations.		✓
6. The country has a policy or strategy to reduce mother-to-child HIV transmission.	✓	

C. Human rights

1. The country has laws and regulations that protect people living with HIV/AIDS against discrimination.	✓	
2. The country has non-discrimination laws or regulations which specify protections for certain groups of people identified as being especially vulnerable to HIV and AIDS discrimination.		✓
3. The country has a policy to ensure equal access between men and women to prevention and care with particular emphasis on most-at-risk populations.		✓
4. The country has a policy to ensure that HIV and AIDS research protocols involving human subjects, are reviewed and approved by an ethics committee.	✓	

D. Care and support		
1. The country has a policy or strategy to encourage comprehensive HIV and AIDS care and support with particular emphasis on most-at-risk populations.	✓	
2. The country has a policy or strategy to ensure or broaden access to drugs related to HIV/AIDS with particular emphasis on most-at-risk populations.	✓	
3. The country has a policy or strategy to be able to deal with the additional needs of orphans and other vulnerable children.	✓	
Calculation of the indicator	55.95	

Interpretation of the indicator

Due to its simple quantitative nature, the national composite policy index does not provide information on the effectiveness of national policies and strategies. Its evaluation enables the country to measure its response and political commitment to a series of actions that have been determined in this composite index.

Analysis of the indicator

This indicator shows the areas in which political and civil commitments - expressed as policies and strategies - are formally constituted in the country, not as specific initiatives but as part of a national commitment.

The country thereby shows strengths in policies and strategies on care and support of HIV/AIDS while in the areas of strategic planning and human rights, much remains to be done for its consolidation as a national commitment.

However, the area dedicated to prevention is the one which shows the greatest weaknesses in the formulation of policies and strategies. It was stated that the country has only consolidated one of the six actions in the form of policies and strategies. However, it is important to highlight that for the remaining actions the country has particular initiatives that lead to HIV/AIDS prevention actions.

The indicator's result is 55.95, which means that the country has integrated half of the actions evaluated in this composite index into its national policies and strategies.

Conclusion of the indicator

The importance of the composite policy index is based on the fact that government bodies and civil society jointly strengthen actions so that particular initiatives and actions in the fight against HIV/AIDS become part of the formulation of national policies and strategies.

National programme and behaviours

1. Number and percentage (most-at-risk population) who received HIV testing in the last 12 months and know the results.

This indicator examines, particularly for most-at-risk populations, whether these populations have been tested in the last 12 months and if the results are known. Currently, the records do not let us determine which are the most-at-risk populations from among those who were tested. If the interest lies in evaluating the awareness of this group towards HIV testing, this value cannot be obtained. However, if the nature of the indicator is to evaluate those who have been tested and know the results, this data has been obtained based on care protocols from the national health sector.

Structure of the indicator

As its name implies, it lets us determine the number and percentage of those who have taken a HIV test in the last 12 months and know the results. It is mainly aimed at populations at risk of HIV infection.

Result and analysis of the indicator

In line with health care regulations and comprehensive HIV/AIDS care, in particular, and based on records, everybody who takes a HIV test is notified of the results.

Thereby, anybody at risk of HIV infection who has taken a HIV test is notified of the result. 100% of this population is therefore notified.

In the country it has been estimated⁴ that there are 1.4 million people at risk of HIV infection in some form or other of which it is not exactly known how many have been tested for HIV.

	Number	Percentage
Number and percentage (most-at-risk population) who have received HIV testing in the last 12 months and know the results.	ND	100.0%

⁴ Taken from Nicole Schwab et al. Optimising the allocation of resources to prevent HIV in Costa Rica, World Bank, 2004.

Conclusion of the indicator

This indicator shows the effort that has to be made in a coordinated manner and at national level by the government and civil society so that the most-at-risk populations are recorded according to the tests performed. This must be done in a context of greater prevention and behaviour-change actions among these populations.

