

Assessment of the HIV and AIDS situation in Guatemala, Honduras and Nicaragua

Mapping out National and Sweden's HIV and AIDS initiatives



Acknowledgements

During the mission which was conducted in Guatemala, Honduras and Nicaragua, between 29 April and 11 May 2005, we met with many knowledgeable people from the government, civil society, bilateral organisations and others. They gave us valuable information on the HIV and AIDS situation and the ongoing activities in each country, which this report try to reflect.

The report also benefited from the invaluable support from all the staff members at the Swedish Embassy in respective country. We would in particular like to thank Martin Ejerfeldt, the Swedish Embassy in Guatemala, Ina Eriksson, Göran Paulsson and Janet Vähämäki, the Development Cooperation Section in Honduras and Helena Reuterswärd, the Swedish Embassy in Nicaragua who gave us a comprehensive picture of the region as well as Sida's contribution in the development cooperation.

Ivonne Camaroni
Consultant

Eva-Charlotte Roos
the HIV/AIDS Secretariat Sida

Published by Sida 2005

Department for Democracy and Social Development

HIV/AIDS Secretariat

Author: Report prepared by Ivonne Camaroni and Eva-Charlotte Roos

Printed by Edita Communication AB, 2005

Art. no.: SIDA4904en

ISBN 91-586-8313-5

This publication can be downloaded/ordered from www.sida.se/publications

Content

Executive Summary	5
Acronyms	8
1. Introduction	9
1.1 Background	9
1.2 Objectives of the mission	11
1.3 Methodology	11
2. Guatemala	12
2.1 Situation Analysis	12
2.2 Institutional and policy framework	13
2.3 Main HIV/AIDS ongoing activities	14
2.4 Recommendations	15
3. Honduras.....	18
3.1 Situation Analysis	18
3.2 Institutional and policy framework	19
3.3 Main HIV/AIDS ongoing activities	20
3.4 Recommendations	23
4. Nicaragua.....	27
4.1 Situation Analysis	27
4.2 Institutional and policy framework	28
4.3 Main HIV/AIDS ongoing activities	29
4.4 Recommendations	31
5. Conclusions and Recommendations.....	36
Annexe 1 List of documents reviewed	41
Annexe 2 List of organizations visited and persons interviewed	44

Executive Summary

HIV spreads along the fault lines of failing development such as poverty, gender inequality and poor social services. Development gaps increase people's susceptibility to HIV and aggravate the impact of the epidemic. Conversely, HIV/AIDS hampers progress or even reverts development achievements. HIV/AIDS is becoming one of the main obstacles to achieve Millennium Development Goals.

According to UNAIDS estimates, 1.7 million people are living with HIV/AIDS in Latin America. Four of the six countries with the highest estimated HIV prevalence in the region are in Central America, i.e. Belize, Honduras, Panama and Guatemala. Honduras is the country worst affected with an adult prevalence (15–49 years) of almost 2% (UNAIDS 2003).

To assess the HIV/AIDS situation and the main actors from different sectors at national level and to identify entry points for the Swedish contribution to the national response, a mission was conducted in Guatemala, Honduras and Nicaragua in May 2005. The mission consisted of one representative from Sida's HIV/AIDS Secretariat in Stockholm, Eva-Charlotte Roos, and one external HIV/AIDS consultant, Ivonne Camaroni.

The first cases of HIV were reported in the late 1980's in the countries visited. The main way of transmission is through unprotected sexual intercourse with a higher number of infected men than women although this trend is quickly reverting. However, due to scarcity of accurate data, HIV prevalence and HIV estimates should be interpreted with caution.

There are many factors that may fuel the epidemic in the region, such as the combination of macho culture and violence against women, the limited negotiation power of women to use condom, the reluctance of conservative forces to allow an open dialogue on sexuality, etc. Social discrimination of the indigenous population and other ethnic groups makes them vulnerable to HIV due to limited access to basic services such as education and health. The illiteracy rate is higher among those groups and the lack of oral and written behavioural change communication material in their own languages contributes further to their vulnerability.

The governments in the three countries visited responded relatively quickly and set up institutional and policy frameworks by creating National AIDS Commissions, National AIDS Programmes, National Strategic Plans and HIV laws. However, the response at national level

has not always been effective and well coordinated. The grants from the Global Fund to fight AIDS, Tuberculosis and Malaria are one of the most important changes in the dynamic of the national response in the three countries. The fund, managed by an international NGO in Guatemala (World Vision), a national NGO umbrella organization in Nicaragua (Nicasalud) and a UN agency (UNDP) in Honduras, has largely contributed to bring care and treatment to the national agenda. However, it has partially disturbed the national processes and initiatives already on place when the grants were granted.

Swedish International Development Cooperation Agency (Sida) has identified scaling up HIV/AIDS related work as one of its three strategic priorities. The strategy to scale up HIV/AIDS includes increasing the dialogue and advocacy, strengthening the direct support of HIV/AIDS and mainstreaming HIV/AIDS into different activities/sectors.

The dialogue is important to ensure political commitment and to create an enabling environment to openly discuss sensitive issues such as the right to accurate information on sexuality, especially among youth, condom use and gender issues. The dialogue is also important to ensure coordination of activities in order to maximize the impact of national and regional initiatives.

People are not vulnerable per se but they become vulnerable as a result of the social, cultural and economic context in which they live. An effective response to HIV/AIDS should therefore be multisectorial, nationwide and designed to address the underlying factors that may fuel the epidemic, such as poverty, poor access to basic services as health and education, especially for women, and political commitment.

The response has to be comprehensive, including prevention, treatment, care and support, and impact mitigation. These components should be seen as a continuum and therefore complementary parts rather than as independent components. However, in countries with low prevalence, prevention activities deserve a special focus.

The response should be gender sensitive and egalitarian taking in account the rights of people living with HIV/AIDS to live in dignity and the rights of the HIV negative people to remain negative. It should build a culture of rights, respect and solidarity but also responsibility.

The role of the government as the coordinator of the national response is indisputable. However, the response should be inclusive and recognize the crucial role that the civil society in general and people living with HIV/AIDS in particular have to play as agents of change and as the social monitors of the implementation of the national response.

As part of Sweden's commitment to reduce the spread of HIV/AIDS and to mitigate the impact of the epidemic, Sida advocates for and contributes to the operationalization of the 'three ones' initiative, i.e. one national HIV coordinating authority, one agreed HIV policy and one national monitoring and evaluation system. The support could be through both financial and technical assistance to the countries to implement the National Strategic Plans and to strengthen the monitoring systems.

The emphasis should be in contributing to a multisectorial response by mainstreaming HIV/AIDS in the different sectors of the Swedish cooperation. The scope of direct support and mainstreaming at country level needs to be defined based on i) the level of ambition set by the Embassy and the human and financial resources needed to achieve that level ii) the epidemiological situation in the country, the underlying factors and the existing national response, and iii) the objectives and

priorities identify by the countries as stated in the respective National Strategic Plan.

This report presents examples of integrating HIV/AIDS in the ongoing Swedish cooperation at country level. The suggestions are intended as a 'food for thoughts' or guidance to programme officers and other relevant Sida staff to initiate the in-house discussion. The day-to-day contact with the implementing agencies and a more comprehensive picture of the external environment place the programme officers in an ideal situation to set the level of ambition for scaling up the support of HIV/AIDS and to prioritize accordingly.

Acronyms

AIDS:	Acquire Immunodeficiency Syndrome
CBO:	Community Based Organization
CCM:	Country Coordination Mechanism for the Global Fund
CONISIDA:	Comision Nicaraguense de SIDA
DFID:	Department for International Development UK
GDP:	Gross Domestic Product
GTZ:	German Agency for Technical Cooperation
GFATM:	The Global Fund to fight AIDS, Tuberculosis and Malaria
HIV:	Human Immunodeficiency Virus
IEC:	Information, Education and Communication
MSM:	Men having Sex with Men
NGO:	Non Governmental Organization
NSP:	National Strategic Plan
PASMO:	Pan American Social Marketing Organization
PASCA:	Central American HIV/AIDS Prevention Project
PENSIDA:	Plan Estrategico Nacional de SIDA
PLWHA:	People Living with HIV/AIDS
PR:	Principal Recipient of the Global Fund
PSI:	Population Services International
Sida:	Swedish International Development Cooperation Agency
STI:	Sexually Transmitted Infection
UNAIDS:	Joint United Nations Programme on HIV/AIDS
UNDP:	United Nations Development Programme
UNESCO:	United Nations Educational, Scientific and Cultural Organization
UNFPA:	United Nations Population Funds
UNICEF:	United Nations Children's Funds
USAID:	United States Agency for International Development
VCT:	Voluntary Counselling and Testing
WFP:	World Food Programme
WHO:	The World Health Organization

1. Introduction

1.1 Background

Poverty, lack of political commitment, gender inequality and poor social services increase people's susceptibility to HIV/AIDS and aggravate the impact of the epidemic. On the other hand, the HIV/AIDS epidemic is a hinder for development, it hampers progress or even turns around development achievements. HIV/AIDS has become one of the main obstacles to achieve the Millennium Development Goals. On the basis of the severe global HIV/AIDS situation, Swedish International Development Cooperation Agency (Sida) has identified HIV/AIDS as one of its three strategic priorities.¹

The Swedish strategy 'Investing for future generations – Sweden's International Response to HIV/AIDS', adopted in 1999, sets up the framework for Swedish efforts to respond to the epidemic. The challenge is how to achieve a balance between the different means of responses, address underlying causes as well as to work with the full chain of activities; prevention, care and treatment and impact mitigation.

The overall objectives of the strategy are to:

- Contribute to reducing the further spread of HIV,
- Contribute to mitigating the effects of the epidemic on individual and society.

Guiding principles behind the strategy are to:

- a. Enhance the capacity, commitment and efforts of partner countries to economic and social development,
- b. Act on the basis of locally identified needs and demands for support to HIV and AIDS programmers in partner countries,
- c. Integrate HIV/AIDS into international development cooperation,
- d. Ensure that priorities and approaches match local needs, and are in line with country and regional strategies,
- e. Involve people living with HIV/AIDS or affected by the epidemic at all stages.

¹ Strategic Priorities 2005-2007, Office of the director General

The goals of the Swedish Strategy are to:

1. Address immediate causes in order to enable people to protect themselves against HIV infection (HIV Prevention),
2. Address immediate effects to allow people infected and affected by HIV/AIDS to pursue their lives with quality and dignity (Care and support),
3. Address underlying causes in order to encourage greater political commitment to HIV prevention programmes (political commitment),
4. Address long-term effects to ensure the development of coping strategies at the individual, community and national level (impact mitigation).

Sida has defined HIV/AIDS as one of the strategic priorities for 2005–2008. The approaches to be used include; increasing the dialogue and advocacy, strengthening direct support to HIV/AIDS activities and mainstreaming HIV/AIDS in development cooperation.

Dialogue is an important strategy to ensure HIV/AIDS is brought up in the development agenda at all levels in order to create an enabling environment where HIV/AIDS related work could be implemented. As a result of the urgent need of an accelerated and comprehensive international response, important global initiatives such as Global Fund for AIDS, TB and Malaria (GFATM) and WHO's 3 by 5 have been launched. Therefore, in order to avoid duplication and to maximize the impact of each of the initiatives, strong coordination mechanisms at national and regional level are essential.

