



Latin America and the Caribbean

and The Global HIV/AIDS Program

THE WORLD BANK

Reducing HIV/AIDS Vulnerability in Central America:

Panama: HIV/AIDS Situation and Response to the Epidemic



December 2006

**Reducing HIV/AIDS Vulnerability in
Central America**

***Panama: HIV/AIDS Situation and
Response to the Epidemic***

Latin America and Caribbean Region
and Global HIV/AIDS Program

THE WORLD BANK

December 2006

World Bank Global HIV/AIDS Program Discussion Paper

This series is produced by the Global HIV/AIDS Program of the World Bank's Human Development Network, to publish interesting new work on HIV/AIDS quickly, make it widely available, and encourage discussion and debate.

The findings, interpretations, and conclusions expressed in this paper are entirely those of the author(s) and should not be attributed in any manner to the World Bank, to its affiliated organizations or to members of its Board of Executive Directors or the countries they represent. Citation and the use of material presented in this series should take into account that it may be provisional.

Papers are posted at www.worldbank.org/AIDS (go to “publications”). For free print copies of papers in this series please contact the corresponding author whose name appears the bottom of this page.

Enquiries about the series and submissions should be made directly to Joy de Beyer (jdebeyer@worldbank). Submissions should have been previously reviewed and cleared by the sponsoring department, which will bear the cost of publication. The sponsoring department and author(s) bear full responsibility for the quality of the technical contents and presentation of material in the series.

This set of papers on Reducing HIV/AIDS Vulnerability in Central America was produced by the Latin America and the Caribbean Region. For questions related to this set of papers, please contact:

Marcelo Bortman, LCSHD
World Bank, 1818 H Street, NW, Washington DC, 20433.
Tel. (202) 458-9730 – fax: (202) 614-0202
Email: mbortman@worldbank.org

Cover photos: Panama HIV/AIDS Situation and Response to the Epidemic
Courtesy of World Bank Photo Library

© 2006 The International Bank for Reconstruction and Development / The World Bank
1818 H Street, NW
Washington, DC 20433

All rights reserved.

Reducing HIV/AIDS Vulnerability in Central America
Panama: HIV/AIDS Situation and Response to the Epidemic

Marcelo Bortman;¹ Luis B. Saenz;² Isabel Pimenta;³ Claudia Isern;⁴ Antonia Elizabeth Rodríguez;⁵ Marianella Miranda, Leonardo Moreira, and Danilo Rayo.⁶

This study was undertaken by the Human Development Department, Latin America and the Caribbean Regional Office (LCSHD) of the World Bank with financial support from the Bank-Netherlands Partnership Program (BNPP). The main objectives of the study were to establish a baseline for measuring progress and identifying new challenges for the Central America HIV/AIDS Regional Project, and to support policy dialogue regarding the political leadership and commitment to prepare a regional HIV action plan with common policies and coordinated strategies.

Keywords: HIV, AIDS, Central America, Panama, World Bank

The World Bank	
Vice President	Pamela Cox
Country Director	: Jane Armitage
Sector Director	: Evangeline Javier
Sector Manager	: Keith Hansen
Task Team Leader	: Marcelo Bortman

¹ Senior Health Public Specialist, LCSHH, World Bank.

² Project Director for this study for Sanigest, Costa Rica.

³ Public Health Specialist, WBIHD, World Bank.

⁴ Administrative Assistant for Client Support, LCSHD, World Bank.

⁵ Coordinator for the Regional HIV/AIDS Project in Central America.

⁶ Consultants Team to Sanigest, Costa Rica.

Acronyms and Abbreviations

AED/F	Academy for Educational Development in Association with The Futures Group
AHMNP	New Men and Women Association of Panama
AIDS	Acquired Immunodeficiency Syndrome
APLAF	International Planned Parenthood Federation
ART	Antiretroviral Therapy
ARV	Antiretroviral Medicines
BNPP	Bank-Netherlands Partnership Program
CAFTA	Central American Free Trade Agreement
CCS	Social Security Office
CDC	Centers for Disease Control
CRP	Panamanian Red Cross
CSW	Commercial Sex Workers
GBLT	Gay, Bisexual, Lesbian and Transgendered Communities
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV	Human Immunodeficiency Virus
ICW	International Community of Women with HIV/AIDS
IDU	Injecting Drug User
IEC	Information, Education and Communication
IIDHESA	Institute of Human Rights in Health Matters
LCSHD	LAC Human Development Department
LCSHH	Health Sector
MOH	Ministry of Health
MSM	Men who have Sex with other Men
NGO	Non-Governmental Organization
PAHO	Pan-American Health Organization
PASCA	Central American AIDS Action Project
PASMO	Pan-American Association for Social Marketing
PLWH	People Living with HIV
PLWHA	People Living with HIV/AIDS
PROBISIDA	Foundation for Welfare and Dignity of Persons affected by HIV/AIDS
STD	Sexually Transmitted Disease
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Fund
USAID	United States Agency for International Development
VIH	Human Immunodeficiency Virus
WBIHD	World Bank Institute Human Development Division
WHO	World Health Organization
WSW	Women who have Sex with other Women

Table of Contents

Acronyms and Abbreviations	iv
Acknowledgements.....	vi
Executive Summary – Regional Overview	vii
Main Findings, Conclusions and Recommendations.....	viii
National Responses.....	ix
Panama: HIV/AIDS Situation and Response to the Epidemic	1
Vulnerable Groups.....	4
Perceptions of the Panama Population on HIV/AIDS	7
The National Response to HIV/AIDS.....	8
Legal and Regulatory Framework	10
Prevention and Care for Vulnerable Groups.....	14
Treatment and Supplies.....	20
References.....	24
Annex 1. Arbitrary Discrimination in Panama 2006	25
Annex 2. Form for Selecting Successful Interventions	27
Annex 3. Form for Evaluating Discrimination	29
Annex 4 Summary of Successful HIV/AIDS Experiences in Panama 2006.....	30

Tables

Table 1: Financing the Response to the HIV/AIDS Epidemic 2004-2005.....	9
Table 2: Expenditures on HIV/AIDS by Function 2004-2005	9
Table 3: Results of the project “ <i>Together we Can</i> ”, 2004-2005.....	16
Table 4: Project Beneficiaries.....	17
Table 5: ART by Group	21

Figures

Figure 1. HIV Prevalence in Panama by Region, 2004	3
--	---

Graphics

Graph 1. HIV Prevalence by Gender and Age in Panama 1984-2004.....	1
--	---

Acknowledgements

This study was carried out by a team led by Marcelo Bortman and which included Luis Sáenz, Marianella Miranda, Leonardo Moreira and Danilo Rayo, Claudia Isern, Isabel Pimenta, and Antonia Elizabeth Rodriguez.⁷ The report benefited from contributions from various individuals and organizations throughout Central America, who provided both information and technical assistance. We are extremely grateful to them.

The team is particularly grateful to the Royal Government of the Netherlands for funding this investigation through the Bank-Netherlands Partnership Program (BNPP). The team would also like to thank the following technical reviewers: Joana Godinho (Senior Health Specialist, The World Bank) and Joy de Beyer (Specialist in Knowledge Management for the Global HIV/AIDS Program, The World Bank), who have both assisted with editing of this series; Jonathan C. Brown (Operations Advisor of the HIV/AIDS Global Program, The World Bank), and Ian Walker (Social Welfare Specialist, The World Bank).

We also are very grateful to:

Panama

Emilio A. Messina G, MA. Head of the National STD/HIV/AIDS Program for the Ministry of Health.

Dr. Orlando Quintero A. Director of PROBIDSIDA

Licda Migdalia Salas, Head of the Department of Health and Human Welfare, Panama Red Cross.

Lic. Ricardo Eloy Beteta, President of AHMNP

Dr. Ernesto Guerrero Director of UNAIDS, Panama

Licda. Hilda Martínez, APLAFA Researcher

Dr. Edilma Berrio. Head of the National STD/HIV/AIDS Program for the Ministry of Health.

⁷ Marcelo Bortman is a Senior Public Health Specialist at the World Bank; Luis Bernardo Sáenz is the Project Director for SANIGEST; his study team included Marianella Miranda, Leonardo Moreira and Danilo Rayo; Isabel Pimenta is a Health Specialist at the World Bank, Claudia Isern is an Administrative Assistant for Client Support at the World Bank, and Antonia Elizabeth Rodríguez is Coordinator for the Regional HIV/AIDS Project in Central America.

Executive Summary – Regional Overview⁸

In Latin America, Central America is the sub region most affected by the HIV epidemic after the Caribbean. Four of the six countries in Latin America with the highest HIV prevalence are in Central America, and two of them have prevalence rates above 1%. The epidemic threatens to run out of control unless prevention efforts among highly vulnerable groups, such as commercial sex workers, men who have sex with men and prisoners, are intensified.

Preventing new HIV infections, treating people with HIV/AIDS, and caring for those affected by the epidemic represents a great challenge for these six countries. The World Bank is currently supporting initiatives by Central American governments to reverse the HIV epidemic. In this context, this study was carried out with the following specific objectives:

- 1) Review the epidemiology of HIV and AIDS in Central America;
- 2) Assess National AIDS Programs, including surveillance systems, laboratory capacity, prevention, treatment and clinical care;
- 3) Assess the legal and regulatory framework, and discrimination against people with HIV and AIDS – particularly women – and its impact on treatment and prevention; and
- 4) Review successful interventions and good practices related to HIV in Central America, carried out by NGOs and public organizations, including to develop monitoring and evaluation systems.

This study was conducted to support the current policy dialogue on strengthening HIV/AIDS national responses, in particular to: (i) build political leadership and commitment to prepare a regional action plan with coordinated strategies and common policies, (ii) strengthen and harmonize the legal and institutional framework for addressing the HIV epidemic in the region, (iii) identify and disseminate “best practices” for prevention through integrated efforts by the health sector, other government agencies and civil society and promote monitoring and impact evaluations, and (iv) set out the rationale for establishing a regional procurement process for HIV-related pharmaceuticals and supplies.

Finally, this study established a baseline against which to measure progress and to identify new challenges for the World Bank-financed Regional HIV/AIDS Project to address. The development objective of the Regional Project is to provide knowledge and tools to decision makers in all countries in the region to manage and control HIV and opportunistic infections. Component 1, *Regional Laboratory*, supports the establishment of a regional laboratory to implement highly specialized functions, as a single regional institution. Component 2, *Epidemiological Surveillance*, supports the implementation of a regional second-generation epidemiological surveillance system, to enable improved

⁸ The study included Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, and Panama. Separate reports have been published on each country, and a regional overview, from which this summary is taken.

characterization of the HIV epidemic in Central America. Component 3, *Strengthening the Regional Response Capacity*, will increase the harmonization of legal and institutional frameworks needed to scale-up strategic interventions, in response to the HIV epidemic. It will also strengthen leadership and political commitment leading to a Regional Action Plan to address the epidemic in a coordinated way. Finally, component 4, *Prevention in Mobile Populations*, focuses on groups that are particularly vulnerable to HIV, i.e., mobile populations, considered to be a key factor in the spread of the epidemic. Prevention programs focusing on these populations are still few and small scale.

