Latin America and the Caribbean

and The Global HIV/AIDS Program

THE WORLD BANK

Reducing HIV/AIDS Vulnerability in Central America:

Costa Rica: HIV/AIDS Situation and Response to the Epidemic

December 2006

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Cover photos: Costa Rica HIV/AIDS Situation and Response to the Epidemic
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Reducing HIV/AIDS Vulnerability in Central America

Costa Rica: HIV/AIDS Situation and Response to the Epidemic

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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, Costa Rica, World Bank

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Acronyms and Abbreviations

AED/Futures	Academy for Educational Development and the Futures Group
AIDS	Acquired Immunodeficiency Syndrome
ALCA	Free Trade Area for the Americas
ART	Antiretroviral Therapy
ARV	Antiretroviral medicines
ASOVIHSIDA	Association of People who Live with AIDS
BNPP	Bank-Netherlands Partnership Program
CAFTA	Central America Free Trade Agreement
CCP	American Population Studies Center
CCSS	Costa Rican Social Security Office (Caja CosARTricense de Seguro Social)
CDC	Centers for Disease Control
CEPRESI	Center for AIDS Education and Prevention – Nicaragua
CIPAC	Human Rights Research and Promotion Center for Central America
CONADEH	National Human Rights Commission of Honduras
CONASIDA	National Council for Integral HIV/AIDS Care
CPMP	Committee for Proprietary Medicinal Products
CCSS	Costa Rican Social Security Office
CSW	Commercial Sex Worker
CTAMS	Technical Commission for Medical and Social Care
FDA	Food and Drug Administration of the United States
FUNDESIDA	Foundation for the Development of the Fight against AIDS
GDP	Gross Domestic Product
GTZ	German Agency for Technical Cooperation
HIV	Human Immunodeficiency Virus
IAFA	Institute for Alcoholism and Drug Dependency
ICAS	Central American Institute for Social Action
ICMRT	International Center for Medical Research and Training
IDA	International Development Association
IDB	Inter-American Development Bank
IDESPO	Institute for Population Studies
IDU	Injecting Drug User
IEC	Information, Education and Communication
IIDH	Inter-American Institute of Human Rights
ILO	International Labor Organization
INAMU	National Women's Institute
INCIENSA	Institute for Research and Training in Nutrition and Health
INEC	National Institute of Statistics and Censuses
INISA	Health Research Institute
INS	National Insurance Institution
IPEC	International Program on the Elimination of Child Labor
LCSHD	LAC Human Development Department
LCSHH	Health Sector

MINSA	Ministry of Health
MSM	Men who have Sex with Men
NGO	Non-governmental Organization
OPEC	Organization of Petroleum Exporting Countries
PAHO	Pan-American Health Organization
PAIA	Priority Areas for Interdisciplinary Action
PANI	Child Welfare Office
PASCA	Central American AIDS Action Project (Proyecto Acción SIDA para Centroamérica)
PASMO	Pan-American Association for Social Marketing
PLWH	People Living with HIV
PLWHA	People Living with HIV/AIDS
PNS	National HIV/AIDS/STD Program
RHS	Reproductive Health Survey
SIDA	Swedish International Development Cooperation Agency
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
UCR	University of Costa Rica
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VIH	Human Immunodeficiency Virus
WBIHD	World Bank Institute Human Development Division
WHO	World Health Organization
WTO	World Trade Organization

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[8] The Global Fund to Fight AIDS, Tuberculosis and Malaria.

Executive Summary – Regional Overview [9]

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

[9] 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 report 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.[10] 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.

[10] 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.[11]

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

[11] 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.

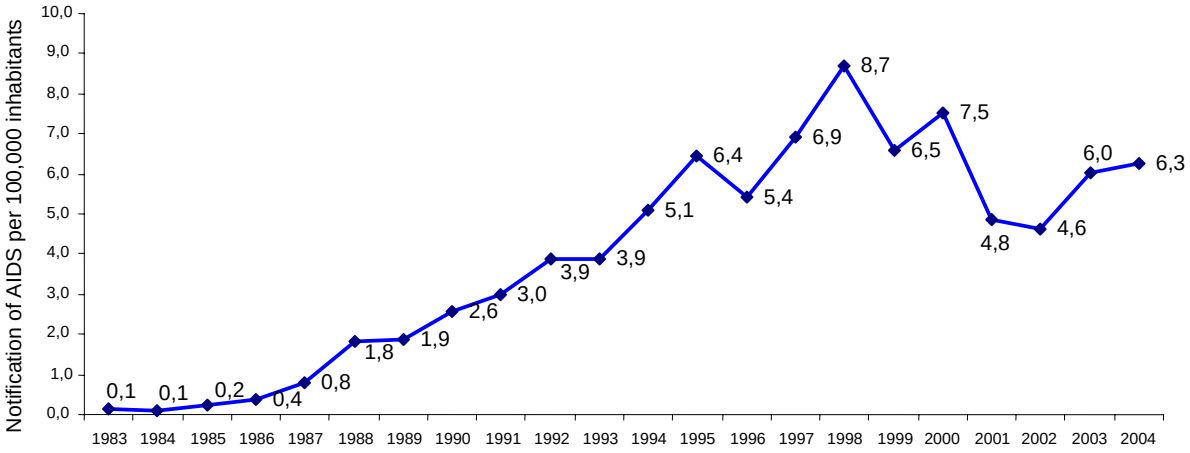
Costa Rica: HIV/AIDS Situation and Response to the Epidemic

This section presents information on HIV and AIDS epidemiology in Costa Rica, and on how the general population perceives the epidemic. The final section includes information on the national response to HIV and AIDS.

HIV and AIDS Situation

From 1983 to 2004, a total of 3,196 AIDS cases were registered. The annual incidence increased during the first 16 years of this period (Graph 1). After 1998, a point of inflexion, the rate oscillated between 6.5 and 4.5 people per 100,000 people. The figures for this latter period may be explained by various factors: data from 2001 on are preliminary, there may have been a reduction in the number of cases related to changes in people's behavior, there may be underreporting, or the introduction of ART.

Graph 1. AIDS Incidence Rate 1983-2004[12]
per 100,000 population



Source: Ministry of Health and the CCP-UCR 2006

In 2003, UNAIDS estimated that HIV prevalence was 0.6% of the population 10-49 years old. There were approximately 12,000 people living with HIV, of whom 33% were women 15-49 years of age. While data are lacking, it is believed that 1.4 million people are vulnerable to the epidemic.[13] It remains unknown how many of these people have been tested for HIV. Table 1 presents estimates on the number of HIV-positive cases.[14]

[12] Figures for the years 2001- 2004 are preliminary data from the Ministry of Health 2006.
[13] Schwab N and others. *Optimizing the Allocation of Resources for HIV Prevention in Costa Rica*, The World Bank, 2004.
[14] Compulsory communication of HIV cases is a recent event in the country. In 2006, the Ministry of Health started systematic epidemiological surveillance of HIV/AIDS.

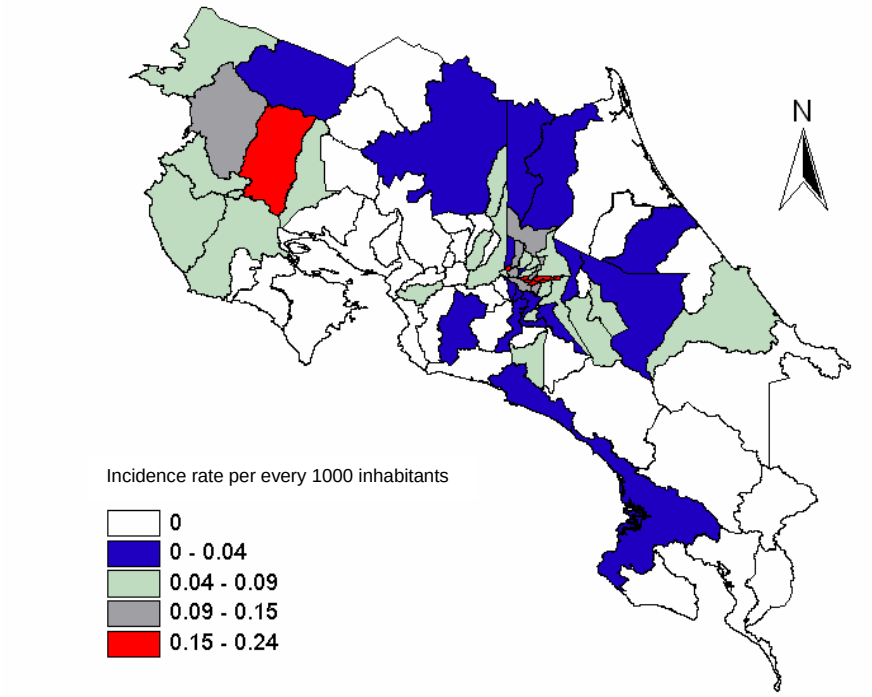
Table 1. HIV and AIDS in Costa Rica

Indicator	Value
Number of children and adults living with HIV 2003	12,000 (range: 6,000-21,000)
HIV prevalence among 15-to-49 year olds, 2003	0.6%
Percentage of PLWH on ART (%) 2004	68%
Number of women (15-49) who live with HIV, 2003	4,000
Deaths due to AIDS (adults and children) in 2003	900 (range: 400-1600)

Source: UNAIDS and Ministry of Health

An assessment by the Ministry of Health in 2005 shows the spatial distribution of the disease by district (Figure 1). These rates were calculated based on new cases reported in 2004 (the district in red –Bagaces– includes some cases from 2003 that were notified in 2004). Almost all districts have cases, but rural areas have fewer cases. Most cases are concentrated in the Greater Metropolitan area, where the largest percentage of the population lives, and where people from rural areas come for treatment. The capital city, San Jose accounts for 58% of all HIV cases in the country, and the city of Alajuela has 12%.

Figure 1. HIV Incidence Rate by District in Costa Rica 2004



Source: Based on data from the Statistical Information Unit, Ministry of Health and INEC.

