



COMPREHENSIVE CARE AND SUPPORT SERVICES ASSESSMENT IN FIVE CENTRAL AMERICAN COUNTRIES

**Summary Version
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Abbreviations and Acronyms

AIDS	acquired immunodeficiency syndrome
ARV	antiretroviral
ASI	Asociación de Salud Integral
AZT	zidovudine
FSW	female sex worker
G-CAP	Guatemala–Central American Program (USAID)
HDI	Human Development Index
HIV	human immunodeficiency virus
IAPAC	International Association of Physicians in AIDS Care
INCAP	Instituto de Nutrición de Centroamérica y Panamá
LAC	Latin America and the Caribbean (USAID Bureau)
MSF	Mèdecins Sans Frontières
MSM	men who have sex with men
NGO	nongovernmental organization
PAHO	Pan American Health Organization
PLWHA	people living with HIV/AIDS
PEP	post-exposure prophylaxis
PMTCT	prevention of mother-to-child transmission
STI	sexually transmitted infection
UNAIDS	Joint United National Programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Session (on HIV/AIDS)
USAID	United States Agency for International Development
VCT	voluntary counseling and testing
WHO	World Health Organization

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Executive Summary

This document is a summarized version of a thorough needs assessment of comprehensive care and support for HIV/AIDS in Central America. The assessment was conducted by the United States Agency for International Development Guatemala-Central American Program (USAID/G–CAP) in five countries (Honduras, Panama, El Salvador, Guatemala, and Nicaragua) during a three-week period in October and November of 2002. Some of the needs identified during the assessment now serve as a basis for the design of activities to be supported by USAID/G–CAP during the next four years. The full-length version of this document contains numerous annexes with detailed information on the current response to HIV/AIDS in the region, with a special focus on care and support issues.

USAID/G–CAP has been working in Central America since 1995 to improve the regional response to HIV/AIDS. This effort will be reinforced in the period 2002–2008 as part of the implementation of USAID’s global “Expanded Response” strategy. The new G–CAP Strategic Objective, “The HIV/AIDS problem in Central America Contained and Controlled,” includes aspects of comprehensive care and support that have been the focus of policy and public awareness and nongovernmental organization (NGO) strengthening.

The assessment team identified three sets of issues related to the comprehensive care and support situation for people living with HIV/AIDS in Central America. They include: 1) care and support within the health care system; 2) training issues for health care professionals and others; and 3) quality of life issues for people living with HIV/AIDS.

Comprehensive HIV/AIDS Care Needs

Issues:

- HIV diagnosis is late, methods used are too complex, and coverage of testing is low.
- Antiretroviral (ARV) therapy is increasingly available in the public health systems in most of the region.
- The AIDS care system has good quality standards, but often inadequate means, and is concentrated at the tertiary/specialized level, which is overburdened and understaffed.
- Local health centers and peripheral hospitals are seldom involved in care and support of people living with HIV/AIDS.
- Comprehensive care is not integrated; it is composed of many unlinked initiatives. There are important exceptions that could be utilized as models. In each country, there is limited integration of related activities among health programs (mother and child health, sexually transmitted infections, HIV/AIDS, tuberculosis) and the management level of health systems.
- Officials and professionals seldom communicate among countries on programmatic issues, resulting in duplication of guidelines, norms, and protocols.
- Though political interest in the region for improving care and support for people living with HIV/AIDS is increasing, concrete results are still scarce.

Recommendations:

- The many actors working in the area of HIV/AIDS prevention and comprehensive care and support need to be linked more effectively.
- National governments should be encouraged to provide adequate staff, means, and infrastructure to improve the quality of AIDS care.
- The Pan American Health Organization Building Blocks strategy provides a useful model for providing comprehensive care for people living with HIV/AIDS, which should be promoted with Ministries of Health and others. This should be accompanied by a detailed follow-up and thorough evaluation, including possibilities for scaling-up.

Capacity Building for Health Care Workers

Issues:

- There are relatively few well-trained and experienced professionals in each country.
- Primary training in AIDS is biologically oriented and generally does not consider comprehensive care, especially in the medical school faculties.
- Formal in-service training is absent (except in Panama).
- Short-term training activities in different subjects linked with comprehensive care exist, but there is almost no organized follow-up.
- Several universities in the region and neighboring countries offer or are able to develop postgraduate courses in HIV/AIDS.
- Existing links and partnerships among trained professionals and U.S. hospitals and universities could be further expanded.

Recommendations:

- USAID/G–CAP should support efforts to decentralize quality care of HIV/AIDS, including improvement of ARV treatment coverage. This may involve establishing, organizing, and/or coordinating in-service and primary training for health professionals adapted to the different needs and tasks of care and support team members.