While the coordination of the HIV/AIDS national response should mainly be the responsibility of the national authorities, development partners could ensure the prioritization of HIV/AIDS by engaging in the dialogue at high political level and by supporting the national authorities through financial and technical assistance.

Mainstreaming is another strategy prioritized by Sida. A working definition of mainstreaming proposed by UNAIDS is 'Mainstreaming AIDS is a process that enables development actors to address the causes and effects of AIDS in an effective and sustained manner, both through their usual work and within their workplace'². Development actors should analyze and address the impact of HIV/AIDS both on their own capacity and on the people they serve.

HIV prevention contributes to increase awareness and knowledge on HIV/AIDS. However, information alone is not sufficient to achieve behavioural changes neither to fully address social and cultural values and norms underpinning the spread of the epidemic. At the same time, providing medical treatment may contribute to decrease the impact of the epidemic both at individual, family and community level, but cannot fully address the underlying factors that contribute to their vulnerability such as poverty and/or gender inequality.

Therefore, direct HIV/AIDS projects/programmes and mainstreaming HIV/AIDS are not an either/or alternative but two complementary approaches. What is crucial in countries with low prevalence is to take pre-emptive action to address underlying factors and vulnerability before the impact of the epidemic hampers the national capacity to respond.

Four of the six countries in Latin America with the highest estimated HIV prevalence are in Central America – Belize, Honduras, Panama and Guatemala (World Bank 2003). Although some studies have been

² Support to Mainstreaming AIDS in Development, UNAIDS Secretariat, Strategy Note and Action Framework 2004–2005,

conducted to better understand the seriousness and the dynamic of the epidemic in the region, it is difficult to know the exact magnitude of the epidemic due to the scarcity of accurate data and the lack of a comprehensive surveillance system.

A mission comprising one member of the HIV/AIDS Secretariat at Sida HQ (Eva-Charlotte Roos) and one external consultant (Ivonne Camaroni) visited Guatemala, Honduras and Nicaragua between 29 April and 11 May 2005. This report presents the results of the mission. The chapter two to four present a brief situation analysis of the HIV/AIDS epidemic in each of the countries and different aspects of the national response, including the policy framework and coordination mechanisms as well as some of the major initiatives by the international community and civil society. Also, in each of these chapters some of the recommendations for further action are presented.

1.2 Objectives of the mission

Objectives of the mission were:

- To assess the specific HIV/AIDS situation in each of the countries, including hot spots and the most vulnerable groups and their needs,
- In the area of HIV prevention, care and treatment and impact mitigation, identify and assess the main actors from the public sector, civil society and private sector as well as from regional institutions, multilateral and bilateral donors.
- To identify and assess strategic entry points for the Swedish response to HIV/AIDS including mapping out the ongoing project/programme portfolio in all sectors of the Embassies (HIV and others),
- To perform a half-day training on scaling up of HIV/AIDS for the staff at the Embassies.

1.3 Methodology

- Desk review of relevant documents (Annex 1 presents the list of documents reviewed)
- Interview with key actors (Annex 2 presents the list of person met by country)

2. Guatemala

2.1 Situation Analysis

Guatemala is a multiethnic, multicultural and multilingual country, ranking 121 in the Human Development Index of the UNDP report³. In spite of a higher GDP compared with other countries in the region, Guatemala is characterized by social and economic inequality with 60% of the population living in poverty and 20% in extreme poverty.

Poverty and illiteracy rates are higher among indigenous population. The historical social discrimination of the indigenous population makes them vulnerable to HIV/AIDS not only due to their limited access to basic services such as education and health services but also due to the high illiteracy rate and the lack of oral and written behavioural change campaigns and material in their own languages.

After more than three decades of a devastating armed internal conflict, the Peace Accords were signed in December 1996. While there is still a long way to go in the reconstruction of the society, the peace process has created a space for social dialogue among different groups. The Peace Accords with its 17 Agreements can be seen as the framework for a long-term development plan for Guatemala. It can also be seen as a guiding framework for the national response to HIV/AIDS with its focus on human rights and the rights of the indigenous people.

The first known case of HIV in Guatemala was identified in June 1984. Since then, 7,054 people living with HIV/AIDS have been reported, with an estimated overall prevalence of 1%⁴. However, the actual number of people living with HIV/AIDS may be much higher due to lack of access to testing as well as underreporting especially from the private sector. It is estimated that the number of cases may be as high as 67,000 and it is assumed that the epidemic is expanding not only to different groups of the population but also to different geographical areas.

Since 1998, there have been attempts to systematize the surveillance system, however, the information available is still mainly extracted from the reported cases and from ad hoc studies rather than a systematic surveillance. Therefore, it is difficult to analyze trends of the epidemic in an accurate way. The groups most studied are pregnant women, blood

³ Human Development Reports HDR 2003 – UNDP

⁴ Plan Estratégico Nacional ITS/VIH/SIDA 2005–2008. Primer borrador, Ministerio de Salud Pública y Asistencia Social, Guatemala, Febrero 2005

donors and women working as sex workers and more recently, men having sex with men.

Among the people who know their HIV status, 87% has been infected through sexual intercourse, 6% are children born from HIV positive mothers/couples and 1% has been infected through blood transfusion. The majority of cases reported are men with a proportion of three HIV positive men per each HIV positive women. However, the proportion of women has increased from one woman per 6.5 men in 1986 to one per each third in 2004 (National Strategic Plan, 2005–2008).

In a study conducted in 2002–2003 among pregnant women from different sites, the overall prevalence was 0.5%, with a considerable geographical variation (from 0% in Santa Rosa to 1.39% in San Marcos). Studies among uniformed forces showed an overall prevalence of 0.69% also with geographical disparity of up to 3.95% in one of the sites in San Jose (National Strategic Plan, 2005–2008).

Epidemiological studies conducted in Central America showed an HIV/AIDS prevalence of 11.5% among men having sex with men. The prevalence among female sex workers varies from 1.6% to 9.5% in Guatemala City and Izabal respectively (PASCA 2002). There is also indication of an increased number of people living with HIV/AIDS among prisoners. Almost all blood donors in the public sector and in the social security facilities are screened. In 2002, the prevalence reported among blood donors was 0.5% (WHO, 2004). However, there is no accurate information from the private sector on percentage screened or prevalence found.

The reported cases of people living with HIV/AIDS are mainly from six geographical areas ('departamentos') namely Guatemala (45%), Escuintla (8.0%), Suchitepéquez (7.3%), Quetzaltenango (7.0%) and Izabal (6.4%) all of them with intensive commercial activities. The prevalence found in these 'departamentos' may reflect a true higher prevalence or it may reflect a higher awareness among the public and the health staff as well as better access to diagnosis facilities in those areas.

2.2 Institutional and policy framework

In 1987, few years after the first case of HIV was reported in the country, a National Commission for AIDS (CONAVISIDA) was set up. In 1995, a medium term plan for AIDS (1995–2000) was drawn, replaced later on by the first National Strategic Plan for AIDS (NSP) 1999–2003. The process for updating the NSP has already been initiated.

The NSP was developed as the result of a comprehensive consultative process, and the objectives were to: i) contain the epidemic in the vulnerable groups and in the general population, ii) minimize the economic and social impact of the epidemic and iii) decrease the vulnerability of the population. In spite of the participatory approach used to design the plan, the implementation has faced problems due to poor commitment and coordination between different sectors as well as lack of a strong national coordination mechanism.

The National AIDS Programme operates within the Ministry of Health. It is one of the few programmes within the Ministry of Health with own budget, which may indicate a certain degree of political commitment. However, the funds allocated are not enough with an allocation of 1,000,000 USD per year against the 5,000,000 USD budgeted in the implementation plan of the NSP. The Programme Manager has an extensive experience from the NGO sector, which has contributed to improve the communication between the programme and the civil

society. In 2000, an HIV law was approved⁵. The law regulates the creation of the National Programme to Prevent and Control HIV/AIDS and of a multisectorial commission, the National AIDS Commission. However, the Commission has not operated during the last years.

2.3 Main HIV/AIDS ongoing activities

The response from the civil society in Guatemala has played a crucial role in the response to the epidemic. An assessment conducted in preparation of the National Strategic Plan (Fernandez, 2005) found that there are 85 HIV-related projects implemented by 33 NGOs. The projects work with different groups covering different programmatic aspects, such as prevention and comprehensive services. However, the geographical coverage is limited to the five 'departamentos' with highest HIV prevalence, i.e. Guatemala, Izabal, San Marcos, Quetzaltenango and Retalhuleu.

Coordinating Association to fight against AIDS

(Asociación Coordinadora de Sectores de Lucha contra el Sida)

The Association was created in 1995 and it comprises 30 organizations from the civil society. The main objectives of the Association are i) to coordinate efforts among organizations working with HIV/AIDS related projects, ii) to promote human rights of people living with HIV/AIDS iii) to represent the civil society in different forum such as the UN Expanded Theme Group on HIV/AIDS and the Country Coordination Mechanisms for GFTAM. The Association has been conceived as a peak body, but conflicts between member organizations have hampered its work.

A couple of years after the creation of the Association, the Network for people living with HIV/AIDS was established. Currently, there are three support groups of people living with HIV/AIDS (Gente Nueva, Gente Positiva and Gente Unida).

Global Fund to fight AIDS, Tuberculosis and Malaria (GFTAM)

In 2004, GFTAM approved the proposal presented by Guatemala, 'Intensification of prevention and comprehensive attention of HIV and AIDS in vulnerable groups and priority areas in Guatemala'⁶. The total budget for the five years proposal is 40 million, out of which 55% is allocated for treatment and care.

The objectives of the proposal are: i) prevention among vulnerable groups, ii) increase participation of the civil society, iii) decrease mother to child transmission and iv) decrease HIV-related morbidity and mortality among people living with HIV/AIDS.

World Vision, the principal recipient of the grant, has a monitoring unit for the overall programme of the organization that has developed a framework for the implementation and monitoring of the grant. It has been proposed to expand the scope of that framework to comprise not only the monitoring of the GFTAM but also the national response. While the approach may be cost-effective, it may not be the best way to ensure government ownership of the monitoring of the HIV/AIDS response.

Before the grant was approved, only 10% of HIV related activities were funded with external support. With the grant the proportion has increased to 35%.

⁵ Ley General para el combate de VIH y SIDA y de la promoción, protección y defensa de los derechos humanos ante el VIH/SIDA

⁶ Intensificación de las acciones de prevención y atención integral del VIH/SIDA en grupos vulnerables y áreas prioritarias de Guatemala

International Development Partners:

- *Medecins Sans Frontiers (MSF)*: provides antiretroviral treatment to 600 people living with HIV/AIDS. The project will face out shortly although there is not yet a clear plan on how the government will take over the initiative and continue providing treatment for these 600 people. While funds from the GFTAM grant will cover antiretroviral treatment, the agreement is to provide drugs only for new cases and not for those already in treatment. Therefore, those who are currently receiving treatment from MSF or any other project would not be eligible for treatment from GFTAM.
- *UNFPA*: supports projects of reproductive health and procurement of condoms.
- *WHO*: provides technical support for the surveillance system and support for advocacy activities within the framework of the 3 by 5 initiative.
- *UNICEF*: implements projects on prevention of parents to child transmission, including post partum antiretroviral drugs for those women who are eligible for treatment.
- *USAID*: supports the surveillance and information systems.
- *PASMO*: funded by USAID, works since 1996 in Central America with prevention among vulnerable groups such as men having sex with men, female sex workers and their clients, mobile population, and youth.

