

**MINISTRY OF PUBLIC HEALTH AND POPULATION (MSPP)
JOINT UNITED NATIONS PROGRAM FOR HIV/AIDS (UNAIDS)**

UNGASS REPORT

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*Prepared by the Haitian Children's Institute (IHE)
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Preface

This report is presented as a follow-up to the commitment made by the Haitian government at the United Nations General Assembly on the fight against AIDS in 2000.

Acknowledgements

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LIST OF ABBREVIATIONS AND ACRONYMS

	(Jacmel, south-east of the country) against STI and HIV/AIDS
AIDS	: Acquired Immunodeficiency Syndrome
ARV	: Antiretroviral
ASON	: National Association for Solidarity with people affected and infected
AZT	: Zidovudine (Azidothymidine) by HIV/AIDS
CARLI	: Lawyers' committee for the respect of personal freedom
CCC	: Communication for behavioural change
CCM	: Country Coordination mechanisms
CDC	: Centres for Disease Control and Prevention
CECOSIDA	: AIDS Communication Centre
CERA	: Applied Research and Evaluation Centre
CPFO	: Centre for the Promotion of Working Women
CRS	: Catholic Relief Services (Secours catholique)
EMMUS	: Mortality, morbidity and use of services survey
ESC	: Behavioural monitoring survey
FEBS	: Esther Boucicault Stanislas foundation
FHI	: Family Health International
FOSREF	: Reproductive health and family education foundation
GHESKIO	: Kaposi Sarcoma and opportunistic infection Haitian study group
GIPA	: Greater Involvement of People living with or affected by AIDS
GRASADIS	: Anti-AIDS and anti-sexual discrimination action and research group
HIV	: Human Immunodeficiency Virus
IBESR	: Institute of social well-being and research
IEC	: Information, Education, Communication
IHE	: Haitian Children's Institute
IHSI	: Haitian Institute of statistics and information technology
INH	: Isoniazide
I-TECH	: International Training and Education Center on HIV
JSI	: John Snow International
MARCH	: Management and Resources for Haitian Communities
MCFDF	: Ministry of Women's Affairs

MEASURE/	: Monitoring and Evaluation to Assess and Use Results Evaluation
MENJS	: Ministry of National Education, Youth and Sports
MESI	: Monitoring Evaluation and Surveillance Interface
MHDR	: Haitian movement for rural development
MSPP	: Ministry of Public Health and Population
MTCT	: Mother-to-Child Transmission of HIV
MTCTP	: Mother-to-Child Transmission (HIV) Prevention
NGO	: Non-governmental Organisation
OVC	: Orphans and Vulnerable Children
PAHO	: Pan American Health Organisation
PEPFAR	: President Emergency Plan for AIDS Relief
PHAP	: Haitian platform of PLWH
PIH	: Partners in Health
PLWH	: People living with HIV
POZ	: Zero AIDS objective promoters
PSI	: Information Health Program
PSNE	: National Sectorial Plan for Education
REHPIVIH	: Haitian network of people living with HIV
REVIH	: Network of people living with HIV
RNDDH	: National network for the defence of human rights
STI	: Sexually Transmitted Infections
UCC	: Control and Coordination unit for the National Program to fight
UNAIDS	: Joint United Nations program on HIV/AIDS
UNGASS	: United Nations General Assembly Special Session
UNICEF	: United Nations Children's Fund
USAID	: United States Agency for International Development
VDH	: Voluntary program for development in Haiti
VTC	: Voluntary Testing Centre
WHO	: World Health Organisation

INTRODUCTION

The Republic of Haiti shares the island of Haiti with the Dominican Republic. It covers the western part of the island, with a surface area of 27,500 square kilometres. In 2003, Haiti counted 7 929 048 inhabitants, with young people of under 17 accounting for 46% of this population, according to the results of the last census carried out by the Haitian institute of statistics and information technology (IHSI). In 2005, total population was estimated at 8 196 686.

On the health front, STIs and HIV/AIDS are major public health problems and Haiti is one of the countries where the AIDS epidemic is generalised. In 2005, the number of people living with HIV was estimated at 271 582, including 11 634 children. An estimated 32 511 people die every year because of the disease. The main transmission route for HIV remains sexual, particularly by heterosexual transmission, followed by mother-to-child transmission. The epidemic has become increasingly feminine, with the male/female ratio moving from 6 : 1 in 1988 to 1 : 1 since 2002 (approximate figures).

Multisectorial interventions undertaken as a result of public/private partnerships and the high level of lethality among people living with AIDS¹ have led to a certain stabilisation of the epidemic (*and even a slight inflection of the prevalence curve*). Indeed, HIV prevalence in pregnant women dropped from 5.96% in 1996 to 3.44% in 2004.

However, the situation remains worrying despite this positive result, in view of the importance of certain crucial factors, including:

- Sexual promiscuity (*unfaithfulness to a partner reported by 66% of women, non-use of condoms and multiple partners reported by 42.4% and 42.5% of men respectively are the main reasons proposed by those interviewed who think there is a moderate or high risk of contracting HIV*)²
- discrimination and stigmatisation (*50.4% of women are not prepared to look after a PLWH in their homes and 67.9% state that such a person should not continue to work with other people; these percentages are 45.2 and 62.5 in men*)³
- violence against girls and women either by partners, friends, strangers or members of the family
- male chauvinism coupled with women's limited power of decision in sexual matters
- lack of financial independence for women

¹ Antiretroviral therapy was only introduced recently (3-4 years ago) and only concerns a small percentage of those requiring treatment

² Source: EMMUS III

³ Source: EMMUS II

- low condom use (5.6% and 14% of women and men respectively claim to have used a condom during their last sexual relations, regardless of the partner)
- high prevalence of STIs.