2. Number and percentage (most-at-risk population) reached with HIV/AIDS prevention programmes.

There is a lack of accurate information for this indicator. However, a section has been added to the first part of the report highlighting the main actions carried out on prevention aimed at most-at-risk populations and the number of people concerned. Some details are presented below:

- 97,920 students and 19,187 teachers with the comprehensive sex education programme by the Ministry of Education
- 50,000 information leaflets distributed
- Prisoners from eight prisons attended workshops comprising eight sessions per workshop on HIV/AIDS
- 30 social security civil servants received training on prevention and education activities
- 1600 people were attended in CIPAC psychological clinics, counselling and self-support groups
- More than 4000 consultations were made through the electronic on-line system and 4800 telephone calls were taken thanks to the free-phone line. All of the consultations and calls concerned sexuality and HIV/AIDS (CIPAC)
- Consolidation of work among peers, involving ASOVIHSIDA carrying out a survey among PLWHA. During 2005, 998 condoms were requested and 251 PLWHA were provided with general information and two volumes of the magazine Ser + were published and distributed, one aimed at prisoners and the other at young people and adolescents.
- In the greater metropolitan area, the Foundation to Develop the Fight against AIDS (FUNDESIDA) detected 136 girls as being sexually exploited, of which 35.3% received medical care and attention.

This indicator refers to activities so that civil society and the government can strengthen actions aimed at monitoring and evaluating most-at-risk populations comprehensively and nationally to determine national policies and strategies in the field of prevention aimed at these populations.

3. Number and percentage (most-at-risk populations) who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV/AIDS transmission.

This indicator shows in the area of prevention and in the context of change of behaviour, the amount and percentage of those represented in different groups at risk of HIV infection that correctly identify how to avoid the sexual transmission of HIV and those that reject misconceptions on how the disease is transmitted.

Structure of the indicator

The indicator is based on determining for each group at risk of HIV infection, the number and percentage who correctly identify the prevention routes of sexual transmission of HIV, and whether they reject misconceptions on how the disease is transmitted.

In this context, information must be gathered through a national survey or census that asks questions on these two specific items.

Result and analysis of the indicator

In 2004, there were 356 MSM, representing 48.8% of the sample⁵, who correctly identified ways of preventing the sexual transmission of HIV out of a total of 730 MSM to whom the survey was applied. Due to the nature of the question, it is believed that they also reject major misconceptions about how the disease is transmitted.

As the total estimated number of MSM in the country in 2004 stands at 153,370, given that this is a representative sample, this implies that approximately 78,844 of them positively responded to this indicator; in other words, a little under half the total MSM in the country.

	Number	Percentage
Number and percentage (MSM) who both correctly identify ways of preventing sexual transmission of HIV and who reject major misconceptions about HIV transmission	74,844	48.8%

Conclusion of the indicator

Regarding the evaluation of the indicator for MSM, the sample highlights that 48.8% give a positive response to the indicator. In addition to this, in the same survey it is concluded that 43.9% of MSM who do not know whether they live with HIV/AIDS, maintain risky sexual practices. Furthermore, 19.8% of those interviewed do not know about safe sexual practices. Faced with this situation, the country must strengthen its surveillance of most-at-risk populations by applying national instruments to ascertain the situation of these populations in order to guide preventative actions and mitigate harm on a national level under a national strategic plan.

⁵ Taken from research on drugs and alcohol among MSM by CIPAC, 2004.

4. Percentage of male and female sex workers reporting the use of a condom with partners.

According to the institutions questioned on this issue, this information is not available for Costa Rica. This was confirmed in the participatory workshop in which members of civil society and the government participated.

There are approximately 8750 sex workers in Costa Rica of which a total of 2700 consulted the CCSS STI/HIV/AIDS control unit, and 0.8% of which are infected with HIV/AIDS.

	Percentage
Percentage of male and female sex workers reporting the use of a condom with partners.	ND

In this context, it is essential to incorporate issues concerning sex workers and their sexual behaviour, including the use of preventative methods, into national studies and surveillance instruments.