In addition, the metropolitan area is characterized by high mobility and interaction among people from diverse social backgrounds. However, according to specialists, the province with the greatest incidence of HIV currently is Heredia, although the majority of people receive treatment in hospitals located in the metropolitan area. Patient records are filed according to place of origin, so it is possible to know where cases originate. Populations

in border areas also are at higher risk of acquiring HIV, a pattern that confirms the relationship between HIV and population mobility.

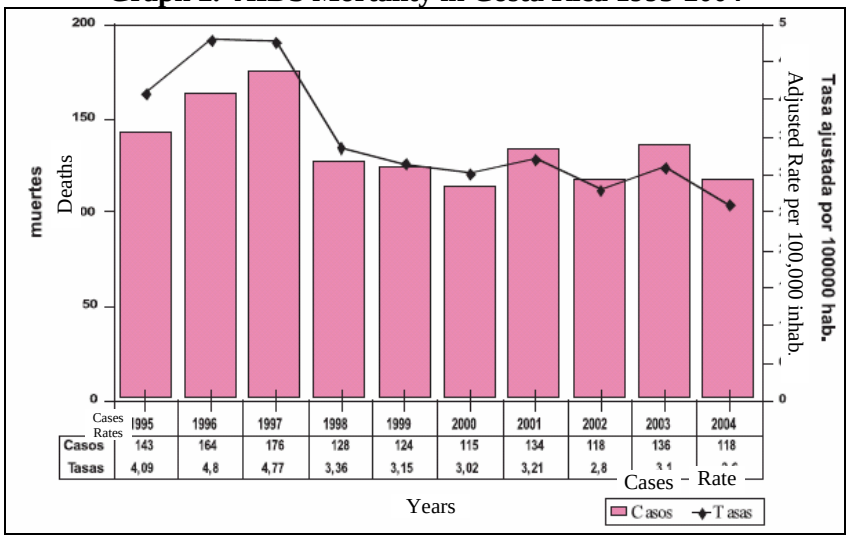
Until September 2001, of the total number of reported AIDS cases, 1,948 were male and 271 female. The male-female ratio has changed considerably: in 1992, it was 13-to-1 and in 1999, 5-to-1. In 2004, there were 266 new cases, of which 86% were males, meaning there were 5.4 new cases in males for each new case in a female. The data reflect a clear feminization of the epidemic.

The most affected age group consists of 25-to-39 year olds; they represent 58% of all cases, this means that most transmission happens in adolescents and young adults. This reinforces the importance of concentrating preventive efforts in this group, especially since these are people of reproductive age and productive age.

Since the epidemic began, transmission has been mainly sexual, with greatest frequency among men who have sex with men (44%), followed by heterosexuals (25%) and bisexuals (16%).[15] Since 2000, the number of new HIV cases has been decreasing every year, but experts believe there is under-reporting. Transmission in hemophiliacs and through blood transfusion seems to have been interrupted; these account for 3% of all cases. Perinatal transmission comprises 1.3% of cases, and transmission among intravenous drug users about 1%.

According to data from the Ministry of Health, the number of deaths from AIDS increased five times between 1990 and 2003, and peaked in 1996-1997. The mortality rate has tended to decrease since 1997 (Graph 2). Of the total number of deaths, 78% were males and 22% were females. 53% of all deaths are in the 35-to-49 year age group.

Graph 2. AIDS Mortality in Costa Rica 1995-2004



Source: Statistics Unit, Ministry of Health, 2005. *Deaths - Adjusted Rate per 100,000 inhabitants*

[15] HIV/AIDS and STIs Control Unit, CCSS, November 2001.

The trend after 1997 could reflect the fact that HIV and AIDS became a national priority in this period, and as a result, initiatives were developed to prevent the disease and the Social Security Administration (CCSS in Spanish) began providing ART as well as third-level care that included specialized integrated services. The initiatives include: the requirement that cases be reported, implementation of the General AIDS Law, start-up of the National Council for HIV/AIDS Integrated Care, safe sex campaigns, and provision of integrated health services with a special focus on at-risk populations.

Epidemiological Surveillance. Costa Rica lacks an efficient system for collecting data on the disease. As a result, the dimensions and complexity of the epidemic are probably underestimated. In general, little is known about HIV in mobile populations, migrants – particularly people who are undocumented and thus do not go to health centers – and other vulnerable groups. The records that are available concern people living with AIDS or who have voluntarily submitted to testing, since HIV tests are voluntary except in certain cases.

The Epidemiological Surveillance System for HIV and AIDS collects data provided by HIV/AIDS clinics and some private institutions throughout the country. This information is gathered on epidemiological forms that include an ID code for gender, age and patient address. These characteristics define the system as a first-generation, passive surveillance system. Information in the system is not reliable, since there is no standard method to create an ID code. In addition, information regarding patients is not carried over; as a result, patients can be registered more than once. There may be cases in which people have been registered each time they are tested – even without having confirmatory positive results – as required by the guidelines.

Tests are performed in all clinics and hospitals that are part of the Social Security Administration (CCSS), the institution responsible for providing medical attention for the entire population. Tests also are performed in private laboratories and clinics. Reporting of positive results is compulsory. Positive cases involving children are detected in antenatal screening programs.[16] If a child is already hospitalized, the hospital must do everything that is clinically necessary to improve his or her health. If doctors believe an HIV test should be administered, they do not require parental consent for executing it.

Lack of information is an obstacle to development of programs and policies that focus efforts and establish effective strategies. A new, more trustworthy protocol is needed for identifying patients and protecting their data (confidenciality) using a technological platform and an interconnected system for registering and consolidating all cases in the health system.

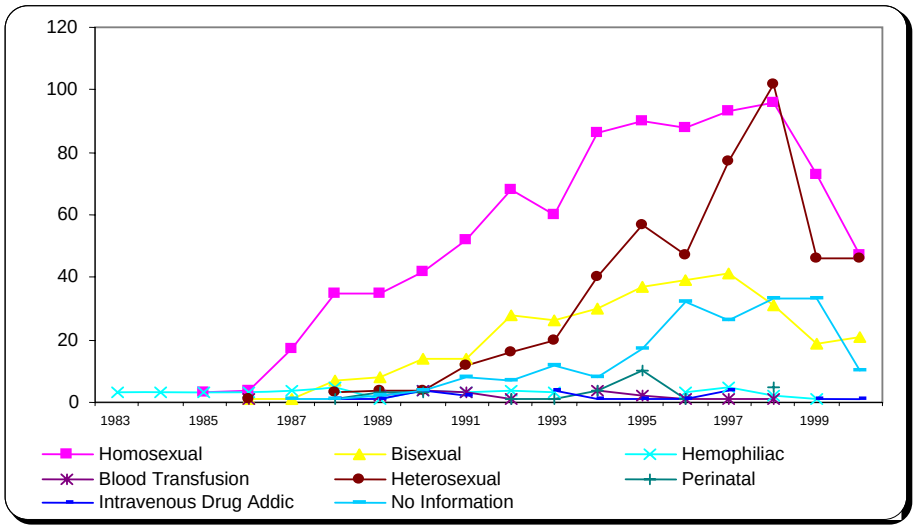
Vulnerable Groups

Graph 3, which covers 1983 to 1999, shows that different groups have been identified as vulnerable. Although information is available only for certain groups, it must be noted

[16] Immunological Service at the National Children's Hospital.

that the spectrum is broad and encompasses numerous population groups. According to Schwab's estimates in 2002, 0.23% of the vulnerable population was infected with HIV.[17] UNAIDS and the Ministry of Health estimate that for every person registered as positive, four may actually be infected.[18]

Graph 3. HIV Cases among by Transmission Type in Costa Rica 1983-1999



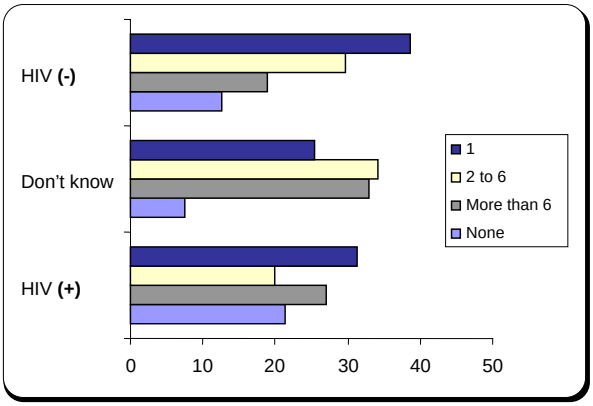
Source: Ministry of Health and CCP-UCR

Sex Workers. In Costa Rica there are an estimated 8,750 female sex workers (SW), of whom a total of 2,700 have contacted the STIs and HIV/AIDS Control Unit at the CCSS, and 0.8% were infected with HIV.[19] Of every 100 female sex workers, six have syphilis and one is HIV positive, and of every 100 male sex workers, six have syphilis and seven are HIV positive.

Men who have Sex with Men. More than half of the HIV cases in Costa Rica during 1998-2002 were in MSM, a significant percentage of whom also had sexual relations with women. Therefore, the rate of HIV infection among MSM affects the rate of infection in the general population. According to a 2004 survey of sexual practices and HIV transmission, only 49% of a sample of 730 MSM was able to identify correctly methods of preventing sexual transmission of HIV,[20] and only 47% said they used a condom during sexual relations. As Graph 4 shows, 27% of MSM living with HIV had more than six sexual partners in the six months before the survey. In this study, it was determined that neither age nor degree of awareness about safe sex were determining factors for sexual practices. MSM who are unaware of their serologic status have more sexual partners, and have the highest number of risky sexual practices.

[17] Schwab N and others. *Optimizing the Allocation of Resources for HIV Prevention in Costa Rica*, The World Bank, 2004.
[18] UNAIDS, Ministry of Health, "La situación del VIH/SIDA en Costa Rica", 2004.
[19] HIV/AIDS and STIs Program of the Costa Rican Social Security Office/CCSS 2006.
[20] CIPAC, 2004. HIV/AIDS Drugs, Alcohol, and AIDS in Costa Rica.

