



Ministry of Social Protection
Republic of Colombia
General Directorate of Public Health
Promotion and Prevention Group

REPUBLIC OF COLOMBIA
NATIONAL UNGASS REPORT
--- REPORT FOR APPROVAL ---

Period covered: January 2003 - December 2005

Sent to the UNAIDS Evaluation Unit in Geneva

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I. Current situation

Colombia is organised into 32 departments and 4 districts. The country estimates the total population at 46,039,144 inhabitants: 22,764,130 men and 23,275,014 women. The dependence rate per thousand is 561.5, the ratio of children per woman is 0.38, there are 97.8 men for every 100 women and the median age is 25.43.

A natural population growth rate of 16.83 is estimated for the five-year period 2000-2005, the birth rate per thousand is 22.31 and death rate per thousand is 5.48, corresponding to 4,928,333 births and 1,210,575 deaths estimated.

The under 15 age group represents 31.3%, of the total population, 15-19 year olds represent 9.4% and 27% of the population is of fertile age¹.

Data on the human development index by component for the country in 2001 was calculated at 79.1 for life expectancy, illiterate population of 7.5%, combined education rate of 0.682, educational achievement index of 0.844, life expectancy index of 0.781, adjusted GDP index of 0.688 and a human development index of 0.771.²

In Colombia the general system for health insurance functions as an insurance system which has various affiliation modalities and benefit plans to achieve maximum coverage for provision of healthcare services to individuals:

- The contributory regime is for people who have a formal labour relationship. The insurance premium is paid by the worker and employer. This insurance includes family or dependents.
- The subsidised regime is for poorer and more vulnerable people who are identified by means of a classification instrument for poverty and vulnerability levels known as SISBEN (beneficiary identification system). They have no formal labour relationship and the insurance premium is paid by the state. This insurance is individual.
- Exceptional regimes. In this group people also have a continuous labour relationship but care benefit plans differ from those of the General System for Health and Social Security (GSHSS). Workers from the military forces and the police, workers from the Colombian oil company – ECOPETROL - and civil servants from the National Court are included in this type of insurance. The insurance premium is paid by the worker and the employer. This insurance includes family or dependents.

¹ Source: National series and projections. National Administrative Department for Statistics January 2006 at www.dane.gov.co

² Ten years of human development in Colombia pp8. National Program for Human Development, NPHD National Department for Planning NDP, Colombian Agency for International Corporation, CAIC, United Nations Development Program, UNDP ISBN: 958-682-432-2



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- Care for the uninsured population is paid for by the state from the public services network. There is no insurance to pay. Services are covered in the main by the government by means of an entry known as "offer subsidy". The user pays for part of the service.

Moreover, there is a benefits plan for group actions which are provided free of charge via a state system. This is aimed at promotion and prevention actions known as the basic care plan (BCP). BCP resources are administered by the state in a decentralised manner with various types of competition according to whether responsibilities are assigned on a central, departmental, district or municipal level.

The central level acts as a policy generator and head of the system; in turn the relevant regulations are issued and the technical assistance necessary is provided for actions on a regional and local level in accordance with international commitments and guidelines. The program has a decentralised structure with regional and local autonomy for the use of resources in corresponding to the epidemiological profile and political priorities given to health matters.

The Sexual and Reproductive Health Policy establishes the strategic orientation of actions to be carried out on HIV/AIDS, among others. The technical developments in force are set out in the documents known as the Intersectorial Plan for the Response to HIV/AIDS - Colombia 2004-2007, the fruit of a joint effort by various national actors and sectors. Similarly, a national policy for the provision of health services was recently issued, adding leverage to the strength of this plan.

The country has legislation in force in the area of HIV/AIDS (Decree 1543 from 1997). It is based on the respect of human rights and considers prevention and integral care aspects. The National Aids Council (NAC) is an intersectorial coordination authority, set up to help guide policies and strategies related to HIV. It is defined by decree 1543/97 and is the highest advisory institution in this area. The NAC includes civil society participation and has PLHA representatives.

Moreover, other groups support this national coordination authority:

- The UNAIDS theme group which joins together agencies from the system, state agencies and other civil society actors participating in the joint response to the epidemic.
- The Country Coordinator Mechanism (CCM) constituted under the guidelines of the Global Fund and which functions as the authority responsible for drawing up and implementing projects presented to the Global Fund as part of the national response to the epidemic.

Furthermore, the national technical regulations have been updated. These technical documents will contribute to improving the quality and opportunity of preventive and care services for PLHA. These are the "Program Model on HIV/AIDS" and the updated version of the "Integral Care Guide"

The organisation of UNGASS indicators, the Intersectorial Plan for the Response to HIV/AIDS - Colombia 2004-2007 and their correlation in agreement with the three sectors defined in the latter document, are represented below.



The information can thus be viewed with the following example. Indicator from impact n° 1 from UNGASS is evaluated in Main line II on Promotion and Prevention in the document Intersectorial Plan for the Response to HIV/AIDS - Colombia 2004-2007.