Quality of Life Issues for People Living with HIV/AIDS

Issues:

- The basic needs of people living with HIV/AIDS (PLWHA) remain unmet, especially regarding employment or food for those in severe poverty.
- There are frequent reports of HIV-based discrimination.
- PLWHA groups are effective at influencing policy. Many PLWHA groups, however, are dependent on health structures or support organizations, and most are not organized.
- There are good linkages among NGOs and PLWHA groups. PASCA (El Proyecto Acción SIDA de Centroamérica) has played an important role in creating and supporting this network.
- Most supporting organizations have difficulties covering operational expenses.

Recommendations:

USAID/G–CAP should reinforce and empower PLWHA groups and support organizations to improve treatment follow-up, access to work, and food supplies for those people living with HIV/AIDS most in need; and it should defend their human

rights. Training, financial support, and monitoring of these groups are essential to increase effectiveness.

I. Introduction

Since the beginning of the HIV/AIDS epidemic in Central America, government and donor resources have largely concentrated on prevention, the development of appropriate national policies and strategies, and the implementation of public awareness campaigns, especially among at-risk groups, men who have sex with men (MSM), and commercial sex workers. Until recently, only limited resources have been allocated for HIV/AIDS care and support. Most often, the burden of care in Central America is assumed by people living with HIV/AIDS (PLWHA), their families, friends, occasional local support groups, and public health facilities within each country. In recognition of this situation, USAID/Guatemala–Central America Program (G–CAP) commissioned a needs assessment in five Central American countries, with the aim of reviewing the current issues around comprehensive care and support and making recommendations for future activities.

During the early years of the HIV/AIDS epidemic in Central America, USAID focused its efforts and resources on supporting governments to develop strategic plans; behavior change communication activities accompanied by condom social marketing aimed at at-risk populations; community-based advocacy groups; training of health care workers; information and education materials and campaigns; information systems and monitoring of program activities. In 2001, USAID initiated its global “Expanded Response” strategy, which is designed to strengthen the capacity of countries to prevent new HIV/AIDS infections and to support the creation of services for those infected or otherwise affected by the epidemic, especially mothers, children, and youth.

The Expanded Response strategy’s categorization of affected countries means that in the Central American region, Honduras qualifies as an “intensive focus” country, with support for activities aimed at reducing the severity and magnitude of HIV/AIDS, maintaining low HIV prevalence; reducing mother-to-child transmission; and increasing support services to people living with and affected by HIV/AIDS. El Salvador, Guatemala, and Nicaragua are eligible for “basic support” to help them move toward the 2007 targets.

USAID’s Expanded Response Strategy: Global Targets for 2007

- Reduce HIV prevalence rates among 15-24-year-olds by 50 percent in high prevalence countries
- Maintain prevalence below 1 percent among 15-49-year-olds in low prevalence countries
- Ensure that at least 25 percent of HIV/AIDS-infected mothers in high prevalence countries have access to interventions to reduce HIV transmission to their infants
- Help local institutions to provide basic care and psychosocial support to at least 25 percent of HIV-infected persons and to provide community support services to at least 25 percent of children affected by AIDS in high prevalence countries

In addition to the bilateral support channeled through USAID Missions at country level, USAID dedicates considerable resources to HIV/AIDS issues at the regional level through USAID/G–CAP. The overall goal of the regional HIV/AIDS program is *to contain the spread and mitigate the impact of HIV/AIDS*. In the 2002-2008 period, the program will be expanded to provide technical assistance for programs that focus on sub-epidemics among the most at-risk populations, implement cross-border activities and support programs aimed at mobile populations. The G–CAP HIV/AIDS results framework specifies the following:

- Continuing support for increased use of prevention practices and services to combat HIV/AIDS
- Improved policies implemented at the national and local levels
- Effective and efficient delivery of comprehensive care and treatment for people living with HIV/AIDS

The present document is a summarized version of an October 2002 assessment that was conducted by The Synergy Project of TvT Global Health and Development Strategies, a division of Social & Scientific Systems, Inc. (SSS/Synergy). The full length version of the assessment report presents an in-depth survey of the current status of HIV/AIDS care, support and treatment, and related human resource issues in five Central American countries: Guatemala, Honduras, El Salvador, Nicaragua, and Panama. Findings and recommendations, as well as detailed annexes and site visit reports, are presented for future USAID/G-CAP activities.¹

II. HIV/AIDS in Central America

Central America consists of seven countries: Belize, Guatemala, Honduras, El Salvador, Nicaragua, Costa Rica, and Panama. Only Costa Rica is classified as “high human development,” while the remaining six are considered “medium human development.” Given that Costa Rica and Belize are not included in the plans to expand the USAID G-CAP response to HIV/AIDS in the region, this document concentrates on five of the seven Central American countries: Guatemala, Honduras, El Salvador, Nicaragua, and Panama. Table 1 presents basic socioeconomic data for these countries.

Table 1. Central America: Selected Socioeconomic Indicators 2000.