In terms of education, an improvement in the level of instruction has been noted; the level of literacy increased from 36% in 1982 (census) to 63% in 2000. However, the gender gap is still too wide, as the level of literacy is higher in men than in women (66.6% Vs 56.7%).

From an economic point of view, purchasing power has been deteriorating for a number of years, which contributes to an increase in population poverty and greater vulnerability in sexual matters for young girls. "Approximately 2/3 of the population lives below the poverty line, monetary poverty is getting worse and human poverty remains a prime concern"¹. At the beginning of the 1980s, one US dollar was worth five (5) gourdes: the current rate is 43.50 gourdes.

On a social/political level, the situation remains worrying despite interventions to stop violence; sexual violence against women is increasing and gang rape is a new problem. This increases the risk of exposure to STIs and HIV/AIDS for women. The number of rape cases reported rose from 362 in 2004 to 722 in 2005, and 33% of cases reported are gang rapes, according to the report published by three (3) institutions that look after violence victims². According to an independent human rights expert from the United Nations, "85% of human rights' violations concern women, of which 47% are sexual assaults on minors"³.

To face up to the HIV/AIDS scourge, Haiti, like other countries, has set up a prevention and control program for STIs and HIV/AIDS, with support from a number of partners. This program has been running for almost two decades. The availability of resources from the Global Fund and the President BUSH AIDS Initiative have represented and still form a real opportunity for stepping up the fight against the epidemic.

¹ Republic of Haiti, United Nations System in Haiti: Haiti, joint country report, October 2000. The serious social-political crisis rampant in the country since has worsened the social-economic situation.

² Nouvelliste, November 30th 2005, # 37283, reporting the words of the Ministry of Women's Affairs on the International Day for the Elimination of Violence against Women

³ Nouvelliste, November 29th 2005, # 37282

RESULTS

International action and commitment

Expenditure	
Amount of national funds disbursed by governments in low and middle income countries	----

Policy development and implementation status
National policy composite index Areas covered: prevention, care and support, human rights, civil society involvement, monitoring and evaluation Target groups: people living with HIV and AIDS, women, youth, orphans and most-at-risk populations

The form provided by UNGASS was used for the composite policy index. It is divided into two (2) parts:

- the first to be filled in by public authority representatives (*National AIDS Control Council or similar organisation*)
- the second to be managed by government partner representatives.

STRATEGIC PLAN

As soon as the infection appeared, decision-makers and a group of scientists took action to set up discussions to help understand the dynamics of the infection and to create suitable structures to respond to it in an efficient and opportune manner.

The Ministry of Public Health and Population (MSPP) created two (2) Technical Commissions in 1983 and 1985 respectively. In 1987, the first National AIDS Control Commission was set up. In the 1987-1991 period, an inter-ministerial council for the fight against AIDS was also formed. The MSPP then opened the coordination office for the National AIDS Control Program. A medium term National AIDS Control Program was also outlined.

The social and political unrest from 1991 to 1994 slowed these activities.

At the end of 1994, the MSPP organised a forum whose aims included the formulation of recommendations for outlining a second medium term plan.

On December 1st 1996, the Minister of Public Health and Population (MSPP), in collaboration with partners, devised a National Strategic Plan for the prevention and control of STIs and HIV/AIDS for the period 1996-2000. However, this plan was unable to meet the challenges of this problem for a number of reasons, including its limited view of the health sector, the lack of commitment of the various players, organisational and financial limits and a lack of coordination between interventions.

In 2002, a second National Strategic Plan for the fight against and control of STIs and HIV/AIDS for the period 2002-2006 was launched. A number of sectors, including the Ministries of National Education, Youth and Sport (MENJS), Social Affairs, Women's Affairs (MCFDF), Justice, as well as non-governmental and international organisations, and other groups were involved in its design. The plan comprised three (3) strategic objectives:

- reducing the risk of STI and HIV infection to slow down the epidemic
- reducing vulnerability
- reducing the impact of the epidemic

The National Strategic Plan for the fight against AIDS was validated by a workshop including a number of different intervention sectors, with, to a lesser extent, participation of Civil Society.

The plan covers preventive and corrective aspects; the interventions proposed address the whole population, with an emphasis on women of child-bearing age, particularly pregnant women and infected children, young people of both genders, orphans and vulnerable children, sex workers, men who have sex with other men, health personnel and employment sectors. It should be noted that, at the time of this plan, ARV drug therapy was not available on a large scale because of its exorbitant cost, therefore, medical care including ARV therapy was not sufficiently covered. The corrective treatment aspects of this plan were concentrated on opportunistic infections.

Departmental operational plans were drafted, with a detailed budget and guidelines on potential sources of funding. The MENJS and MCFDF have strategic plans but their application is not fully effective.

It should be pointed out that, in practice, the national strategic plan was only partially implemented. Certain elements were prioritised in favour of the Global Fund project and the PEPFAR project.

POLITICAL SUPPORT

The HIV/AIDS issue has been publicly debated by the government head and representatives. Certain representatives have attended national and international

forums/ symposiums on AIDS. Certain national development programs and the United Nations development aid framework include the HIV/AIDS issue. The latter covers aspects concerning the prevention of HIV, care and support, reduction of the impact of HIV and AIDS and the reduction of gender-related inequalities.