TABLE N° 1
COMPARATIVE INDICATORS FOR CRIS

UNGASS INDICATORS

NATIONAL LEVEL - 13		
COMMITMENT AND ACTION - 2	PROGRAM AND BEHAVIOUR - 9	IMPACT - 2

IPR INDICATORS³ COLOMBIA

IPR - 66		
SECTOR I - 9	SECTOR II - 45	SECTOR III - 12
INTERINSTITUTIONAL AND INTERSECTORIAL COORDINATION. MONITORING AND EVALUATION	PROMOTION & PREVENTION	CARE AND SUPPORT

SHARED INDICATORS

	COMMITMENT AND ACTION	PROGRAM AND BEHAVIOUR	IMPACT
SECTOR I C M+E	2 A 4		
SECTOR II PAP	1, 7, 8, 2 A 7, +- 2 B 4,	1, 8 A 1, 8 A 2, 8 pp 50, 6, 8 A 4 j!!, 4,	1, 1 B, 1 B, 2,
SECTOR III C+S	2 D 1, 2 C 1	5, 9, 9 B,	

Source: National Observatory for the Management of HIV/AIDS Ministry of Social Protection 2005

³ Intersectorial Plan for the Response to HIV/AIDS - Colombia 2004-2007



II. Overview of the AIDS epidemic

National prevalence has been evaluated by means of sentinel studies. The years and the general results of these studies are listed below.

● I	1988	0.02%
● II	1991	0.10%
● III	1994	0.30%
● IV	1996	0.40%
● V	1999	0.49%
● VI	2003	0.65%

Since 2000, the National Health Institute has been responsible for generating reports on national epidemiological monitoring on the basis of two information sources: passive monitoring of weekly notification of events of interest to public health (SIVIGILA) and characterisation of cases via the notification file.

The total number of cases reported in the country from 1983 to 31 December 2005 stands at 46,815 cases of HIV infection and AIDS. These figures include 28,060 people with HIV, 10,283 people living with AIDS and around 27,055 deaths caused by AIDS. Women (9044) represent 19.7% of reported cases and it is recognised that a significant number of files do not specify the person's sex.⁴ According to the projection made by the excel file designed for this purpose by UNAIDS there will be 171,504 people with HIV/AIDS aged 15-49 in 2005, 55,804 of whom will be women. The estimated prevalence in the same age group is 0.6921%.⁵

Following indications, the updated data up to the cut-off date (31/Dec/05) are presented below

- By means of SIVIGILA, from January 2003 to December 2005, **9015** cases of HIV/AIDS were reported and the highest percentage of notification was found in the 15-44 age range.
- Due to the files on HIV/AIDS cases, **8415** cases of HIV/AIDS have been reported of which **2463** correspond to women, **5696** to men and **266** registers without data. With respect to the probable transmission mechanism, the most frequent data are heterosexuals with **3363** entries followed by **839** reported as homosexuals, **260** as bisexual and **180** as perinatal cases. The breakdown of reported cases by age range is as follows: **143** cases for 0-4, **83** cases for 5-14, **935** cases for 15-24, **1837** cases for 25-34, **1399** cases for 35-44, **710** cases for 45-59, **136** cases for over 60 and **3172** cases without data.⁶

⁴ Data presented for this report. National Health Institute NHI January 2006

⁵ Estimate of the HIV/AIDS epidemic in Colombia. Ministry of Social Protection and experts. Bogota August 2005.

⁶ Data presented for this report. National Health Institute NHI January 2006



The percentage of women presents a constant upward trend and the man:woman ratio continues to reduce with 3:1 as the national average and 2:1 in departments on the Atlantic coast.

On second generation monitoring, biological monitoring data were presented from 2000. No behavioural studies have been carried out on a national level except for some work in small groups.

III. National response to the AIDS epidemic

The intersectorial plan for the response to HIV/AIDS - Colombia 2004-2007, is divided into three subject sectors (area used in the other documents):

Main line I: Interinstitutional and Intersectorial Coordination. Monitoring and Evaluation.

Main line II: Promotion and Prevention.

Main line III: Care and Support:

Human rights and gender equality are considered throughout.

The plan includes various UNGASS indicators as well as others of particular interest. It is hoped that a document of results for the first half of the period, i.e. 2004 and 2005, will be available in the first semester of 2006 on the Intersectorial Plan for the Response to HIV/AIDS - Colombia 2004-2007.

For Main line I Interinstitutional and Intersectorial Coordination - Monitoring and Evaluation, since 2003 the NAC has been active and since **2005** the Ministry of Social Protection has brought forward work with the aim of implementing a monitoring and evaluation model to enable follow-up of the plan's main indicators. Similarly, efforts have been made to strengthen the technical assistance for program management on a regional level.

Furthermore, the NATIONAL HEALTH INSTITUTE is re-engineering the monitoring system. This includes strengthening information collation processes and designing a new unique event notification form.