Country	Human Development Index (HDI) (2000)	2000 HDI rank (of 174 total)	GDP Per capita (US\$)	% of population living below the poverty line
El Salvador	0.704	104	2,104	45.5
Guatemala	0.632	120	1,680	56.2
Honduras	0.638	116	909	71.6
Nicaragua	0.643	118	472	45.8
Panama	0.707	57	3,508	40.5

With the exception of certain areas of the Caribbean coast, particularly that of Honduras, the HIV/AIDS epidemic in Central America is concentrated among certain vulnerable groups, and has not yet reached generalized levels. Groups such as MSM and female sex workers (FSW) are particularly affected. There has been a slow but continuous empowerment of people living with HIV/AIDS (PLWHA) in the region, with local activists focusing on broader access to antiretroviral (ARV) treatments for people affected. However, in general terms, awareness of HIV/AIDS issues is limited in most of the region, and various cultural elements present obstacles to a broader consciousness and behavior change. These barriers include machismo, homophobia, social violence, low status of women, low educational levels, fear, and rejection.

Honduras reports the highest number of reported AIDS cases in Central America, and the epidemic there verges on generalization. The male-to-female ratio of AIDS cases is

¹ The full-length version of this document is entitled: *Comprehensive Care and Support Services Assessment in Five Central American Countries*. SSS/ The Synergy Project. February 2003.

the lowest in the region (1.2:1 in the last five years), which explains the relatively high prevalence in children aged 0-4 years: more than five percent of all reported cases through June 2002.²

With the exception of Honduras, where the epidemic has been well established since the mid-1980s, most cases in other Central American countries have been recognized only recently. In Guatemala more than 38 percent of all AIDS cases have been reported since January 1999; the same holds true for Panama (46 percent); El Salvador (51 percent); and Nicaragua (58 percent).

Table 2: Central America: Selected HIV/AIDS Indicators

COUNTRY	Reported AIDS cases ³	Estimated HIV/AIDS cases, end 2001 ⁴	Prevalence among vulnerable groups ⁵	Estimated prevalence among Pregnant women
El Salvador	5,250 (as of 7/02)	24,000	3.9 (FSW) 17.8 (MSM)	1% (main maternity hospital, 2000)
Guatemala	4,914 (as of 12/02)	67,000	4.6 (FSW) 11.5 (MSM)	0.75% (Guatemala City, 2000) 0.36 national average, 11 sites, 2000)
Honduras	14,181 (as of 12/02)	57,000	10.3 (FSW) 13.0 (MSM)	1.9% San Pedro Sula, 1999 1.5% Puerto Cortes (1999) 0.8% Tegucigalpa (1999)
Nicaragua	406 (as of 08/02)	5,800	0.6 (FSW) 9.0 (MSM)	No data available.
Panama	5,483 (as of 12/02)	25,000	1.9 (FSW) 10.6 (MSM)	0.9% (Panama west, 1997)

The vast majority of AIDS cases in the region (92 percent) are attributed to sexual transmission, though within this category, infections through homosexual activity are under-reported. The strong stigma that surrounds homosexuality means that many homosexual and bisexual men maintain relationships with women and hide their homosexual activity. Many men diagnosed with HIV cite heterosexual transmission, but homosexual activity is probably the actual mode of transmission for many of them. Nonetheless, a significant proportion of AIDS patients are acknowledged to be men who have sex with men, as indicated in Table 3.

Table 3. Men and AIDS in Central America

Country	Percentage of Reported AIDS Cases among MSM	Reported AIDS Cases: Male to Female Ratio (cumulative)
Nicaragua	33.5	4.2:1 ¹
Panama	19.7	3.2:1
Guatemala	14.9	2.8:1 ¹
El Salvador	9.64	2.4:1 ¹
Honduras	7.3	1.5:1

In addition to the groups already noted for their vulnerability to HIV such as men who have sex with men (MSM) and female sex workers (FWS), some ethnic groups in the region, already marginalized, can be noted for their enhanced vulnerability to the virus. The highest rates of HIV in all of Central America are found among the Garifuna of Honduras (8.4 percent in 1998), a group of 200,000 people settled mainly on the

² Secretaría de Salud de Honduras. *Informe estadístico mensual de la situación del VIH/SIDA en Honduras, 1985–June 2002.*

³ PAHO. AIDS Surveillance in the Americas. June 2002.

⁴ UNAIDS. Update on the HIV/AIDS epidemic.

⁵ PASCA. Estudio Multicéntrico. 2001.

Atlantic coast. Information on the epidemic's impact among other ethnic groups is more difficult to find, but in Panama, numbers of reported cases among the Kuna people are approximately 45 percent higher than the average for the entire population. In one clinic in the Guatemalan capital, the proportion of cases among ethnic Mayan has increased markedly over time.

With the exception of the Caribbean coast of Honduras, the epidemic is located mainly in urban areas. As in other regions, transmission of the virus has generally followed major economic corridors, especially in Panama, where it is concentrated around the Canal. In Guatemala, the virus is spreading between the two oceans and across the southern coast. In Nicaragua, the most affected regions are Managua and Chinandega, and in El Salvador, almost sixty percent of cases are in the metropolitan area of the capital city.