2.4 Recommendations

Sida's support to the country has changed after the signature of the Peace Accords. It has not only increased but also it has focused more in the consolidation of the peace process and democracy and in the long-term development of the country. The main thematic areas of intervention are: 1) implementation of the Peace Accords, human rights and democratic participation with emphasis on the local level, 2) participation of women and indigenous peoples and 3) support to activities promoting structural economic changes.

The recommendations on potential strategic entry points for the Swedish response on HIV/AIDS are divided in a) dialogue b) direct support and c) mainstreaming. However, the scope of Sida's contribution to the national response should be determined based on further analysis of the level of ambition and preparedness of the Embassy to allocate human and financial resources.

a) Dialogue

Sida should bring up HIV/AIDS in the dialogue at all levels with the national counterparts and development partners, as well as in the different donor's coordination mechanisms such as in the Grupo de Dialogue (Dialogue group) which comprises 13 of the major donors active in the country, and in the Mesodialogue, a coordination mechanism run by the European Commission.

Sida could also follow up the CAFTA agreement in order to assess how the agreement could impact in the procurement of antiretroviral drugs in the region.

b) Direct HIV/AIDS support

Sida could consider technical and financial support for development of the implementation plan of the National Strategic Plan. Technical and

financial support could also be provided to the national authorities to coordinate the development of a National Strategic Communication Plan, which should include an assessment on what is the most effective way to address the needs of the indigenous groups.

c) Mainstreaming of HIV/AIDS in ongoing activities

The Human Rights Ombudsman Office:

Sida has supported the Human Rights Ombuds Offices since 1993. During the last year, Sida's support has been directed towards the consolidation of the strategic planning process, institutional development and strengthening of the Special Office for Indigenous Affairs (Country Report Guatemala, 2004).

Anecdotal evidences indicate that HIV prevalence rates may be higher among indigenous populations due to the social vulnerability of these groups. People living with HIV/AIDS are discriminated and indigenous people may face a double discrimination if they are infected.

Sida could consider including HIV/AIDS as one of the issues in the special office for indigenous affairs.

Access to Justice and Civil Society Participation (PASOC):

The main areas of activity of Access to Justice, implemented through the Soros Foundation, are to facilitate conflicts between indigenous and common law on one hand and the official law on the other. PASOC, implemented through UNDP since 2000, aims to stimulate the civil society in its contribution to the construction of participatory democracy rooted in human rights (Country Report Guatemala, 2004).

Sida could consider the inclusion of a component in these two projects in order to promote and follow up the implementation of the Special Law on HIV and the rights of people living with HIV/AIDS.

National Justice Commission:

The project is implemented through UNDP. All public judicial institutions and universities as well as three honourable citizens participate in the multi sector commission (Country Report Guatemala, 2004). The commission could be a good discussion forum for issues related to stigma and discrimination towards people living with HIV/AIDS in general and within the health care settings in particular.

Sida could commission a study to assess the extension of human rights abuses towards people living with HIV/AIDS. Universities and the Network of people living with HIV/AIDS could conduct the study jointly. The results of the study could be used as a strong advocacy tool and to guide further development of activities in that sector.

Ombudsman Office for the rights of Indigenous Women in Guatemala – DEM II:

Sida has supported the indigenous women's ombuds office project through UNDP since 1999. The office provides legal, social and psychological advice/support for indigenous women (Country Report Guatemala, 2004).

Indigenous women infected by HIV/AIDS may suffer discrimination due to their ethnical background, gender and HIV status.

Sida could explore the possibility that the Ombudsman Office develops specific support activities for women living with HIV/AIDS. This could be done in consultation with the Network of people living with HIV/AIDS in order to determine the main areas to be covered as well as to explore the possibility to have a person living with HIV/AIDS working in the Ombudsman Office.

Household surveys:

The support was channelled through UNDP to the National Statistic Institute in order to strengthen its technical capacity for household surveys and analysis (Country Report Guatemala, 2004). The project was completed in 2004. However,

Sida could consider technical support to the Institute in order to develop questions related to HIV that could be included in the household survey. While the inclusion of questions in this kind of survey would not replace systematic HIV second-generation sentinel surveillance, it would help to follow trends in knowledge, attitudes and practices.

Micro credits for poverty reduction through local development:

The objective of the Fund for Local Development in Guatemala is to contribute to improve living conditions for poor people in urban and semi urban settlement in ten provinces. The programme works through nine micro credit organizations/cooperatives (Country Report Guatemala, 2004).

Sida could explore the possibility of including a quota for HIV/AIDS affected families (i.e. families with one member living with HIV/AIDS) as beneficiaries of the micro credit scheme and promote the system through the network of people living with HIV/AIDS.

Health system reform programme:

The reform has a strong connection to the peace agenda from 1996, which stipulates the obligation to increase public spending on the health sector and more resources for preventive health care. It aims to develop an integrated and decentralized system for health services (country Report Guatemala, 2004).

Sida could ensure that HIV/AIDS related activities are integrated in a comprehensive way in this project. One example is to include voluntary and counselling testing in selected sites as an entry point for prevention. The selection of the sites could be done based on the available epidemiological situation or be more focused within reproductive health services.

Support to Swedish NGOs:

Several Swedish NGOs work in Guatemala – Caritas, Diakonia, Forum Syd, the Sami Council and the Swedish Cooperative Centre with issues related to local democracy, indigenous peoples, gender dimension and land.

Sida could encourage Swedish NGOs to mainstream HIV/AIDS in their work, starting with an assessment of their own institutional vulnerability to HIV/AIDS.

3. Honduras

3.1 Situation Analysis

Globally, poverty is recognized as one of the main underlying causes of the HIV epidemic. Honduras ranks 115 in the Human Development Index with two third of the population living under the poverty line (UNDP 2004). Poverty may force people into survival strategies that may put them at risk. Such is the case for many women who are forced to be involved in transactional sex. Poverty may also force people to move from their homes in search for better opportunities. While migration per se is not a risk factor, people's vulnerability to HIV may increase when they are away from their family and social network.

Another important underlying factor is gender inequality. 'Macho' culture is pervasive in Honduras as it is in many other countries in the region. A culture that combines machismo and fatalism may result not only in violence against women but also in low condom use (PENSIDA II). The policy framework and the political will to support equal opportunities exist as it is indicated by the signature of international agreements and by the Law on Equal Opportunities (April 2000) and National Women Policy (November 2002). However, the challenge is to guarantee the implementation of those agreements and laws in order to ensure the rights of the women.

The first known cases of people living with HIV were reported in Honduras in 1985. Since then, 20,624 people living with HIV/AIDS have been reported, with an increased number of women and youth (PENSIDA II).

Studies among pregnant women in Tegucigalpa and San Pedro de Sula have shown prevalence of 1% and 3 to 4% respectively. Based on the limited data available, it is estimated that the prevalence rate of HIV is around 3%. However, these rates may underestimate the real situation as it is believed that at least half of those living with HIV/AIDS are not aware of their HIV status and hence not known by the health authorities. Nevertheless, available data shows a clear upwards trend since the onset of the epidemic.

The access to services such as providing voluntary testing and counselling is still limited and therefore the majority of people become aware of their HIV status first when they have developed AIDS. A delay in the diagnosis may have severe consequences not only for the individuals and their chances to survive but also for the dynamic of the epidemic as it may increase the risk of transmission from people who are not aware of

their HIV status. The pattern of transmission in Honduras is primarily through sexual intercourse (90%), followed by mother to child transmission (6%) and blood transfusion (0.5%) (PENSIDA II).

The results of a study conducted in 2001 showed relatively high prevalence among the groups studied, i.e. men having sex with men (13%), female sex workers (10.3%), garifuna population (8.4%), and prisoners (6.8%) (PASCO; 2003). It can be concluded from the study that the prevalence among these groups is high and that these groups are vulnerable. However, it cannot be concluded that those are the only vulnerable groups in the country. Until a systematic surveillance of different groups of the population is introduced, it would not be possible to draw definitive conclusions.

The epidemic in Honduras can be characterized as a generalized epidemic, i.e. with prevalence higher than 1% among pregnant women. However, this epidemiological characterization is not enough to capture the complexity of HIV. Neither the definition nor the number of cases reported capture the dynamic of the epidemic and it might disguise geographical differences.

3.2 Institutional and policy framework

In 1999, a special law on HIV and AIDS (Ley Especial del VIH/SIDA) was approved. As established in the law, a National AIDS Commission (CONASIDA) was set up the same year. However, during the first years the commission did not play a very active role in the implementation and coordination of the national response.

In the same year, the National AIDS Programme of AIDS (Programa Nacional de Control de Sida) was set up within the Ministry of Health and the First National Strategic plan for 1998–2002 was developed. However, the implementation of the plan was inadequate, possible as the result of a limited participation in the design of the plan by the sectors that were supposed to implement it.

Fortunately, the lessons learnt from the failure of the first plan were used in the development of the Second National Strategic Plan 2003–2007 (PENSIDA II). The plan was designed based on the outputs of four workshops in which more than 200 people participated representing different sectors of the government, civil society and international community. It remains to be seen whether this approach will guarantee an improvement in the implementation or if the plan will remain a declaration of good intentions.

The strategic areas identified in the PENSIDA II are: i) promotion of sexual and reproductive health by development of IEC, strengthening of local authorities, addressing violence against women and inclusion of sexual and reproductive health in the school curricula, ii) provide comprehensive health services, iii) coordination of social policies, iv) promotion of Human Rights and v) promotion of research.

The plan stresses the importance of achieving a balance between prevention, treatment and care. It also highlights the need for a coordinated nationwide and multidisciplinary response and the value of an ongoing monitoring and evaluation of the implementation of the plan.

In 2003, UNAIDS facilitated the set up of a donor forum, Coordination Table (Mesa Coordinadora de SIDA) chaired by the Government. The forum is an information sharing and coordination mechanism for the implementation of the PENSIDA. However, the forum has not have any meeting scheduled during 2005 as the problems with the proposal funded by the Global Fund to fight AIDS, Tuberculosis and Malaria (see below) has been prioritized by almost all the stakeholders.

One of the limitations faced by the Government is the inadequacy of human and financial resources, which hampers an appropriate response not only for HIV/AIDS but in the provision of basic services within the education and health sector.

In spite of these constraints, the government has shown commitments in the response of the epidemic by including HIV/AIDS related activities in the PRSP, the promulgation of a special law for HIV/AIDS, and the support to a vibrant and active NGO community.

Table 1. presents the main funding sources for HIV/AIDS work currently available in Honduras.