For Main line II. Promotion and Prevention:

- Social Communication Campaigns. Concentrated on vulnerable populations (MSM, women, young people, HIV carriers) and campaigns for the promotion of altruistic blood donation with an approximate investment of US\$ 250,000. It should be pointed out that there is very little feedback and that the campaigns are broadcast during low audience timeslots.
- The project financed by the Global Fund aimed at the prevention of STI-HIV-AIDS in young people and adolescents having no choice but to live outside their home, began activities in May 2004 with an emphasis on planning and coordination together with authorities and civil society. In January 2005, the execution phase began for 15 of the project's 48 target municipalities. The main achievements of this first execution phase were local positioning of the project by means of the constitution and functioning of intersectorial coordination authorities where 440 governmental organisations and civil society participated, along with international co-operation. 18 integral care plans have been set up for the displaced



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population and 579 members of this population have been trained. 18 municipal bases have been set up which has enabled selection of 24 action base units (ABU) to centralise and implement the project. 90 education institutions are working in ABUs where 531 teachers have been trained and 6535 young people educated to improve the quality of sex education; work is being carried out in 51 health institutions in which 180 civil servants have been trained to improve the quality of sexual and reproductive health services with an emphasis on HIV. 13,371 young people have been seen. A total of 8299 young people have benefited from training and empowerment programs and 300 family members of these young people have been made aware of the problem. In January 2006, planning and coordination activities began in the other 33 municipalities where execution of the project is planned.

- Child-mother project. The national project for the reduction of mother-to-child transmission began in 2003 with financial support from the EU. The objective is to anticipate mother-to-child transmission by incorporating the voluntary test during prenatal monitoring, antiretroviral treatment and prophylaxis in the infected mother and exposed child, caesarean birth and the replacement of breast feeding. The project has been implemented in 898 municipalities from 33 departments and actions carried out in 1246 health institutions. Acceptance of the test reported up to October 2005 was 85%. Between April 2003 and November 2005, 351,196 ELISA tests were carried out for HIV in pregnant women; 710 women were diagnosed with HIV infection corresponding to 0.20%. The highest rate of seropositivity was found in the Caribbean, Quindío and Santander regions. Of the 710 pregnant women diagnosed, 17% were under 20 during the training and 89% were housewives. Total application of the protocol enabled a 1.7% reduction in the probability of HIV transmission from mother to child. Factors related to transmission were: initial viral load $> 10.000/mm^3$, absence of prenatal monitoring and late diagnosis during pregnancy. The Caribbean region had less coverage for prenatal monitoring and a higher rate of late diagnosis. Implementation of this project nationally has strengthened prenatal monitoring services. Maintaining this strategy nationally is currently a priority for national and regional governments as well as insurance companies.

For various prevention actions, the GSHSS has made progress by increasing the availability of supplies and services for the insured population. Moreover, supplies (condoms, reagents, informative material among other things) have been acquired for the implementation of specific preventive projects, such as the national plan for the elimination of gestational and congenital syphilis, prison interventions, project Lambda phase 2 with MSM in Bogota, preventive projects in the tourist sector on the Caribbean coast, social awareness of safe sex in the city of Bogota, educational projects with the national police, preventive projects with Afro Colombian communities in Chocó and indigenous populations in Paeces en Cauca, among others.

It is important to note that most of the country's preventive actions aimed at highly vulnerable populations, especially PLHA, have been led by NGOs.

- **MEN activities on sex education with UNFPA.**



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In 2004, the Ministry of National Education, with the support of the United Nations Population Fund, reinitiated concrete actions to reactivate and resize the sex education project which is now called Education for Sexuality and Construction of Citizenship. On the basis of past experience, this project aims to help educational institutions to build educational projects on sexual and reproductive human rights within an organisational structure that enables permanent monitoring over time.

This project responds to a 30-month pilot experiment in 5 principal areas that are based on three fundamental outcomes.

A conceptual and operational project validated for generalisation throughout the country

A teacher training strategy and

A mobilisation strategy with institutional and social support.

This translates into educational institutions with educational projects based on sufficient broad ranging strategies so that children and young people, as well as adults from the education community, may promote and defend sexual reproductive human rights and as a result of this process, help reduce the risks taken with respect to sexual health.

For Main line III: Care and Support

The regulations in force since 1997 establish the concept of integral care for PLHA. In 2000, actions recommended on this subject under Resolution 412 were implemented. These include an HIV/AIDS guide. In 2005, the Ministry of Social Protection updated this guide using medical methods based on evidence. The product was adjusted and evaluated in the context of existing benefit plans. It was subsequently hoped in the first quarter of the following year to have an administrative Act to enable national players to implement the actions agreed in the guide.

