

Republic of Nicaragua  
Central America

Report on monitoring the follow-up to the Declaration of commitment on HIV/AIDS  
Nicaragua 2006

**UNGASS Nicaragua report  
2003-2005**

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## ABBREVIATIONS

SICA:	Spanish International Cooperation Agency
ASONVIHSIDA:	Nicaraguan association for people living with HIV/AIDS
CNLCSSC:	Civil society national commission for the fight against AIDS
CONISIDA:	Nicaraguan AIDS Commission
CONCASIDA:	Central American Congress on HIV/AIDS
COSEP:	Superior Council of Private Enterprise in Nicaragua
CRIS:	Country Response Information System
STD:	Sexually transmitted diseases
ERCERP:	Strengthened Economic Growth and Poverty Reduction Strategy
IEC:	Information, Education and Communication
INSS:	National Social Security Institute
STI:	Sexually transmitted infections
MSM:	Men who have sex with other men
CCM:	Country Coordinating Mechanism
MECD:	Ministry of Education, Culture and Sport
MIFAMILIA:	Ministry for the family
MIGOB:	Ministry of the Interior
MINSA:	Ministry of Health
MITRAB:	Ministry of Labour
MSETS:	Syndrome-based management of Sexually Transmitted Diseases
NORAD:	Norwegian Agency for Development Cooperation
WHO:	World Health Organisation
UNAIDS:	Joint United Nations Programme on HIV/AIDS
PAHO:	Pan American Health Organisation
NGO:	Nongovernmental organisation
PASCA:	Central America HIV/AIDS Prevention Project
PASMO:	Pan American Social Marketing Organization
PEN:	National Strategic Plan
UNDP:	United Nations Development Programme
PLWHA:	People living with HIV/AIDS
ART:	Anti-retroviral therapy
RAAN:	North Atlantic Autonomous Region
RAAS:	South Atlantic Autonomous Region
SILAIS:	Local System of Integrated Health Care
AIDS:	Acquired Immune Deficiency Syndrome
SISCA:	Department of Central American Integration
UNGASS:	United Nations General Assembly
UNICEF:	United Nations Children's Fund
USAID:	United States Agency for International Development
HIV:	Human Immunodeficiency Virus

## INTRODUCTION

The Ministry of Health in the Republic of Nicaragua, in close and fruitful collaboration with its national and international health sector partners, has been making the necessary organisational changes to ensure that people living with HIV/AIDS receive appropriate care and that the spread of the HIV/AIDS epidemic in Nicaragua is contained. The 2004-2015 National Health Plan has shown the swift rise, as of 1998, of the HIV/AIDS incidence rate and it considers current levels to be almost out of control. This situation requires swift and comprehensive measures to be taken by the whole of Nicaraguan society.

The National Plan bolsters the health sector's response capacity and guarantees the sustainability of health measures and actions. These factors are the building blocks behind the national effort and they go hand in hand with the National Health Policy and the commitment to intra- and inter-sectorial actions and social participation.

The National Plan also recognises that the elements causing HIV/AIDS are exacerbated by poverty, unsafe sex and the high STI incidence rates, especially among population groups of reproductive age. In addition to signalling that young people run a high risk of contracting HIV/AIDS, it also points out that the epidemic tends to affect women to a greater extent and mentions what has been called the epidemic's "feminisation".

The strengthening of primary care and the implementation of measures and services concerning promotion, prevention and protection at all levels is a priority. Care provided to the population is covered in the Model for Integral Attention in Health (MAIS). This model must serve as a reference for any proposal concerning HIV/AIDS, the search for quality and access to health services and measures, in line with MAIS. The issue of improving access to essential health services for the poor and those living in extreme poverty also arises. It also considers ethnic and indigenous populations and vulnerable groups with difficult access, such as people living with HIV/AIDS.

The progress mentioned has been possible thanks to the participation of various players who, thanks to the trust built during these processes, and through their experience and strengths, have contributed to the achievements outlined in this Country Report.

The monitoring and evaluation of the national response must be regarded as an on-going effort and commitment made by all, from the commitments taken in plans and policies to the specific initiatives, while ensuring that social participation is a strategy that strengthens all of the institutions, organisations and local, national and international bodies contributing to the national effort.

Our commitment as a country has been effective thanks to the participation of one and all. It will continue to be effective in the future thanks to the lessons we will be able to draw from monitoring and evaluating our response, which is the subject of this report.

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CONISIDA Chairwoman  
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## INDEX

Abbreviations  
Introduction

### Chapter

- I Status at a glance
- II Overview of the AIDS epidemic
- III National response to the AIDS epidemic
- IV Major challenges faced and actions needed to achieve the UNGASS goals/targets
- V Support required from the country's development partners
- VI Monitoring and evaluation environment
- VII Bibliography

### Appendices

- Appendix 1* Consultation/preparation process for the national report on monitoring the follow-up to the *Declaration of Commitment on HIV/AIDS*.
- Appendix 2* National Composite Policy Index questionnaire
- Appendix 3* National Return Forms for programme, knowledge, behaviour and impact indicators

**Report on monitoring the follow-up to the Declaration of commitment on  
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**I STATUS AT A GLANCE**

As of 1987 in Nicaragua, with the appearance of the first HIV/AIDS case, this health problem has formed part of the programme dealing with sexually transmitted diseases, later known as the National programme to prevent, control and treat STI/HIV/AIDS. The aim of this programme was to reduce the transmission of these diseases by implementing policies, plans, programmes and projects which ensured promotional, preventive, recovery and rehabilitation measures aimed at the population, thus encouraging the participation of civil society.

Nicaragua is characterised by inequalities caused by poverty. The head of one in four households is a woman. The risk of contracting HIV/AIDS and its spread among the country's population is exacerbated by the violence and sexual exploitation affecting children and teenagers, population flows from rural to urban areas and from Nicaragua to neighbouring countries, particularly Costa Rica. The small number of cases reported to date, according to official data, lulls the majority of the population into a false sense of security which could be undermining the effectiveness of the measures and initiatives aimed at improving the population's capacity to prevent the spread of the epidemic.

The Nicaraguan AIDS Commission (CONISIDA), the legal body whose task is to apply Law 238, guides the country's response to HIV/AIDS. CONISIDA is coordinated by the Ministry of Health and is made up of government bodies such as the Ministry of Labour, Ministry of Education, Culture and Sport, Ministry of the Interior, the Nicaraguan Social Security Institute, representatives of Nicaragua's north and south Atlantic autonomous regional councils, and representatives from the Civil society national commission for the fight against AIDS, the Nicaraguan human rights commission, the Human rights protection agency, Nicaraguan red cross and the People living with HIV/AIDS delegation.

In 1999, the National Strategic Plan to fight STI/HIV/AIDS<sup>1</sup> was approved for 1999-2004. In this plan, eight transversal strategies aimed at countering the impact of HIV/AIDS and promoting risk-free behaviour were laid down. It also proposed multi-sectorial and cooperation agency participation, such as NORAD, UNAIDS<sup>2</sup>, USAID and international support programmes for Central America, such as PASCA.

Another important step forward was the setting up of CONISIDA with the aim of strengthening multi-sectorial coordination and providing an effective and consistent response to the epidemic while considering that HIV/AIDS poses such a complex epidemiological profile that it has to be tackled through complete, concerted and coordinated measures between various government and civil society sectors.

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<sup>1</sup> Government of Nicaragua. National Strategic plan to fight STI/HIV/AIDS. Managua, Nicaragua. Ministry of Health, 2000.

<sup>2</sup> UNAIDS. New outlook in the fight against HIV/AIDS in Nicaragua. Called up for Action...time to act. Published by UNAIDS, 2000.

Nicaragua tabled its proposal when the Global Fund to fight AIDS, Tuberculosis and Malaria was created and it is now one of the countries benefiting from the Fund. This meant a coordinating body had to be set up to comply with the Fund's regulations. The Country Coordinating Mechanism (CCM) was thus established in 2002. Its initial members were six government institutions, two multilateral bodies, three NGOs, five educational organisations, one private sector company, one religious group and one association representing people living with HIV/AIDS.

In 2003 and as a result of its members' preparatory work, the CCM tabled a proposal to the Fund entitled, 'Nicaragua, commitment and action against AIDS, Tuberculosis and Malaria'<sup>3</sup>. The total budget for this project stood at US \$ 18,865,903, of which the HIV/AIDS component was US \$ 10,399,709,00. In compliance with the criteria which shape the donation's acceptance and allocation, the CCM suggested to the Fund that Federación Red NicaSalud should be the main recipient to manage and administer the donation.

The Global Fund, through the main recipient (NicaSalud) and the CCM, at the request of the Ministry of Health (MINSa) and the Ministry of Education, Culture and Sport (MECD), expressed its concern over the effective and opportune use of the funds granted to Nicaragua. This is due to a number of delays in some activities concerning the execution and respective rendering of the funds for the first disbursement, which could compromise the conditions in which the funds for subsequent phases are transferred. For this reason, the elements needed to strengthen multi-sectorial coordination for the national response to HIV/AIDS in Nicaragua were identified. This study was undertaken between July and October 2005.<sup>4</sup>

Among these elements, the need to strengthen coordination between the various players involved in the country's response, mainly in areas connected to the management of resources already available to strengthen and implement the country's response, was mentioned. This ranges from CONISIDA members to cooperation agencies, and not just the Global Fund and its main recipient in Nicaragua, but also those living with HIV/AIDS represented by ASONVIHSIDA and other PLWHA groups.

This document also outlines the need for CONISIDA to be supported in its role as a key player in the coordination of the various local and national initiatives. Local initiatives go through departmental commissions and are then passed on to the national CONISIDA body, which needs to be promoted to the level of a Secretariat so that it can support the implementation of programmes and campaigns launched to prevent and control HIV/AIDS. These programmes and campaigns are not the sole responsibility of MINSa or NICASALUD, as the main recipient of the Global Fund donation.

