



Latin America and the Caribbean

and The Global HIV/AIDS Program

THE WORLD BANK

Reducing HIV/AIDS Vulnerability in Central America:

El Salvador: HIV/AIDS Situation and Response to the Epidemic



December 2006

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Reducing HIV/AIDS Vulnerability in Central America
El Salvador: 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, El Salvador, World Bank

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Acronyms and Abbreviations

ABC	Abstinence, Fidelity and use of Condom
AIDS	Acquired Immunodeficiency Syndrome
ALCA	Free Trade of the Americas
ANEP	National Association for Private Enterprise (El Salvador) (Asociación nacional de empresa privada)
ANSP	National Academy for Public Safety
ART	Antiretroviral Therapy
ARV	Antiretroviral medicines
ATLACATL	Defense of Human Rights of PLWHA
BMI	Body Mass Index
BNPP	Bank-Netherlands Partnership Program
CAFTA	Free Trade Agreement with Central America and the Dominican Republic
CDC	Centers for Disease Control
CEMUJER	Norma Virginia Guirola de Herrera Women's Studies Institute
CEPAL	United Nations Economic Commission for Latin America
CEPRESI	Center for AIDS Education and Prevention
CIPE	Center for International Private Enterprise
CONADEH	National Human Rights Commission of Honduras
CONASIDA	National Council for Integrated HIV/AIDS Care
CONCASIDA	Central American STDs/HIV/AIDS Conference
CSSP	Higher Council for Public Health
CSW	Commercial Sex Workers
DGEC	General Statistics and Census Directorate
FESAL	National Family Health Survey, El Salvador (Encuesta Nacional de Salud Familiar)
FUNDASIDA	National Foundation for the Prevention, Education and Accompaniment of Persons with HIV/AIDS
GTZ	German Agency for Technical Cooperation
HIV	Human Immunodeficiency Virus
HIVOS	Dutch Humanist Institute for Cooperation with Developing Countries
HON	
IADB	Inter-American Development Bank
ICAS	Central American Institute for Social Action
IDU	Injecting Drug Users
IEC	Information, Education and Communication
IEC	Information, Education and Communication
IGSS	Guatemalan Social Security Institute
IIDH	Inter-American Institute of Human Rights
IMPSIDA	Mesoamerican Initiative for the HIV/AIDS Prevention
ISSS	Salvadoran Social Security Institute (Instituto Salvadoreño de Seguridad Social)
LCSHD	LAC Human Development Department
LCSHH	Health Sector

MCT	Ministry of Science and Technology
MINED	Ministry of Public Education (El Salvador)
MINED	Ministry of Education
MSM	Men who have Sex with other Men
MSPAS	Ministry of Public Health and Social Assistance
NGO	Non-governmental organization
NRTI	Nucleoside Reverse Transcriptase Inhibitor
NSP	National Strategic Plan
PAHO	Pan-American Health Organization
PASCA	Central American AIDS Action Project (Proyecto Acción SIDA para Centroamérica)
PASMO	Pan-American Association for Social Marketing
PEN	National Strategic Plan
PLWH	People Living with HIV
PLWHA	People Living with HIV/AIDS
PNS	National HIV/AIDS/STD Program (Progama Nacional de HIV/AIDS/STD)
PNUD	United Nations Development Programme
PREVENSIDA	Prevention of AIDS Organization
PTMI	Prevention of Mother-infant HIV/AIDS transmission
REDSAL	Security Network and Defense of Latin America
SIDA	Swedish International Development Cooperation Agency
SIDALAC	Latin American and Caribbean AIDS Initiative
SIPPE	Prophylaxis Post Exhibit System
STI	Sexually Transmitted Infections
UNAIDS	Joint United Nations Program on HIV/AIDS
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
VCT	Voluntary Counseling and Testing
VIH	Human Immunodeficiency Virus
WBIHD	World Bank Institute Human Development Division
WHO	World Health Organization

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Executive Summary – Regional Overview ⁸

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

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

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

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

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

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

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

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

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

Main Findings, Conclusions and Recommendations

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

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

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

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

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

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

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

National Responses

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

El Salvador: HIV and AIDS Situation and Response to the Epidemic

Economic, social, political, cultural and religious factors shape the nature of the HIV epidemic in El Salvador and the response to it. This paper describes the epidemic's trends, and the general perception of society regarding HIV and AIDS. It next looks at the main legal, political, economic and social responses, focusing on the role of the government, civil society and international agencies in dealing with the epidemic.

HIV and AIDS Situation

The HIV epidemic is considered to be concentrated in El Salvador, with a prevalence rate that exceeds 5% in highly vulnerable groups (MSM and CSW), but a rate in pregnant women of 0.22% in 2004, according to PNS.^{1,2} UNAIDS estimates overall prevalence at 0.7%, and based on trend data, projections in 2003 suggested that there would be a total of 81,904 PLWH by 2010, and an estimated prevalence of 1.7%.³ Prevalence is higher among economically active youth and in the central regions of the country. The main mode of transmission is sexual, and the epidemic is becoming feminized.

The first case of HIV was reported in 1984. As of July 2005, the official number of cases registered since 1984 was 15,609, of which 8,461 were HIV cases and 7,148 were AIDS cases (Graph 1). Those figures represented an increase of 19.4% in new HIV cases reported and 8.6% in AIDS cases from a year earlier. Data from December 2005, which were preliminary, showed that the cumulative total number of HIV cases was 16,334, of which 9,004 were HIV cases and 7,330 were AIDS cases. As compared to the previous year, there were 193 fewer HIV cases reported and 262 fewer AIDS cases reported in 2005. The HIV incidence rate reached 20 per 100,000 inhabitants in 2004, and was estimated to be slightly lower at 17 per 100,000 inhabitants in 2005 (Graph 2). The estimated number of people living with HIV in El Salvador in 2004 was approximately 30,000.⁴

From 1984 to July 2005, men accounted for 9,931 HIV cases, or 64% of the total, while women accounted for 5,678 cases, or 36% of the total. On the other hand, 43% of the cases involved women aged 15 to 49 years, and the PNS believes that women initiate sexual activity at an earlier age than they did in the past.⁵ The disparity between the number of cases involving men and women declined over time. From 1984 to 1990, 4.5 men had HIV for every female, while the ratio was 1.3 men for each woman in July 2005.

¹ According to UNAIDS, the epidemic is considered to be concentrated when the HIV prevalence rate exceeds 5% of a population subgroup, but is less than 1% among pregnant women in urban areas.

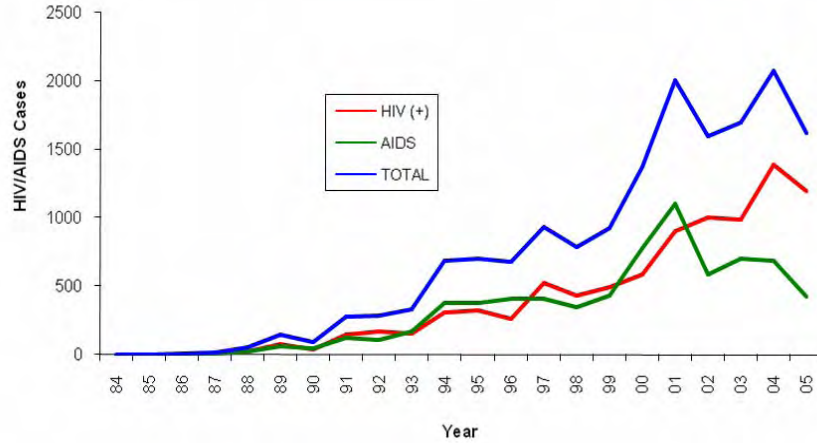
² PNS HIV/AIDS Epidemiological Bulletin July 2005.

³ Integrated Care for HIV/AIDS Policy, CONASIDA. 2005.

⁴ Preliminary data from the HIV/AIDS Epidemiological Unit, December 2005.

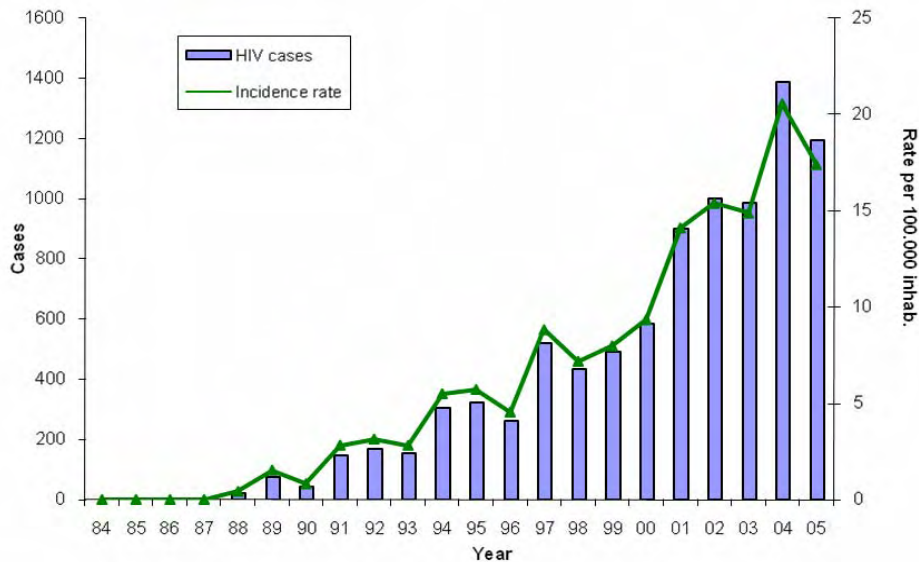
⁵ PNS Epidemiological HIV/AIDS Bulletin July 2005.

Graph 1. New HIV and AIDS cases in El Salvador 1984-2005



Source: Epidemiological Unit of the Ministry of Health 2006

Graph 2. Trends in HIV cases and incidence rate El Salvador 1984-2005
(Rate per 100,000 inhabitants)



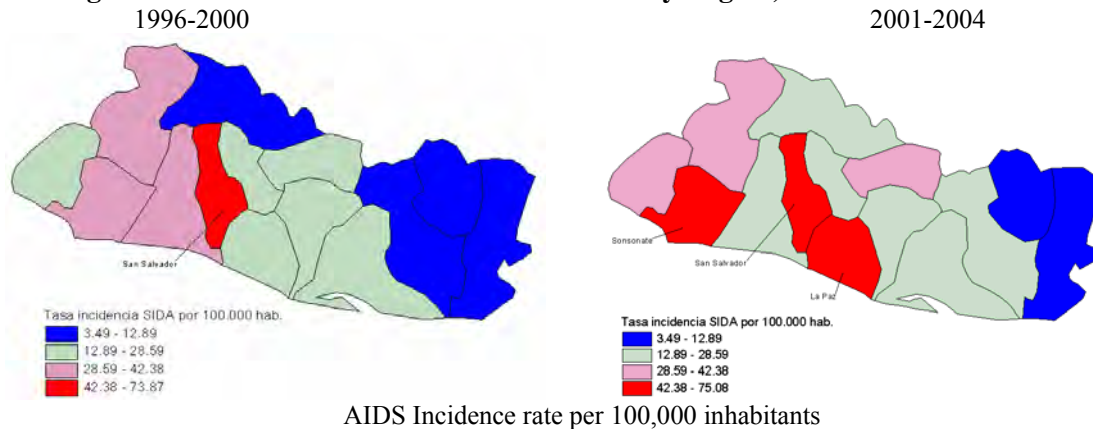
Source: Based on PNS Epidemiological Unit data and population estimates by the Central American Population Center, University of Costa Rica 2006

The main mode of transmission is heterosexual relations (77% of all cases), followed by vertical transmission (7.1%) and men who have sex with men, or with men and women (4.2% and 3% respectively).⁶

⁶ The percentage of MSM infected may be higher; due to social stigmatization, some MSM may identify themselves as heterosexual.

According to the geographic distribution pattern of the epidemic, risk levels are highest in the western and central parts of the country.⁷ Some 56% of cases are concentrated in San Salvador, 7% in Sonsonate, 6% in La Libertad and 6% en Santa Ana, with the remaining cases distributed among the 10 other regions of the country. No studies were found regarding the geographical location of high-risk groups in El Salvador; however these groups, mainly MSM and CSW, have been associated with major cities.