Coverage for access to antiretroviral therapy varies according to the type of insurance. The latest national estimate reported approximately 54.8%. It is estimated that approximately 12,000 patients currently receive combined antiretroviral therapy.⁷ Antiretroviral therapy drugs available include Didanosin, Estavudin, Indinavir, Lamivudin, Nelfinavir, Lamivudin + Zidovudin, Nevirapin, Ritonavir, Zidovudin, Abacavir, Efavirenz and Lopinavir + Ritonavir.

The most frequently used initial combination is AZT+3TC+EFV. Formulation variations are established by referring physicians. Drugs not included in the benefit plans defined by the country must be approved by a medical board that evaluates the need for their use and has limited finance.

For the group of uninsured people for whom the territorial public health directorates should cover treatment, a convention has also been signed with the government of Brazil to enable support of 100 patients in 2 cities.

Despite all the efforts to guarantee access to and continuity of antiretroviral therapy and treatment of associated pathologies, there is still evidence of major difficulties in complying with this aim.

⁷ *Consensus meeting for the estimate of antiretroviral coverage. Ministry of Social Protection October 2006*



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It is important to refer to the high cost Act or Act 972/2005 that obliges providers to guarantee the continuity of treatment and the government to generate strategies that lead to the reduction of costs for this purpose:

- Keep the care guides updated
- Participation in the antiretroviral therapy price negotiations in Buenos Aires
- Establish contact with the Bill Clinton Foundation
- Contract-specific consulting equipment for implementation of the Act
- Bring forward the project to strengthen SSR services for early access to diagnosis and accreditation of health personnel with the theme group

Even in cases where Act 972 was not implemented, a number of BPAs⁹ used mass negotiations for antiretroviral therapy, leading to overall savings of 32% in the case of ISS.)

a. Change in knowledge and behaviour

The most recent national information on the social behaviour of young people and adolescents remains the year 2000 publication corresponding to the national survey of approximately 20,000 secondary education students. Results showed evidence of an early initiation to penetrative sex and a low rate of consistent use of condoms. 71% of those questioned reported having used a condom during their first sexual relationship and 34% had used one during their most recent sexual relationship. In departments on the Atlantic coast these figures were even lower.

In agreement with results from the 2002 survey of young people and adolescents not having any choice but to live outside their homes (n = 690), 70% of men and 34% of women had their first penetrative sexual relationship (PSR) before the age of 16. 40% reported more than one sexual partner in the last year; 15% of men and 12% of women used a condom for their first PSR; 24% of men and 11.3% of women reported consistent use of condoms in the last year. In another similar survey (n=1728) carried out in 2003 in Montería, a municipality in the Caribbean region, 11.2% of men and 7.4% of women reported consistent use of condoms, 15.8% of men and 10.8% of women used a condom during their most recent PSR. In another survey of the general population (n = 960) carried out in Bogota, 44% of those questioned perceived no personal risk of acquiring infection, 48% used no contraceptive method during their last sexual relationship and 24% used a condom in their most recent relationship and 46% believe that it is not possible to get infected.

The rate of condom use is still very low in the group of sex workers and their customers. In a behavioural study carried out in the city of Bogota in 2001 (n=120 sex workers and 120 customers), 41% of the women included in the study reported that they rarely used a condom for various reasons; the main one being the offer of more money (72%). Similarly, 61% of customers reported that they never used a condom; 75% responded that they sometimes paid to have sexual relationships without a condom; and 69% did not use a condom when under the influence of psychoactive substances.

Information on ENDS is missing



b. Mitigation of the impact and human rights.

Despite measures in the Social Security Act and Decree 1543 that guarantee integral care for PLHA, there are still shortcomings with respect to care; a recent study by the Office of Public Defence (a governmental institution) showed that more than 30% of the guardianships (legal mechanism covered by the National Constitution in Colombia for the defence of fundamental rights) presented in the country are for health issues which put people's lives at risk; of these more than 70% are for refusing drugs and procedures and more than 95% comply with the minimum contribution period necessary to care for high-cost diseases. The study therefore provides evidence of a high level of vulnerability of the rights of the insured. This vulnerability is especially due to two reasons: the state institutions responsible for monitoring the system are weak and do not exercise due control and secondly, citizens are not well informed about their rights and therefore do not claim them.

Some action has been carried out to mitigate this impact. First, the NGO Leaders in Action, supported by UNAIDS, carried out a series of training exercises on citizen inspection to inform and empower the community, as well as other actions carried out by civil society. Second, the establishment of Act 972 is being considered with the aim of establishing stronger sanctions for insurers to put a stop to these problems. For several years, NGOs and networks have been constantly defending human rights and providing training and consultancy for their members.

As well as the right to care, other rights of PLHA are vulnerable, especially in areas of armed conflict, where forced displacement, disappearances, persecution and even death are common, if only due to the irrational fear of their state of health. Moreover, some private companies continue to dismiss employees with HIV from their jobs; it is important to recognise that even though in the last few years there has been significant progress on human rights, we are still building a more inclusive and respectful Colombia in terms of the rights of PLHA and much remains to be done.