Table 1. Mayor external funding sources for HIV/AIDS activities in Honduras

Funding Source	Million US\$
Global Fund	26.2
Bilateral Donors (USAID, CIDA, KfW)	6.7
UN Agencies	3.2
World Bank	5.0
Inter American Development Bank	0.5

3.3 Main HIV/AIDS ongoing activities

National AIDS Forum

The Forum, an umbrella organization of NGOs working with HIV related activities, was set up by UNDP in 2001. Initially, the Forum had a similar structure as CONASIDA. Many of the persons met during the mission, expressed their perception that the Forum was originally established to fill the gap left by what at that time was an inoperative CONASIDA.

However, since 2003 CONASIDA has become more operational which initially resulted in duplication of roles between the Commission and the Forum and generated some tension between the two bodies. As a result, the Forum is currently in a transition period to redefine its own role. One of the steps taken is the change of the organizational structure of the Forum agreed on at their last annual meeting. The main role of the Forum, as identified during the meeting, should be to ensure that the voice of the civil society is brought up and heard in the public debate. In addition, the Forum should take into its role as social auditor of the implementation of PENSIDA II.

The Forum with its 190 members has a secretariat located in Tegucigalpa and eleven chapters around the country. The role of the secretariat is to provide technical assistance to the members as well as fundraising. The role of the chapters is to disseminate the strategic priorities set up by PENSIDA and to manage funds.

Sida provides financial support to the Forum to manage a small grant fund to support innovative initiatives from NGOs and CBOs. An independent panel reviews the project proposals presented to the Fund. The review panel comprises representatives from the Government, multi and bilateral agencies, NGOs and HIV positive groups. The selection process is complemented by a physical assessment of the applicant organizations and letter of reference from previous donors.

International development partners

- *COMCAVI*: This project, with financial support from USAID, provides technical and financial support to ten NGOs working with

different groups such as people living with HIV/AIDS, sex workers, men having sex with men and garifuna population. The activities of the NGOs are mainly located in San Pedro de Sula. The annual budget is around 6 million USD.

- *PASMO*: a regional organization funded by USAID, works with social marketing of condoms.
- *UNICEF*: works in three areas 1) in collaboration with GZT, UNICEF provides support to local authorities for the implementation of COMVIDA – a project on prevention for youth in 14 municipalities, 2) support to projects working with orphans and 3) prevention mother to child transmission.
- *WFP*: works with food safety for families affected by the epidemic.
- *UNDP*: has played an active role in advocating for inclusion of HIV/AIDS in national plans and budgets.
- *UNFPA*: has concentrated its efforts on HIV prevention among youth and garifuna population, mother to child prevention, and condom promotion.
- *WHO*: has provided technical support for the implementation of the 3 by 5 initiative and has supported surveillance activities. WHO is in the process to recruit a person to work with issues related to antiretroviral drugs (sustainability of projects, etc) at regional level.

Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM)

In February 2003, the proposal ‘Strengthening of the National Response for Protection and Promotion of Health in HIV and AIDS’ presented by Honduras to the Global Fund to fight AIDS, Tuberculosis and Malaria was approved. A total of 42 million USD was granted, out of which 27,5 million USD for the HIV and AIDS component. The Foundation to fight AIDS, Tuberculosis and Malaria is the Country Coordination Mechanism (CCM) and UNDP, the Principal Recipient (PR). The CCM has an executive committee with one representative from the Government, one from the civil society and one from development partners.

The project is implemented in 39 municipalities with prevalence rates greater than 150/100,000. The main activities include: a) promotion of the Human Rights of PLWHA, b) promotion of healthy conducts that will decrease the risk of HIV and c) implementation of an integrated approach in the health care provided to all people living with HIV/AIDS.

The project faced severe problems during the inception phase and the implementation of activities was delayed. A representative of the GFATM who visited the country in October 2004 informed for the first time the concern of the GFATM Secretariat regarding the delay in the implementation. To respond to the concern of the GFATM and to improve the country performance, an emergency plan was agreed. As part of that plan, the structure of the CCM was modified by reducing the number of members (from 26 to 15) and by increasing the representation of the civil society (50% of the members). Both the CCM and the PR has a technical unit with one coordinator and several technical members in each of them.

The prevailing perception among the people interviewed for the preparation of this report is that the role of the PR vis-à-vis the role of the CCM are not clearly defined or at least not clearly known and understood by many stakeholders. Many of them perceived the existence of two technical units as a duplication of efforts. Defining line of accountability as well as roles in coordination, technical assistance and

implementation would enhance the dialogue not only with the GFTAM Secretariat but also with stakeholders at the national level.

In spite of the progress made since October 2004, and in spite of the recommendations made by the Board of the Global Fund, the Secretariat did not agree with the decision of the Board to approve the second phase of the grant. The issue was again submitted to the Board, which decided on in its 10th meeting to request Honduras to present a revised version of the proposal before a final decision on the continuation of funds is taken.

The revised proposal has to be presented by 1 July 2005 and it will be assessed following the routine process, i.e. assessment by the Technical Review Panel that will recommend the approval /disapproval of the proposal to the Board. Final decision will be communicated to the CCM not later than October 2005. In the meanwhile, an extension of the grant has been agreed to ensure continuation of activities until the final decision is taken.

Based on the information gathered during the mission, it seems that the relationship between the country and the Secretariat of the GFATM has been, at least partially, characterized by misunderstanding and communication gaps between different actors. The Global Fund is a new funding mechanism, which purpose is “to attract, manage and disburse additional resources through a new public private partnership that will make a sustainable and significant contribution to the reduction of infections” (GFTAM 2005). As a new approach, it requires certain degree of adaptation from the countries accustomed to collaborating with multi and bilateral donors. It also requires certain degree of flexibility and creativity from the Secretariat to respond to the peculiarities and diversity of problems that different countries may have.

An objective assessment and analysis of the process in Honduras seems to be needed to better understand why the country was not able to implement at the speed expected by the Global Fund. It is also important to understand why the communication between the Secretariat and the country did not work as expected. Such an analysis may contribute to improve both Honduras and the Global Fund performance and it may also be useful for other countries in the region.

For the past year, the proposal funded by GFATM has monopolized the attention of the government, the civil society and the international community. Many people have wrongly perceived the implementation of the proposal as the national response rather than just as one component (albeit the biggest one). Undoubtedly, Global Fund has contributed to bring antiretroviral treatment to the top of the agenda at national level. However, other essential aspects of the response such as gender and Human Rights have not been given the same priority by the project. The reason for the confusion may depend on the absence of a wide recognized national authority and the lack of promotion of the PENSIDA as the framework for the national response.

The Global Fund has contributed to establish a national coordination mechanism for the implementation of the project. However, the CCM is still a parallel structure that may or may not contribute to developing ownership and technical capacity within the Government. The focus needs to be changed and attention should be paid to the implementation of the National Strategic Plan. Strong technical and financial support will be needed to assist CONASIDA and the National AIDS Programme to take leadership and the coordinating role in order to ensure a coherent, coordinated and effective national response to HIV/AIDS.

3.4 Recommendations

Existing Swedish development co-operation projects and programmes can be grouped into four main areas; i) good governance and democracy, ii) economic reforms, iii) local development and iv) social development (Country Plan of Honduras, 2005–2007).

The potential entry points for Sida's response of HIV/AIDS are grouped into the three following main strategies, a) dialogue, b) direct support and c) mainstreaming.

a) Dialogue

Although Honduras has a well-designed National Strategic Plan (NSP), the plan has not yet been recognized as the policy framework and guiding instrument for a nationwide, coordinated and multisectoral response. The NSP is to be seen as the long-term strategy designed by the nation after a multisectoral consultative process and as such it should be considered in the design of every single project or programme that donors are interested in supporting.

The variety of financial sources in the country and a poor coordination may have contributed to reinforce the structural weakness of the Government or at least has not contributed to its strengthening. In order to maximize the impact and to achieve a high degree of synergism, there is an urgent need to strengthen the coordination mechanism among donors, government and civil society. The Government of Honduras has to take the leadership of the response and the international community should support the Government in its efforts to achieve it. Therefore, it is recommended that:

- Sida takes an active role in the dialogue with other bilateral donors and with multilateral agencies to advocate for shifting the focus of stakeholders and development partners to the National Strategic Plan and for supporting CONASIDA.
- CONASIDA and the National Programme for AIDS are key actors in the coordination of the implementation of the plan. Therefore, Sida should consider providing technical and financial assistance to these bodies. The first step could be to assess the actual capacity of CONASIDA to play its role as oversight and coordinating body. The assessment could be commissioned jointly with other stakeholders and the term of reference for the assessment agreed by the members of the Coordinating Table (Mesa Coordinadora).
- Sida should bring HIV/AIDS to the agenda of the Group of 17 to ensure that HIV/AIDS is recognized as one of the main development challenges Honduras has ahead.
- Sida should consider providing technical support to the CCM for the revision of the proposal to be presented to the GFATM. A national consultant hired by Sida to work full time with CCM could provide the technical support.
- Sida should seek the support of Sida Headquarter to advocate at the GFATM Secretariat to conduct a comprehensive external evaluation of the process of implementing the proposal at country level. The process has been characterized by an innovative approach in the formation of a CCM with legal status. Unfortunately, it has also been characterized by communication gaps and misunderstanding between the CCM and the GFATM Secretariat. As an important contributor to the GFATM,⁷ Sweden should ensure that the reasons

⁷ Sweden contribution to GFATM was 100 000 000 and 361 000 000 SEK for 2003 and 2004 respectively

behind the problems generated in Honduras are understood and properly addressed in order to avoid the same mistakes in the future.

b) Direct HIV/AIDS support

The National Forum has an important role to play in the national response. Therefore, it is recommended that:

- Sida continues and eventually increases the financial support provided to the Forum. The scope of the support should be redesigned in consultation with the Forum. Funds could be allocated not only for the grants to NGOs and CBOs through the Small Grants Funds, but also to strengthening the capacity of the chapters (with technical staff allocated in each of the chapters). A capacity building plan for implementing agencies should also be considered.

c) Mainstreaming of HIV/AIDS in ongoing activities

Good governance and democracy

Political reform after the primary elections in February 2005:

The dialogue will be held with the five presidential candidates to create a new pre-electoral manifest on political and economic reform issues. It is recommended that

Sida considers including HIV/AIDS as an important development issue in the agenda for discussion with the presidential candidates.

Institutional support to the National Women's Institute (INAM):

Sweden provides a bilateral institutional support to the Institute. It is recommended that

Sida considers the commission of a study on gender and HIV/AIDS. The study could address how gender inequality in Honduras may impact the vulnerability of women to the HIV/AIDS epidemic, what are the social values related to gender that needs to be reinforced and what are the ones to be changed. The terms of reference for the study could be developed jointly with the National Forum.

Agreement with the Human Rights Ombudsman:

The agreement ends during 2005 but an evaluation has been carried out to assess future support. If the agreement is to be extended after the evaluation for a future support it is recommended that

Sida provides technical assistance to the Ombudsman office to liaise with the support groups of people living with HIV/AIDS to assess how Human Rights and HIV/AIDS can be put in the public agenda.