However, there is no legal national coordination organisation. The CCM, a committee set up to coordinate financing from the Global Fund, currently plays the role of a national organisation. It encourages interaction between the various players (*government, people living with HIV, private sector and civil society*) for the implementation of strategies / programs to fight the epidemic. It has an action plan and a functional secretariat.

Most of the people questioned observed that the political commitment was not yet confirmed.

PREVENTION

A support committee for the promotion of HIV/AIDS information, the “CCC cluster”, was set up to improve coordination of IEC activities. It includes a number of partners with expertise in this field.

A media organisation, the AIDS Communication Centre (CECOSIDA), organises forums, training sessions and periodical information sessions on AIDS, as part of a partnership.

Advertisements for the offer of services, behavioural change, negotiating sexual relations, promotion and use of condoms are broadcast several times a day on the radio and television. Educational equipment, such as signs, magazines, videos, pamphlets, posters, booklets, shirts and gadgets is designed and produced for distribution. Sketches are devised and produced as part of a program to improve awareness and motivation of the general public, particularly young people. Information sessions are held during patronal festivals, world AIDS day commemorations, youth days, women’s days, etc. Football tournaments are organised for young people.

Set up several years ago, a national telephone hotline provides psychological support and advice.

A protestant religious non-governmental organisation has also set up a telephone hotline service with the same goals, aimed at the general public, particularly young people.

The MSPP and its partners organise events every year to commemorate the International AIDS Candlelight Memorial.

The MENJS jointly hosts a TV show broadcast by a state channel, called “Kite jenn yo pale” (*Giving voice to the young*).

Certain institutions have developed specific IEC programmes addressed to young people, sex workers and men who have sex with other men.

Youth centres and clubs also develop specific activities for the prevention of STIs and HIV/AIDS.

The Information Health Program (PSI) has dealt with the social marketing of both male and female condoms for the past few years.

For cross-border migrants, a bi-national project (*Republic of Haiti / Dominican Republic*) has been devised by the North-East department.

Measures have been taken concerning blood safety and risk-free injection, and for waste management, particularly bio-medical waste: the MSPP has given the Haitian Red Cross the responsibility of managing transfusion activities, creation of the national blood safety program, injection safety project, personnel training, equipment installation, supervision etc.

Screening for syphilis has always been a component of the package offered during prenatal consultations as part of the reproductive health program. The MTCTP program set up in 1999 has been intensified. It is currently available in 72 healthcare institutions.

All those encountered in both the public and private sectors agree that efforts for the implementation of HIV prevention programs were intensified in 2005 thanks to a greater availability of resources from the Global Fund and PEPFAR.

CARE AND SUPPORT

Since 1996, with the 1996-2000 strategic plan, the MSPP has focussed on the integral treatment aspect of infected and affected people. With the possibilities available (*better access to drugs, increased interest from funding agencies for therapeutic care, international solidarity in favour of low income countries*), the MSPP has been able to strengthen its institutional treatment capacity and include the community aspect, with a concern for harmonising the various interventions. Two (2) manuals of standards have been drafted and distributed, one concerning clinical and therapeutic care (2004) and the other concerning community care (2005), to people infected and affected by HIV/AIDS.

The care program mainly covers HIV screening activities, the treatment of opportunistic infections, STIs and antiretroviral treatment, prophylaxis via cotrimoxazole and INH.

These activities were reinforced in 2005, particularly in the field of antiretroviral treatment, thanks to a increase in the budget from the State and certain NGOs, through the Global Fund and PEPFAR. Access is still low and national cover is very limited. For some, the eligibility criteria are too strict and should be reviewed and possibly amended.

Several people reported that the psychological and social support provided to people infected and affected by HIV was meagre.

Nutritional care is not widespread; it remains dependent on the actions of certain NGOs and international agencies.

Post-exposure prophylaxis, previously implemented only at the two (2) main screening and treatment sites (GHESKIO and PIH centres), was extended in 2005 to other centres in both the metropolitan area and in certain major provincial cities; the metropolitan area is better covered.

However, some consider that progress remains insufficient.

Home care is not yet well organised. According to those interviewed, there has been no progress in this field.

Support is given to orphans and other vulnerable children via specific activities by a small number of national and international organisations and the extended family. The organisations take on the costs of schooling and set up community programs aimed at restoring children to their original family, social and professional training, economic support to families via income-generating activities, training of community leaders, women's awareness by HIV+ women, medical support, etc.

HUMAN RIGHTS

The country still has no laws or legislation to protect PLWH against discrimination. However, the country has signed the convention concerning the rights of children and has a child protection code. No laws or regulations require healthcare personnel to give care to people infected or affected by AIDS and article 19 of the constitution stipulates that *"the State has the absolute obligation to guarantee the right to life, health and respect of the human person, to all citizens without distinction, in conformity with the Universal Declaration of the Rights of Man"*.

The HIV and AIDS control strategy includes a section on promoting protection of the rights of infected and affected people. All those interviewed agree that the government gives neither political support nor financial backing to encourage the participation of vulnerable populations in the design of public policies related to HIV and program implementation.

The health policy is based on principles of equality and fairness guaranteed by the Constitution. Women and children receive more care in Haiti than men. Policy implementation is not effective.

No policy prohibits HIV screening for employment.