IV. Main problems faced and action necessary to achieve the aims and objectives of UNGASS

The situations considered are listed:

ECONOMIC RESOURCES: As leverage to the actions programmed in the Intersectorial Response Plan.

OPPORTUNITY: for diagnosis, insurance, continued therapy.

COVERAGE: of duly evaluated promotion and prevention actions, insurance and integral care.

STANDARDISATION: of procedures, monitoring methods and sending data and reports.

HUMAN RESOURCES: insufficient professionals specialised at different levels and institutions, insufficient preparation of available resources to offer integral care services. This deteriorates with the high turnover of trained human resources.



ARTICULATION: between insurance areas, development of services, public health and planning that enable the generation of clear guidelines to system operators.

Although it is certain that promotion and prevention activities are not yet a priority in all health promoting institutions (HPI) and subsidised regime administrators (SRA), it is also clear that there has been particular progress on consensus processes between public health sectors and health insurance as well as the formulation of legislative regulations aimed at improving the integral care of people affected by HIV or AIDS.

- Deficiencies in human resource management plans that include: training, mobilisation and instability of personnel and their respective costs.
- Deficiencies in plans for acquisitions, procurement and distribution of the necessary supplies for prevention (male and female condoms and lubricant), diagnosis (HIV, CD4, CV, opportunistic infection tests) and treatments (antiretroviral therapy, opportunistic infections and other STDs).
- High cost of supplies for prevention, diagnosis and treatment.
- Lack of specific resources for institutional development and existing networks on a national and regional level.
- Maintenance of the high level of stigma and discrimination against the most vulnerable groups (women, gays, other MSM, transvestites, sex workers, children and adolescents, PLHA, drug users, towns with PLHA/natives, people being held against their will and people deprived of freedom, among others).
- Apparent invisibility of Latin America among international co-operation agencies in forums for the negotiation of international resources.
- Little dialogue and limited collaboration with religious groups.
- Deficiency of national budgets for prevention and care.
- Lack of baseline principles for the evaluation of programs.
- Insufficient intersectorial collaboration expressed by the difficulty in building alliances, establishing coresponsibility and co-authoring public health actions.
- Maintenance of a paradigm for care models and biomedical care without a basis for action and intervention on structural aspects and intersectorial responses

V. Support required from allies for the development of the country

GLOBAL

- Create a certification instrument to evaluate universal access on a national and regional level with external certification.
- Search for allies, such as international agencies, to correct problems relating to economic and political agreement when searching for the best prices.
- Revise eligibility indicators of countries for international resources including inequality as a visible criterion.



- Discussion on vulnerable populations as well as orientation due to epidemiological criteria. Include consideration of criteria such as analysis of the social, structural and gender conditions experienced by these populations.
- Favour HIV/AIDS prevention based on scientific evidence and research from the social and health sciences.
- Make documents, including international agreements and recommendations, accessible in Spanish and Portuguese to communities and governments.

REGIONAL

- Maintain and strengthen a joint regional response for the negotiation of prices and consider unified regional or sub-regional procurement to reduce prices.
- Search for solution strategies for patents related to second line antiretroviral costs.
- Broaden and strengthen the technological and multisectorial regional network made up of government and civil society to guarantee the technological transfer and local/regional production of strategic supplies for diagnosis, prevention and treatment.
- Draw up proposals for regional projects to present to the Global Fund and other agencies.
- Ensure/facilitate technical assistance for the strengthening and creation of monitoring and evaluation systems with gender perspectives.
- Ensure/facilitate technical assistance for the establishment of baseline prevention principles by concentrating on vulnerable populations

NATIONAL

- Ensure that national budgets include sufficient resources for the prevention of HIV/AIDS and other STI in different state sectors (multisectorial).
- Strengthen the effective participation and decision-making power of civil society in existing public policy commissions.
- Advocate in favour of national governments supporting civil society actions with financial resources.
- Include sex education with gender perspectives, fighting homophobia or transphobia as an integral part of national HIV/AIDS strategic plans.
- Elaborate methods to strengthen the response capability of social movements implemented by networks and finance occasional projects.
- Develop the human capital in the organisations that participate in the response of each country and region.
- Formulate and strengthen public policies and laws with gender perspectives to anticipate all forms of discrimination and promote the defence of human rights of the most vulnerable populations.
- Intensify quality processes associated with the provision of services.
- Provide departmental / district / municipal technical assistance.
- Strengthen operation of the National Management Observatory.

VI. Monitoring and evaluation system



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The monitoring and evaluation system is in development by the Ministry of Social Protection. It requires the support of all national and international institutions to be able to form an interdisciplinary technical group to magnify the national response and therefore the integral evaluation of management.

The intention and support of various institutions in specifying this action should be recognised, in particular GTZ and PAHO/WHO.