Figure 1. AIDS Incidence Rate in El Salvador by Region, 1996-2000 and 2001-2004



Source: Based on data from Epidemiological HIV/AIDS Bulletin, July 2005, Public National Strategy and Population Projections for the Republic of El Salvador 1995-2010, DGEC 2006

Incidence of the epidemic has increased in all regions except in San Vicente y La Libertad. The department of San Salvador had the highest incidence in 1996-2000 and 2001-2004 (74 and 75 cases per 100,000 inhabitants, respectively). The region where incidence increased the most during the two periods is La Paz. In 1996 to 2000, the rate was 28 per 100,000 inhabitants, and it practically doubled – to 54 per 100,000 – in 2001-2004.

The AIDS mortality rate increased from two deaths per 100,000 inhabitants in 1998 to 5.2 deaths per 100,000 inhabitants in 2004, making AIDS the seventh cause of death in hospitals and the primary cause of death for both men and women 20-59 years old. MSPAS hospitals reported that there were a total of 1,611 deaths from AIDS between 1998 and December 2004. An MSPAS study in 2002 showed that 42% of the patients who died of TB during a three-year period were living with HIV; 74% of them were men and 26% were women.⁸

Information on the epidemic characteristics and trends is gathered by the Epidemiological Surveillance System of the Ministry of Health (MSPAS). It has been available since the beginning of the epidemic in 1984, and consists of a registry of new HIV and AIDS cases. Reporting of HIV and AIDS cases has been compulsory since the epidemic began. Although information has been put into the database for the National Program for the

⁷ CDC-GAP 2004.

⁸ PEN 2005-2010.

Prevention and Control of STIs and HIV/AIDS (PNS) regularly since August 1991, reporting of the official number of cases began only in 2001. Surveillance information includes social and demographic data, as well as information on age, gender, place of residence and transmission mode.

Greater efforts are being made to avoid under-reporting, and conditions continue to improve for vulnerable groups regarding access to HIV tests. However, specialists believe underreporting may be as high 50%, while others argue that it is lower or practically non-existent.⁹ Information relating incidence of HIV and AIDS to behavior is scarce and not systematically organized. Nevertheless, behavioral studies of the general population have been carried out.¹⁰

Vulnerable Groups

Sex Workers (CSW). Seven studies were carried out on sexual behavior, type of sexual partners, knowledge and use of condoms, reasons for using condoms and high-risk practices in this group. The prevalence of HIV is six times higher among CSW who work on the street compared to those who work at fixed sites (16.2% versus 2.7%), and the prevalence of syphilis is 1.5 times greater. A study of 491 CSWs found that 30% were 20-24 years old and the average age of first sexual relations was 15 years; 80% said they used condoms with clients, but only 10% did so with their regular partners. This study found an HIV prevalence of 3.6% among CSW.

A study of HIV and STIs Prevalence and Behavior of Commercial Sex Workers in El Salvador determined that on average, half engage in risky behavior and have false information about HIV. The study covered the city of San Salvador and the port of Acajutla, and 491 women participated in this behavior survey.

Table 1. Indicators for Commercial Sex Workers, El Salvador 2003

Indicators	2003
	N=491
20-24 years of age	30%
Average age of first sexual relation	15
Weighted HIV prevalence	3.6%
Reported systematic use of condoms	80%
Do not use condoms with regular partners	90%

Source: Epidemiological Surveillance System, CDC/GAP 2004

⁹ The PNS refers to "...the epidemiological surveillance system, which lacks under-reporting." PEN VIH/SIDA 2005-2010, Pg. 5. However, the Final Report of the El Salvador Epidemiological Surveillance System 2005, Pg. 21, recognizes that, "...there are conditions in which cases are not registered or reported due to the deficiencies of the surveillance system in specific areas of the country."

¹⁰ FESAL, Evaluation of the Epidemiological Surveillance System in El Salvador CDC/GAP, 2004. Family health surveys.

A study by the Department of Public Health from the Universidad Centroamericana "José Simeón Cañas" in 2004 established a baseline on knowledge, attitudes and practices related to HIV/AIDS/STIs in CSW in four cities in El Salvador. The study covered the cities of San Salvador, Puerto La Libertad, San Miguel and Sonsonate. The total number of sex workers was 206, of whom 64% were in the 17 to 30 age group; 65% were married or in a relationship with someone and 68% had at least a ninth grade educational level; 77% had an average family income below \$316. More than 80% had potable running water in their homes, electricity and sewage services.

Some 76% of CSW had reasonable knowledge about HIV transmission - 95% knew that using condoms avoids transmission. However more than half believed that HIV is transmitted through saliva or mosquito bites. Although 90% used condoms when they last had sexual intercourse, only 23% used condoms with their regular companions. About 83% of CSW surveyed requested an HIV test, and 95% of these received the results. Of these, 1.24% had HIV; 58% were provided pre-counseling services before taking the test, and 45% received post-counseling; 87% of those who received counseling stated that it was quality information.

Men who have Sex with Men (MSM). Four studies were found for this demographic group -- the PASMO¹¹ and Multicenter¹² studies focused on correct ways for preventing HIV, anal relations with multiple partners, men who receive penetrative anal sex and systematic use of condoms. As Table 2 shows, the prevalence of syphilis and HIV in this population is high, especially HIV (18%). The prevalence of both is greater in the MSM group that self-identified as gay/homosexual. The Multicenter study showed that 40% of the MSM population who participated in the study engaged in high risk behavior and had false beliefs about the transmission of HIV.

Table 2. MSM HIV-Related Behavior in El Salvador 2003

Indicators (n=356)	2003
HIV Prevalence	17.7%
Syphilis Prevalence	15.1%
Age Group 20 -24 years-old	44.5%
Sexual Relations with women	64%
Systematic use of condoms	80%
Use of Intravenous Drugs	40.3%
Use of Condoms with Occasional Partners	74.8%

Source: Epidemiological Surveillance System CDC/GAP 2004

Another baseline study for this group¹³ determined that about 75% had access to information, and 97% had adequate knowledge regarding HIV and AIDS; 66% recognized that they could prevent infection through the use of condoms; 94% accepted

¹¹ PASMO. HIV/AIDS Knowledge, Attitudes and Practices towards HIV/AIDS and the Use of Condoms in CSW and MSM in El Salvador 2002.

¹² Central American Multicenter Study of HIV and STIs Prevalence and knowledge of CSW in El Salvador 2003.

¹³ Department of Public Health of the Universidad Centroamericana José Simeón Cañas 2004.

that having sexual relations with various people increases the risk of infection; and more than 97% were aware that HIV may be transmitted by having sex without a condom, by getting tattoos with a needle used by someone else and by sharing needles with a PLWH; 83% knew that a pregnant woman can transmit HIV to her child, while 90% were aware that a mother who has HIV and breastfeeds can transmit the virus to the child. Older MSM – those aged 31-34 – were more likely to use condoms than MSM aged 14 to 20 (88%, compared to 81%), and usage is lowest among those aged 21 to 25 years (67%).

Only 29% had stable relationships; 13% used condoms the first time they had sex, and 76% used condoms the last time they had sex. While 51% used condoms with their life partners occasionally, only 11% had life partners that accept using condoms; 62% of MSM had sexual relations under the influence of alcohol, and 44% used condoms the last time they had sex under the influence of alcohol. On the other hand, 69% used condoms the last time they had sex with an intravenous drug user.

Prisoners. There were 12,106 prison inmates in El Salvador in March 2005. However, there is no information regarding the prevalence of HIV in this population. It is estimated that only 50% of prison inmates who have HIV and require treatment actually have access to health centers. The number is limited because they must go outside the prison for treatment.¹⁴

Other information¹⁵ related to this group indicates that 87% have adequate knowledge about HIV and AIDS, and 62% know that using condoms is a method of avoiding transmission.¹⁶ About 60% have received information on HIV and AIDS, and more than 90% know how HIV can be prevented or transmitted. More than 95% recognize that the epidemic may be transmitted through sexual relations without a condom, getting tattoos with a needle used by someone else, sharing needles with a PLWH and receiving blood; 92% acknowledged that the disease can be transmitted by sharing another person's razor blade. In addition, 90% are aware that a pregnant woman can transmit HIV to her child and that a mother can transmit it to her baby through breastfeeding.

However, only 21% used a condom the last time they had sex, 38% reported using a condom the last time they had sex with a man, and 47% stated that they frequently used condoms during sexual relations. Prisoners who had better knowledge about the use of condoms used them more frequently (44%) than those who had less knowledge regarding the topic (6%). 54% have had sexual relations under the influence of alcohol, and 22% reported using a condom the last time they had sex under the influence of alcohol; 50% stated that the last time they used an intravenous drug during the previous month, they had shared the needle with another person; 49% have had sex with CSWs, and 32% paid for sex the last time they had it.

¹⁴ In 2005, an initiative for prevention and care of STIs and HIV/AIDS among prison inmates throughout El Salvador's Penitentiary Centers was launched.

¹⁵ Department of Public Health, Universidad Centroamericana "José Simeón Cañas" 2004. Baseline study regarding knowledge, attitudes and practices related to STIs and HIV/AIDS in the prison population in El Salvador.

¹⁶ Sample of 220 inmates in four prisons, La Esperanza, The Prison for Women, Ilobasco, Cabañas and Apanteos.

Women. The feminization of the epidemic is evident from the Epidemiological Surveillance reports, and from the 2002-2003 FESAL survey reports. Domestic violence, sexual abuse and low empowerment of women all place females in a position of greater risk of HIV. Women, especially younger women, are particularly vulnerable because they may be unable to avoid sexual relations or to negotiate to have protected sex. The high number of single mothers is also a factor.

The population of El Salvador was nearly seven million in 2005, 51% of whom were female. The average age for the first sexual relationship was 18.4 years. A survey by Family Health FESAL 2002-2003 revealed that from 1997-2002 the global fertility rate was 2.97 children per woman. Data from the Family Health Survey indicate that Salvadoran women between the ages of 14 and 44 began to use contraception on average when they had 1.6 children – at an average age of 22.4 years, or 3.8 years after their first conjugal relationship. It is estimated that 51% of all pregnant women in El Salvador are between 20 and 29 years of age.¹⁷ The level of HIV infection has increased among adolescent women — a trend that may relate to an early beginning of sexual activity and little use of protection.

Violence against women is one factor that makes them vulnerable to HIV and other STIs. About 20% of females between the ages of 15-49 who are married or have lived with someone at some point in their lives, have experienced at least one act of physical violence in their conjugal lives. Of the people who experienced violence, the percentage that sought help was lower among younger females (ages 15-24) who are not employed outside of the homes and are single.¹⁸ The 2003 Report on Human Development for El Salvador¹⁹ indicates that “gaps still exist between men and women. For example, men present an average literacy rate 5.5% higher than women and average income 2.2 times greater than women.” The difference in the Gender Development Index between rural and urban areas is even more pronounced. This has ramifications for how the HIV epidemic is perceived and spread.

Pregnant Women. Five studies are available regarding HIV among pregnant women.²⁰ They are the only group who are periodically monitored through a seroprevalence surveillance study in every health institution throughout the country that is capable of providing a diagnosis (82% of all health institutions). Three studies were carried out by the Ministry of Health in 1992, 1997 and 2003, and two were carried out by other organizations in 1997 and 2002. Variables studied included seroprevalence, sexual behavior, sexual partners, the use of condoms and knowledge about sexual transmission through breastfeeding.

According to PNS reports, mother-to-child transmission represents about 5% of the total number of cases. In 2003, HIV transmission occurred in 0.33% of all pregnancies, while

¹⁷ Estimates obtained from CEPAL, “*Proyecciones de las tasas de fecundidad. Hipótesis media*”.2006

¹⁸ PEN 2005-2010.

¹⁹ Report on Human Development, El Salvador PNUD 2003.

