

# National STI/HIV/AIDS Programme UNGASS COMMITMENT PROGRESS REPORT

Annelise Hirschmann  
National Programme Director  
STI/HIV/AIDS  
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*[Ministry of Public Health  
Official Logo]*

**NATIONAL REPORT  
GUATEMALA**

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## INTRODUCTION

Guatemala is a country located on the extreme northern part of the Central American isthmus. It is bordered to the north and west by Mexico, to the south by the Pacific Ocean and to the east by El Salvador, Honduras, the Caribbean and Belize. Its geographical coordinates are 15° 30' North, 90° 15' West.

Guatemala has a total area of 108,889 km<sup>2</sup> and a warm climate that predominates all year round. The lower coastal areas are warmer as are the arid parts to the east of the country and the subtropical rainforest in the north. The rest of the country is covered by two mountain ranges. The temperature in these areas tends to be fresh and variable according to the season. The temperature drops during the rainy season.

Of the 11.2<sup>1</sup> million inhabitants in Guatemala, 40% of the population descends from American Indian/indigenous nations with a predominantly Mayan ethnic background. *Mestizos* (European/indigenous) and *criollos* (whites of Spanish, German and other European origin) are known as *ladinos* and comprise nearly 60% of the population. There is also a low percentage of Afro-Caribbeans who live on the Atlantic coast.

The majority of the Guatemalan population is rural although there is an accelerated pace of urbanisation. Migratory movements from the countryside to the city mean that more than 40% of the population is currently concentrated in the country's main cities. Other types of significant internal migration are those that occur annually from the Guatemalan plains towards the south coast, especially during the harvesting of sugar beet and coffee.

The main religion is Catholicism, to which many indigenous Guatemalans have added other forms of prayer. Protestantism and traditional *Mayan* religions are practised by 33 % of the population.

Although the official language is Spanish, this is not universally used among the indigenous population. Twenty-three autochthonous languages are spoken in Guatemala; the majority of these are of Mayan origin, with the exception of Xinca and Garífuna.

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<sup>1</sup> National Statistics Institute, 11th National Population Census and 6th Housing Census, 2002

The national response to the epidemic has not been easy due to the complexity of Guatemala's social fabric and the extreme poverty which exists.

According to the World Bank's classification, Guatemala is a low to middle-income country and the socio-economic pyramid <sup>2</sup> breaks down as follows:

> Superior level (AB)	2%
> Intermediate level (C+, C, C-)	25%
> Popular level (D, D-)	33%
> Marginal level (E and F)	40%

This situation is explained by the conditions of poverty that affect 57% of the population and extreme poverty that affects 26.8%.

The health service system in Guatemala <sup>3</sup> is highly segmented in terms of the populations covered. The highest income group uses private health care facilities and formal sector workers are covered by the social security system (+/-11% of the population). More than half the population depends on the network of public health services maintained by Ministry of Public Health and Social Welfare resources, which come from the general budget.

The political and economic climate that the country is going through impacts on the health situation and service provision. The worsening trade balance due to the drop in the volume and prices of the main exports, the depreciation of the national currency, the quetzal, and the deterioration of its purchasing power have all had an impact.

The fragility of the public service system from a financial perspective is reflected in the difficulties in extending the coverage of basic services to the indigenous, poor and farming populations in rural areas as well as the populations which are marginalized and excluded due to their sexuality, these being the populations that are most-at-risk to HIV in Guatemala.

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<sup>2</sup> Biannual study on income and consumer habits by Corporate Intelligence of the LVI Group, January 2004

<sup>3</sup> Guatemala initiative to the Global Fund for AIDS, Country Coordination Mechanism, 2003

The emergence of the AIDS epidemic, characterised by rapid growth and significant costs, competes for the service system's sparse resources. This poses a serious problem as the country cannot shoulder the enormous financial burden of the drugs required. In addition to this, the efforts made by the Ministry of Health on prevention and patient care are constricted by the small budget and the lack of interest shown by society in general to respond to the epidemic effectively. This does not mean that there is no effort by society to reduce the impact of the epidemic, but we have to recognise that this is limited and mainly concerns Guatemala City and a few other cities

Although significant achievements exist in the areas of legislation, access to treatment, prevention, training of social networks of at-risk groups and others, it is also true that much remains to be done. Stigmatisation and discrimination are still an impassable barrier. Also, access to ART is not universal although many people have managed to gain access. Prevention campaigns focus on the Spanish-speaking population but it has not been possible to overcome the language barrier and reach out to indigenous communities.

These obstacles are the challenges at hand and those which we must tackle to significantly minimise the harm inflicted by the HIV epidemic in the country.

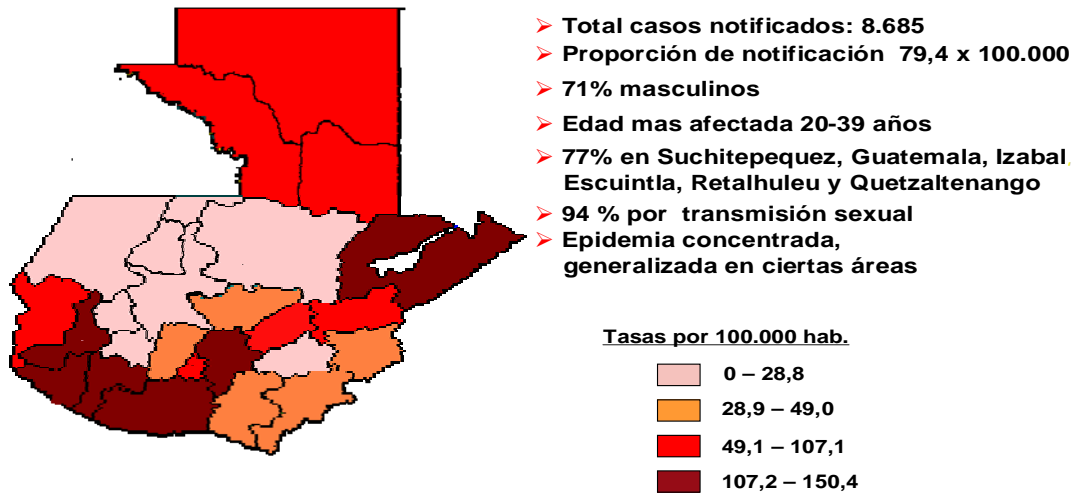
The Declaration of Commitment approved in the United Nations General Assembly Extraordinary Session on HIV/AIDS held in June 2001 in New York established the need to follow-up the achievement of the goals set out in the Declaration. After the 2003 country evaluation, it was noted that achievements had been limited. That is why it is important to measure the extent to which the 2005 targets have been fulfilled; this document aims to do just that.

We would like to highlight the enormous difficulties in collecting information due in part to the lack of a national surveillance and evaluation system. This has meant that the information is not up-to-date in some cases and varies between the different authorities, which in many cases have valuable data but which has not been integrated into a national information system, thus making its dissemination problematic.

## I. STATUS AT A GLANCE

From January 1984 to August 2005, 8685 AIDS cases were reported (rate according to cases notified of 79.4 per 100,000 inhabitants)<sup>4</sup>. The HIV/AIDS surveillance system was modified in June 2003. This has enabled better monitoring of the actual system.

### Caracterización de casos SIDA, Guatemala, 1984-agosto 2005



(\*) Según datos PNS, 2005

- > Nature of AIDS cases, Guatemala, 1984 – August 2005
- > *Total cases notified: 8685*
- > *Proportion of notification 79.4 x 100,000*
- > *71% male*
- > *Most affected age 20-39*
- > *77% in Suchitepequez, Guatemala, Izabal, Escuintla, Retalhuleu and Quetzaltenango*
- > *94% due to sexual transmission*
- > *Concentrated epidemic, generalized in certain areas*

#### Rates per 100,000 inhabitants.

0 - 28.8

28.9 - 49.0

49.1 - 107.1

107.2 - 150.4

(\*) According to National AIDS Programme data, 2005

<sup>4</sup> National programme for the prevention and monitoring of STI/HIV/AIDS

The departments with the highest rates are:

Suchitepéquez (150.1)

Guatemala (149.5)

Izabal (136.8)

Escuintla (128.2)

Retalhuleu (127.1)

Quetzaltenango (109.7)

77.3% of notified AIDS cases concern these six departments, of which 38.18% correspond to the Department of Guatemala. It is noteworthy that these departments are characterised by their high levels of production and trade. 65.4% of AIDS cases were reported between 2000-2005. Data for the rest of the country is presented in the following table:

#### **Notified AIDS cases by department**

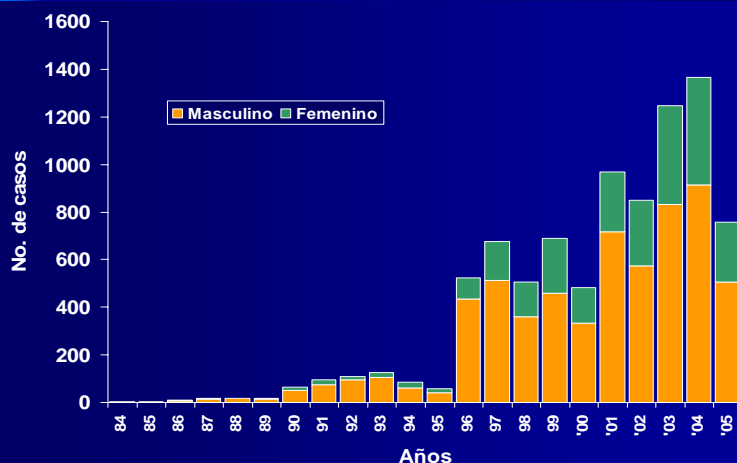
January 1984 - August  
2005

DEPARTMENTS	PERSONS NOTIFIED	2005 population (According to the National Statistics Institute)	Rate per 100,000 Inhabitants
Suchitepequez	599	355,936	150.4
Guatemala	3,316	449,064	149.5
Izabal	499	266,286	136.8
Escuintla	771	609,478	128.2
Retalhuleu	337	2,82,400	127.1
Quetzaltenango	675	690,057	109.7
Sacatepequez	198	207,150	99.3
Zacapa	162	277,518	93.8
El Progreso	92	145,302	78.8
San Marcos	517	887,948	66.4
Peten	170	315,770	56.2
Santa Rosa	121	489,210	41.9
Baja Verapaz	74	236,419	36.5
Chiquimula	98	328,248	36.1
Jutiapa	119	400,847	31.1
Chimaltenango	111	272,454	29.2
Jalapa	60	515,832	28.7
Solola	54	362,151	20
Alta Verapaz	127	923,428	19.2
Quiche	97	777,999	15.1
Totonicapan	46	394,567	14
Huehuetenango	73	973,556	9.1
No data	369		
<b>Total</b>	<b>8,685</b>	<b>12,700,620</b>	<b>79,4</b>

Source: National AIDS Programme database

The male ratio shifted from 8:1 in 1988 to 2:4 in 2005 and its marked decrease began in 1997. This clearly shows that there is a growth trend for the epidemic in the general population since the number of infected women has increased.