Graph 4. Number of Sexual Partners in the Last Six Months, MSM by HIV Status, Costa Rica 2004



Source: CIPAC. HIV/AIDS Drugs, Alcohol, and AIDS in Costa Rica.

Prison Inmates. In all, there are some 12,800 prisoners. An estimate based on results for inmates who were tested on their own initiative, since prisoners are not systematically tested, indicated that 0.03% were HIV positive in 2004.[21] UNAIDS determined that the causes of HIV transmission among the prison population are: sharing needles for intravenous drug use, sexual relations (which in some cases involve rape), and sharing tattoo needles and guns.

Women. The incidence of HIV in pregnant women is 0.2%. In 2003, out of 45 pregnant women infected with HIV, seven transmitted the disease to their children. In 2004, out of the 35 registered cases, two children were infected. Only 11% of women interviewed in the Reproductive Health Survey (RHS) of 1999-2000 used condoms; a 5% decrease compared to the 1992 RHS. Among immigrant women from Nicaragua, the figure was 7%.

Vulnerable Youth. In 2004, the estimated AIDS incidence rate in the 30-to-34 year old age group was 17.4 per 100,000 people, and in the 35-to-39 year old age group, it was 15.2 per 100,000. Some factors that determine this group's vulnerability, as shown by different studies, are:[22, 23]

1. Early initiation into sexual activity without protection. According to the National Survey on Risk Behavior, the Huetar Norte region had the second highest percentage of the adolescent population who reported having had sexual relations (33%), along with the highest percentage of young people who never used any birth control methods (14%).
2. Commercial sexual exploitation of boys and girls, mostly adolescents.

[21] Schwab N and others. *Optimizing the Allocation of Resources for HIV Prevention in Costa Rica*, The World Bank, 2004
[22] UNFPA 2003. Our Population: Challenges and Opportunities.
[23] Valverde, Solano, Alfaro, Rigioni and Vega 2001. The National Survey on Risk Behavior in Adolescents in Costa Rica

3. A greater incidence of poverty in the population under 17 years old.
4. The growing phenomenon of children dropping out or being expelled from school.
5. Adolescent workers exposed to job exploitation and the associated risks. According to the National Survey on Risky Behavior, after the Brunca region, the Huetar Norte region had the most adolescents who worked without the employer paying social security benefits.
6. Migration exposes young people to greater risks by increasing their social exclusion. According to data from the Statistics and Census Institute, 16% of Nicaraguan immigrants in Costa Rica are adolescents (52,800), of whom just 38,385 (a little more than 50%) are enrolled in the public education system.
7. Low access to health services. In addition to attitudinal barriers, a lack of sensitivity to the particular needs of young people and little recognition of the right to health, among other things, also are factors.

Children. Since 2003, there have been eight new cases per year of children infected with HIV. In 2006, there were 51 registered cases of HIV at the National Children's Hospital Clinic. Their ages ranged from under one year to 18 years. Of this group, 26 were boys and 25 were girls. 94% of these HIV infections were acquired before birth, and one was a hemophiliac whose infection occurred outside of the country. No reasons were determined for 4% of the cases. By age group, 21 cases were in children aged 0 through 4 with the highest concentration in 3-4 year olds. There were 27 cases in the 5-11 age group, and three cases in children older than 12. The areas with the highest number of cases were San José (16 cases), Limon (9), Puntarenas and Alajuela (8 each), Guanacaste and Heredia (4 each) and Cartago (2). 48 patients were taking medications regularly, two were in the process of beginning medication, and the family had not agreed to therapy in one case. Medications for children are in syrup form, and follow the same treatment scheme as adults.

Orphans. According to estimates for 2005, 12% of children who are orphans lost their parents to AIDS, a figure that has been increasing since 1990. In 1995, the figure was 3%, and in 2001 it was 9%.[24]

Perceptions of the Costa Rican Population Regarding HIV/AIDS.

Table 2 summarizes the findings of studies on public perceptions about HIV and AIDS, including measures and strategies for facing it.[25] The majority of those interviewed know about the disease and the messages of prevention campaigns. Ten years of distributing condoms, a state-wide campaign, and multiple efforts by NGOs and donor agencies have

[24] UNICEF, UNAIDS, USAID. Global Report: Children on the Verge of an Abyss 2002.
[25] AED/Futures and CID-Gallup 1997 and 2003. AIDS Action Project of Central America; and Institute for Social Studies in Population (IDESPO) and Program for the Prevention and Control of HIV/AIDS of the Social Security Administration and the Department for Integrated Education on Human Sexuality (DEISH) of the Ministry of Public Education 2005 – study on public perceptions on HIV/AIDS.

resulted in more general knowledge about the disease. Nevertheless, in 2003, there remained a need to incorporate broader and socially controversial elements, such as work with highly vulnerable groups (MSM, CSW, youth). Some of these topics are taboo in Costa Rica given its cultural traditions. This has constrained the government response to the epidemic, so NGOs take the lead in this area.

Table 2. HIV/AIDS Perceptions in Costa Rica

Points	1997	2003	2005
General Perception	The majority of Costa Ricans have some knowledge about HIV/AIDS: 83% indicate that they know at least something about the subject and consider it a serious problem for the country.	The majority of participants (62%) say they have heard a great deal about the disease. 34% consider that CSW with HIV "got what they deserved for their bad behavior"	In general, nine of every ten people are aware that HIV is a virus that attacks the immune system, and that once people develop AIDS they will suffer a series of diseases that can lead to their death. A significant percentage of the population continues to believe that AIDS is a CSW disease (13%) or homosexual disease (16%).
Forms of Prevention	The majority of citizens, regardless of socio-economic characteristics, believe it is possible to protect themselves from HIV.	82% consider that a person can protect him/herself against HIV	Three fourths state that the use of condoms is an effective way to prevent HIV infection, and 68% state that HIV can be acquired by practicing oral sex without protection. In this sense, it is important to emphasize that a little more than 30% consider the latter false; and do not know or recognize the potential for using condoms to prevent HIV.
Prevention Campaigns	70% strongly favor strengthening HIV and AIDS educational programs, both for children and adults. Only 10% oppose making condoms and other contraceptives available to all.	69% believe condoms (or contraceptives) should be easily available for persons who wish to use them, including adolescents 72% favor programs for prevention of of HIV for MSM	Respondents said that future campaigns for prevention of HIV should be: directed at self care and responsible sexual relations (24%); address general topics such as the causes and consequences, risks of infection, myths, medications, symptoms, etc, (18%); promote and provide information about condom use (12%); encourage faithfulness, monogamy and abstinence (11%); emphasize sexual education, communication and information (11%) and touch on aspects related to care, help and non-discrimination of PLWH (10%); and forms of transmission (9%).

The National Response to HIV/AIDS

The first HIV case was identified in 1985 in Costa Rica, but it was not until 1997 that the government took actions addressing prevention, care and the legal framework. Currently, the national response includes efforts by NGOs and groups of PLWH managing specialized projects and programs aimed at vulnerable groups, and by the government, notably the Ministry of Health and Costa Rican Social Security Office (CCSS), which provide treatment through established AIDS clinics. Donor agencies have funded government and NGO projects dealing with research, communications, and prevention, among other issues.

The measures adopted up to now fall into two categories – prevention and care. The government and civil society have collaborated in both areas. Prevention efforts have been directed at specific population groups. There have been no communication programs regarding the implications and repercussions of HIV directed at the general public at a national level.

The National Integrated HIV/AIDS Council (CONASIDA)[26] operates as the government agency in charge of HIV/AIDS policies and programs throughout the public sector. As part of the national response, the government passed the Law on HIV/AIDS Care and the National Strategic Plan, and included control of the epidemic as part of the National Health Plan for 2002-2006. In addition, it provides treatment at national level through the CCSS. Costa Rica stands out in the Central American region in having a system of universal access to health services that includes ART.

LEGAL AND REGULATORY FRAMEWORK FOR HIV/AIDS CARE AND RESPONSE

The General HIV/AIDS Law was published in 1998 after advocacy by governmental and non-governmental organizations on the need for a legal framework to address the HIV/AIDS epidemic. The law provides for education, health promotion, prevention, epidemiological surveillance, diagnosis, care and research on HIV/AIDS. It also addresses the rights and responsibilities of PLWH and the rest of the population in the country (see Table 3).

Other laws, codes and complementary plans that guarantee the right to health and to Human Rights include the Political Constitution of the Republic of Costa Rica; General Health Law; Labor Code; Agreement on Discrimination (Employment and Occupation); International Covenant on Economic, Social and Cultural Rights; American Convention on Human Rights (San Jose Pact); Fundamental Education Law; Constitutional Law on the National Child Care Institute; Penal Code; Family Code; Founding Law of the Social Security Administration; Convention for the Elimination of all forms of Discrimination against Women; Additional Protocol to the American Human Rights Convention with regard to Economic, Social and Cultural Rights (San Salvador Protocol); Convention on

[26] CONASIDA includes the Ministries of Health, Education and Justice, the Costa Rican Social Security Office, the University of Costa Rica, NGOs, young people and people living with HIV.

Children's Rights; Law to Promote the Social Equality of Women; Law for the Ombudsman's Office; Law Against Domestic Violence; Equal Opportunities Law for People with Disabilities; Children and Adolescents Code; Regulations of Law No. 7771; Law on Rights and Responsibilities of persons who use the public and private health system. These rights can be asserted in ordinary tribunals, the Constitutional Court and the Ombudsman's Office.