²⁰ Final Report of the Surveillance System of El Salvador, CDC/GAP 2004.

in 2004, according to PNS, it was 0.22% (two HIV-positive cases for every 1,000 pregnant women).²¹

Table 3. HIV Prevalence in Pregnant Women by Region 2003

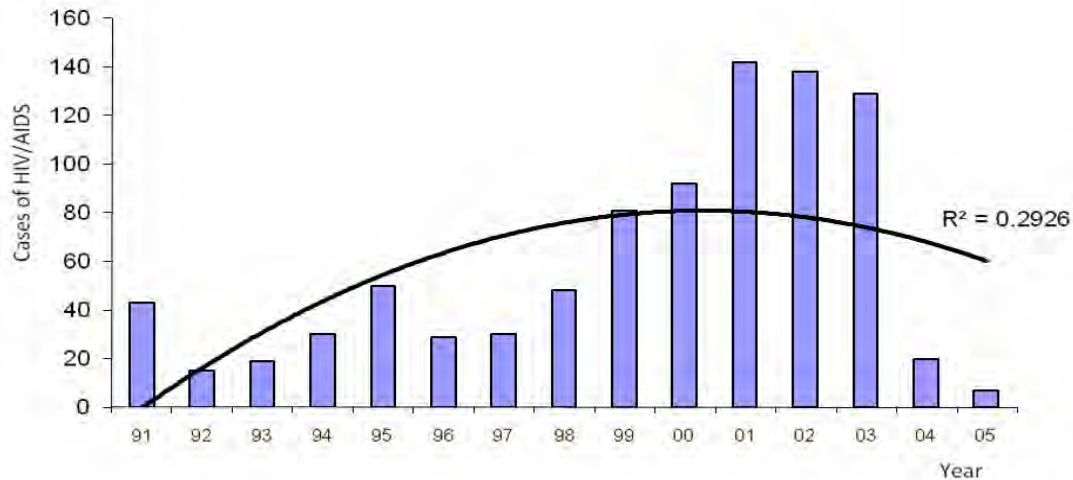
Department	Sample Size	No. Cases	%
La Libertad	819	1	0.12
San Miguel	521	2	0.38
San Salvador	1818	9	0.50
Santa Ana	786	1	0.13

Source: Surveillance of HIV Seroprevalence in Pregnant Women

A survey by Family Health FESAL 2002-2003 revealed that that from 1997-2002, the global fertility rate was 104 children for every 1,000 females between the ages of 15-19. Although the specific fertility rate in adolescents has recently dropped, levels of HIV infection in this demographic group appear to be increasing, possibly because first sexual relations tend to occur more often at an early age and use of protection in this group is relatively low.²²

From 1991 to 1998, a fluctuating but increasing trend in HIV positive cases among children younger than one became evident. The first decrease in the curve occurred in 1996, possibly because of the start of the Prevention of Mother-Infant HIV transmission (PTMI) program at the National Maternity Hospital. In 2000, with the opening of the Clinic for Children with Immunodeficiency at the Benjamin Bloom Children’s Hospital, a significant increase was recorded in new infections, mostly due to the detection of new cases. However, the number of cases decreased significantly in 2004 and 2005 (Graph 3).

Graph 3. HIV Cases among Children younger than 1 year 1991-2005



Source: PNS 2005

²¹ PNS 2005. Epidemiological Surveillance Bulletin for HIV/AIDS and STIs .

²² PEN 2005-2010.

Vulnerable Youth. FESAL 2002-2003 indicates that 32% of females aged 15-19 have had sexual relations; 22% of all women who are 15-24 had their first sexual relationship before they were 15 years old, and 66% did so between 15-19 years of age.²³ Until 2004, 50 HIV cases had been reported in the age group 10-14, of which 62% were girls. For the 15-19 age range, the total number of cases was 684, of which 54% were female. The average age at which a woman initiated sexual relations was 17.2 years. The average number of sexual partners in the last two years was 1.4. About 73% said that people could protect themselves from HIV by using condoms, and 87% said that being faithful could prevent the transmission of HIV; 94% knew that a woman could transmit HIV to her child during pregnancy, and 89% said they could transmit it through breastfeeding.

Youth Who Are Intravenous Drug Users. From 1984 to July 2005, 1% of approximately 1,500 HIV cases surveyed were in drug addicts. In 2004, a baseline study²⁴ was conducted to learn about knowledge, attitudes and practices related to HIV and other STIs among children and adolescents addicted to drugs in four regions in El Salvador. The results indicate that 72% have some knowledge regarding HIV and AIDS and 57% know that using a condom prevents transmission; more than 90% know how the disease is transmitted; 90% recognize that having sex with more than one partner increases the risk; people in this group acknowledged that the disease may be transmitted by sharing another person's razor blade. In addition, 80% recognize that a pregnant woman can transmit HIV to her child and that a mother who has HIV and breastfeeds her baby also can transmit the virus.

About half of the IDUs surveyed had received some information about HIV and AIDS. About 73% knew where they could take the test; 49% asked to take an HIV test; 96% of these actually took the test; of these, 70% were given their results; 11% of a total of 66 young people who took the test were HIV positive. Only 31% received counseling when they took the test. Of those who received counseling, 97% believed that the information provided was clear.

Almost 70% had had sexual relations under the influence of alcohol or drugs, and 45% had had sexual relations with CSW. However, older youngsters were more likely to use condoms with CSW than younger ones (59% vs. 29%); 32% of the youth reported using condoms the last time they had sex, and 19% reported frequently using condoms when they had sexual intercourse.

Youth Gang Members. A baseline study of 158 gang members was carried out in 2004 in the departments of San Salvador, La Libertad, San Miguel and Santa Ana.²⁵ The study showed that 60% knew that they could prevent HIV infection by using condoms; 95% knew that having sexual relations with more than one partner increases the risk of infection; 98% knew that HIV is transmitted through sexual relations without a condom and sharing needles with a PLWH, while 90% knew that it can be transmitted through

²³ FESAL 2002-2003.

²⁴ Department of Public Health, Universidad Centroamericana "José Simeón Cañas". Sample of 204 youngsters from the regions of San Salvador, La Libertad, San Miguel and Sonsonate.

²⁵ Idem.

blood or being tattooed with a needle that had been used by another person; 76% recognized that pregnant women may transmit HIV to their children, that a mother who has HIV and breastfeeds can transmit HIV to her child, and that the virus can be transmitted by using someone else's razor blade.

Of this group, 42% had received some information about HIV and AIDS; more than 70% knew where to take an HIV test, and 22% requested a test, of whom 76% received the results. About 57% received pre-counseling and 41% received post-counseling when they took the HIV test. Of these, 62% received clear information during the counseling session.

Only 20% reported using condoms the last time they had sexual relations, and 51% had sexual relations under the influence of alcohol. Among gang members, 67% of intravenous drug users had shared a needle the previous month with another person; 37% had sexual relations with CSW, and 64% reported using condoms the last time they had sexual relations with a CSW.

Migrant Groups in Affected Regions. One of every 10 families has a member who lives or has lived in a foreign country, almost always countries in North America; 68% of all people who emigrate are male, and 32% are female; one of every two people who have migrated were less than 25 years old. On average, migrants had approximately seven years of schooling when they left the country.²⁶

A study of mobile populations with a sample of 1,704 people in 11 cities determined that 84% of this group had some knowledge of HIV and AIDS. More than 95% knew that HIV can be transmitted through sexual relations without a condom, tattoos with a needle that has been used by another person, sharing needles with PLWH, and receiving blood; 90% knew that HIV may be transmitted by using another person's razor blade; 96% knew that having sexual relations with more than one partner increases the risk; 93% recognized that pregnant women may transmit HIV to their children. On the other hand, 50% thought that use of condoms is actually a way of transmitting the epidemic, a significant percentage said there are other forms of transmission; for example 58% cited kisses on the cheek or mosquito bites, and 51% said HIV is transmitted through saliva.²⁷

About 98% of customs and immigration employees have some knowledge about HIV and AIDS. Knowledge increases with schooling - 100% of technical workers have excellent knowledge, compared to 63% of those who have no schooling.

Among migrants, 37% requested an HIV test; and 98% took the test the last time they requested it; of these, 92% were given the results, and only 39% were counseled when they took the test.

²⁶ FESAL 2002-2003.

²⁷ Department of Public Health, Universidad Centroamericana José Simeón Cañas, 2005. Knowledge, attitudes and practices related to HIV/AIDS and STIs in mobile populations in eleven cities in El Salvador: Puerto de Acajutla, Aeropuerto, El Poy, La Tachadura, Angiatú, El Amatillo, Puerto de La Libertad, La Unión, Las Chinamas, Lourdes and San Cristóbal.

Military/Police. The armed forces are permanent members of CONASIDA. However this study did not find enough information to evaluate the HIV status of this group. USAID identified the Civil National Police as a significant focus population for the reduction of HIV in the country. Studies conducted as part of the Change project reached the following conclusions based on a sample of 1,224 agents from the National Police Force (PNC) and the National Academy for Public Safety (ANSP):²⁸

- (1) 58% stated that HIV could be transmitted by sharing personal objects such as combs, towels, handkerchiefs and soap; 39% that it could be transmitted through mosquito bites.
- (2) At least 92% knew that mutual fidelity; sexual relations with only one partner, avoiding intravenous drugs, reducing the number of sexual partners and using condoms with all sexual partners were effective ways of reducing the risk of disease.
- (3) 50% stated that avoiding casual contact (not sexual) with PLWH and avoiding public bathrooms were effective ways of preventing HIV transmission.
- (4) 99% had heard of condoms, and of that group, 99% knew of at least one place where they could be obtained; 22% had purchased condoms in the 30 days before the survey, while 38% had obtained them for free. Only 20% stated that they were carrying a condom at the time of the interview.
- (5) 99% had heard of STIs: 89% mentioned gonorrhea, 74% mentioned syphilis and 58% HIV or AIDS. 99% of those interviewed knew that there were tests for determining if a person had HIV. Of this group, 50% had been tested for HIV (53% of these had taken the test voluntarily, while 47% had taken it once because they had been asked to do so). 83% knew the results of their tests, although only 41% had received counseling before testing and only 29% received counseling after the test results.
- (6) 11% stated that they had consumed drugs; marijuana and cocaine were the most popular drugs (used by 80% and 26% of the sample group respectively).

Popular Perceptions. The general perceptions of the population in El Salvador regarding the epidemic were captured in a national survey conducted in 2003. It indicates that:

- (1) 86% of the population has heard about HIV and AIDS.
- (2) More than 98% consider the epidemic to be a serious problem for the country.
- (3) 97% of the population is aware that there are ways of protecting oneself against HIV, and that condoms are one method of protection; 93% believe that they should be readily available for people who need them, especially young people.
- (4) When specific populations with HIV are mentioned, 54% of the population believes that God has punished prostitutes and homosexuals with the virus due to their

²⁸ United States Agency for International Development (USAIDS). HIV/AIDS country synopsis.

lifestyles. Even so, more than 91% of the population supports HIV prevention programs directed at these populations.

- (5) Only 15% believe infected women have the right to become pregnant. It is expected that this situation will change as a result of the National HIV/AIDS Program's Vertical Transmission project.
- (6) 81% still believe that employers have the right to request HIV tests as a requirement for obtaining employment.
- (7) Similarly, 51% state that people with the disease should not be able to use public places.
- (8) 65% believe that children with HIV should be educated at separate institutions.
- (9) 61% believe that the government is responding adequately to the epidemic, more than 99% approve of HIV and AIDS education programs for children in schools and high schools, and believe that larger educational campaigns are the responsibility of the government.
- (10) More than 98% believe the government should provide medications to people with AIDS.
- (11) More than 98% state that mass media, such as the press, radio and television should include more information on HIV and AIDS.

Separately, the National Family Survey 2002-2003 (FESAL) found that 60% of women know three ways of HIV transmission, while 46% of men are aware of them; 6% of women have taken an HIV test voluntarily, and almost 5% of all men; 6% of women and 20% of men reported using condoms during their most recent sexual relationship. The average age at which women stated that they had sex for the first time was younger than 15 years.