Democratization of the media:

Sweden supports strategic work regarding the right to information and the right of free speech through a network of journalist. The role of media in creating a non-discriminatory environment for people living with HIV/AIDS is crucial. Therefore, it is recommended that

Sida ensures that HIV/AIDS is included in the training of journalist. Areas that could be addressed are how journalists can contribute to decrease the stigmatization and discrimination of people living with HIV/AIDS and how a responsible and ethical reporting should be done. The development of a code of conduct in HIV/AIDS reporting could also be considered as an output of this project.

National Anti corruption council:

In the framework of this project, it is recommended that

Sida explores whether the council could coordinate the development of a Code of Conduct for NGOs and other agencies working in the field of HIV/AIDS or promote the adaptation and adoption of existing Codes.

Economic reforms

Civil service law:

Sweden is committed to support the implementation of a new civil service law to create an efficient and de-politized cadre of civil servants (Country Plan 2005–2007). Anecdotal evidences point out that discrimination at the work place is a reality faced by many people living with HIV/AIDS in the country. Therefore, it is recommended that

Sida advocates for inclusion of non discrimination of employees based on HIV status, no mandatory HIV test as well as development of a national workplace HIV/AIDS policy. If successful, this experience could then be replicated in other workplaces.

Social development

Cooperation with the Education sector:

This is the most complex and at the same time the most crucial sector to mainstream HIV/AIDS. To achieve a long-term sustainable impact it would be needed a short and a long-term strategy.

A short-term strategy for Sida could be to support the introduction of HIV/AIDS-related activities in the activities implemented in the youth clubs (Casa de Jovenes) within the Access to Health Services programme. The programme will be evaluated this year, and Sida could include in the terms of reference of the evaluation to assess the feasibility of introducing HIV/AIDS-related activities during the next phase. Later, the model can be replicated by other agencies than the Ministry of Health. As part of the initiatives, it is important to ensure the involvement of parents and communities.

In the long term, the objective should be the introduction of Sexual Reproductive Health and Rights (SRHR) including HIV/AIDS, in the curricula. However, it can be expected that the process of introduction will be neither quickly nor without problems. There are conservative and powerful forces in the society, such as religious groups, that may oppose the introduction of sexuality education in schools. In spite of the evidences supported by extensive research, the argument usually used is that the introduction of sexuality education will encourage sexual activities among youth.

The introduction of curricula of SRHR and HIV/AIDS is important, but even more important is how it is introduced. Experiences from other countries indicate that many times HIV/AIDS and sexuality education are introduced as a biological and 'sterile' subject. While the biological approach may help to increase the knowledge it may alienate youth of the idea of their own sexuality and their own risk for sexually transmitted infections including HIV/AIDS. Therefore, a participatory and open approach is needed if the teaching of sexuality and HIV/AIDS are to have any impact on the behaviours of youth. It is recommended that

Sida supports the development of curricula that includes SRHR and HIV/AIDS. A component of the support provided by Sida, should be the training of teachers on participatory methodology and sexuality. In the

planning process of this activity, Sida may consider to commission a study with the focus on teachers (organized by the teacher association if any in the country) to explore what are the potential factors that may hamper participatory approach and teaching sexual and reproductive health and rights and what can be done to overcome the difficulties faced by teachers and schools.

Support to the Swedish NGOs working in the country, i.e. Diakonia, Forum Syd and the Swedish Cooperation Centre

Sida should consider supporting the Swedish NGOs in conducting an assessment of their own institutional vulnerability to HIV/AIDS. The staff of the NGOs needs to understand not only basic facts on HIV/AIDS but also how HIV/AIDS can affect their work and how their development projects may have an impact (negative or positive) in the spread of the epidemic.

4. Nicaragua

4.1 Situation Analysis

Nicaragua is a low-income country, however, the percentage of people living in extreme poverty has decreased and social indicators have improved during the last years. To protect and improve these achievements, the government jointly with the civil society, the private sector and the international community has to ensure the implementation of a strategic, comprehensive, timely and coordinated response to the emerging HIV epidemic.

The first HIV case was reported in 1987. Since then, 1608 people have been reported as living with HIV/AIDS. The most frequent way of infection is through sexual intercourse (90.7%). Less than 4% are intravenous drug users and 3.7% are children born from HIV positive mothers. The male and the female rate have changed through the years from seven HIV positive men for each HIV positive women at the beginning of the epidemic to the current three men per one woman. Epidemiological studies have shown that the HIV prevalence among men having sex with men is higher than the prevalence found in other groups studied. The majority of cases have been reported from Managua, Chinandega, Leon and Masaya.

However, as in other countries in the region, the available information does not give us a full and accurate picture of the epidemic. Many people living with HIV/AIDS become aware of their HIV status first when they have developed AIDS. Late recognition of the HIV status may be explained by lack of awareness on HIV/AIDS among health care staff but even more important due to the limited access to voluntary counselling and testing services.

The attitude of conservative forces in the society may hamper the dialogue on sexuality and gender and contribute to poor knowledge on HIV/AIDS among the population in general and youth in particular. An example of the intolerance existing in the Nicaraguan society is a Statement issued by the Episcopal Conference of Nicaragua⁸. In the letter, it is stated that gender equality is against the essence of the women and of the creation. Gender is seen by the authors of the letter, as a foreign ideology and as a way to promote homosexuality and abortion (sic). It can be argued that also Christianity was once upon a time a foreign ideology

⁸ Pronunciameinto de la Conferencia Episcopal de Nicaragua ante el anteproyecto de Ley sobre igualdad de derechos, aprobada por la comisión de la mujer de la asamblea legislativa, Managua 1st March 2005

introduced in Central America by the European. However, that is not the point, rather the argument is that gender equality is based on human rights endorsed by almost all countries in the world and the promotion of gender equality should be one of the cornerstones in the national response to HIV epidemic.

4.2 Institutional and policy framework

The Ministry of Health established the National AIDS Programme and set up a multisectoral National AIDS Commission (CONISIDA) in 1986. The year before the first person living with HIV was tested and reported in the country. However, neither the Programme nor the Commission played an active role in the response during the following decade.

The first National Prevention Plan and Control of AIDS was designed in 1989 and replaced by the first National Strategic Plan (NSP) for Sexually Transmitted Infections (STIs) in 2000. The strategic areas identified in the NSP are to strengthen existing networks; to advocate for national policies on human rights and equality of PLWHA; to design, implement and raise funds for the implementation of the NSP; to design and implement communication plan; to control and prevent STIs; to ensure safe blood and to strengthen surveillance system for STIs and HIV/AIDS.

Important progress has been made to ensure blood safety. Since the launching of the NSP, commercial donation of blood is forbidden and currently all donations are done through the blood banks run by the Red Cross. Blood is routinely screened for HIV, syphilis, chagas, hepatitis B and hepatitis C. However, apart from the safe blood component, the NSP have been hardly implemented, probably due to lack of a strong coordinating body and the lack of specific budget line for HIV/AIDS. An evaluation of the NSP has recently been carried out but the results of the evaluation are not yet available.

An HIV law was approved on defence of the human rights of people living with HIV/AIDS. The law is based on the principles of the International Declaration of Human Rights and the Nicaragua National Law and addresses not only rights of people living with HIV/AIDS but sets up the institutional framework in which the national response will be organized. In the law it is clearly stipulated the composition and objectives of CONISIDA. The Commission has the right, according to the law 238, to raise funds from the private sector and international community for the implementation of HIV/AIDS related activities. Further, the Commission is responsible for the implementation of the law. It is also specified that the Government have to allocate a budget line in the National Budget to support the work of the commission (Article 34).

CONISIDA comprises representatives from four Ministries (Health, Education, Labour and Interior), one from the Institute of Social Security, one from the National Assembly, three from the Human Rights Commission, one from the trade union of health workers and two from NGOs working with HIV/AIDS. The regional chapters of CONISIDA have been more active since the grant from the Global Fund to fight against AIDS, Tuberculosis and Malaria (GFATM) was awarded to Nicaragua.

The law also regulates the rights of people living with HIV/AIDS and penalizes discrimination and stigmatization (Chapter 5). However, an important gap is that the responsibility of people living with HIV/AIDS to protect others from infection and the rights of the HIV negative persons to remain negative are not specifically mentioned in the law.

In spite of the opposition from conservative forces in the society against promotion and distribution of condoms, in the Article 12 it is stated that the means to prevent sexually transmitted infections that are scientifically accepted are to be promoted and the accessibility to these means to be guaranteed. In addition, Article 11, 12 and 13 state that public and private universities and primary and secondary school will promote prevention of HIV and that sexual education should be included in the primary and secondary schools in a scientific way. In subsequent articles, the law regulates education to health staff, prevention among people in institutions including prisons and mental health settings, and information on the epidemiological situation in the country.

Nicaragua has adopted the Sector Wide Approach (Swap). The aim of the Swap is to attain sector specific objectives and to ensure national ownership through genuine partnerships in development cooperation⁹. The approach is intended to reduce aid fragmentation and improve coordination, strengthen national institutional capacity, enhance effectiveness of public sector expenditure and promote institutional reforms. The partnership is understood as a shared framework of common values and objectives.

While the 'Estrategia Reforzada de Crecimiento Economico y Reducción de la Pobreza' (Poverty Reduction Strategy-PRS) and the National Development Plan give the broad policy guidance for all sectors and the National Health Plan 2004–2015 spells out the overall vision, it is the Five-Years Health Plan that assess the financial requirement for the sector, identify the funding sources and provide the framework within which the operational plan (Plan Operativo Annual or POA) is drawn.

Unfortunately, the National Strategic Plan for HIV/AIDS is not mentioned among the background documentation and used in the elaboration of the Five-Years Plan. The question is whether the absence of the NSP as background document was an involuntary omission or if it reflects the intention of the Ministry of Health to have the NSP and hence HIV/AIDS outside the health sector.

The Government is committed to increase the harmonization and coordination of aid and therefore they have launched discussion forums in the form of round tables lead by the Government and with the participation of donors, private sector and civil society organizations.

4.3 Main HIV/AIDS ongoing activities

Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM)

In October 2003, Nicaragua has been awarded a grant from the Global Fund to fight against AIDS, Tuberculosis and Malaria. CONISIDA has the role as a Country Coordination Mechanism (CCM). However, in order to comply with the recommendations of the GFATM in relation with the composition of the CCM, an expanded CONISIDA was created with representatives from 30 institutions from the government, civil society and international community. The Principal Recipient (PR) of the grant is NICASALUD, an umbrella organization that was established by USAID-funded NGOs to facilitate the management of funds in the aftermath of the Mitch.

The stakeholders interviewed during the mission conveyed different perceptions of the contribution of the Fund to the national response. Some of them expressed that one of the positive impacts the Fund has had in Nicaragua was the expansion of CONISIDA, by which a better representation of the Nicaraguan society in the Commission has been

⁹ Sida's policy for sector programme support an provisional Guidelines, Sida 2004

achieved. Other positive improvement in the national capacity has been the strengthening of the administrative capacity of NICASALUD achieved after the recommendations received by the organization from Price Waterhouse, the local agency responsible for auditing the PR. Although the role of the Ministry of Health as the coordinating body should be strengthened, the Fund has contributed to increase the collaboration between the Ministry and the civil society.