Appendix 1 National report on the vigilance of the follow-up of the declaration of commitment on HIV/AIDS

1) Which institutions were responsible for filling in the indicator forms?

a) National Aids Committee or equivalent	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>
b) National AIDS Program	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>
c) Others	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>

(Specify) the group of people that represents various institutions which make up the subcommittees of the National AIDS Council NAC.

2) With data from:

Ministry of Education	Yes	<input type="checkbox"/>	No	<input checked="" type="checkbox"/>
Ministry of Health	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>
Ministry of Work	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>
Ministry of Foreign Affairs	Yes	<input type="checkbox"/>	No	<input checked="" type="checkbox"/>
Other Ministries	Yes	<input type="checkbox"/>	No	<input checked="" type="checkbox"/>

(Specify)

Civil society organisations *	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>
People with HIV/AIDS	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>
Private sector	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>
United Nations Organisations	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>
Bilateral organisations	Yes	<input type="checkbox"/>	No	<input checked="" type="checkbox"/>
International NGOs	Yes	<input type="checkbox"/>	No	<input checked="" type="checkbox"/>
Others	Yes	<input type="checkbox"/>	No	<input checked="" type="checkbox"/>

* represented as national NGOs

- 3) Was the report debated in a major forum? Yes No
 4) Is the survey data stored centrally? Yes No
 5) Is the data available for public consultation? Yes No

Name / Position: LENIS URQUIJO / DIRECTOR OF PUBLIC HEALTH
 Ministry of Social Protection – Republic of Colombia.
 Date: 20 January 2006

Signature: _____



Appendix 2 Composite Index of National Policy Questionnaire

Strategic plan

1. Has your country drawn up multisectorial strategies to fight against HIV/AIDS?
 (Multisectorial strategies should include, without being limited to these, the health, education, labour and agriculture sectors).

Yes	X	No		N/A	
Observations: The Intersectorial Plan for the Response to HIV/AIDS - Colombia 2004-2007 is the reference document for strategies and action to be carried out by various actors including other sectors.					

2. Has your country integrated HIV/AIDS into its general development plans (such as National Development Plans, the United Nations Development Assistance Framework, Strategy Documents for the Reduction of Poverty and Common Country Evaluation)?

Yes		No	X	N/A	
Observations:					

3. Does your country have a national body for the multisectorial management/coordination of HIV/AIDS? (Such a body should have mandates or the equivalent, a defined composition, action and support plans for the provision of personnel and should have met at least once in the last 12 months).

Yes	X	No		N/A	
Observations: The NAC is an authority which advises the Ministry of Social Protection. It is supported by three subcommittees (integral care, promotion and prevention and public health monitoring). It met on eight occasions in 2005. It does not have its own personnel.					

4. Does your country have a national HIV/AIDS body that promotes interaction between the government, private sector and civil society? (Such a body should have mandates or the equivalent, a defined composition, action and support plans for the provision of personnel and should have met at least once in the last 12 months).

Yes	X	No		N/A	
Observations: This is the National AIDS Council - NAC. It met twice in 2005.					

5. Does your country have a HIV/AIDS body that helps the coordination of civil society organisations? (Such a body should have mandates or the equivalent, a defined composition, action and support plans for the provision of personnel and should have met at least once in the last 12 months).

Yes		No	X	N/A	
Observations:					



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6. Has your country evaluated the impact of HIV/AIDS on its socioeconomic situation for the purposes of planning?

Yes		No	X	N/A	
Observations:					

7. Does your country have a strategy to fight against HIV/AIDS problems among international uniformed bodies including the Armed Forces and civil protection forces?

Yes	X	No		N/A	
Observations: The technical framework is defined in the National Policy on Sexual and Reproductive Health which operates within the Intersectorial Plan for the Response to HIV/AIDS in Colombia 2004-2007. The armed forces and police participated in its formulation. This is how this regime should guarantee promotion and prevention actions and define health care actions. Moreover, UNFPA and the Ministry of Social Protection have supported the development activities for this population for some years.					

Prevention

1. Does your country have a general policy or strategy to develop information, education and communication (IEC) on HIV/AIDS?

Yes	X	No		N/A	
Observations: Established in the National Policy on Sexual and Reproductive Health; complemented in the Intersectorial Plan for the Response to HIV/AIDS - Colombia 2004-2007					

2. Does your country have a policy or strategy to develop education on the sexual and reproductive health of young people?

Yes	X	No		N/A	
Observations: Established in the National Policy on Sexual and Reproductive Health; complemented in the Intersectorial Plan for the Response to HIV/AIDS - Colombia 2004-2007					

3. Does your country have a policy or strategy that promotes IEC and other health actions aimed at groups with high or growing HIV infection rates? (Such groups include but are not limited to, injecting drug users, men who have sex with other men, sex workers, young people, mobile populations and prisoners.)