National Response to HIV/AIDS

The country has taken an approach to HIV/AIDS that emphasizes care and treatment, as is characteristic of the rest of the countries of Central America. Since the first case of HIV in El Salvador was registered in 1984, measures have been taken by the MSPAS, civil society and international agencies to address the disease. In 1984, a network of NGOs called PREVENSIDA was established to support prevention in general and vulnerable groups (MSM, CSW) in particular. But it was not until 2001 that Congress approved the HIV/AIDS Law, representing a new social consensus about fighting the epidemic. In part, this was reflected in the establishment of the Strategic Alliance for HIV/AIDS Legislation, an agency that is supported by the Government and through which various NGOs that promote human rights are integrated. The Alliance comprises the National HIV/AIDS Program, FUNDASIDA, PASMO, the Flor de Piedra Women's Association, CEMUJER, UNAIDS, Medicos del Mundo (Doctors of the World)-Spain, PASCA, UNICEF and REDSAL.

HIV/AIDS programs enjoy strong support from high level national political authorities. A national HIV/AIDS response framework includes laws to address the epidemic politically and technically, a National Strategic HIV/AIDS Plan for 2005-2010, and a National Policy for Integrated AIDS Care. The law made the state responsible for integrated care for HIV and AIDS. To carry out that mandate, the government formed the National Commission against AIDS (CONASIDA) as a high-level agency that spans institutions and sectors.

Support from international agencies including the Global Fund, UNAIDS, PAHO and the World Bank, and regional organizations such as PASMO and PASCA, have helped the country advance a national response to HIV/AIDS.

During the last five years, the national response has consisted mostly of training staff and reinforcing the public sector health service infrastructure that deals with prevention and integrated care. Because of this effort, the country won a score of approximately 80% in the Evaluation of Effort Index of the Program against AIDS (API) for the year 2003.

CONASIDA. The National Council on HIV/AIDS (CONASIDA) consists of representatives from different national sectors fighting the epidemic. The government is represented by the MSPAS, the National Secretary on Family Matters, The Ministry of Labor and Social Planning, the Ministry of Education, the Military Health Services Division, the State Department, and the Salvadoran Institute of Social Security. Also participating are NGOs, the mass media, the National Private Enterprise Association, and the Medical Association of El Salvador. In 2004, the National Council on HIV/AIDS was reactivated in compliance with the law that took effect in April of that year. Its main actions have included developing the Policy for Integrated Response to the HIV/AIDS Epidemic, which spells out 10 lines of action that follow international criteria regarding response to HIV. In addition, multi-media campaigns such as “Win the AIDS Battle” and “The Beautiful Life” were planned and carried out in order to increase knowledge about HIV and AIDS among young people and generate acceptance for PLWH. These projects cost approximately \$800,000 – a significant investment by the government for prevention and education about the epidemic.

National Program for Control and Prevention of STDs/HIV/AIDS (PNS). The PNS is operationally integrated, and works with a national HIV/AIDS-care network through a Technical Advisory Committee, a Coordinating Committee from El Salvador and the Global Fund. Among other measures, the PNS has prepared 50 regulatory and legal documents to strengthen and improve the quality of care provided to the population through the health services network of the MSPAS. Some areas that are highlighted include:

- Guidelines for prevention of STIs and HIV among Commercial Sex Workers.
- Guidelines for health intervention on STIs and HIV/AIDS among prison inmates.
- Guidelines for Controlling and Preventing STIs and HIV in Mobile Populations.
- Protocol for prevention and treatment of sexually transmitted diseases.

- Care protocols for people who live with HIV and AIDS.
- Guidelines for pre- and post-test counseling for the HIV test.
- Guidelines for prophylaxis after exposure to HIV (SIPPE).
- Community guidelines for prevention of HIV and other sexually transmitted diseases.

Important government activities include the signing of the “Declaration of San Salvador” for fighting AIDS in Central America and the Caribbean, the launching of a National Strategic Plan for Prevention, Attention and Control of HIV/AIDS 2005-2010, the establishment of mobile clinics for HIV testing, the Program for mobile populations, as well as work on other preventive measures and national campaigns with CONASIDA and other national organizations, reduction in maternal-infant transmission of HIV at national level, strengthening of the National Plan for Decentralization of Antiretroviral Therapy and Universal Access to Medications, the Basic Food Basket program for people with AIDS, and the second STIs and HIV/AIDS Forum for Latin America and the Caribbean and the fourth CONCASIDA 2005.

Financial Resources. Since 2000, the national budget has included financing for HIV/AIDS, mainly for antiretroviral treatment. Government spending on HIV/AIDS was estimated at \$5.6 million in 2000, and reached \$16.8 million in 2002 (Table 4). But it was only \$2.5 million in 2003. On the other hand, growing international and foreign financing translated into significant overall growth of program financing; in 2000, it added up to \$1.6 million, but in 2003 it totaled \$13.6 million. Table 4 shows how overall spending rose, while government spending decreased in relation to that of private and foreign entities from 2000 to 2003.

Table 4. Sources of HIV/AIDS Expenditures in El Salvador 2000-2003
(millions of dollars)

Year	Public Sources	Private Source	Foreign Sources	Total
2000	5.7	2.6	1.7	9.9
2001	12.8	3.9	1.5	18.2
2002	16.9	4.3	1.7	22.9
2003	2.5	14.6	13.7	30.7

Source: Regional Aids Initiative for Latin America and the Caribbean (SIDALAC) 2005

In 2003, public sources accounted for just 8% of all the funding invested in the epidemic, compared to 48% from private sources and 45% of foreign origin (Table 4). For 2001 and 2002, the proportion of public funding amounted to 70% and 73% respectively. Comparing the different program components, the largest share of spending was directed at prevention in 2000, but as ARV treatment was scaled up, the treatment category has been the largest since 2001 (Table 5). Table 6 shows the breakdown of the budget for the components of care for 2004.

**Table 5. HIV/AIDS Expenditures by Activity in El Salvador 2000-2003
(Millions of dollars)**

HIV/AIDS Expenditures	2000	2001	2002	2003
Prevention	4.9	6.5	7.3	7.0
Treatment (including ARV)	3.2	7.4	10.8	9.4
Support services	0.5	1.2	1.5	3.9
Public Health	0.3	1.4	1.0	0.9
Others	1.1	1.6	2.2	9.7
Total	9.9	18.2	22.9	30.7

Source: Regional Aids Initiative for Latin America and the Caribbean (SIDALAC) 2005

Table 6. Proportion of HIV/AIDS funds by Budget Line

Care Functions	2004	
	US \$	%
Health Personnel	18.2	62.76
Public Health	7.7	26.54
Prevention	1.0	3.61
Management	0.6	2.03
Investment	0.4	1.37
Memorandum Items	1.1	3.69
Total Expense	29.0	100.00

Source: Regional Aids Initiative for Latin America and the Caribbean (SIDALAC) 2005

External cooperation increased in 2003-2005 through a Global Fund grant, which will continue until 2007. The Global Fund allocated \$12 million to the two-year phase from 2003 to 2005. But \$4 million were not spent by the end of the phase, leading to a significant cut in the resources – to \$6 million – assigned to the country for 2005-2007. In 2003, resources from the Global Fund enabled a significant increase in expenditures such as staff training, political dialogue, management, and social support for people living with AIDS. Once this support runs out, the project’s activities will have to be absorbed by the government in order to ensure their future sustainability. The regional project will count on support from the World Bank, as well as cooperation from UNAIDS, PAHO, UNICEF, PASMO, USAID, and the Central America HIV/AIDS Prevention Project (PASCA), among others.

LEGAL AND REGULATORY FRAMEWORK

El Salvador’s approval of the HIV/AIDS Law in 2001 involved the participation of civil society through the Strategic Alliance for HIV/AIDS Legislation, which helped win approval of law and its regulations. It also got section “d,” which allowed HIV testing prior to employment, removed from Article 16 of the regulations implementing the HIV/AIDS law. The law ensures non-discrimination, confidentiality, autonomy, personal intimacy, non-isolation, integrated care, as well as work security and education for people living with HIV.

The section below is based on baseline research on HIV and AIDS stigma and discrimination following the UNAIDS Arbitrary Discrimination Protocol.²⁹ The results were confirmed and updated in a meeting with the Strategic HIV/AIDS Alliance and interviews with personnel from the Atlacatl Association, an NGO. The UNAIDS Arbitrary Discrimination Protocol does not include criteria regarding the number of times discrimination occurs or the severity of the cases presented. As a result, some situations are presented that no longer occur or occurred only once. The cases arose from October 2001 to October 2004.³⁰ Testimony, interviews and documents indicated that most of the cases of discrimination arose from prejudiced attitudes among health personnel towards PLWH or groups at risk of contracting HIV.³¹ Annex 3 summarizes the findings regarding topics covered in the UNAIDS Arbitrary Discrimination Protocol.

Health Care. Of the seven basic forms of arbitrary discrimination in health care listed in the UNAIDS Protocol that were evaluated, two are addressed in the laws of El Salvador. They are: (a) administering an HIV test without prior consent and (b) required reporting of seropositive status to partner/s and/or spouse. Article 16 of the HIV/AIDS Law states that requests for obligatory HIV tests are prohibited except in the following cases: (i) when in the doctor's opinion the test is necessary solely for the purpose of caring for the patient's health and in order to obtain better criteria for establishing a diagnosis and treatment plan. This circumstance must be expressly stated in the patient's clinical file; (ii) when it is related to donation of breast milk, blood, semen, organs or tissue; and/or (iii) when it is required for court proceedings and requested by a competent legal authority. Persons who are diagnosed with HIV must notify their regular or occasional partner(s) of their serological status.

Three forms of arbitrary discrimination occur in practice: refusal to administer treatment due to HIV status, administration of HIV tests without prior knowledge, and lack of confidentiality. Two of the basic forms of discrimination in the UNAIDS Protocol were not found, either in law or in practice. One involves quarantine, compulsory hospitalization and/or segregation in hospitals, hospices, clinics, etc., and the other involves refusal to inform a person about his or her HIV test results.

The PAHO Study on HIV/AIDS Stigma and Discrimination in the Health Sector in Latin America and the Caribbean, stated, "Discriminatory actions exist in practice." It said the most common problems included delayed treatment and lack of action to ensure adherence to treatment.

According to statistics maintained by the Atlacatl Association, denial of treatment is commonplace. In February 2003, 10 HIV-positive men and 10 HIV-positive women presented complaints to the Salvadoran Social Security Institution, the Ministry of Health and the Head of the HIV/AIDS program, alleging refusal of treatment. Antiretrovirals

²⁹ UNAIDS 2000. Survey by PREVENSIDA Network Western Association and sponsored by UNDP.

³⁰ After that date, Arbitrary Discrimination Actions that are still current or new actions that were detected through a session of the Strategic Alliance for the HIV/AIDS Legislation and a personal interview with ATLACTL personnel are cited according to their corresponding source and when they occurred.

³¹ In-Depth Research on HIV/AIDS-Related Stigma and Discrimination. IBED, UNDP, 2004

were provided as a result of the complaints. In another documented case, a patient died without ever receiving treatment. Atlacatl attributed the cases to depletion of antiretroviral supplies in the Ministry of Health. The organizations “Flor de Piedra” (Stone Flower) and “Huellas de Ángel” (Angel Prints), register complaints of differential treatment of CSW based on the assumption that they are HIV carriers.³²

The number of HIV tests performed without the patient’s consent appears to be increasing in the health care sector and among employers generally. The Ministry of Health recognizes that this occurs. The situation arises mostly in the case of pregnant women. An MSPAS employee explained that a test may be done without the patient’s consent when it is for treatment. This argument is based on Article 16 of the HIV/AIDS Law, which states in paragraph (a) “if in the doctor’s opinion the test is necessary exclusively in caring for the patient’s health in order to have better criteria for diagnosis and therapy, this circumstance should be stated in the corresponding clinical file.” Some companies require HIV tests without consent as a general practice. In many cases, such tests are performed by referral of the company clinic (ISSS) and by agreement with private laboratories.