III. The Response to the Epidemic

Despite some progress in raising awareness of the dimensions and implications of the HIV/AIDS epidemic among high-level decision-makers in the region, considerable obstacles remain. Relatively low prevalence, a multitude of competing priorities for limited resources, and social perceptions of HIV/AIDS and the groups seemingly most vulnerable to infection mean that the epidemic remains largely hidden, despite efforts to disseminate information regarding modes of transmission and prevention. Until recently, AIDS has been closely associated with homosexuality, prostitution, punishment for immoral behavior, and inevitable death. Double standards continue to dominate perceptions of sexuality: Men gain in social status through risk-taking and the sexual conquest of women, whereas women must keep their virginity for marriage and remain passive in their sexual lives. Men who have sex with men, transvestites, commercial sex workers, and other vulnerable groups are both subject to widespread discrimination and disproportionately affected by the epidemic.

Fear of HIV/AIDS leads to an insidious silence at all levels in Central America: Individuals, families, communities and health workers express this fear in various ways. Even when families and close friends react supportively when a person discloses his or her HIV-positive status, problems in communities occur when information circulates more broadly. Neighbors sometimes refuse to buy in PLWHA-owned shops, or reject members of the PLWHA families even if they are not HIV-positive themselves. When a person with AIDS dies, often at the request of the family an alternative cause of death is cited on the death certificate.

Many people living with HIV/AIDS express widespread dissatisfaction with the health care systems, in which they often experience rejection by health care workers, lack of appropriate care, and violations of confidentiality. Health care workers' fear of contamination of diagnostic instruments often leads to delayed attention or to none at all. Surgical care is even more difficult to obtain because of frequent compulsory HIV testing (though illegal and often unnecessary) and refusal on the part of some surgeons to proceed with scheduled operations. National guidelines sometimes exaggerate recommendations regarding surgical care for people living with HIV/AIDS. Many of those interviewed for the assessment agreed that training for health care workers should include an accurate description of risks, appropriate protection measures, and universal precautions, which in turn could reduce discrimination that people living with HIV/AIDS face in tertiary care units.

Though prohibited by law in most of Central America, loss of employment based on HIV status and the inability to find a new job are the most feared and frequent forms of HIV-related discrimination. There are frequent reports of compulsory testing by employers, followed by dismissal of HIV-positive employees or refusal to appoint new HIV-positive employees.

Every national constitution in Central America guarantees the right to life and consequently the right to health and the responsibility of the state to provide health care. At least three countries officially consider AIDS as a social problem of national priority (Honduras), national interest (Panama), or emergency (Guatemala). All promote state responsibility for comprehensive care and treatment of AIDS and establish measures to enhance respect for the human rights of people living with HIV/AIDS and to protect them against discrimination. However, these AIDS laws have yet to be broadly disseminated and enforced.

Lack of educational programs in schools

Comprehensive curricula for sexual education in schools are not widely used in the region, particularly those that consider aspects of sexual orientation and provide information on the risks of HIV/AIDS and sexually transmitted infections. Most of the sex education materials in use are didactic and leave little room for open discussion. Important initiatives for open sex education have come from NGOs and universities and have been well received by the students and their families, but these initiatives remain isolated. Churches have created considerable and well-organized resistance to sexual education and the promotion of condom use, especially among young people.

All countries in this assessment (with the exception of Panama) produced national strategic plans for HIV/AIDS between 1999 and 2001, in broad, participatory processes supported by UNAIDS and PASCA (El Proyecto Acción SIDA de Centroamérica). The plans, many of which have been updated and expanded to include more specific targets, call for the introduction or scaling up of comprehensive HIV/AIDS care, training of health professionals, strengthening and decentralization of treatment services, guaranteed access to ARV drugs, and promotion of community and PLWHA participation.

The response of civil society to the epidemic in Central America is well established. There are numerous national, international NGOs, and community-based organizations involved in prevention, care, and support. Networks of people living with AIDS, both national and regional, are increasingly well organized and effective in advocating for improved care and broader access to treatment.

IV. The State of HIV/AIDS Care and Support in Central America

Given the relatively low prevalence of HIV infection in Central America, and a multitude of competing priorities, most health systems in the region have not prioritized prevention or care for people living with HIV/AIDS. Even where commitment at the central level exists, other issues complicate the response within the health care system: ongoing health sector reform initiatives that emphasize privatization, decentralization, and health services management at the local/municipal level; a concentration of specialized care in the capital cities; and difficulties in early HIV diagnosis.