The information presented in this report was gathered in interviews with key stakeholders in Central America and from reviews of documents provided by national organizations, NGOs, and bilateral and international development organizations. In addition, seven workshops were held to present and discuss the information gathered by the study with the various stakeholders.

The study is published in a series of seven reports: one summarizes the HIV situation in Central America; the other six describe the situation in each Central American country. Information from different countries is not always comparable. This partly reflects differences in the organizational level of the different programs responding to the epidemic, as well as variations in the study's access to information held by different institutions and organizations.

Main Findings, Conclusions and Recommendations

Honduras and Guatemala are two of the six countries with the highest HIV prevalence in Latin America. HIV prevalence among adults is already over 1% in Honduras (1.6%) and Guatemala (1%). Panama (0.9%), Costa Rica (0.6%), El Salvador (0.6%) and Nicaragua (0.2%) still have an HIV prevalence rate below 1%. By the year 2010, the epidemic may reach a 2% prevalence rate among the adult population in Central America, and in some cases it may surpass it.

It is estimated that over 200,000 people currently live with HIV in Central America.⁹ HIV transmission in Central America is primarily associated with heterosexual sex, as in the Caribbean. The exception is Costa Rica, where men who have sex with men (MSM) account for a much higher share of infected people than in other countries in the region. Although there are more men than women with HIV in Central America, the gender gap is closing fast. The epidemic is still concentrated in high-risk groups such as commercial sex workers and their clients, men who have sex with men, prisoners, and the Garifuna (an Afro-Caribbean population group from the Atlantic Coast of Honduras). The increase in adult deaths from AIDS has led to a rising number of orphans and vulnerable youth being left without homes, food, health care and education. The epidemic has economic repercussions both for households and country health systems, as well as for the economy.

⁹ CDC. Global AIDS Program for Central America. Program Profile, 2004.

In addition to the variations in prevalence and groups affected across the six countries, there are also important variations within each country. The epidemic is concentrated in certain geographic areas – particularly urban areas, internal commercial routes and ports. Groups associated with mobile populations, commercial sex workers and men who have sex with men have the highest prevalence of HIV, and are bridge populations for transmitting the epidemic to the general population, mainly due to them engaging in risky behaviors and the high level of interactions between these groups and the general population. However, the mechanisms of HIV transmission need to be better known so that effective public health interventions can be designed and implemented. Identifying the nature and extent of the problem in certain groups – such as people with disabilities, children at risk of sexual abuse, prison inmates, ethnic minorities, businessmen and the military/police – remains a challenge.

There are important differences in social and economic conditions among the Central American countries which may partly explain the differences in HIV prevalence rates. Other factors contribute to the epidemic, such as migration, tourism and proximity to the Caribbean. Migration has two components: 1) temporary workers moving within countries in this sub region; and 2) migrants attempting to move permanently to the United States, of whom only about 10% succeed, while 90% return to their countries. While in transit, migrants may be exposed to high risk sexual behavior, increasing their risk of becoming infected with HIV and other sexually transmitted infections. Higher HIV prevalence rates in Honduras, San Pedro Sula (a Caribbean port) and among the Garifuna population (indigenous people with roots in the Caribbean) suggest that transit between Central America and the Caribbean has had an impact on the Central American epidemic.

Some of the differences in HIV prevalence among these countries may be explained by poor surveillance systems and under-reporting. For example, although the role of injecting drug users (IDUs) does not seem to be an important factor in the epidemic in Central America, this may be the result of under-reporting. The higher HIV prevalence reported among MSM in Costa Rica may reflect more liberal cultural norms and less discrimination in this country, rather than real differences between Central American countries.

Once an HIV epidemic becomes generalized, the most affected groups are people in the prime working years of life. This has negative consequences for labor force size and productivity, with long-term repercussions for both the economy and health system, as has been witnessed in Africa. Countries such as Brazil, Thailand and Uganda have shown, however, that it is possible to keep the epidemic in check if there is strong country leadership, and evidence-based, cost-effective interventions that achieve high coverage of highly vulnerable groups such as commercial sex workers and men who have sex with men, are implemented.

National Responses

All Central American countries have established coordinated national responses to address the HIV epidemic. Nonetheless, important challenges remain to make these

systems effective. With respect to prevention, the main challenge continues to be to effectively reach the most vulnerable groups with evidence-based and cost-effective interventions, including appropriate prevention strategies to promote healthier and safer sexual and reproductive practices. On the treatment side, responses need to provide not only anti-retroviral drugs but also all the necessary clinical support and follow-up. At the regional level, efforts supported by the World Bank-financed project and other organizations will continue to focus on inter-country “transmission corridors” and border areas.

It is essential that each country defines national strategic priorities and allocates resources that reflect the realities of its own epidemic. Surveillance systems are still very weak, and most focus on notification of AIDS cases only. However, some of the necessary information about the epidemic is available and is included in this study. The Central American countries need to improve the analysis of available data to allow for appropriate planning and execution of national HIV/AIDS policies and programs.

Vulnerable groups and the general population still have a very limited understanding of HIV and AIDS. Swift action is required to discourage risky sexual practices, especially among highly vulnerable groups, and to better identify HIV cases and provide ARV treatment. A specific challenge is coordinating the actions of NGOs and the public health services, especially to provide effective responses at the three levels of care.

The country workshops that discussed the study findings and analyzed cost-effective intervention strategies concluded that at current resource levels, only 25% of infections could be prevented. This reflects the difficulty of reaching groups at greater risk. Cost-effective strategies identified by workshop participants include: i) free distribution of condoms among highly vulnerable and vulnerable groups, ii) social marketing of condoms, iii) targeting information, education and communication at highly vulnerable and vulnerable groups; and iv) providing counseling and access to rapid diagnostic tests.

Current funding to prevent and control the epidemic is far from adequate, and needs to be allocated to prevention among high risk and highly vulnerable groups. The World Bank developed a cost-effectiveness model to help governments determine the allocation of resources that would prevent the maximum number of new infections. According to this model, a well designed national program can have a substantial impact on the epidemic even with limited resources, provided these are channeled to the most cost-effective interventions. An analysis in Guatemala, Honduras and Panama suggests that health spending would have to increase by \$1 million per year to prevent the number of patients from growing 10-20%. In 2000, the three countries spent approximately \$9.6 million on HIV/AIDS programs.¹⁰

Surveillance Systems. Surveillance of HIV and AIDS in Central America is based on mandatory notification of cases, and some prevalence studies. At the country level, by merely identifying and following up on HIV and AIDS cases, surveillance systems do not

¹⁰ The World Bank. HIV/AIDS in Central America: The Epidemic and Priorities for its Prevention. LAC Region: Washington DC: 2003

fully respond to information needs posed by the dynamic of the epidemic. These systems need to increase their capacity to gather and analyze data related to risk factors and behaviors, known as second-generation surveillance. Upgrading the system to second-generation requires new strategies (sentinel units and sites). At the regional level, it is necessary to agree on common standards that will allow the exchange of information among countries, as well as on case definitions, implementation of sentinel units and sites, case reports, and indicators. To achieve this goal, it is important to consider the development of a regional integrated electronic information platform.

Legal and Regulatory Framework. Although all countries have developed a legal framework for health care provision for people living with HIV and AIDS (PLWHA), many cases of discrimination have been reported, and PLWHA have had to file law suits to defend their rights. In some countries, contradictions among the laws need to be resolved. In addition, improving knowledge about people's rights under the law remains a challenge, as does defining and implementing sanctions for discrimination. Successful interventions in the field of human rights, particularly in Guatemala and Panama, have seen a number of cases resolved in favor of patients who filed complaints. The study was able to identify areas where changes in general legislation or HIV/AIDS laws are necessary. Issues of reciprocity in treatment and care need to be resolved. Regional organs such as the Central American Integration System (SICA) can provide the necessary umbrella to integrate legal frameworks at the regional level.

Prevention. All countries have taken a broad approach to the prevention and control of the HIV epidemic. The list of potential target groups has increased to include the whole population. This strategy should be reviewed to ensure that the limited resources available are allocated to groups that are critical for preventing transmission of the virus – commercial sex workers, men who have sex with men, prisoners, and mobile populations.

In Central America, in addition to public services, there are many NGOs supporting the national responses against HIV and AIDS. These NGOs cover a wide range of interventions, offering protection of human rights, and prevention, treatment and care services. Judging from coverage indicators, many of these projects have been successful in achieving their goals. However, many interventions only track process indicators, and their outcomes are unknown.

Some projects are able to report on results: for example, an increase in the use of condoms by the target population was observed in Guatemala following a social marketing effort by PASMO. Similarly, the Basic Food Basket project of the Ministry of Health in El Salvador has shown a reduction in mother-to-child transmission of HIV. Projects aimed at the Garífuna population in Honduras have great potential. The same can be said of programs targeting the Xochiquetzal population in Nicaragua and of an effort by the United Nations Population Fund (UNFPA) and the Youth Ministry to draw attention to the epidemic in Costa Rica. Two successful interventions involve translating prevention messages for the Honduran Garífuna into the indigenous language. However, issues involving indigenous and afro-descendant groups in the region are very complex and require more attention. Some projects were successful in transferring knowledge to

vulnerable groups. However, most interventions have not selected indicators to measure impact on outcomes, such as HIV prevalence in vulnerable populations. The lack of appropriate measurement mechanisms does not mean that these interventions have not had an impact, or will not have one in the future. Rather, it points to the need for better monitoring and evaluation systems, including better indicators.

Treatment and Care. All Central American countries are providing treatment and care to people living with HIV and AIDS (PLWHA), including access to ARTs. Treatment is delivered through a mix of public and private care. The coordination of follow-up activities by health services and NGOs that provide ART is a serious challenge for country programs. In fact, there are significant challenges regarding the management of adverse effects of treatment, follow up with laboratory tests, and ensuring adherence to treatment. Dealing with illiterate patients or ethnic groups, many of whom are not covered by healthcare, adds to the challenge.

All countries also face challenges regarding the availability of ARVs. Agreements have been reached to attain preferential prices for brand-name drugs. In addition, generic medicines are available through institutional bidding processes or through procurement agencies and international foundations. Specific challenges remain in planning joint purchases by Ministries of Health and Social Security institutions, having uniform treatment protocols, establishing an infrastructure for patient follow-up, and monitoring resistance to medicines.

At the national level, countries need to establish mechanisms to facilitate the purchase of high quality generic drugs, using mechanisms such as the PAHO Revolving Fund or bilateral agreements. At the regional level, the possibility of establishing an alliance of Central American countries for the bulk purchase of drugs, aiming at reducing costs, should be considered. This alliance would improve these countries' bargaining power, ensuring access to drugs and related supplies at lower prices.