## Casos SIDA notificados según género, Guatemala enero 1984 – agosto 2005



Fuente: Unidad de Informática, Departamento de Epidemiología

### Graph legend

*Notified AIDS cases according to gender, Guatemala January 1984 – August 2005*

*Nº de casos - N° of cases*

*Años - Years*

*Masculino - Male*

*Femenino - Female*

*Source: Information Technology unit, Department of Epidemiology*

83.2% of all cases occurred in the 15-49 age group. The 20-34 age group represented 52.11% of all cases. The most frequent transmission route is sexual (94.43%). There are no cases reported with transmission by injecting drug use (IDU). It is known that the sub-register may exceed 50%.

As the country has the characteristics of **a concentrated epidemic** in men who have sex with men and sex workers, we have included the following indicators in this report:

### **Core indicators:**

1. Amount of national funds disbursed by the governments in low and middle-income countries
2. National Composite Policy Index.

3. Percentage of most-at-risk populations who received HIV testing in the last 12 months.
4. Percentage of most-at-risk populations reached by HIV prevention programmes.
5. Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.
6. Percentage of female and male sex workers reporting the use of a condom with their most recent client.
7. Percentage of men reporting use of a condom the last time they had anal sex with a male partner.

**Impact:**

8. Percentage of most-at-risk populations who are HIV-infected.

## **II. OVERVIEW OF THE EPIDEMIC**

Seroprevalence figures taken from research carried out between 1988 and 2003 enable the analysis of the trends among most-at-risk populations: men who have sex with men (MSM), female sex workers (SW) and pregnant women.

These figures show that the HIV/AIDS epidemic is moving from a low level (seroprevalence less than 5% in high risk groups) to a **concentrated level** (HIV seroprevalence above 5% in high risk groups and less than 1% in pregnant women).

Results from the multi-centre study on HIV and STI prevalence and behaviour among MSM <sup>5</sup> reveal that HIV prevalence among the 165 MSM studied stands at 11.5%. This places this group as the most affected and the group which is in the most vulnerable situation as a whole, well above the rest of the population.

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<sup>5</sup> Multi-centre study on HIV and STI prevalence and behaviour among MSM in ports and the capital, PASCA, Guatemala 2002.

In the case of female sex workers, the trend according to studies carried out in 1991 in Guatemala city, Antigua Guatemala, Puerto Barrios and Escuintla has shown an accelerated increase in the level of HIV infection, moving from 0.45% in 1992 to 2.7% in 1998 and 4.7% in 2000 for Guatemala city; similarly, there was a change from 0% in 1991 to 10% in 2000 in Puerto Barrios, Izabal. This makes this group the second most affected.

In relation to pregnant women attending prenatal check-ups, the National programme for the Prevention and Control of STI/HIV/AIDS, according to a study carried out in 1998, showed that the levels of HIV infection varied from 0% in the Puerto Barrios health centre, to 1.7% in the Los Amates, Izabal and Escuintla health centres.

During 2002-2003, studies conducted in the same population in chosen municipalities exceeded 1% in at least two of these municipalities (Retalhuleu and San Marcos).

### **AIDS and Tuberculosis coinfection**

In 1996, 33.6% (1149) out of a total of 3422 patients being treated for tuberculosis agreed to undergo HIV testing. 5.5% of these (63 cases) resulted positive. Between 1997 and 2000, the number of HIV-positive cases rose from 3.9% to 9% and studies carried out in Quetzaltenango show that in 1995, 1996 and 1997, HIV prevalence in tuberculosis patients stood at 5% and increased to 9.3% in 1998.

In Roosevelt Hospital, 50% of people with tuberculosis are infected with HIV and 21% of those with HIV develop tuberculosis. In 2003, HIV+ prevalence in a sample of tuberculosis patients reached 14.4%. This proves that tuberculosis is the most frequent opportunistic infection among AIDS patients.

Looking at the problem from the perspective of AIDS cases associated with tuberculosis, the proportion exceeds 20% in notified cases, which makes it the most frequent opportunistic disease associated with AIDS. To this we have to add the ever-increasing presence of the multi-drug resistance of bacillus, which is resistant to first and second line treatments.

The care and treatment of HIV patients is still concentrated in the country. The most important care services are located in the two large hospitals in Guatemala City (San Juan and Roosevelt). Care is also provided in the Puerto Barrios hospital, the national hospital and the LIFE Project in Coatepeque, Quetzaltenango.

In these facilities, medical care is mainly offered for opportunistic infections and antiretroviral therapy. This is provided by various sources including *Médecins Sans Frontières*, the Global Fund and the Guatemalan government.

The Guatemalan Social Security system also provides treatment to contributors. By the end of 2005, approximately 2400 people were receiving antiretroviral therapy. Nevertheless, this service is limited to the infectious diseases clinic in area 7 of Guatemala City.

Beyond medical care, there has been significant improvement in, for example, laboratory services, consultancy, psychosocial support and referrals. This cannot be considered a success, however, given the limitations to cover the population's demands and the centralised nature of the services.

It is important to note the role that people living with HIV and some civil society organisations have played in the last few years by actively participating in, for example, information activities, the training of support groups and the provision of emotional support.

Despite this, it has not been possible to cover the total national demand for care. This is, in principle, due to geography and the centralised nature of the services which stops people living in extreme poverty from reaching the cities where specialised medical care is provided.

The lack of resources to ensure minimum quality care for all PLWHA in the country must be mentioned as this affects this group's quality of life and the significant reduction in the number of deaths caused by AIDS.

### **III. NATIONAL RESPONSE TO THE AIDS EPIDEMIC**

Action has been carried out in the field of prevention since the end of the 1980s, mainly, as part of a weak and incipient effort by civil society. Over time these activities have gathered force as more sectors got involved in the activities.

In the mid-1990s, educational activities began with sex workers, men who have sex with men and young pupils. Other events with prisoners, housewives, migrants and other groups in general were added. This process included models related to behaviour change, the *BEHAVE framework* ('*cadena de cambios*'), peer education, training of leaders, holistic workshops and other activities.

Since 1997-1998, PASMO (Pan American Social Marketing Organisation) has implemented education and behaviour change strategies while incorporating the social marketing of condoms. At the end of the 1990s, the standardisation of a syndrome-based approach to the management of STIs and the first pilot experiments began. Between 2002-2003, this process was consolidated and implemented at the second level of care. However, current coverage is below 50 %. Nevertheless, there is an intention to extend coverage to all priority health districts in 2006.

In 2005, an information, education and communication plan was developed aimed at behaviour change based on community participation with a multi-sectorial, gender and multi-ethnic approach. This plan is in a preparatory phase and it is hoped that it will be launched at the start of 2006.

In 1998, the Ministry for Public Health's National Programme for the Prevention and Control of STI/HIV/AIDS began to administer AZT to HIV-positive pregnant women to prevent mother-to-child HIV transmission (PMTCT). In 2003, a structured PMTCT programme began in the Roosevelt Hospital. These successful measures are being expanded nationwide with the support of UNICEF and the Global Fund. It is hoped that in 2005, a total of 61 districts will be applying the strategy through the Country Coordinating Mechanism and the Ministry of Public Health.

The indicators selected for Guatemala and their relevant information are shown below.

#### **INDICATOR 1. Amount of national funds disbursed by governments in low and middle-income countries**

Spending on HIV/AIDS and its development over time is reflected in the national health account system, which consists of a systematised matrix analysis of the financial flows aimed at the prevention, management and supply of HIV/AIDS services<sup>1</sup>. Despite not having information on 2004 to 2005, we believe that the data from 2002 and 2003 reflects the trend of growing investment.

The budget for 2002 was Q98,437,706.03<sup>2</sup>. There was a significant spending increase in 2003: Q126,014,830.80. This clearly shows a rise in spending. This may be due to the rise in demand caused by a larger number of people requiring direct care.

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<sup>1</sup> Original is unclear (Translator's note)

<sup>2</sup> 1 GTQ = 0.13 USD (Translator's note)

For 2002 and 2003, the higher amount of investment concerns social security and is mainly aimed at the care of contributors living with HIV. Both for central government and the Guatemalan Institute of Social Security (IGSS) spending, the investment goes to the purchasing of antiretroviral drugs, reagents and other materials for care. This is followed by other actions such as spending on hospitalisation, prevention, etc. However, it is necessary to highlight the contribution made by other collaborators:

### Multilateral bodies

Body	2002	2003
Multilateral agencies	Q.2,216,611.00	Q.2,530,290.44
Bilateral bodies	Q.6,404,646.20	Q.5,479,252.14
Other international non-profit bodies	Q.10,186,581.00	Q.15,465,445.00

*Source: National Health Accounts. 2002/2003*

Other sources of finance concern other state authorities, national and international NGOs and other international bodies.

### Budget for the National STI/HIV/AIDS Programme, awarded by the Ministry of Public Health and Social Welfare

Year	Budget awarded (GTQ)	Extension (GTQ)
2002	5,000,000	0
2003	7,000,000	0
2004	7,000,000	0
2005	10,392,200	1,419,984
2006	20,000,000	

As can be seen in the table above, the increase in investment by the Ministry of Public Health has been more than 100% in the last few years. This reflects the importance that this issue has acquired in national policies.

We do not have information on HIV expenditure made by all players involved in the response for 2004 and 2005. This means that we cannot compare the increase in such spending.

### INDICATOR 2: National Composite Policy Index

To obtain information on the National Composite Policy Index, civil society representatives (NGOs, PLWHA associations, external cooperation and the government sector) individually filled in the parts of

the document corresponding to each body. A meeting was subsequently held in which the data from the different participants was consolidated through consensus. It was not possible to achieve full consensus on the subject of care and prevention. This was due to lack of time to discuss the points that could have clashed with the responses. Nevertheless, there was little variation in differences as can be seen in those consolidated by sector, which is included in the appendix.