In terms of research, a bio-ethics and individual protection committee was formed in 1999 by ministerial decree. There is a Human Rights Committee in the GHESKIO centres and a training, screening, treatment and research institute was set up in 1984. These committees include representatives from Civil Society but no confirmed PLWH. Concerning anti-HIV vaccination tests in Haiti, a representative appointed by the MSPP sits on the international technical and scientific supervision committee, the "Data Safety Monitoring Board". A consultant community committee was created by the GHESKIO centres to inform the community about AIDS issues and the vaccination test program in which Haiti first participated in 2001 (project implemented in the GHESKIO centres).

In the legal sector, the rare activities come from private initiatives, such as the PHAP (*Platform for PLWH, grouping together several Associations: ASON, GIPA, REHPIVI, FEBS, MHDR and GRASADIS*), the CARLI and the RNDDH; national cover remains very limited. According to certain interviewees, the CARLI is involved for the review of legal texts and the RNDDH is involved in the protection of the rights of PLWH and prison inmates.

A few legal personalities were reached by Human Rights day celebrations.

Information collection, education and awareness programs aimed at PLWH concerning rights issues are mainly achieved via the PHAP.

Concerning the reduction of the effects of stigmatisation and discrimination, the MSPP has validated a document related to social awareness of this issue. Certain NGOs have programs in this field.

Efforts aimed at designing and applying non-discriminatory laws/regulations for infected and affected people are not significant. For some, the fundamental rights of the person must be envisaged without consideration of serological status.

CIVIL SOCIETY PARTICIPATION

Civil society has expressed its desire to contribute to the fight against AIDS. However, its participation in the planning and implementation of the response to the epidemic remains low according to many in spite of the fact that a higher level of involvement was observed in 2005.

MONITORING AND EVALUATION

The country has no national monitoring and evaluation plan. A national framework for Monitoring/Evaluation is being set up. The following elements will be taken into account:

- data collection and analysis strategy,
- strategy to assess data quality and accuracy,
- data distribution and use strategy
- and a defined set of indicators for program management.

In parallel, a new strategic plan to supply the framework is in development.

A monitoring and evaluation unit exists and is based in the MSPP. It has encountered some difficulties because of its limited resources. A full-time administrator has been appointed.

A work group called the "Monitoring/Evaluation Cluster" has been formed. It is responsible for coordinating activities. It comprises a number of representatives from those working in the field and was formed in 2004. However, it still cannot fulfil its missions to full extent. Its last meeting dates back to November 23rd 2005. It includes representatives from the two (2) largest contributors to the fight against HIV/AIDS, the Global Fund and the PEPFAR. These two organisations each manage their own databases. Negotiations are underway to achieve better harmonisation of tools. Civil society and PLWH are not represented.

One national NGO, the Haitian Children's Institute (IHE), is responsible for monitoring data under a contract signed with the CDC as part of the PEPFAR project. It validates and, to a certain extent, analyses the data. It works in partnership with the MSPP and collaborates with other institutions that are involved.

The indicators related to voluntary screening activities and the MTCTP program were finalised in workshops, the collection and transmission tools were designed and distributed; personnel were trained in their use and supervised.

In 2004, monitoring and evaluation training sessions were organised on a national and regional basis for personnel from the MSPP and other partner institutions involved.

A medical file developed by another contributor (I-TECH) is used and has been evaluated. The necessary corrections have been made and the results and perspectives were discussed during a workshop.

An electronic database, MESI, has been developed by SOLUTION – a private computer engineering firm – with support from the IHE and is managed by the IHE and the monitoring and evaluation unit. It is in the process of being adopted.

There is no single health information system, but several sub-systems. Reporting is made either on a monthly or on a three-monthly basis, depending on the procedures laid out by the MSPP or contributor. However, these deadlines are not always respected.

Since 1993, sentinel serosurveillance studies on the prevalence of HIV, Syphilis and hepatitis B in pregnant women have been carried out every three (3) years in Haiti. The last one, in 2003-2004, included the prevalence of hepatitis C. The fifth study is presently in the planning stage. Furthermore, the fourth mortality, morbidity and use of services survey (EMMUS-IV) is underway. It also aims to determine the prevalence of HIV/AIDS on a national level.

Epidemiological projections of HIV/AIDS are made on the basis of seroprevalence data, among other sources. The latest update was in November 2004. Experts are waiting for the results of EMMUS-IV and those of the seroprevalence study to make new projections.

Active surveillance of HIV/AIDS cases will be restarted in February 2004, on a pilot basis in four (4) ARV sites. Surveillance has been evaluated, the results are conclusive and have been published at the last Monitoring/Evaluation Cluster meeting. A consensus workshop involving the various contributors will be organised before extension of this surveillance.

Information is regularly shared during meetings, by e-mail or by regular mail.

In the Ministry of Education, there is no information system in operation.

NATIONAL PROGRAMS: PREVENTION/EDUCATION	
Percentage of schools with teachers who have been trained in life-skills-based HIV education and who taught it during the last academic year	----

The results of several studies carried out in Haiti reported the precarious situation of young people's protection in sexual matters. During a discussion day organised before the development of the national sectorial education plan (PSNE), one of the observations on the impact of HIV/AIDS on education is the reduction of the offer in terms of inadequate resources for education (*loss of qualified managers, reduced productivity of infected/affected people*) and the reduction in the number of children going to school and completing their schooling (*death of responsible adults, re-assignment of family resources, reduction of public and private funds, school abandon*). Conscious of this reality, the government, through the Ministry of National Education, Youth and Sport (MENJS), in collaboration with international organisations and the private sector, set up a family life education project in 1998. Most parents are in favour of their children receiving sex education. According to the EMMUS-III survey in 2000, 62% of men and 49% of women questioned considered that children of 12-14 years should be educated in condom use. After development of the national strategic plan, the PSNE was devised in 2003 but is not yet implemented in full. At present, the MENJS is running an STI and HIV/AIDS prevention project, again in partnership with international agencies and the private sector. This project is run in public sector schools for the moment. A TV show, "Kite jèn yo pale/Giving voice to the young" has been launched, with debates between youngsters at school, coordinated by specialists in the topic on subjects related to lifestyle, prevention and treatment of STIs, HIV/AIDS and reproductive health.