Yes	X	No		N/A	
If yes, specify the groups: young people (whether or not), MSM, sex workers, injecting drug users, displaced populations, orphans and people deprived of freedom.					
Observations: Established in the National Policy on Sexual and Reproductive Health; complemented in the Intersectorial Plan for the Response to HIV/AIDS - Colombia 2004-2007					

4. Does your country have a policy or strategy that promotes IEC and other health actions aimed at cross-border migrants?

Yes		No	X	N/A	
Observations:					



5. Does your country have a policy or strategy to broaden access to basic prevention products, including by vulnerable groups? (These products include but are not limited to, condoms, sterile needles and HIV tests.)

Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>
If yes, specify the groups and products:					
Groups: Everybody.					
Basic products: Offer of voluntary tests for diagnosing HIV infection.					
Observations: Established in the National Policy on Sexual and Reproductive Health; complemented in the Intersectorial Plan for the Response to HIV/AIDS - Colombia 2004-2007. Established mainly in Decree 1543/97 and Resolution 412/00.					

6. Does your country have a policy or strategy to reduce transmission of HIV from mother to child?

Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>
Observations: Established in the National Policy on Sexual and Reproductive Health; complemented in the Intersectorial Plan for the Response to HIV/AIDS - Colombia 2004-2007. Established mainly in Decree 1543/97 and Resolution 412/00.					

Human rights

1. Does your country have laws and regulations that protect against the discrimination of people with HIV/AIDS (e.g. general provisions against discrimination and measures concentrating on education, housing, employment, etc.)?

Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>
Observations: Established generically in the National Policy Constitution and specifically for PLHA in Decree 1543/97.					

2. Does your country have laws and regulations that protect against discrimination of groups of people identified as especially vulnerable to HIV/AIDS (in other words groups such as injecting drug users, men who have sex with other men, sex professionals, mobile populations and prisoners.)

Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>
If yes, specify the groups: anyone that may be considered as a high vulnerability group.					
Observations: Established generically in the National Policy Constitution and specifically for PLHA in Decree 1543/97					

3. Does your country have a policy or strategy that ensures the access of men and women to equal conditions for prevention and care with an emphasis on vulnerable populations?

Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>
Observations: Established generically in the National Policy Constitution and specifically for PLHA in Decree 1543/97.					

4. Does your country have a policy to ensure that investigation protocols on HIV/AIDS are revised and approved by an ethics committee?

Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>
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Observations: Established generically in the National Policy Constitution and specifically for PLHA in Decree 1543/97. Moreover, an ethics code proposes specific criteria for health investigation.

Care and support

1. Does your country have a policy or strategy to promote integral care and support of HIV/AIDS with emphasis on vulnerable groups? (Integral care includes but is not limited to advice and voluntary tests, psychological care, access to drugs and care based on the household and community.)

Yes	X	No		N/A	
If yes, specify the groups and products: Groups: young people (whether or not educated), MSM, sex workers, injecting drug users, displaced populations, orphans and people deprived of freedom. Basic products: pre and post advice, diagnosis, psychological support, general and specialised health services, pharmacological handling and domiciliary care					
Observations: Established generically in the National Policy Constitution and specifically for PLHA in Decree 1543/97					

2. Does your country have a policy or strategy that ensures or broadens access to drugs related to HIV/AIDS with emphasis on vulnerable groups? (Drugs related to HIV/AIDS include antiretrovirals and drugs for the prevention and treatment of opportunistic infections and palliative care.)

Yes	X	No		N/A	
If yes, specify the groups and products: Groups: young people (whether or not), MSM, sex workers, injecting drug users, displaced population, orphans and people deprived of freedom. It should be pointed out that the regulation includes all PLHA. The new care guide includes recommendations for prophylactic drugs. Basic products: Antiretroviral drugs available include Didanosin, Estavudin, Indinavir, Lamivudin, Nelfinavir, Lamivudin + Zidovudin, Nevirapin, Ritonavir, Zidovudin, Abacavir, Efavirenz and Lopinavir + Ritonavir.					
Observations: The importance of Act 915/05, that reaffirms undertakings made on pharmacological care, is highlighted. At the time of writing this report, this Act is being implemented.					

3. Does your country have a policy or strategy to deal with the additional needs of orphans and other vulnerable children?

Yes		No	X	N/A	
Observations: The scope of responsibility for children who have lost one or both of their parents, whatever the situation, is defined by legal action. When the state is responsible for minors, there is a national territorial institution responsible for the relevant care. This institution is called the Colombian Institute for Family Well-being -					



Ministry of Social Protection
 Republic of Colombia
 General Directorate of Public Health
 Promotion and Prevention Group

Appendix 3 National feedback forms for indicators on the program, knowledge, behaviour and impact (via SIRN).