#### **a. Strategic plan:**

National strategic plans have been developed in Guatemala since 1996. However, there have been some difficulties in implementing these plans. This does not include all the Ministries from the executive body but only actions carried out with the Ministries of Health, Education and Defence as well as actions with the National Youth Council.

The 2006-2010 National Strategic Plan is currently being prepared. Unlike previous plans, this document has been the subject of an exhaustive consultation process with government, civil society and international cooperation representatives. This plan's action framework considers:

- a. Counselling and voluntary tests
- b. Promotion and distribution of condoms
- c. Prevention and treatment of sexually transmitted infections
- d. Blood safety
- e. Prevention of mother-to-child HIV transmission
- f. Breastfeeding
- g. Treatment and care
- h. Migration

Due to the characteristics of the epidemic, this plan is aimed mainly at most-at-risk populations in the country. These are: men who have sex with men and women sex workers. However, it does not ignore actions with other population groups such as pregnant women, uniformed personnel, adolescents at risk, prisoners, mobile populations and the general population.

Of course, there is no operational plan at the moment as we are still finalising the national strategic plan. Nevertheless, this will be drafted and implemented in 2006. However, it must be mentioned that Guatemala has integrated the issue of AIDS into national development plans and poverty reduction strategy documents.

At the moment there is no recent study on the socio-economic impact of HIV on the country.

### **b. Political support:**

To date it has not been possible to implement a multi-sectorial body. However, there is a political will in the country by means of Legislative Decree 27-2000 and the National AIDS Policy (Dec 2005) that establish the need to implement this body.

However, in the last few years the National AIDS Programme has maintained better communication with civil society and other institutions to coordinate national efforts in all fields. In fact, technical committees have been established to standardise care and diagnosis, etc. These committees are led by the National AIDS Programme but with multi-sectorial participation.

### **c. Prevention**

In the area of prevention, the National AIDS Programme has worked this year on the formulation of the national strategy for information, education and communication. This establishes the general lines of intervention lines for the various groups who will benefit from the programme.

AIDS and sexual and reproductive health have been introduced into the school curriculum. However, this only concerns primary, and not secondary, schools. It should be mentioned that actions in schools are still being carried out in an isolated manner and as a result of the work of NGOs in some areas of the country.

In the area of most-at-risk populations, there is specific work on information, education and communication performed by NGOs who play a leading role in access to sex workers and men who have sex with men. Small programmes are also carried out with prisoners, street children and mobile populations.

In the past two years the various prevention programmes around the country have been extended. However, activities have focused mainly on urban areas. In the case of MSM, measures have mainly concerned the capital city.

In the last few years, the Ministry of Health has been improving access of most-at-risk populations to health services for voluntary testing with counselling, STI care and condoms. Sentinel sites have been established for STIs and the prevention of MTC HIV transmission in various regions of the country. However, female sex workers have benefited most from the service due to the compulsory sexual prophylaxis which

they undergo. To date, there has not been a significant number of MSM using the health services.

Currently, the Ministry of Health has programmes for blood safety and the prenatal diagnosis of syphilis. The programme for the administration of safe injections in health care services is being enhanced day by day.

#### **d. Care and support:**

Programmes existing in 2003 on care and treatment for those living with HIV/AIDS have been maintained. However, there has been a significant increase in the number of people receiving care. This has meant not only the need to increase coverage but also the need to search for quality by developing protocols and supervising their application. Fully supported by NGOs and international bodies, we are looking to improve the quality of care. We also hope to improve the procurement and supply system and the training of personnel.

Despite all of these endeavours and the multi-sectorial effort, access is still not universal and coverage is concentrated in the country's main cities. It is hoped that with the implementation of the strategic plan we can decentralise services and thereby increase the coverage of care available to PLWHA.

In the case of AIDS orphans, these children are usually taken in by relatives. There are no policies or strategies defined to deal with this group. Nevertheless, the Ministry of Health provides funds to some organisations helping orphans so as to support their comprehensive care.

#### **e. Human rights:**

Legislative Decree 27-2000 forms part of national efforts to protect PLWHA against discrimination. This Decree guarantees access to information, care and treatment services for people living with HIV or AIDS. The penal code has also been reformed. The Policy on HIV was recently signed and approved by the President of the Republic and all of the Ministers. This policy includes guidelines to promote the respect of the human rights of people living with HIV.

However, these laws and reforms have not been widely implemented across the justice system or adopted by the general population. This constitutes an obstacle to preventing HIV-based discrimination.

Despite there being a concentrated epidemic, there are no legal mechanisms that protect or reduce the vulnerability of men who have

sex with men, sex workers, women and other groups. On the contrary, there are still laws and regulations that punish and hinder these groups from becoming rightful citizens. There are discriminatory laws in, for example, the civil, labour, penal and health codes. This makes it difficult for these groups to access education, health and employment services, etc.

Despite these difficulties, it has been possible to involve people living with HIV, sex workers and men who have sex with men in the definition of national strategic plans, the IEC strategy and the Policy on HIV. It has not been possible to do this with ethical research committees as up to now they have all been made up by doctors.

As for the collection of human rights abuses, a legal human rights network has recently been formed for vulnerable groups and people living with HIV and AIDS. The Office of the Attorney General for human rights in Guatemala has been involved in this process. Nevertheless, the only action has been the collection of abuses. There is no obligation to exercise the rights of these populations. Some NGOs are also working on the promotion of human rights and specific legal support for PLWHA. Their coverage is still very limited, however.

#### **f. Civil society participation**

Civil society has played a vital role in all of the actions that deal with the epidemic. Although not all social sectors which make up the country's social fabric are represented, organisations that work in this area have fully backed the drawing up of strategic national plans, inter-sectorial coordination, elaboration of protocols, laws and specific actions with the most affected population.

#### **INDICATOR THREE: Percentage of MSM and sex workers who received HIV testing in the last 12 months and know the results.**

Measurement instrument: special surveys, programme surveillance

Number of interviewees (from the most-at-risk population) who received HIV testing during the last 12 months and know the results

----- x 100  
Number (from most-at-risk population) included in the sample or estimation methods to determine the size of the most-at-risk population for the denominator

No information was found for this indicator. However, we used the results from the 2003-2004 multinational study on the knowledge, attitudes and practices concerning HIV, condom use and other sexual health subjects carried out by PASMO (December 2004). Three hundred

sex workers and 299 MSM from Guatemala City took part in this study. We also took the data registered on sex workers last year by the Barcelona foundation in Escuintla and data from the Association for Comprehensive Health (ASI) in Guatemala. The results are:

87% of sex workers interviewed stated that they had received HIV testing. Of these, 95% received the result. <sup>6</sup>

The Barcelona Foundation has monitored 370 sex workers in Escuintla and Santa Lucia Cotzumalguapa and carried out tests on all of the sex workers and also notified all of them of the outcome. <sup>7</sup>

The Association for Comprehensive Health reported testing 753 sex workers in Guatemala City. 100% of these received the results. <sup>8</sup>

We should clarify that this information does not reflect the real situation affecting Guatemala but only the areas that are being targeted by organisations that work with these populations.

On MSM, information held is very sparse for which reason we will only consider information from the Knowledge, attitudes and practices survey by PASMO. This survey interviewed 93 MSM who are sex workers and 206 who are not sex workers. The results were the following:

Have you ever received HIV testing?

71% of male sex workers received HIV testing.  
61.7% of MSM received HIV testing.

Of these: 98.5% of MSM sex workers and 99.2% of MSM have received the results.

**INDICATOR 4: Percentage of MSM and sex workers reached with HIV prevention programs.**

The following formula was used to evaluate this indicator:

$$\frac{\text{Number of interviewees (MSM/SW) who have had access to HIV prevention programmes.}}{\text{Number of MSM/SW interviewed}} \times 100$$

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<sup>6</sup> PASMO study. Dec 2005

<sup>7</sup> Annual report of cases attended. Escuintla 2005

<sup>8</sup> Annual report. ASI July 2004 - August 2005. Area of prevention.

Due to a lack of data, we have used the PASMO study again. However, this study did not specify that participation in prevention programmes referred to the last 12 months. Nevertheless, the information is seen as relevant due to the results presented in the study.

According to the information provided by PASMO, out of the 300 women interviewed, only 29% stated that they had participated in HIV prevention activities.

As for the 93 male sex workers interviewed, 53.8% stated that they had participated at some time in prevention activities. In the case of 206 MSM non-sex workers, 46.9% stated that they had at some time participated in prevention activities.

**INDICATOR 5: Percentage of MSM and sex workers who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.**

The numerator and denominator adapted to respond to this indicator is again based on the PASMO study. This is defined in the following way:

$$\frac{\text{Number of interviewees that correctly answered each question}}{\text{Number of interviewees that answered each of the five questions}} \times 100$$

There were six options presented in the study:

- a. Correct condom use
- b. Avoiding unsafe blood transfusions
- c. Avoiding injections when the needle is not sterile
- d. Having few partners
- e. Having only one uninfected sexual partner and remaining faithful
- f. Abstaining from sex

The most frequent answer from the 300 women interviewed was correct condom use with 97.6%. This was followed by avoiding unsafe blood transfusions (76.5%) and then injections when the needle is not sterile (75.2%). After these three responses the following practices were mentioned in descending order: having few partners (73%), having just one sexual partner who is uninfected and remaining faithful (67.5%) and finally with slightly over half of the responses, came abstinence (57.8%).

As for MSM, they showed more knowledge on practices related to condom use (94.3%), avoiding injections with needles that are not sterile (92.6%) and avoiding unsafe blood transfusions (90.3%), having few partners (89%), having just one uninfected sexual partner (89%) and avoiding having anal, oral and vaginal sexual relations (53%).

**INDICATOR 6: Percentage of men reporting use of a condom the last time they had anal sex with a male partner.**

To respond to this indicator we again took the PASMO study related to condom use the last the interviewee had anal sex as a reference. This was stratified between male sex workers and MSM. A quantitative analysis was carried out in the following way.

$$\frac{\text{Number of interviewees who used a condom the last time they had sex}}{\text{Number of interviewees who answered the question}} \times 100$$

76% of interviewees used a condom the last time they had sex.