Table 3. Protection of the Rights of PLWH in Costa Rica

Article 3. Guarantees respect for the fundamental rights of infected persons.
Article 4. Prohibits all discrimination contrary to human dignity and any other act to stigmatize or segregate carriers of HIV, as well as their relatives and friends.
Article 5. Persons who are carriers of HIV have the rights and obligations granted in the Constitution, international instruments on fundamental rights ratified by Costa Rica, those stipulated in the General Health Law, this law and other related legislation on this matter.
Article 7. Carriers of HIV have the right to medical-surgical care, psychological care and advisory services, to all treatment guaranteed to lessen their ailment and alleviate, as much as possible, complications originating from the disease.
Article 8. Subject to exceptions contained in the legislation, confidentiality is a fundamental right of HIV carriers. Nobody shall either publicly or privately refer to the ailments from this disease without prior consent of the patient.
Article 10. All labor-related discrimination against any worker with HIV is prohibited. If a worker develops any disease that will impede his continuing with normal activities, he shall receive the treatment as provided by labor laws.
Article 11. No HIV tests can be requested without a medical prescription as a requirement for entering or remaining within an educational center.
Article 36. Prison inmates requiring specialized health care due to complications arising from the HIV infection who cannot receive care in the prison center must receive out-patient treatment, hospital admission or whatever is required.
Article 38. Segregation, isolation and restrictions on labor, sports, recreational and other types of activity to the detriment of prison inmates infected by HIV is prohibited.
Article 44. Public or private social workers or persons in charge of an institution who deny, omit or delay administering health care to a person infected by HIV, without prejudice to other responsibilities, may be condemned to one to three years of prison.
Article 48. Whosoever applies, disposes of or practices discrimination by race, nationality, gender, age, political party, religion or sex, social position, economic situation, marital status or for any health problem or disease shall be subject to a fine or imprisoned for 20 to 60 days.

The existence of these regulatory systems has brought to light situations faced by persons living with HIV. One of the challenges in enforcing the General HIV/AIDS Law is dissemination and regulation of compliance in institutional settings, for example the educational sector, where there is no institutional plan as required by the General

HIV/AIDS Law and its regulations. The law needs modification concerning sanctions for persons who unjustly violate the confidentiality of PLWH. Current regulations only allow for sanctions for health workers, not for any other person who commits the same act. A contradiction in the law is that while it protects the confidentiality of PLWH, it also establishes an obligation to communicate the diagnosis to sexual partners in order to prevent spread of the virus. This has personal consequences for PLWH, but is justified as defending the rights of others, as established in the Constitution.

A study by the Inter-American Institute of Human Rights states that forms of discrimination that violate human rights of people who live with or who are suspected of living with HIV include the following:[27] physical violence; refusal of some type of service; rejection by healthcare centers; refusal of insurance coverage; expulsion from their relatives' homes; in the case of infected women, abandonment by their husbands; being avoided by friends; unjust firing from their jobs; exclusion or refusal to be allowed to enroll at an educational institution; being forced to take a test when being hired or by an employer; having their names reported to the Ministry of Health without respecting their anonymity and without prior consent; police raids; and forced testing of sex workers.

The UNAIDS Arbitrary Discrimination Protocol was applied as part of this study's assessment of discrimination in Costa Rica. The results are summarized below and in Annex 1. Some areas or forms of discrimination identified in the UNAIDS Protocol are not listed in the table because of lack of response from interviewees. Although there is a defined regulatory framework protecting the rights of PLWH, discrimination that is justified through other administrative or legal regulations does occur in practice, and can only be resolved through litigation. According to a leader from the Association of Costa Rican People who Live with HIV/AIDS, discrimination occurs against people who are affected by the disease because traditionally it has been associated with homosexuality.[28]

Health Care. Those who were interviewed state that discrimination has occurred in practice, through denial of treatment due to a person's HIV status. Cases of discrimination have occurred during cytology exams in patients with cervical cancer and in procedures performed by some dentists. Although PLWH and members of NGOs say these problems occur, they are not public knowledge since they are difficult to prove or because victims do not discuss them for fear of further discrimination. NGOs and the Ministry of Health found isolated cases of administration of HIV tests without consent when they were advocating for adoption of the HIV/AIDS law. Regarding pregnant women, interviewees emphasized that taking an HIV test must be an informed decision made exclusively by the woman.

Employment. Interviewees said the most frequent cases of discrimination in practice involve compulsory testing before being hired or during employment. This occurs mostly in multinational companies, and leads to firing, demotion or a change in the affected

[27] IIDH - Módulo para la promoción y defensa de los derechos a la igualdad, a la justicia, al desarrollo y al respeto de las personas que viven con SIDA 2003, p. 29
[28] Murillo, 2005

person's employment situation. In some cases employees were told that they were not fired because of their condition, but rather for reasons related to restructuring of their jobs.

Legal/Judicial Processes. A case was presented in 2004, in which the Criminal Court ordered a bartender to be prosecuted for three separate crimes of spreading the disease. The accused had learned through a blood test he took at the Golfito Hospital in 1999 that he was HIV positive. The Court ultimately found him innocent.

Prisons. None of the five forms of arbitrary discrimination in prison administration appears to have occurred. However, it was stated that HIV-positive inmates run the risk of contracting other infections due to overcrowding in most prisons.

Entrance and/or Residency in the country. There are no statutory provisions involving discrimination with respect to entrance or residence in the country, and the research did not yield any indications that such discrimination occurs in practice. The Immigration Law establishes a general entrance impediment to people with communicable diseases, although it clearly is difficult to apply this provision in practice.

Family and Reproductive Life. There is no mention in the law of compulsory pre-matrimonial or prenatal HIV testing. Nor is abortion or sterilization compulsory for women with HIV. Cases observed in practice are related to divorce or psychological pressure by some doctors who believe that seropositive women should not be mothers and recommend that they be sterilized.

Education. There are no laws that deny access or impose restrictions on education due to a person's HIV status. In certain cases, young people have limited access to information because some institutions do not provide them with information, counseling or supplies such as condoms, especially in formal educational programs.

Social Welfare. There is no law that stipulates denial or restriction of a person's social welfare benefits on grounds of HIV status.

Housing. There are no laws that require HIV testing or certification in connection with access to housing or the right to remain in a dwelling. However, in telephone inquiries about the requirements for obtaining mortgages or life insurance, various banks noted that applicants are required to be insured by the National Insurance Institution (INS), which does not cover PLWH. Thus, although there is no direct rejection of PLWH in housing, there is an instrument that functions as a discriminatory tool.

Insurance and other Financial Services. Since 1999, the National Insurance Institute (INS), the public insurance monopoly in the country, has not authorized people infected with HIV to acquire life insurance policies since it considers AIDS a disease with a high probability of death.

Other Institutions and Public Services. No law denies or restricts a person's access to public services or accommodations on the basis of their HIV status.

Response to Arbitrary Discrimination. Efforts have been made to identify the causes of discrimination at government level and within the civil sector. The Ministry of Health provides counseling and training to public organizations and health service providers. The Ombudsman's Office has a legal specialist who works on HIV/AIDS issues and is in charge of filing complaints and lawsuits. In addition, the government has established ties with CONASIDA that in some cases makes recommendations to the different ministries or organizations. In the non-governmental sector, the work of Agua Nueva, ASOVIHSIDA, Ameritas and CIPAC stand out because they have a formal telephone complaint system that simplifies counseling. This demonstrates the leadership of these organizations in defending the rights of PLWHA.

PREVENTION AND CARE FOR VULNERABLE GROUPS

While prevention efforts reach the whole national population, greater attention is paid to vulnerable groups, including men who have sex with men, sex workers of both genders and prisoners. Various projects promote prevention through information, education and communication directed to educators, medical staff, PLWH and their families, as well as the general population. They use advertising, television and radio campaigns, workshops and training courses, posters and brochures that include statistical results of epidemiological surveillance. In addition, there are projects that distribute condoms and provide information about human sexuality. A series of projects provide integrated treatment for HIV and AIDS patients, including early disease detection and laboratory tests at the national level and universal coverage at the four national hospitals and 27 blood banks. Treatment and care includes psychological care for the patient, family and loved ones, treatment with antiretroviral drugs and adequate follow-up. As a result of monitoring efforts, projects were established directed at identifying genotype and ARV resistance. Housing support also is provided for patients in need of homes and in cooperation with national hospitals, and economic aid for families to bury AIDS patients who die.

Projects related to awareness promotion and social integration are focused on people with HIV and their families, workers, companies and the general population. The projects include human rights workshops and marches to raise awareness. The objective is for the general public to become aware that people have HIV and need to be accepted by the rest of society. There also are projects to strengthen the self-esteem, abilities, and skills of PLWH for joining or re-joining the job market and economy.

The health and social system has established STI and HIV/AIDS Control Units and HIV/AIDS clinics at each hospital, provides direct treatment to PLWH (diagnosis, treatment and follow-up), and trains staff at national level. Successful experiences are acknowledged below at the National Children's Hospital and the Mexico Hospital, part of the CCSS.

Below is a summary of four successful interventions that were reviewed by this study. It would be important to review as well three projects that are directed at care for vulnerable groups:[29] (i) The CCSS HIV/AIDS Program; (ii) Prisoner Programs through the Ministry of Justice; and (iii) Adolescent Integrated Care Program, PAIA CCSS.

Manos a la Obra

The project is called "Facilitating Healthy Living Conditions: Preventing HIV/AIDS in Young People Shunned Socially" also known in the communities as "Manos a la Obra."[30] The goal of the project is to reduce STIs and HIV among young people who are socially excluded in selected communities, in accordance with the global objective of the regional OPEC-UNFPA project. It targets five selected border communities: Upala, Los Chiles, Guatuso, Coopevega and Ciudad Quesada, where young people between 15 and 24 years of age represented 18-20% of the population in 2000. From 1993-2002, 49 HIV cases were registered in these communities.

The project seeks to increase commitment and support for STI and HIV prevention in adolescents and young people among local, regional and national authorities, community leaders, NGOs, grassroots organizations, local networks, other relevant stakeholders, and mobile adolescents and young people, immigrants and local residents of the five selected border communities. It also seeks to increase local capacity to provide information, education, and friendly services for mobile adolescents and young people, immigrants and local people to prevent HIV and other STIs. In addition, it develops innovative interventions for effective, sustainable prevention of HIV and other STIs in young people and adolescents of both sexes, especially the most vulnerable, and documents and disseminates the interventions so they can be replicated and used in creating national public policies.