[NHI LOGO] NATIONAL HEALTH INSTITUTE	NATIONAL HEALTH INSTITUTE NATIONAL PUBLIC HEALTH MONITORING SYSTEM INFORMATION SUBSYSTEM NOTIFICATION OF EVENTS OF INTEREST TO PUBLIC HEALTH BASIC INDIVIDUAL NOTIFICATION FILE	 S I R E
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1. GENERAL INFORMATION	
1.1 EVENT: _____	1.2. NOTIFICATION DATE CODE DAY MONTH YEAR
1.3. WEEK*: _____ <small>*EPIDEMIOLOGICAL YEAR</small>	1.4. YEAR: _____
1.5. DEPARTMENT MAKING THE NOTIFICATION: _____	1.6. MUNICIPALITY MAKING THE NOTIFICATION: _____
1.7. CORPORATE NAME OF THE PRIMARY UNIT GENERATING THE DATA (UPGD): _____	
1.8. UPGD CODE: DEPT MUNICIPALITY CODE SUB.	

2. PATIENT IDENTIFICATION	
2.1. FIRST NAME OF THE PATIENT: _____	2.2. MIDDLE NAME OF THE PATIENT: _____
2.3. FIRST SURNAME: _____	2.3. SECOND SURNAME: _____
2.5. TYPE OF IDENTIFICATION: <input type="checkbox"/> NU (1) NIUP <input type="checkbox"/> CR (2) CIVIL REGISTER <input type="checkbox"/> IDC (3) ID CARD <input type="checkbox"/> CID (4) CITIZEN ID CARD <input type="checkbox"/> FID (5) FOREIGN ID CARD <input type="checkbox"/> PA (6) PASSPORT <input type="checkbox"/> MW (7) MINOR WITHOUT ID <input type="checkbox"/> AW (8) ADULT WITHOUT ID	
2.6. IDENTIFICATION NUMBER: _____	
2.7. AGE: _____	2.8. AGE MEASUREMENT UNIT: <input type="checkbox"/> 1 YEARS <input type="checkbox"/> 2 MONTHS <input type="checkbox"/> 3 DAYS <input type="checkbox"/> 4 HOURS <input type="checkbox"/> 5 MINUTES
2.9. SEX: <input type="checkbox"/> M (1) MALE <input type="checkbox"/> F (2) FEMALE	2.10. ADDRESS OF RESIDENCE: _____
2.11. DISTRICT: _____	2.12. MUNICIPALITY OF RESIDENCE OF PATIENT: DEPT CODE
2.13. ZONE: <input type="checkbox"/> U (1) URBAN <input type="checkbox"/> R (2) RURAL <input type="checkbox"/> P (3) PERIURBAN	
2.14. LANDLINE OR MOBILE Nº: _____	2.15. OCCUPATION OF PATIENT: _____
2.16. TYPE OF SOCIAL SECURITY SYSTEM: <input type="checkbox"/> 1 CONTRIBUTORY <input type="checkbox"/> 2 SUBSIDISED <input type="checkbox"/> 3 LINKED <input type="checkbox"/> 4 PARTICULAR <input type="checkbox"/> 5 OTHER	
2.17 INSURER: _____	2.18. ETHNIC BACKGROUND OR RACE: <input type="checkbox"/> 1 INDIGENOUS <input type="checkbox"/> 2 AFROCOLOMBIAN <input type="checkbox"/> 3 OTHER
2.19. DISPLACED: <input type="checkbox"/> 1 YES <input type="checkbox"/> 2 NO	

3. NOTIFICATION	
3.1. MUNICIPALITY OF ORIGIN: _____ DEPT MUNICIPALITY	3.2. DATE OF CONSULTATION: _____ DAY MONTH YEAR
3.3. START OF SYMPTOMS: _____ DAY MONTH YEAR	
3.4. TYPE OF CASE: : <input type="checkbox"/> 1 SUSPICIOUS <input type="checkbox"/> 2 PROBABLE <input type="checkbox"/> 3 LAB CONF. <input type="checkbox"/> 4 CLINICAL CONF. <input type="checkbox"/> 5 EPIDEMIOLOGICAL NEXUS CONF.	
3.5. HOSPITALISED: <input type="checkbox"/> 1 YES <input type="checkbox"/> 2 NO	3.6. HOSPITALISATION DATE: _____ DAY MONTH YEAR
3.7 FINAL STATE <input type="checkbox"/> 1 ALIVE <input type="checkbox"/> 2 DEAD	3.8. DATE OF DEATH: _____ DAY MONTH YEAR
3.9. NAME OF PROFESSIONAL WHO SIGNED THE FILE: : _____	

SPACE RESERVED FOR THE EXCLUSIVE USE OF TERRITORIAL INSTITUTIONS		
A. FOLLOW UP OF CASE: <input type="checkbox"/> 1 RULED OUT <input type="checkbox"/> 2 CONFIRMED	B. OBSERVATION UPON ADJUSTMENT: _____	C. DATE OF NOTIFICATION: _____ DAY MONTH YEAR
D. OBSERVATION _____	E. DATE OF NOTIFICATION: _____ DAY MONTH YEAR	
F. OBSERVATION _____	G. DATE OF NOTIFICATION: _____ DAY MONTH YEAR	

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<<SIDE A>>

Information... for action!



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