Since 2003 other political and social factors have arisen in Nicaragua which favour the development of joint actions to fight against HIV/AIDS, as the impact of the epidemic on the country's development has shown.

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<sup>3</sup> Government of Nicaragua. 'Nicaragua, commitment and action against AIDS, Tuberculosis and Malaria'. 2003

<sup>4</sup> Elements to strengthen multi-sectorial coordination for the national response to HIV/AIDS in Nicaragua. July-October 2005. Anne Christian Largaespada Fredersdoff. NICASALUD. Document for discussion.

On a basis of consensus, the political, strategic and technical milestones which shape the country's response to HIV/AIDS have gradually been built. The Strengthened Economic Growth and Poverty Reduction Strategy (ERCERP) lays down the measures that Nicaragua will implement to fight poverty and create development pools in various parts of the country. The National Development Plan also defines sustainable human development strategies in Nicaragua. Both initiatives would be seriously compromised if the spread of HIV/AIDS went unchecked.

In the same period, Nicaragua's health sector has seen a significant step forward with the drafting and launch of the 2004-2015 National Health Policy.<sup>5</sup> This achievement is still not specific enough to HIV/AIDS. It only looks at the epidemic from the perspective of prevention and control of transmissible and non-transmissible diseases as well as the main re-emerging and emerging diseases, like HIV/AIDS. Although it mentions intra- and inter-sectorial participation as an approach, it is the only mention of a strategy which looks at the HIV/AIDS epidemic.

For this reason, for many sectorial players, the way in which HIV/AIDS has been approached is far from appropriate given the magnitude of the epidemic and the potential risk. This contradiction is shown in the Policy itself: although the chapter on dangers to health refers to STI/HIV/AIDS as "specifically harmful to priority health", these diseases are not prioritised in the rest of the document.

Another element needed to bring the effort made into a political and technical framework was the evaluation of the 2000-2004 National Strategic Plan (PEN) and the 2006-2010 draft version of the Plan, still in a draft form in December 2005. This represents the streamlining and continuation of the efforts that have been made in Nicaragua. The Ministry of Health coordinates the process and the following bodies take part in it: CONSIDA members, civil society organisations, government bodies who deal with HIV/AIDS and international cooperation, in which intra- and inter-sectorial coordination has formed the basis upon which the proposals were discussed.

The National Strategic Plan is the tool with which MINSA deals specifically in paragraph D (Rise in HIV/AIDS) of priority area 6 (High prevalence of endemic diseases) in the 2004-2015 National Health Plan, which acknowledges the rapid rise, as of 1998, of the HIV/AIDS incidence rate and considers current levels to be almost out of control. The main aims of the National Plan are to increase the response capacity of the Health Sector and ensure the sustainability of the measures and actions taken in the area of health according to National Health Policy guidelines and within the commitment to intra- and inter-sectorial and social participation.

The National Plan also recognises that HIV/AIDS is exacerbated by poverty, unsafe sex and the high STI incidence rates, especially among population groups of reproductive age. The most common cases are gonorrhoea (17.7 per 100,000 inhabitants), genital warts (10.9 per 100,000 inhabitants), acquired syphilis (7.4 per 100,000 inhabitants) and 68% of cases concern the 15-29 year old bracket, most frequently in Chinandega, Managua and the autonomous regions of the North and South Atlantic.

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<sup>5</sup> Republic of Nicaragua. 2004-2015 National Health Policy. Managua, Nicaragua. Ministry of Health, 2004.

It also states that the epidemic tends to affect women to a greater and mentions the ‘feminisation’ of the epidemic.

The strengthening of primary care and the implementation of measures and services concerning promotion, prevention and protection at all levels constitutes the second general aim of the 2004-2015 Strategic Plan. Care given to the population is covered within the Model for Integral Attention in Health (MAIS), which must serve as a reference for any proposal concerning HIV/AIDS.

Higher quality and improved access to health services and actions in line with MAIS is the first general aim. Within this aim, coverage is the main specific goal. This looks at the issue of improving access to essential health services for the poor and those living in extreme poverty, considering ethnic and indigenous populations and, in particular, vulnerable groups with difficult access, including those living with HIV/AIDS. Widening the coverage of the National Social Security Institute (INSS) is the measure proposed.

Among the aims of the 2004-2015 National Health Plan, one national objective is “the containment of HIV/AIDS in 2015, reversing its spread and increasing the detection of cases”. This would be reflected in a number of indicators with the following results:

Results indicators	Unit of measurement	2003	AIMS		
			2005	2010	2015
HIV prevalence among young women and men aged 15-24	Per 100,000	6.2	7	8.5	10.6
HIV incidence rate	Per 100,000	4.1	6.2	10.1	15
HIV prevalence rates	Per 100,000	13.8	15.6	18	20
Number of orphans caused by HIV	Number	443	46		

Regarding access to treatment, the 2004-2015 National Health Plan considers that this should increase from 7% in 2003 to 56.6% in 2005 and 20.2% in 2010. The number of HIV-positive cases stands at 191 in 2003, 328 in 2005 and 463 in 2010.

Another important event is the IV Central American Congress on STD/HIV/AIDS (CONCASIDA), the III Latin American and Caribbean Forum of HIV/AIDS/STD and the IV Central American Encounter of People Living with HIV/AIDS held in San Salvador, El Salvador, in November 2005. A very large number of Nicaraguan delegates attended and actively participated in these events. Most of those involved in the fight against HIV/AIDS in Nicaragua took part in discussions on the future of this fight and learned about the experiences of other countries in this area.

An added strategic value mentioned by Nicaraguan participants was the chance to make contacts, learn about initiatives and establish links with those in other countries who are implementing or have implemented initiatives which are now being discussed as possibilities in Nicaragua or are being implemented as part of the country’s response to HIV/AIDS.

Many of these contacts and links have resulted in the boosting and encouragement of the initiatives being raised in Nicaragua as options to improve the quality of the country's response. The exchange between country representatives at different stages regarding the implementation and use of antiretroviral therapy and its management methods, from purchasing, distribution and application, is also noteworthy. This did not only involve those whose task is to supply such treatment but also people living with HIV/AIDS and their support groups, who took advantage of the various platforms available at the IV CONCASIDA.

Within these activities, the exchange on defending the rights of people living with HIV/AIDS to access full antiretroviral therapy from a syndrome-based perspective was given particular importance. In this context, the various experiences of countries which are also implementing Global Fund projects were looked at in great detail. This will help analyse what will soon be put in place in Nicaragua in accordance with the 2006 Plan. This was best illustrated in the various activities held to celebrate World AIDS Day on December 1 2005. One important consequence of the CONCASIDA exchanges was the support given by the Brazilian government to Nicaragua through the donation of a sufficient number of antiretroviral therapy batches to cover supply shortages and to increase the size of the population covered. Brazil will also provide technical support in 2006: laboratory staff will be trained in an effort to improve the effectiveness of their work.

ASONVIHSIDA announced that among the children of its members who have died, at least fifty are orphans and twelve live with HIV/AIDS. The lack of policies and programmes for this group was addressed at the end of November 2005 in the Central American forum for vulnerable children and other groups vulnerable to HIV/AIDS organised by the Department of Central American Integration (SISCA) and held in Nicaragua under the aegis of the Ministry of the Family.

UNICEF is preparing measures to support this effort at a regional level. These measures were included in the 1999-2004 Plan and have also been taken up again in the 2006-2010 Plan.

## **II Overview of the AIDS epidemic in Nicaragua**

### **2.1 The first step before HIV/AIDS: STI (Sexually Transmitted Infections)**

The morbidity and mortality rates are related to STI and HIV/AIDS rates. It has been proven that some of the factors that increase the vulnerability of individuals and that influence sexual behaviour propitious for the transmission of the most common STIs, are the same as those associated with the transmission of HIV through sex. It has also been proven that the presence of STIs significantly increases the risk of HIV infection.

The knowledge, attitudes and practices of those suffering from such infections, together with the stigmatisation and rejection that such infections induce, mean that these individuals seek a solution to their condition outside of the institutional health care framework and resort to known traditional practices.

The continuing existence of unofficial STI registers in Nicaragua means that a well-founded assessment on the scope, behaviour and geographical and generational distribution of the problem is not possible. Furthermore, the use of the Syndrome-based management of Sexually Transmitted Diseases manual<sup>6</sup> in health centres is still not systematic and the quality of the information completed in the obligatory notification slips is considered equally unsatisfactory.

Between 2000 and 2004, no significant changes were noted in the fluctuations of the STI incidence rate. It remained similar to what was seen in the period between 1987 and 1999 with values close to or above 100 per 100,000 inhabitants; we can thereby deduce that actual values are very high, as is the case in other countries with similar trends. Departments with the highest number of STI cases are the South Atlantic Autonomous Region (RAAS) and the North Atlantic Autonomous Region (RAAN), followed by Masaya, Chinandega, León and Managua. Among 15-24 year olds, an increase in the number of women infected is noted. This trend can be seen in the number of increasingly younger women contracting HIV/AIDS.

## **2.2 HIV/AIDS situation in Nicaragua**

Forecasts made by the Ministry of Health for 2006-2010 reveal that those living with HIV/AIDS will increase by 11.2%, bringing the prevalence rate up to 0.24% of the population aged between 15 and 49. It is believed that treatment needs and requirements at the end of the period covered in the Strategic Plan will pose a challenge to the country's response capacity to HIV/AIDS.

To date, the HIV/AIDS epidemic in Nicaragua has remained at a low prevalence level among the general population but the incidence of HIV has risen sharply. Between 1993 and 1999, a yearly average of 22 new infections were diagnosed; between 2000 and 2004 the yearly average of new HIV-positive cases rose to 131, representing an increase of 495% in only four years.