Laboratory Capacity. At the national level, laboratory capacity needs to increase not only to provide diagnostic services, but also to be able to follow up on people receiving ART. This will require investment in equipment and skilled workers; and improvements in health services referral processes. At the regional level, the World Bank is supporting the establishment and implementation of a regional laboratory in Panama City. This facility will have the following functions to support national laboratories: (i) diagnostic and follow up testing for complex cases, (ii) access to, and transfer of new laboratory technologies, (iii) quality control, (iv) training in new techniques, (v) research, and (vi) development of an integrated information system with country laboratories.

Panama: HIV/AIDS Situation and Response to the Epidemic

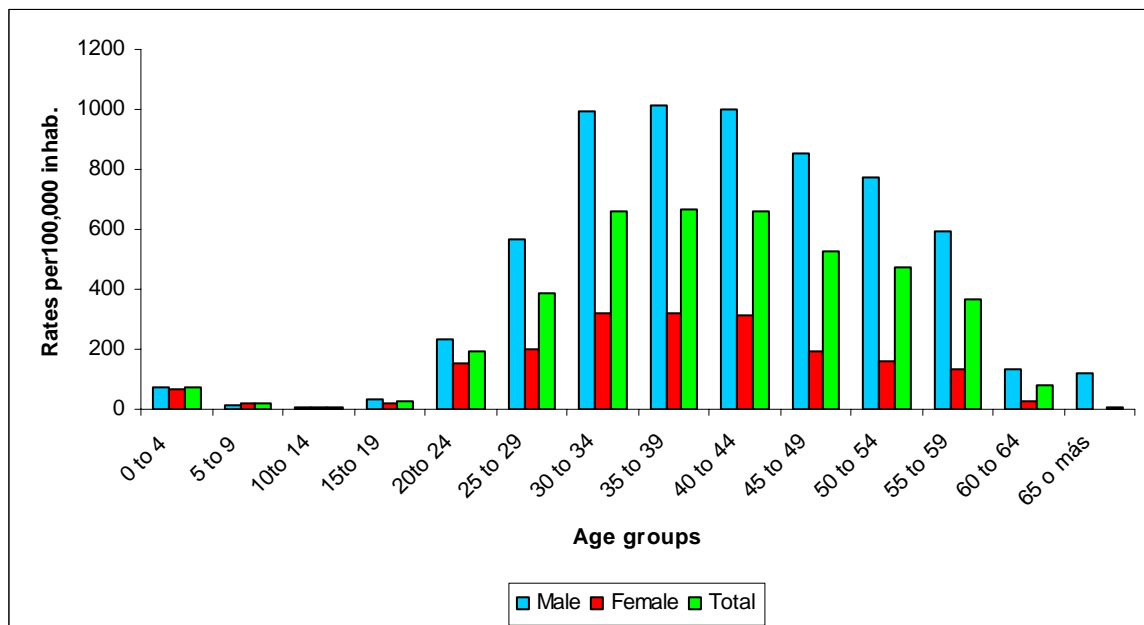
Panama is classified by the UNDP as among the five nations in the world with the most skewed distribution of income. Although its GNP per capita is US\$4,020, approximately 40% of its population live in poverty. About 63% of the population in rural areas is poor, and 17% live in extreme poverty; fully 90% of its indigenous population live in extreme poverty.

HIV and AIDS Situation

Panama registered its first case of AIDS in 1984, and established its first HIV/AIDS Center for testing, physical examinations and counseling the following year. The epidemic is mostly concentrated in groups identified as highly vulnerable: commercial sex workers (CSW), men who have sex with men (MSM), prisoners, young people, and indigenous people, mainly Kunas (about 10% of the Panamanian population is indigenous).

One reason for the spread of HIV in the country is its location as a bridge connecting Central and South America, which has made it a transit point for migrant populations who are difficult to identify and provide with information on HIV prevention and condoms. Graph 1 shows cumulated data on HIV according to age from 1984 to 2004.

Graph 1. HIV Prevalence by Gender and Age in Panama 1984-2004



Source: Based on data from the MoH 2004. Epidemiological Status of HIV/AIDS in Panama 1984-2004

In an interview, the head of the Reproductive Health Division of UNFPA considered the advance of the HIV epidemic in Panama alarming, and warned that if solutions are not found quickly, the disease will become a serious social and economic problem. Furthermore, statistics do not reflect the full reality, since many private clinics do not report HIV cases. She believes that the spread of the disease is gathering force, and that the country will soon enter a critical phase of economic hardship for which it is not prepared.¹¹

Overall, Panama has a prevalence rate of 0.92% for adults between 15 and 49 years of age, which represents an increase of over 0.2% since 2002. Prevalence is considerably higher among vulnerable groups: 2% among CSW and above 10% among MSM.

As of September 2005, a total of 7,111 HIV cases had been reported throughout the country; of these, 67% resulted from sexual transmission and 27% were of unknown origin. Mother-to-child transmission accounted for 4% of the cases, and blood transmission (IV drugs, contact with hemophiliacs and blood transfusions) represented 2%. In 2004, 73% of cases of sexual transmission involved heterosexual contact, 20% homosexual relations and 7% bisexual relations. Intravenous drug-users do not represent a significant number of the total number of HIV-positive cases; however, cases of sexual transmission linked to drug abuse have been reported.

That same year, 74 pregnant women were reported as HIV positive – 0.7% of all pregnant women; however, only 30% of pregnant women with HIV received anti-retroviral treatment (ART) to prevent their children from becoming infected. Pregnant women often refuse HIV testing (only 21% agreed to be tested in 2004), either because they believe it is unnecessary since they have only one sexual partner, or because they fear social stigma and rejection. In 2005, the highest number of perinatal transmission cases were in the greater metropolitan area (Panama City, 31% cases), San Miguelito (27%), Colón (17%), and West Panama (11%). Coclé, Chiriquí, Veraguas and the Darién together had 14% of cases.¹²

Analyzing HIV prevalence by age, the epidemic is concentrated in individuals who are sexually and economically active (ages 25-44). The highest percentage of cases is in people in the 30-34 age group (19%), followed by those in the 35-39 age group (16.5%), and by those in the 40-44 and 25-29 age groups (13% each group).

HIV prevalence has increased among both genders over the years, but the difference between the sexes has tended to narrow; in 2005, 75% of reported cases of infection were males and 25% were females. In young people, HIV occurs with equal frequency in both sexes.¹³

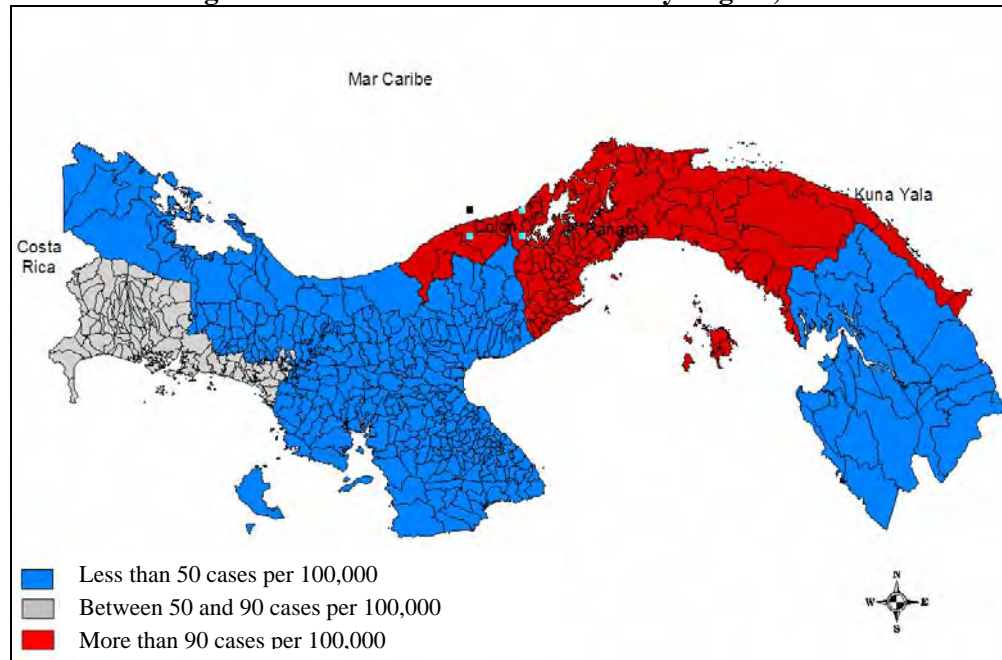
¹¹ AHMNP News Bulletin. Vol. 8, No. 7, February 2006.

¹² MoH 2004. The Epidemiological Status of HIV/AIDS in Panama 1984 - 2004.

¹³ Rapid Diagnostic: Report on Findings and Preliminary Results of the Study and Analysis of the Situation of Orphans and At-Risk Children Affected by HIV/AIDS in Panama 2005.

The regions with highest prevalence in Panama large urban centers: Colón, the greater Metropolitan Area, San Miguelito, and West Panama. Although the majority of cases are in these areas, there are reports of HIV cases in every part of the country. Border areas such as Chirriquí and Kuna Yala have the second highest prevalence. It is evident that in Panama, HIV is spread throughout the country, although it is still concentrated in certain groups and regions.

Figure 1. HIV Prevalence in Panama by Region, 2004



Source: PAHO and WHO Fact Sheets on HIV/AIDS 2004; and geographic data from the Central American Center on Population.

Prevalence has grown steadily year after year. There appeared to be a small decline in the period 2002-2004, but recent reports show an increase in cases. Moreover, data from the Association of New Men and Women of Panama (AHMNP) suggest that many cases go unrecorded since many MSM will not use social services for fear of having to undergo HIV testing and subsequently having to face social ostracism and discrimination if they test positive.

Nevertheless, mortality has decreased in the past few years, probably because eligible patients have been treated with ARV. Since 1999, the Social Security Office has been in charge of supplying antiretroviral medications to the insured population, while the Ministry of Health began this activity in 2002. The mortality rate from AIDS dropped from 16.57 deaths per 100,000 inhabitants in 2002 to 12.92 in 2004.¹⁴

¹⁴ Report on progress made in the country in response to the HIV/AIDS epidemic. Ministry of Health, 2005.

Vulnerable Groups

This section discusses the impact of the HIV epidemic on sex workers, men who have sex with men, prisoners, vulnerable young people, migrant groups, military personnel, and members of the Kuna indigenous population. Very few data are available for some of these groups, since the available studies have only baseline information or are exploratory in nature.

Commercial Sex Workers. In 2000, between 5,445 and 7,000 women in Panama engaged in sex work. The prevalence of HIV in sex workers in general is 2%: it is 3.5% in those who work as street walkers, and 1.5% in those who work at fixed locations. These differences may reflect the work environment in which the various subgroups operate; because street walkers do not work in fixed locales, they face harder working conditions, which force them to yield more to the demands of their clients. Sex workers who operate at established sites have the advantage of receiving care each week from the country's health centers, thanks to the Social Hygiene Program; thus, they are able to get more information about HIV prevention methods. Both groups of sex workers use condoms less frequently with regular clients and with their steady sexual partners, greatly increasing their vulnerability to disease.