On the other hand, some people perceive the Fund as an interfering factor in the national response, affecting the ownership and independence of decision making processes. One of the interviewees claimed that the PR was chosen by the GFATM with limited participation of the Government on the final decision.

Nevertheless, in spite of the different opinions, it is clear that a dynamic process has taken place in Nicaragua after the award of the grant. The mechanism used by the Fund is a new one that may open new funding alternatives for both multi- and bilateral donors. It is essential that the experiences are documented and that the lesson learnt as a result of such a process are capitalized by the Government and the civil society.

One of the main activities funded by the grant is the provision of antiretroviral (ARV) treatment for those who are HIV positive and eligible for treatment¹⁰. The Fund has contributed to increase the access to ARV and brought the crucial issue of treatment to the political agenda. The number of people receiving treatment increased from 20 to about 120¹¹ after the onset of the project. However, issues related to regular flow of medicines, development of resistance and long-term sustainability remains unresolved.

The Ministry of Health has developed a guideline for the use of ARV but it has not yet been approved and therefore not available in hospitals or any other health care settings. Access to laboratory facilities and drugs for treatment of opportunistic infections is still very limited.

The use of ARV is centralized in three hospitals in Managua (Roberto Calderon, Hospital Infantil Docente Manuel de Jesus Rivera “La Mascota” and Berta Calderon). This centralized approach has been chosen in order to develop in a cost effective manner the skills of a group of health care workers. However, the main shortcoming of this approach is the almost unbearable workload that it has created for the staff at the mentioned hospitals and even more important, the inconvenience for those on treatment who lives outside Managua in terms of working days lost, transport and accommodation costs etc. In addition, the geographical distance may hinder a fluent communication between those on treatment and the team at the respective hospital.

A comprehensive care and treatment package for people living with HIV/AIDS should be included to comprise more than distribution of ARV and clinical follow up. It should also, among other things, include psycho-social and legal support for the whole family, and nutritional counselling and support i.e. from information to actual food distribution.

Finally, it should imply support to increase adherence to treatment and a healthy life style including protective behaviour practices by people living with HIV/AIDS in order to protect him/her and her/his environment. This comprehensive package can hardly be offered in a hospital far away from people’s residence.

The possibility to have access to ARV may act as an incentive for people to know their HIV status. It may, therefore, be expected that the

¹⁰ Eligibility based on clinical and laboratory criteria, such as low CD 4 cells

¹¹ Personal Communication DrHospital Calderon

number of people living with HIV/AIDS who knows their status will increase in the near future. This collateral effect of the programme needs to be taken into account in the monitoring of one of the HIV/AIDS indicators included in the PRSP, i.e. HIV prevalence rates as the impact of this collateral effect may result in an initial increase of the rates.

Ministry of Education

As a sub receptor of 500,000 USD from the Global Fund, the Ministry of Education is implementing a project called Education for Life. The project aims to introduce HIV on the agenda of the Ministry, sensitize decision makers within the Ministry and other workers in the sector, and increase tolerance towards people living with HIV/AIDS. The Minister of education has stated that fighting against HIV is fighting against the macho culture and that education is the main tool for prevention.

National Commission to fight AIDS, Tuberculosis and Malaria by the civil society is an umbrella organization that comprises more than 90% of the NGOs working with HIV/AIDS related projects. The commission provides a forum for discussion, exchange of information and coordination.

PASMO is an NGO funded by USAID and The Netherlands, has been working with social marketing of condoms since 1996. Their strategy is target interventions, i.e. working primarily with so-called high risk group.

4.4 Recommendations

The recommendations on how best Sida can contribute to the national HIV/AIDS response are presented based on two main strategies: a) dialogue and b) mainstreaming of HIV/AIDS in ongoing activities.

A) Dialogue

Sida should include HIV/AIDS in the agenda of development at all levels as well as advocate HIV/AIDS at high levels in order to ensure that it is addressed as a priority area in the Poverty Reduction Strategy II.

Sida's contribution to the national response should be guided by the principle of the 'Three Ones' i.e. one authority, one policy framework and one monitoring and evaluation system. The Government of Nicaragua has taken the initiative to coordinate the national response by setting up CONISIDA and a National AIDS Programme. However, there is a need for institutional strengthening of both bodies and to better define the roles of each of them. While CONISIDA should provide a strategic guidance in the formulation of the national response, the National AIDS Programme should have a more operational role in the implementation of the National Strategic Plan and therefore be the operational arm of CONISIDA.

Currently, there are two CONISIDA, one established by the law and the other established to comply GFTAM requirement. The latest has a wider representation of the society. Therefore, it would be advantageous to have the expanded CONISIDA as the only oversight body with the mandate of coordinating the implementation of the National Strategic Plan. It is recommended that

Sida advocates among national counterparts and development partners for the recognition of the expanded CONISIDA as the only coordinating body with a mandate beyond the one as the CCM for the Global Fund.

¹² Proyecto Fondo Mundial 'Nicaragua, Compromiso y Acción ante el Sida, Tuberculosis Y malaria. Informe final from ecd, Nicaragua 2005 (page 3 and 10)

The National Development Plan in its Performance Assessment Matrix, includes four HIV/AIDS indicators: i) HIV prevalence rates, ii) percentage of people living with HIV/AIDS receiving treatment, iii) percentage of schools with trained counsellors and iv) percentage of students who has received HIV/AIDS information. The three latest indicators are directly related with the implementation of the Global Fund rather than with the National Strategic Plan.

The National Health Plan has also four indicators: i) HIV prevalence among those between 15 to 24 years ii) HIV incidence rate iii) HIV prevalence and iv) number of HIV orphans. It also contains an intermediate indicator on the percentage of people living with HIV/AIDS receiving ARV treatment.

The five-year health plan has under point two of the first strategic objective ‘to provide public health services to the population, and one indicator is “Services from the special health programmes (HIV, Tuberculosis, Malaria and others) are provided’.

While all the core documents guiding the Health Sector include indicators related to HIV/AIDS activities, it is clear that a common monitoring framework has not yet been developed. The indicators should measure the impact of the implementation of the National Strategic Plan, i.e. the national policy framework for the response to the epidemic rather than the achievement of the Global Fund. It is recommended that

Sida should support the development of a monitoring and evaluation framework as part of the update of the National Strategic Plan. A comprehensive mapping of HIV/AIDS interventions, including funding sources and responding to ‘who is doing what, where and how’, should precede the update of the plan.

The main challenge for Sida in Nicaragua is whether to get financial and technical support through the sectorial approach or to have separate mechanisms to support the implementation of the National Strategic Plan for HIV. There are some potential risks of having HIV/AIDS as part of the Swap instead it should be carefully analyzed by Sida and other development partners. Firstly, it may reinforce the conception of HIV/AIDS as a health issue rather than a multisectoral responsibility. Secondly, given the amount of other pressing health priorities, HIV/AIDS may be neglected in the allocation of resources. Thirdly, among the potential risks of the Health Programme Sector Approach identified by Sida are the lack of continuity of the Government’s commitment to policies and strategies and the limited capacity at the Ministry of Health to manage the implementation of the five-year health plan¹³. This may have detrimental consequences for the implementation of HIV/AIDS related activities if the implementation and follow up of the National Strategic Plan is funded through Swap.

On the other hand, supporting the plan as a separate component may contribute to create parallel mechanism that will betray one of the guiding principles of the ideology behind the sector approach. It is recommended that:

If Sida decides to channel funds only through Swap, efforts should be made to ensure that all the signatories of the Memorandum of Understanding for the support to the health sector are in agreement to speak with one voice in order to guarantee that funds for HIV/AIDS related activities are guaranteed.

While the support for HIV/AIDS activities related to health sector has to be channeled as part of the financial support to the sector as

¹³ Assessment of the Health Sector Support in Nicaragua 2005–2009, Managua April 2005 (page 24)

whole, it is recommended that financial support for HIV/AIDS related activities within other sectors is directly channeled to the relevant line minister such as education and youth.

2) Mainstreaming and direct HIV/AIDS support

Health sector

PROSILAIS programme:

Sida has supported the Nicaraguan Health Sector Reform (26.6 million for 1992–2005) through UNICEF and WHO. The Ministry of Health and the donor community have recognized the model as a very successful and effective to achieve the decentralization of primary health care. The model constitutes an important part of the National Health Policy (2004–2015), and the Five-Year Health Plan (2005–2009). The primary health care sector needs to be prepared for a worsening of the HIV epidemic situation and also for the eventuality of the expansion of the treatment of people living with HIV/AIDS outside Managua. Stigma and discrimination of people living with HIV/AIDS, based on lack of knowledge among health care workers is one of the main factors that may contribute to reluctance of people living with HIV/AIDS to seek help or a hinder to receive a proper treatment.

Sida could commission a need assessment on HIV/AIDS knowledge and attitude among health care workers toward people living with HIV/AIDS. The study could be conducted jointly by a research agency and the support groups of people living with HIV/AIDS.

Training of 500 midwives:

This is another ongoing project (25 million SEK for 2004–2009) implemented by the Ministry of Health and the Polytechnic Health Institutes.

Sida should ensure that the current HIV training included in the training package offered, includes not only training in basic facts on HIV/AIDS but also gender and Human Rights aspects related to HIV/AIDS. It should also include training on universal infections precaution.

Sida could also ensure that antiretroviral drugs are available to midwives as post-exposure prophylaxis (PEP.)

Democracy and Human Rights

Programme “Access to Justice in Rural Areas”:

The programme is currently implemented in 57 municipalities, including the Atlantic coast.

Sida could ensure that activities aiming to achieve the sensitization on issues related to Human Rights and HIV/AIDS for those working in the sector. Also, this project offers a good forum for promotion of the Law 238 and the defence of the rights of people living with HIV/AIDS.

Modernization and development plan of the National Police of Nicaragua:

The five-year plan aims to create a democratic and efficient police force. The police have developed a gender equity policy that is a model for the region.

Sida could, as a complement to the ongoing training on HIV/AIDS, promote that they as part of the gender equity policy, supports an assessment on their institutional vulnerability for HIV/AIDS. By understanding their own vulnerability as an individual and as institution, they will better understand the epidemic and their role on the national response.

Project Network of Services for Women, Children and Adolescents victims and Survivors of Family and sexual Violence’.

In its Article 8 the law on AIDS regulates the possibility of compulsory test in criminal cases. However, there is no provision in the law for criminalization of the spread of the infection.

Sida could encourage activities aiming to sensitize health care workers on the risk of HIV infection and other sexually transmitted infections among victims of rape.

Sida could also advocate for the development of a guideline on ARV as post exposure prophylaxis for victims of rape and explore mechanisms¹⁴ on how to ensure access to ARV when needed.

Finally, and probably more controversial Sida could explore the feasibility of criminalizing the spread of HIV by rape perpetrators who knew their HIV status at the time of the rape.

Support to civil society

Collaboration with Swedish NGOs working in Nicaragua and with Nicaraguan civil society in projects focused on education and legal studies in human rights with particular emphasis on women and children as well as participation and local democracy. Diakonia is working in the Caribbean Coast, an area believed to be more vulnerable to HIV/AIDS.