Employment. The lack of consistency between the Labor Code and the HIV/AIDS Law is an obstacle for PLWH seeking to protect their labor rights. The laws of El Salvador protect PLWH from stigma and discrimination in employment. However, it was not until recently (2004) that paragraph “d” of Article 16 authorizing HIV tests for job applicants was revoked. In practice, stigma and discrimination happen in the following four situations: compulsory testing before hiring, compulsory testing while employed, lack of confidentiality regarding HIV status and firing or change in the conditions of employment due to HIV status. Statistics supplied by the Atlacatl Foundation confirm that compulsory testing prior to employment is a recurrent problem. “Fundación Huellas” (Herrera) also has provided testimony on this matter. PLWH commonly obtain false negative laboratory results so they can work (*Case 19*). NGOs like the National Foundation for Prevention, Education AND Support of PLWH, or FUNDASIDA and the Atlacatl Foundation report that this occurs because employers require tests.³³

Compulsory testing during employment is stipulated in Article 31, paragraph 10 of the Labor Code (Obligation of Workers), which states that workers must “submit to a medical exam when required by the employer or by administrative authorities for the purpose of verifying their medical condition.” This contradicts the HIV Law, which in Article 16 states that a “compulsory request for testing to diagnose HIV infections is prohibited when not for diagnosis or therapy.” Many institutions copy internal work regulations from the Labor Code, adding articles specific to their activities and interests. This suggests that the majority of companies may have, in their internal regulations, the capacity to require tests from their employees, including an HIV test, even though the practice is an act of discrimination.

Breaches of confidentiality with respect to HIV test results occur in practice, according to

³² Director, Flor de Piedra – IBED, PNUD, 2004.

³³ IBED, UNDP, 2004

the testimony presented to NGOs. Such violations of the HIV law are not reported since there is no connection between the law and the Labor Code, and the HIV law is not in the purview of the Ministry of Labor. Firing or change(s) in work conditions due to HIV serology test results occurs in practice. The Atlacatl Association, for instance, says it recorded seven such cases in 2004. In 2005, of the 50 complaints that the Atlacatl Association supported and processed, 25 involved firing of people from their jobs, and 20 resulted in favorable decisions for the employee. However, no affected person was rehired because no one wanted to go back.

Legal Processes. There is no evidence of the forms of arbitrary judicial-legal discrimination listed in the UNAIDS Protocol. No evidence was found in practice of administrative sanctions for behavior (prostitution, sex between males) thought to favor the propagation of HIV, or of penal sanctions for deliberate transmission of HIV. Nor is there evidence that people living with HIV have been denied the right to due process, denied or been limited in their right to file legal actions such as appeals or requests for review, or denied the right to representation.

Prisons. The greatest problem with regard to stigma and discrimination among the prison population involves lack of medical care and access to medication.³⁴ The three forms of discrimination in the UNAIDS protocol – compulsory testing in prison, compulsory testing upon release from prison and the imposition of special conditions at the time of arrest based on HIV status (for example segregation and/or denial of the right of access to installations, privileges and parole programs) – are not contemplated in the legislation, and no indication was found that they occur in practice. With regard to compulsory testing upon entering the prison, Article 122 of El Salvador’s Criminal Law states that anyone who is imprisoned must be examined by a doctor. The Criminal Law also states in Chapter 1, Article 88, that the prisoner’s file should include a medical report on the medical condition of the inmate.” No records are kept on HIV tests performed on prisoners. Unofficial sources say the tests are required for prisoners who have conjugal visits.³⁵ Paragraph (a) of Article 13 of the Regulations states that an inmate must have a test to ensure that the health of the visiting party is not endangered. Restrictions in access to care and treatment in the penitentiary system occur in practice, although Article 26 of the HIV/AIDS Law states that people detained or imprisoned by judicial order “have the right to prevention and treatment of HIV/AIDS”. The Criminal Law also requires prisons to provide medical care.

Entrance and or Residency in a Country. There are two possible forms of discrimination in this area. One involves compulsory testing, declaration of test results or certification of HIV negative status as conditions for entrance, residence or freedom of movement in a country. Although by order of the Ministry of Governance this form of discrimination is not currently practiced, Salvadoran law does require HIV testing when a person applies for Salvadoran citizenship. The other form of discrimination is expulsion due to HIV status without appropriate procedures as stipulated in the Immigration Law. The Atlacatl Association presented a brief before the Ministry of Governance, arguing that it would be

³⁴ IBED, UNDP, 2004.

³⁵ Agua Buena NGO reports that there are recent cases in which the HIV test is required for intimate visits.

a violation of the HIV/AIDS Law to require such a test, which led to elimination of the test as a requirement. Nevertheless, it still is within the discretion of the Officials of the Ministry of Governance to require an HIV test, unless Article 38, paragraph 6 of the Immigration Law is modified.

Education. An evaluation of two possible forms of education-related discrimination turned up no judicial-legal instrument for discrimination on the basis of a person's HIV status. Moreover, there was no evidence that segregation occurs in practice. But denial of access to education due to HIV status does, in fact, occur. A Board of Directors' resolution at the School of Dentistry at the University of El Salvador, for instance, denied PLWH access to this area of study due to bio-safety standards. Aspiring residents at the Evangelical University and University of El Salvador medical schools are required to have HIV tests during their residency at the hospitals. This also occurs at the National School of Agriculture.

Family and Reproductive Life. For the four forms of possible discrimination involving family and reproductive life, there is no discrimination from a strictly legal point of view: no law requiring compulsory premarital and prenatal tests, and no requirement compelling women with HIV to have abortions or be sterilized. In practice, however, compulsory premarital testing, compulsory abortion and compulsory sterilization of women with HIV do occur. But there were no indications of compulsory prenatal testing and the withdrawal or modification of conditions for exercising paternal custody, support and rights to inheritance on grounds of HIV status. It has been reported that some evangelical congregations require HIV testing as a condition for performing a religious marriage.³⁶

The Protocol for the Prevention of Mother-to-Child Transmission of HIV (MSPAS) does not stipulate any obligation for sterilization of women with HIV, but an annex mentions "encouraging planning methods" and permitting medical personal, under the guise of encouragement, to obligate infected future fathers and mothers to select permanent planning methods. One case of discrimination in this area has been reported, and is acknowledged by PNS. However, many women who live with HIV have more than one pregnancy and participate in the Vertical Transmission Prevention Program, suggesting that mandatory pressure to submit to family planning is not common practice.

Social Welfare. The laws of El Salvador do not provide for denial or restriction of access to benefits, and no cases appear to have occurred.

Housing. PLWH do face discrimination in home lending, both from private banks and the Social Housing Fund. There are indications that serology tests results or HIV-negative certifications are required as a condition for gaining access to housing. A review of home mortgage credit applications showed that, although HIV tests were not requested, clients were required to sign sworn statements authorizing a review of their medical records. The application form for the Social Fund for Housing, a credit

³⁶ Flores, FUNDASIDA; IBED, UNDP, 2004.

institution whose target population includes public and private employees, did not require an HIV test to be eligible for housing, but an employee said that loan insurance is required as a condition for receiving financing, and will not be approved for a person with HIV. Insurance company forms do include HIV on the list of high-risk diseases that can result in denial of loan insurance.

Insurance and other Financial Services. There are no judicial-legal instruments in Salvadoran law to support any of the three possible forms of discrimination in this field. There were no known incidents involving the denial or restrictions on social security or national insurance due to HIV status. However, as mentioned before, there are bank and insurance company forms and mortgage applications that ask the applicant to make a sworn statement indicating that he or she has not been diagnosed with HIV and authorizing doctors, hospitals, clinics and laboratories to provide information and reports on his or her medical condition to the insurance companies. It was confirmed that such statements are requested in practice.

Response to Arbitrary Discrimination. The Strategic Alliance of the HIV/AIDS Legislation and the National Human Rights Network support legislation and other efforts to fight discrimination and stigmatization. The Alliance's main achievements have been the approval of the HIV Law and its Regulation and the reform of the Work and Criminal Codes. The National Human Rights Network is part of the Regional Human Rights Network. It works for compliance with laws that protect the human rights of PLWH. The *ATLACATL* Association helps PLWH who feel that their rights have been violated, to file complaints. Participants in workshops on the dissemination of successful experiences mentioned other NGOs that participate in the fight against discrimination, including the Salvadoran Network of PLWHA (REDSAL), PREVENSIDA and the NUEVA VIDA Association. Two information and educational campaigns related to the fight against discrimination are the National STD/HIV/AIDS Conference and the PLWHA Conference which takes place each year.

PREVENTION AND CARE FOR VULNERABLE GROUPS

Free HIV testing began in El Salvador in 1997, and involved 132 clinical laboratories belonging to the National PNS Service Network. That year, 77,000 tests were administered. By 2004, the number of annual tests had increased substantially to 198,000. The increase may reflect diagnosis decentralization strategies, the use of quick tests, the establishment of regional laboratories for diagnostic confirmation, and new methods for conducting tests, such as the Mobile Unit Project (mobile units that travel to the main areas where there are vulnerable populations).^{37, 38}

The government has adopted the Abstinence, Fidelity and Condom Use Campaign (ABC), which is financed by the Global Fund grant, as part of the basis for the national response to the epidemic. But some NGOs have suggested that there should be a more

³⁷ PNS HIV/AIDS Epidemiological Bulletin July 2005.

³⁸ See section below on successful interventions in El Salvador.

aggressive campaign directed at vulnerable populations, and that the use of condoms should be emphasized more.³⁹

One effort to address HIV by encouraging sexual and reproductive health in young people was the abstinence campaign “Decide to Wait” in 2003. The campaign promoted abstinence by delaying initiation of sexual relations, and encouraged mutual fidelity. 25,000 adolescents between ages 13 and 15 participated directly, and nearly 140,000 adolescents benefited indirectly by receiving the campaign message through the mass media (press, radio, TV) and promotion, informative and educational materials.

The objective of the CHANGE project (a project aimed at changing behaviors by the Academy for Educational Development/Manoff Group) is to strengthen institutional capacities to foster changes in behavior in order to reduce the transmission of HIV in the Civil National Police, the National Academy for Public Safety, and their families and associates.⁴⁰

Another method of prevention and promotion involves health institutions. During October 2005, the St. Jude Children’s Hospital started implementing the National Plan for HIV/AIDS training, which is directed at health promoters at the different institutions in the country using resources from such sources as MSPAS. More than 2,000 health promoters were trained.

The section below describes a few NGO and public sector experiences in El Salvador (summarized in Annex 4), although there are other relevant ones, such as projects in education (MINED Youth Project), prevention methods (PASMO), prevention projects directed at youth (PNS Group Project: Love, Sex and Values-NSP), and community organizing and political activism (CONASIDA and networks such as Strategic Legislation Alliance).

Atlatl Association

This institution was established in 1997 as a PLWH support group. Since 1999, the organization has offered free legal, advisory and follow up services on a national level for cases involving human rights violations of PLWH. This program contributes to the accomplishment of strategic objectives 7 and 8, which refer to protecting human rights and gender equality in the prevention, care and control of HIV and AIDS, and using the legal system to respond to the needs of people with HIV. Its financial resources come from international cooperation agencies including HIVOS, Global Fund and UNAIDS. The success of the program lies in the fact that its founders were carriers of the virus who wanted to have a voice in society and have their rights respected. Establishment of the organization ended the invisibility of PLWH, and challenged stigmatization and discrimination by showing that people with HIV are productive and can live and face their disease. The principal results and lessons learned are listed below.

³⁹ ATLACTL and Huellas Foundation.

⁴⁰ United States Agency for International Development (USAIDS). HIV/AIDS country synopsis in El Salvador .

Results and Lessons Learned

- National impact on HIV/AIDS legislation, initiative for the preparation of the HIV/AIDS law, and successfully pushed for modifications in the Labor and Criminal Codes.
- Alliances with the Attorney General, Ministry of Labor, Ministry of Public Education.
- Active participation of PLWH in the organization's strategies.
- Helped resolve cases in which PLWH demand access to treatment by the government
- Won free services for PLWH whose human rights had been violated.
 - In 2005, 50 complaints were presented, of which 25 were labor-related, particularly involving firing of PLWH; 20 of these cases were won. The remaining 25 cases dealt with health care; nearly 40% of these cases were won. The organization provided complete legal support, starting with full investigations of the complaints.
 - One of the most publicized cases (and one of the first in El Salvador) was a suit presented by Odir Miranda and four carriers of the virus requesting antiretroviral medication from the State of El Salvador. The testimony stated that Miranda, who was gravely ill but alive thanks to donated medications, filed a complaint in April 1999 against the Social Security administration, saying it did not provide him or hundreds of other seropositive citizens of El Salvador with antiretroviral medication. When the courts of El Salvador did not respond to the complaint in a six-month period, Miranda filed a complaint with the Inter-American Human Rights Commission (IHRC) in Washington, D.C.; a total of 36 people infected with HIV signed the document. The commission declared that the Social Security Administration violated rights protected under Articles 2, 24, 25 and 26 of the American Convention. As a result, the Social Security administration is now obligated to provide ARV drugs to PLWH, a change that has given thousands of people affected with the disease access to medication.