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<sup>6</sup> Government of Nicaragua. Syndrome-based management of Sexually Transmitted Diseases. Pocket book. Ministry of Health, National STI/HIV/AIDS Programme. [sf](#)

## **HIV/AIDS INCIDENCE RATE ACCORDING TO YEAR OF DIAGNOSIS. NICARAGUA 1987 – September 2005.**

See chart on page 11

Source: National STI/HIV/AIDS Programme, MINSA. Projected on the basis of records covering a 6-month period.

Between 2000 and September 2005, the accumulated HIV/AIDS incidence rate increased by a factor of three, moving from 2.52 to 8.24 per 100,000 inhabitants.<sup>7</sup> Due to progress made in the care provided to those living with HIV/AIDS, the number of people living with HIV/AIDS has rapidly increased; in September 2005, 1,914 cases were recorded. Incidence has increased while mortality has dropped due to improved access to care for PLWHA, which, in turn, increases prevalence.

Recent forecasts made by the Ministry of Health together with other institutions, calculated a HIV/AIDS prevalence rate of 0.13%<sup>8,9</sup> for this year for people aged 15 to 49. As the HIV/AIDS prevalence rate does not exceed 1% of the general population, the epidemic is considered as nascent. Nevertheless, studies carried out on men having sex with other men have revealed levels exceeding 9% among the groups studied.<sup>10</sup>

All of the country's departments have reported cases of HIV/AIDS. The highest incidence and prevalence levels are recorded in Chinandega, Managua, RAAS, León, RAAAN and Masaya.<sup>11</sup> HIV prevalence per 100,000 inhabitants in these departments as of September 2005 is: Chinandega 74.1, Managua 65.7, Leon 37.73 and Masaya 32.13.

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<sup>7</sup> MINSA. National STI/HIV/AIDS Programme. September 2005 evaluation.

<sup>8</sup> MINSA. STI/HIV/AIDS epidemiological surveillance. Nicaragua, September 2005.

<sup>9</sup> HIV/AIDS forecasts based on the spreadsheet calculation method. August 2005.

<sup>10</sup> Central American multi-centre STI/HIV/AIDS prevalence study among men having sex with other men. Nicaragua, 2002.

<sup>11</sup> MINSA. HIV/AIDS epidemiological situation. Epidemiological bulletin, June 2005.

## **HIV/AIDS prevalence period according to SILAIS, Nicaragua 1987 – September 2005.**

See chart on page 12

Source: National STI/HIV/AIDS Programme, MINSA.

At the country's other geographic and cultural extreme, the autonomous Atlantic regions have high levels of poverty and social inequalities which concern, in particular, ethnic groups and Afro-descendant communities. These populations are affected especially by geographic isolation and the fact that their needs are shunned by state institutions. The HIV prevalence rate per 100,000 inhabitants up until September 2005 in RAAS is 47.13 and 25.89 in RAAN.

Up until September 2005, 51.4% of HIV-positive individuals diagnosed at the beginning of the epidemic belong to the 20 to 39 years of age bracket, while 10.44% are children and adolescents between 0 and 19 years of age; in this bracket, 73% are between 10 and 19 years of age. This is directly linked to the early start to unprotected sexual activity in which sex without consent due to sexual abuse and rape is not to be considered. It is noteworthy that among adolescents who are HIV-positive aged 10 to 14, 71.4% are female.<sup>12</sup>

In the adolescent population, the percentage of females is almost twice the percentage of adult women. In September 2005, MINSA states that women account for 29.17% of all those who are HIV-positive aged between 20 and 35. However, out of the total number of adolescents infected aged between 10 and 19, girls account for 45.32%.

As of 1992, the yearly number of AIDS cases has tended to grow despite some fluctuations. The AIDS incidence rate per 100,000 inhabitants has continued to rise steadily over the past five years, moving from 0.51 in 2000 to 0.81 per 100,000 inhabitants in 2004.

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<sup>12</sup> Vulnerability and Gender: women and HIV/AIDS. CONCASIDA. Pizarro, Ana M., November 2005.

## **HIV/AIDS prevalence and mortality rates Nicaragua 1993 – September 2005**

See chart on page 13

Specific prevalence rate
Mortality rate

National STI/HIV/AIDS Programme; rate per 100,000 inhabitants.

The total number of deaths since the beginning of the epidemic until the end of 2004 represents 30.12% of all accumulated AIDS cases. The total number of HIV-positive cases rose by 55.12%. AIDS cases identified over the same period rose to 14.74%.<sup>13</sup> Although this percentage cannot be considered as an accurate measurement of the risk of death caused by AIDS, it reveals its highly lethal nature<sup>14</sup> due to the fact that access to appropriate care is still poor, including antiretroviral therapy and treatments for opportunistic infections.

The late detection of AIDS cases, very close to the moment of death, prevailed in the epidemic's early years. In 1994, 66.33% of the total number of cases of AIDS resulted in death<sup>15</sup>. Ten years later, this percentage dropped to 48.93%,<sup>16</sup> which is still high and proves that the disease is detected late. There is still work to be done to improve the coverage and quality of health care for those living with HIV/AIDS so that these individuals trust and are attracted to a health service which is reliable, complete and suited to their needs.

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<sup>13</sup> Out of 1,872 recorded in September 2005. National STI/HIV/AIDS Programme.

<sup>14</sup> Nicaraguan Ministry of Health. Epidemiological surveillance, National STI/HIV/AIDS Programme.

<sup>15</sup> Number of deaths (67) in comparison to the total number of AIDS cases (101). Sequential HIV/AIDS analysis in Nicaragua, Ana María Pizarro, 2001.

<sup>16</sup> Out of 1,872. National STI/HIV/AIDS Programme, September 2005.

### 2.3 HIV/AIDS and gender

Over recent years there has been a clear and rapid trend towards the disease affecting both genders equally. While in March 2001, there was one woman for every 3.12 HIV-positive men at a national level<sup>17</sup>, in September 2005 the ratio dropped to 2.61 men per woman. The man-woman ratio is gradually dropping in younger generations and men and women are almost equally affected among the 15-19 age group.

Considering the various age ranges for women, between 20-29 years of age there are 2.22 HIV-positive men per woman and in the 30-39 bracket there are 3.46 men per woman. Nevertheless, between 15-19 years of age, this ratio drops to 1.2 men per woman and goes as far as 1.14 men per woman if early adolescent years (10-19 years of age) are included in this bracket<sup>18</sup>. The feminisation of the epidemic is greater when the age of women is lower.

According to National STI/HIV/AIDS Programme records, the HIV incidence rate among women increased from 1.5 per 100,000 inhabitants in 2002 to 3.4 per 100,000 inhabitants in 2004. The same records show that housewives represented 53% of the total number of women infected in this period and that this group moved from 4.6% of all cases in 1996 to 16% of the total in 2004.

In December 1994, 97.29% of women living with HIV/AIDS were aged between 15 and 49.<sup>19</sup> Ten years later, this percentage dropped to 90.73%, a drop which occurred to the detriment of girls aged 10 to 14, who are not included in the calculation. This drop is probably due to statistical reasons as more girls aged 10 to 14 were tested.

The National STI/HIV/AIDS Programme does not make full use of the data available so as to take a closer look at the situation from a first and second generation perspective. This situation deserves to be studied in more detail to find out about the causes of such a trend and thus produce measures or adjust the care and promotion programmes to the situation affecting Nicaraguan women in particular.

HIV-infection among women falling pregnant mostly occurs among the youngest, who have the least opportunity to request contraceptive methods, avoid risky relationships and obtain suitable services and forms of treatment. In June 2005 in Nicaragua, MINSa recorded 62 HIV-positive pregnancies as of the start of the pandemic, of which 53.22% were aged between 15 and 24, among which 22.58% were aged between 15 and 19.<sup>20</sup>

Since 1999, the National Strategic Plan to fight STI/HIV/AIDS has included voluntary abortions for HIV-positive women. Nevertheless, this policy is not applied in the health system and women infected with HIV often request an abortion without ever finding an answer. Poor women, who represent the biggest category attended in the public services, may carry an unwanted and high-risk pregnancy which often results in these women being refused good-quality care. Rejection and discrimination are frequent and

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<sup>17</sup> There were 487 men and 156 women. National STI/HIV/AIDS Programme. MINSa, March 2001.

<sup>18</sup> National STI/HIV/AIDS Programme, MINSa, September 2005.

<sup>19</sup> However, it must also be noted that between 10 and 44 years of age there are not only early pregnancies but also maternal deaths. In 2002, out of 35 maternal deaths among women aged under 19, five affected girls aged 10 to 15.

<sup>20</sup> See June 2005, National STI/HIV/AIDS Programme, MINSa, Nicaragua.

end up adding further harm to that already caused by the disease. Since the beginning of the epidemic until September 2005, 54 perinatal infections were detected, which represent 2.82% of the accumulated total. Between 2000 and 2005, there was an increase in the detection of new mother-to-child infections, moving from two in 2001 to eleven in 2004, which represents a shift from 2.4% of the total in 2001 to 4% in 2004.

In Nicaragua, like in most other Central American countries, there is still no clear proof of HIV transmission during breastfeeding. International research reveals large discrepancies over the probability of a HIV-positive woman infecting the foetus or the newborn during pregnancy, delivery and breastfeeding, especially when breastfeeding lasts a long time, as the research places MTC transmission between 7% and 45%<sup>21</sup> in developing countries.<sup>22</sup>

## **2.4 The predominance of transmission through sex**

In the HIV/AIDS accumulated total in September 2005, the main mode of transmission was through sex, representing 92% of the total with the heterosexual ratio predominating: 73% of the total. In the same period, the ratio of men having sex with other men reached 27%. The validity of this information is not certain as recorded cases of transmission between men who have sex with other men is very low. This is very likely due to the culture of machismo which tends to deny that this situation exists. There could be a 'grey population' arising between those who really are heterosexual and those with a hidden life who do not reveal the contact they have with same-sex partners.