Sida could explore the possibility that Diakonia (and/or Forum Syd) sets up a small grant mechanism similar at the one already created by NICASALUD (with USAID funds), to strengthen ongoing HIV related activities or to initiate new ones among the NGOs and CBOs already working with Diakonia.

Promotion of Gender Equality:

Sida channel resources through Forum Syd for the implementation of gender equality activities in line with Sida’s policy for gender equality.

Sida could commission a research on gender inequality and HIV/AIDS to answer to the questions on whether (and how) the HIV epidemic in Nicaragua contributes to intensifying gender inequality and how the gender inequality contributes to the spread of the epidemic.

Support to the Office of the Ombudsman for Human Rights:

The aims of the project are to strengthen institutional capacity, and human rights education and protection.

Sida may explore the possibilities to support a position at the Office of the Ombudsman for a person specialist in Human Rights and HIV/AIDS who may assist all the people discriminated on basis of his/her HIV status. Ideally, the position should be filled by a person living with HIV/AIDS.

Social sectors

Foundation Prodel:

The overall objective of Prodel is to improve the living conditions for poor families and to support local development with revolving funds for micro financing of home improvement and small business.

Sida could explore how the support groups of people living with HIV/AIDS could be involve in this initiative in order to ensure that their members and the families of the members are included as beneficiaries of the micro finance scheme.

¹⁴ Post exposure prophylaxis (PEP) should be provided within 72 hours. Therefore, a smooth procurement scheme has to be developed

Research co-operation

The support focuses on activities within the four state universities. One of the areas identified as strategic priority is health, especially preventive medicine and infectious diseases. This offer a good entry point to develop HIV/AIDS research.

Sida could, as part of the ongoing programme, encourage set up of an email forum with the participation from university hospitals in Sweden and Nicaragua to strengthen the Nicaraguan capacity on the use of ARV.

Sida could support exchange visits of professionals (doctors, nurses, social workers and nutritionist). It could also encourage the formation of Association of University students against HIV/AIDS who may become advocates or ambassadors of HIV/AIDS among students and University authorities.

Sida could also offer additional support to the support already provided by USAID (through a regional project implemented by PASCA) to set up a sentinel surveillance system.

Education sector

The Education sector is implementing a very successful initiative supported by GFTAM.

It is recommended that Sida follows up closely the impact of the initiative and if needed provide economic support for scaling up of the current project.

5. Conclusions and Recommendations

One common feature found in the countries visited by the mission is their early response to the epidemic as shown by the promulgation of HIV laws and the establishment of National AIDS Programme and National AIDS Commissions already in the 1980's. However, the existence of an institutional and policy framework does not necessarily imply an effective response neither reflects a genuine political commitment. This is clearly showed by the fact that the AIDS Commissions set up in the countries and the National AIDS programmes did not have an active role or received the allocation of needed human or financial resources. While HIV laws were promulgated years ago, the laws have not been disseminated neither has the mechanism for their enforcement been clearly established.

One explanation could be that political commitment was difficult to achieve in such an early stage of the epidemic when HIV/AIDS was probably perceived as something happening in other countries. It could also be that the response was donor driven rather than demand driven based on the needs by the national authorities or the civil society. Whatever the explanation is, it is important to draw lessons in order to avoid a similar 'hollow' response to the 'Three Ones' initiative. While Sida should advocate and promote the initiative of the "Three Ones", efforts should be made to avoid a blueprint approach. Instead, the initiative should be shaped to fit the peculiar characteristics of each of the countries if a comprehensive and effective response is to be achieved.

An effective response to HIV/AIDS should be multisectorial, nationwide and designed to address the underlying factors, such as poverty, poor access to health services and to education, especially for women. People are not vulnerable per se but they become vulnerable as a result of their social, cultural and economic reality. The response should aim to change the social and cultural values that may fuel the epidemic.

One example of the values to be changed are the prevailing religious and cultural prejudices that strongly condemn sexual diversity and that results in the isolation of individuals or groups who do not follow the same path of the majority. At the individual level, men having sex with men are not biologically more vulnerable to HIV: *'the virus had no interest in the sexual orientation of its host, only in gaining access to his or her bloodstream'* (Reay, 1999). However, the culpability generated by social intolerance may increase their vulnerability as found in studies showing a clear

correlation between level of social discrimination and level of risk behaviour adopted (Diaz 1997).

One of the priorities set up in the three countries visited is to work with groups that have been socially and economically marginalized already before HIV/AIDS. While the so-called target intervention approach may be cost effective in settings with emerging epidemics, the main risk attached to that approach is its potential contribution to increase even more the stigmatization and discrimination of certain groups of the population. As one sex worker said “The campaigns present us as responsible for the epidemic, but nothing is mentioned about the responsibility of our clients”¹⁵.

The response to the epidemic has to be comprehensive, including prevention, treatment, care and support and impact mitigation. These components should be seen as a continuum and therefore complementary parts rather than as independent components. However, in countries with low prevalence, prevention activities deserve a special focus.

The response should also be inclusive and recognize the crucial role that the civil society in general and people living with HIV/AIDS in particular have to play as agents of change and, even more important in the social monitoring of the implementation of the national response. The role of the government as the coordinator of the national response is indisputable. However, there is impossible to have a comprehensive response if organizations from the civil society are not incorporated in a sincere spirit of collaboration and partnership.

The response should be gender sensitive and egalitarian taking in to account the rights of people living with HIV/AIDS and the rights of the HIV negative people. In the context of HIV/AIDS work, it is important to build a culture of rights, respect and solidarity but also a culture of responsibility.

In September 2003 at the International conference on AIDS and STIs in Africa (ICASA) officials from African nations, multilateral and bilateral agencies, NGOs and the private sector reached a consensus around three principles applicable to all stakeholders at national level of HIV/AIDS response: one authority, one policy and one monitoring and evaluation framework, known as the ‘Three ones’ initiative.

One national AIDS coordinating authority with a broad based multisectoral mandate can ensure the operationalization of the agreed HIV/AIDS action framework. The mandate of the HIV authority is to coordinate the development, implementation, monitoring and evaluation of the national HIV/AIDS response.

One agreed HIV/AIDS policy can provide the basis for coordinating the work of all partners and it can set up the priorities for resource allocation and mechanisms for accountability. The framework has to be linked with poverty reduction strategy and the national development frameworks. It requires a great commitment from international donors to coordinate within the agreed HIV/AIDS action framework in a way that is consistent with their own mandate.

One national monitoring and evaluation system agreed among stakeholders with a core of indicators can allow the monitoring of the results achieved by the national efforts. The monitoring framework should also be in line with the indicators agreed at global level such as the ones linked to the UNGASS Declaration of Commitment on HIV/AIDS and the Millennium Development Goals.

¹⁵ Personal communication, Xu Marabu

The approval of project proposals by the Global Fund to Fight AIDS, Tuberculosis and Malaria has contributed to bring up HIV/AIDS in the national agenda in general and access to antiretroviral treatment in particular. However, it has also partially overshadowed the national response and it has interfered with ongoing initiatives. While it is clear that the Global Fund mechanism has contributed to strengthen the capacity of the civil society, it is not yet clear what will be its contribution to strengthening the capacity of the AIDS national authority to respond to the epidemic.

Countries were not necessarily well prepared for the challenge of managing the implementation of the proposals when they applied for the funds. The mechanism of the Global Fund calls for a strong civil society and for a strong national authority that could provide the required coordination. Existing bodies were reactivated or restructured as in Guatemala and Nicaragua or new ones were created as in Honduras, in order to fulfil the requirements (real or perceived) of the Global Fund.

It is almost naïve to expect that new structures set up in response to a new funding mechanism would be fully operational from the onset of the implementation. The inception phase of a project is always time and labour consuming and requires a certain degree of flexibility from the implementing agencies as well as from donors. It would be unrealistic to expect that implementation of the proposals funded by the Global Fund are an exception. Access to financial resources is a needed condition to implementing a comprehensive response but it is not sufficient per se. Challenges generated by bureaucratic procedures within national and international agencies as well as competition for funds among NGOs are both well-known realities in development work in general and HIV/AIDS work in particular.

Recommendations:

The Swedish strategy 'Investing for future generations' outlines the basis for the Swedish policy. The strategy aims to reduce the spread of the HIV/AIDS epidemic and to mitigate its effects. It defines HIV/AIDS as a major threat to development that has to be addressed as a multisectoral rather than as a health issue.

The strategy to scale up HIV/AIDS is based on intensify i) the dialogue, ii) direct HIV/AIDS interventions and 3) mainstreaming of HIV/AIDS.

The strategy to be adopted at country level, needs to be defined based on two considerations: i) the level of ambition set by Sida/the Embassy and the human and financial resources needed to achieve that level, ii) the epidemiological situation in the country, the underlying factors and the existing national response.

When planning the operationalization of the strategy, it is important to ensure that a balance is achieved between prevention, care, support and impact mitigation, bearing in mind that in low prevalence countries, preventive activities have to be stressed. It is also important to ensure that underlying causes such as Human Rights and gender inequality are addressed, that people living with HIV/AIDS are involved in the design, implementation and monitoring of HIV/AIDS related activities, and that the rights of both HIV positive and HIV negative are respected.

Integration of HIV/AIDS in programmes and projects in the various sectors of development cooperation needs to be scaled up, and HIV/AIDS needs to be brought up in the dialogue and the planning with counter partners.

a) Dialogue

The dialogue is important to ensure political commitment and to create an enabling environment to openly discuss sensitive issues such as the right to accurate information on sexuality, especially among youth, condom use and gender issues. It will also be important to highlight the importance of not losing the focus on prevention while continuing to fight for the rights to treatment and care and support for people living with HIV/AIDS.

The dialogue has to be multi-sectoral and it should include all partners i.e. government, civil society, private sector, and international agencies. The dialogue is needed to put HIV/AIDS on the agenda of decision makers and to increase the coordination among stakeholders.

Sida should highlight controversial areas such as the link between HIV/AIDS and Human Rights, and HIV/AIDS and gender both in HIV specific forum and in any other forum in which national governments and development partners are represented.

The opportunity for dialogue with other bi- and multilateral donors should be also used by Sida to advocate for support to the national authority in charge of the coordination of the National Strategic Plan.

Guatemala, Honduras and Nicaragua have developed their respective National Strategic Plans (NSP). The identification of strategic areas in each of the countries is the result of a consultative process with involvement of different sectors of the society. In spite of that, implementing agencies has not necessarily used the NSP as the guiding principles. While the majority of people working in the field of HIV/AIDS know about the existence of the NSP at the country level, and many of them have participated in the development process, few of the people interviewed during the mission expressed a feeling of ownership in relation to the NSP.

The challenge is how to support the government to ensure that the National Strategic Plan gets an existence outside the bookshelves and instead is used as the framework within which development partners design their activities. A first step to be taken by Sida during the planning to scale up HIV/AIDS is to analyze how their activities will contribute to the strategic areas identified by the NSP and how the specific project or programme will contribute to reinforce the national response.