**INDICATOR 7: Percentage of MSM and sex workers who are HIV- infected**

We do not have specific information on the percentage of most-at-risk populations who may be infected with HIV. However, the National AIDS Program, based on studies carried out with some populations and data obtained by the 2002-2003 multi-centre study on sex workers and MSM, presents the following information:

Infección VIH y otras ITS en grupos específicos

Tendencias de la prevalencia (\*):

- ❖ **Hombres que tienen sexo con hombres con 11,5% para VIH y 12,7% para sífilis**
- ❖ **Trabajadoras comerciales del sexo con 8,7% para VIH**
- ❖ **Embarazadas con 1,4% para VIH en San Marcos**
- ❖ **Uniformados con 0,7% para VIH**

(\*) Investigaciones múltiples sobre seroprevalencia de VIH y otras ITS

## *HIV infection and other STIs in specific groups*

### *Prevalence trends (\*):*

- ❖ *11.5% HIV-infected and 12.7% syphilis-infected men who have sex with men*
- ❖ *8.7% HIV-infected sex workers*
- ❖ *1.4% HIV-infected pregnant women in San Marcos*
- ❖ *0.7% HIV-infected uniformed personnel*

*(\*) multiple research on HIV prevalence and other STIs*

## **IV. MAJOR CHALLENGES FACED AND ACTIONS NEEDED TO ACHIEVE THE UNGASS GOALS AND TARGETS:**

In order to construct the core indicators for the follow-up to the UNGASS Declaration of Commitment, we have come up against the difficulty of obtaining up-to-date and coherent information which had been requested. This may be due to the lack of a national information system capable of collecting the results of the work performed by the various players in the national response to the epidemic. However, we know that we do have valuable and significant information on the achievements made. Nevertheless, this information is disparate and in some cases access is difficult.

Some problems are:

1. The general health information system (SIGSA) does not provide up-to-date and permanent information on the epidemic in Guatemala and it only provides a minimum amount of data on the epidemic.
2. There are not enough second-generation surveillance studies or sentinel studies to monitor the epidemic in specific groups better. This makes it difficult to plan actions on certain groups in specific geographical areas.
3. Information collected on specific aspects related to prevention, care, support, human rights and others, carried out by civil society, is in some cases in the hands of organisations involved in this type of work. Not all of them have managed to build databases that let them quantify the achievements made by their activities.
4. Although the epidemic is concentrated in the country, instruments from the Ministry of Health do not generate precise information on the most vulnerable groups, specifically MSM. In the case of sex workers, more information may be found through the compulsory check-ups which they undergo. Despite this, there are significant shortfalls

concerning reporting at a national level. Therefore, many services do not present information on STIs among these groups.

5. There are more educational activities in the capital city followed by small-scale measures in the southwest of the country and along the Atlantic coast. However, the latter are not significant and in the majority of cases constitute isolated and poorly coordinated actions.
6. Prevention activities with sex workers and men who have sex with men have not managed to cover the whole country. In fact, the main civil society organisations that work with these populations are concentrated in the capital city. There are small and isolated efforts in other areas of the country, mainly in the southwest.
7. There are efforts from different collaborators to care for the population in general (including schoolchildren). However, there is no evidence of close coordination relationship between them and the highest levels of the Ministry of Education. Nor has there been a national education policy for prevention with this population group.
8. We need to promote more systematic prevention activities with prisoners, adolescents at risk, youth gangs ('*maras*') and indigenous groups, in particular, given that the *Mayan* population makes up nearly half of the country's population. Despite this, there is very little experience of prevention work with these groups which has been adapted to their mother tongues.
9. Access to drugs has been provided in the main by *Médecins Sans Frontières* followed by the Guatemalan Institute of Social Security and the Guatemalan government. But this is centralised in three, which makes access difficult for people who need drugs but who live in distant rural areas and whose situation of extreme poverty prevents them from travelling.
10. Access to HIV testing is still limited throughout the country. This is concentrated in a few cities but Area directors need to be involved in budgetary planning to include the purchasing of reagents for quick tests and facilitate access in particular to most-at-risk populations so as to obtain more accurate data on the actual situation of the epidemic in the country.
11. Despite the substantial effort made by the National AIDS Programme and other civil society organisations to train health personnel with the aim of reducing stigmatisation and discrimination, health personnel still reject sex workers, MSM and people living with HIV. This acts as a barrier to bringing these groups closer to services due to their fear of discrimination when they require care.

12. Although a legal network already exists for the human rights of people living with HIV and most-at-risk groups, this is only limited to collecting abuses of their fundamental rights. We need more involvement of other sectors in society to strengthen this partnership and promote action that enforces the rights of those affected and avoids violations in the future.
13. Current laws mean that STI and HIV interventions among adolescents who are sexually exploited, homosexual adolescents and other adolescents living in vulnerable conditions are limited. As long as the laws remain unchanged, intervention among these populations will be difficult. Civil society needs to be active so that these changes may occur.
14. There is no strong relationship with the Guatemalan judicial system. In fact, there is no information on awareness-raising campaigns for law-enforcing personnel in Guatemala. This makes it difficult to apply the laws meant to protect affected groups as the law-enforcers do not know about these laws.
15. To date there is no data on the existence of people who have been infected through needle sharing or data on drug users. More research will have to be carried out on this type of population to ascertain the actual situation.
16. There is no specific information on the situation of HIV orphans. There is a perception that these children are taken in by their relatives but it is important to know more on this subject. We only have data on two households supported by the Ministry of Health that have a small number of orphans living with HIV.

## **V. SUPPORT REQUIRED FROM THE COUNTRY'S DEVELOPMENT PARTNERS.**

It is important that the different players carry out the following action as part of the national response to the epidemic:

1. Support for the implementation of the national strategy for information, education and communication for behaviour-change.

This component is fundamental as it will guide the efforts of the various bodies under a national plan for HIV prevention among most-at-risk populations and other groups in society in general. Local and national efforts will be integrated into this plan. This plan has already been drawn up and its implementation will depend on the active

participation of all players involved in the national response to the AIDS epidemic.

2. Guarantee of universal care and treatment for people living with HIV.

For this component, the need of ensuring universal and free access to ART for those needing treatment is important. This will lead to a significant rise in public spending, decentralisation of care, training of human resources and creation of an infrastructure in different areas of the country. It is important to include local organisations, groups of people living with HIV and the private sector in this measure.

3. Reduction of the stigma and discrimination towards the groups most-at-risk of acquiring HIV.

It is important to carry out massive awareness campaigns targeted at the general population and health personnel, in particular, on non-discrimination towards MSM, sex workers and people living with HIV or AIDS. This will improve measures introduced among these groups and bring them closer to health services. This could have positive effects as it will facilitate the development of information and prevention programmes aimed at these groups.

It is also important to make sure that the laws which protect these groups are respected and that when laws do not exist that they are created to at least ensure that they are allowed to enjoy the fundamental rights that the country's constitution grants to all of its citizens.

4. Strengthening inter-sectorial participation in the national response to the AIDS epidemic.

The inclusion of groups of people living with HIV, MSM and sex workers in the formulation and implementation of plans and programmes for prevention, care and support will determine the quality of such plans and programmes. Therefore, the formation of new groups should be encouraged and already existing groups supported by strengthening their institutional capacities so that they can carry out their work plans.

5. Development of a national surveillance and information system.

It is important to develop a single system at the level of the Ministry of Health and other ministries so as to have more accurate tools for quick, appropriate and accurate information on the epidemic's development so that specific decisions may be taken and appropriate interventions carried out where necessary. This should be done by

ensuring that the system includes aspects related to most-at-risk populations such as MSM and sex workers, given that the epidemic in the country is still concentrated.

## **VI. SURVEILLANCE AND EVALUATION SYSTEM**

To date, the country does not have a national surveillance and evaluation plan. Consequently, there is no specific budget for actions of this kind. This is being developed jointly with the 2006-2010 national strategic plan, which is to be implemented in 2006.

The information gathered on STI/HIV and AIDS is by means of a small unit in the Ministry of Health that is responsible for monitoring the work of ALL Ministry of Health programmes through the general health system (SIGSA). It is therefore difficult to comply with the requirements for information on HIV.

The information obtained nationally on HIV is limited to epidemiological surveillance and its analysis. It should be recognised that national efforts on the subject are still incipient and must be developed.

**APPENDIX:  
NATIONAL COMPOSITE POLICY INDEX (NCPI)**

**PART A.  
GOVERNMENT**

**I. STRATEGIC PLAN**

**Has your country drawn up a national multi-sectorial strategy/action framework to combat HIV/AIDS?**

1. Yes

**1.1. IF YES, which sectors are included?**

Sectors included	Action framework	strategy	Focal point/representative
Health	Yes		Yes
Education	Yes		Yes
Labour	No		No
Transportation	No		No
Military	Yes		Yes
Women	No		No
Youth	Yes		Yes

**Comments:** 'women' are in the process of being integrated.

**1.2. IF YES, does the national strategy/action framework address the following areas?**

PROGRAM	
a. Counselling and voluntary tests?	a. YES
b. Condom promotion and distribution?	b. YES

c. STI prevention and treatment?	c. YES
d. Blood safety	d. YES
e. Prevention of mother-to-child transmission?	e. YES
f. Breastfeeding?	f. YES
g. Care and treatment?	g. YES
h. Migration?	h. YES
TARGET POPULATIONS	
i. Women and girls?	i YES
j. Youth?	j YES
k. Most-at-risk populations?	k YES
l. Orphans and other vulnerable children?	l YES
CROSS-CUTTING ISSUES	
m. HIV/AIDS and poverty?	m. YES
n. Human Rights?	n. YES
o. PLWHA involvement?	o. YES

**1.3 IF YES, does it include an operational plan?** NO. This is to be implemented.

**1.4 IF YES, does it include a strategic/operational plan include:** N/A

**1.5 Has your country ensured full involvement and participation of civil society in the planning phase?** YES

**1.6 Has the national strategy/action framework been endorsed by key stakeholders?** NO

**Comments:** the Ministry of Public Health has but not on a governmental level due to the lack of a legal strategy.

**2. Has your country integrated HIV/AIDS into its general development plans (such as: a) National Development Plans, b) United Nations Development Assistance Framework, c) Poverty Reduction Strategy Papers and d) Common Country Assessments)?** YES

**2.1. IF YES, into which development plan?** a. yes. b. no. c. yes

Which of the following aspects does it cover?

	a)	b)	c)
HIV Prevention	Yes	No	Yes
Care and support	No	No	Yes
HIV/AIDS impact alleviation.	Yes		
Reduction of gender inequalities as related to HIV/AIDS prevention/care	Yes		
Reduction of income inequalities as related to HIV prevention/care.	Yes		
Others			

**3. Has your country evaluated the impact of HIV/AIDS on its economic development for the purposes of planning? NO**

**Comments:** one was elaborated by the World Bank in 2003. An exercise on socio-economic impact was carried out (1996) but this is too outdated for planning and decision making.