It is important to note the similarity between this sexual transmission trend with the progress made in Africa. Central America and Nicaragua, since the beginning of the epidemic, have been characterised by transmission through sex, unlike all of the other areas in Central America.<sup>23</sup> Among HIV-positive individuals over the past five years, a percentage increase in the share of women, who represented 31% in 2000 and 37% in September 2005, has been noted.<sup>24</sup>

The discrimination and stigmatisation of men having sex with other men increases their vulnerability due to the social consequences of homosexual sex. HIV/AIDS has had a disproportionate affect on gay men and men who have sex with other men. As this group is mainly composed of young people, it is highly probable that HIV infection is also advanced among adolescents and youngsters. Research on the vulnerability to HIV/AIDS of men having sex with other men indicates that there are factors which contribute to this vulnerability ranging from individual to structural causes, such as poverty, male dominance of society and of power, gender transgression and social marginalisation.

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<sup>21</sup> Breastfeeding and HIV/AIDS. World AIDS Campaign, UNAIDS.

<sup>22</sup> Although other sources estimate this percentage at over 50%. It is stated that breastfeeding represents 3% to 4% of all MTC transmission cases, although other sources put it at between 14% and 19%. The situation of breastfeeding and HIV transmission in Latin America. SIDALAC, 2001.

<sup>23</sup> AIDS surveillance in the Americas. PAHO, June 2005. UNAIDS

<sup>24</sup> Ditto.

According to the Multi-centre STI/HIV prevalence and behavioural study among men having sex with other men<sup>25</sup>, 32% of those interviewed stated that they were not living with a sexual partner at the time of the interview, 63% lived with a male sexual partner and 10% lived with a woman. Out of all the men who have sex with other men (MSM) interviewed, 51% stated that they had had sex at some time with women. This illustrates the link between the MSM population and the general population, and women in particular. In this population group, the frequency of condom-use with a casual partner over the previous 30 days did not exceed 38.5%.

72% of homosexuals and 44% of bisexuals have taken the HIV test on the basis of sexual self-identification. 94% of MSM participating in the multi-centre study (162 out of 172) agreed to take the dual Elisa test, resulting in a HIV prevalence rate of 9.3% and a syphilis rate of 10.5%. The perception of a high risk of contracting HIV, according to sexual self-identification, stood at 61.8% for homosexuals and 73% for bisexuals; 38.20% of homosexuals and 27% of bisexuals stated that they were not at risk

### **HIV/AIDS TRANSMISSION MODES Nicaragua 1987 – September 2005**

See chart on page 16

Key: HT: Heterosexual, HSH: (MSM) Men having sex with other men, P/N: Peri-natal, DIV: Intravenous drugs, T/S: Blood transfusion, DI: Incomplete data

Source: National STI/HIV/AIDS Programme, MINSA.

Several factors that contribute to the persistence of HIV in this segment of the population are noted. Nevertheless, the continuous action undertaken by organisations related to this group significantly helps to prevent the contracting of the disease.

Sex workers live in a situation in which alcohol and drug consumption is frequent and they are generally the object of physical, psychological and sexual violence. They do not manage to use a condom with all of their clients and report low levels of protection when having sex with their regular partners.<sup>26</sup>

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<sup>25</sup> Multi-centre STI/HIV prevalence and behavioural study among men having sex with other men in Nicaragua. March –July, 2002. Technical and financial support from PASCA/USAID, University of Washington, PAHO, UNAIDS, CDC and the Spanish International Cooperation Agency

<sup>26</sup> Identification of behaviours and practices related to HIV/AIDS among sex workers in eight departments of Nicaragua. CONISIDA, 2004.

According to nationwide research in 2003, 97.7% of sedentary and ambulatory sex workers became sexually active before the age of 20. This clearly reveals an early exposure to sexually transmitted infections. Out of these, 62% were 15 years of age or under and 35.7% were aged between 16 and 20.<sup>27</sup>

### Multi-centre study results among sex workers

See graph on page 17

Inicio RS antes 20 años	Sexually active before the age of 20
TS < 15 years of age	Sex worker under 15 years of age
TS entre 16-20 años	Sex worker between 15-20 years of age
Características TS	Sex worker characteristics
Percentage	Percentage

Most sex workers, between 71% and 97.6%, were aware of methods to avoid contracting HIV, such as, condom-use, avoiding blood transfusions, avoiding injecting oneself with dirty needles, only having one sex partner and reducing the number of partners. Nevertheless, despite a high level of awareness on preventive measures, between 4% and 46% still harboured incorrect beliefs on HIV transmission and their own perception of the risk.

88.47% of sex workers stated that they were somewhat or greatly at risk of infection; 55% stated that they did not consistently use condoms with their clients and 33% revealed that they had had a lot of partners. This data is similar to the results of the 2003-2004 multinational study on the knowledge, attitudes and practices concerning HIV, condom-use and other sexual health issues (PASMO), in which it is noteworthy that 9.7% of the commercial sex workers interviewed had constantly used a condom in the past 12 months.

The main reasons for which they stop using condoms is that they trust their partner or because the partner does not want to use them. 78.3% of those interviewed said that they would stop using condoms when they started to have sex with their partner or husband. Nevertheless, a high percentage of sex workers stated that they had used condoms consistently in the 30 days prior to the interview and that they themselves suggest a condom should be used to their clients. The number of condoms used drops with regular customers compared to new customers.

The vulnerability of sex workers varies: while the overall HIV prevalence rate stands at 0.3%, the rate among ambulatory sex workers stands at 1.4% and, in contrast, among sedentary sex workers none were HIV-positive.

<sup>27</sup> Multi-centre HIV/STI prevalence and behavioural study among sex workers. Nicaragua, 2003.

## **2.5 Other most-at-risk populations**

Studies carried out among mobile populations reveal that there is a low level of awareness of the risk of contracting an STI or HIV and that risky, unprotected sexual behaviour exists. There are also other factors that contribute to making this group more vulnerable, such as visiting countries with higher HIV/AIDS prevalence rates and the greater frequency of casual sex.

The issues of migration and AIDS are not covered in the political agenda of the opposition parties or the government. The issue of migration is only considered when undocumented migrants are deported or arrested. The life of mobile populations is not of political interest.

The lack of satisfactory actions by government and civil society bodies dealing with migration issues and HIV/AIDS together with the shortfall in material and human resources affecting institutions working in these areas result in an unsatisfactory social response to tackling the vulnerability of these groups towards HIV/AIDS.

Among prisoners, the low level of risk perceived by individuals is aggravated by the boredom, tension, frustration and sexual promiscuity common in prisons.

## **2.6 HIV/AIDS among boys, girls and adolescents subject to sexual exploitation**

There is little information available about boys, girls and adolescents who work as sex workers or who are exploited sexually for commercial reasons and about people using intravenous drugs. This group is of great interest due to the influence of several factors that increase their vulnerability, including poverty, marginalisation and physical and sexual abuse.

In the National Health Plan, there were an estimated 443 children made orphans because of AIDS in 2003<sup>28</sup>. This figure could be higher if the country's reproductive trend in previous decades and the poor recording of pregnancies in this period are taken into account.

### **III National response to the AIDS epidemic in Nicaragua: Organising hope better.**

In general, significant progress was made in the fight against HIV/AIDS in Nicaragua between 2003 and 2005, which will make response efforts easier in the future. This progress is reflected in the integration and functioning of several areas of communication and cooperation between the various governmental and nongovernmental players as well as international cooperation agencies with the specific task of supporting the fight against the epidemic. Most of the players committed to this

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<sup>28</sup> MINSA. 2004-2015 National Health Plan, page 109.

fight highlight achievements such as the existence of a suitable legal and regulatory framework, availability of funds, political will and broad participation shown in the large number of projects funded by different sources.

The Global Fund to fight AIDS, Tuberculosis and Malaria has played a strategic role during this period by strengthening the country's capacity to fight against the epidemic and managing to create synergies between the various players involved as well as by providing various kinds of resources based on the country's proposal.

Some sectors which were initially against taking part or even openly critical of certain strategies developed by Nicaraguan society to fight against the epidemic, have committed themselves to supporting the national response despite having reservations over some of these strategies.

In various technical reports on the need to strengthen multi-sectorial coordination in the national response to HIV/AIDS in Nicaragua, firm evidence reveals that obstacles to reaching greater efficiency in HIV/AIDS prevention and treatment do not concern the availability of resources, the legal framework or political will, but better inter-sectorial planning, coordination and communication so as to make better use of the resources at the disposal of all of the bodies and players participating in the national response.<sup>29</sup>

### **3.1 Coordination of the National Response**

Regarding coordination, progress has been made in improving multi-sectorial participation. In this area, various ministries stand out for having actively joined the projects within CONISIDA, by developing initiatives to empower their workers and by developing preventive measures and improving care given to the segments of the population that they see to, including work-related areas of HIV/AIDS prevention and care. The challenge of providing complete and humane care to people living with HIV/AIDS by continuing the fight against stigmatisation and discrimination still remains to be tackled by national response partners.

Civil society organisations have increased their participation in CONISIDA through the Civil society national commission for the fight against AIDS (CNLCSSC). It has coordinated NGO efforts, on the basis of their significant ability to rally people and to make the public aware of the need to defend and promote the human rights of people living with HIV/AIDS. It also has experience in the development of projects related to HIV/AIDS, including the care of specific groups.