5. Percentage of men reporting the use of a condom when they have anal sex with a male partner.

This indicator is specifically aimed at one of the populations at risk of HIV infection, MSM, and within this population, the percentage reporting the use of a condom during anal sex with a male partner.

This indicator measures actions aimed at preventing HIV/AIDS among MSM in terms of their effectiveness in assessing how many MSM effectively use a condom when having sex with another man.

Structure of the indicator

To determine this percentage indicator a survey carried out by CIPAC in 2004 has been used which asks MSM how many of them use a condom when having sex with another man.

The accuracy of the response is important as it is the actual use of a condom among MSM that is considered and not its distribution in order to determine the effectiveness of its use during sexual relationships between men.

Result and analysis of the indicator

In Costa Rica more than half of the AIDS cases between 1998 and 2002 concerned men who had sex with other men. A large percentage of this group also had sex with women. The evaluation of this indicator in line with the epidemic's pattern in the country is therefore fundamental.

47.3% of MSM use a condom as a safeguard out of a total of 730 individuals who make up the entire survey with data from 2004.

	Percentage
Percentage of men reporting use of a condom when they have anal sex with a male partner	47.30%

Conclusion of the indicator

Further to the 47.3% of MSM who report the use of a condom during anal sex with another man, it was also determined, as part of the study carried out in the country in 2004 by CIPAC, that 32.1% of MSM never or almost never practise safe sex when under the effects of drugs and alcohol. Another noteworthy result is that 15.3% of those surveyed never practise safe sex during casual encounters or only do so sporadically.

In such a situation, it is important to strengthen actions aimed at MSM populations who still maintain unsafe sexual practices and those who are mainly associated with people who do not know whether or not they have HIV. These actions on prevention and behavioural change require joint efforts by all players in such a way as to reflect a national strategic plan and national HIV surveillance carried out by a surveillance unit in the country.

6. Percentage of most-at-risk population that is infected with HIV/AIDS

Most-at-risk populations are considered to be sex workers, men who have sex with men, prisoners, adolescents, children at risk of exclusion, homeless children and children being sexually exploited, pregnant women - newborns, individuals receiving blood transfusions and immigrants. The evaluation of this indicator is aimed at ascertaining the percentage of this group infected with HIV/AIDS.

Structure of the indicator

This indicator is based on the determination of the percentage of people from most-at-risk populations who are infected with HIV and AIDS. Although the indicator integrates both data in line with the information sources consulted and therefore the availability of information, the evaluation of this indicator has only been carried out for those with HIV.

The data was taken from a 2004 World Bank study and data supplied by the Ministry of Health and the CCSS on AIDS cases by population group.

Result and analysis of the indicator

0.23% of the most-at-risk population is infected with HIV according to calculations carried out on estimated databases from 2004 (Schwab, 2004).

There are approximately 460 new cases of HIV/AIDS a year. In general terms, in line with estimates obtained by the PAHO at the end of 2003⁶, the prevalence of HIV/AIDS in Costa Rica is 0.6, which represents 12,000 HIV/AIDS cases in the country. However, this is a figure which is underestimated by the sub-register of HIV cases mainly due to the under-notification of cases.

In 2004, a piece of data on the sex worker population was presented. Out of 3734 who attended a STI/HIV/AIDS control unit, 1897 had a HIV test and only two sex workers tested positive. This represents 0.1% in accordance with the study carried out by this CCSS unit.

	Percentage
Percentage of the most-at-risk population that is infected with the HIV virus	0.23%

Conclusion of the indicator

"As for HIV, the country does not have reliable statistics on the incidence of the virus in the general population or the main groups at risk." (1998-2003 National HIV/AIDS accounts. Expenditure and financial movements for HIV/AIDS). This is also reflected in the statement made by various civil society members who participated in the workshop aimed at sharing the results, namely, that there was a sub-register for HIV/AIDS data, principally in the recording of HIV-positive people.