Mobile Population Project

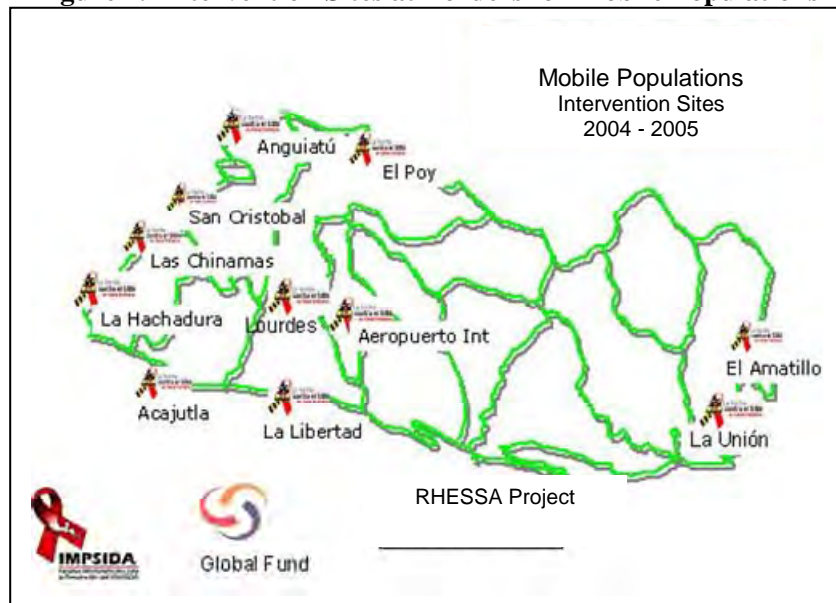
Groups that are part of the mobile population include CSW, MSM, businessmen, military/police, truck drivers and others who travel from one place to another for reasons that are either voluntary or involuntary. This project was initiated in 2001 after a pilot project was carried out along the border in San Cristobal. A guideline for caring for mobile populations was developed, along with pamphlets, posters and other tools designed to transfer knowledge about HIV and AIDS to mobile populations; one of the first brochures targeted truck drivers, and was titled, "The King of the Road and his 18 Dark Beauties" (a reference to the tires of a tractor-trailer). Personnel at health centers along the border and health units in charge of ports and airports in the transit zones of Lourdes Colon also received training in how to provide care for mobile populations. A search was carried out for leaders among the most vulnerable population along the border

zone. Areas most frequented by truck drivers were identified as a potentially critical route for transmission of HIV; restaurants, markets, bars, hotels, bordelos, and other places in this areas were established as points for making presentations on transmission of the virus and the importance of safe sex in order to prevent disease.

Results and Lessons Learned

- The project has established permanent sites at the 11 border points marked in Figure 2. In 2006, two more sites were established.
- Currently six clinics operate at border locations (Anguiatu, San Cristóbal, Las Chinamas, La Tachadura, El Poy and El Amatillo).
- Local access to HIV testing at the health units that use the rapid test contributes to fast diagnosis; results are now available in one day or less, compared to two weeks previously. Efforts are being made to establish a mobile laboratory.
- Customs administrators and border police have access to condoms.
- The mobile population is generally receptive and interested in the subject.
- CSW are reached by locating a leader, who then helps assemble other CSW in the same geographic area for talks or workshops.
- Trans-border committees against AIDS (COINSIDA) have been established.
- The Ministry of Health has raised the awareness and empowered health personnel with regard to mobile populations.
- Neighboring countries are expected to replicate the experience in order to improve the response to the problem in border areas.

Figure 2. Intervention Sites at Borders for Mobile Populations



Source: PNS 2006

Achievements for the period October 2004 to October 2005 are as follows:

- 855 IEC interventions with CSW; 1,698 with drivers; and 40,192 with younger people, workers, students, women and other populations at risk close to the border. 371 radio transmissions, written articles and television spots were executed. 66,400 educational materials were distributed. 610 focus groups and 110 workshops have been organized.
- 460 counseling sessions were provided to drivers, 483 to people at airports, 461 to CSW and 2,032 to businessmen.
- About 60,000 condoms were available, of which 47,289 were distributed.
- 6,379 HIV tests were administered, and 2,803 results were delivered. Of these, 45 were positive and 20 cases were referred to a health center.
- 1,165 health workers were trained in HIV and mobile populations. No additional health workers were trained to provide counseling.
- The community network was strengthened. Training was provided to 505 leaders and 175 adolescent couples who are not in school. In addition, 359 social mobilization activities took place.

Mobile Clinics for HIV Testing

Two Mobile Units for HIV testing were established in 2005, at a cost of \$250,000. These units are part of the 150 health centers of the Ministry of Health, and travel throughout El Salvador to offer free HIV testing. The PEN contemplates universal access to HIV testing. To strengthen HIV/AIDS epidemiological surveillance, this project provides access to at-risk populations who do not have laboratory services in their areas or do not visit facilities in their own areas for fear of being stigmatized. The units are unique in Latin America, and short term results are already apparent. Each unit is operated by a team of one clinical laboratory professional, a medical advisor and a driver. The units performed 630 tests in December 2005, and 17 were positive. In January and February 2006, they performed 1,177 tests, and 11 were positive. People who were tested were in the 16-to-42 year age group. The male/female ratio of those tested was 1.3-to-1, and 15% were PLWH. In the future, these units will also visit penitentiaries and universities, and will contribute to strengthening the coverage of commercial sex workers and mobile populations.

Program for Preventing Maternal-Infant Transmission (PTMI)

Strategic objective 2 of the PEN 2005-2010 regarding increasing integrated care services and prevention of HIV and other STIs in El Salvador calls for actions to reduce vertical transmission. The Program for Preventing Mother-to-Infant Transmission was developed by the Ministry of Public Health and Social Assistance through the PNS in rural and urban areas of El Salvador to minimize the risk of exposure and transmission of HIV at the different stages of the female reproductive cycle – pregnancy, birth and breastfeeding.

Epidemiological data show that 7% of HIV cases result from vertical transmission, but that the incidence rate in this population has declined. This shows that the PTMI is making a positive difference.

The Program has made significant efforts to prevent mother-to-child transmission, and aims to ensure that 95% of pregnant women register for integrated prenatal care. Women who register receive information, counseling and voluntary HIV tests. Those infected with HIV received treatment for reducing HIV transmission, as well as infant formula and antiretroviral treatment. However, access by pregnant women to prenatal care and institutional childbirth is still a great challenge.

The specific objectives and goals of the program are presented below.

Primary Prevention Prevention of mother-to-child transmission of HIV.	Goals Progressive screening of all pregnant women: 50% the first year, 75% the second and 95% the third year.
Secondary Prevention Prevention of MCT in future infected parents, and the infected pregnant woman to the child.	Reduce MCT from the expected 35% to 15% in the first year ultimately to 3% in the third year.
Management Area Achieve efficiency and effectiveness of MCT management.	The MCT Program is managed strategically and under strict epidemiological surveillance in each institution and at each level.

The following are some of the main principles in the project:

- The PTMI focus is on integrated care;
- Participation of health personnel in planning, epidemiological surveillance and evaluation of PTMI so that actions are accepted and motivation and effectiveness are increased;
- Community participation in planning and implementation;
- Education and promotion of safe and responsible sexual practices.

In 2002, a baseline study was carried out to determine the current situation at 57 health centers in 14 regions throughout the country.⁴¹ Testing is currently offered to all pregnant women in all healthcare centers and 10 hospitals where integrated care is offered. Since 1999, the National Maternity Hospital “Raúl Arguello Escolán” has been the national reference hospital for all pregnant women who are HIV positive, and the National Children’s Hospital “Benjamin Bloom” cares for children with HIV. Training was also provided at all MSPAS operating levels, and an intensive educational media campaign was launched.

The project began with a diagnostic or baseline of the target population; subsequently, communication strategies, as well as guidelines for supporting health personnel and training, were designed. Finally, ARVs were purchased and distributed, HIV tests

⁴¹ Martínez A 2002. Baseline study for extending the Program for Preventing Mother-to-Child HIV Transmission (TMI) in health centers offering the three levels of care. UNICEF and MSPAS El Salvador.

performed and formula distributed. Alliances were made with key organizations in order to locate pregnant women who were outside the health system and develop new ways of bringing them into the system. The following are the main program activities:

- Research on the knowledge and attitudes of pregnant women, their partners and health personnel about HIV
- Elaboration of a baseline for extending PTMI
- Preparation of Guidelines on Prevention of Mother-to-Child Transmission of HIV
- Purchase and distribution of antiretroviral drugs and HIV detection tests
- Purchase and distribution of a one year supply of baby formula for HIV-positive infants
- Free HIV testing for pregnant women throughout the country
- Delivery of baby clothing to encourage pregnant women to have the voluntary HIV test
- Decentralization of the PTMI to 13 maternal wards at a national level
- The design of a communication strategy, including mass media campaign on the voluntary test for HIV
- Training of medical personnel, paramedics and midwives.

Results and Lessons Learned.

- As Graph 3 (above) shows, the decrease in cases of vertical transmission and HIV infection in children younger than one year demonstrate the effectiveness of the initiative for Preventing Maternal-Infant Transmission of HIV. While 129 children were diagnosed in 2003, 20 children were diagnosed with the infection in 2004 and only seven in 2005.
- Free HIV testing is now provided for all pregnant women in the country.
- 2,000 pregnant women in youth clubs were informed about preventing MCT.
- Between August 2003 and July 2004, 215 pregnant women living with HIV initiated antiretroviral therapy. All pregnant women who had positive HIV test results were referred to hospitals that provide ART. In most cases, referral occurred seven days after the test results were reported.
- The referral of women living with HIV after giving birth was adequately done.
- Children with perinatal exposure to HIV were treated at the Benjamin Bloom Children's Hospital.
- 100% of health institutions had the reagent necessary for HIV testing, complied with the protocol for confirmation of cases, had personnel trained in the Guidelines for Prevention of Maternal-Infant Transmission of HIV, and provided HIV/AIDS consulting services.

- 16 decentralized hospitals provide antiretroviral treatment in the country, 13 to pregnant women.
- 1,250 medical personnel and paramedics were trained in the Guidelines
- 2,200 authorized midwives were trained in PTMI, and timely referrals were made for pregnant women to take the voluntary HIV test.

Future Plans and Priorities. The hours scheduled for HIV testing of pregnant women should be extended in health units. The Program wants to offer increased methods for family planning for women living with HIV who are not pregnant and who are of reproductive age, as a strategy for secondary prevention of maternal-infant transmission of HIV; continue awareness programs concerning HIV and AIDS for personnel at the three levels of care so they will give quality care and respect the human rights of pregnant women living with HIV; and ensure sustainability of universal access to HIV testing and antiretroviral therapy.

Theater Experiences

Huellas Foundation: Project La Muerte Afuera (Death Be Gone)

The Huellas Foundation was established in 1998, and its main objective is to prevent HIV in young people subject to commercial sexual exploitation. This NGO also works to benefit PLWH in urban and rural parts of El Salvador, as well as to organize and strengthen other civil organizations. Preventive measures such as those carried out by this NGO are an important part of the National Strategic Plan. Strategy 4 emphasizes the need for Information, Education and Communication. Its funding comes from grants; in particular, \$45,000 from the Global Fund.

The Project La Muerte Afuera is a musical theater production that deals with the situation faced by people living with HIV in today's society and people who are vulnerable to the epidemic. The project seeks to incorporate innovative strategies for preventing HIV in at-risk populations. Since the epidemic is concentrated among young people, reaching this population group in an innovative manner based on their tastes in music helps motivate them and helps them better understand the information that is being transmitted. The idea of raising awareness and informing the public in an interactive manner – through a musical theater production – had not been tried before in El Salvador. The project began in November 2004 and ended on May 5, 2005, when Global Fund funding ended.