The specific objectives are to:

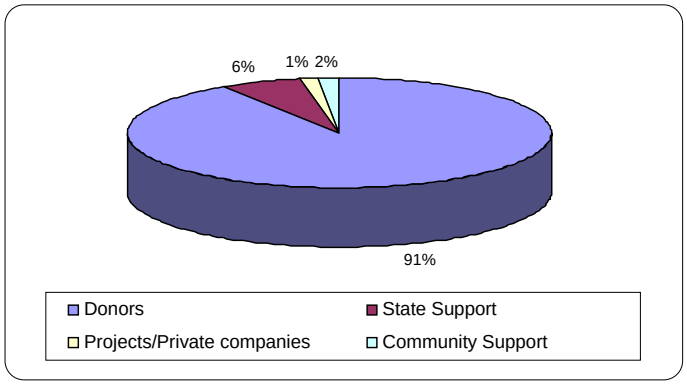
- Contribute to decreasing the incidence of HIV among young people who live in social exclusion in selected communities, in line with the global goal of the regional OPEC project.
- Support policy making that focuses on rights; help the Costa Rican population to learn about and exercise their sexual and reproductive rights (SRR), gain access to quality educational, sexual health and reproductive services, and participate in making decisions; and conduct social surveillance on the quality of these services.
- Facilitate awareness-raising, training, mobilization, coordinated action and synergies with key stakeholders – including and emphasizing young people – in the different areas encompassed in the project's strategy (local, regional, and national), directed at social, legal and institutional change for young people, immigration, SRR, and HIV prevention.

[29] These projects were not reviewed by this study as the coordinators were not available.
[30] "Manos a la Obra" (Let's get to work) was the name given by the young people participating in the project.

In order to achieve positive results, it is necessary to develop actions and alterative strategies (not merely alternatives) for institutional, social, and community realities that enable the establishment and maintenance of the conditions necessary for developing healthy life styles (especially for SRR and HIV prevention) in 15-24 year olds (immigrant and native). People in this age group are not only a beneficiary population, but are also social and strategic development stakeholders.

The Vice-Ministry of Culture, Youth and Sports, which presides over the National Council for Public Policies for Costa Rican Youth, is the political head of the Costa Rican component of this regional project. The Council for Young People is the governing agency in charge of elaborating and implementing public policies for youngsters in accordance with the General Law on Youth. The project is supported by UNFPA, an international aid agency that helps countries use socio-demographic data to formulate policies and programs to reduce poverty and to ensure that each pregnancy is wanted, that all births are safe, that all young people are free of HIV, and that all girls and women are treated with dignity and respect. The project was launched regionally with financial support from the Organization of Petroleum Exporting Countries (OPEC) Fund for International Development.

The following graph shows sources of support for operations during 2005. OPEC-UNFPA has provided the majority of resources, with funding for three years of project operations; state support represents 6% of all contributions and is concentrated mainly on logistic activities. Private companies have provided technical support. Community participation has also been concentrated on logistical aspects. The projects aims at encouraging and adopting inter-institutional agreements to ensure the sustainability of the project when donor sponsorship ends. UNFPA planned to follow-up on these agreements from June to December 2006, and assigned a budget for that purpose.



Results

- The most important results are directly related to the active participation of young people in HIV prevention and the development of educational, recreational and institutional initiatives to prevent HIV and generate political commitment to support this work locally and nationally.
- Based on successful practices, the project has formulated a series of recommendations for CONASIDA that support the development and implementation of the Strategic Plan in Costa Rica. As a response, project leaders

were asked to propose a work plan and to become advisors of the Committee.

- The project has had other important political and legal dimensions, presenting recommendations to high-level offices such as the Government Council, the Social Government Council, National Council for Integrated Care for HIV/AIDS, the Board of Directors of the Costa Rican Social Security Institute, and others. These offices have considered the recommendations and followed them to varying degrees. The current project development process seeks to provide technical assistance and follow-up of agreements for the execution of these recommendations.
- Negotiations have been conducted for other organizations to use certain successful experiences from this project.

Contribution to Eradication of Commercial Sexual Exploitation in Girls and Female Adolescents in the San Jose Greater Metropolitan Area.

Foundation for the Development of the Fight against AIDS (FUNDESIDA)

The violation of the rights of children and adolescents through sexual exploitation is a growing and complex problem. While the HIV epidemic has spread to all population groups, children and adolescents living in a situation of sexual violence are among the groups most vulnerable to contracting STIs and HIV. Abused children are more vulnerable because it is more likely that sexual penetration of a child by an adult will lead to tears or cuts, facilitating transmission of the virus to the child's body. In Costa Rica, figures are under-reported. Girls and adolescents do not go to health clinics for medical treatment because they are ashamed. Moreover, medical care for STIs and HIV is not designed to give minors involved in sexual violence the specialized care they need. And abusive adults have no interest in having the public find out that a minor is infected, precisely because the commercial exploitation of the child for sex would become evident. For all of these reasons, hundreds of abused children and adolescents do not receive medical treatment, and thus are at high risk of HIV and AIDS.

This project was developed in response to the need to provide direct comprehensive care to the victims of sexual exploitation. This was the first national experience in direct care for girls and female adolescents. The project's general objective was to help eradicate sexual exploitation of girls and adolescent females in four different districts in the Province of San Jose. The project encompasses three action areas: care, prevention, and defense and protection.

The project specific objectives were:

- Explain, ensure, and defend the rights of minors in line with the current legislation.
- Create conditions to meet the basic psychological, health, education, recreation and food needs of girls and female adolescents.
- Generate personal growth opportunities.

- Promote and support primary, secondary, technical, and business education.
- Develop and implement strategies to sensitize different social stakeholders about the negative impact of sexual exploitation.
- Mobilize social forces to disband networks of people who facilitate sexual exploitation of minors.

This project was implemented by FUNDESIDA, and helped to implement the National Strategic AIDS plan. FUNDESIDA aims to develop HIV/AIDS research programs and projects to monitor the epidemic, gather accurate and updated information for decision-making, and create new education, information, and training strategies. It is a highly specialized foundation for developing research programs and projects for HIV prevention, education, information, training, and awareness targeting vulnerable populations. This includes use of international aid programs to help strengthen work done by the government. The Foundation focuses on gender and human rights.

FUNDESIDA was founded in 1990. From its beginning, FUNDESIDA has successfully carried out different projects with international agencies such as WHO, PAHO, IDA, IDB, Louisiana State University School of Medicine – International Center for Medical Research and Training in Costa Rica (ICMRT-LSU), the European Economic Commission, and the International Labor Organization International Program to Eradicate Chile Labor (ILO/IPEC).

The main sources of financing for the project in Costa Rica were the International Program for Child Labor Eradication and the International Labor Organization. The project also worked in coordination with the National Children's Safety Board (PANI) and the Latin American Institute for Health Prevention and Education (ILPES). Other contributors included Ticopager, which provided pagers to provide better service coverage; Amnesty International, which provided office space for holding meetings; the AIDS/STI Control Unit, which provided physical space to develop activities with girls and adolescent females; and INISA-UCR and the UCR Clinical Laboratory, which helped prepare laboratory exams.

The project involved work with nine groups of girls aged 8 to 13 and 14 to 17 during 20 months. On average, 15 participants participated in meetings held once a week. Each work session lasted two hours, including time to create a playful atmosphere at the beginning to provide the right atmosphere to deal with the subject at hand. The project also worked with educators since they are in daily contact with minors and provide support for people in abusive situations they witness. In most cases, educators have not been trained in helping minors deal with sexual abuse, but they understand that they have the obligation to safeguard their wellbeing and use the law to present complaints and provide support. For this reason, a sensitization module was established to train teachers. The project also produced training manuals to help police deal with situations involving commercial sexual exploitation of girls, boys, and adolescents.

Results

Action Areas	Objective	Results
Care	Create conditions for girls and female adolescents to receive care	Care for 212 girls. Mapping sexual exploitation focus points Sessions were held in community spaces. Home visits were made. A medical consultation was given with nurses and a laboratory. Agreements were established with different offices to suggest alternatives for education and training to the girls and young women
	Generate personal growth opportunities	
	Provide physical health care	
	Promote and support a primary, secondary, technical, and business education	
Prevention	Develop and implement strategies to sensitize different social stakeholders about the negative impact of sexual exploitation.	Training of a group of national police. A specific module for this population group was created. Educators from the metropolitan area were trained. A sensitization and training module was created specifically for this population group.
	Mobilize social forces to disband the networks of people who facilitate and sexually exploit minors.	Discussion themes directed at social communicators (three workshops). A sensitization module directed at social communicators to address issues from a human rights perspective.
Defense and Protection	Disseminate information about the rights of girls and adolescent females	Sensitization and training workshops for the target population. Coordination with the PANI (National Children's Protection Board). Coordination of training workshops for the target population with the INAMU (National Women's Institute).
	Guarantee and defend the ability to exercise their rights	References to situations and to the instance for protection and fulfillment of human rights: PANI.

Clinical HIV/AIDS research projects on the incidence and prevalence of STIs in specific populations have been developed through ICMRT since 1992. These projects focus on interventions involving different governmental institutions such as: the Ministry of Health, INCIENSA, the National Children's Protection Board, IAFA, the Latin American Institute for Health Prevention and Education (ILPES), the Ministry of Justice, the Ministry of Security, the Costa Rican Social Security Institute, the University of Costa Rica, INISA, and other local agencies. The work done through the different research and education projects has led to new action strategies for prevention, education, information, attention, and awareness, strengthening the work done by professionals at the National AIDS Program and the AIDS/STDs Control Unit.