Voluntary Counseling and Testing (VCT). This essential component of secondary prevention has been neglected in Central America. A general lack of awareness (and

sometimes fear) of HIV among health care workers, limited availability of simple and rapid HIV test kits, and lack of trained HIV counselors mean that many HIV cases go undetected until they progress well into “full-blown” AIDS. Considerable efforts have been made to train counselors throughout the region, though the quality and consistency of these initiatives are less uniform. National protocols for HIV testing have, until recently, required complex and expensive tests that only formal clinical laboratories can perform; simple, quick, and ready-to-use HIV tests are not widely available in most countries. All countries are revising or have recently revised their national guidelines for testing. Rapid tests are being introduced; however, test results usually take at least one week to be reported (and sometimes much longer), and a significant number of clients never return for their results. Limited availability of test kits in the public sector delays testing in the public laboratories for long periods, and only specialized referral centers have a continuous supply. Lack of availability has pushed some testing to the private sector, where costs are high and there is little control over the accuracy of results or compliance with appropriate counseling, and testing algorithms.

Access to Antiretroviral Therapy. Access to ARV therapy has increased markedly in the region since the beginning of 2002. Factors accounting for this increased access include:

- USAID/G–CAP-organized and supported strategic alliances advocating for access to treatment
- Efforts by the international cooperation committee such as Médecins Sans Frontières (MSF), which campaigns for access and treats an increasing number of people
- Price reductions by some pharmaceutical companies
- Increased competition from producers of generic ARV medications

Pressure on governments from well-organized activist groups, and a better understanding of the costs and benefits of treatment for people living with HIV/AIDS have also been key to expanding access to care and support.

In many countries of the region, AIDS activists have directly influenced the availability of ARV medications. Initiatives have ranged from street demonstrations, Supreme Court cases, and decisions handed down by the Inter-American Commission on Human Rights. A

Negotiating Improved Access to ARV Treatment

Access to medications has also been facilitated by bilateral and regional price negotiations with pharmaceutical companies. In November 2001, Honduras negotiated ARV drug price reductions with the companies included in the WHO/UNAIDS Accelerated Access Initiative. This set benchmark prices for the rest of the region and stimulated political will to expand access to AIDS treatment. A few months later, the Central American heads of state signed the Madrid Declaration, which requested common regional negotiations for price reductions, and consideration of the use of other mechanisms to expand access to treatment, such as PAHO’s revolving fund for drug purchases, and SICA, (Central American Integration System). By mid-2002, several generic drug producers had their ARV drugs registered in several countries, and El Salvador had negotiated a reduction with major pharmaceutical manufacturers.

well-known Honduran activist's plea to Parliament resulted in a special emergency appropriation for ARV medicines in 2001, and a larger appropriation for 2002. In Guatemala, the AIDS NGO network and groups of people living with HIV/AIDS sued the President, who then instituted a special fund for immediate treatment and an increased budget for medications.

Health care systems. The team assessed several tertiary care units in each country visited. The clinical care of people living with HIV/AIDS and the management of ARV therapy are concentrated at this level of the public health and social security systems. Some private clinics, mainly nonprofit, have developed ARV treatment programs. In most countries, antiretroviral therapy and the treatment of opportunistic infections are offered by infectious disease specialists but only in the major urban centers (see Table 4).

A lack of coordination among various levels of care in the health system (primary, secondary and tertiary), and with other health programs such as maternal and child health, tuberculosis, and prevention and care of sexually transmitted infections, sometimes translates into missed opportunities for referrals and collaboration on mutual priorities. Health staff at the primary and secondary levels are often not clinically trained in AIDS, and cases often go unrecognized and undiagnosed; late diagnosis is the

Table 4. Clinics Treating PLWHA Using Antiretroviral Drugs in Central America (Data as of November 2002)

COUNTRY	CAPITAL CITIES			OTHER CITIES
	Ministry of Health	Social Security	Private organizations	Public and private
Honduras	Instituto Nacional del Torax Hospital Escuela		Solidaridad y Vida	Hospital Mario Catarino Rivas (San Pedro Sula) IHSS (San Pedro Sula) Juntos por la Vida (San Pedro Sula) Clinica de MSF (Tela)
Panama	Hospital Santo Tomás Hospital del Niño	IPSS		Hospital de Colón
El Salvador	Hospital Rosales Hospital Bloom Hospital de Maternidad Hospital Zacamil	ISSS		
Guatemala	Hospital Roosevelt	IGSS	Clínica Luis Angel García (ASI, H. San Juan de Dios) Clínica Yaloc (MSF) Clínica de Gente Nueva	Proyecto VIDA de Coatepeque
Nicaragua	Hospital Roberto Calderón Hospital Manuel de Jesus Rivera		Fundación Nimehuatzin	

norm. VCT is limited to some peripheral units and the tertiary centers. Once a person is diagnosed as HIV-positive or presents AIDS symptoms, he or she is generally immediately referred to the infectious disease unit or to a specialized AIDS clinic (most often in the capital city) for further follow-up for treatment of opportunistic infections or for ARV therapy. There is often no referral back to the primary care level, even if

most of the patient's needs could be met there. Perhaps because of some of these difficulties, individuals with HIV are often not referred to specialty clinics in the first place.