According to the MENJS's school health manager, the project favours peer education strategies. However, teachers and parents are important contributors in the fight, and are included in the program.

During this year, around thirty teachers of 7th year, fundamental in philosophy, from the metropolitan area and the North-East department have been trained. This training was organised in collaboration with the MSPP School health service VDH, FOSREF and Plan Haiti. However, these teachers have not yet put their training into practice.

NATIONAL PROGRAMS: PREVENTION/ WORKPLACE POLICIES

Percentage of large enterprises/companies which have HIV/AIDS workplace policies and programs

One of the negative consequences of HIV/AIDS is its impact on the economy, affecting mostly the production class and causing increased use of resources for care of people affected and infected by HIV/AIDS, in spite of the significant reduction in the prices of drugs (ARV).

The commercial and industrial sectors, via the Haiti Chamber of Commerce and Industry and the Association of Industries in Haiti, are committed to the fight against HIV/AIDS, with the support of the Centre for the Promotion of Working Women (CPFO) and the government, with a view to diminishing the economic and social impact of the pandemic.

For approximately twenty (20) years, the CPFO has been working with working women to fight against STIs and HIV/AIDS. Its activities include the preventive and corrective aspects of the fight.

NATIONAL PROGRAMS: PREVENTION/ PREVENTION OF MOTHER-TO-CHILD TRANSMISSION COVERAGE

Percentage of HIV-positive pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of MTCT

19.37%¹

In 1999, the Ministry of Public Health and Population (MSPP) launched a pilot project for the Prevention of Mother-to-Child transmission of HIV in Haiti with help from a number of partners, such as UNICEF, PAHO/WHO, UNAIDS, French Cooperation, the GHESKIO centres, the Haitian Children’s Institute, the Haiti state academic hospital and the Fort de France academic hospital, with funding from UNAIDS, UNICEF and the INTERNATIONAL THERAPEUTIC SOLIDARITY FUND. Three (3) institutions took part before the project was extended to around sixty institutions throughout the country. The drugs supplied under this program are AZT and Nevirapine. A low percentage of pregnant women receive short-term triple therapy.

The coverage of HIV-positive pregnant women under prophylaxis treatment remains low; it is estimated at 19.36%.

¹ Estimations according to methods proposed by the UNAIDS Guidelines for the Construction of Core Indicators, for the period January to September 2005, using seroprevalance study data

Several factors may explain this low coverage:

- Limited access of women to healthcare (*non-existence of health services: 39% and distance from healthcare institutions: 37%*)
- Late prenatal consultation
- Low rate of institutional birthing: 23%
- Stigmatisation

The low rate of institutional birthing is the most important factor.

NATIONAL PROGRAMS: PREVENTION/ BLOOD SAFETY	
Percentage of transfused blood units screened for HIV	100% of blood units delivered were tested (HIV-1 and 2)¹

In Haiti, there is no data on the transmission of HIV via blood transfusion but the experts agree that this mode of transmission represents a negligible percentage of cases. However, like the other countries committed to the fight against HIV/AIDS, the authorities have made blood safety one of the priorities because of the risk of infection in the blood and its derivatives. A national blood safety program has been set up. The MEASURE/Evaluation project, an injection safety and waste management project, has also been set up.

In 1986-1987, the MSPP gave the Haitian Red Cross sole responsibility for blood collection and transfusion supply. The network comprises twelve (12) sites. Three (3) of the ten (10) departments, North-East, North-West and Nippes, have no sites.

According to the information collected by the Haitian Red Cross, 100% of blood units produced were screened for HIV-1 and HIV-2 antibodies. Most blood donations come from inter-family donors (95%) and 5% of permanent donors are altruistic. For a number of years, the Haitian Red Cross has had to face up to a lack of regular voluntary donors, causing stock formation and renewal problems. A media awareness campaign (*newspapers, radio, television*) is run by the Red Cross, with support from the MSPP, international agencies and non-government organisations, to increase altruistic donations and increase loyalty of previous donors.

¹ Haitian Red Cross

KNOWLEDGE AND BEHAVIOUR	
Percentage of young women and men who have had sex before the age of 15 (Percentage of young people aged 20-24, claiming to have had their first sexual relations before the age of 18)	<p>Women 15-19 years: 12%¹ Women 20-24 years: 13.9%</p> <p>Men 15-19 years: 28.3% Men 20-24 years: 33.8%</p>

Early sexual relations create a risk of unwanted pregnancy and sexually transmitted infections. In Haiti, relatively high proportions of young people (12% of women aged 15-19 / 13.9% of women aged 20-24 and 28.9% of men aged 15-19 / 33.8% of men aged 20-24) had had sex before the age of 15.

Early sexual relations are more common in boys than in girls. This may be explained by certain cultural beliefs in our country.