Recognition and Pride for Living a Healthy Life

Center for Research and Promotion of Human Rights for Central America (CIPAC)

The goal of this project is to address personal factors related to health, as well as factors related to self-esteem and empowerment. It aims to create a safe place where gays, bisexuals, and transvestites can receive education on preventing HIV in a non-discriminatory context. The project aims to promote knowledge, attitudes, and healthy practices among young men who have sex with men, to reduce their risk of contracting HIV and sensitize them about their duties and rights. Launched in 2003, the project is slated to end in 2008.

The project's objectives are to:

- Improve knowledge, attitudes, and safe sex practices among men who have sex with men in the greater metropolitan area
- Provide information, support, and referrals to specialized MSM services
- Monitor MSM services at the Center
- Use the telephone and internet to improve the amount of services and adapt them to the needs of this population group.

First year Goals	Second year Goal s
• Establish an MSM support group • Build MSM training modules • Provide 1,350 MSM with information about HIV/AIDS and referrals to specialized MSM services • Prepare the physical space for providing care as well as being an operational area for the implementing Center. • Establish an 800 number for information and support • Design the research and data recording tools for drug and alcohol research among MSM in the greater metropolitan area.	• Establish two nationwide MSM self-support groups • Develop two manuals on self-image, caring for the body, STIs, HIV/AIDS, violence, addictions and similar topics. • Hold 16 workshops for MSM and the general population • Arrange 260 psychological appointments • Answer 6,000 telephone calls • Provide 2,600 hours of 800 line attention • Hold eight training workshops for helpline operators • Answer 4,000 questions "on-line"

The project is implemented by the Center for Research and Promotion of Human Rights for Central America (CIPAC). This non-profit organization is dedicated to promoting the rights of gay, lesbian, bisexual, and transgender populations. It also maintains that there is a fundamental right to health care, so it created the Cultural Sexual Diversity Center of Costa Rica aimed at preventing HIV and STIs. The Center's goals are to:

- Strengthen institutions, organizations and/or groups who face direct or indirect discrimination because of their sexual orientation.
- Increase levels of respect, tolerance, and acceptance for the gay, lesbian, bisexual, and transgender populations.
- Promote awareness of the rights of these groups.

- Fight to incorporate these populations' rights into legislation and administrative mechanisms that ensure equal access to resources and development services in each Central American country.

The Global Fund provided financing for this project for five years (about $650,000). MINSA also provided support through CTAMS and CONASIDA. UNAIDS provided technical support. The CCSS, Women's Institute, ASOVIHSIDA and the Institute on Alcoholism and Drug Dependency provided assistance in preparing the protocols to be used on the telephone line. Thought has been given to building relationships with institutions such as the Costa Rican Social Security Institute and PAIA so that they may take over medical care and the counseling aspect of the 800 line when funds from the Global Fund end.

Results

The results and achievements of the project are summarized in Table 4:

Table 4: CIPAC Project Results

Project Indicators	**Baseline**	**Results**
Condom use among MSM (based on 2001 CIPAC study)	60%	75%
MSM who have received formal training or personalized information	145	1,181
MSM who report having used a condom regularly	25%	45%

Activities	**Results**
MSM with direct access to specialized HIV/AIDS information, counseling and services	1,631
Calls answered on the free counseling line	4,887
On-line questions answered on the web site	4,016
Trained line operators	45
Operator training workshops	10
Self-support groups in operation	6 groups meeting weekly
Condom distribution	More than 200,000
Workshops on diverse topics	More than 20
Informational material distribution	More than 15,000 about correctly using a condom
	More than 10,000 about HIV/AIDS

Table 5 details the strategic actions for which CIPAC is responsible within the National Strategic Plan for comprehensively dealing with HIV/AIDS. The project is directly related to the section on health promotion and protection.

Table 5: National Strategic Plan: CIPAC Activities

Component	Objective	Strategic Action	Objective	Budget
Epidemiological Surveillance and Research	Have accurate and timely epidemiological information to guide the strategic actions for integrated HIV/AIDS care.	Group research focused on residents of the leading cities of the province on the impact of HIV prevention campaigns	Determine whether prevention campaigns have changed sexual practices among gays, lesbians, bisexuals and transgender individuals, housewives, adolescents, and prisoners	¢32,640,000 ($102,000) for 3 years
		Socio-economic impact study about HIV/AIDS in Costa Rica 2004	Determine the social and economic effects of the AIDS pandemic from 1980 to 2003 in Costa Rica	¢16,100,000 ($50,470)
Health Promotion and Protection	Change social perceptions of sexuality	Educate 20,000 students on sexuality-gender and HIV/AIDS in the metropolitan area in Costa Rica.	Train high school and public school students in the metropolitan area in Costa Rica about sexual education	¢19,750,000 ($61,912)
		Promote the right to health through safe sex with active participation in events Sensitization about the PLWH population and other vulnerable groups	Sensitize and raise awareness about the importance of safe sex	¢1,179,840 ($3,687)
		Promote the right to health and information over the telephone inquiry line for MSM in relation to HIV/AIDS	Provide support, assistance, and reference instruments for MSM	¢ 46,800.000 ($146,708)
		Sensitize inspectors from the Ministry of Labor about PLWH and other vulnerable populations regarding employment rights	Train and sensitize job inspectors from the Ministry of Labor about HIV/AIDS and their employment rights	¢4,894,000 ($15,294)
Prevention	Strengthen prevention actions nationally to reduce infection incidence and its economic and social effects.	Promotion, use, and distribution of 10,000 condoms in centers where MSM socialize in the metropolitan area.	Raise the awareness of the MSM population about the importance of protection and using condoms	¢6,880,000 ($21,250)

Working with Peers

The Costa Rican Association for People Who Live with HIV/AID (ASOVIH/SIDA)

This project, which started in 2003, offers care for PLWH by other PLWH. A positive HIV diagnosis leads to a new way of life, including significant challenges at the workplace, in the family and in the social environment. There also are significant psychological effects. Support from people with the disease who have been able to make the necessary changes and maintain healthy and active lifestyles and hope for the future can fundamentally help other PLWH improve their quality of life. Since 2001, peer work has been one of the key activities of ASOHIV/AIDS, along with the formalization and systematization of the Hospital Mexico HIV/AIDS Integrated Care Clinic. National

meetings have been held since 1997, and self-support groups organized since 2002. There are now three groups in which 25-45 PLWHA participate on a weekly basis.

The project aims to achieve 80% sustained adherence among people on antiretroviral treatment, and to increase their employment level; and to improve the ability of PLWH to manage the diverse stages of the disease from the moment they know that they are seropositive, by connecting them to people in the same health situation. The specific objectives are the following:

- Provide orientation and information to PLWH and their support networks (family members and friends)
- Create the opportunity for trust and communication
- Strengthen adherence to antiretroviral treatment
- Develop the capacity for socio-economic reintegration
- Strengthen group organization to resolve problems identified
- Create conditions for working with HIV-positive couples at health centers, shelters and when dealing with prisoners.

ASOHIV/AIDS was established in 1997, so that PLWH could empower themselves and enhance their personal development and quality of life. The organization currently comprises 200 associates. The project contributes to implementation of objective 4 of the Country's Strategic Plan on AIDS: To provide integrated care for HIV patients, providing the best treatment possible so they can overcome their condition and reintegrate themselves into society. Project indicators include changes in PLWHs' knowledge and attitudes regarding the disease; adherence of PLWH to ART; and percentage of PLWH who are working.

ASOHIV/AIDS receives funds from the Global Fund, and offers five people an economic subsidy to run the Peer Work Consolidation Project. Rental of a building, maintenance and other overheads are financed by a few associates and donations, and the work that is performed there is done on a volunteer basis. Currently, efforts are underway to create a strategic alliance with the staff of the Costa Rican Social Security Institute so it can manage the project and offer this service as an integral part of care for PLWH.

Results. In 2004, a diagnostic survey was conducted on the needs of people living with HIV and an evaluation of the work performed by peers and health staff. The survey was conducted in urban and rural hospitals that care for PLWHA. Resuls are reported in Tables 6, 7 and 8.

Table 6: Results of PLWHA Survey on Urban and Rural Hospitals 2004

	Yes	No	Total
Knowledge of ASOVIH/SIDA	113	55	168
Receive peer counselling	66	92	158

Source: ASOVIH/SIDA

Table 7: Proportion of PLWH under care

Number of years	% PLWH
5 years or more	15.5%
4 to 5 years	4.2%
2 to 4 years	11.9%
6 months to 2 years	2.4%
0 to 6 months	6.4%

Source: ASOVIH/SIDA

Table 8: Tasks Performed by Peers

Tasks	Percentage
Information about ART	39
Awareness about importance of continuing integrated treatment	38
Positive influence on going to medical appointments	38
Information on importance of being helped by different health specialists	35
Information about the diagnosis provided	31
Questions about living with HIV/AIDS answered	30
Emotional support provided in time of crisis	30

Source: ASOVIH/SIDA

TREATMENT AND CARE OF PLWH

Costa Rica's health services offer coverage to all PLWH who request care, and guarantees triple drug therapy. Integrated care for PLWH is provided by four national hospitals and one regional hospital administered by the CCSS. This service covers not only nationals, but also foreign patients residing in Costa Rica who are insured. However, the first and secondary care levels do not have the financial and human resources to provide quality integrated care for the community. Treating physicians must report use of ARVs to the CCSS. The regulations for the General Law on HIV/AIDS determine the conditions, frequency and other requirements of these reports.

ART is prescribed by doctors specialized in immunology or infectious diseases. The patient sees a doctor, who determines if he or she meets the criteria for initiating treatment according to the protocol. Rural areas do not have HIV/AIDS specialists, which constrains access to care for some patients who live in remote areas. In the private sector, Fischel pharmacies and the CIMA hospital provide ART.

One of the issues mentioned by patients receiving ART is the complexity of the regimen and side-effects of the therapy, which may imperil adherence or lead to incorrect use of the medicines. Treatment schemes for pregnant women are the same as for other patients. There are no studies or specific references for this population group. At least 2% of mothers who adhere to the prevention protocol have seropositive children.