**4. Does your country have a strategy/action framework for addressing HIV/AIDS issues among its national uniformed services, military, peacekeepers and police? YES**

**4.1 IF YES, which of the following has been implemented?**

HIV Prevention	YES
Care and support	YES
Voluntary HIV testing and counselling	YES
Obligatory HIV testing and counselling	NO
Others. Please specify.	

**Comments:** An important project began recently with the support of UNAIDS, UNFPA and the National AIDS Programme (NAP) with the aim of broadening the response.

<b>Overall, how would you rate strategy planning efforts in the HIV and AIDS programmes?</b>										
2005 poor					good					
0	1	2	3	4	5	6	7	8	9	10
2003 poor					good					
0	1	2	3	4	5	6	7	8	9	10
<b>In case of discrepancies between the 2003 and 2005 rating, please provide main reasons supporting such differences:</b> the involvement of all sectors has improved, coordination has improved and care and										

prevention coverage has been extended in comparison to 2003.

## II POLITICAL SUPPORT

Solid political support includes government and political leaders that often speak openly about AIDS and regularly hold important meetings. It also includes the allocation of public money to support AIDS programmes and the effective use of government and civil society organisations and support processes for efficient programmes against AIDS.

### 1. Does the head of the government or other high officials speak publicly and favourably against AIDS at least twice a year?

A. Head of government YES  
Other high officials YES

\*Especially the Minister of Health.

### 2. Does your country have a national multi-sectorial HIV and AIDS management/coordination body recognised by law? (National AIDS Council or Commission) YES

2.1 IF YES, when was it created? 2000. By means of Law 27-2000

#### 2.2 Does it include:

Mandate	yes
Civil society participation	yes
People who live with HIV/AIDS	no
Private sector	yes
Action plan	no
Functional secretariat	no
Date of last meeting of the secretariat	2002 (beginning)

**Comments:** This was created but it is not functional. Currently efforts are being carried out to guarantee that it starts to work again.

### 3. Does your country have a national HIV/AIDS body that promotes interaction between the government, people living with HIV, the private sector and civil society for implementing programmes and strategies against HIV and AIDS? YES

#### 3.1 IF YES, does it include?

Mandate	yes
Defined membership	yes
Action plan	yes
Functional secretariat	yes
Date of last meeting	October 2005

**Comments:** The technical committee is for the development of protocols, follow-up of patients, drug surveillance, etc.

<b>Overall, how would you rate the political support for the HIV/AIDS programmes?</b>										
2005 poor					good					
0	1	2	3	4	5	6	<b>7</b>	8	9	10
2003 poor					good					
0	1	2	3	<b>4</b>	5	6	7	8	9	10
<b>In case of discrepancies between the 2003 and 2005 rating, please provide main reasons supporting such differences:</b> Currently, there is a higher budget, more human resources, more coverage and the publication of a government policy on HIV/AIDS.										

### III. PREVENTION

**1. Does your country have a policy or strategy that promotes information, education and communication (IEC) on HIV/AIDS to the general population?** YES

**1.1 In the last year, did you implement an active programme to promote accurate HIV and AIDS reporting by the media?** NO

**Comments:** Work has been carried out since May 2005 and will conclude with implementation of the national strategic plan.

**2. Does your country have a policy or strategy promoting HIV and AIDS-related reproductive and sexual health education for young people?** YES

**2.1 Is HIV education part of the curriculum in:**

Primary schools: YES

Secondary schools: NO

**2.2 Does the strategy/curriculum provide the same reproductive and sexual health education for young men and women?** YES

**Comments:** This is in the process of being implemented for 2006.

**3. Does your country have a policy or strategy to promote information, education and communication and other preventive health measures for most-at-risk populations?** Yes

**3.1 Does your country have a policy or strategy for these most-at-risk populations?**

Injecting drug users, including:	YES	NO	N/A
----------------------------------	-----	----	-----

Risk reduction information, education and counselling?			N/A
Needle and syringe exchange programmes?			N/A
Treatment services?			N/A
IF YES, drug substitution treatment?			N/A
Men who have sex with men?	YES		
Sex workers?	YES		
Prison inmates?		NO	
Cross border immigrants and mobile populations	YES		
Refugees or displaced populations?		NO	
Other most-at-risk populations? ( <i>please specify</i> ) pregnant women and adolescents.	YES		

**Comments:** people who use drugs are not a priority because only one case has been reported that could have been another form of prevention

**4. Does your country have a policy or strategy to expand access, including among most-at-risk populations, to essential preventative commodities? (These products include, but are not limited to, access to confidential and voluntary counselling and testing, condoms, sterile needles and drugs to treat sexually transmitted infections).** YES

**4.1 Do you have programmes in support of the policy or strategy?**

- A Ministry of Health and Consumer Affairs programme yes
- A blood safety programme yes
- A programme to ensure safe injections yes
- A programme on antenatal syphilis screening yes

<b>Overall, how would you rate policy efforts in support of prevention?</b>										
2005 poor					good					
0	1	2	3	4	5	6	7	8	9	10
2003 poor					good					
0	1	2	3	4	5	6	7	8	9	10
<b>In case of discrepancies between the 2003 and 2005 rating, please provide main reasons supporting such differences:</b> The difference is that in 2005 a national IEC Plan, sentinel sites plan for STI (34 districts) and for mother-to-child transmission (61 districts) already existed.										

**5. Which of the following prevention activities have been implemented in 2003 and 2005 in support of the HIV-prevention policy/strategy?**

	2003	2005
a. A programme to promote accurate HIV and AIDS reporting by the media	YES	YES
b. A social marketing programme for condoms	YES	YES
c. School-based AIDS education for youngsters		
d. Behaviour-change information		
e. Voluntary counselling and tests	YES	YES
f. Programmes for sex workers	YES	YES
g. Programmes for men who have sex with men		YES
h. Programmes for injecting drug users, if applicable		
i. Programmes for other most-at-risk populations	YES	YES
j. Blood safety	YES	YES
k. Programmes to prevent mother-to-child transmission of HIV		YES
l. Programmes to ensure universal precautions in health care settings		YES
m. Other ( <i>please specify</i> )		

<b>Overall, how would you rate the efforts in the implementation of HIV-prevention programmes?</b>
2005 poor <span style="float: right;">good</span>
0 1 2 3 4 5 <b>6</b> 7 8 9 10
2003 poor <span style="float: right;">good</span>
0 1 2 3 4 <b>5</b> 6 7 8 9 10
<b>In case of discrepancies between the 2003 and 2005 rating, please provide the main reasons supporting such differences:</b> The availability of testing has increased in the districts identified. There is an IEC plan. Multi-sectorial participation has increased. Expansion of comprehensive care coverage of STI and guidance. More human resources.

#### IV. CARE AND SUPPORT

1. Does your country have a policy or strategy to promote comprehensive HIV/AIDS care and support, with sufficient attention to barriers faced by women, children and most-at-risk populations? (Comprehensive care includes, but is not limited to, confidential voluntary counselling and testing, psychosocial care, access to medicines, and home and community-based care.)? Yes

2. Which of the following activities have been implemented under the care and treatment of HIV and AIDS programmes?

a. Systematic HIV screening of blood transfusion.	YES	YES
b. Universal precautions.	YES	YES
c. Treatment of opportunistic infections (OI)	YES	YES
d. Antiretroviral therapy. (ART)	YES	YES
e. Nutritional care.	YES	YES
f. Sexually transmitted infection care.	YES	YES
g. Family planning services.	YES	YES
h. Psychosocial support for people living with HIV and their families.	YES	YES
i. Home-based care.	NO	NO
j. Palliative care and treatment of common HIV-related infections: pneumonia, oral thrush, vaginal candidiasis and pulmonary TB (DOTS).	YES	YES
k. Cotrimoxazole prophylaxis in people who live with HIV infection.	YES	YES
l. Post exposure prophylaxis (e.g. occupational exposures to HIV, rape).	YES	YES
m. Other. ( <i>please specify</i> )		

**Comments:**

<b>Overall, how would you rate the efforts in care and treatment of the HIV and AIDS programme?</b>										
2005 poor						Good				
0	1	2	3	4	5	6	<b>7</b>	8	9	10
2003 poor						Good				
0	1	2	3	<b>4</b>	5	6	7	8	9	10
<b>In case of discrepancies between the 2003 and 2005 rating, please provide the main reasons supporting such differences:</b> Treatment coverage is more widespread; purchasing processes have been improved, services have been improved. There is long term planning to improve PLWHA care. Improvement in the quality of care.										

**3. Does your country have a policy or strategy to address the additional HIV and AIDS-related needs of orphans and other vulnerable children?**  
NO

**3.1 IF YES, is there an operational definition for orphans and other vulnerable children in the country?** NO

**3.2 Which of the following activities have been implemented under orphan and vulnerable children programmes?**

School fees for orphans and vulnerable		
--	--	--

children.	NO	NO
Community programmes.	NO	NO
Other: <i>(please specify)</i>	NO	NO

**Comments:** There are no comments

<b>Overall, how would you rate efforts to meet the needs of orphans and other vulnerable children?</b>										
2005 poor					Good					
0	1	2	3	4	5	6	7	8	9	10
2003 poor					Good					
0	1	2	3	4	5	6	7	8	9	10
<b>In case of discrepancies between the 2003 and 2005 rating, please provide the main reasons supporting such differences:</b>										

**Comments:** The Ministry of Public Health allocates five million to NGOs supporting orphans. (Hogar San José).

#### **V. SURVEILLANCE AND EVALUATION**

1. Does your country have one national Surveillance and evaluation (S&E) plan? NO

2. Does the Surveillance and evaluation plan include the following? N/A

3. Is there a budget for the Surveillance and evaluation plan? NO

4. Is there a Surveillance and evaluation functional unit or department?  
Yes

**IF YES:**

Based in the national AIDS council or equivalent

no

Based in the Ministry of Health

yes

4.1 IF YES, are there mechanisms in place to ensure that all key players submit their reports to this unit or department? NO

**Comments:** This is a small unit that deals with S&E for all of the Ministry of Public Health programmes and it does not comply with HIV information requirements.