Where ARV treatment is available and the referral system functions well, scarce human resources are generally stretched to capacity. Most tertiary clinics have multidisciplinary teams, though they are often insufficiently staffed to face constantly growing demand, especially since ARV became available. The lack of physical space for private individual counseling is an important limitation. Basic laboratory testing is usually available, but specific tests such as CD4 count and viral load are normally available only in national referral laboratories. Drug supply differs widely in each country, with Nicaragua suffering a national crisis in general availability of essential drugs. Honduras also has limited supplies, while Guatemala and El Salvador experience shortages of the more expensive drugs. Panama is better off in general terms.

Promotion and distribution of condoms and other family planning services are frequently absent. The concept of a "network of services" is often in name only, and frequently operates in one direction only, i.e., from the peripheral to the central, more specialized level. There is also a "vertical" concept of care in which specialized health staff directs the activities of other levels.

International cooperation in El Salvador has financed the creation of support groups within the clinics,⁶ resulting in positive people's dependence on health staff to organize them. In countries with stronger health systems, like Panama and Costa Rica, the civil society movement is weak. Detailed information on each unit can be found in Annex 3 of the full-length document.

With the exceptions of those of Nicaragua and Honduras, social security systems have better resources than the Ministries of Health. Panama and El Salvador have a regular supply and a wide variety of ARV drugs. The Guatemalan system has offered ARV for several years but currently faces temporary shortages and a limited number of drugs. Honduras recently began offering treatment; however, only three drugs (AZT, 3TC, and efavirenz) have been purchased, allowing for no flexibility in the event of side effects or resistance. The

staff at these centers are motivated and willing to improve the quality and quantity of services, but they are already reaching their capacity to cope with increasing demand.

Challenges to Expanding Access to ARV in Central America

- The need to increase quickly the number of PLWHA on ARV treatment may decrease quality of the care they receive.
- Low priority is given to managerial aspects of care, such as registry systems. Databases, essential for monitoring, are heterogeneous and difficult to analyze.
- The lack of human resources continues to put a strain on efforts to increase compliance with treatment.
- Yearly planning for health services must predict needs in advance. It is difficult to estimate a growing demand. Supplies are often exhausted before the end of the budgetary period.
- Ensuring equity and ease of access to ARV therapy among various groups. Some treatment schemes have been designed to offer therapy to children first and then to pregnant women and/or the children's parents. Members of the gay community who are most at risk perceive this as discriminatory. Other high-risk groups, such as FSWs, have different problems with access because they tend to work in cities or even countries other than their own, and as such are hard to reach and track.

⁶ Memoria de Labores 2001. Programa Nacional de SIDA, El Salvador.

Estimated needs for ARV treatment. Table 5 provides estimates of numbers of people living with AIDS that require ARV treatment in order to slow the progression of their disease. The limiting factor for extending ARV treatment for Central Americans living with HIV/AIDS is not the total number of people in need, but rather the ability of the health system to cope with existing demand. All countries assessed in this report are extending or planning to extend coverage of ARV treatment. The number of clinics able to provide such treatment should be increased, but equally important will be the improvement of space, means, and staffing to guarantee quality of care, promotion of comprehensive care strategies, and avoidance of rapid spread of resistance due to poor compliance with treatment regimens.

Table 5. Estimate of Number of People Living with HIV/AIDS in Need of ARV Treatment in Selected Central American Countries

National and regional estimates	Population 2001 (UNAIDS) ¹	People living with HIV/AIDS (UNAIDS)	% of adults living with HIV (15-49 years) (UNAIDS)	Estimated numbers in ARV treatment	People in need of immediate treatment ¹
El Salvador	6,400,000	24,000	0.6%	650	1,500
Guatemala	11,687,000	67,000	1.0%	1,400	4,600
Honduras	6,575,000	57,000	1.6%	450	5,000
Nicaragua	5,208,000	5,800	0.2%	50	450
Panama	2,899,000	25,000	1.5%	1,150	200
Total	37,202,000	192,300	1.05%	4,730	12,050

New Resources. All five countries included in the assessment have presented HIV/AIDS proposals to the Global Fund to Fight AIDS, Tuberculosis, and Malaria in the first two rounds; all but Guatemala have received at least provisional approval. In general terms, all the proposals contain initiatives to rapidly scale up treatment for those infected, expand existing VCT services, train health care workers, and emphasize prevention of mother-to-child transmission. The massive influx of resources will undoubtedly make a huge difference to the fight against HIV/AIDS in the region and will contribute to ongoing efforts to scale up care and support for affected people

In addition, several new donors are getting involved in AIDS care and treatment but have not yet defined specific scopes of work. While new and increased resources for HIV/AIDS care and support are undeniably required, duplication of activities and concentration of resources in a few settings may impede expansion of care to areas and populations that need it most. Programming must include sufficient flexibility to provide its input where most needed or to place it elsewhere if duplication is foreseen.