The NGOs have focused on the prevention of STIs and HIV by promoting responsible and safe sexual practices, the respect for diversity, the teaching of universal human values and the recognition of protective measures against the pandemic including the consistent use of condoms, faithfulness, encouraging young people to wait before starting sexual relationships and the promotion of rights through political action.

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<sup>29</sup> Ibid 4.

Nevertheless, a low level of participation in the drafting of HIV/AIDS policies has been noted among other areas in the public sector, NGOs and community groups. Although there is support from political and governmental leaders (including the President of the Republic), this kind of support is more formal than practical and does not translate into specific actions, such as a national HIV/AIDS policy which specifies long-term measures aimed at guiding the participation of the various players. The only national HIV/AIDS prevention and control policy in Nicaragua is the draft proposal tabled by the Youth secretariat which was discussed at the beginning of December 2005.<sup>30</sup>

The main strengths developed to date have consisted in boosting the organisational capacity of society, in both government and nongovernmental and community sectors. Nevertheless, this requires greater coordination to ensure more effective management of the various kinds of resources available in Nicaraguan society. A key component behind such coordination will be the provision of data banks on the activities performed and the resources available, which are already provided by CNLCSSC. This body is working on a guide for NGOs working with HIV/AIDS. The guide will detail their lines of work, available resources, subjects and areas of intervention in order to make these resources accessible in a specific location, to enable joint projects and more effective intervention by drawing on the strengths of all those who fight against HIV/AIDS.

Some of the priorities are given below:

An increase in the number of civil society bodies working on various areas concerning HIV/AIDS and which manage to work together with state bodies; a rise in the number and quality of inter-sectorial measures; the training and empowerment of multidisciplinary medical teams in the provision of antiretroviral therapy to people living with HIV/AIDS; the inclusion of PLWHA follow-up with the study of the viral load; the social and community-based support of people living with HIV/AIDS receiving treatment; the updating of the Ministry of Education, Culture and Sport (MECD) programmes<sup>31</sup> by including the HIV/AIDS and prevention issues. Another priority which has been adopted but not yet given full attention is the undertaking of research on issues related to better understanding the size of the epidemic and the impact of the measures put in place to fight it.

The HIV/AIDS information, education and communication (IEC) strategy is a clear example of this situation. Despite its existence and extensive use, it is fragmented and the messages transmitted do not consider the groups at risk and their particularities. Furthermore, it is characterised by focussing more on adults and is limited regarding gender and age.

With regard to the shortfalls still affecting measures against HIV/AIDS, the lack of a National policy to fight against STI/HIV/AIDS is highlighted, as mentioned earlier on. Another shortfall is the incipient leadership provided by CONISIDA at the head of the national response, mostly funded by the Global Fund. The problem of HIV/AIDS has not been duly identified and recognised as a national priority. Likewise, the

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<sup>30</sup> National HIV/AIDS prevention and control policy, Nicaragua. First draft: Main lines of the policy. Managua, Nicaragua. Youth Secretariat, December 2006

<sup>31</sup> Government of Nicaragua. Education for life programme. Managua, Nicaragua. Ministry of Education, Culture and Sport. 2003.

commitments made by Nicaragua to UNGASS and the Millennium Goals are not adequately reflected in national plans.<sup>32</sup>

An effective and complete multi-sectorial approach aimed at HIV/AIDS prevention among groups which are most-at-risk, particularly in the departments and regions most affected by the epidemic, has been difficult to achieve and has yet to be implemented.<sup>33</sup>

The most-at-risk groups do not receive the priority care that they require. Furthermore, the effective integration and coordination of the work and resources of organisations which participate in the fight against HIV/AIDS has not been achieved and nor has the private sector been brought on board. This sector has made a move through the Superior Council of Private Enterprise (COSEP) and the Nicaraguan chamber of health, a body representing the National Social Security Institute's medical care organisations.<sup>34</sup>

Return-on-experience opportunities are lost due to the lack of follow-up and monitoring mechanisms which allow for the systemisation of and learning from measures now in place. This, in turn, means that the knowledge needed to come up with better measures based on progress made in previous actions and which identify the best practices for the country in its fight against HIV/AIDS is lacking.

The situation concerning human and technological resources is not much different. The technical and technological capacity to diagnose and treat people living with HIV/AIDS through the Ministry of Health's and the NGOs' decentralised response clearly has its limits.

The availability of resources depends almost exclusively on what is provided through external cooperation, which, in turn, depends on the projects and funds aimed at measures which are not necessarily part of the Strategic Plan. The need for better coordination of help provided by international cooperation has been recommended time and again so that this help strengthens a more solid approach based on national priorities, as long as these priorities are ordered through a clear, consensus-based and official national policy that promotes social participation with a multi-sectorial mindset.

The creation of a Donor coordination forum aimed at HIV/AIDS prevention and treatment was suggested as a measure meant to improve coordination and which could provide effective assistance to the national response. Central American regional coordination, through mechanisms created for this purpose in the Ministry of Health, such as the Department of Central American Integration (SISCA), would complement this measure.<sup>35 36</sup>

### **3.2 Antiretroviral therapy (ART)**

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<sup>32</sup> Ibid. 1, 5.

<sup>33</sup> Interviews with representatives from ASONVIHSIDA, Nimehuatzin, Xochiquetzal, CNLCSSC.

<sup>34</sup> Interview with CONISIDA, INSS and CANSALUD team.

<sup>35</sup> Ibid, 4.

<sup>36</sup> Interview with the National Strategic Plan consultant, Dr. Guillermo González. December, 2005.

In 2003, antiretroviral therapy for 17 PLWHA began in Nicaragua with funding from the Global Fund and the technical and financial managerial support of UNAIDS Nicaragua. In 2004, treatment was extended to 52 people and currently 156 are receiving treatment. It is hoped that by the end of this year, 227 PLWHA will be receiving treatment. This would fulfil the official commitment made by the President of the Republic in 2004 in Monterrey, Mexico to the 3 x 5 initiative launched by the WHO and supported by UNAIDS.

The country's ability to assume the cost of ART when the project funded by the Global Fund comes to an end is a concern shared by almost all players involved in the national response.<sup>37</sup> This response must be formulated through the national policy so that the necessary confidence is instilled in all of the players.

In 2004, ART was decentralised with specific attention to the departments of Managua, León, Chinandega, RAAS and RAAN for which multidisciplinary medical teams in the hospitals of the departmental capitals received appropriate training and empowerment to provide complete care for PLWHA and handle antiretroviral therapy. Nevertheless, there is no surveillance system in the units offering ART.

The aim is to make services more accessible to PLWHA and pregnant women through antiretroviral therapy. Also in 2004, the monitoring of some PLWHA began through the studying of the viral load, by purchasing and installing the necessary technology in the National Laboratory. Problems relating to unsafe food and nutrition, which affects the progress and quality of life of PLWHA, as well as other social issues which have repercussions not only on PLWHA but also on their relatives, are areas that still require consideration for all PLWHA.<sup>38</sup>

As part of this effort to improve the ability to meet ART needs, the capacity to diagnose and treat PLWHA must be improved. Complementarity is essential between medical and non-medical resources needed to treat STDs from a syndrome-based approach<sup>39</sup>, whose guidelines have already been published and whose human resources have been empowered, must also be achieved. This would be easier to achieve if the existing norms were known at every level. Progress was achieved recently when the Antiretroviral therapy guidelines were published in 2005.<sup>40</sup>

The quality and number of staff working in the area of ART is unsatisfactory. Within the public sub-sector, staff rotation means that doctors and paramedics are taken out of their posts dealing with people with STI/HIV/AIDS without first having adequately passed on to the new members of staff their knowledge, experience, skills and awareness.<sup>41</sup>

Due to the country's structure, rural areas do not provide HIV/AIDS care. Community personnel is more stable and despite efforts to interlink existing networks, the capacity

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<sup>37</sup> Interviews with representatives from ASONVIHSIDA, INSS, Xochiquetzal, Nimehuatzin.

<sup>38</sup> Interview with an ASONVIHSIDA representative.

<sup>39</sup> Ibid 6.

<sup>40</sup> Republic of Nicaragua. Antiretroviral therapy guidelines. Managua, Nicaragua. Ministry of Health. National STI/HIV/AIDS Programme, 2005.

<sup>41</sup> Interview with Xochiquetzal representatives.

to deal with the epidemic is still lacking. For example, care for orphans and drug users are segments which are not catered for in the 2004-2010 National Strategic Plan.<sup>42</sup>

In the public sub-sector, there are no incentives to encourage health workers to provide better care and improve their skills when caring for people living with HIV/AIDS. This includes a lack of bio-safety strategies, medical material (including ART drugs for the treatment of opportunistic infections) and the working conditions for their provision (ventilation, lighting, ambient temperature).

There are problems concerning access to drugs, which is guaranteed under Law 238. Statistics up until 2005 reveal that 155 PLWHA are receiving treatment. Nevertheless, there are more than 155 people living with HIV/AIDS. The CNLCSSC also outlines serious problems concerning generic drugs as they identify the patient only according to his medicine, and therefore, the adherence. The medicine's supply chain is not clear and this has a negative effect on complete care.

Although there are standards and protocols on the subject of care, they are still very recent and need to be accompanied by a complete implementation strategy in order to generate an immediate positive effect on the care given to people living with HIV/AIDS. Complete and personalised care must be put in place so that the specific situation of each person living with HIV/AIDS and his social and family environment is considered from a humane perspective.

Concerning financial benefits, a basic and very small package<sup>43</sup> has been distributed by the Ministry of Health with Global Fund resources. A food programme for people living with HIV/AIDS is being discussed but it remains a proposal which is trying to encompass everyone on a national level and it requires participation by others.<sup>44</sup>

Laboratory tests in the private sector remain very expensive while the public sector does not provide enough security and accessibility for the tests. People are more aware of the need to take the test, nevertheless, as the test is not accessible, the treatment's continuity is undermined and the acceptance of those living with HIV/AIDS is harmed as is the diagnosis of new cases.