KNOWLEDGE AND BEHAVIOUR	
Percentage of young women and men aged 15-24 who have had sex with a non-marital, non-cohabiting sexual partner in the last 12 months	<p>Boys: 9.0% (paid relations)² Girls in relationship: 38.2%³ Boys in relationship: 66.7%</p>
** Percentage of young women and men aged 15-24 reporting the use of a condom the last time they had sex with a non-marital, non-cohabiting partner (<i>Use of a condom in the 12 months preceding the survey with a partner other than regular partner</i>)	<p>Women 15-19 years: 24.6%⁴ Women 20-24 years: 17.1% Women 15-24 years: 20.0%</p> <p>Men 15-19 years: 32.9% Men 20-24 years: 27.4% Men 15-24 years: 30.0%</p>

It is difficult to evaluate the percentage of girls who have had paid sexual relations outside marriage, because of the taboo surrounding this subject.

Monogamy is the officially recognised form of union. However, multiple partners are relatively common and more so with men than women. Indeed, 38.2% of girls in a relationship and 66.7% of boys in a relationship have had sexual relations with other partners during the 12 months preceding the survey⁵ carried out in 2000.

¹ EMMUS-III, HAITI 2000

² ESC, HAITI 2003

³ EMUUS-III, HAITI 2000

⁴ EMMUS-III, HAITI 2000

⁵ EMMUS-III, 2000

Furthermore, 9% of boys have had paid sexual relations during the 12 months preceding the survey, whereas none of the girls questioned had had this type of relations.¹

Despite the fact that the condom remains one of the reliable methods of preventing STIs and HIV/AIDS, a relatively high percentage of those interviewed (24.6% of women aged 15-19 and 17.1% aged 20-24 years; 32.9% of men aged 15-19 and 27.4% aged 20-24) have unprotected sexual relations with partners other than their regular partner.

For a number of years, “casual prostitution” has been developing in young girls living with their parents, mainly because of the deterioration of social and economic conditions. On this basis, there is reason to believe that the respondents may not report having had sexual relations in return for money / payment in kind.

The low level of condom use is mainly due to the taboos concerning this means of prevention and the idea that condom use can only be negotiated by sex workers.

NATIONAL PROGRAMS: CARE AND TREATMENT / STI CASE MANAGEMENT	
Percentage of women and men with sexually transmitted infections at healthcare facilities who are appropriately diagnosed, treated and counselled (Percentage of people with an STI who are treated)	84.03%² Men: 86.1% Women: 83.6%

It is recognised that STIs, particularly syphilis, besides the fact that they may cause other health problems (*blindness, sterility, womb cancer, etc.*), increase the risks of contracting HIV. The seroprevalance study carried out among pregnant women in 2003/2004 corroborates the results of the work done in 1999 by the GHESKIO centres; pregnant women testing positive for syphilis are three times more likely to be infected by HIV than pregnant women without syphilis. According to EMMUS-III, reported STI prevalence (declarations and symptoms) is 15% in women and 9% in men. A recent behavioural study (2003) showed prevalence among 15-24 year olds of 44% in street boys, 8% in boys, 25% in girls and 24% in women aged 25-49. Girls aged 15-24 and women aged 25-49 were equally affected. Prevention and care activities have been stepped up but their coverage remains insufficient.

¹ ESC, 2004

² Source: *monthly statistical reports from the PEPFAR network (comprising 93 VTC sites, including 72 MTCTP sites), January - September 2005*

At present, we have no information that enables compliance with the operational definition of the indicator as specified. However, as part of the VTC program, the definition adopted refers to people screened for STI who received treatment.

From January to November 2005, of the 32 342 STI cases diagnosed in the network of institutions financed by the PEPFAR, 5 021 of whom were male and 27 322 of whom were female, 27 178 received a course of treatment, i.e. 84.03%. This percentage is 86.1% for men and 83.6% for women. The behavioural surveillance survey carried out in 2003, it was noted that treatment and counselling was sought mainly by women aged 25-49 (58.4%) and by women aged 15-24 (46.3%) (p=0.004).

This disparity in seeking treatment between men and women results from the way the health system operates; it has long since favoured women and children.

Concerning young people, this major difference may be explained by the taboo surrounding such pathologies and the low level of availability of services dedicated to them.

NATIONAL PROGRAMS: CARE AND TREATMENT / ANTIRETROVIRAL COMBINATION THERAPY COVERAGE	
Percentage of women and men with advanced HIV infection receiving antiretroviral combination therapy	11.2%

The therapeutic care of people living with HIV is one of the strategies given priority by the HIV/AIDS control program. Although for a long time the exorbitant cost of antiretroviral therapy was a major obstacle to treatment accessibility, over the past four (4) years, access to such drugs has improved with additional resource contributions from the Global Fund and PEPFAR. This has enabled the country to strengthen its response to the pandemic, by broadening the range of services offered to PLWH. A manual of clinical and therapeutic care standards for people living with HIV has been published in collaboration with several partners who have developed expertise on the topic, to help standardise the care given to patients. The manual was presented to managers and partners at a science day event. Training sessions have been organised to reinforce the technical capacities of service providers to improve the care of PLWH.

According to estimations for 2005, approximately 40 000 people (15% of the 271 000 HIV-positive) should receive antiretroviral therapy. However, according to the managers of the Monitoring/Evaluation unit, the MSPP/UCC with its

partners aim to provide treatment for 9 200 people with advanced HIV infection, in view of the resources available and other limiting factors.