Registration. ARV must be registered at the Ministry of Health through an expeditious process. Drugs must have been previously approved by either the Food and Drug Administration of the United States (FDA) or the Committee for Proprietary Medicinal Products (CPMP) of the European Union. Article 35 of General Law Regulations requires the Ministry of Health and the Ministry of Economy, Industry and Commerce to monitor compliance with rigorous quality standards for the preparation of drugs on a regular basis. Each November, a report on compliance with these standards is presented to the National Council on HIV/AIDS Integrated Care.

Procurement. The CCSS is responsible, as provided by Article 7 of the HIV/AIDS Law, for importing, purchasing, stocking and directly supplying antiretroviral medicines to patients for treatment of HIV. However, hospitals, since they are decentralized, have the authority to purchase the medicines they need, if they are not supplied by the CCSS. This is the case with Abacavir and Saquinavir. The current policy is to restock warehouses with an 11-month supply of ARVs. Central hospital warehouses have adequate facilities for conserving and maintaining ARVs in safe condition.

Medicines are selected by a technical committee. The CCSS pharmacies procure nine (9) antiretroviral medicines, (6) generic medicines and three (3) original medicines administered in different combinations, as indicated in Table 9. The largest number of vendors are from Costa Rica, followed by companies from India, Guatemala and Mexico. Most offer medication for treatment of opportunistic infections and ARVs. Some examples are Fluconazol, Ketoconazol, Zidoduvine and Nistatine suspensions that are distributed by laboratories such as Gutis, Chemo and Raven.

Table 9: ARV Procured by CCSS

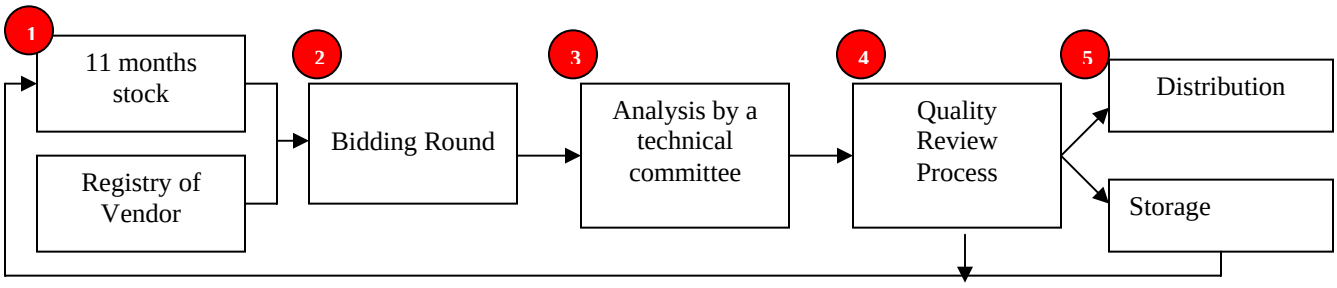
Medication	**Description**	**User**	***Use***
Didanosine 100 mg	Chewable, water-soluble tablets	National and Specialized Hospitals	For exclusive use for the treatment of HIV patients who meet the criteria for inclusion into the protocol and have defined resistance criteria subsequent to use of tri-associated scheme.
Efavirenz 200mg	Capsules		
Estaduvine 40mg	Capsules		
Indinavir 400mg	Capsules	National and Specialized Hospitals HNN	For exclusive use for treatment of HIV patients
Lamivudine 10mg	Oral solution		
Lamivudine150 mg	Coated tablets		
Nelfinavir 250 mg	Tablets or coated tablets		
Ritonavir 100mg	Capsules made of bland gel		
Zidoduvine 50mg/5mL	Oral solution, syrup, 240mL bottle		
Zidoduvine 100mg ó 300mg	Capsules	National and Specialized Hospitals	For exclusive use for treatment of HIV and in prevention of vertical transmission

The purchase of medicines is accomplished according to the priorities of the country following the National Therapeutic Formulary, which is the official list of medicines that must be used by public health services. The acquisition and distribution of drugs by the CCSS currently faces issues of internal efficiency and organization of administrative procedures. Although the procedures are well laid out from the point of view of quality control, they are not carried out efficiently. For example, some vendors who have been informed that their products do not pass quality control tests do not have many medicines to replace them, a problem that has led to a scarcity of ARV.

The purchasing process for medications (Figure 2) is as follows:

- Recording the levels of medications in stock: when there are 11 months of stock coverage remaining, the CCSS purchases drugs. Records are kept of vendors that keep up to date with regard to generic medicines.
- The purchasing department requests quotes freely from national and international companies that are on a list of offering companies. Their responses are considered formal offers if they fulfill the requirements. To be eligible for consideration, such responses must be given by offering companies within three working days following receipt of the quote request.
- A technical committee analyzes the best conditions and prices. Members must answer for the selections they make and for damages that may eventually be caused.
- Contracts to purchase medicines are awarded. The latest purchases have run into an issue related with the interpretation of Law 6914, which involves revoking awarded bids; this has increased the delivery time from 5.5 months to 9 months.
- Once the drugs are received, they are tested before they are distributed to hospitals. If the results are unsatisfactory, a new purchasing process begins. If the results are satisfactory, the medicines are distributed or stored.

Figure 2. Procurement of Pharmaceutical Drugs



Costs of Prevention and Treatment. According to the Ministry of Health,[31] the cost of HIV prevention and treatment increased from 0.07% of GDP in 1998 to 0.08% in 2003. As a percentage of public spending, the cost diminished during the same period from

[31] Allen, P. Expenses and Finance Unit. Office of Health Development, Ministry of Health, 2004.

1.06% to 0.60%, and increased as a paercentage of private health expenditures from 0.15% to 2.88%. Safe blood management takes the biggest share of resources. Unit costs provided by the MoH according to the type of intervention are shown in Table 10.

Table 10: Costs of Prevention and Treatment of HIV/AIDS in Costa Rica 2004

Interventions	Unit (US$)
1. Integrated care for people with STIs	$52.8
2. IEC (Information, Education and Communication) of groups at risk (MSM, CSW, Prison Inmates) with interpersonal strategies	$10.5
3. IEC (Information, Education and Communication) of groups at risk (MSM, CSW, Prison Inmates) through specific media	$0.22
4. IEC in adolescents with interpersonal strategies	$7.4
5. IEC in adolescents through mass media	$0.28
6. IEC in the general population	$0.40
7. IEC in children and street children in risk of social exclusion	$9.0
8. Free Distribution of condoms by public channels and NGOs	$15.8
9. Social marketing of condoms	$0.60
10. Access to rapid tests and HIV counseling with a gender focus	$17.9
11. Prevention of HIV vertical transmission	$17.9
12. Safe Blood	$147.0
13. Support for promotion and defense of human rights of PLWHA and their families	$33.9
14. Support for promotion and defense of human rights of children who are sexually exploited, on the street or at risk of social exclusion	$5.4

Source: Ministry of Health Statistical Unit 2004

ARV Prices. According to information supplied by the Pharmacotherapy Department, purchases of antiretroviral medicines make up about 5% of the total CCSS budget for medicines. Average annual treatment costs per patient are US$1,350 (Table 11). Costs have decreased because of price reduction policies and greater use of generic drugs. Prices for generic drugs have been negotiated since they were first introduced in the country, and regional purchases have helped to obtain lower prices. However, Costa Rica follows South American medicine scheme policies rather than Central American policies.

CAFTA Impact on ARV Prices. There are two views in the HIV/AIDS community on the impact of the free trade agreement: some believe that the intellectual property provisions have led to an increase in drug prices, and some maintain that it will only extend registration periods with regard to the WTO TRIPS agreement (Trade-Related Aspects of Intellectual Property Rights). The first position is based on a view that a monopoly will develop within the pharmaceutical companies that produce and market the drugs, placing the CCSS purchasing power for generics at risk. This problem would occur two years before the expiration of current contracts. Patent renewal would cause intellectual property rights to be upheld, thus leaving generics out of the market and making therapy more expensive. Average unit costs of patented drugs are much more expensive than generics - 20 times more in the example in Table 12 (for drugs for cardiovascular

diseases). An increase of that magnitude would affect the CCSS's drug purchasing capacity, and as a result, coverage. On the other hand, some believe that CAFTA just extends time frames in which intellectual property rights operate. Table 13 is a summary comparison between the Free Trade Agreement and TRIPS policies.

Table 11: Cost of Treatment According to Treatment Regime in Costa Rica 2006

Scheme	Product	Daily Dosage	$Price	Cost $
	Zidovudine 100	6	0.06	0.36
	Lamivudina150 mg	2	0.09	0.18
Scheme 1	Indinavir 400mg	6	0.2469	1.48
	Daily Cost			**2.02**
	Yearly Cost			**737.81**
	Zidovudine 100	6	0.06	0.36
	Lamivudina150 mg	2	0.09	0.18
Scheme 2	Nelfinavir 250 mg	9	0.509	4.58
	Daily Cost			**5.12**
	Yearly Cost			**1,869.17**
	Didanosine 100 mg	4	0.41	1.64
	Estaduvine 40mg	2	0.06	0.12
Scheme 3	Indinavir 400mg	6	0.509	3.05
	Daily Cost			**4.81**
	Yearly Cost			**1,757.11**
	Didanosine 100 mg	4	0.41	1.64
	Estaduvine 40mg	2	0.06	0.12
Scheme 4	Nelfinavir 250 mg	9	0.509	4.58
	Daily Cost			**6.34**
	Yearly Cost			**2,314.47**
	Zidovudine 100	6	0.06	0.36
	Lamivudina150 mg	2	0.09	0.18
Scheme 5	Efavirenz 200mg	3	0.53	1.59
	Daily Cost			**2.13**
	Yearly Cost			**777.45**
	Didanosine 100 mg	4	0.41	1.64
	Estaduvine 40mg	2	0.06	0.12
Scheme 6	Efavirenz 200mg	3	0.53	1.59
	Daily Cost			**3.35**
	Yearly Cost			**1,222.75**
Average Cost				**1,350.79**
Patients				**2,000.00**
Total Average Cost				**2,701,580.00**
Cost of Kaletra				370,788.00
	TOTAL COST			**3,072,368.00**

Table 12: Price Comparison in Dollars of Generic and Patented Drugs for Cardiovascular Diseases

Description	Generic Unit Price	Unit Price Patent	Annual Cost Generics	Annual Cost Patent
Enalapril	0.96	15	34,588.00	5,227,950.00
Amlodipine 5 mg	0.41	32.2	90,508.00	7,178,249.40

Source: Murillo, 2005.