V. Capacity-Building for Health Care

There is little formal in-service training for health professionals in HIV/AIDS comprehensive care and treatment in the region. Countries such as Guatemala, El Salvador, and Honduras, which are in the process of expanding ARV therapy, are in great need of trained HIV/AIDS health staff. The AIDS clinics in Honduras are already saturated. PAHO's Building Blocks Strategy would be a useful basis for an in-service training program based on the Building Blocks strategy to reinforce the secondary and primary levels of the health systems.

Primary training of health workers. Pre-service training curricula refer to the curricula for the primary training of health workers in universities, nursing schools, and other health schools that make up part of the health profession's multidisciplinary team. The assessment team visited medical and nursing faculties at national universities in Honduras, Panama, El Salvador, Guatemala, and Nicaragua. Individuals interviewed agreed on the need to review and update curricula on HIV/AIDS for health professionals because they do not focus specifically on comprehensive care and treatment. In medical faculties, HIV/AIDS issues are included in different disciplines such as microbiology, virology, pharmacology, and infectious diseases. Medical faculties in Honduras, El Salvador, and Guatemala are currently reviewing their medical curricula. Key activities needed for upgrading the quantity and quality of HIV/AIDS materials within these curricula include the identification of minimum requirements for HIV/AIDS comprehensive care and treatment content, didactic material, and curriculum evaluation methods; training, updating, technical exchanges, and horizontal collaboration among faculties and universities; ensuring that university libraries are well-supplied with pertinent bibliographies, journals, and other kinds of scientific information related to HIV/AIDS; and support for regional universities' participation in international conferences and training sessions related to HIV/AIDS.

Continuing Education Focused on HIV/AIDS

A postgraduate HIV/AIDS diploma program might address ongoing training needs of those health care workers already involved in care. Possible scenarios for a diploma course include:

- Each country organizes and implements the course in close coordination with medical and nursing faculties, post-qualification units of selected universities, and health facilities that provide HIV/AIDS care and treatment.
- A regional diploma course, with scholarships for selected health staff for training in different diploma courses on HIV/AIDS.
- Distance training based on curricula developed by IAPAC (GALEN) could be organized to help increase the number of trained people.

Several regional networks that could be very helpful in this review and upgrading process were identified, and include the Central America Council of Universities (CSUCA), the Central American Association of Faculties and Schools of Medicine (ACAFEM). The Latin American Association of Faculties and Schools of Nursing, and the Association of Private Universities of Central America (AUPRIC).

In-service training. The team reviewed possibilities for postgraduate and in-service training at universities and health facilities providing HIV/AIDS care and treatment. All countries indicated local capacity and expertise for in-service training, but a detailed in-service curriculum for health staff at AIDS clinics does not exist. PAHO's Building Blocks strategy could form the basis of an in-service training program that would support health care workers to implement comprehensive care and treatment activities. Early diagnosis and treatment of tuberculosis and sexually transmitted infections are especially important basic components of prevention that need to be included in the concept of comprehensive HIV/AIDS care. Cervical cancer prevention among HIV-positive women is another important secondary prevention issue.

VI. Recommendations

The situation of people living with HIV/AIDS, combined with the capacity of the health care system to respond effectively to these needs now and in the future, led the assessment team to make three sets of recommendations aimed at ensuring efficient, comprehensive care for PLWHA in Central America. They include improving the

response of the health care system to comprehensive care needs; providing flexible, effective training to health professionals in various disciplines; and linking support to NGOs and groups of people living with HIV/AIDS to integrate these individuals back into society.

Improve the response of the health care system to comprehensive care needs. There is an urgent need to expand and to integrate activities to provide comprehensive care for people living with HIV/AIDS. Knowledge and best practices must be shared among Central American countries to find and apply the most efficient methods to improve survival and quality of life for people living with HIV/AIDS. VCT must be widely extended to promote early case detection and care and to provide individually-oriented education to prevent the further spread of HIV/AIDS. The team recommended that one or two pilot projects in each country be supported to expand coverage and to increase comprehensive care and support of people living with HIV/AIDS. Possible project sites in each country identified in the interviews at the time of the assessment are summarized in Table 6.

Table 6: Possible Project Sites (Referral Centers and Network Links)

Country	Suggested referral center	Suggested links
Honduras	(San Pedro Sula) Existing clinic in Hospital Mario Catarino Rivas	<ul style="list-style-type: none"> ▪ Health Center of Miguel Paz Barahona ▪ Hospital of La Ceiba ▪ Hospital of Tela
	(Tegucigalpa) Hospital del Torax	<ul style="list-style-type: none"> ▪ Alonso Suazo Health Center ▪ Las Crucitas Health Center ▪ Comayagua Hospital
Guatemala	Roosevelt Hospital	<ul style="list-style-type: none"> ▪ Hospital of Coatepeque ▪ Hospital of Malacatan in San Marcoson ▪ Hospital of Mazatenango
	San Juan de Dios Hospital (Clinica Luis Angel Garcia).	<ul style="list-style-type: none"> ▪ Hospital of Puerto Barrios ▪ Morales Health Center ▪ Poptun Hospital
El Salvador	Rosales Hospital, in close coordination with the Maternity Hospital for pregnant women and Bloom Hospital for children	<ul style="list-style-type: none"> ▪ Concepción Health Center in San Salvador ▪ Hospital of Sonsonate ▪ Hospital of Santa Ana
Nicaragua	Hospital Roberto Calderón Gutierrez Manuel de Jesus Rivera Children's Hospital	<ul style="list-style-type: none"> ▪ Managua health centers to be identified ▪ Hospital of Chinandega ▪ Teaching Hospital of León
Panama	Hospital del Seguro Social or Santo Tomás Hospital del Niño	<ul style="list-style-type: none"> ▪ Hospital Manuel Amador Guerrero of Colón ▪ Two polyclinics ▪ Health centers of Colon Department