Impact

1. Reduction of HIV prevalence among young people aged 15-24

The composition of the national population in 2004 reflects that 19.8% is represented by young people aged 15-24, or 839,247 young people. In accordance with data from the Ministry of health statistical information unit, 39 AIDS cases were recorded in 2004 from this age group which represent 43.3% of the 90 cases recorded that year (preliminary figures). However, there is no information on HIV cases in this age group and therefore prevalence cannot be determined.

In line with the sources consulted, the data to calculate this indicator is not available and it cannot therefore be incorporated as a result.

	Percentage
Reduction of HIV prevalence in young people aged 15-24	ND

Conclusion of the indicator

Effort should be concentrated in the country by creating a single HIV/AIDS surveillance information system that enables the creation or application of instruments for the

⁶ UNAIDS. Costa Rica: Epidemiological Fact Sheets on HIV/AIDS and Sexually Transmitted Infections.

generation and obtaining of information on people who have HIV. This in turn should reduce the number of sub-registers which exist in the country.

2. Reduction of mother-to-child transmission (% of children infected by HIV)

HIV/AIDS incidence among pregnant women stands at 0.2%. In 2003, there were 45 pregnant women infected with HIV/AIDS; the disease was transmitted to seven children. In 2004, there was only one child infected out of the 35 registered cases. Currently, there are 50 children infected with HIV/AIDS due to maternal transmission⁷ and these children are being treated in the national children's hospital.

An instrument: "Guide: recommendations for the prevention of perinatal transmission of the Human Immunodeficiency Virus in Costa Rica" has been elaborated in this field which briefly mentions the importance of appropriate screening of pregnant woman by means of the ELISA test. However, the document does not consider important aspects from the point of view of epidemiological surveillance (steering and operational) according to the level of care. Health authorities observe that standardised and uniform implementation of screening at a national level has been difficult especially on a primary care level, which is the level at which most pregnant women are seen.

Another reason why screening pregnant women is not carried out methodically by comprehensive care services was the lack of planning of the necessary materials (for carrying out the test) as well as the method used for the reference and counter reference of results between different levels (metropolitan clinics, health areas and national and regional hospitals) which are the only ones which have the infrastructure to carry out this analysis.

Another important aspect is the fact that due to the absence of protocols for the epidemiological surveillance of HIV/AIDS, the laboratories that carry out tests do not have the appropriate information systems to identify the screening test for pregnant women.

Despite the fact that records must be reinforced for their systematisation and integration into an information system, the value of this indicator refers to 2004, which recorded a total of 35 HIV-positive mothers and only one case of an infected child.

	Percentage
Reduction of Mother-to-child transmission (% of children infected by the HIV virus)	2.86%

⁷ Children of HIV-positive mothers who attend the national children's hospital have to wait 18 months for a definitive diagnosis on their results due to the fact that the child may still have maternal antibodies. Treatment begins following a positive diagnosis of the disease and two high viral load counts.

Conclusion of the indicator

From 2003 to 2004, the number of recorded cases of mother-to-child transmission dropped. While in 2003, 15.6% of the 45 children born to HIV-positive mothers were diagnosed with HIV, in 2004 the figure was 2.86% of the 35 cases recorded.

Just as with the indicators on the most-at-risk population and those that refer to HIV in particular, the country must strengthen its measures through the formal constitution of a national surveillance structure that monitors the statistical and diagnostic data and the capacities that the country has on HIV/AIDS.

3. Other important data which have an impact on the national response to HIV/AIDS
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A notable aspect in the country was the reduction of mortality due to AIDS from 2003 to 2004 as reflected in the data supplied in the institutional report by the Ministry of Health for 2004.

While in 2003 there were 136 deaths caused by AIDS, or a rate of 3.26 for every 100,000 inhabitants, in 2004 the figure was 118 deaths, or a rate of 2.78 for every 100,000 inhabitants.