**4.2 Is there a full-time officer responsible for surveillance and evaluation activities of the national programme?** There is no surveillance and evaluation officer

**5. Is there a committee or working group that meets regularly to coordinate Surveillance and evaluation activities?**

Yes, on an irregular basis. The last meeting was in February 2005

**5.1 Does it include representation from civil society, people living with HIV?** Yes, although this is not linked to the national process.

**6. Have individual agency programmes been reviewed to harmonise surveillance and evaluation indicators with those of your country?** No.

**7. To what degree (*Low to High*) are UN, bi-laterals and other institutions sharing surveillance and evaluation results?**

Low  
0 1 2 3 4 5 **6** 7 8 9 10 High

Comments: **This did not occur.**

**8. Does the Surveillance and evaluation unit manage a national central database?** YES

**8.1 IF YES, what type is it?** SIGSA. General Health Information System with core health indicators.

**9. Is there a functional health information system?**

National level                      yes  
Sub-national level                yes

**Comments:** It is SIGSA - General Health Information System.

**10. Is there a functional Education Information System?**

National level                      NO  
Sub-national level                YES\*

\*This is regional according to educational levels.

**11. Does your country publish at least once a year an evaluation report on HIV and AIDS, including HIV surveillance reports?** YES

**12. To what extent is strategic information used in planning and implementation?**

Low High  
 0 1 2 3 4 **5** 6 7 8 9 10

**Comments:** The document only has epidemiological surveillance information and its surveillance analysis.

**13. In the last year, was training in Surveillance and evaluation conducted?**

At national level no  
 At sub-national level no  
 Including civil society no

<b>Overall, how would you rate the surveillance and evaluation efforts of the HIV and AIDS programme?</b>										
2005 poor					Good					
0	1	<b>2</b>	3	4	5	6	7	8	9	10
2003 poor					Good					
0	<b>1</b>	2	3	4	5	6	7	8	9	10
<b>In case of discrepancies between the 2003 and 2005 rating, please provide the main reasons supporting such differences:</b> It is very incipient and is still in the process of being developed.										

**PARTICIPATING INSTITUTIONS:**

National Programme for the Prevention and Control of STI/HIV/AIDS.  
 Department of Military Health  
 Ministry of Education

**PART B** (Consolidated by international cooperation representatives)

**I. HUMAN RIGHTS:**

1. **Does your country have laws and regulations that protect people with HIV/AIDS against discrimination (such as general non-discrimination provisions or those that specifically mention HIV and focus on schooling, housing, employment, etc)?** YES

**Comments:** Law 27-2000, Reform of the Penal Code against discrimination.

2. **Does your country have laws and regulations which specify protections for certain groups of people identified as being especially vulnerable to HIV/AIDS (groups such as injecting drug users, men who have sex with men, sex workers, mobile populations and prison inmates)?** No

3. **Does your country have laws and regulations that present obstacles to effective HIV prevention and care for most-at-risk populations?** Yes. The labour, civil and penal codes restrict human right guarantees of the most-at-risk groups, and where this exists, there are shortfalls, such as laws on street children.

4. **Is the promotion and protection of human rights explicitly mentioned in any HIV and AIDS policy or strategy?** YES.

**Comments:** Promotion has been carried out but is still limited to urban areas.

5. **Has the government, by means of political and financial support, involved at-risk populations in governmental HIV-policy design and programme implementation?** YES.

**IF YES, please list examples:** Participation in the formulation of the AIDS policy, IEC strategy, formulation of the national strategic plan.

6. **Does your country have a policy or strategy to ensure equal access, between men and women, to prevention and care?** YES

**Comments:** Although established legally the application does not guarantee equal access. There is more access for women than for men when it is the latter group that is the most affected.

7. **Does your country have a policy or strategy to ensure equal access to prevention and care for most-at-risk populations?** NO

**Comments:** There are no services in the country for this population and discrimination exists.

8. **Does your country have a policy prohibiting HIV screening for general employment purposes (interviews, promotion, training, benefits)?** YES. Although some institutions continue to request the HIV test.

9. **Does your country have a policy to ensure that HIV and AIDS research protocols involving human subjects are reviewed and approved by a national/local ethical review committee?** YES

a. **IF YES, does the ethical review committee include civil society and people living with HIV?** NO

**Comments:** They are all made up of doctors.

**10 Does your country have the following monitoring and enforcement mechanisms?**

Collection of information on human rights, HIV and AIDS issues and use of this information in policy and programme formulation reform.	YES	
Existence of independent national institutions responsible for the promotion and protection of human rights including human rights commissions, law reform commissions and ombudsmen which consider HIV- and AIDS-related aspects within their work.	YES	
Establishment of focal points within governmental health departments and other departments to monitor HIV-related human rights abuses		NO
Development of performance indicators or benchmarks for compliance with human rights regulations in the context of HIV and AIDS efforts.		NO

**11. Have members of the judiciary been trained/sensitised to HIV and AIDS and human rights issues that may come up in the context of their work?** YES

**Comments:** This is very limited for NGOs. 2% in the whole country.

**12. Are the following legal support services available in your country?**

Legal aid systems for HIV and AIDS casework.	YES	
State support to private sector law firms or university based centres that provide free pro bono legal services to people living with HIV and AIDS in areas		NO

such as discrimination.		
Programmes to educate and raise the awareness among people living with HIV and AIDS on their rights.	YES	

**13. Are there programmes designed to transform societal attitudes of discrimination and stigma associated with HIV and AIDS into attitudes of understanding and acceptance?**

<b>Overall, how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV and AIDS?</b>										
2005 poor					Good					
0	1	2	3	4	5	6	7	8	9	10
2003 poor					Good					
0	1	2	3	4	5	6	7	8	9	10
<b>In case of discrepancies between the 2003 and 2005 rating, please provide main reasons supporting such differences:</b> Human rights have been promoted more. There has been more emphasis on the protection of human rights.										

<b>Overall, how would you rate the effort to enforce the existing policies, laws and regulations?</b>										
2005 poor					High					
0	1	2	3	4	5	6	7	8	9	10
2003 poor					Good					
0	1	2	3	4	5	6	7	8	9	10
<b>In case of discrepancies between the 2003 and 2005 rating, please provide main reasons supporting such differences:</b> There has been some improvement but the policy must be acclaimed by civil society. The state is not interested in implementing these policies, laws and regulations.										

## II. CIVIL SOCIETY PARTICIPATION

**1. To what extent has civil society made a significant contribution to strengthening the political commitment of top leaders and national policy formulation?**

Low  
0 1 2 3 4 5 **6** 7 8 9 10 High

**2. To what extent have civil society representatives been involved in the planning and budgeting process for the National Strategic Plan**

on HIV and AIDS or for the current activity plan (attending planning meetings and reviewing drafts)?

Low 0 1 2 3 4 5 6 7 **8** high 9 10

3. To what extent are the humanitarian services provided by civil society in areas of prevention and care included in both the national strategic plans and reports?

Low 0 1 2 3 4 5 6 7 **8** high 9 10

4. Has your country conducted a national periodic review of the Strategic Plan with the participation of civil society: YES  
 Month \_\_\_\_\_ year: 2003 and 2005

5. To what extent does your country have a policy to ensure that HIV and AIDS research protocols involving human subjects are reviewed and approved by an independent national/local ethical review committee in which people who live with HIV and their caregivers participate?

Low 0 1 2 3 4 **5** high 6 7 8 9 10

Observation: There is no participation of PLWHA.

<b>Overall, how would you rate the efforts to increase civil-society participation?</b>										
2005 poor good										
0	1	2	3	4	5	6	7	<b>8</b>	9	10
2003 poor good										
0	1	2	3	4	5	<b>6</b>	7	8	9	10
<b>In case of discrepancies between the 2003 and 2005 rating, please provide main reasons supporting such differences:</b> More participation of PLWHA. Change and opening of civil society and more public policies. More regeneration of social fabric.										

**III. PREVENTION**

1. Which of the following prevention activities have been implemented in 2003 and 2005 in support of the HIV-prevention policy/strategy?

	2003	2005
a. A programme to promote accurate HIV and AIDS reporting by the media		
b. A social marketing programme for condoms	YES	YES
c. School-based AIDS education for youngsters		YES
d. Behaviour-change information	YES	YES
e. Voluntary counselling and testing		YES
f. Programmes for sex workers	YES	YES
g. Programmes for men who have sex with men	YES	YES
h. Programmes for injecting drug users, if applicable	NO	NO
i. Programmes for other most-at-risk populations		YES
j. Blood safety	YES	YES
k. Programmes to prevent mother-to-child transmission of HIV		YES
l. Programmes to ensure safe injections in health care settings		YES
m. Other ( <i>please specify</i> )		

<b>Overall, how would you rate the efforts in the implementation of HIV-prevention programmes?</b>
2005 poor <span style="float: right;">Good</span>
0 1 2 3 4 <b>5</b> 6 7 8 9 10
2003 poor <span style="float: right;">Good</span>
0 1 2 3 <b>4</b> 5 6 7 8 9 10
<b>In case of discrepancies between the 2003 and 2005 rating, please provide main reasons supporting such differences:</b> Very limited coverage. Prevention not directly dealt with. The budget is very low.

#### IV. CARE AND SUPPORT

- Which of the following activities have been implemented under the HIV and AIDS care and treatment programmes?

a. HIV screening of blood transfusion		
b. Universal precautions		
c. Treatment of opportunistic infections (OI)		
d. Antiretroviral therapy (ART)		
e. Nutritional care		

f. Sexually transmitted infection care		
g. Family planning services		
h. Psychosocial support for people living with HIV and their families		
i. Home-based care		
j. Palliative care and treatment of common HIV-related infections: pneumonia, oral thrush, vaginal candidiasis and pulmonary TB (DOTS)		
k. Cotrimoxazole prophylaxis among HIV-infected people		
l. Post exposure prophylaxis (e.g. occupational exposures to HIV, rape)		
m. Other: (please specify)		

<b>Overall, how would you rate the care and treatment efforts of the HIV and AIDS programme?</b>										
2005 poor <span style="float:right">good</span>										
0	1	2	3	4	5	6	7	8	9	10
2003 poor <span style="float:right">good</span>										
0	1	2	3	4	5	6	7	8	9	10
<b>In case of discrepancies between the 2003 and 2005 rating, please provide the main reasons supporting such differences:</b> Care of PLWHA that succeed in gaining access to health centres or hospitals has improved. Additional services have improved.										