In February 2004, a multinational study was conducted on the attitudes and practices of sex workers and men who have sex with men concerning HIV, condom use, and other matters related to sexual health.¹⁵ The main findings concerning sex workers were that 64% were between 20 and 29 years of age, 60% earned upwards of \$400 a month; 99% identified condoms as a means of HIV prevention, but 86% were considered at risk for HIV infection because they did not always practice safe sex; 89% had undergone HIV testing during the previous year.

Men Who Have Sex with Men. Another highly vulnerable group are men who have sex with other men. HIV prevalence among this group is estimated at 10.6%;¹⁶ even this high number is known to be underreported because many men who have sex with men do not go to health centers for fear of having to take the HIV-test and then enduring subsequent social discrimination and rejection. Moreover, in 27% of all HIV cases reported, the means of transmission is not mentioned, possibly because of the same fear of victimization. This phenomenon makes it necessary to reconsider the validity of the figures reflecting homosexual and bisexual HIV-transmission. Furthermore, this group also is afflicted by other STIs; 4.7% had syphilis, for instance. Underscoring the vulnerability of this group is the fact that until 2000, the government of Panama did not allocate sufficient funds for HIV prevention and treatment for men who have sex with men.¹⁷

¹⁵ MOH, Pan-American Association of Social Marketing (PASMO), USAIDS, and other agencies 2003. Multinational study.

¹⁶ Study on Observed Behavior 2001-2002

¹⁷ AHMNP. The situation of the gay, bisexual, lesbian, and transsexual communities (GBLT) of the Republic of Panama. 2000.

The multinational study conducted in February 2004 about the attitudes and practices of sex workers and men who have sex with men found the following for MSM: 52% are between the ages of 20 to 29; 42% earn more than \$400 a month; 93% identified condoms, limiting the number of sexual partners, and mutual fidelity between partners as ways to prevent HIV infection. The two main reasons given for not using condoms were that the respondents either engaged in oral sex (53%) or had sexual relations with their regular partners (42%). Finally, 92% felt that condoms are an effective method of preventing HIV; however, some believed lubricants reduced the effectiveness of condoms; when asked about the efficacy of condoms combined with lubricants, only 70% believed this was effective.

Prisoners. The prevalence of HIV among prison inmates varies between 5% and 13%.¹⁸ In a population of 11,584 prison inmates nationwide, 55 cases have been reported. However, because few resources are allocated to HIV testing in prisons, tests are performed only on inmates who are suspected of being infected. As a result, many asymptomatic carriers are not reported as HIV-positive. Most HIV-positive inmates were infected before being imprisoned.

Alarming, condoms are not available in detention centers because their use commonly leads to outbreaks of violence and even death. This happens because most incarcerated men who have sex with men do not consider themselves homosexuals. They justify their sexual behavior in prison as being merely circumstantial, and do not want it publicly recognized through distribution of condoms.

Women. Infected females represent 25% of all HIV cases in Panama. The most affected groups of women since the first case was recorded in 1984 have been those in the 30-34, 35-39, and 40-44 age groups. The three-to-one gender gap has narrowed since 1985, when the ratio was 16 to 1. The rise in the number of cases involving women may reflect cultural, biological, socioeconomic, and educational factors. For one thing, in Panama the *macho* or chauvinist culture dominates; it relegates women to sexually passive roles, with practically no power to negotiate the use of condoms during sexual intercourse. Moreover, the low educational level of women and their economic dependence on their male partners increases their vulnerability. Added to this is the fact that sexuality tends not to be discussed in the home except when there is an unwanted pregnancy, and public school instruction on the topic is limited mainly to a physiological focus.¹⁹

Vulnerable Young People. A study dealing with current attitudes, knowledge, and practices related to STIs and HIV/AIDS among male and female adolescents who attend public high schools, teachers, parents, and healthcare outreach workers in the 14 regions assigned to the Ministry of Health was carried out in 2003. The goal of the study was to raise awareness about the benefits of providing information and instruction to encourage changes in behavior and attitudes. Among the conclusions reached in the study are that adolescents identify unsafe sex as one of the main reasons for the spread of HIV; moreover, they recognize that condom use is a basic way to prevent HIV and other STI

¹⁸ Ministry of Health. Progress Report for the country's response to the HIV/AIDS epidemic. 2005.

¹⁹ Women and HIV/AIDS, <http://www.probidsida.org/mujer.html>

infections, and pregnancy. In addition, parents, teachers, and outreach workers completely support the proposal for providing adolescents with information on sexuality and the use of condoms.

Orphans. According to unofficial estimates from the Ministry of Health, in 2001 approximately 8,100 children were orphaned as a result of the AIDS. It is estimated that by 2010, approximately 13,000 children will have lost one or more parents to the disease. About 21% of all orphans nationwide have lost their parents as a result of AIDS, a figure that is expected to rise to 60% by 2010. It is also calculated that around 1,000 children under age 15 are HIV-positive.

A study gathered information about the magnitude and consequences of the HIV/AIDS epidemic on children and their relatives.²⁰ It showed that people in charge of caring for orphans and at-risk children (minors whose siblings were HIV-positive) lack places and support groups for sharing experiences with others who are in the same situation. Moreover, most did not have adequate knowledge for addressing HIV and AIDS, and were afraid they would face social ostracism and rejection if their relatives, neighbors or friends found about their involvement with these children. Among the recommendations stemming from this study are that support, care and treatment should be provided for children affected by HIV, and for their family members; nationwide campaigns focusing on HIV prevention, including mother-to-child transmission, should be carried out; and that pregnant women should be provided with universal prenatal health services and HIV-testing along with pre-test and post-testing counseling.

Members of the Indigenous Kuna Group. According to estimates from the epidemiological surveillance system, this ethnic group has an HIV prevalence rate double that of the general population. In 2005, a preliminary study was conducted in the Kuna territory and its communities in regions surrounding metropolitan areas.²¹ Among the main findings and recommendations were the following: the Kunas generally lack information about STIs and HIV/AIDS, and most of them do not use condoms - or even know what condoms are.

Sexual activity for Kuna women typically begins between 11 and 15 years of age, with males starting slightly later. Males are initiated in sexual intercourse by the *omegit* (a male transsexual group that are perceived as being women). There is great stigmatization with respect to HIV and AIDS; Kuna people do not know how to interact with infected people due to their own profound lack of knowledge about the disease. Nevertheless, the Sahilas (community leaders) as well as traditional doctors or healers are highly receptive to learning more about HIV and AIDS.

The main recommendations that can be drawn from this study are the following: the Kunas are collaborative in terms of providing information, although they prefer that

²⁰ National Program on STIs and HIV/AIDS, UNICEF, and the Family Planning Association (APLAFA) 2005.

²¹ Silvestre E, Núñez A 2005. Ethnic and anthropological exploration of the Kuna region and peripheral metropolitan Kuna communities.

information sharing be approved by the Sahilas. They would like interviews to be held in their native language (Dulegaya) and in pairs, rather than one on one. There is more cooperation with interviewers who are of the same age and sex. And the best way to provide information to the Kunas is through their spoken language or audio-visual materials.

Military/Police. A baseline study is being carried out on the knowledge, attitudes and practices of recruits and cadets 18 – 25 years old in the national police force, navy and air force.²² One of the main goals of the study is to determine which STIs are most frequently contracted by this population, and analyze high-risk sexual behavior and vulnerability. The study is also assessing the knowledge of this group concerning the rights of PLWH and sexual and reproductive health issues in general. The study already has concluded its initial phase, which consisted of a survey questionnaire administered to a sample of this population, and the second phase, in which data on human and gender rights are being analyzed.

Perceptions of the Panama Population on HIV/AIDS

In 2003, an opinion survey was carried out to assess the general perceptions of the adult population in the Central American region regarding HIV/AIDS.²³ Significant findings for Panama include the following:

- (1) Of those interviewed, 73% stated that they had heard a great deal about HIV/AIDS, while 3% said that they had not heard about the epidemic.
- (2) 51% believed that prostitutes with HIV and AIDS deserved the disease because of their sexual behavior.
- (3) 40% stated that people with HIV and AIDS should not have access to public places.
- (4) 64% agreed that business owners should have the right to require prospective employees to undergo HIV testing as a condition for being hired.
- (5) 99% agreed that HIV/AIDS information should be provided in high schools.

²² Study on knowledge, attitudes, and practices of recruits and cadets in the national police force, navy, and air force, regarding STIs and HIV/AIDS and sexual and reproductive health issues from the standpoint of human and gender rights.

²³ AIDS Action Project of Central America of the AED/Futures (PASCA), USAID/G-CAP, Interdisciplinary Development Consulting firm (CID-Gallup) Study 2003. The sample consisted of 7,272 men and women from the six Central American countries (Guatemala, El Salvador, Honduras, Nicaragua, Costa Rica and Panama).

The National Response to HIV/AIDS

Panama began to respond to the epidemic shortly after cases were first detected in the country. In 1985, the first HIV testing and counseling center opened, with support from the Initiative for Central American Health and Concern for Borders program, as well as the government of Panama, PAHO and donors.

The Ministry of Health and the Social Security Office are the main government entities leading the HIV response. These institutions are required by law to provide integrated care to people living with HIV and provide access to antiretroviral medications.

Panama has drafted laws addressing all aspects of the epidemic. In 2000, General Law 3 on STIs and HIV/AIDS was enacted. One year later, Executive Decree 119 was issued to regulate General Law No. 3.

The civil sector – mainly PLWH groups, NGOs, and international organizations – also have responded to the epidemic. Groups that have joined the fight include AHMNP, PROBIDSIDA, the Genesis group, APLAFA, and others, together with the Panamanian Red Cross (CRP), the Office of the People’s Ombudsman, and the Inter-American Institute of Human Rights in Health Matters (IIDHESA). Many of the activities of these organizations are geared toward providing social and psychological support, though they do not do so in a systematic manner and have only scant resources for groups identified as most vulnerable.

The Safe Blood Project, which started in 2000, has reduced infections caused by blood transfusions. In addition to the vulnerable groups described above, pregnant women are a priority for the Government of Panama. Pregnant women using the Mother and Child Program have free access to HIV testing. In addition, HIV testing fees for the general population have been reduced in an effort to extend national coverage. Starting in 2005, the *Zero Vertical Transmission* and *Woman, Get Tested* campaigns started to meet the government’s objective of reducing perinatal transmission. Meanwhile, international organizations (United Nations, the Pan-American Health Organization, and UNICEF among others) as well as the National STD/HIV/AIDS Program have sponsored studies designed to increase understanding of the HIV/AIDS situation in Panama. One of the most meaningful studies carried out in Panama and the rest of Central America is a Public Opinion Survey for Central America and Panama regarding perceptions of AIDS in Central America. Completed in 2003, it was funded by USAID, and conducted by the Pan-American Association for Social Marketing.

Panama is considered a medium-high income country, a classification that limits what it receives in donations. It is the only country in Central America that has not received support from the Global Fund to Fight AIDS, TB and Malaria (GFATM). Yet Panama has high rates of poverty and extreme poverty, especially in rural and indigenous areas.