The formal links among the selected institutions, including referrals and counter-referrals need to be strengthened. These links should support the development of an early HIV diagnostic system (VCT) in all centers of the network, and must guarantee minimum standards of quality comprehensive care. In the selected areas, there should also be an effort to include community organizations and PLWHA groups.

Given that the care scenario is changing rapidly, particularly in the availability of increased funds for treatment through Global Fund-supported activities, the coordination and integration of activities with others will be increasingly important.

Most of the Global Fund proposals emphasize decentralization and network development. MSF can be an important partner in Honduras and Guatemala as the organization is already supporting peripheral clinics (including ARV drug supply) and has developed useful monitoring and training instruments. Other donors (such as the Inter-American Development Bank) are supporting reform toward decentralization of the health system. Parallel prevention or education programs in the geographical areas selected for intervention must also be considered.

Provide training to health professionals in various disciplines in a flexible and effective way. Currently, primary training is heavily oriented towards the basic sciences and does not include many of the complex, interdisciplinary aspects of comprehensive care. Prevention, sexuality issues for people living with HIV/AIDS, and use of condoms are subjects avoided even by the best-trained specialists. There are not enough well trained professionals to cope with the increasing treatment needs. Many short in-service training workshops exist, but there is no national training program, and there is a lack of appropriate follow-up.

One strength in the region worth noting is the existence of formal networks and the willingness of experienced professionals who can contribute to improvements in ongoing training. There is an urgent need for political and budgetary commitments to increasing human resources dedicated to HIV/AIDS care and support in the public health systems. Local experts should be able to dedicate part of their time to training new staff.

Cooperation among donors working at the regional level is especially important in this area of training activities. Primary training curricula should be standardized regionally and adapted to include all aspects of comprehensive care using the networks of schools and universities. In-service training must avoid short training workshops without follow-up. A flexible training program must be developed using regional strengths and promoting international exchange. This program could range from formal three-month diploma courses to distance learning. Consistent follow-up must be organized and based on experts' regular visits to the peripheral centers.

Link and support PLWHA NGOs and groups to integrate positive people back into society, overcoming stigma and discrimination. The first issue raised by people living with HIV/AIDS is always access to ARV treatment. Once access is obtained, other problems emerge, namely the ability to live productive lives. Stigma and discrimination increase suffering and complicate lives once progression toward AIDS is controlled by ARV therapy. Stigma and discrimination may impede adequate adherence to treatment and accelerate the appearance of resistant strains of HIV.

Although legislation exists to protect their rights, most people living with HIV/AIDS in Central America experience discrimination in the health care system, at their places of employment or in their job searches, and in their communities in general. The majority of people living with HIV/AIDS live in poor conditions with few opportunities for finding jobs. In particular, many poor positive people, especially those in the advanced stages of the disease, are in desperate need of food and nutritional supplements.

Governments and donors can make significant efforts to fight discrimination and defend the human rights of people living with HIV/AIDS, including training and awareness activities for PLWHA, medical and health staff, and other public servants involved in

resolving their needs. Three actions could be considered as new initiatives to help meet the needs of people living with HIV/AIDS:

- Access to work should be promoted by different means. Long-term actions reinforcing confidentiality should be directed to fight discrimination by employers who request HIV testing of employees. Finding jobs for positive people can be promoted by including them in active searches or in micro-credit programs.
- Training for the creation of micro-enterprises or for improving qualifications and increasing skills for finding jobs—including basic literacy—could improve chances for self-support.
- Supplemental food support should be provided for those in precarious situations, along with general nutritional education to help people living with HIV/AIDS adapt to and comply with ARV treatment.

These activities should be channeled through international cooperation programs (food support or micro-credit), local NGOs, and support groups. Training, financial support, and monitoring of these groups are essential to increase effectiveness. Existing national institutions and networks can be used for training for people with HIV/AIDS. In Guatemala, the Instituto de Nutrición de Centroamérica y Panamá provides professional training courses. Most countries offer free literacy programs. Legal advice can be included in wider programs to defend human rights. PLWHA groups or supporting NGOs, if adequately funded, could also directly provide some of these activities, including training and human rights defense.

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