The main target populations were adolescents and children belonging to 60 communal organizations, parishes and educational centers in San Salvador, La Libertad and Sonsonate. Other target groups comprised PLWH, commercial sex workers, men who have sex with men, migrant groups in affected regions, armed forces (military and police), orphans, commercial agents and religious seminarians. Initially it was directed towards the three regions with greatest HIV prevalence (San Salvador, La Libertad and Sonsonate). The play was presented at different locations organized by diverse public and

private institutions. To evaluate audiences, Huellas Foundation handed out entrance tests that determined what the public knew. After a play ended, a panel of PLWH and the Foundation's physician took questions. Finally, an exit test was given out, along with an evaluation sheet of the event, to a sample group.

Results and Lessons Learned

- 9,600 youngsters became aware of their vulnerability to the disease through the play, which was performed in public and private schools. They were also informed about HIV prevention in a forum held after each presentation.
- The project encouraged the establishment of theater groups for young people in San Salvador, La Libertad and Sonsonate to deal with different social problems. A variety of local organizations including mayors' offices, community leaders, religious organizations and educational centers joined the initiative.
- There were 37 presentations throughout the project (22 in San Salvador, seven in La Libertad and eight in Sonsonate). There were 13 presentations during the project extension (six in San Salvador, four in Santa Ana and three in Sonsonate). Of the 50 presentations made during the seven months of the project, 30% were hosted by NGOs, 24% by MSPAS, 19% by the Ministry of Education and 13% by private high schools and the rest by the University and faith-based organizations. To date, 96 additional performances have been requested and are still pending. Funding is not sufficient to comply with all the requests.
- The Foundation learned that prevention efforts should be innovative and should give young people the opportunity to work as a team.

Zacamil National Hospital PLWHA Support Group: Ray of Light Project

The Ray of Light project is another theater performance. Zacamil National Hospital, which operates in the urban region of El Salvador, is one of 16 hospitals that provide antiretroviral treatment to people with AIDS. A support group emerged at the facility to provide support to PLWHA and their families. Members meet once a week to exchange experiences. The play deals with the experiences of people at different stages of living with HIV: at the beginning and then one year, two years and five years later. During the performance, the actors call for prevention and emphasize that having AIDS does not mean death, noting that they are HIV-positive professionals who can continue living with the disease. All participants work as volunteers. The play helps achieve strategy 4, which calls for reaching out to the general population and people who are at risk, using different forms of art. It has reached 700 PLWH.

Basic Food Basket Project for Inclusion of ART in People Who Live with HIV/AIDS in the MSPAS Network

Recent studies have demonstrated that macro- and micronutrient deficiencies contribute to dysfunction of the immune system, while good nutrition supports adherence to

antiretroviral therapy and contributes to better health outcomes for PLWH. The basic food basket project was built on this basis. It provides basic food baskets that meet the minimum daily caloric requirements (2,000 Kcal/day) to infected people who receive integrated care including ART, at public facilities. The objective is to strengthen their adherence to treatment and enhance their quality of life by improving their nutrition level. The project includes a monitoring and evaluation system to ensure that all PLWH who need the incentive for adherence to ART have access to it, and that the beneficiaries' nutrition level improves. The baskets are provided as individual baskets for adults and pregnant women, or family baskets if there are more than two PLWH.

PEN calls for holistic care for people receiving ART. The validity of this concept is supported by the fact that the food subsidy has strengthened adherence to the treatment and improved beneficiaries' general health. The Ministry of Health carries out the program in coordination with the National STIs and HIV/AIDS Program. The Global Fund provides financial support. The project began in July 2005, with Benjamin Bloom National Hospital giving beneficiaries certificates for family baskets and the National HIV/AIDS Program giving certificates for individual baskets. Initially, 2,000 certificates for individual baskets were distributed based on applications sent by multidisciplinary teams at hospitals that provide holistic care.

The people who benefit from the basic food basket must fit the following profiles:

Adults

- Have HIV and receive care at hospitals in the El Salvador Public Service Network, where the care of PLWH has been decentralized.
- Follow the holistic care program (be on time for appointments) and participate in a support group.
- Have $BMI \leq 18$ or loss of muscular mass of 5%.
- Be from families with monthly income less than the minimum urban salary (\$5.25 a day) based on a socioeconomic assessment by the social work department.
- Receive ART at health services and follow the program.

Children

- Have HIV and receive care at the Benjamin Bloom National Children's Hospital and referral hospitals.
- Follow the holistic care program (be on time for appointments) and participate in the support and nutrition group.
- Be from families with income less than the minimum urban salary (\$5.25 a day) based on a socioeconomic assessment by social work department.
- Receive follow up or permanent ART.
- Be from families with two or more members affected by HIV. In these cases families can receive the family basket rather than the basic basket.

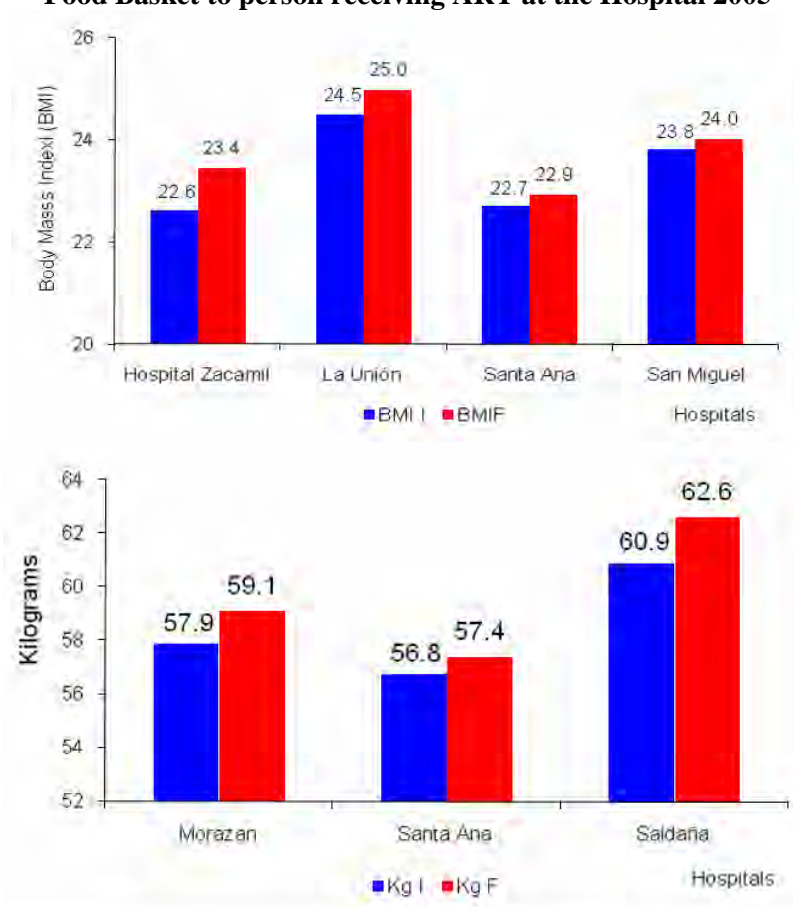
Results and Lessons Learned

- Between July and December 2005, more than 700 PLWH received 9,000 food baskets at a cost of more than \$120,000. The number of beneficiaries is greater in

hospitals that are in the departments most affected by HIV. There are currently beneficiaries at all 16 hospitals.

- Beneficiaries come more often for medications. Before, they would not take their medication because they had no food.
- As Graph 4 shows, average body mass of participants increased.

Graph 4. Average BMI and Kg in the Initial and Final Phase with Delivery of the Basic Food Basket to person receiving ART at the Hospital 2005



Source: PNS - Basic Food Basket Project 2006

Future Plans and Priorities. This project faces an important challenge with regard to sustainability. The feminization of the epidemic and its relationship to poverty require integrated responses. But the Food Basket Project is mostly palliative and short-term in nature. It must be reinforced with long term sustainable actions such as the creation of a labor exchange, work related education and professional training for people with HIV.

TREATMENT

In 2001, 73 people received antiretroviral treatment (ART); by 2005, the number was 3,049, including 814 treated at the Salvadoran Social Security Institute (ISSS). The availability of integrated care and “universal” access to ART, supported by services

offered at 16 health and care institutions for all citizens of El Salvador diagnosed with HIV, represents one of the greatest achievements of the PNS. However, many NGOs argue that access is not really universal; the ISSS has presented cases of people who do not receive treatment, mainly because of stock depletions as well as inadequate follow-up care mechanisms. Nevertheless, MSPAS and PNS have made great efforts in this area, and the challenge they now face is to address cultural opposition to testing and treatment.⁴²

With the introduction of antiretrovirals worldwide, PLWH filed a series of lawsuits that pressed the state to provide ARVs to all Salvadorans who needed them. Before 2000, people who required treatment had to turn to the private sector or go abroad. El Salvador has been providing antiretroviral treatment since 2000, first through the Salvadoran Institute of Social Security and since 2001 through the Ministry of Public Health and Social Welfare. Between 2001 and 2005, the MSPAS started to decentralize antiretroviral treatment in the country, increasing the number of hospitals that provided it from four to 16. The decentralization of ART led to an expansion in coverage in less than five years from four hospitals to 16 hospitals, and from 73 to 3,049 people.⁴³

In 2001, ARV treatment cost \$10,000 a year, but in 2005 the average cost was \$1,500. This reduction has been achieved by negotiation with the pharmaceutical companies. Negotiations in 2003 among the Central American countries and pharmaceutical companies reduced prices of ARVs by 55%. The current sources of finance for ARVs include funds from the Ministry of Health, the El Salvador Social Security Office and the Global Fund. In 2004, the Government and the Global Fund each spent \$2.4 million. In 2005, the government again spent \$2.4 million, while the Global Fund decreased its contribution to \$1.2 million. In 2006, the government spent another \$2.4 million, and the Global Fund spent \$0.5 million.⁴⁴

The greatest national challenge in the medium term is to be able to obtain adequate supplies, particularly of antiretrovirals and reagents, in the face of high prices. Laboratory tests are also needed for follow-up to treatment. While the financial capacity exists to acquire test kits, supplies occasionally become depleted for reasons ranging from inadequate management of medications and other supplies to worldwide shortages.

Regulation. The Superior Council for Public Health (Consejo Superior de Salud Pública - CSSP) is the state regulatory agency for the health sector. It can audit the operations of health institutions and monitor and control the chemical and pharmaceutical industries so that they provide their services in a transparent and integrated manner and respect fundamental rights. The council oversees health establishments and drugs. It also monitors health professionals to guarantee that the public receives timely service and that pharmaceutical products are provided according to established regulations. In addition, it

⁴² Although many PLWHA only visit hospitals and clinics when they are in the most advanced states of AIDS, visits to two sites showed that some were diagnosed months before and were treated for opportunistic infections but had never received ART.

⁴³ National Review: Universal Access to Prevention, Treatment and Care for HIV/AIDS. PNS 2006.

⁴⁴ Idem.

monitors manufacturing practices in the pharmaceutical industry to ensure that drugs provided to El Salvador's population are of the best quality.⁴⁵

The MSPAS Regulations for specialized pharmaceutical products expressly prohibit the sale of these products without authorization by the council and inscription in the respective registers. Importation, sale and advertising of specialized pharmaceutical products produced overseas are only allowed if the country of origin permits their use, and if they comply with all other regulatory requirements. Sale and advertising of specialized medications produced in the country are only permitted if they are manufactured by laboratories registered with the Superior Council for Public Health. Article 6 indicates that every person who wishes to manufacture, import, sell or advertise any specialized pharmaceutical product must apply for authorization from the Superior Council for Public Health, which in turn must seek the advice of the Monitoring Board before granting authorization.

An application made by a pharmaceutical company located in a foreign country must include a duly authenticated certificate issued by a competent authority of the Department of Health or other authority stating that it has the authority to authorize use of the product in that country. If the product comes from a federated state, the certificate must be issued by the relevant federal authority. This document must certify that the product is sold and used without restriction in the country of origin.