2. Does your country have a policy or strategy to address the additional HIV and AIDS-related needs of orphans and other vulnerable children (OVC)? YES

**Comments:** The policy is recent and it has yet to be implemented.

- 2.1. Which of the following activities have been implemented under the orphan and other vulnerable children programmes?

	2003	2005
Payment of school fees for orphans and vulnerable children.		YES
Community programmes.		YES
Other: (please specify)		

**Comments:** PLWHA children are cared for by the private sector and NGOs. There are few orphaned children and they are taken in by relatives.

<b>Overall, how would you rate efforts to meet the needs of orphans and other vulnerable children?</b>										
2005 poor					good					
0	1	2	3	4	5	6	7	8	9	10
2003 poor					good					
0	1	2	3	4	5	6	7	8	9	10
<b>In case of discrepancies between the 2003 and 2005 rating, please provide the main reasons supporting such differences:</b>										

Participating institutions:

United States Agency for International Development, USAID  
 Central American HIV/AIDS Prevention Programme, PASCA  
 Disease Control Centre, DCC  
 UNAIDS

**PART B** (Consolidated by PLWHA association representatives)

**I. HUMAN RIGHTS:**

1. Does your country have laws and regulations that protect people living with HIV and AIDS against discrimination (such as general non-discrimination provisions or those that specifically mention HIV, that focus on schooling, housing, unemployment, etc) YES

**Comments:** This does not contain the entire social component required in line with poverty indices. Its application process is very inefficient.

2. Does your country have non-discrimination laws or regulations which specify protections for certain groups of people identified as especially vulnerable to HIV and AIDS discrimination (i.e. groups such as injecting drug users, men who have sex with men, sex workers, youth, mobile populations, and prison inmates)? No. No comment.

3. Does your country have laws and regulations that present obstacles to effective HIV prevention and care for most-at-risk populations? Yes. Canon laws.

4. Is the promotion and protection of human rights explicitly mentioned in any HIV and AIDS policy/strategy? YES

**Comments:** Government agreement on a public HIV policy (needs to be applied) Law 27-2000 and regulation 317-2002.

5. Has the government, through financial and political support, involved at-risk populations in governmental HIV-policy design and programme implementation? No.

IF YES, please list examples:

6. Does your country have a policy to ensure equal access between men and women to promotion and care for most-at-risk populations? YES

**Comments:** Constitution of the Republic of Guatemala. Law 27-2000.

7. Does your country have a policy to ensure equal access to prevention and care for most-at-risk populations? YES

**Comments:** This could be enhanced if the public policy was turned into law.

8. **Does your country have a policy prohibiting HIV screening for general employment purposes (interviews, promotion, training, benefits) YES.**
9. **Does your country have a policy to ensure that HIV and AIDS research protocols involving human subjects are reviewed and approved by a national/local ethical review committee? YES**
- 9.1. **IF YES, does the ethical review committee include civil society and people living with HIV? YES**

**Comments:** There is no permanent surveillance committee. It does not include civil society and PLWHA.

10. **Has your country established the follow-up and application mechanisms shown below?**

Collection of information on human rights and issues related to HIV and AIDS and use of this information in policy and programme development reform.		NO
Existence of independent national institutions for the promotion and protection of human rights including human rights commissions, law reform commissions and ombudsmen which consider HIV- and AIDS-related aspects within their work.		NO
Establishment of focal points within governmental health departments and other departments to monitor HIV-related human rights abuses		NO
Development of performance indicators or benchmarks for compliance with human rights standards in the context of HIV and AIDS efforts.		NO

11. **Have members of the judiciary been trained/sensitised to HIV and AIDS and human rights issues that may come up in the context of their work? YES**

**Comments:** very limited for NGOs. 2% in the country.

12. **Are the following legal support services available in your country?**

Legal aid systems for HIV and AIDS casework.		NO
State support to private sector law firms or university based centres that provide free pro bono legal		

services to people living with HIV and AIDS in areas such as discrimination.		NO
Programmes to educate and raise the awareness among people living with HIV and AIDS on their rights.		NO

13. Are there programmes designed to transform societal attitudes of discrimination and stigma associated with HIV and AIDS into attitudes of understanding and acceptance?

<b>In general how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV and AIDS?</b>										
2005 poor					Good					
0	1	2	3	4	5	6	7	8	9	10
2003 poor					Good					
0	1	2	3	4	5	6	7	8	9	10
<b>In case of discrepancies between the 2003 and 2005 rating, please provide main reasons supporting such differences:</b> More information. More intervention outside the capital. Participation in training from time to time.										

<b>Overall, how would you rate the effort to enforce the existing policies, laws and regulations?</b>										
2005 poor					Good					
0	1	2	3	4	5	6	7	8	9	10
2003 poor					Good					
0	1	2	3	4	5	6	7	8	9	10
<b>In case of discrepancies between the 2003 and 2005 rating, please provide main reasons supporting such differences:</b> There is no social auditing.										

## II. CIVIL SOCIETY PARTICIPATION

1. To what extent has civil society efficiently contributed to strengthening the political commitment of key leaders and national policy formulation?

Low high  
0 1 2 3 4 5 6 7 8 9 10

2. To what extent have civil society representatives been involved in the planning and budgeting process for the National Strategic Plan on HIV and AIDS or for the current activity plan (attending planning meetings and reviewing drafts)?

Low 0 1 2 3 4 5  7 8 9 10 high

3. To what extent are the humanitarian services provided by civil society in areas of prevention and care included in both the national strategic plans and reports?

Low 0 1 2 3 4 5 6 7  9 10 high

4. Has your country conducted a national periodic review of the Strategic Plan with the participation of civil society: NO

month \_\_\_\_\_ year: \_\_\_\_\_

5. To what extent does your country have a policy to ensure that HIV and AIDS research protocols involving human subjects are revised and approved by an independent national or local ethical review committee in which people who live with HIV and their caregivers participate?

Low  1 2 3 4 5 6 7 8 9 10 high

<b>Overall, how would you rate the efforts to increase civil-society participation?</b>										
2005 poor					Good					
0	1	2	3	4	5	<input type="text" value="6"/>	7	8	9	10
2003 poor					Good					
0	1	2	3	4	<input type="text" value="5"/>	6	7	8	9	10
<b>In case of discrepancies between the 2003 and 2005 rating, please provide main reasons supporting such differences:</b> Due to expanding care and prevention coverage.										

### III. PREVENTION

1 .Which of the following prevention activities have been implemented in 2003 and 2005 in support of the HIV-prevention policy/strategy?

	2003	2005
a. A programme to promote accurate HIV and AIDS reporting by the media	NO	NO
b. A social marketing programme for condoms	YES	YES
c. School-based AIDS education for youngsters	YES	YES
d. Behaviour-change information	NO	YES
e. Voluntary counselling and tests	YES	YES
f. Programmes for sex workers	NO	NO
g. Programmes for men who have sex with men	NO	NO
h. Programmes for injecting drug users, if applicable	NO	NO
i. Programmes for other most-at-risk populations	NO	NO
j. Blood safety	NO	NO
k. Programmes to prevent mother-to-child transmission of HIV	NO	YES
Programmes to ensure safe injections in health care settings	NO	NO
m. Other ( <i>please specify</i> )		

**Overall, how would you rate the efforts in the implementation of HIV-prevention programmes?**

2005 poor Good  
 0 1 2 3 **4** 5 6 7 8 9 10

2003 poor Good  
 0 1 **2** 3 4 5 6 7 8 9 10

**In case of discrepancies between the 2003 and 2005 rating, please provide main reasons supporting such differences:** Little involvement between civil society and government sectors. Little extension of budget.

#### IV. CARE AND SUPPORT

1. Which of the following activities have been implemented under the care and treatment of HIV and AIDS programmes?

a. HIV screening of blood transfusion	YES	YES
b. Universal precautions		
c. Treatment of opportunistic infections (OI)		
d. Antiretroviral therapy (ART)		YES
e. Nutritional care		
f. Sexually transmitted infection care		YES
g. Family planning services		
h. Psychosocial support for people living with HIV and their families		
i. Home-based care		
j. Palliative care and treatment of common HIV-related infections: pneumonia, oral thrush, vaginal candidiasis and pulmonary TB (DOTS)		
k. Cotrimoxazole prophylaxis among HIV-infected people		
Post exposure prophylaxis (e.g. occupational exposures to HIV, rape)		
m. Other: <i>(please specify)</i>		

<b>Overall, how would you rate the care and treatment efforts of the HIV and AIDS programme?</b>										
2005 poor					Good					
0	1	2	<b>3</b>	4	5	6	7	8	9	10
2003 poor					Good					
0	1	<b>2</b>	3	4	5	6	7	8	9	10
<b>In case of discrepancies between the 2003 and 2005 rating, please provide main reasons supporting such differences:</b> Lack of government commitment.										

2. Does your country have a policy or strategy to address additional HIV and AIDS-related needs of orphans and other vulnerable children (OVC)? NO

Comments:

a Which of the following activities have been implemented under orphans and other vulnerable children programmes?

	2003	2005
Payment of school fees for orphans and vulnerable		

children.		
Community programmes.		
Other: (please specify)		

**Comments:**

<b>Overall, how would you rate efforts to meet the needs of orphans and other vulnerable children?</b>										
2005 poor						Good				
0	<b>1</b>	2	3	4	5	6	7	8	9	10
2003 poor						Good				
0	<b>1</b>	2	3	4	5	6	7	8	9	10
<b>In case of discrepancies between the 2003 and 2005 rating, please provide the main reasons supporting such differences:</b>										

Participating organisations:

*Asociación Gente Positiva*

*Asociación Gente Nueva*

**PART B** (Consolidated by NGO representatives)

**I. HUMAN RIGHTS:**

**1. Does your country have laws and regulations that protect people with HIV/AIDS against discrimination (such as general non-discrimination provisions or those that specifically mention HIV and focus on schooling, housing, employment, etc)? YES**

**Comments:** there are laws and regulations but, in general, they are not applied. They are dead letters. They should be implemented with greater emphasis on the judicial system. Guatemalan citizens are unaware of protection laws and only when they acquire HIV do they also acquire these rights, which are not guaranteed by the state.