### **3.3 Stigma**

At a primary care level, a lot of progress has been made; nevertheless, the stigma persists. This is the case in hospitals, where a lot of work remains to be done with hospital staff. Stress must be placed on quality, confidentiality and ethical principles.<sup>45</sup> It is important that the patient receives good counselling and is well prepared for the test, regardless of its outcome. The CNLCSSC has put together a 'Training guide for facilitators concerning the guidance method and counselling support for those affected by HIV/AIDS', which is still in a draft form and has yet to be validated (2005).

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<sup>42</sup> Interview with Minehuatzin representatives.

<sup>43</sup> Interview with ASONVIHSIDA and CNLCSSC representatives.

<sup>44</sup> Interview with CNLCSSC representatives.

<sup>45</sup> Interview with CNLCSSC representatives.

Regarding stigma and discrimination, the actual patients discriminate against themselves. The CNLCSSC is preparing a method to work with the families of people living with HIV/AIDS. ASONVIHSIDA has also made progress in the empowerment of PLWHA, their relatives and friends so that they take of for their main needs and concerns.

The country's cultural legacy lives on and restricts the issue of people living with HIV/AIDS from being addressed. The disease is still mainly associated with sex.

#### **IV Major challenges faced and actions needed to achieve the UNGASS goals/targets**

The 2004-2015 National Health Policy, the 2004-2015 National Health Plan<sup>46</sup>, and the 2004-2009 National Strategic Plan constitute sectorial, institutional and national reference frameworks for the best possible development of measures for the fight against the epidemic and for the provision of the quality care needed and requested by people living with HIV/AIDS.

These references must be used and respected when governmental and nongovernmental sectors draft and table new initiatives, and must go hand in hand with the firm and coherent support of development partners in the international cooperation sector.

The monitoring and evaluation of the country's response must be based on these references and must strengthen social participation as a strategy to reinforce all of the local, national and international institutions, organisations and bodies which participate in the national effort.

The knowledge created through systemising the information provided by monitoring and evaluation will serve for the continuous and systematic improvement of the country's ability to respond to HIV/AIDS. It shall enhance the resources available and encourage citizen participation from all kinds of national sectors.

This is complemented through the enhanced surveillance of the epidemic during the first generation and innovative surveillance during the second generation. Greater resource management requires both forms of surveillance and it is quite easy to update and implement the technology needed for its optimal running in view of supporting the management and follow-up of local and national activities.

CONSIDA must see its organisational and technical capacities boosted so that it can fulfil its role in supporting efforts that arise both from the government and civil society so as to meet the fair demands made by those living with HIV/AIDS and to prevent the epidemic's spread by promoting a healthy and responsible lifestyle based on concern for others.

This proposal must also encompass a partnership agreement so that CONSIDA's strategic functions are implemented over the long-term. For this purpose, national and international partners, who have shown their willingness to continue supporting and

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<sup>46</sup> Republic of Nicaragua. 2004-2015 National Health Plan. Managua, MINSA, 2004.

participating in this effort in the long run on a basis of openness, transparency and effectiveness while ensuring the delivery of technology and resources, can and must be relied upon.

CONISIDA can and must become the body which legally and legitimately promotes areas in which donors and local and national bodies can coordinate their activities. It must promote areas for the exchange of experience and resources with other countries and international organisations, the management of national resources, the systemisation of experience and the generating of knowledge, including the management of data banks covering resources, research, survey results, surveillance results and other sources to access knowledge about HIV/AIDS and the causes of the epidemic.

The continuous updating of the national HIV/AIDS accounts is something urgent which remains to be done. It deserves specific attention in this report given its strategic importance. This tool provides better awareness of the national response and it provides any missing information needed at the time of taking decisions and crafting better cost-effective programmes.

It is a relatively simple exercise and one which is very informative if the appropriate databases are available. This is why it is important to revise the 2003 commitment to implementing CRIS and other technological tools so as to be able to rely on these databases which are updated at the appropriate times and used as a source of basic information in the coordination platforms and in the monitoring and evaluation initiatives needed for an effective review of the national response.

Another strategy for coordination will be maintaining the coherence of local and national measures with the National Strategic Plan and the 2004-2015 Strategic Plan as well as the National Health Policy. Multilateral and bilateral international cooperation must also play an active part in this respect by promoting and supporting those initiatives which are in line with and meet the priorities and strategies specified in the National reference documents. Monitoring and evaluation will gradually highlight which strategies are the most effective and which coordination mechanisms promote the most effective and synergy-based action between players participating in the national effort.

Those who provide care for people living with HIV/AIDS, protect the population's health, make the monitoring and evaluation mechanisms work, update first and second generation surveillance correctly, administer the databases and undertake the appropriate analyses to produce the information needed for decision making have a very complex task to fulfil.

It is therefore necessary to design and introduce training measures that not only deal with clinical issues but also prevention and care with a humane touch. Training must also tackle actions necessary for bio-safety and to maintain a spirit of service in line with the high emotional load imposed by this situation. The institutions, on their part, must give due recognition and make the most of this human capital, which is so difficult to train and retain in our health centres.

The appropriate technology must be accessible from a geographical, economic and cultural perspective so as to avoid the obstacles posed by displacement, assistance and

stigmatisation with which people living with HIV/AIDS are faced. Therefore, the organisation of care for these people must consider issues related to greater availability of trained personnel, appropriate monitoring technology and social support to alleviate the problems associated with the epidemic.

## **V Support required from the country's development partners**

Over the past three years, international bodies (both bilateral and multilateral), as well as civil society institutions, private bodies, United Nations programmes present in the UNAIDS Theme Committee, the Global Fund project's Country Coordinating Mechanism, the National health council and NGOs working in this area, such as the NICASALUD federation network, have provided the technical support which was needed and expressed in the UNGASS 2003 follow-up report. Nevertheless, such support arrived late and it is still considered as inadequate.

The Country Response Information System (CRIS) has yet to be implemented in the Ministry of Health's SILAIS system (Local System of Integrated Health Care) and the majority of the NGOs are unaware of this. With partner support, universities could play an important role in increasing the number of people who are able to use CRIS and thus increase coverage and the recording of data needed for it to work while supporting the monitoring and evaluation of the country's response.

Its implementation depends on the publication of the National Strategic Plan, as the indicators are in line with the Plan and with its monitoring and evaluation component, on the Plan itself and on the way the epidemic behaves.

Partners could provide support by substantially improving the first generation surveillance tool which would allow the analysis of cohorts and the impact of strategies so the overall care given to people living with HIV/AIDS and their families and friends can be improved.

Although the national health accounts have been updated yearly, the national HIV/AIDS accounts have not been updated since 2000, as planned. This is not due to a technical shortfall but to a lack of financial resources. The technical resources to fulfil this task for 2004 and 2005 are currently being sought.

An observatory on the impact of the future National policy to fight against HIV/AIDS is possible if partners provide their support. To get off to a good start, this initiative must first have a database which allows the construction and updating of indicators needed for monitoring and following up the actions put in place.

The same strategy should be applied to research and other activities aimed at gathering knowledge based on experience in the response to the epidemic so that all of this is available in a data bank that can be of use when evaluating the epidemic and prompting those involved in the response. The same kind of experience exists in the preparation for disasters and in the area of health in general.

So as to fulfil its tasks, CONISIDA needs to develop technical secretariat capacities so that it can coordinate the initiatives provided by its members effectively. Specialised agencies have to support CONISIDA so as to enhance its ability to monitor the accomplishment of agreements taken within the body itself.<sup>47</sup>

Full support from all players involved in the response to the epidemic, greater implementation of behaviour surveillance and adherence to and effectiveness of (adverse reactions) ART, according to best practices in this field, are essential.<sup>48 49</sup>

Nicaragua, together with its response partners, will have to select and implement studies on at-risk populations and operational research in health care services which address the issues of a timetable that complies with the commitments adopted under UNGASS and the National Strategic Plan.

Each development partner whose task is to support Nicaragua in its efforts against the epidemic must identify how it can best provide this support on the basis of its own individual capabilities and its own particular mission. We could cite the example of UNICEF, which has supported diagnosis through the use of quick tests and the treatment of MTC transmission and special care for orphans, which led to the Central American forum on the special protection of children with HIV/AIDS. On several occasions, UNICEF has declared that it will continue providing support in this area over the next five years.

Other partners can complement these actions, thus allowing the country, through all national governmental and nongovernmental bodies, to stop the spread of the epidemic and to improve its response capacity to the benefit of people living with HIV/AIDS. PAHO-WHO can prioritise the development of second generation HIV surveillance; USAID can contribute by improving resource management so as to enhance the organisational ability of participants.

Another area in which partners can help is in the purchasing of cheaper drugs whose therapeutic benefits are proven. Partners can also provide technical support for the development of diagnostic technology.<sup>50</sup> This can help improve the implementation of universal precautionary measures in view of the biological risk assumed by medical staff and which is at times a reason for rejection and stigmatisation due to fear of accidents and the lack of satisfactory protective means for attending patients infected with HIV/AIDS.

The need to coordinate the actions of Central American governments is increasingly apparent and vital. The Department of Central American Integration (SISCA) has been organising regional events in which coordination and cooperation are the main focal points and in which various bilateral and multilateral regional agencies have promoted a regional approach in the fight against HIV/AIDS.

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<sup>47</sup> Ibid 4.

<sup>48</sup> UNAIDS. Practical guidelines for the implementation of second generation HIV surveillance. Published by PAHO-WHO and UNAIDS. No date.