Once the applicant has fulfilled all the requirements stipulated in the Articles above, the Council sends two samples of the product for analysis to the Pharmaceutical Profession Surveillance Board, which must report results within 15 days of the date the samples were received. The Surveillance Board can drop the requirement of a certificate from the foreign authority, and instead send the samples to a national or foreign laboratory for analysis. If the composition of the product is found to be consistent with the formula provided by the applicant, the Council will ask the Medical Profession Surveillance Board to confirm the therapeutic qualities attributed to the product.

Once registration requirements are met, the Council will authorize the manufacture and/or import, sale and advertising of the product. And once the permit is obtained, the product presentation must be in a package or container with the words "Registered with the Superior Council for Public Health, under N° - Republic of El Salvador, C. A." clearly visible on it. Also, the following must be clearly visible:

- a) Whether it is an over-the-counter product or requires medical prescription
- b) If it is for external or internal use
- c) Its expiration date
- d) The name of the manufacturer, and place and country of origin of the product.

Procurement. There are two methods of purchasing ARV medications in the country. MSPAS buys them directly through a public bidding process that takes approximately three months. A committee that includes the PNS and other authorities responsible for ARV medications makes specifications and chooses the winning product based on price

⁴⁵ CSSP Website: <http://www.cssp.gob.sv>

and quality. The other method is to purchase ARVs through the UNDP. During 2003, the Global Fund paid for the purchase of ARVs from abroad.

The MSPAS official Drug List includes 28 antiretroviral drugs, including 12 of the 22 drugs approved by international regulatory agencies. Antiretroviral medications are manufactured by international pharmaceutical companies. Some manufacturers (Glaxo-Smith Kline and Merck Sharp & Dohme) have distributors in the country, while others (Roche, Abbott Laboratories, Bristol Myers Squibb and Boehringer Ingelheim) have headquarters for local sales. Because the products of these companies are protected by the Patent Law, there are impediments to the purchase of generics by the MSPAS.⁴⁶ Purchases made abroad must be executed through local representatives.

There is no national production of generic medications. In contrast to the rest of the Central American countries, in El Salvador generics are only purchased by the private sector. The availability of generic ARVs is subject to the expiration of patents and obligation under CAFTA, registration of foreign-patented or foreign-registered drugs, or enactment of emergency legislation. It is the responsibility of the government to apply the exception guidelines of the WHO regarding medications in the event of national emergencies.

During the early years when medications were purchased on the national market, stocks sometimes were depleted due to delays in delivery by some pharmaceutical companies. Even today, the MSPAS and ISSS separately buy medication on the national market, even though the Global Fund finances generic medication at a much lower price through the UNDP.

One significant event that affected the availability of antiretroviral drugs occurred in 2004. As described in the Closing Report of the epidemiological monitoring system dated October 2004, “...in the last six months a significant shortage of supplies occurred which interrupted the delivery of ART particularly to the patients of the ISSS. The causes of this shortage were associated with planning on the one hand and the limited production available in the market. The MSPAS managed to obtain medication donations from the STD/HIV/AIDS Program of the Brazilian Government and the Costa Rican Social Security Office.”⁴⁷ The report stated that the PNS had subsequently made plans to reduce the possibilities of a future shortage of supplies. Now, of the \$6 million in Global Fund resources assigned to the country for 2005-2007, 35% is designated for financing the purchase of antiretroviral medicines.

Projections of the amount of ARVs to be purchased are based on estimates that include the diagnosis of new HIV cases over the last four years and of AIDS patients who are under medical care. In all, eight instruments comprise the system for making projections. Each hospital keeps a record of the medical statistics, and information on epidemiological surveillance as well as the monitoring system for mortality. After a one-year supply of

⁴⁶ However, not all ARVs are patented.

⁴⁷ Final Report of the Epidemiological Surveillance System, El Salvador. CDC/GAP, Pgs. 36 and 37

drugs is requested through a public bidding process based on the country's annual budget, the companies awarded contracts are asked to supply the amounts requested.

Purchased medications are stored at MSPAS, in a special warehouse for ARVs that is anti-seismic and has an electric generator and a refrigeration system. ARVs are distributed to hospitals every three months based on client demand. Currently a Logistics System for Antiretrovirals (SICLON) from Brazil is being prepared to improve the handling of ARVs in El Salvador.

ART Guidelines. Drugs are distributed to 16 health care institutions that provide ART in the country, including one institution that cares for pregnant women and children. Some 80% of ART is performed at MSPAS hospitals, and the remaining 20% is done by the IGSS. Information available suggests that practically all private sector patients are remitted to the public sector.

The use of ARV medications is guided by the Protocol for Care for people who live with HIV/AIDS (November 2005), with the support of a multidisciplinary team. The protocol, which was prepared by the PNS with the support of the National Technical HIV/AIDS Committee, covers ART for adults, pregnant women and children. It also includes a chapter on bio-security regulations that covers methods for personal protection, hospital care, and post-infection prophylaxis in health workers. An annex to the protocol includes guidelines for managing tuberculosis in adults with HIV.

The initial protocol for ART in adults recommends the following combination: Indinavir, Efavirenz and Nevirapine. Some of these may be combined with Zidovudine + Lamivudine. In addition, Stavudine (d4T) may be considered if a rescue therapy treatment is needed, provided the patient does not have anemia due to AZT or other contraindications. Furthermore, ddI should be administered as another rescue treatment in the event of adverse effects or therapeutic failures of other antiretrovirals.⁴⁸

With respect to HIV positive pregnant women, the protocol states that the decision about the ARV drug regimen will depend on the clinical, immunological, and viral state of the maternal disease at the stage of pregnancy when the diagnosis is made, whether ART was initiated prior to pregnancy, the presence of complications such as opportunistic infections or adverse reactions to medication as well as suspicion of pre-established viral resistance. If an HIV-positive mother has had prior ARV treatment, the protocol recommends considering discontinuing ART during the first trimester and changing from EFV to NVP or IP. For the newborn, ZDV and a single dose of NVP are recommended based on the viral load of the mother. If the mother had no previous exposure to ARV, she will require ARV treatment in order to live longer. The initial treatment for her will be the same as for any adult, with the exception of EFV. The suggested scheme for first-line treatment is ZDV+3TC+NVP or D4T+ 3TC+NVP. ZDV is recommended for the newborn with or without a single dose of NVP. If the mother was not previously exposed to ARVs and does not require treatment, ZDV is recommended for her at week 14 or 28, and EV during childbirth and/or NVP four hours before childbirth, while ZDV is

⁴⁸ National Review: Universal Access to Prevention, Treatment and Care for HIV/AIDS. PNS 2006.

indicated for the newborn for six weeks after the first eight hours of life and/or a single dose of NVP.

Regarding children, recommendations are made based on their particular conditions, and include two Nucleoside Reverse Transcriptase Inhibitors (NRTI), plus Nevirapine or Efavirenz, NFV or RTV, or Lopinavir-Ritonavir. The NRTI are AZT and 3TC.

The country is currently reducing the number of treatment schemes handled by the PNS. It has been estimated that this treatment harmonization will save about \$500,000.⁴⁹

⁴⁹ Interview with UNAIDS representative, 2006.

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ANNEX 1. FORM FOR EVALUATING DISCRIMINATION

Questions about 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 Discrimination

- 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 2. FORM FOR SELECTING SUCCESSFUL INTERVENTIONS

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

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

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

ANNEX 3. ARBITRARY DISCRIMINATION IN EL SALVADOR 2006

Area	Finding	Facts/Evidence
Healthcare		
Denial of treatment due to HIV status	Has occurred in practice	Testimony from PLWH
Differential treatment due to HIV status.	Has occurred in practice	Testimonies from PLWH, denouncements, complaints and interviews with NGO directors and leaders.
HIV tests done without the person's prior knowledge.	Although the law states that it should not occur, it has occurred in practice	Statements by NGOs and company employees
Lack of confidentiality: informing others of the names of people who have tested HIV positive or allowing, either in a conscious or negligent manner, that confidential records be checked.	Has occurred in practice	Occurs in the health sector, mainly among the nurses, health promoters and laboratory personnel
Employment		
Compulsory testing as a condition for being hired.	Has occurred in practice	Although there is no evidence for discrimination, members of the Strategic Legislation Alliance have commented that if a person is HIV positive, he or she most likely will not be hired.
Compulsory testing while performing a job.	Allowed by law and occurred in practice	Internal work regulation
Lack of confidentiality concerning HIV/AIDS status.	Has occurred in practice	NGO testimony
Firing of an employee or changing the employment conditions of an employee due to HIV status.	Has occurred in practice	Evidence is based on testimony and complaints.
Restrictions due to HIV status (for example, elevators, work location).	Has occurred in practice	
Denial of employment due to the HIV status of the applicant.	Has occurred in practice	

Area	Finding	Facts/Evidence
Judicial/Legal Processes		
Punishment of criminal behaviors thought to spread HIV (such as prostitution or men having sex with other men).		No evidence was found of punishment or sanctions by administration due to this behavior
Prison Management		
Compulsory testing for prison inmates upon entrance.	The law does not state that testing is compulsory. This occurred in practice during a personal visit.	Article 112 of the Criminal Law says: “any person indicted or condemned upon entering the prison must be examined by the doctor...”
Restrictions in accessing care and treatment	Has occurred in practice, even though the Law states that medical assistance must be provided	PLWHA Testimony
Entering and/or residing in a country		
Compulsory tests, requirement to declare one’s serological status or present a certificate of HIV-negative status as a condition for entry, residency or traveling in a country.	Stipulated by the Immigration Law, but a directive from the Ministry of the Government prohibits it in practice	PNS argues that various tests are required other than the HIV test
Expulsion from a country without proper procedures due to HIV/AIDS status.	Stipulated by the Immigration Law but does not occur in practice	
Housing		
Compulsory tests, requirement to state the serological status or present a certificate of HIV negative status as a condition for accessing housing or living in a dwelling.	Some indications presented	In bank and insurance forms, the client is required to sign an affidavit in which he grants an authorization for his/her medical records to be reviewed. If a high risk disease is found, access to credit is denied.
Education		
Access to education denied due to HIV status.	Has occurred in practice	In high school

Area	Finding	Facts/Evidence
Family and Reproductive Life		
Compulsory pre-matrimonial tests	Not in the law but has occurred in practice	Some evangelical congregations require the AIDS test
Compulsory Abortion/sterilization of women with HIV/AIDS.	Not in law but has occurred in practice	Testimony from a woman who was obliged to be sterilized
Insurance and Other Financial Services		
Denial or restrictions on insurance (life insurance, for instance) due to HIV status or belonging to a group considered to be at high risk for HIV	Has occurred in practice	Evidence was found in a series of bank and insurance application forms.
Denial or restrictions on access to credit (for example, mortgages) due to HIV status or belonging to a group considered to be at high risk for HIV	Has occurred in practice	On credit request forms, the applicant is asked to present an affidavit stating that he or she has not been diagnosed with HIV

ANNEX 4. SUMMARY OF SUCCESSFUL HIV/AIDS EXPERIENCES IN EL SALVADOR 2006

Institution	Project	Initiated	Direction	Population Benefited	Zone
ATLACTL Association	Defense of Human Rights of PLWHA	1997	Human Rights	PLWHA	Urban and rural
Huellas Foundation	Musical theatre production "Death Be Gone" ("La Muerte Afuera")	2005	Prevention	Youth and general population, students, workers and health professionals	Urban and rural
Zacamil National Hospital	Rayo de Luz en la Vida	2005	Prevention	PLWHA and their families, health personnel and the general population	Urban and rural
National STIs and HIV/AIDS Program	Mobile populations	2002	Prevention	Mobile populations and CSW as well as other vulnerable border populations	Urban and rural
National STIs and HIV/AIDS Program	Project for preventing mother-to-child transmission of HIV/AIDS	2003	Prevention	Pregnant women who are HIV positive and their babies	Urban and rural
National STIs and HIV/AIDS Program	Mobile HIV Units	2005	Prevention and Assistance	Vulnerable groups	Urban and rural
National STIs and HIV/AIDS Program	Basic Food Basket Project	2005	Treatment and Assistance	PLWHA on ART	Urban and rural



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