In 2002, the government assigned 12.5% of its budget to healthcare, including 2% for HIV and AIDS. Since 90% of the amount allocated for HIV and AIDS was spent on antiretroviral medications, there was not enough funding for other important activities

such as prevention, training, and new studies on highly vulnerable groups. The government increased its allocations in 2004 and 2005 as part of its commitment to provide treatment and comprehensive support to all people living with HIV. Table 1 shows financing from the public and private sectors and international sources in 2004 and 2005.

Private sector and international aid resources have supported prevention and communications interventions. These resources have also supported building capacity to strengthen the National HIV/AIDS Program. These interventions led to development of the Multisector Strategic Plan for STIs and HIV/AIDS, guidelines for care of HIV/AIDS patients, and a number of studies to improve already initiated strategies.

**Table 1: Financing the Response to the HIV/AIDS Epidemic 2004-2005
(US. Dollars)**

SECTOR	2004	2005
Public	11,097,993	12,415,219
Private	2,085,832	2,202,894
International	405,826	642,880
TOTAL	13,589,261	15,260,993

Source: MEGAS 2006

Panama targeted its interventions to treatment and care, which were allocated US\$8.9 million in 2004 and US\$9.9 millions in 2005 – 66% of all resources available for the national HIV/AIDS response in those years. About 25% of available funds were targeted to prevention and research. Yet there are so many risk factors and practices that a large number of strategies and interventions are required if Panama is to achieve the Millennium Development Goal of slowing the spread of the HIV/AIDS epidemic by 2015.

Table 2: Expenditures on HIV/AIDS by Function 2004-2005

	2004		2005	
	US\$	%	US\$	%
Prevention	3,306,416	24.3	3,662,310	24.0
Treatment and Orphans and Vulnerable Children	8,921,480	65.6	9,990,660	65.5
Program Development	277,128	2.0	319,540	2.1
HR	924,627	6.8	1,059,145	6.9
Social Mitigation	0	0.0	0	0.0
Community Development	0	0.0	55,892	0.4
Research	0	0.0	36,000	0.2
TOTAL	13,589,651	100.0	15,260,997	100.0

Source: MEGAS 2006

LEGAL AND REGULATORY FRAMEWORK

This section describes Panama's current laws by referring to chapters of the constitution that deal with discrimination and rights, and other laws adopted and specifically directed towards PLWH care. It then presents results of a survey on discrimination based on the UNAIDS discrimination protocol.²⁴

Panama's Constitution has provisions designed to protect the rights of all of its citizens, but many highly vulnerable groups such as commercial sex workers, men who have sex with men, and others experience discrimination, and some laws discriminate against people with HIV. Key constitutional provisions include the following:

- *Chapter VI on Health, Social Security, and Social Assistance* specifically states that the state is required to protect, preserve, and promote the health of all of its citizens. In the case of HIV and AIDS, that can be inferred to obligate the government to provide integrated medical care, including ART and follow-up that will extend and improve the quality of life for PLWH. Specifically:
 - *Article 105* says that a basic function of the State is to safeguard the health of its population. The individual, as part of the community, has a right to the promotion, protection, preservation, and rehabilitation of his or her health. It is understood that health refers to a person's complete physical, mental and social health.
 - *Article 106*. Regarding health concerns, the state is primarily responsible for prevention, healing, and rehabilitation by (i) developing a national policy on food and nutrition that will ensure the optimal nutritional condition for the entire population, while promoting the availability, consumption, and biological or metabolic use of suitable food; and (ii) training and informing individuals and groups accordingly.
- *Chapter III, Article 64 on Employment* says that work is considered both a right and duty of the individual, and that it is the obligation of the State to develop economic policies directed at promoting full employment and ensuring that every worker has the necessary conditions for a decent existence. This implies that obligating an individual to undergo HIV testing would violate one of the basic rights of citizens, since HIV carriers cannot find employment, and cannot live with dignity due to the subsequent lack of income.
- The Government is also responsible for punishing actions that put other citizens at risk – for instance, purposefully spreading diseases or epidemics.

Key provisions of Panama's Penal Code include the following:

- *Chapter V on Crimes against Public Health* opens the door to the persecution of CSW and MSM.
 - *Article 252* says that whoever spreads a dangerous or contagious disease or interferes with measures taken by the proper authorities to prevent an

²⁴ UNAIDS 2000.

epidemic from being introduced and spreading will be sentenced to one to three years in prison.

- *Article 253* says that whoever exposes someone to a sexually transmitted disease by sexual contact or other means will be sentenced to six to 12 months in prison plus fines. If the offense is not knowingly committed, the sentence will be the equivalent of 10 to 50 days in fines.
- *Article 20* of the Panamanian Constitution also fosters harassment of PLWH. It says that all foreigners intending to enter Panama as permanent residents or residents for more than one year must present upon entry health certificates issued by a public or private hospital and duly approved by the Ministry of Health or other official entity in charge of public health, attesting that they have taken an HIV test and that the results were negative. If results were positive, entry is denied. This health certificate must be authenticated by the Panamanian diplomatic mission office or consulate in the country of origin, and will be valid for a period of only two (2) months. This law is discriminatory since it denies positive individuals the right to free transit and movement.

Since the constitution does not cover all issues dealing with HIV, Panama adopted General Law 3 on STIs and HIV/AIDS in 2000.

This law was created to fill the void that existed at the judicial level with respect to public information, education, and promotion of health. It also provides guidelines for epidemiological surveillance, research, prevention, training, diagnosis and integrated care for STIs and HIV/AIDS. The law specifically delineates the rights and duties of sick people and carriers of STIs and HIV/AIDS, as well as the rights and duties of others. Article 2 says: “It is declared that sexually transmitted diseases, the human immunodeficiency virus, and the acquired immunodeficiency syndrome are the problem of the state and in the national interest.” The law also says that it is the responsibility of all state, autonomous, decentralized, mixed, or municipal entities, including the legislative and judicial bodies, electoral college, and Ministry of State, to present and execute strategic plans to prevent, control, and manage STIs and HIV/AIDS for their entire staff.

However, participants in the workshop held in Panama City in May 2006 stated that not all vulnerable groups are aware of Law 3 and its regulation. In addition, it was suggested that the law is very general regarding certain issues – for instance, it does not include all groups now known to be vulnerable.

Among the most noteworthy articles are the following:

- The chapter related to the rights and duties associated with this law prohibits any form of discrimination, stigmatization, or segregation that may cause harm to a sick person, carrier of an STI or HIV, or to their relatives and acquaintances. Although acts of intolerance are hard to mitigate in practice, the law establishes the legal principle that these attitudes and types of discrimination are wrong.

- *Article 17* states that hotels, motels, pensions, and boarding houses that do not register guests are required to have condoms available for their clients in a visible location, and provide a minimum of two condoms as part of their basic services. As a public health measure, the Ministry of Health must provide condoms for every boat docking at any Panamanian port, the quantity depending on the size of the crew and the amount of time the vessel will be in port. The cost of this and other measures taken to prevent HIV from spreading are covered by funds assigned for the provision of maritime health and safety.
- *Article 21* states: “All people diagnosed with sexually transmitted infections, the human immunodeficiency virus, or with AIDS should receive timely and fair treatment and care, whether at a public or private institution, and their right to confidentiality must be respected.” These regulations assume that people with HIV have the right to fair treatment, as do all citizens with medical needs.
- Prison inmates are also mentioned in this law, especially in Article 40, which states that they “have the right to receive the same integrated health care, as well as preventive measures, as the rest of the population at large.” This section is of great importance since it serves as a reminder that being deprived of personal freedom does not imply losing all of one’s rights as an individual and human being.

In 2001, the Ministry of Health issued Regulation 119 to regulate General Law 3. Among the provisions that stand out most in this regulation are the following:

- Article 1 designates the General Head of Public Health as responsible for handling intra-institutional and inter-institutional coordination of the national Program for STIs/HIV/AIDS.
- Article 24 states that all cases of STIs and HIV/AIDS in public and private health centers must be reported to the appropriate epidemiological department of the Ministry of Health. Unfortunately, many private clinics do not report the cases that they treat.
- Article 40 designates the Ministry of Health, through its Department of Pharmaceuticals and Drugs, as the legally authorized entity to enforce compliance with quality control norms for condom inspection, which in turn must meet current international standards.
- Article 60 aims at eliminating all forms of discrimination that PLWH may experience at any health care center. It obliges directors of centers, whether public or private entities, to ensure that the staff provide appropriate and suitable attention and care for all patients with STIs and HIV/AIDS.

Response to Arbitrary Discrimination. The results of the survey on discrimination toward PLWH carried out according to the UNAIDS protocol are summarized below and in Annex 1. The information in this section was provided by PROBISIDA and the International Community of Women with HIV/AIDS in Panama (ICW-PANAMA). Cases of discrimination reported may have occurred in earlier years. In some cases, explanatory notes provided by the Ministry of Health were included in the Annex 1 summary.

Health Care. Denial of treatment due to the serological status of individuals occurs mainly among drug addicts, prison inmates and sex workers. This is in clear violation of the declaration in General Law 3 that any person diagnosed with STIs and HIV or AIDS must receive timely and fair treatment in private and public health care facilities. It also violates Article 40, which stipulates that prison inmates “shall receive the same integrated care as well as preventive measures, as the rest of the population at large.” According to those interviewed, Article 5 of the General Law No. 3 on STIs and HIV/AIDS also is violated when HIV test results are not handled in a confidential manner due to the negligence of workers at health centers. Because of this problem, many people refuse to be tested even though they suspect that they may be infected since they fear that a seropositive status will subject them to discrimination.

Employment. According to the survey, HIV testing is performed without consent at private enterprises under the guise of general exams to ascertain the health of employees. This is in violation of Article 7 of General Law No. 3, which states that no one can be tested without his or her “lawfully obtained consent.” Individuals who were interviewed stated that workers who test positive are fired without explanation, and are not told the results of their HIV tests. This violates Chapter III of the Constitution, which defines work as a right and duty of an individual.

Judicial and Legal procedures. There was one case of a seropositive individual who reported unequal legal treatment in a legal case in 2000.

Prisons. According to inmates interviewed about discriminatory practices, there are cases of prison inmates who did not receive suitable health care or antiretroviral therapy despite living with HIV/AIDS. This violates Article 40 of General Law 3.

Social welfare. No cases of discrimination were reported in the area of social welfare.

Housing. In Panamanian legislation, there are no provisions for HIV testing as a requirement for access to housing. However, cases have been reported of seropositive individuals in search of housing who have been required to submit to HIV testing, and who were rejected when the test results were positive.

Education. An HIV-positive girl was denied access to schooling in 2005 by her school’s principal.

Family Life and Reproductive Rights. The law states that all couples who wish to marry must first be tested for HIV, as well as pregnant women. There are reports that at the start of the epidemic, HIV-positive pregnant women were subjected to abortions and sterilization procedures. In 2004, a custody agreement was affected by the fact that the father was HIV-positive.