From January to November 2005, 4 478 people¹ started a course of ARV, i.e. 11.2%. 48.7% of objectives have been achieved.

Accompanying measures have also been taken to increase coverage and ensure compliance with treatment, for example: intensification of awareness efforts, home visits, availability of service providers outside working hours, food support, transport aid, distribution of telephone cards to facilitate patient/service provider communication and addition of an accompanying person (*for certain institutions*).

However, certain factors still limit access to treatment: people are afraid of knowing whether or not they are HIV+, denial, stigmatisation (*forcing an HIV+ person to refrain from contacting a healthcare facility to obtain treatment or else going to a facility outside his/her area of residence*), geographic inaccessibility and the taboo surrounding this infection (*50% and 43% respectively of women and men questioned in 2000 stated that AIDS could be transmitted by witchcraft*).

NATIONAL PROGRAMS: CARE AND TREATMENT / SERVICES FOR ORPHANS AND OTHER VULNERABLE CHILDREN	
Percentage of orphans and vulnerable children whose households receive free basic external support in caring for the child	----

According to the EMMUS-III survey, 1% of Haitian children are orphans (no mother or father). The exact number of orphan and other vulnerable children is difficult to determine. A study ² carried out in July and August 2002 among the 32 orphanages registered by the IBERS revealed a concentration of these centres in the West department (97%), mainly in the metropolitan area (72%). These orphanages do not only accommodate orphans: 19.4% were not orphans and status was not specified for 38% of boarders. A small proportion of orphanages (3%) targeted children infected with HIV. These 32 orphanages accommodate a total of 2 958 children, aged between 1 and 21 years. In 2/3 of cases, accommodation conditions were considered acceptable.

As part of the Global Fund financing, certain institutions provide support for vulnerable children, including food aid, schooling, housing, etc.

¹ Global Fund and PEPFAR networks

² HS-2004/USAID with technical support from the IHE

According to information collected for five of the ten departments, i.e. Artibonite, Central Plateau, Grande-Anse, Nippes and North-West, a total of 1470 OVC were supported by the program.

KNOWLEDGE AND BEHAVIOUR	
** Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission (Target: 90 % by 2005 and 95 % by 2010)	Girls: 40.7%¹ Boys: 55.9%

Haiti's population is young: 46% of its inhabitants are less than 17 years old. The results of the EMMUS-III survey revealed relatively high fertility in women aged 15-19 (80 for one thousand women) and an earlier start to sexual activity in boys than in girls (among the 15 - 19 year old age group, 12% of girls had their first sexual relations before 15 compared to 28% of boys). A sentinel serosurveillance study of HIV prevalence and syphilis in pregnant women carried out in 2003-2004 reported prevalence of 2.6% and 3.8% respectively among under 25 year olds.

The government and its partners are developing and reinforcing projects aimed at young people, focussing mainly on the prevention of sexually transmitted infections and HIV/AIDS. A number of strategies are used: education in schools or in youth centres, dispensed by teachers or health workers, peer education, public awareness (*radio, television, country festivals or commemorative events, social and cultural activities, etc.*) to help young people better negotiate their sexual relations and adopt safer behaviour.

According to the results of a behaviour monitoring study carried out in 2004 aiming, among other things, to "collect data to assess the impact of prevention interventions", 40.7% of girls and 55.9% of boys aged 15-24 knew the three (3) main methods for preventing HIV infection and rejected three (3) incorrect methods of HIV transmission.

Insofar as knowledge of a disease affects the behaviour and attitudes to be adopted, preventive actions must be intensified in order to consolidate the existing and above all to increase the level of knowledge in young people. It should be noted that 24.7% and 14.7% of girls think or know respectively that AIDS cannot be avoided.²

¹ Behavioural Surveillance Survey, Haiti 2003, Applied Research and Evaluation Centre

² EMMUS-III, 2000

IMPACT	
** Ratio of current school attendance among orphans to that among non-orphans aged 10-14	100 : 96

The loss of one or both parents upsets family life, particularly for children. The EMMUS-III survey revealed that 1.7% of children aged 10-14 have lost both parents. This loss usually deprives children of both affection and certain care and services, including instruction. Introduction of a new member into an already weakened family may cause frustration and tension.

The ratio of current school attendance among orphans to that among non-orphans aged 10-14 is 100 : 96.

In Haiti, care is largely provided by the immediate or distant family. The compassion felt for such children may explain that the level of school attendance is not lower in orphaned children than among non-orphans, at least in the 10-14 age range. Above this age limit, the situation may well be different.

IMPACT	
** Percentage young women and men aged 15-24 who are HIV infected <i>(Target: 25 % reduction in most-affected countries by 2005 and 25 % globally by 2010) (Indicator calculated using data on pregnant women attending maternity wards/clinics)</i>	Pregnant women aged 15-24: 2.6%¹ Pregnant women aged 15-19: 2.1% Pregnant women aged 20-24: 2.9% Young people aged 15-24: 3.08%² Girls aged 15-24: 4.20% Boys aged 15-24: 1.98%

It is unanimously agreed that young people are the future of a country. Haiti's population, as previously mentioned, is mainly composed of young people. Several studies have identified irresponsible sexual behaviour by young people, which can be put down to a number of factors. For a number of years, the government and its partners in both the public and private sectors, have developed and implemented programs aimed at this age group, to increase their awareness of the dangers of STIs and HIV/AIDS and to "fill their leisure time and solitude" with instructive recreational activities. Campaigns are run to encourage them to find out their serological status so that they can protect themselves and other people; 45% and 55% of young girls aged 15-19 and 20-24 respectively and a slightly higher percentage of boys 56.2% aged 15-19 and 63.7% aged 20-24 wanted to be screened, according to the EMMUS-III survey.