V. Conclusions and recommendations

The effort made by all collaborators in the participatory workshops and individually inside their organisations, with the aim of responding to the UNGASS report for 2005, has meant that this report could be drawn up.

The country has basically responded to ten UNGASS indicators of which seven have received either total or partial responses. The majority of indicators with a lack of information correspond to actions aimed at prevention, most-at-risk populations and the identification of the impact, i.e. HIV incidence in these groups. Given the circumstances, the last participatory workshop highlighted the enormous task at hand befalling both the government and civil society to gather this information, not with the simple aim of completing a report but rather due to the importance this has in taking decisions and leading policies and strategies that the country must have to fight HIV/AIDS.

The following recommendations are listed in the hope that this is just the beginning of new comprehensive and national actions which aim to improve the quality of life of people who live with HIV/AIDS and strengthen the national response to this disease.

1. Constitution of a HIV/AIDS surveillance unit in the country and the integration of a single national surveillance system with information generated by institutions that work on HIV/AIDS.
2. Consolidation and integration of information collection instruments (surveys, censuses) on HIV/AIDS at a national level. A health module that includes HIV/AIDS should be integrated into the household surveys.
3. Integrate UNGASS indicators into the national strategic plan as part of the national response to the epidemic.
4. Dissemination of UNGASS indicators within CONASIDA and civil society networks in response to the commitment made by the country.
5. Strengthen the national information system on HIV/AIDS.
6. Strengthen CONASIDA and its technical secretariat so that it has its own resources and actively bring other important players into the Committee (ICT, MEP, INA, the private sector).
7. Strengthen participatory events and those for the dissemination of results and the formulation of policies and strategies to share the actual HIV/AIDS situation in the country.

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Appendices

Appendix n° 1: Work plan

To complete the UNGASS country report that is to be presented in December this year, the following work plan is outlined. It is made up of three chapters corresponding to the way the consultation process was carried out and how the final report's layout.

The working methodology is characterised by its participatory nature and CRIS is used as a means to facilitate the collection and processing of information to determine how far the country has complied with the UNGASS agreement.

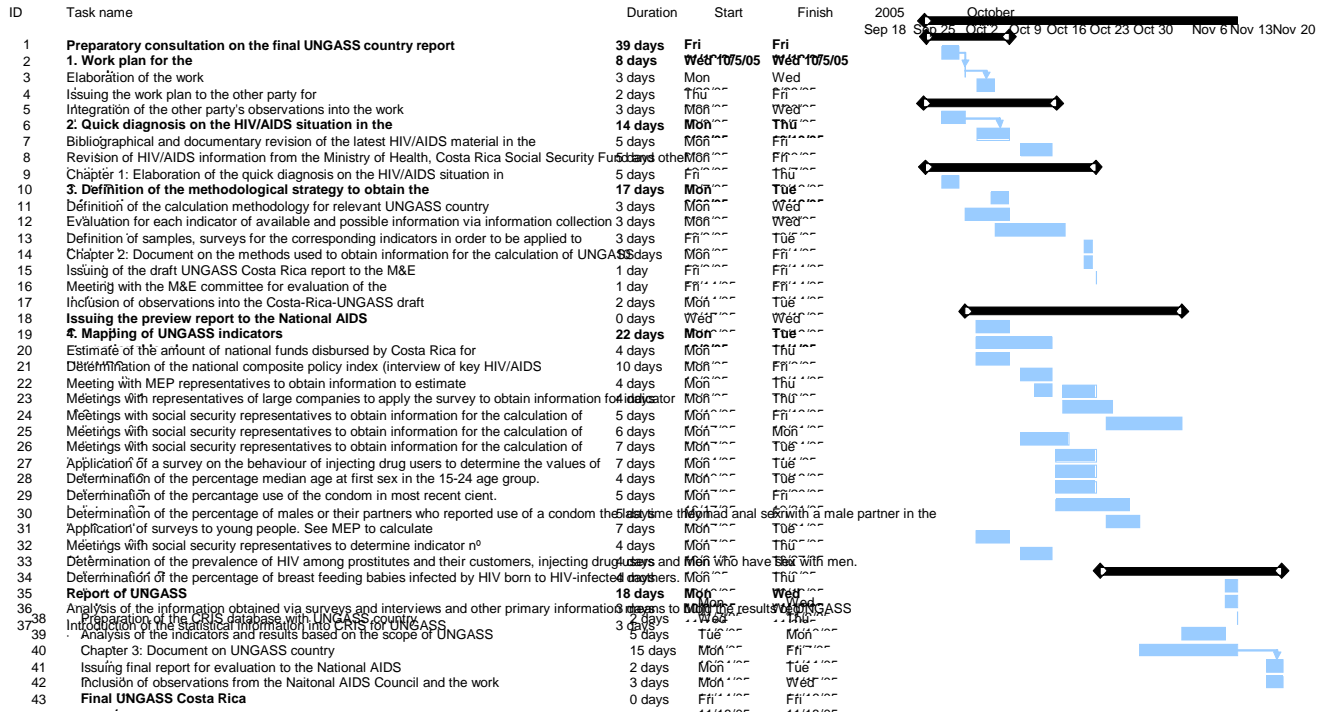
We also hope to continue with the UNAIDS guide for the correct determination of UNGASS indicators so as to establish the true dimension of the indicator in a global interpretative framework and its suitable analysis.