Insurance and other Financial Services. According to the survey, various examples of discrimination have occurred in practice. For example, a person who is HIV-positive

cannot obtain an insurance policy or credit. Although these situations are not addressed by any law, they are part of the daily life of people who live with HIV.

Response to Arbitrary Discrimination. General Law 3 includes a number of articles designed to prevent discrimination toward PLWH. Nevertheless, discrimination is still prevalent – often the product of widespread ignorance about how HIV can be contracted. Among the main articles aimed at ending discrimination, are the following:

- *Article 5* states that results of HIV tests must be handled with strict confidentiality.
- *Article 7* states that no one may be subjected to HIV testing without his or her consent.
- *Article 21* states that everyone diagnosed with STIs and HIV/AIDS must receive timely and fair medical attention, whether at private or public institutions.
- *Article 26* states that no one with HIV may be the subject of experimentation for testing medications or medical procedures.
- *Article 31* prohibits all forms of discrimination, stigmatization, or segregation committed against people with HIV or their relatives and acquaintances.

PREVENTION AND CARE FOR VULNERABLE GROUPS

This section describes projects for fighting HIV/AIDS in Panama and the organizations that run them. To be selected, projects had to be in operation for at least two years; be directed at vulnerable groups according to the classification used in the study; have a measure of effectiveness; and have one or more of the following objectives: effective prevention strategies towards MSM, disseminating information to control the epidemic, diminishing stigma and discrimination, increasing access and coverage, and changing behavior.

Association of New Men and Women of Panama

AHMNP is a non-governmental, non-profit organization that began its work in 1996. The organization seeks to promote the rights and equality of the gay, bisexual, lesbian and transsexual population (GBLT), men who have sex with men (MSM), and women who have sex with women (WSW) through education, promotion, legislation and dissemination of information about human rights.

The actions of this organization are mainly geared towards defending the rights of sexual minorities and making the gay community socially aware of STIs and HIV/AIDS and the risk of their transmission. Activities are executed according to an operational and strategic plan that is developed each year. The organization is well regarded in health circles at national level for working directly with highly vulnerable groups that other organizations have difficulty reaching.

Among its programs, the most successful involves the free distribution of condoms at gay discos and nightclubs. In addition to the condom distribution program, the organization

provides information and organizes workshops focused on education, prevention and training. Within the framework of prevention, the goal is to provide target groups with different options for seeking disease-free sex in a safe and efficacious manner.

The organization has 75 active volunteer members. In addition, it also includes a team of collaborators, including doctors, psychologists, lawyers and teachers. Its ultimate authority is the General Assembly. However the organization follows guidelines set by its Board of Directors, which meets twice a month, and has the following five units: Ombudsmen's and Human Rights Unit, Management and Business Unit, Monitoring and Evaluation Unit, Public Affairs and Communications Unit, Education and Health Unit. In most cases, the organization relies on its own funds. However, on occasion it has been able to obtain funds for small projects from UNAIDS or other international agencies. The management and administration of the funds are executed under the supervision of an authorized public accountant.

In the future, it plans to implement and strengthen research processes and increase knowledge about self-care of sexual health. In addition, it plans to offer free and rapid tests. For this activity, officials hope that they will be able to attract the interest of the broader community since it believes that homophobia at the health centers --caused by lack of knowledge regarding the danger of STIs and the rise in cases of HIV -- drives away target groups.

Panamanian Red Cross

Project for Preventing STIs and HIV/AIDS in Prison inmates

The Panamanian Red Cross is a non-governmental organization that was founded in 1917. Since its inception, it has become well known for its work in health and humanitarian aid. Its main objective is to alleviate the suffering of vulnerable people. The organization is committed to reducing the vulnerability of Panamanian people to HIV through prevention, care, support and assistance to people affected by the epidemic. The organization developed its own national strategic HIV/AIDS plan for 2004-2008, which specifies the work methodologies to be developed according to the priority groups: PLWH, youth, indigenous groups and prisoners.

To achieve its various objectives, the organization implemented the program *Together We Can*, which is a peer education program first implemented in Jamaica in 1993 as a result of collaboration between the Jamaican Red Cross and the American Red Cross. Due to the success it obtained in that country, many countries in the Caribbean have now adopted it. It is currently recognized as a standard education methodology of Red Cross organizations throughout the region.

The Panamanian Red Cross also ran an STIs and HIV/AIDS prevention project for prison inmates that has been identified as the organization's most successful project. The project is preventive, and gender directed. It seeks legal protections for its target populations. It was initiated in 2004 and its first stage ended one year later in 2005. The objective was to choose a prison where knowledge regarding HIV and AIDS was low, and to train peers

within the prison who later would be in charge of transmitting the knowledge acquired to other inmates.

The main sources of finance were the Ministry of Health and the International Federation of the Red Cross. The project has attracted support from health and education authorities who want to extend it. Consultants were allowed to study it so that it can be implemented in prisons throughout the country.

During 2004 and 2005, 145 people benefited from the program. Given the results (Table 3), it is expected that the project *Together we Can* will be executed in most of Panama's prisons.

Table 3: Results of the project “*Together we Can*”, 2004-2005

Human Resources	2004				2005		
	July	September	February	April	July	September	December
National Instructors	4	4	8	8	8	6	6
Facilitators	7	7	13	13	13	15	15
Peer Educators	0	13	20	20	20	31	31
Beneficiaries	0	0	0	81	92	109	145

Source: Panamanian Red Cross

Both the project *Together we Can* and the STIs and HIV prevention projects for prison inmates are in agreement with the National Plan of the Ministry of Health and the Panamanian Red Cross.

National HIV/AIDS Program

Project Educational Strategy for Preventing STIs and HIV/AIDS among Students

The National STIs and HIV/AIDS Program is in charge of recommending, establishing, implementing, supervising and evaluating compliance with policies and strategies related to these diseases in all state, autonomous, semi-autonomous, mixed, municipal and private agencies in Panama.

Its mission lies in promoting healthy lifestyles that contribute to reducing risk of sexually transmitted infections, including HIV, in a coordinated manner with all sectors of society. The general objective is to diminish morbidity associated with STIs and HIV through a national commitment that involves all members of society. Among the specific objectives are: to determine the epidemiological characteristics of STIs and HIV/AIDS epidemics in the country, diminish the socio-economic impact of STIs and HIV/AIDS on Panamanian society, increase coverage and access to available therapies, promote healthy lifestyles in order to improve the health of the population with special emphasis on groups that are vulnerable to these diseases, develop research that will increase knowledge about STIs

and HIV/AIDS and the factors that determine these diseases, and guarantee human, physical and financial resources for the adequate operation of the program.

The National STIs and HIV/AIDS Program has six components for addressing these diseases in an integrated manner: management, prevention and promotion, integrated care, laboratories and blood banks, epidemiological surveillance, and research.

The most successful project of the program is called Educational Strategy for Preventing STIs and HIV/AIDS in Students in the Fourth, Fifth and Sixth Grades. The project has a close connection to the main objective of the Multisectorial Strategic STIs and HIV/AIDS Plan – namely to reduce the prevalence of these diseases through the implementation of an information, education and communications plan aimed at vulnerable populations including school-aged youth.

The project consists of an educational and preventive strategy aimed at children and adolescents between 10 and 14 years of age who attend the fourth, fifth, and sixth grades of elementary school. The objective is to encourage children to develop healthy lifestyles and safe sexual practices. The project involves teachers, parents, health providers and the general community through activities such as the use of popular theatre and other playful methodologies, work with parents, use of didactic guides, teaching of skills, and workshops for teachers and health providers as well as for the community (Table 4).

Table 4: Project Beneficiaries

Population	2004	2005	Total
Students	5,554	3,381	8,935
Teachers	577	276	853
Parents	300	300	600
Health Personnel	69	69	138
Total	6,500	4,026	10,526

Source: Ministry of Health of Panama

The main results of the program in 2004 were: diagnosis of educational needs identified through a survey on Knowledge, Attitudes and Practices; establishment of 10 children’s clubs against AIDS in pilot schools, and training of health personnel and 70 teachers to train and teach others on the topic of sexual and reproductive health with emphasis on preventing HIV. In addition, theater productions led to development of didactic guides, notebooks and an educational video.

The survey on Knowledge, Attitudes and Practices was carried out, in 762 children, 93 parents, 133 teachers and 41 health professionals. The main findings of the survey were that 26% of the children had a boyfriend or girlfriend, and 10% had had sexual relations; 32% said the main reason they had sexual relations was curiosity. Television was identified as the main source of information regarding sexuality.

Only half of the parents surveyed felt that they were prepared to speak about sexuality to their children. However, 49% agreed that children between the ages of 9 and 12 should

be spoken to about sex. 86% of the parents had received information on HIV/AIDS, and 83% correctly identified the meaning of AIDS from a multiple-choice list. 68% of the teachers did not feel prepared to educate others about sexual and reproductive health, and said they required training regarding STIs, sexual abuse and HIV/AIDS (60%, 55% and 48% respectively). Although 59% of health personnel had received training in sexual and reproductive health, many felt that they needed training on sexual abuse (75%), STIs and HIV/AIDS (68%) and puberty (56%).

This program began as a pilot project, and now seeks to introduce itself into two new health regions in the country in 2006, Colón y Kuna Yala. A cost-effectiveness study is planned jointly with the Instituto Conmemorativo Gorgas de Estudios de la Salud and the Ministry of Education. Given the positive results obtained from the program in the past two years, there are additional actions planned for the future: implementation of the project in 12 new schools each year, training children to be peer educators so that they can transfer what they learn to other children, running the “School for Parents” program in other pilot schools, forming theater clubs against AIDS in all participating schools, launching initiatives for project participants and evaluating the interventions.

*Foundation For the Welfare and Dignity of People Affected by HIV/AIDS
(PROBIDSIDA)
Project for Prevention, Control and Follow-Up of HIV/AIDS in Panama*

PROBIDSIDA is a non-governmental, non-profit organization integrated by PLWH, health professionals and community volunteers. Its main objective is to protect the welfare, right to life and dignity of PLWH, as provided by the Constitution, law, regulations and international agreements. The organization was established in 1997, when it appealed on the internet for international support for suing the Panamanian Social Security Office in court in order to obtain antiretroviral treatment for people who were HIV-positive. It was not until May 1999, after 20 months of promotion as well as public defense, that the Social Security Office (CCS) approved antiretroviral therapy for all insured individuals. This was an important step since triple therapy restored the physical capacity of infected people, allowing them to reintegrate and have active and productive lives.

When PROBIDSIDA was established, there already were nine NGOs working on HIV and AIDS in Panama. Two exclusively focused on preventing HIV; HIV was not the main objective of the seven others. However, none of the groups was directed by people who were HIV-positive.