<sup>49</sup> UNAIDS. Guidelines for second generation HIV surveillance. Published by WHO and UNAIDS. 2000.

<sup>50</sup> United Nations. Declaration of commitment to the fight against HIV/AIDS. Geneva, United Nations General Assembly, 2001.

## VI Monitoring and evaluation environment

Since 1980 Nicaragua has had a First generation HIV/AIDS surveillance system and it has undertaken efforts with the support of partners such as PAHO, UNICEF, USAID, SICA, UNPD and other UNAIDS members, to bolster the surveillance of cases and the start of surveillance of changes in high-risk behaviours.

The surveillance and evaluation plan is currently in force. Its data collection and analysis strategy still uses a centralised approach. Nevertheless, the indicators needed for the evaluation of processes related to STI/HIV/AIDS programmes still have to be specified. This is also the case for the construction of clearly defined impact indicators. These indicators are fully compatible with UNAIDS and UNGASS indicators. There are standards to identify data sources but we lack evaluations that grade the quality, coverage and precision of the data collected to construct the indicators.

In its support for CONISIDA, the Global Fund has provided financial and technical resources for monitoring and evaluation. These resources are added to the funds, which are usually a minimum amount for monitoring and evaluation, that the Ministry of Health allocates in its budget. This contribution has meant that monitoring and evaluation has been extended to cover measures taken by civil society. Nevertheless, the surveillance and evaluation committee does not include among its members people living with HIV/AIDS<sup>51</sup> as representatives of civil society. Nevertheless, the country has not considered essential monitoring and evaluation costs in its budget and this unit is currently being created within the Ministry of Health.

The special surveys carried out by nongovernmental bodies, governmental institutions, universities and projects have not been brought together in one place where this information can be consulted.

Despite the fact that the monitoring and evaluation indicators cover society more broadly, the first generation surveillance data, included in an Epi, Info and Spectrum database, is not accessible to those requesting such information as it is still centralised in the Ministry of Health. Nor is it used to undertake stratified analyses which would provide better sources upon which new initiatives and decisions could be made and the impact of the measures implemented could be evaluated.

The information drawn from the first generation surveillance system has allowed the National programme to publish the indicators in the epidemiological bulletins, Programme presentations and Central American surveillance.

In the past three years, surveillance, monitoring and evaluation skills have been honed, particularly those of MINSAs staff, but not those of civil society.<sup>52</sup> CRIS has been warmly accepted as a software program to monitor and evaluate actions, programmes and projects, etc. and it is hoped that it will be widely used in 2006. It also hoped that

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<sup>51</sup> Various interviews with NGO and CNLCSSC representatives. Used when constructing the 2005 National Composite Policy Index.

<sup>52</sup> Surveys among NGO representatives.

the HIV/AIDS database will be made more user-friendly by rendering it more dynamic and by allowing users to consult annual behaviour and not just accumulated behaviour.

Full-time personnel follow up surveillance and evaluation activities and they have been producing indicators since 2003. At a national level there is an information system concerning education and an evaluation report is published every three months on HIV/AIDS, including an analysis of HIV monitoring. This strategic information is used at an intermediate level for planning and implementing measures.<sup>53</sup>

Although it is not the most highly evaluated component, the respondents who filled in the Response composite index for the effort evaluation referred to the improvement of the HIV/AIDS surveillance and evaluation programme in 2005 compared to the 2003 programme.

The 2000-2004 Strategic Plan lacked a monitoring and evaluation component for its results. This was partly due to the Plan's lack of goals and forum-based activities meant for such a purpose. The lack of a national policy to fight against STI/HIV/AIDS in this period has been rectified by civil society; there is now a draft policy. During its consultation process, the 2005-2010 National Strategic Plan was criticised for not having its own aims and for not adopting the Millennium Goals.

#### Requirements to fulfil UNGASS objectives and technical assistance

1. Reach a consensus and approve the National policy to fight against HIV/AIDS.
2. Through goals and indicators, strengthen the 2005 National Strategic Plan and include a section on monitoring and evaluation.
3. Make the best possible and most efficient use of the first generation databases and in the case of gaps, consider replacing it with a dynamic database.
4. Nicaragua must clearly lay down the goals concerning national commitments to UNGASS.
5. CRIS must become the collection tool for the information generated by the country's response. It must therefore be introduced and used.
6. Special surveys for the monitoring and evaluation of plans to stop the epidemic and assess its impact must be developed.

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<sup>53</sup> Interview with the National STI/HIV/AIDS Programme director.

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Report on monitoring the follow-up to the Declaration of commitment on HIV/AIDS  
Nicaragua 2006

**UNGASS Nicaragua report  
2003-2005**

**Appendices**

## Appendix 1

Consultation/preparation process for the national report on monitoring the follow-up to the *Declaration of Commitment on HIV/AIDS, Nicaragua, December 2005*.

		Answers	
		Yes	No
1	Which institutions or bodies were responsible for filling in the indicator forms?		
	a) CONISIDA (Nicaraguan AIDS commission)	X	
	b) PNIVS (National STI/HIV/AIDS Programme)	X	
	c) Others		
	INSS (National Social Security Institute)	X	
	MECD (Ministry of Education, Culture and Sport)	X	
	MINGOB (Ministry of the Interior)	X	
	MITRAB (Ministry of Labour)	X	
	CNLCSSC (Civil society national commission for the fight against AIDS)	X	
2	With data from		
	Ministries:	X	
	Education (MECD)	X	
	Health (MINSAP-PNIVS)	X	
	Labour (MITRAB)	X	
	Foreign affairs (MIREX)		X
	Other: Social Security (INSS)	X	
	Civil society organisations:		
	CNLCSSC (Civil society national commission for the fight against AIDS)	X Interviewed	Did not complete NCPI questionnaire
	Xochitquetzal (NGO)	X Interviewed	Did not complete NCPI questionnaire
	Nimehuatzin (NGO)	X Interviewed	Did not complete NCPI questionnaire
	NICASALUD (the Nicaraguan NGO Health Network),		X Did not complete NCPI questionnaire
	People living with HIV/AIDS		
	ASONVIHSIDA (Association for people living with HIV/AIDS)	X	
	Private sector		
	PEN consultant (National Strategic Plan)	X	
	United Nations organisations		
	UNICEF	X Interviewed	Did not complete NCPI questionnaire
	UNPD		Did not complete NCPI questionnaire
	Bilateral/multilateral organisations		
	PAHO		Did not complete NCPI questionnaire
	The Global Fund (specialist in HIV/AIDS)		Did not complete NCPI questionnaire
	USAID		Did not complete NCPI questionnaire
3	Was the report debated in a large forum?		X
4	Was the survey data stored centrally?	X	

5	Is the data available for public consultation?	x	
Names/positions, Date and signature (See next page)			

Consultation/preparation process for the national report on monitoring the follow-up to the *Declaration of Commitment on HIV/AIDS, Nicaragua, December 2005*

**People interviewed who returned the National Composite Policy Index questionnaire**

Full name	Name of organisation, institution or association	Date
Hazel Fonseca	Xochiquetzal (NGO)	December 2 2005
Pascual Ortells Rita Aráuz	Nimehuatzin (NGO)	December 3 2005
Claudio Sequeira	INSS. Certification manager	December 6 2005
Francisco Bolaños	MITRAB. Health and safety director	December 6 2005
Matilde Román	MINSA. National STI/HIV/AIDS Programme director	December 7 2005
Esperanza Camacho	CNLCSSC-CEPS-CONCASIDA	December 7 2005
Carolina Aguilar	MECD Education for life programme.	December 11 2005
Juana Mercedes Delgado	MECD Education for life programme.	December 11 2005
Brenda Mayorga	MIGOB. Social prevention and care director.	December 12 2005
María Elena Guerrero	CORLUSIDA. RAAN. Regional council president.	December 12 2005
Valeria Bravo	CONISIDA, Technical coordinator.	December 12 2005
Guillermo González	PEN 2005 consultant	December 12 2005
Arely Cano	ASONVISIDA. President.	December 13 2005
Norwin Solano Delgado	CENIDH	December 12 2005
Eveling Carranza	MIGOB. Hospital epidemiological team member	December 13 2005
María Elena Márquez	MIGOB. Sub-management and hospital epidemiology.	December 13 2005
Denis Alemán	Youth secretariat	December 13 2005
José Espinoza	UNICEF	December 15 2005

## Appendix 2

### Core indicators for the application of the Declaration of Commitment Nicaragua 2006

#### National commitments and actions

Nº	Indicator name	Construction / Source	Measurement
<b>Expenditures</b>			
1	Funds disbursed by the government of Nicaragua, 2003 and 2005	Amount in córdobas and its equivalent in US dollars in the middle of the year (2003 and 2005)	2004: C\$ 64,572,322,00 2005: C\$ 52,143,602,00
<b>Policy development and implementation status</b>			
2	National Composite Policy Index (Part A)	CRIS	2005: 78.27% 2002: 1.1%
<b>National programmes: HIV analysis and prevention programmes among the most-at-risk populations</b>			
3	Percentage (most-at-risk populations) who received HIV testing in the last 12 months and who know the result		
	3.1. Percentage of people who received HIV testing and know the result	STI/HIV/AIDS programme data	3.1. 89%
	3.2. Percentage of people who tested positive and received counselling	STI/HIV/AIDS programme data	3.2. 100%
	3.3. Percentage of HIV infected children + children receiving ART	STI/HIV/AIDS programme data	52.3%
4	Percentage (most-at-risk populations) who attended prevention programmes <b>4.1. Care coverage for most-at-risk:</b>	<b>4.1. STI/HIV/AIDS programme data</b>	<b>25%</b>