The first chapter refers to a quick diagnosis of the current situation on HIV/AIDS in the country in the context of the generation of information and updating of national indicators on this pandemic. The second chapter contains the method by which the country report will be tackled. Therefore, the phases are mentioned for the determination of the country's UNGASS indicators and the way in which the CRIS indicators will be used as an instrument to complete the UNGASS results. The third chapter deals with indicator analysis and results in which country compliance with UNGASS agreements on each target established in the indicator is highlighted.

We are interested in this report being structured in such a way as to serve as a guide for future reports with the aim that this process is useful for setting up a national M&E committee to follow up the agreements and actions on HIV/AIDS in the country.

The information collected on indicators will also be processed through CRIS, as is the information held in the databases of national projects on this disease. This is in order to consolidate - as a starting point - current information on HIV/AIDS which can be used as resources for decision-making so as to improve the quality of life of people living with HIV/AIDS and their families.

Final report on UNGASS commitments in Costa Rica 2005



Appendix n° 2: List of participants involved in drafting the UNGASS Costa Rica Report 2005.

- Patricia Arce, Ministry of Education
- Dr. Patricia Allen, Ministry of Health
- Dr. Johanna Sandí, San Juan de Dios Hospital
- Dr. Antonio Solano Chinchilla, Calderón Guardia Hospital (HCG)
- Dr. María Paz León B, México Hospital
- Dr. Solom Chavarría, HIV/AIDS Control Unit, CCSS
- Dr. Manuel Moraga, HIV/AIDS Control Unit, CCSS
- Dr. Gloria Terwes, HIV/AIDS Control Unit, CCSS
- Dr. Nora Quirós, HCG Clinical Laboratory
- Ana Victoria Valdivia, CIPAC/Human Rights
- Carlos Alfaro, Fight against HIV/AIDS Movement
- Marco Díaz, PAIA. CCSS
- Cinthia Chacón, Costa Rica Demographic Association
- Luis Leiva, ASOVIHSIDA
- Ginet Vargas, Hivos
- Marianne Arends, HIV/AIDS Focal Point, ILO
- Cristian Vargas, UNAIDS Costa Rica
- Dr. Jessica Salas, Global Fund
- Dr. Guiselle Lucas, Advisor to the Deputy Minister for Health
- Lcda. Patricia Salgado, UNFPA-CR Representative
- Dr. Francisco Cubillo, Deputy Minister for Health and Chairman of CONASIDA.