As the organization became more involved with the problems faced by people with HIV, its focus grew to incorporate defense of human rights and dissemination of information on prevention and awareness to the general society as well as the government sector through complaints to the media. Because of these actions, the organization became recognized both nationally and internationally, turning it into one of Panama’s leading NGOs on the topic. Because of the stigmatization of people with HIV, the organization decided to broaden its horizons in the field of prevention, directing a large part of its

activities to education and prevention of STIs and HIV in the general population and vulnerable groups. The organization currently has a team of 18 people. Most are PLWH who work in various areas including management, education and primary care.

The organization's most successful project was Prevention, Control and Follow-up of HIV/AIDS in Panama, which had a preventive focus and was implemented for a three-year period between 2001 and 2003. The main objective was to support efforts of the Ministry of Health and non-governmental organizations to reduce the effects of HIV infection in the Panamanian population. The people who benefited from this project were commercial sex workers, indigenous groups and descendants of African origin, MSM, vulnerable youth and the general population.

The project was directly related to Strategic Objective 1 of the Multi-Sectoral Strategic Plan, which calls for reducing the incidence of STIs and HIV. In particular, the project was directed at implementing an IEC plan for STIs and HIV/AIDS for the most vulnerable groups. It indirectly affected the implementation of services and counseling, as well as voluntary HIV tests corresponding to Strategic Objective 2. In addition, the project was related to Strategic Objective 4, which calls for increased efforts to defend the human rights of PLWH.

The International Spanish Cooperation Agency financed the project in 2001, and requested the foundation to organize prevention workshops directed at health personnel, PLWH and people from communities in different regions of the country. The foundation received 53,000 euros to carry out the project in 2002. The most important need for the future is to raise funds to continue the project.

Phase I: Educating trainers in STI and HIV/AIDS prevention. The general objective outlined in the first phase of the project was to train 75 people as health promoters in five three-day workshops throughout Panama over a period of one year. The project was extended, and a total of seven workshops were held, with the participation of 112 people. The HIV/AIDS Knowledge Pre-Evaluation Test and Post-Test revealed that participants had a basic knowledge of STIs and HIV/AIDS. The percentage with knowledge was 86% in the pre-test and 94% in the post-test. The individuals who were trained were members of NGOs, health personnel or volunteers who work with CSW, MSM and PLWH. The topics covered in the workshops were human sexuality, and STIs and HIV/AIDS awareness. The training improved relations between PLWH and healthcare workers, and led to reduced discrimination and rejection in certain areas.

Phase II: Training health personnel in human rights, emotional support, biosecurity guidelines, adherence to treatment, guidance and counseling of PLWH. During this phase of the project, four workshops were held, in which 49 people participated. The workshops took place in the Panama City metropolitan area and Colon, Azuero (Los Santos and Herrera), Chiriquí and Veraguas. Both the pre-evaluation test and the post-test revealed that participants (86% and 96%, respectively) had basic knowledge regarding biosafety standards because their health centers or hospitals had educated them on this issue. Staff trained in the provinces continue to receive updates through the PROBIDSIDA web page.

They also continue attending workshops and disseminating the material learned in their own regions and work areas. The interactive methodology allowed attendees to evaluate situations in their own areas and then apply their knowledge as needed.

Results. PROBIDSIDA has executed various educational projects with support from international and national organizations. It has trained facilitators, private and public school students, health personnel, employees from the private sector and organized civil society groups as well as the general community. In four years, more than 350 facilitators were trained in preventing STIs and HIV, and they in turn shared what they learned in their own communities and work areas. During an interview, the director of PROBIDSIDA stated that the most important result of the project was the impact that the testimony of PLWH had on people who do not live with the disease. The director said testimonies create awareness of HIV and promote activities that must be developed to prevent HIV/AIDS.

*Project on Prevention of STIs and HIV/AIDS in the Border Zone and Port Area
United Nations International Development Fund*

This UN project aimed to reduce the incidence of STIs and HIV among migrant workers, improve the quality of care for workers with STIs and HIV, and encourage the use of better public information strategies targeted at the workers in the Bocas del Toro, Chiriquí and Colón provinces. A diagnostic instrument was designed to ascertain the need for interventions in the areas of knowledge and prevention of STIs and HIV, negotiation and use of condoms, as well as related issues such as self-esteem, gender, and safe sex practices. Other achievements include training 120 facilitators (40 workers per province) on issues related to STIs and HIV/AIDS, self-esteem, gender, and drug use. Some 3,000 people benefited from the process of informing and counseling peers.

TREATMENT AND SUPPLIES

Testing. By 2004, there were laboratories for HIV testing in each of the 14 assigned districts of the Ministry of Health. But a person needed medical authorization to undergo testing. At present, tests are available in public facilities for diagnosis, confirmation, and follow-up. The number of test kits purchased by the government annually is based on the number of HIV cases reported; the goal is to obtain one or two tests per reported case. Another factor is the budget assigned for HIV/AIDS each year. Over the last three years, Panama has acquired more test kits, even though their prices tended to rise year after year. While the cost of follow-up tests has remained steady since 2003, fewer of them were acquired last year.

HIV testing is mandatory for pregnant women. Nevertheless it does not always occur. Refusal to take this test is frequently attributed to a lack of awareness of the possible consequences, fear of stigmatization and social rejection should the test prove to be positive, or simply because women do not consider themselves to have been at risk of infection. By 2004, 74 female HIV cases had been identified – an overall prevalence rate of 0.7%. However, only 30% of these women received ART from the Ministry of Health.

When a pregnant women is diagnosed as seropositive and it is determined that she has not received triple therapy, Zidovudine is prescribed in order to prevent mother-to-child transmission.

Condoms. Regulation 119 of General Law 3 puts the Ministry of Health in charge of ensuring that all health clinics and facilities, whether public or private, have enough condoms to meet the needs of people who request them. At the state level, about 100,000 units are acquired each year; nevertheless, as with the HIV test kits, this number is subject to budgetary limitations for each fiscal period. Condoms may either be distributed free of charge or sold. To be distributed free, brands must be registered with the Ministry of Health, through its Department of Pharmaceuticals and Drugs. In order to issue this authorization, they must comply with internationally accepted standards and be manufactured with materials approved by the World Health Organization.

ARV Treatment. Through figures supplied by the National Program on AIDS, it is known that treatment coverage for 2004 was 58%; according to the Children’s Hospital records, 3.4% of those covered were children under five years of age. There are no records regarding access to ARV by age group or vulnerable group, nor have files been kept on patient resistance to antiretroviral medications.

Panama provides six different types of ART for four different groups: mothers of newborns, newborn babies, children and adults. A specific treatment has been defined for each group and an alternative therapy is also available for most groups (Table 5).

Table 5: ART by Group

Type	Antiretroviral Treatment
Adults	Zidovudine + Lamivudine + Efavirenz
Alternative for adults	Zidovudine + Lamivudine + Indinavir
Newborns	Zidovudine for six weeks
Children	Zidovudine + Lamivudine + Lopinavir/Ritonavir
Alternative for children	Lamivudine + Estavudine + Lopinavir/Ritonavir
Prevention of MCT	Zidovudine, if the mother is not receiving triple therapy

Source: PAHO and WHO Fact Sheets on HIV/AIDS 2004

Individuals with prescriptions may obtain ARV free of charge at the following medical facilities and institutions: Santo Tomas Hospital, Children’s Hospital, the Social Security System, as well as at the public health clinics that are located in the regions of West Panama, Colón, Azuero, Veraguas and Chiriquí.

Funding for ARVs is provided through the national budgets of the Social Security System and the Ministry of Health. By 2004, the average annual cost of treatment in the public sector for adults was US\$1,251, and US\$1,372 for alternative therapies. Outlays for ART by the MoH totaled \$2.5 million in 2003, \$3 million in 2004 and \$2.8 million in 2005, while the Social Security System spent \$2.9 million in 2003, \$3.5 million in 2004, and \$3.9 million in 2005. Funds assigned by the government to prevent perinatal transmission

have been on the rise in recent years. In 2001, the government provided \$51,222 for this purpose, and in 2003, the sum increased to \$191,384.²⁵

Registration. The Ministry of Health, through its Department of Pharmaceuticals and Drugs, is in charge of regulating pharmaceuticals in Panama. Antiretroviral medicines are included on the list of essential medicines, and thus are subject to the department's inspection and authorization for sale. The requirements for registering an antiretroviral medicine are the same as those for any other kind of medicines, and are specified in the Law on Pharmaceuticals since 2001. The main requirements include: certification of analysis, Good Manufacturing Practices, and Right to Free Sale issued by regulating authorities in the country of origin, clinical studies, stability studies (for new products), sale permits, product monograph, its qualitative formula, specifications on the finished product, pre-registry checks and endorsement by an appropriate pharmacist who belongs to the National College of Pharmacists. Furthermore, two post-registration analyses are carried out during the five-year period in which the authorization is in effect.

Procurement. In recent years, government institutions in charge of supplying these medications have purchased progressively greater quantities. The quantity purchased by the MoH increased 19% in 2004 compared to 2003, but declined 9% in 2005. However, purchases by the Social Security System have increased steadily, rising 15% in 2004 and 13% in 2005. The amount of ARV purchased is determined based on the number of people who require treatment as indicated by medical prescriptions. Decisions about who needs to receive treatment are based on laboratory tests counting the number of CD4 lymphocytes, viral load, and the presence of opportunistic infections. Purchases generally are made once or twice a year.

No antiretroviral medicines are manufactured in Panama. All medicines provided for HIV patients are brand name drugs. Generic drugs are not available in Panama because none of the pharmaceutical companies manufacturing generics have participated in the procedures for obtaining the required permits. To obtain a permit, the first requirement is a certificate of bio-equivalency, which must be issued by the Ministry of Health; the company must then comply with the remaining requirements as for drug sales.

Prices of medicines are negotiated through national and international bidding processes, and the medicines are mostly purchased in a centralized fashion, although some are obtained directly at the institutional level (for example, by the Santo Tomás Hospital). In 2003, Panama benefited along with the other Central American nations from joint, sub-regional negotiations with companies that produce ARV. As a result, government institutions obtained discounts of up to 50% of the price of some of these medications. Moreover, the government was assured that prices would be reduced even more in the future relative to private sector prices.

No information was obtained concerning the likely impact of the Central American Free Trade Agreement (CAFTA) on drug acquisition, although North American

²⁵ Report on progress made in the country in response to the HIV/AIDS epidemic. Ministry of Health, 2005.

pharmaceutical companies are expected to file requests to participate in the public bidding processes for drugs. In addition, it is expected that once CAFTA goes into effect with the United States, changes will be made to the law regulating drug purchases. CAFTA provisions concerning Panama differ from those in the agreements involving other Central American nations.

References

Asociación de hombres y mujeres nuevos de Panamá. Information Bulletin, (Boletín informativo) Vol. 8, # 7. February, 2006.

Banco Mundial (The World Bank). HIV/AIDS in Central America: Epidemic and Priorities for STD Prevention) *VIH/SIDA en Centroamérica: La Epidemia y Prioridades para su Prevención*. Latin American and Caribbean Bank, Global HIV/AIDS Program, September, 2003.