¹ Seroprevalence study, HAITI 2003

² FOSREF youth clinics (a total of 9 located in the West, Nippes and North departments), October – September 2005

According to the results of the seroprevalance survey (2003/2004), 2.6% of pregnant women aged 15-24 receiving screening were HIV-positive, 2.1% of whom were aged 15-19 and 2.9% aged 20-24.

Data from the FOSREF youth clinics (one of the institutions recognised for its expertise in this field) for the October 2004-September 2005 period, reports a percentage of seropositivity of 3.08% among young people aged 15-24. Girls are more affected than boys, 4.2% and 1.98% (p=0,0000), corroborating the observation that the epidemic is becoming increasingly feminine. These centres each receive an average of 60 to 100 young people per day for the following services: sexual health counselling, sex education / family life training, awareness sessions, VTC/HIV, gynaecological consultations, STI.

IMPACT	
Percentage of adults and children with HIV still alive 12 months after initiation of antiretroviral therapy	93.52%

The living conditions of PLWH have improved with the introduction of antiretroviral therapy. The mortality rate has dropped from 20% at 4.9 months in 1991 to 44% at 18 months in 1994. The results of a recent study carried out by the GHESKIO centres, in collaboration with US universities on 1004 patients who commenced treatment in March 2003 reveal that 90% of patients were still alive after six (6) months and 87% after twelve (12) months.

Data collected by the GHESKIO centres and the Béthel de Fonds des Nègres clinic shows that 93.52% of the 139 patients registered in the past twelve months are still alive.

IMPACT	
Percentage of infants born to HIV-infected mothers who are infected <i>(Target: 20 % reduction by 2005 and 50 % by 2010)</i>	26%

As for indicator # 6, a mother-to-child HIV transmission prevention program was started as a pilot action in 1999. MTCTP services are only on offer in 8.4% of the country's healthcare institutions. The level of transmission without

intervention is estimated at 30%. However, on a national scale, this program has not yet had the effects expected, as a relatively low percentage of pregnant women (19.36%) were able to complete their antiretroviral prophylaxis treatment.

According to estimations made on the basis of data collected by the PEPFAR network and the rate of seroprevalence in pregnant women, the percentage of HIV+ infants born to HIV-infected mothers remains high: 26.

In institutions like the GHESKIO centres, *(which have developed expertise in this field)* where patient loyalty exists, a reduction has been observed: from 30% to 8% in the case of single therapy and to 2% in the case of triple therapy.

CONCLUSION

Progress has certainly been made in the fight against AIDS in Haiti, as shown by the level and evolution of many indicators in this report. For certain indicators, the absence of data makes it impossible to specify the current situation.

It is important that the MSPP updates the national AIDS control strategic plan (PSN) as quickly as possible to guarantee and even reinforce the progress already made. Revision of the content of Global Fund and PEPFAR projects is also important to include them in the PSN thereby ensuring optimal synergy between current activities and maximise effectiveness and efficiency.

Specific attention must be given to making the PSN operational in order to eliminate the weaknesses observed. Particular emphasis should be given to the following:

- A stronger and more concrete commitment from the Haitian state (government and civil society) in this fight
- A reinforcement of the rights of PLWH to reduce stigmatisation and discrimination considerably
- Making the PSNE and PSMCFDF operational
- Broadening coverage of MTCTP
- Reinforcement of care and treatment and the management of STIs, particularly aimed at men.
- Widening the access to antiretroviral treatment, whilst ensuring strict compliance with standards in the administration of such care
- A reinforcement of the services available to orphans and other vulnerable children.

It is obvious that reinforcement / harmonisation of the Monitoring-Evaluation component is essential to enable better monitoring of the scheduled activities and make the necessary corrections to their implementation.

In the future, the UNGASS report preparation process must be started much earlier.

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REPORT PREPARATION METHODOLOGY

Collection procedures

Before commencing the collection process, potential data sources were identified and the reference list was finalised with the members of the Monitoring/Evaluation “Cluster”.

Several techniques were used for data collection: interview, document review, consultation of existing databases.

Mini interviews were held with managers and/or representatives of the Ministry of Public Health and Population (MSPP), national and international organisations

Technical documents and the database (MESI) were consulted for the purposes of this report.

Collection instruments

The “Guidelines for the Construction of Core Indicators” containing the list of indicators were used for data collection.

The national composite policy index questionnaire provided by UNGASS was used for the mini-interviews with managers and/or representatives of the Ministry of Public Health and Population (MSPP), national and international organisations.

Data processing / analysis

After completion of each chapter, the data was analysed. Consensus was reached on data collected during a Monitoring/Evaluation Cluster meeting organised by the UCC. Corrections were made to take the proposed modifications into account.

LIMITS

The main difficulty encountered was linked to the non-existence of a central information system enabling generation of all the indicators for the UNGASS report. Instead, a number of different databases had to be consulted and reports prepared by the various organisations. In most cases, up-to-date data was not available, which meant using figures from before 2005 or calculating estimations.

The second main difficulty was the non-availability of financial information, which meant it was impossible to determine the amount of national funds disbursed for AIDS control, thereby eliminating this important section from the report.

Finally, the short amount of time given to prepare the report was a further constraint.

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