Table 13: Comparisons between TRIPS and CAFTA Policies

TRIPS Stance 1996	CAFTA 2006
Inventions may be patented, whether products or procedures in all the fields of technology, so long as they are new, involve an inventive activity and are suitable for industrial application.	
This may exclude diagnostic, therapeutic, and surgical methods for treating people or animals.	No acknowledgement of patents on surgical techniques and diagnostic methods.
Grants the right to block third parties, without consent, from manufacturing, using, providing for sale, selling, or importing for these purposes a product that receives a patent	
The government may authorize the patent to be used without the owner's permission by the government itself or third parties authorized as exceptions.	Application of mandatory licenses determined by our health authorities.
The patent is protected for a 20-year period beginning on the date when the application is filed.	Patent protection for 20 years initiating with the first request No new clinical information intending to extend the protection period will be accepted.
Individuals and companies may block any information legitimately under their control from being disclosed to third parties or acquired or used by third parties without their consent contrary to honest commercial uses.	The information is in the public domain and is not considered to be information that is undisclosed. New information is not accepted for second clinical use.
Presentation of test data or other undisclosed data which involved considerable effort in elaborating will be protected from unfair commercial use.	The authorities may divulge the data available as undisclosed information based on the public benefit. Recognition of test data for five years.
Use may be made of patented chemical entities for registration so long as the new products are marketed after the patent protection has expired.	Undisclosed information may be used prior to the drug patent's original expiration for registration purposes, to allow generic production, facilitating market entry, immediately after the patent expires.
There is no prohibition on parallel imports: drug supplies are purchased in countries where the cost is lower.	Parallel imports are maintained.

Source: CCSS Drug Therapy Dept.

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ANNEX 1. ARBITRARY DISCRIMINATION IN COSTA RICA 2006

Area	Findings	Evidence
Health Care		
Denial of treatment due to HIV/AIDS status .	Occurs in practice	Although evidence was observed, no particular case was mentioned.
Different treatment due to HIV/AIDS status.	Occurs in practice	
Performance of HIV tests without consent	Occurs in practice	
II. Employment		
Compulsory testing before hiring. Article 71, paragraph F of the Labor Code authorizes employers to request medical exams and laboratory tests.	Occurs in practice Privacy with regard to performance of tests is stipulated by the HIV/AIDS Law	Although evidence was observed, no particular case was mentioned.
Questions related to HIV/AIDS status or life style on forms, or during job interviews.	Occurs in practice	
Firing or change(s) in work conditions due to sexual preference or related to HIV/AIDS.	Occurs in practice	
Restrictions due to HIV/AIDS status (i.e.promotions, work location, formation and or legal benefits).	Occurs in practice	Although evidence was observed, no particular case was mentioned.
Denial of employment due to HIV/AIDS serology test results.	Occurs in practice	
Judicial proceedings		
The deliberate transmittal of HIV/AIDS is a crime.	Prohibited by law, but occurs in practice.	One particular case was mentioned.
Education		
Restrictions imposed in an educational context due to HIV/AIDS test results. (i.e., segregation).	Occurs in practice	Although evidence was observed, no particular case was mentioned.
Family and Reproductive Life		
Compulsory prenatal tests.	Occurs in practice	Although evidence was observed, no particular case was mentioned.

ANNEX 2. FORM FOR SELECTING SUCCESSFUL INTERVENTIONS

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

B. INFORMATION ABUT THE PROJECT-PROGRAM	
Name of the Project:	
1. Type of activity Addressed: ☐ Prevention ☐ Testament ☐ Mitigation of the damage ☐ Legal actions in defense of human rights ☐ Gender ☐ Other (specify):	**2. Year it initiated:** ☐ **3. Year it ended:** ☐ **4. Description of the Project:** Historical Background Objetives Personnel

5. Population Benefited:

☐ Commercial Sex Workers	☐ Prison inmates
☐ Indigenous groups and Afro-descendents	☐ Vulnerable Youth
☐ Men who have sex with other men (MSM)	☐ Orphans
☐ Migrant groups in affected regions and direct victims of the epidemic	☐ Businessmen
	☐ Manufacturing Plant Employees
☐ Military and Police	☐ Other (specify):

6. Sources of Finance:

7. Reasons explaining why it is considered a successful experience:

- Impact
- Coverage
- Access
- Particular characteristics, innovation, permanence, methodology.

This data must contain qualitative, quantitative and demonstrative success indicators. Files, pamphlets, samples of work can be attached.

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 realting to UNAIDS Annex 5

1. Are there agreements or communications forums that fight against discrimination?
2. Are there agencies for defending human rights?
3. Is there an NGO whose objective is defending the human rights of PLWHA?
4. What is the degree of coordination among the agencies that defend human rights?
5. 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 EXPERIENCIES IN COSTA RICA 2006

Institution	Project	Initiated	Direction	Population Benefited	Zone
United Nations Population Fund	Facilitates a healthy lifestyle: helps youth who are social excluded in order to prevent HIV. It is also known as "Manos a la Obra."	2002	Prevention, human rights, gender, immigrants	Youth that live in situations of social exclusion	Urban and rural
FUNDESIDA Foundation for Figthing AIDS	Contributes to eradicating commercial sexual exploitation of children, adolescents and women in the metropolitan San Jose area	1998	Integral care, gender and care	Vulnerable youth and girls, adolescents and women facing conditions of sexual violence	Urban and rural
Central American Center for Research and Promotion of Human Rights	Recognition and pride in a healthy lifestyle	2003	Prevention	Men who have sex with men	Urban and rural
ASOVIHSIDA Costa Rican Association of People who live with AIDS	Peer work	2003	Care	PLWHA	Urban and rural

ANNEX 5. LOGIC FRAME FOR: "FACILITATING HEALTHY LIVING CONDITIONS: YOUNG PEOPLE SHUNNED SOCIALLY IN PREVENTING HIV/AIDS" PROJECT. (MANOS A LA OBRA)

Result	Indicator	Sub-Indicator	Goal
1. Greater commitment and support for preventing HIV/AIDS among young people by legislators, local authorities, religious leaders, community inhabitants and other major participants, particularly in the areas where the project operates	Number of key organizations committed to support HIV/AIDS prevention among young people in the project areas	Number and type of key organizations involved in the project's activities that are committed to support preventing HIV/AIDS in young people.	1. Community teams (inter-sector, inter-institutional, and inter-generational) composed of at least 10 trained and aware people who carry out HIV/AIDS prevention activities among young people 2. Participation of at least five political, institutional and organizational authorities from the regional and local sectors in supporting HIV/AIDS-prevention activities
	Number of provisions in HIV/AIDS policies oriented to prevention among young people	Number and type of legal and institutional reforms designed to prevent HIV/AIDS among youth.	Community teams formed by at least 10 participants trained and carrying out actions to prevent HIV/AIDS infections among youth.
2. Strengthened local capacity to provide information, education, and friendly services to young people through training, strengthening network support, and material development and distribution.	Percentage of health care facilities providing counseling and friendly services to young people about HIV/AIDS in the project areas.	Demonstrative community actions for HIV/AIDS prevention implemented among youth.	At least one demonstrative community action for HIV/AIDS prevention implemented for each community team with participation of youth.
		Proposals prepared to correct gaps, adverse situations, or rights violations in social youth participation, friendly SS/SR services, HIV/AIDS prevention, and social inclusion.	At least five proposals elaborated for resolving gaps, adverse situations or rights violations.
	Percentage of young men and women in the project who can state at least three ways of preventing HIV infections	Demonstrated community actions executed in prevention of HIV/AIDS among youth	80% or more of the young people who participate in HIV/Prevention programs developed by the project can mention at least three ways of preventing HIV infection.
	Percentage of young people satisfied with HIV/AIDS services and counseling.	Percentage of young men and women involved in HIV/AIDS preventive actions developed by the Project and by Community Teams who can mention at least three ways of preventing HIV infection..	At least 80% of the young people participating in the HIV/AIDS prevention actions developed by the project and the community teams were satisfied with the proposed HIV/AIDS educational and

Result	Indicator	Sub-Indicator	Goal
			counseling activities.
	Percentage of young men and women in the project who can state at least three ways of preventing HIV infections	Percentage of young men and women involved in HIV/AIDS preventive actions developed by the Project and by Community Teams who can mention at least three ways of preventing HIV infection.	Not fewer than 80% of the young people who participate (men and women) in HIV/Prevention actions developed by the project and the Community teams can mention at least three ways of preventing HIV infection.
	Amount of IEC materials for youth regarding HIV/AIDS prevention that have been produced and distributed	Percentage of young men and women involved in HIV/AIDS preventive actions developed by the project and by Community Teams who can mention at least three ways of preventing HIV infection.	- Four different radio spots - Two different types of posters with HIV/AIDS prevention messages - Two different types of information and educational brochures (expandable)
3. Innovative experiences to effectively and sustainably prevent HIV/AIDS, especially among the young and vulnerable, documented and made available for reproduction.	The number of reports, documents and publications that demonstrate the interest and commitment to innovative ways to deal with HIV prevention among vulnerable young people	Percentage of young men and women participating in HIV/AIDS activities developed by the Project and for the Community teams who can mention at least three ways of preventing HIV infections	At least one systematization document for each community and regional setting on the experiences and best practices in preventing HIV/AIDS among young people

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