**2. Does your country have laws and regulations which specify protections for certain groups of people identified as being especially vulnerable to HIV/AIDS (i.e. groups such as injecting drug users, men who have sex with men, sex workers, mobile populations and prison inmates)? No.**

**3. Does your country have laws and regulations for effective HIV prevention and care for most-at-risk populations? Yes.** The civil code for sexual abuse and the recognition of same sex couples. The penal code, especially as of article 300; it does not recognise poor professional practices as illegal. Rape is only defined for women, men are "not susceptible to rape due to their anatomy". Obsolete STI code. Labour code, especially article 16C. Guatemalan Institute of Social Security Organic Law. Health code that permits abuse of human rights by making sex workers carry ID cards; it promotes stigma and discrimination, corruption and non-recognition of male and transvestite sex workers, foreigners or minors for STI treatment.

**4. Is the promotion and protection of human rights explicitly mentioned in any HIV and AIDS policy or strategy? YES.**

**Comments:** Law 27-2000, its regulations and, recently, the public policy on HIV/AIDS.

**5. Has the government, by means of political and financial support, involved at-risk populations in governmental HIV-policy design and programme implementation? YES.**

**IF YES, please list examples:** Law 27-2000, its regulation, the public policy on HIV/AIDS, National Strategic Plan for AIDS. However, the it took a year to publish the AIDS policy after it was announced by the President of the Republic.

**6. Does your country have a policy or strategy to ensure equal access between men and women to prevention and care? YES**

**Comments:** In the actual law there is no sex discrimination. However, equal treatment is not provided to males and females by health personnel.

**7. Does your country have a policy or strategy to ensure equal access to prevention and care for most-at-risk populations? NO**

**Comments:** The law does not mention most-at-risk populations and although most-at-risk populations are mentioned in the recent public policy on HIV/AIDS, there is no such measure.

**8. Does your country have a policy prohibiting HIV screening for general employment purposes (interviews, promotion, training, benefits) YES.**

**Comments:** Law 27-2000, but this contradicts the labour code, which allows employers to carry out tests before contracting workers.

**1. Does your country have a policy to ensure that HIV and AIDS research protocols involving human subjects are reviewed and approved by national/local ethical review committee? Yes.** There are two national ethical committees, one independent and the other institutional; both are based on the Helsinki protocol.

**a. IF YES, does the ethical review committee include civil society and people living with HIV? YES**

**Comments:**

**10 Does your country have the following monitoring and enforcement mechanisms?**

Collection of information on human rights and HIV and AIDS issues and use of this information in policy and programme development reform.		NO
Existence of independent national institutions for the promotion and protection of human rights including human rights commissions, law reform commissions and ombudsmen which consider HIV- and AIDS-related issues within their work.	YES	
Establishment of focal points within governmental health departments and other departments to		NO

monitor HIV-related human rights abuses		
Development of performance indicators or benchmarks for compliance with human rights standards in the context of HIV and AIDS efforts.		NO

11. Have members of the judiciary been trained/sensitised to HIV and AIDS and human rights issues that may come up in the context of their work? NO

Comments:.

12. Does your country have the following legal support services?

Legal aid systems for HIV and AIDS casework.	YES	
State support to private sector law firms or university-based centres to provide free pro bono legal services to people living with HIV and AIDS in areas such as discrimination.		NO
Programmes to educate and raise awareness among people living with HIV and AIDS concerning their rights.	YES	

13. Are there programmes designed to transform societal attitudes of discrimination and stigma associated with HIV and AIDS into attitudes of understanding and acceptance?

<b>Overall, how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV and AIDS?</b>										
2005 poor					Good					
0	1	2	3	4	5	6	7	8	9	10
2003 poor					Good					
0	1	2	3	4	5	6	7	8	9	10
<b>In case of discrepancies between the 2003 and 2005 rating, please provide the main reasons supporting such differences:</b> in 2005 there was a public policy in addition to the Law passed in 2000. The reason for the rating above is because although the legal framework exists (despite shortfalls), in practice it is not applied.										

<b>Overall, how would you rate the effort to enforce the existing policies, laws and regulations?</b>										
2005 poor					Good					
0	1	2	3	4	5	6	7	8	9	10
2003 poor					Good					
0	1	2	3	4	5	6	7	8	9	10
<p><b>In case of discrepancies between the 2003 and 2005 rating, please provide the main reasons supporting such differences:</b> In 2005 there was still no substantial commitment by the state to deal with the epidemic, to protect the human rights of people living in HIV/AIDS and to implement preventative measures among most-at-risk populations. However, the HIV/AIDS programme is making a tangible effort but it does not have sufficient resources to fulfil its commitments.</p>										

## II. CIVIL SOCIETY PARTICIPATION

1. To what extent has civil society made a significant contribution to strengthening the political commitment of key leaders and national policy formulation?

Low high  
 0 1 2 3 4 **5** 6 7 8 9 10

**Comments:** Civil society has done its level best. The small amount achieved is down to civil society but this has not been effective due to lack of technical, financial and community resources etc.

2. To what extent have civil society representatives been involved in the planning and budgeting process for the National Strategic Plan on HIV and AIDS or for the current activity plan (attending planning meetings and reviewing drafts)?

Low high  
 0 1 2 3 4 5 6 7 **8** 9 10

3. To what extent are the humanitarian services provided by civil society in areas of prevention and care included in both the national strategic plans and reports?

Low high  
 0 1 2 3 4 5 6 7 8 9 10

**Comments:** We do not know / understand.

**4. Has your country conducted a national periodic review of the Strategic Plan with the participation of civil society: NO**

Month \_\_\_\_\_ year: \_\_\_\_\_

**Comments:** This has not been at established intervals although reviews exist and a new National Strategic Plan is being drawn up.

**5. To what extent does your country have a policy to ensure that HIV and AIDS research protocols involving human subjects are reviewed and approved by an independent national/local ethical review committee in which people who live with HIV and caregivers participate? NO**

Comments: There is no national ethical committee. However it is guaranteed by law that research complies with that set out in the Helsinki protocol.

Low high  
 0 1 2 3 4 5 6 7 8 9 10

<b>Overall, how would you rate the efforts to increase civil-society participation?</b>										
2005 poor					Correct					
0	1	2	3	4	5	6	7	8	9	10
2003 poor					Correct					
0	1	2	3	4	5	6	7	8	9	10
<b>In case of discrepancies between the 2003 and 2005 rating, please provide the main reasons supporting such differences:</b>										

**III. PREVENTION**

**1 .Which of the following prevention activities have been implemented in 2003 and 2005 in support of the HIV-prevention policy/strategy?**

	2003	2005
a. A programme to promote accurate HIV and AIDS reporting by the media	YES	YES
b. A social marketing programme for condoms	YES	YES
c. School-based AIDS education for youngsters	YES	YES
d. Behaviour-change information	YES	YES
e. Voluntary counselling and tests	YES	YES
f. Programmes for sex workers	YES	YES
g. Programmes for men who have sex with men	YES	YES
h. Programmes for injecting drug users, if applicable		

i. Programmes for other most-at-risk populations	YES	YES
j. Blood safety	YES	YES
k. Programmes to prevent mother-to-child transmission of HIV	NO	YES
l. Programmes to ensure safe injections in health care settings	YES	YES
m. Other: <i>(please specify)</i> Secondary prevention	YES	YES

<b>Overall, how would you rate the efforts in the implementation of HIV-prevention programmes?</b>										
2005 poor					Good					
0	1	2	3	4	<input checked="" type="checkbox"/> 5	6	7	8	9	10
2003 poor					Good					
0	1	2	3	4	<input checked="" type="checkbox"/> 5	6	7	8	9	10
<b>In case of discrepancies between the 2003 and 2005 rating, please provide the main reasons supporting such differences:</b>										

## V. CARE AND SUPPORT

1. Which of the following activities have been implemented under the care and treatment of HIV and AIDS programmes?

a. HIV screening of blood transfusion	YES	YES
b. Universal precautions	YES	YES
c. Treatment of opportunistic infections (OI)	YES	YES
d. Antiretroviral therapy (ART)	YES	YES
e. Nutritional care	YES	YES
f. Sexually transmitted infection care	YES	YES
g. Family planning services	YES	YES
h. Psychosocial support for people living with HIV and their families	YES	YES
i. Home-based care	YES	YES
j. Palliative care and treatment of common HIV-related infections: pneumonia, oral thrush, vaginal candidiasis and pulmonary TB (DOTS)	YES	YES
k. Cotrimoxazole prophylaxis among HIV-infected people	YES	YES
l. Post exposure prophylaxis (e.g. occupational exposures to HIV, rape.)	YES	YES
m. Other: <i>(please specify)</i> Provirial copy (PVC).		YES

<b>Overall, how would you rate the care and treatment efforts of the HIV and AIDS programme?</b>										
2005 poor					Good					
0	1	2	3	4	5	6	7	8	9	10
2003 poor					Good					
0	1	2	3	4	5	6	7	8	9	10
<b>In case of discrepancies between the 2003 and 2005 rating, please provide the main reasons supporting such differences:</b> Lack of funding. National Strategic Plan committed without resources, lack of political will.										

2. Does your country have a policy or strategy to address additional HIV and AIDS-related needs of orphans and other vulnerable children (OVC)? NO

Comments:

b. Which of the following activities have been implemented under the orphan and other vulnerable children programmes?

	2003	2005
Payment of school fees for orphans and vulnerable children.	NO	NO
Community programmes.		
Other: <i>(please specify)</i>		

Comments:

<b>Overall, how would you rate the efforts to meet the needs of orphans and other vulnerable children?</b>										
2005 poor					Good					
0	1	2	3	4	5	6	7	8	9	10
2003 poor					Good					
0	1	2	3	4	5	6	7	8	9	10
<b>In case of discrepancies between the 2003 and 2005 rating, please provide the main reasons supporting such differences:</b>										

Organisations participating in this group:

*Médecins Sans Frontières*  
 Barcelona Foundation  
 Marco Antonio Foundation  
 OASIS

Coordinator of Sectors for the Fight against AIDS