#### Knowledge and behaviour

Nº	Indicator name	Construction / Source	Measurement
5	Percentage (most-at-risk populations) who both correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission		
	5.1. Percentage of mobile populations who correctly identify one or two ways to avoid transmission	Knowledge, attitudes and practices concerning safe sex among mobile populations along borders	Nov 2004: 6%
	5.2. Percentage of MSM who mention two ways of transmitting STI-HIV	2004 Multinational study PASMO	Aug-Oct 2004: 64.4%
	5.3. Percentage of MSM who mention two ways of preventing STI-HIV	2004 Multinational study PASMO	Aug-Oct 2004: 46.8%
6	Percentage of male and female sex workers reporting the use of a condom with their most recent client		
	6.1. Percentage of sex workers reporting that they discuss the use of a condom with their clients	Knowledge, attitudes and practices concerning safe sex among mobile populations along borders	Nov 2004: 32.34%
	6.2. Percentage of sex workers who always used a condom in the last 30 days (new or regular client)	PASMO 2004	Nov 2004: 84.1% / 4.6% for new and regular clients respectively
	6.2. Percentage of imprisoned men who have ALWAYS used a condom	Knowledge, attitudes and practices concerning safe sex among prisoners, February 2005	Feb 2005: 19.4% (men) Feb 2005: 16.9% (women)
	6.3. Percentage of women who had at least one client who did not use a condom among the last ten clients	Knowledge, attitudes and practices concerning AIDS among sex workers in nine Nicaraguan departments	Oct 2004: 27.6%
7	Percentage of men reporting the use of a condom the last time they had sex with a male partner		
	7.1. Percentage of MSM under 20 years of age who used a condom the last time they had sex (under 20, 20-29 years, 30-39 years, 40 years and over)	PASMO 2004	Nov 2004: 54.7% (under 20); 63.3% (20-29 years); 67.6% (30-39 years); 0% (40 years and over)

	7.2. Married/cohabiting MSM who used a condom; single/living with a partner MSM who used a condom; and single/living alone MSM who used a condom.	PASMO 2004	Nov 2004: 52% (married/cohabiting MSM) 61.4% (single/living with a partner MSM) 64.7% (single/living alone MSM)
8	Percentage of injecting drug users who have adopted behaviours that reduce transmission of HIV i.e., who avoid using non-sterile injecting equipment and use condoms in the last month.	No data	No data

## Impact

N°	Indicator name	Construction / Source	Measurement
9	Percentage of (most-at-risk populations) who are HIV infected		
	9.1. Prevalence of HIV-AIDS among pregnant women from Nov 2004 to Feb 2005	Source: Pregnancy at sentinel sites	0.11%
	9.2. Percentage of HIV cases caused by MTC transmission	Source: National STI/HIV/AIDS Programme	Up until Sept 2005: 4% Up until Sept 2002: 2.5%

NCAI-2

## National Composite Policy Index

See the indicator data for other periods of time

<b>Name of data source</b>	National Composite Policy Index questionnaire
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<b>Kind of data source</b>	Interviews with key respondents
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<b>Time period</b>	01	01	2003	<b>Until</b>	31	12	2005
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<b>Frequency</b>	year
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<b>As of</b>	dd	mm	2003
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**Comments:** Policy Indicators

<p>The Ministry of Education, Culture and Sport is developing the “Education for Life” programme aimed at ...</p> <p>Mobile populations are considered within the National Strategic Plan.</p> <p>The Department of Central American Integration (SISCA) has launched a regional initiative which looks at preventing...</p> <p>The Ministry of Health is putting in place a health research ethics committee...</p>
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### **A. Strategic Plan**

<b>1</b>	The country has developed multi-sectorial strategies to combat HIV/AIDS	Yes
<b>2</b>	The country has integrated HIV/AIDS into its general development plans	No
<b>3</b>	The country has a national multi-sectorial body for the coordination / management of HIV/AIDS	Yes
<b>4</b>	The country has a national HIV/AIDS body that promotes interaction between the government, the private sector and civil society	Yes
<b>5</b>	The country has a functional HIV/AIDS body that is supporting the coordination of civil society organisations	Yes
<b>6</b>	The country has evaluated the impact of HIV/AIDS on its socio-economic status for planning purposes	No
<b>7</b>	The country has a strategy that tackles the issue of HIV/AIDS among its national services (including the armed forces and civil protection forces)	Yes

### **B. Prevention**

1	The country has a policy or strategy that promotes information, education and communication (IEC) on HIV/AIDS	Yes
2	The country has a policy or strategy promoting reproductive and sexual health education for young people	Yes
3	The country has a policy or strategy promoting IEC and other health measures for populations with high or growing HIV infection rates	Yes
4	The country has a policy or strategy promoting IEC and other health measures among cross-border migrants	Yes
5	The country has a policy or strategy to expand access, including among vulnerable groups, to essential preventative commodities	Yes
6	The country has a policy or strategy to reduce vertical transmission	Yes

### C. Human rights

1	The country has laws and regulations that protect people living with HIV/AIDS against discrimination	Yes
2	The country has non-discrimination laws or regulations which specify protection for certain groups of people identified as being especially vulnerable to HIV/AIDS discrimination	Yes
3	The country has a policy to ensure equal access, between men and women, to prevention and care with a specific focus on most-at-risk populations	Yes
4	The country has a policy to ensure that HIV and AIDS research protocols involving human subjects are reviewed and approved by a national/local ethical review committee	No

### D. Care and support

1	The country has a policy or strategy to promote comprehensive HIV and AIDS care and support with particular attention to most-at-risk populations	Yes
2	The country has a policy or strategy to ensure or improve access to HIV/AIDS-related medicines with a specific focus on most-at-risk populations	Yes
3	The country has a policy or strategy to address the additional needs of orphans and other vulnerable children	No

<b>CALCULATION OF INDICATORS</b>	<b>78.27</b>
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## BACKGROUND REFERENCES FOR THE COUNTRY COMPOSITE INDICATOR: NICARAGUA 2005.

### Strategic Plan

INDICATOR NUMBER	SOURCE	REMARKS
1	2000-2004 National Strategic Plan 2006-2010 National Strategic Plan	The 2006-2010 National Strategic Plan has been developed but no final draft is available. It contains strategies that support the strategies.
2	National development plan 2004-2010 National health plan 2004-2015 National health policy	The national development plan does not deal with the impact of HIV/AIDS. The sectorial documents do not develop the priority of HIV/AIDS despite acknowledging its impact and the commitments made by Nicaragua at a regional and international level.
3	CONSIDA	Established on September 17 2000 by Law 238 (September 26 1996, Gazette N° 232, December 6 1996)
4	Expanded CONSIDA	Currently the Country Coordinating Mechanism for the Global Fund's project set up in 2003
5	CNLCSSC Nicaraguan civil society national commission for the fight against AIDS	Stronger than in 2003 as it has increased its number of members and activities
6	No studies	They have not been updated since 2001 despite the commitment made by the government to UNGASS 2003 to evaluate the national HIV/AIDS accounts every year
7	Plans from the Ministry of the Interior, National army and prisoners	MIGOB and national army plans and programmes in line with the 2000-2004 PEN and with various sources of funding

### Prevention

Indicator number	Source	Remarks
1	Global Fund reports	Communication strategy aimed at changing HIV/AIDS related behaviour, containing a conceptual and a legal framework and a values-care-health approach
2	Ministry of Education's 'Education for Life' programme  Ministry of the Interior's 'Teaching literacy and AIDS together' educational programme  Other initiatives financed by the Global Fund (NGOs, universities, institutions)	Subjects included in the teachers' curriculum.  Subjects channelled through programmes teaching military personnel and prisoners to read and write  Training on standards, Syndrome-based management of STIs, Bio-safety issues, IEC issues  Mass media AIDS campaigns
3	In PEN strategies	The 2006-2010 National Strategic Plan has been developed but does not have a final draft. It contains strategies that support the prioritisation of MSM and pregnant women groups/MTC transmission and other groups.
4	Regulated by the MIGOB	In addition to the PEN, in the MIGOB programme for mobile populations
5	Strategies included in PEN  Global Fund project	Began with ART and the Ministry of Health started to supply viral load and CD4 tests. Decentralised access to tests. The Global Fund project coordinates comprehensive care (a strategic activity) which provides part of ART and promotes the adherence to ART and multidisciplinary committees.
6	National STI/HIV/AIDS Programme National program, 'AIM'	Supported by UNICEF and the Global Fund

### Human rights

Indicator number	Source	Remarks
1	Law 238 Regulation 238 Global Fund CCM ethical committee Draft national STI/HIV/AIDS prevention and control	Ethics committee established in 2005

	policy, December 2005	
2	Law 238 Regulation 238 Global Fund CCM ethical committee Draft national STI/HIV/AIDS prevention and control policy, December 2005	Protection of the rights of people living with HIV/AIDS
3	Law 238 Draft national STI/HIV/AIDS prevention and control policy, December 2005	
4	General health law Helsinki 2002 international standards Does not exist	The Ministry of Health is reviewing its health research policies. Health research standards and regulations review, December 2005. There is no specific HIV/AIDS regulation. Up until now (Dec 2005), ad-hoc committees have been used

## Care and support

Indicator number	Source	Remarks
1	National STI/HIV/AIDS Programme 2000-2004 & 2006-2010 PEN Global Fund	In various hospitals, multidisciplinary committees for people living with HIV/AIDS are up and running Public, private and community sector health staff training
2	Central American ART joint purchasing strategy WHO-PAHO agreement UNICEF agreement Global Fund Bill & Melinda Gates Government of Brazil USAID	The programme has standardised ART purchasing and this programme has served as a guideline when drawing up these initiatives
3	Does not exist	UNICEF and the Ministry of Health presented an analysis of the impact of children being made orphans SISCA promoted the Central American forum on care for vulnerable children in Central America, November 2005