To ensure a comprehensive and coordinated HIV/AIDS national response, the AIDS national authority has to be capable to perform its role as coordinator. However, the existing national structures in Guatemala, Honduras and Nicaragua are not consolidated enough or have not received the necessary political support to take the oversight role in the national response.

Sida should advocate for high-level political commitment at country level in order to ensure that national governments make the needed human and financial resources available for the national bodies responsible for the HIV/AIDS programme. Sida should also advocate with other development partners to strengthen harmonization and coordination between donors and with governments to avoid duplication of efforts and to ensure synergism. This is particularly important due to the various global initiatives currently implemented in the region.

b) Direct HIV/AIDS support

It can be defined as the work directly focused on HIV prevention or care and treatment for people living with HIV/AIDS. The focus of the direct work varies from country to country and some examples have been provided in the respective chapter of this report.

c) Mainstreaming HIV/AIDS in ongoing activities

The mainstreaming of HIV/AIDS in different sectors will contribute to strengthen the capacity of Project Officials working in other sectors than health at Sida/the Swedish Embassies in the region. The implementation of some of the proposed activities may be launched as pilot, and after evaluating the impact and cost effectiveness of the initiatives, it may be replicated and/or scaled up.

Activities proposed for mainstreaming in each of the countries interventions may appear as vague and patchy. However, the recommendations and suggestions made are to be considered as 'food for thought' for further discussion when the level of ambitions is discussed and agreed on at each Embassy. At that point, a strategic prioritization of the engagement of Sida at country level could be done with guidance and assistance from the HIV/AIDS Secretariat in Stockholm.

The level of ambition set for scaling up of HIV/AIDS has to be guided by an analysis of the epidemiological situation and the current response in the country. Based on the level of ambition, Sida has to define the human and financial resources needed to achieve it. An increased focus on HIV/AIDS requires commitment on time as well as knowledge from the staff.

In addition to the support already provided by the HIV/AIDS Secretariat in Stockholm, the process of scaling up needs to be accompanied by strengthening the technical capacity of the staff at field level. It could also be addressed by having a regional advisor for HIV/AIDS with similar terms of reference as the regional HIV/AIDS advisors based in Asia.

Initially, capacity building of field staff could be provided by the HIV/AIDS Secretariat or by national consultants, and it could be organized once a year on 1st of December as part of the commemoration of the World AIDS Day.

Annexe 1

List of documents reviewed

Regional and General:

1. Act as one for future generations, the Swedish response to HIV/AIDS, Sida
2. America Central: Proyecto Regional de VIH/SIDA, Evaluación social y estrategia para pueblos indígenas y afro-descendientes. Ximena Traa Valareno, World Bank December 2004
3. HIV/AIDS in Guatemala and Honduras. An assessment on Sida's support to HIV/AIDS prevention and control projects in Guatemala and Honduras, Britta Nordost, Claudia Cabrera Moksnes and Erik Wagberg,
4. HIV/AIDS in Central America: an overview of the epidemic and priorities for prevention. World Bank, 2003
5. Human Development Report 2003, UNDP 2004
6. Initiative Mesoamericana para la prevención del VIH/SIDA en Centroamérica y México. Silvio Martinelli and Roberto Leon. UNAIDS March 2005
7. Latin American and Caribbean Network on strategic planning and AIDS (REDPES), UNAIDS Case study, February 2003
8. Scaling up the Swedish response to the global HIV/AIDS epidemic. Promemoria, DESO HIV/AIDS Secretariat, April 2004
9. Strengthening public private partnerships in Latin America to address gender-based violence within the health sector, Program for Appropriate Technology in Health (PATH) June 2004 Support for PATH's gender, violence and human rights program and the Latin American Consortium on Gender-based violence and health. Path
10. Support to the regional AGI project 'Ensuring Sexual and reproductive health and rights for the next generation in Guatemala, Honduras and Nicaragua. Martin Ejerfeldt, Swedish Embassy Guatemala, November 2004
11. UNAIDS at Country Level, Progress Report UNAIDS 2005
12. Vision Salud, Tankar kring det regionala hälsobiståndet i Centralamerika, DESO-Hälsa, Juli 2004

Guatemala

1. Country report Guatemala 2004, Swedish Embassy, Guatemala 2005
2. Guatemala, Epidemia de VIH/SIDA de nivel concentrado, estimaciones y proyecciones. Sergio Aguilar, April 2003
3. Guatemala: Reported AIDS cases, by sex and year, Guatemala 1984 to June 2004
4. Guia de Servicios Guatemala. Asociación Coordinadora de sectores de lucha contra el SIDA, 2005
5. Informe preliminar de Consultoria, Guatemala., Victor Hugo Fernandez, January 2005
6. Lineamientos Basicos y politicas de Salud 2004–2008, Ministerio de Salud Publica, Guatemala 2004.
7. Minutes of meetings of the Expanded Theme Group UNAIDS, Guatemala 2004 and 2005
8. Modelo Integral de Salud implementado sobre la base de la rectoría, la participación social y la gestión local. ASDI III. Ministerio de Salud Publica, Guatemala, April 2005
9. Plan Estratégico Nacional ITS/VIH/SIDA 2005–2008 Primer Borrador Victor Hugo Fernandez, Ministerio de Salud Publica y Asistencia Social, Guatemala February 2005
10. Propuesta de política publica respecto a las infecciones de transmisión sexual y a la respuesta a la epidémica del SIDA, Guatemala, November 2004
11. Proyecto para el fortalecimiento del sistema nacional de vigilancia epidemiológica del VIH/SIDA en Guatemala, informe final. Beatri Hernandez y Sergio Aguilar. Undated
12. Serologías positivas, Bancos de sangre 2002, WHO 2004

Honduras

1. Assessment of the HIV/AIDS Grant Performance of Global Fund Project in Honduras, Government of Honduras, February 2005
2. Country plan for development co-operation with Honduras 2005–2007, Swedish Embassy Honduras, October 2004
3. Descripción de Programa COMCAVI USAID Honduras. Undated
4. Evaluación del impacto del Segundo Plan Estratégico Nacional (Pensida II) en la prevención del VIH en Honduras, Secretaria de Salud de Honduras, April 2004
5. II Plan estratégico nacional de lucha contre el VIH/SIDA, Pensida II. CONASIDA Secretaria de Salud, Departamento ITS/VIH/SIDA, Honduras, February 2003
6. Informe de avance Fondo Global, Honduras y el Foro Nacional de VIH/SIDA, Foro Nacional de SIDA, Honduras Marzo 2005
7. Ley especial del VIH/SIDA, Secretaria de Salud, Honduras, 2003
8. Sida Country Report for Honduras 2004. Embassy of Sweden Guatemala
9. Situación del VIH/SIDA, Rosalinda Hernandez, Departamento ITS/VIH/SIDA, Secretaria de Salud, Honduras, 2004
10. Strengthening the participation of civil society through the National AIDS From, FORO Nacional de SIDA, June 2003
11. VIH/SIDA en Honduras, antecedentes, proyecciones, impacto e intervenciones, Secretaria de Salud, March 2004

Nicaragua

1. Assessment of the Health Sector Support in Nicaragua 2005–2009, Helena Reuterswärd, Embassy of Sweden, Managua April 2005
2. Proyecto Fondo Mundial Informe Final ‘Nicaragua, compromiso y acción ante el SIDA, tuberculosis y malaria. Ninoska Salazar et al, undated
3. General Budget Support for poverty alleviation, Nicaragua 2005–2009. Embassy of Sweden Managua, May 2005
4. Plan Quinquenal de Salud 2005–2009, Republica de Nicaragua Ministerio de Salud, Marzo 2005
5. Plan Nacional de Desarrollo Nicaragua 2005–2009, Capitulo 4
6. Situación de la pandemia del VHI/SIDA en Nicaragua. Informe prepared by Fundación Sochiquetzal. March 2005
7. Analisis situacional sobre los contextos de vulnerabilidad con respecto a la infección for VIH en hombres gay y otros hombres que tienen sexo con hombres. CEPRESI, February 2005
8. Ley 238 Ley de promoción, protección y defensa de los derechos humanas ante el Sida, Managua, September 2004
9. Sida Country Report Nicaragua 2004. Sida March 2005

Annexe 2

List of organizations visited and persons interviewed

Guatemala, 27th to 29th April 2005

UNICEF

Karen Hickson,
Oficial del Programa de Educacion y Protección de la Ninez

UNAIDS

Michael Bartos
Country coordinator Guatemala, Belize and Mexico

OMS

Dr Enrique Gil Belloring
Asesor en Enfermedades Transmisibles
Prevention and Control of Diseases

OASIS

Jorge Lopez Sologaistoa
Director Ejhecutivo

Gente Positive Asociación

Edgar Cajas
Director

Honduras: 2nd to 6th May 2005

USAID

Jan Andersson
Kellie Stewart, HIV focal point

PAHO

Jose Fiusa
Country Representative

Programme Accesso
Ramon Pereira

DFID

Emilia Alduvin
Consultant

Foro Nacional SIDA
Iomara Bu

BID
Sergio Rios

Global Fund to fight AIDS, Tuberculosis and Malaria
Orlando Pinel
Coordinator, CCM

UNPFA
Alanna Armitage (chair UNAIDS)

UNICEF
Carlos Carrera
Programme Coordinator

UNAIDS
Maria Tallarico
CCA

Nicaragua 9th to 11th May 2005

National Program AIDS
Ministry of Health
Dr. Juan Jose Amador
Director
Epidemiology and Environmental Health
Dr Beatriz Delgado
Dr Teresa Lopez

CONISIDA
Valeria Bravo Delgado
Coordinator

(La Mascota)
Dr. Sheyla Silva
Hospital

UNFPA
Pedro Pablo Villanueva
Country Representative
UNAIDS Chair

World Health Organization
Patricio Rojas
Country Representative

UNICEF
Debora Comin
Country Representative

Hospital Roberto Calderon
Norman Gutierrez
Cepresi
Carlos Quant

Asociation Tesis
Danilo Medrano
Executive Director

Forum Syd
Anja Norlund
Marie Fredriksson

PASMO
Donald Moncada Sequiera
Gerente de pais

Ministry of Education
Rodrigo Alvarez
Director Education for Life

Fundación Xochiquetzalt
Hazel Fonseca

Nicasalud
Josefina Bonilla
Executive Director
Rafael Arana
Coordinator

Embassy of Finland
Riita Tyolajarvi
Counsellor Health Sector
Rosemary Vega
Advisor Social Sector

GTZ
Helga Piechulek
Team Leader

USAID Nicaragua
Claudia Evans
Project Management Specialist
Reproductive and Sexual Health

Swedish Embassy
Programme Officers
Assistants

Halving poverty by 2015 is one of the greatest challenges of our time, requiring cooperation and sustainability. The partner countries are responsible for their own development. Sida provides resources and develops knowledge and expertise, making the world a richer place.



SWEDISH INTERNATIONAL
DEVELOPMENT COOPERATION AGENCY

SE-105 25 Stockholm Sweden
Phone: +46 (0)8 698 50 00
Fax: +46 (0)8 20 88 64
sida@sida.se, www.sida.se