CDC, Global AIDS Program for Central America. Program Profile, 2004

Document on Arbitrary Discrimination adapted from the UNAIDS Protocol.(www.unaids.org)

Jáuregui Rommel. (A Quick Diagnosis: An Analysis of the Situation of Orphans and Vulnerable Children Affected by HIV/AIDS in Panama) *Diagnóstico Rápido: Análisis de la Situación de Huérfanos y Niños Vulnerables afectados por el HIV/AIDS en Panamá*. Dec 2005.

Ministry of Health, Panama, Dirección General de Salud, Department of Health Surveillance, “Epidemiological Situation of AIDS in Panama”, *Situación epidemiológica del sida en la república de Panamá 1984-2004*

National STD, HIV,AIDS Program. Organization and Operations Manual, *Manual de organización y funcionamiento*. Panamá 2002.

National Program for STD/HIV/AIDS of the Ministry of Health. Report about the progress regarding the country’s response to the HIV/AIDS epidemic: Panama.2005

Núñez, Silvestre E. Ethnic and anthropological exploration of the Kuna region and peripheral metropolitan Kuna communities. 2005

Panamanian Red Cross. Strategic HIV/AIDS Plan 2004 – 2008.

PASMO/USAID and others. Hidden Risks in Central America, *A multi-national study 2003-2004, knowledge, attitudes and practices regarding HIV, use of the condom and other health topics*, Panama. Dec 2004.

PASCA, USAID, CID Gallup. *Perception about AIDS in Central America*, Public Opinion Survey in Central America. 2003

PAHO/WHO. Fact Sheets Regarding Care and Treatment for HIV/AIDS Infections, 2004

UNAIDS. Protocol for Identifying Discrimination against People who Live with HIV/AIDS, Best Practices Collection, UNAIDS, Geneva, 2000

ANNEX 1. ARBITRARY DISCRIMINATION IN PANAMA 2006

Area	Finding	Evidence
Healthcare		
Denial of treatment due to HIV/AIDS status	Occurs in practice	Not addressed by the law, although drug users, prison inmates and former inmates, and sex-workers have been denied treatment. The Ministry of Health and the Social Security System should provide treatment to all patients who are eligible.
HIV-testing without consent	Occurs in practice	Occurs in the private sector, particularly in casinos. Often, employees are required to have HIV-testing.
Failure to inform people of HIV test results	Occurs in practice	Occurs in both health centers and private enterprises; in the latter, employees are simply fired without an explanation. All HIV-testing by the MoH is performed with pre-test and post-test counseling, and as such, failure to inform a person of their HIV-test results does not occur. What takes place in the private sector is due to ignorance of the law.
Compulsory notification of sexual partner(s) or relatives of an HIV/AIDS patient regarding his or her condition	Stipulated in the regulations and by-laws (R)	If a person is HIV-positive, he or she has one month to inform his or her partner(s), but in practice, this is often not done.
HIV-test results are not handled in a confidential manner, and other people are told the names of people who test positive or are even permitted to examine patient files.	Occurs in practice	Many cases occur at healthcare centers
Employment		
Mandatory testing before hiring	Occurs in practice	Many cases have been reported to PROBIDSIDA Foundation.
Mandatory testing during the course of employment	Occurs in practice	Many cases have been reported to the PROBIDSIDA Foundation.
Questions about HIV/AIDS status and/or lifestyle on application forms or during job interviews	Occurs in practice	Company doctors have asked job applicants about their sexual behavior
Lack of confidentiality about HIV/AIDS status	Occurs in practice	Takes place at various health care institutions
Employees getting fired or shifted to new positions due to their HIV/AIDS status	Occurs in practice	Reports of cases of employees getting fired or shifted to new positions for being HIV-positive.
Restrictions due to employees' HIV/AIDS status (i.e., promotions, job sites, training opportunities, or work benefits)	Occurs in practice	Reports of these types of restrictions occurring
Job applicants being denied employment due to HIV/AIDS status	Occurs in practice	Cases have been reported
Judicial/Legal Procedures		
Unequal treatment before the law for people living with HIV/AIDS or those associated with groups considered to be high-risk (for example, refusal to initiate a case involving a victim who is a PLWH, or denial or limitation of due legal process, such as the right to review and appeal, to be legally represented, notified, and the right to privacy.	Occurs in practice	PROBIDSIDA Foundation handled a case.

Prison Management		
Restrictions in access to healthcare and treatment	Occurs in practice	In some cases, inmates with serious health conditions are not provided care or treatment, but it is not known how often this happens.
Housing		
Mandatory testing, declaration of one's serological condition, and/or requiring a certificate of HIV status as conditions for access to housing or for the right to remain in housing.	Occurs in practice	Reports of people who have been asked to undergo HIV testing and were denied housing when the test results were positive.
Education		
Denial of access to schooling due to students' HIV/AIDS status	Occurs in practice	In 2005, a school principal refused to allow an HIV-positive girl to attend classes.
Family life and reproductive rights		
Mandatory pre-matrimonial HIV testing	Stipulated by law and occurs in practice	Mandatory by law
Mandatory prenatal HIV testing		By law, pregnant women are required to undergo HIV testing.
Mandatory abortions/sterilization of pregnant women with HIV/AIDS	Occurs in practice	Cases took place when the epidemic began and may still occur.
Withdrawal or unfavorable modification of paternal custody rights based on a parent's HIV/AIDS status	Occurs in practice	One case reported in 2004
Insurance and other financial services		
Denial or restrictions applied to social security or national insurance policies due to the applicant's HIV/AIDS status	Occurs in practice	A person with a chronic disease may not acquire Social Security benefits <u>MoH reports that</u> some people unlawfully attempt to obtain benefits after finding out their HIV/AIDS status.
Denial or restrictions applied to insurance because the applicant is HIV positive, has AIDS, or belongs to a group that is considered highly vulnerable	Occurs in practice	This is not stipulated by law. Insurance companies do not officially permit such practices.
Denial or restrictions applied to requests for access to credit (for example, bank mortgages) because the applicant is HIV positive, has AIDS, or belongs to a group that is considered highly vulnerable	Occurs in practice	Cases have been reported.

Source: PROBIDSIDA - Panama and Ministry of Health

ANNEX 2. FORM FOR SELECTING SUCCESSFUL INTERVENTIONS

Name of the Institution:	
Participation: <input type="checkbox"/> Program <input type="checkbox"/> Project	
Country: Region: <input type="checkbox"/> Urban <input type="checkbox"/> Rural	Type of activity addressed: <input type="checkbox"/> Prevention <input type="checkbox"/> Treatment <input type="checkbox"/> Mitigation of Damage <input type="checkbox"/> Legal actions in defense of human rights <input type="checkbox"/> Gender <input type="checkbox"/> Other (Please indicate):
A. GENERAL INFORMATION OF THE ORGANIZATION THAT IS CARRYING OUT THE SUCCESSFUL EXPERIENCE	
1. Type of Organization: <input type="checkbox"/> Community Organization <input type="checkbox"/> Non-governmental organization <input type="checkbox"/> Governmental Organization <input type="checkbox"/> Private Sector <input type="checkbox"/> Associations <input type="checkbox"/> Other (Please indicate):	2. Year it was established: <input type="text"/> 3. Description of the Organization: Background Objectives Personal

B. INFORMATION ABOUT THE PROJECT-PROGRAM	
Name of the Project:	
1. Type of activity Addressed: <input type="checkbox"/> Prevention <input type="checkbox"/> Testament <input type="checkbox"/> Mitigation of the damage <input type="checkbox"/> Legal actions in defense of human rights <input type="checkbox"/> Gender <input type="checkbox"/> Other (specify):	2. Year it initiated: <input type="text"/> 3. Year it ended: <input type="text"/> 4. Description of the Project: Historical Background Objetives Personnel

5. Population Benefited:	
<input type="checkbox"/> Commercial Sex Workers	<input type="checkbox"/> Prison inmates
<input type="checkbox"/> Indigenous groups and Afro-descendants	<input type="checkbox"/> Vulnerable Youth
<input type="checkbox"/> Men who have sex with other men (MSM)	<input type="checkbox"/> Orphans
<input type="checkbox"/> Migrant groups in affected regions and direct victims of the epidemic	<input type="checkbox"/> Businessmen
<input type="checkbox"/> Military and Police	<input type="checkbox"/> Manufacturing Plant Employees
	<input type="checkbox"/> Other (specify):
6. Sources of Finance:	
7. Reasons explaining why it is considered a successful experience:	
<ul style="list-style-type: none"> • Impact • Coverage • Access • Particular characteristics, innovation, permanence, methodology. <p>This data must contain qualitative, quantitative and demonstrative success indicators. Files, pamphlets, samples of work can be attached.</p>	
8. Future Perspectives of the Project	
9. Relationship to the Strategic Plan of the Country Regarding AIDS	
10. Sources of Finance.	
11. Relationship to the AIDS problem. What is the relationship does the dimension and severity of the HIV/AIDS problem have in the country?	
Contact:	
Name of Contact:	
Address:	
Tel(s):	
Fax:	
e-mail:	
Web Site:	

ANNEX 3. FORM FOR EVALUATING DISCRIMINATION

Questions relating to the UNAIDS Discrimination Protocol

Are there agreements or communications forums that fight against discrimination?

Are there agencies for defending human rights?

Is there an NGO whose objective is defending the human rights of PLWHA?

What is the degree of coordination among the agencies that defend human rights?

Are there information and educational campaigns directed at fighting discrimination?

People Interviewed Regarding the Discrimination Survey

- Fernando Cano, PASCA, Guatemala
- Janeth Flores, National Commission of Human Rights (Comisión Nacional de Derechos Humanos), Honduras
- Alexia Alvarado, PASCA and President, Alliance for Legislation (Alianza para la Legislación), El Salvador
- Karla Aburto, VIH-AIDS Advisor, UNFPA, Nicaragua
- Eda Quirós, Head of Health Human Resources, Ministry of Health, Costa Rica
- Maite Cisneros, Ombudsman, Panama

ANNEX 4 SUMMARY OF SUCCESSFUL HIV/AIDS EXPERIENCES IN PANAMA 2006

Institution	Project	Initiated	Direction	Population Benefited	Zone
PROBIDSIDA Foundation	Prevention, control and follow-up of HIV/AIDS in Panama Phase I and II	2001	Prevention	Sex workers, indigenous groups and afro-descendants, MSM, vulnerable youth and the general population.	Urban and rural
Association of New Men and Women of Panama (AHMNP)	Free condoms	2002	Prevention	MSM	Urban
National HIV/AIDS Program	Educational strategy for preventing STIs and HIV/AIDS in 4-6th graders	2004	Prevention and Promotion	Fourth, fifth and sixth graders	Urban and rural
Panamanian Red Cross	STIs and HIV/AIDS Prevention Project for Prison inmates	2004	Prevention	Prison inmates	Prisons



For more information, please contact:

Human Development Department

Latin America and the Caribbean Regional Office

The World Bank

1818 H St. NW,

Washington, DC 20433

Tel: +1 202 458 9730

Fax: +1 202 614 0202

mbortman@worldbank.org